SCA - Provider

XYZ PACKAGE

UNIFORM RATE SETTING PACKET

FISCAL YEAR 2024-2025

# Providers must use the forms and package currently posted on the PACDAA website. Earlier versions of these forms will not be accepted.

TIMELINE for 2024-2025

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| --- | --- |
| November 1st | Provider audits due to SCAs, unless otherwise specified in the DDAP/SCA Grant Agreement |
| By or before March 1nd | Providers submit the completed XYZ package to the SCA |
| By or before April 15th | SCAs respond to providers with the approved rates |
| Between April 15th – April 30th | Provider appeals are submitted to the SCA |
| April 30th – May 15th | Appeals that are unable to be resolved at the SCA level are submitted to DDAP |
| By or before June 3st | SCA posts rates to PACDAA’s webpage |

Provider appeals to the decision made for the Fiscal Year 2024-2025 rate request must be made in writing to the home SCA. Requests must include the information or facts that support the appeal.

No less than three SCAs, one of which must be the home SCA, must be involved in the rate setting review process. At a minimum, the SCA Administrator and Fiscal Officer from each SCA must participate in the review of the XYZ package submitted by providers. An SCA employee with a comprehensive understanding of the programmatic aspects of treatment must participate in the review. This SCA committee may ask to meet with the provider staff to clarify answers submitted in the rate setting package.

All rates must be entered onto the PACDAA website ([www.pacdaa.org](http://www.pacdaa.org)) Rate Setting Section by the home SCAs on or before **June 3, 2024.**

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| --- | --- | --- |
| **Program/Service:** |  |  |
| **Agency:** |  |  |
| **Address:** |  |  |
| **Facility License #:** |  |  |
| **Contract Contact Person:** |  |  |
| **Phone Number:** |  |  |
| **Email Address:** |  |  |

**FY 2024-2025 Rate Setting Appeal Process**

**Treatment Provider Appeal Process:**

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| --- | --- |
| **Appeal Action** | **Appeal Committee:** |
| **Level 1 Appeal:** If a treatment provider is unsatisfied with the results of the negotiation process or the rate being offered by the Single County Authority (SCA), that provider may appeal in writing to the SCA for reconsideration. | * SCA * SCAs from surrounding areas |
| **Level 2 Appeal:** If a provider is dissatisfied with the results of the Level 1 appeal, that provider may appeal in writing to DDAP for reconsideration. All relevant documentation and correspondence (see below) must be included in the submission and can be sent to [RA-DABAPS@pa.gov](mailto:RA-DABAPS@pa.gov). | * DDAP Deputy Secretary * DDAP Bureau Director, Quality Assurance and Administration * DDAP County Program Oversight (optional) * Input may be requested of SCAs or additional stakeholders as needed by DDAP |

**Single County Authority Appeal Process:**

|  |  |
| --- | --- |
| **Appeal Action** | **Appeal Committee:** |
| If an agreement cannot be reached between an SCA and a provider regarding a non-hospital inpatient rate, the SCA may make a written request for final determination from DDAP. All relevant documentation and correspondence (see below) must be included in the submission and can be sent to [RA-DABAPS@pa.gov](mailto:RA-DABAPS@pa.gov). | * DDAP Deputy Secretary * DDAP Bureau Director, Quality Assurance and Administration * DDAP County Program Oversight (optional) * Input may be requested of SCAs or additional stakeholders as needed by DDAP |

**Documentation:** Documentation for consideration of an appeal to a disputed rate must include all materials submitted to the SCA review committee, including the XYZ Packet. All correspondence between the SCA review committee and the provider, related to the Level 1 Appeal to the SCA appeal committee, must also be provided. Finally, providers may submit any additional materials, such as financial documents that will further substantiate their request for a rate different from that offered by the SCA review committee.

SCAs submitting an appeal to DDAP must provide justification for the non-acceptance of a rate or rates submitted by a provider.

# FISCAL YEAR 2024-2025

# RESIDENTIAL SERVICES REQUEST FOR INFORMATION CHECKLIST

In order to be considered for a per diem rate with the SCAs, please complete all referenced documents on this RFI Checklist and submit to the home SCA of this facility.

**Section A - Eligibility Criteria Checklist**

* Submit a copy of the current Department of Drug and Alcohol Programs (DDAP) or home state license. (If you do not yet have a current license, please request a letter confirming licensure from the Division of Drug and Alcohol Licensing.)
* If your program is licensed as a dually diagnosed facility, submit a copy of the current Department of Human Services (DHS) license.
* Submit a copy of the most recent year’s independent audit report and management letter. The audit shall include supplemental schedules of revenues and expenditures by facility by level of care.
* Submit documentation of sixty (60) day cash operating capability (i.e., letter of credit, documentation of other revenue source).
* Submit a notarized statement indicating there is no evidence of civil or criminal violations against the management or any employee of the licensed facility during the previous two years, and adherence to one of the industry’s recognized code of ethics (e.g. PCACB). If a notarized statement is not included with the eligibility checklist, please explain the nature of any confirmed ethical or criminal violations against any facility staff within the previous two years.
* Submit a program Organizational Chart
* Tax/Compensation Attestation Form (Attached)
* Submit Act 33 and Act 34 Compliance Certification (Attached) - Provide a certification that your agency, if treating adolescents, is in compliance with Act 33-1985 amending the Child Protective Services Law and Act 34.
* Complete Section B (Program Description General Information) attached.
* Complete Section C (Program Description Specific Information for **Each** service activity) attached.
* Complete Per Diem Rate Determination Process for **Each** Service Modality/Activity by completing and submitting the following forms for each Activity:

1. Personnel Roster - HDA 313RS (Accompanying Excel Workbook)
2. HDA 311RS – Page 1 (Revenues) & Page 2 (Expenses) (Accompanying Excel Workbook)
3. Budget Narrative (Attached)
4. Rate Request Form (Attached)

**Tax/Compensation Attestation**

This is to certify that\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

has paid corporate, federal, and state income taxes (if applicable); paid the employers share of and has withheld the correct amount of income taxes, F.I.C.A. taxes, and unemployment compensation and workmen’s compensation taxes or premiums from employees’ salaries as required by law, and has remitted such amounts to the appropriate federal, state, and local level of government.

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Date Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title

**Act 33 and Act 34 Compliance Certification**

This is to certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

is aware of and is in compliance with the obligations of Act 33 of 1985 (Child Protective Services Law) and Act 34 (Pro Children’s Act of 1994 for program serving minors).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title

# 

**Section B - Program Description General Information**

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| --- | --- |
| **Agency Name:** |  |
| **Activity:** |  |

**Provide a brief description of provider’s target population and program description**

1. Please provide the demographics of your population served within the last six-month period, including **race**, **ethnicity**, **gender**, **age** and **pregnant women**.

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| --- | --- |
|  |  |

1. Document staff composition as it compares to the population your program serves. Please break out clinical staff (including nurses and medical staff) from administrative staff.

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| --- | --- |
| **2.** |  |

1. Submit evidence, in the form of a statement to this fact, of persons in recovery representing your governing or advisory board. Describe the number and composition of your agency’s governing or advisory board. (Persons in recovery representation is defined as an individual with a prior history of drug or alcohol dependency.)

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| --- | --- |
| **3.** |  |

1. Providers must verify experience in serving the Medical Assistance or MA clients. Show evidence of your experience by including socio-economic data, to include percentages of clients on Medical Assistance, SCA, or percentages of clients by income level.

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| --- | --- |
| **4.** |  |

1. To whom should communication regarding contract compliance be directed to (i.e. programmatic issues, monitoring reports, audit issues, etc.)?

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| --- | --- |
| **5.** |  |

1. Who is responsible for oversight and day to day decision making at the local level for the facility?

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| --- | --- |
| **6.** |  |

**Section C - Program Description Specific Information**

|  |  |
| --- | --- |
| **Agency Name:** |  |

**Program Description**

It is important that front line assessment personnel know as much about your program(s) as possible to ensure the best treatment match. Please complete the checklist below and attach narrative items A through Q for each unique service activity you offer at your facility(ies). Description should be brief and concise; thus your narrative is to be limited to one-third page. Do not use attachments unless specifically requested.

**Example:** You offer a clinically managed residential program for adults (3.5). There are no special tracks or target populations. You would only complete one checklist and one narrative. If you also offer a co-occurring program for this same population, you would complete an additional checklist and narrative to present this program.

**NOTE:** The development of a rate for treatment services may take into consideration other clinical activities that are not part of the therapeutic array of services, some of which may be required by regulation, such as aftercare planning as well as the management of non-treatment needs while an individual is in the treatment program. The rate may *not* include the provision of case management activities that are required in the DDAP Treatment Manual, such as screening, level of care assessment, and completion of reporting requirements for specialty grants.

**Program Type:** Only programs that have both a drug and alcohol license and a mental health license can be classified as dual diagnosed/Co-occurring.

Medically Monitored Inpatient Withdrawal Management (3.7WM)

Medically Monitored Intensive Inpatient Services - Adult (3.7) \*\*

Medically Monitored High-Intensity Inpatient Services – Adolescent (3.7) \*\*

Clinically Managed High-Intensity Residential Services – Adult (3.5)

Clinically Managed Medium-Intensity Residential Services – Adolescent (3.5)

Clinically Managed Low-Intensity Residential Services Adult or Adolescent (3.1)

Check the  if the program treats women and their children *together*.

Check the  if the program offers co-occurring services *(must be licensed by DHS)*

**\*\* If 3.7 is being delivered on a separate unit, a separate XYZ package shall be completed.**

**\*\*If 3.7 and 3.5 are being provided on the same unit within the facility, the provider will follow instructions on page 16 to calculate an enhanced cost for 3.7 which will then be added to the rate established for the 3.5 LOC when 3.7 services are provided.**

**Service Activity**

* 1. **Program philosophy/mission statement:**

|  |  |
| --- | --- |
| **A.** |  |

* 1. **Target population:** If coed, please include male/female ratio. If you provide other culturally specific tracks, i.e. deaf/hard of hearing, ethnocentric, LGBTQI, older adults, etc., please list and attach schedule of weekly activities for each. Indicate ratio of target group to the rest of the population, and other information to illustrate what you are providing in this target track that is different from/supplemental to your mainstream program. Show specialized staffing provided under section J.

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| --- | --- |
| **B.** |  |

* 1. **Admission criteria and protocol:** Include any factors which would prohibit your program from serving a particular need (i.e. level of staffing is not sufficient to address particular physical or mental health needs, etc).

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| --- | --- |
| **C.** |  |

* 1. **Specialty Services:** Describe any specialty services, including evidence-based practices (EBPs) that your facility is equipped to provide and explain how you tailor services to meet individualized needs.

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| --- | --- |
| **D.** |  |

* 1. **Describe the client bio-psychosocial history process, to include:**

1. How many days after admission does this process occur?

|  |  |
| --- | --- |
| **1.** |  |

1. How is this process used in the development of the client’s treatment plan?

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| --- | --- |
| **2.** |  |

* 1. **Types of Treatment Activities: Please list the types of services provided by your facility (e.g. individual, group, life skills groups, family groups, education services, specialized groups, twelve step attendance, etc.) and explain how you tailor services to meet individual need.**

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| --- | --- |
| **F.** |  |

* 1. **Please indicate the minimum frequency that each service is provided in the space furnished:**

1. **Per Week**

|  |  |
| --- | --- |
| Individual Counseling: |  |
| Group Counseling: |  |
| Life Skills Groups: |  |
| Addiction Education: |  |
| Specialized Groups (i.e., women’s, cocaine...): |  |
| Twelve Step Attendance (specify on or off-site): |  |

1. **Per Course of Treatment**

|  |  |
| --- | --- |
| Academic Services (specify): |  |
| Physical Exam: |  |
| Psychiatric Exam: |  |
| Medication Checks: |  |
| Psychological Testing: |  |
| Vocational Testing: |  |
| Other Services (please specify): |  |

If specialized services are provided for clients with a co-occurring mental illness, please submit evidence of approval from the Office of Mental Health and Substance Abuse Services, OMHSAS (see Section A Checklist) and indicate frequency of the following:

|  |  |
| --- | --- |
| Counseling with psychiatrist:  Social Worker: |  |
|  |
| Psychologist: |  |
| Specialized Groups: |  |
| Other (Define): |  |

* 1. **Transportation:** Is transportation provided as part of service package?

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| --- | --- |
| **H.** |  |

1. If yes, please mark/highlight all that apply: (include any limitations)

|  |  |
| --- | --- |
| Pick up for Admission: |  |
| To and from support services: |  |
| Drop off at discharge: |  |
| Other (please specify): |  |

1. If transportation is already part of the service package, the cost of that service must be included in the per diem calculation. Please state if there are any limitations on transportation (e.g., number of miles).

|  |  |
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| **2.** |  |

* 1. **Staffing:** Please define your counseling staff by position, and identify their daily schedule availability for day or night coverage. As requested earlier in this package, include a program Organizational Chart. (Insert additional rows as needed):

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| --- | --- |
| **Staff Position** | **Daily Schedule** |
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If your counselor to client ratio is different than below, please explain any variance from the staffing requirements.

* For facilities serving adult clients - one FTE counseling staff is required for every eight clients.
* For facilities serving adolescent clients - one FTE counseling staff is required for every six clients.
* For facilities providing withdrawal management services - one FTE counseling staff is required for every seven clients.

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| --- | --- |
| **Explain:** |  |

Withdrawal Management Only - Please state whether or not you have a physician on-call available at all times:

|  |  |
| --- | --- |
| **Explain:** |  |

If you do not have 24-hour awake staff coverage please explain:

|  |  |
| --- | --- |
| **Explain:** |  |

Please state the turnover rate for the administrative and clinical staff, both separately and combined, during previous fiscal year (FY2022/2023) – note these are three separate rate calculations:

|  |  |
| --- | --- |
| **Administrative Turnover:** |  |
| **Clinical Turnover:** |  |
| **Combined Staff Turnover:** |  |

Justify in writing if the turnover is greater than 30 percent. Evidence of staffing stability as measured by a management and clinical turnover rate which does not exceed 30 percent during the past year.

|  |  |
| --- | --- |
| **Explain:** |  |

Please identify any position that remained vacant in FY 2022-2023 for more than 60 days and explain why the delay occurred. Also, please identify positions that remained vacant for more than 60 days in the current fiscal year (2023-2024).

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| --- | --- |
| **Explain:** |  |

* 1. Provide your policy and procedure for the initial privileging/credentialing of clinical staff (for each type of clinical position). Also include your policy/procedure for re privileging/ credentialing during the period of a staff member’s employment. Include evidence of any required competence in treating clients from multiple cultures and relate this back to item B., Target Population.

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| **J.** |  |

* 1. Please identify any evidenced-based treatment protocols (as defined by SAMHSA) or promising practices, e.g. Motivational Interviewing, Motivational Enhancement Treatment (MET), Motivational Enhancement for Dual Diagnosed Consumers, Naltrexone or other medication agents or antagonists, methadone (protocol for withdrawal management and/or continuing clients on methadone while in their level of care); Suboxone/buprenorphine, clinicians and supervisors certified in Cognitive Behavioral Therapy, Stages of Change, Contingency Management, etc.

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| **K.** |  |

* 1. If your facility is providing withdrawal management, please attach your withdrawal management protocol(s).

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| **L.** |  |

* 1. Describe how you measure outcomes for your program and attach any reports for the prior year on your outcome measures.

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| **M.** |  |

* 1. Please include a copy of any client grievance, complaint and/or appeal process distributed to clients in your facility. Also include a copy of your internal policy and procedure(s) addressing the issue of addressing client grievances or complaints*.*

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| **N.** |  |

* 1. In fiscal year 2023-2024, identify the percent of clients that completed the program as compared to the total number of clients admitted to the program?

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| **O.** |  |

* 1. Please identify the target populations you intend to serve by filling in the below grid.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Facility #** | **Type of Service** | **Adult** | **Adolescent** | **Co-occurring** | **Male** | **Female** | **Pregnant Female** | **IDU** | **Rate Requested** |
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**Q.) Women with Children Programs only:**

* Please provide prevention programming/services for children. Include age groups per activity and frequency of occurrence.

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* Please describe mother’s role, if any, in children’s prevention services.

**R. Medication Assisted Treatment (MAT):** The following pertains to MAT practices within your

facility.

1. How do you ensure that individuals on MAT are not excluded from admission to treatment within your facility?

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1. How do you make available all forms of FDA approved medications for MAT within your facility?

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1. How do you ensure coordination of care for clients on MAT when the prescriber is not your facility?

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1. How do you educate individuals within your facility about MAT options?

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**RATE DEVELOPMENT INSTRUCTIONS**

All providers must submit the enclosed Budget and supporting forms (Personnel Roster and Budget Narrative), as well as a Rate Request form, in order to establish a reimbursement rate for FY 2024-2025. This process has been standardized and will be used by all Single County Authorities (SCAs). The SCA in which the facility is physically located is considered the home SCA.

**1. Personnel Roster**

Providers must submit a Personnel Roster (HDA 313RS), which lists staff as Administrative or Client Oriented. For staff who provide both functions, salaries should be pro-rated across both categories. (See Administration definition under #2 below.) Please ensure prorated salary is based on total annual salary.

The sub-totals for Administrative and Client Oriented Salaries must equal HDA 311RS categories 111 and 121, respectively.

Rosters are to include all staff employed in the facility regardless of activity, and are to list Name, Position, and Salary to be paid in FY 2024-2025.

Staff engaged in Marketing functions, regardless of title, must be shown on the Administrative section of the Roster.

If vacant positions are listed on the Personnel Roster and included in the budget, a written justification and hiring schedule must be attached. It is expected that all vacant positions are filled within 60 days of being vacant.

**2. Budget - Projected Revenues and Expenses**

Providers must submit a Total Facility-based Budget, with an itemization of projected expenses and revenues. Additionally, expenses must be broken out for each activity provided at that facility. Budgets must be prepared using the budget category definitions from the modified DDAP Uniform Chart of Accounts (enclosed).

Use additional copies as needed to show all activities.

NOTE: You must show budget detail for all activities, regardless of whether you will be requesting an SCA rate for that activity. For example, a facility which provides both non-hospital residential and outpatient under the same facility number must display expenses and revenue for both activities, although they will only be requesting an SCA rate for non-hospital residential.

**Page One of HDA 311RS**

Providers must show all Revenue and Income applicable to all facility operations. Revenue and Income must at least equal total facility expense as shown on Page Two of HDA 311RS unless the facility experienced a budget deficit in the fiscal year.

**Page Two of HDA 311RS**

There is a cap of twenty percent (20%) on the amount of allowable administrative cost for the purposes of rate development. Therefore, you will note in completing the HDA 311RS what costs are to be allocated as either administrative or client oriented by category for each activity, as instructed below.

Administration is defined as those costs not incurred in the direct or indirect provision of treatment services.

Most of the personnel costs for CEOs, executive directors, secretaries, administrative assistants, clerks, receptionists, accountants, fiscal assistants are administrative in nature. If identifying some of these position costs as client oriented, identify how you allocated the cost.

**Justify in writing any line item in column J that increased more than 10% over column G.**

Justification **MUST** be detailed and specific; e.g. insurance cost increased by X% over X period of time.

**Definition of Administration**

Administration is defined as general managerial functions or activities which are supportive to, but not an intrinsic part of the provision of direct services. Administrative functions or activities include: executive supervision, personnel management, accounting, auditing, legal services, purchasing, billing, community board activities, activities associated with management information systems (does not include maintenance of individual client case records), and clerical activities which are supportive to these administrative functions or activities.

Clerical activities which provide direct support to the program activity are to be reported as direct costs of the program activity. Room and board, including maintenance, are direct costs for residential programs. For the purpose of rate setting, clinical and program supervision associated with direct client care is to be considered a direct program expense. Staff time associated with such supervision should be allocated among, and reported within, program activities as a direct program expense. The method of allocation is discretionary, as long as it is verifiable and results in an equitable distribution among program activities. Using this definition, budget categories from the HDA Form 311 RS have been classified as follows: (Refer back to budget categories starting on page 2).

Submit one form, including a personnel roster and a budget narrative, for each activity for which a rate is to be established. The form will contain fiscal information for three years: the previous Actual Year, the Current Year, and the Budget Year. Information for each of the three years must be designated as Administration or Client Related. Three years are required in order to allow for comparability between actual, current, and budgeted costs.

For the current fiscal year, provide information that is projected based upon data/numbers you have so far year-to-date. Since the current fiscal year is not completed, some of this information is projections.

NOTE: Revenue and Income figures on page one should relate to the Total Facility Budget Expense Column on page two for each fiscal year.

**3. Budget Narrative**

Complete the enclosed Budget Narrative form, describing the costs included in each category. For those marked with an asterisk (\*), the allocation method must be described.

**4. Rate Request Form**

To calculate your requested rate, use the following procedures:

a. Complete a separate Rate Request Form for each activity for which you are requesting a rate.

b. Total the Client oriented column for that activity divided by *.80* determines the Total Allowable Budget for that Activity. This cannot exceed the total actual budget.

c. To determine Bed Days, use the formula shown on the form.

Number of beds used for each drug and alcohol activity should equal the number of licensed beds for the facility.

Note: a minimum utilization rate of 85 percent is to be used.

d. To arrive at your requested rate, divide the lesser of the Total Budget or the Total Allowable Budget by Bed Days calculation.

**3.5 and 3.7 services provided on the same unit within the facility:**

**If 3.5 and 3.7 services are provided on the same unit within the facility, the provider will in addition to the package required for the 3.5 LOC complete and submit the following specific to the 3.7 LOC:**

1. **Section B – Program Description Specific Information for 3.7 LOC**
2. **Personnel Roster specific to the additional salaries to provide the 3.7LOC not already captured in the 3.5 package.**
3. **Form HDA 311RS Budget (Revenue & Expenses) to capture Revenue and Expenditures for the 3.7 LOC not already captured on the 3.5 package.**
4. **Budget Narrative to justify additional expenses for the 3.7LOC not already captured in the 3.5 package.**
5. **Rate Determination Form for the additional expenses for the 3.7 LOC which will calculate a rate enhancement added onto the determined 3.5 LOC rate when 3.7 services are provided. Under this circumstance, the provider shall estimate the number of bed days expected to be delivered for 3.7 to align with the expected costs captured in items #2,3, and 4 above.**

**Note: If the increase in the requested per diem rate exceeds the current Consumer Price Index (CPI), please explain in one page or less what expenses rose to justify the increase. Identify major changes, purchases and enhancements in detail that contributed to the increase.**

**BUDGET NARRATIVE**

|  |  |
| --- | --- |
| **Provider Name:** |  |
| **Facility Name:** |  |
| **Activity:** |  |

List all activities for which SCA funding is being requested:

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For each budget category on the HDA 311RS, please complete a description of the costs included.

In addition, if the category is marked with an (\*), you must show the methodology for allocating the costs in this category between Administrative and Client Oriented for each activity. One example could be: rent is pro-rated between Administrative and Client Oriented based on square footage used by administrative staff. It is then allocated across the activities based on the number of beds devoted to each activity.

Again, the costs included in each category must conform with the Uniform Chart of Accounts, as included in this packet.

111 Administrative Salaries: Description not necessary. Described on personnel roster.

112 Administrative Benefits: State the percentage used and list all benefits included.

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121 Client Oriented Services Salaries: If any non-clinical staff is listed on the personnel roster as client oriented, please describe why. This includes CEOs, Executive Directors, secretaries, clerical, receptionists, fiscal, etc. (NOTE: Any staff engaged in marketing functions, whether called Outreach or Community Relations personnel, may not be included in this category.)

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122 Client Oriented Services Benefits: State percentage used and list all benefits included.

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131 \*Staff Development:

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301 Meeting and Conference Expense:

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302 Consultant Expense:

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303 Miscellaneous Personnel Expense:

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304 \*Occupancy Expense:

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305 \*Insurance:

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306 \*Communications:

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307 \*Office Supplies:

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308 \*Minor Equipment and Furniture:

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309 Medical Supplies and Drugs (not including medications used for MAT in the form of Buprenorphine, Vivitrol, or Methadone which would be paid for separate from the daily FFS rate):

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310 Food and Clothing:

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311 Program Supplies:

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312 \*Staff Travel:

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313 Client Transport:

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| --- |
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314 Purchased Client Oriented Services: (Psychological consultants should be shown here.)

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|  |

315 \*Equipment Maintenance Expense:

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316 \*Equipment Leases:

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|  |

317 Motor Vehicle Maintenance Expense:

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|  |

318 Motor Vehicle Leases:

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| --- |
|  |

319 \*Other Operating Expense:

Please explain if any costs are placed in Client Oriented.

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|  |

320 Indirect Cost:

Administrative costs to a parent corporation or central office should be included here as administrative. Provide a detailed itemization of this cost.

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320 \*Indirect Cost: Depreciation

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|  |

**UNIFORM CHART OF ACCOUNTS**

DEFINITIONS FOR MAJOR AND MINOR OBJECTS

The Uniform Chart of Account represents the list of major and minor objects that will be utilized for reporting purposes. DDAP suggest that the Single County Authorities (SCA) and Contracted Providers use the Uniform Chart of Accounts as a basis for their accounting journals and ledgers. Those SCAs and Contracted Providers who choose not to set up their books according to the Uniforms Chart of Accounts must maintain, on file, a documented reference sheet used to crosswalk their books onto the required reports.

**PERSONNEL SERVICES**

**MAJOR OBJECT 100 - PERSONNEL SERVICES**

This major object is used to report salaries and wages, payments toward various benefits, and training received by the employees of the D&A Program. Employees working for two or more programs should have their salaries and benefits pro-rated between the programs.

The minor objects are defined below:

**111 - ADMINISTRATIVE SALARIES**

This category should include all wage and salary costs of part-time and full-time employees who render their services within the administrative section.

Administration is defined as general managerial functions or activities which are supportive to, but not an intrinsic part of the provision of direct services. Administrative functions or activities include: executive supervision, personnel management, accounting, auditing, legal services, purchasing, billing, community board activities, activities associated with management information systems (does not include maintenance of individual client case records), and clerical activities which are supportive to these administrative functions or activities.

**112 - ADMINISTRATIVE BENEFITS**

This category should include only the employer’s share of benefit costs incurred on behalf of all part-time and full-time employees who render their services within the administrative section. Included under Administrative Benefits are such items as social security contributions, retirement, employee health, life and other insurance plans, and worker’s compensation.

**121 – CLIENT-ORIENTED SERVICE SALARIES**

This category should include the salaries and wages of all part-time and full-time employees who perform client-oriented services or client support services, and includes Case Management (screening, assessment and intensive case management) salaries and wages as well. Clerical activities that provide direct support to the program activity are to be reported as direct costs of the program activity. Clinical and program supervision associated with direct client care is to be considered a direct program expense. Staff time associated with such supervision should be allocated among, and reported within, program activities as a direct program expense.

**122 - CLIENT-ORIENTED SERVICE BENEFITS**

This category should include the employer’s cost of benefits incurred on behalf of all part-time and full-time employees who perform client-oriented services or client support services. Included under Client-Oriented Service Benefits are items such as social security contributions, retirement, employee health, life and other insurance plans, and worker’s compensation.

**131 – STAFF DEVELOPMENT**

This category covers development and training both within the facility and outside the facility. Expenses incurred for in-house development might consist of meetings or seminars held at the facility, books, videos, other training tools or equipment. Examples of training or development received outside the facility might be special courses, conferences, and training sessions by an outside agency. Only those staff development and training activities (administrative, technical, clerical) that are essential for the continuation or improvement of the program are eligible for State participation. Any activities in question should be cleared through the SCA or DDAP.

This category does not include travel by staff to these developmental activities; such costs would be recorded under minor object 312 - STAFF TRAVEL.

**OPERATING EXPENSES**

**MAJOR OBJECT 300 – OPERATING EXPENSES**

This major object includes the cost of supplies, commodities, services, travel, or manufactured articles that are used in current operations. This major object also includes minor equipment and furniture, as well as other articles not meeting the criteria set forth in Major Object 400, Fixed Assets.

Any expenses entered in the following minor objects must be substantiated by invoices, canceled checks, contracts or other means of documentation that are readily available for review at the SCA and DDAP’s option. Any expenses identified as client oriented must be justifiable.

The minor objects are defined below:

**301 - MEETING and CONFERENCE EXPENSES**

Charge to this category total meeting costs incurred by the provider, excluding travel and advertising. This would include the cost of meetings related to conducting the business of the provider, as well as sponsoring of conferences and training events by the provider. Examples may include room rental, equipment rental, and food services.

**302 -CONSULTANT EXPENSES**

Charge to this category the cost incurred for all consultants hired on a limited term basis for administrative services. Include the total cost of consultants or other specialized and professional administrative services subcontracted or purchased, such as attorneys, auditors, accountants, management analysts and research analysts. Travel and lodging expenses incurred by the consultant are eligible under this category and are reimbursed by State standards as explained in Minor Object 312 - Staff Travel.

**303 -MISCELLANEOUS PERSONNEL EXPENSES**

Charge to this category the cost of administrative personnel that are hired on a temporary basis and do not appear on the Roster of Personnel. Examples may include replacements for any leaves of absence and student interns. If temporary staff is approved for travel, the expense should be charged under Minor Object 312 - Staff Travel.

**304 -OCCUPANCY EXPENSES**

All direct costs for the following expenses may be charged to this category.

1. Rent for an office or other space occupied by the facility. D&A rental will be pro-rated when offices or space is in buildings rented for additional purposes other than D&A functions. An agency must be able to demonstrate, upon request from the SCA or DDAP, that the cost of space per square foot is based on a fair market value for the surrounding area.

2. Utilities include heating fuel, sewage, water, gas, electricity, etc.

3. Housekeeping Services and Supplies include all supplies used in the performance of general housekeeping and grounds care services, or the cost of contracting out those services.

4. Building Repairs and Maintenance include minor building repairs, maintenance, repairs and maintenance to heating, ventilation and air-conditioning units. Repairs are defined as work done to maintain the existing structures and equipment.

5. Minor Renovations are considered to be the adaptation of available space and do not include construction cost for additional space. Minor renovations are those at a cost of less than $10,000.

6. Insurance includes building, content, fire and liability insurance costs.

**305 - INSURANCE**

Charge to this category any insurance not covered under Minor Object 304 - Occupancy Expenses and Minor Object 317 - Motor Vehicle Maintenance Expense. Examples include professional liability, directors’ and officers’ insurance, and fidelity bonds.

**306 - COMMUNICATIONS**

Charge to this category the costs of telephone service (including installation), postage, advertising, marketing, pagers, cell phones, web sites, internet services, printing, duplicating and parcel service.

**307 - OFFICE SUPPLIES**

Charge to this category the cost of all expendable items that are normally consumed within one year and used in the day-to-day operations of an office. Some examples are pens, pencils, paper, calendars and tape.

**308 - MINOR EQUIPMENT AND FURNITURE**

Charge to this category items with a useful life of more than one year and a unit cost of less than $5,000. Examples may include fax machines, copiers, computers and computer-related equipment, software, tables, desks and chairs.

**309 - MEDICAL SUPPLIES AND DRUGS**

Charge to this category the cost of medical supplies and drugs used in the treatment of clients, with the exclusion of medications used for MAT in the form of Buprenorphine, Vivitrol, or Methadone which would be paid for separate from the daily FFS rate.

**310 - FOOD AND CLOTHING**

Charge to this category the cost of necessary food and clothing used by D&A clients. Also, charge all costs associated with specialized or professional food preparation and food delivery services.

**311 - PROGRAM SUPPLIES**

Charge to this category the cost of supplies purchased for activities related to rehabilitation or recreational purposes. Also included are supplies used in client training and education services. Some examples are books, periodicals, games, videos, tapes, creative supplies and drug testing kits.

**312 - STAFF TRAVEL**

Charge to this category the cost of business-related staff travel. Include allowances for meals, lodging, and other related expenses.

**313 - CLIENT TRANSPORT**

Charges to this category include actual miles traveled, parking, tolls, meals and expenses incurred or fees paid to an outside agency for the transportation of D&A clients. Accurate and up-to-date records must be maintained.

**314 - PURCHASED CLIENT-ORIENTED SERVICES**

Charge to this category the cost incurred from the purchase of client-oriented services, such as medical care, laboratory services, psychiatric services and interpreter services. Psychological consultants should be shown here.

**315 - EQUIPMENT MAINTENANCE EXPENSE**

Charge to this category the cost of maintenance agreements and repairs to all types of office or medical equipment.

**316 - EQUIPMENT RENTALS AND LEASES**

Charge to this category the cost of all equipment rentals and leases. An example of such a cost would be rented urinalysis equipment.

**317 - MOTOR VEHICLE MAINTENANCE EXPENSE**

Charge to this category the cost of maintenance to motor vehicles used in the performance of official D&A Program activities (e.g., repairs, insurance, inspection, tires, gas, oil and lubrication).

**318 - MOTOR VEHICLE LEASES**

Charge to this category the cost of motor vehicle leases.

**319 - OTHER OPERATING EXPENSES**

Charge to this category operating costs that cannot properly be recorded in the other minor expense objects. All costs in this category should be documented and held to a minimum.

**320 - INDIRECT COSTS**

Charge to this category costs for supportive activities that are necessary to maintain the direct effort involved in providing the services. A copy of the provider’s indirect cost plan must be maintained on file for review by the SCA or DDAP. Administrative costs to a parent corporation or central office should be included here as administrative.

**320 – INDIRECT COSTS – DEPRECIATION**

In recent years, the DDAP Rate-Setting Committee determined that depreciation would be allowed as an expense for rate setting purposes. Accordingly, depreciation can be charged here. Providers claiming depreciation on Fixed Assets must include as backup with the submission of the package a copy of their depreciation schedule(s) which need to correlate to the amounts claimed on Form 311.

**PROVIDER REVENUE AND INCOME**

**MAJOR OBJECT 500 – PROVIDER REVENUE AND INCOME**

This major object is used to report all income received by the contracted service providers directly from Federal, State, and Local governments, as well as from client and private sources. Funding source, for reporting purposes, shall be defined as the agency from which the checks were received.

The minor objects are defined below:

**501 – Provider Revenues**

Provider revenue is comprised of direct federal revenues received by the contract provider, revenues received from other government or private entities as well as revenues received from other SCAs for the provision of treatment services or related ancillary services. The contract provider must identify the source(s) of these funds.

**502 – Provider Charitable Income**

Income received from unspecified sources such as donations (i.e. funds donated to the contract provider as a general contribution where the donor determines how the funds will be spent) from private firms, unions, charitable organizations and individuals. Identify the source(s) of all provider income.

**503 – Provider Interest Income**

The contract provider must enter any interest income earned in the space provided.

**504 – Client Fees**

Income received from clients who have a full or partial payment for services received.

**505 – Private Health Insurance**

Income received for insurance carriers, e.g. Blue Cross/Blue Shield, employer of union health plans and private purchase health insurance.

**506 – Medical Assistance (include Health Choices Revenue)**

Income received from the DHS for substance use and gambling disorder services provided to MA-eligible recipients.

**507 – Other Third-Party Fees**

Income received as payment for client services from a source such as employers (where insurance coverage is not applicable), client family member, food stamps, etc. (when the payment by such sources is agreed to by the client and does not violate confidentiality requirements).

**508 – Miscellaneous**

Use this code to indicate funding of a special nature or circumstance that cannot be categorized using the definitions and examples cited above.

**FY 2024-2025**

## RATE REQUEST FORM

Please fully complete this form separately for each activity for which an SCA rate is requested.

Provider Name:

Facility Name:

Activity:

**TOTAL ALLOWABLE BUDGET**

Total Client Oriented Costs per Activity divided by .80 = Total Allowable Budget

(HDA 311RS, page 2) (Cannot exceed total actual budget)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ /.80 = \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BED DAYS**

\_\_\_\_\_\_\_\_\_ Beds x 365 days per year x 85% utilization = \_\_\_\_\_\_\_ bed days per activity. Bed capacity should equal the total number of licensed beds for this activity.

**RATE REQUEST FORMULA**

The Lesser of the Total Budget or the Total Allowable Budget as calculated above divided by the Bed Days per activity calculated above = $Rate/Day

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ = $\_\_\_\_\_\_/Day Round down if under $0.49

Or round up if $0.50 or above. Example: $79.48=$79.00

$98.50=$99.00

**RATE REQUESTED OF SCA** $\_\_\_\_\_\_\_/Day

\_\_\_\_\_\_\_\_% increase (decrease) compared to FY 2023-2024 approved state-wide rate

If there are any other contracts with your program at a lower rate, please indicate that rate: $\_\_\_\_\_\_\_\_\_\_/day.

In fiscal year 2022-2023 how many total bed days, for all sources of funding did this facility provide? \_\_\_\_\_\_\_\_\_/days.

**CERTIFICATION STATEMENT**

I certify that I am the Executive Officer of said organization and that to the best of my knowledge the expenses listed on this form are in accordance with the fiscal guidelines, as required by the County; and that the organization understands that any and all payments made as a result of the approval of this budget are made in reliance by the SCA upon the statement herein made.  *I certify that the rate requested in this package does not exceed the rate received from non-public payers.*

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Signature CEO Title Date

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Signature Chief Fiscal Officer Title Date