

ATTACHMENT I

A. Services To Be Provided

1. Definition of Terms

a. Contract Terms

Contract terms used in this document can be found in the Florida Department of Children and Families Glossary of Contract Terms, which is incorporated herein by reference and can be obtained from the contract manager.

b. Program/Service Specific Terms

(1) Advisory committee means a group of local, volunteer stakeholders that come together to collectively support and guide a Florida Assertive Community Treatment (FACT) team. Its purpose is to ensure the team's work is consistent with those portions of the NAMI-published National Program Standards for ACT Teams revised June 2003, that have been adopted by the department and incorporated into the FACT contract. The advisory committee's primary functions are to promote quality FACT programs, review fidelity to the program standards as established by the department and assist in the oversight of the program through problem-solving, advocating to reduce barriers to FACT implementation and reviewing and/or mediating grievances or complaints submitted by individuals or their families served by FACT. The advisory committee shall be made up of at least 51% mental health consumers and family members and include other community stakeholders such as representatives from services for the homeless, consumer support organizations, faith-based groups, criminal justice system, housing authorities, landlords, employers and/or community colleges. Group membership shall also represent the cultural diversity of the local population. Please see **Exhibit L, FACT Advisory Committees: Authorities and Limitations**

(2) Administration means, for FACT purposes only, the giving of a single dose of medicinal drugs by a legally authorized person to an individual for his or her consumption.

(3) Agent means, for FACT purposes only, a person acting in behalf of a person receiving FACT services for obtaining, storing and delivering medication

(4) Agent agreement means, for FACT purposes only, an agreement between a FACT team and a person receiving FACT services. The agreement includes the name of the FACT team who serves as the FACT person's

agent. The agreement shall include information on how to terminate the agreement. Both parties must voluntarily sign the agreement. In those cases where a FACT-enrolled person has been declared legally incompetent, the court appointed legal guardian must sign the Agent Agreement. A copy of the legal guardianship appointment shall be attached to the Agent Agreement. No activity relating to the management of medication on behalf of a person enrolled in FACT shall commence without the expressed consent of the individual being served by the FACT team as evidenced by his or her signature on the Agent Agreement. A copy of the Agent Agreement and any attachments shall be provided to the pharmacy dispensing the medication to the person's agent. The original document with any necessary attachments shall be filed in the individual's medical record.

(5) Case management means, for FACT purposes only, an organized process of coordination among the interdisciplinary FACT team providing a full range of treatment, rehabilitation and support services in a planned manner that promotes recovery.

(6) Circuit means a service area identified by the Department of Children and Families which may include one or more Florida counties. (e.g., Circuit 10 includes Hardee/Highlands/Polk counties, Circuit 11 includes Dade County, Circuit 17 includes Broward County, and Circuit 19 includes Indian River/Martin/Okeechobee/St. Lucie counties).

(7) Clinical supervision means regular, face-to-face contact between the designated clinical supervisor and a team member reviewing a person's clinical status and ensuring treatment, rehabilitation and support services are provided within a framework of recovery to that person by the team member consistent with the recovery plan. Clinical supervision occurs during daily organizational staff meetings and recovery planning meetings, or individual one-to-one supervisory sessions and includes review of written documentation such as assessments, treatments, recovery plans, progress notes, and correspondence.

(8) Community-based services means mental health and substance abuse services provided outside a state mental health facility.

(9) Comprehensive assessment means an organized process of gathering information to evaluate a person's mental and interactional status and his or her treatment, rehabilitation, and support needs that will enhance recovery. The results of the assessment are used to develop an individual recovery plan for the person.

(10) Commodities means supplies, materials, goods, merchandise, equipment, information technology, and other personal property. The definition does not include pharmaceuticals, medical treatment or procedure,

glasses, hearing aides, or lab work.

(11) Conditional release means a court ordered plan for providing appropriate outpatient care and treatment for a person found to be incompetent to proceed and for a person found to be not guilty by reason of insanity. The committing court may order a conditional release of any defendant in lieu of an involuntary commitment to a state mental health treatment facility, or upon a recommendation that outpatient treatment of the defendant is appropriate. A written plan for outpatient treatment, including recommendations from qualified professionals, must be filed with the court with copies to all parties. Such a plan may also be submitted by the defendant and filed with the court with copies to all parties.

(12) Corrective action plan means a method of redress in the event a provider fails to meet or provide a contracted level of service. Use of this term does not imply a waiver of any legal remedies the department may have to secure satisfactory compliance with this contract.

(13) Cost center (synonymous with services) means a grouping of services that is similar in time, intensity and function where the average cost for service is generally the same. See Rule 65E-14.021(2), Florida Administrative Code, F.A.C. for a complete listing of approved cost centers.

(14) Culturally competent services means acknowledging and incorporating variances in normative acceptable behaviors, beliefs and values in determining an individual's mental wellness/illness and incorporating those variances into assessments and treatment that promotes recovery.

(15) Daily log means an electronic or manual record to be maintained by the FACT team on a daily basis that provides:

(a) A roster of persons served in the program; and

(b) For each person, a brief documentation of any treatment or service contacts that have occurred during the day and a concise behavioral description of the person's clinical status.

(16) Daily organizational staff meeting means a daily staff meeting held at regularly scheduled times under the direction of the team leader (or designee) to:

(a) Briefly review the service contacts that occurred the previous day and their status;

(b) Review the service contacts that are scheduled to be completed during the current day and revise as needed;

- (c)** Assign staff to carry out the day's service activities;
- (d)** Revise recovery plans for emergency and crisis situations as needed;
and
- (e)** Use of the daily log and the daily staff assignment schedule to facilitate completion of these tasks.

(17) Daily staff assignment schedule means a written daily timetable summarizing all treatment and service contacts to be divided and shared by staff working on that day. The daily staff assignment schedule will be developed from a central file of all weekly schedules of persons served.

(18) Department of Children & Families, Pamphlet 155-2, Mental Health and Substance Abuse Measurement and Data, effective September, 2008 (9th edition, version 1), or the latest revised edition thereof means a document promulgated by the department and incorporated by reference in Rule 65E-14, F.A.C. that contains required data reporting elements for substance abuse and mental health services, hereafter referred to as "CFP 155-2", and which can be found at:
<http://www.dcf.state.fl.us/mentalhealth/publications/index.shtml>, and is incorporated herein by reference.

(19) Dispensing means, for FACT purposes only, the transfer or possession of one or more doses of a medicinal drug by a pharmacist as provided for in s. 465.003(6), Florida Statutes, to the ultimate individual or his or her agent. As an element of dispensing, the pharmacist shall, prior to the actual physical transfer, interpret and assess the prescription order for potential adverse reactions, interactions, and dosage regimen he or she deems appropriate in the exercise of his or her professional judgment. The pharmacist shall verify that the medicinal drug called for by the prescription is ready for transfer. The pharmacist shall also provide counseling on proper drug usage, either orally or in writing, if in the exercise of his or her professional judgment counseling is deemed necessary. The actual sales transaction and delivery of such drugs shall not be considered dispensing. The administration of medicinal drugs shall not be considered dispensing.

(20) DSM-IV Axis I Diagnosis means, a diagnosis based on the classification system of the American Psychiatric Association (APA), the Diagnostic and Statistical Manual of Mental Disorders (DSM-I). This is one of two, diagnosis and classification systems set up to standardize the description and interpretation of mental disorders.

(21) Empowerment means the process where the provider of services allows the individual to make choices in matters affecting their lives and to accept personal responsibility for those choices. Within the mental health community, empowerment of individuals diagnosed with a mental illness is

accomplished through the provision of high service quality and an individual service orientation. These services shall be provided in a professional manner and will be based on equality and respect. The empowerment process will include, but is not limited to, each of four levels: 1) freedom of choice regarding services; 2) influence over the operation and structure of service provision; 3) participation in system-wide human recovery planning; and 4) participation in decision-making at the community level. This fourth level addresses the role of individuals with disabilities as community citizens in general, not merely as service individuals.

(22) Engagement means the process of identifying, recruiting and considering a person for enrollment in FACT. A person currently in a state hospital, local hospital or Crisis Stabilization Unit (CSU) cannot be “enrolled” in a FACT program until discharge takes place. A person already “enrolled” in a FACT program continues to be “enrolled” even though hospitalization via a CSU, local hospital or state hospital occurs. Even though a person going through the engagement process has not formally been enrolled in a FACT team, the FACT team must keep a written record on:

(a) What activities took place during the engagement process and the person’s response to those activities; and

(b) The name of the FACT staff member conducting the engagement activities.

(23) Enhancement funds mean those funds appropriated by the Florida Legislature to purchase adjunct services or commodities not directly provided by the FACT team. Funding is used to increase or maintain a person's independence and integration into their community. Funding may be used for costs related to housing, pharmaceuticals, tangible items needed for employment/education or other meaningful activity, and specialized treatment consistent with a person’s recovery plan. FACT team enhancement funds is the payer of last resort, and the primary case manager must certify that due diligence was exercised in searching for alternative funding to pay for the commodity or service prior to the use of enhancement funds.

(24) Enrollment means the act of admitting a person formally into the FACT program. The person agrees to accept services by the FACT team. The most significant distinction between engagement and enrollment is the associated requirements. Enrollment begins when the person being considered agrees to be accepted into the FACT program and the FACT team begins the admission process. The admission process consists of the initial assessment, the initial recovery plan and the identification by the team leader of the person’s primary case manager and individualized treatment team. At this time, the sixty (60) day requirement for completing the comprehensive assessment is started. Engagement, on the other hand, are

those activities that informally permit the FACT team to learn more about a person being considered for FACT enrollment. If the person being considered for FACT is in the state hospital, local hospital or CSU, team members will begin to visit the person in the hospital and participate in developing the discharge plan, but will not officially assume responsibility to provide treatment services until the person is discharged. From the first day of enrollment, the FACT team is the primary provider of services and has total responsibility to help individuals to meet their needs in all aspects of living in the community. On the day of admission/enrollment, the team leader will:

- (a)** Begin a medical record for the person;
- (b)** Ensure the person meets with the psychiatrist as soon as possible;
- (c)** Designate a primary case manager and other members of the individual treatment team (ITT);
- (d)** Work with the case manager, the ITT, and the psychiatrist to develop and write the initial assessment and recovery plan;
- (e)** Work with the case manager and the psychiatrist to obtain written consent to treatment from the person and guardian, and inform the person and guardian of their rights; and
- (f)** Schedule initial service contacts.

(25) Family member means a relative or guardian of a person with a psychiatric disability who is receiving or has received psychiatric services either through public or private entities.

(26) Florida assertive community treatment (FACT) means a self-contained clinical team that assumes responsibility for directly providing the majority of needed treatment, rehabilitation and support services to identified individuals with psychiatric disabilities. It is based on the unique characteristics of the Program of Assertive Community Treatment (PACT) model, an empirically established, evidenced-based model of community-based service intervention. These unique characteristics include: (1) the provider is the primary provider of services and fixed point of accountability; (2) services are provided out of office; (3) services are highly individualized; (4) there exists an assertive, "can do" approach to service delivery; and (5) services are provided continuously over time. The FACT team:

- (a)** Assumes responsibility for directly providing the majority of needed treatment, rehabilitation and support services to identified individuals with psychiatric disabilities in order to achieve recovery.

(b) Minimally refers persons served by the FACT team to outside service providers;

(c) Provides services on a long-term care basis with continuity of caregivers over time;

(d) Delivers the majority of the services outside program offices; and

(e) Emphasizes individual preferences, choice, outreach, relationship building, and individualization of services. Persons to be served are individuals who have not been served adequately through traditional service delivery systems. The team leader, program psychiatrist, program assistant, and multidisciplinary staff are to ensure service excellence to people served by the team.

(27) Forensically involved means any criminal defendant who is mentally ill under court jurisdiction pursuant to Chapter 916, Florida Statutes and who:

(a) Has been determined to need treatment for mental illness;

(b) Has been found incompetent to proceed on a felony offense or has been acquitted of a felony offense by reason of insanity;

(c) Has been determined to not meet criteria for involuntary hospitalization; and

(d) Is an adult or a juvenile prosecuted as an adult.

(28) Functional Assessment Rating Scale (FARS) means the rating scale adopted by the Mental Health Program Office that is to be administered consistent with the most current version of the department's pamphlet 155-2 as it is developed.

(29) Health Insurance Portability and Accountability Act (HIPAA) means the federal law that protects the privacy of individuals' qualifying medical records from disclosure except under specified conditions.

(30) Incompetent to proceed means the condition of a defendant being unable to proceed at any material stage of a criminal proceeding due to mental impairment. Those stages shall include a trial of the case and pretrial hearings involving questions of fact on which the defendant might be expected to testify. It shall also include an entry of a plea, proceedings for violations of probation or violation of community control, sentencing, and hearings on issues regarding a defendant's failure to comply with court orders. It also considers conditions or other matters in which the mental competence of the defendant is necessary for a just resolution of the issues

being considered.

(31) Individual treatment team (ITT) means a group of three to five staff members with a range of clinical and rehabilitation skills who are assigned to the team by the team leader within one (1) week of the person's admission. The basic members of the ITT are:

- (a)** The primary case manager;
- (b)** The program psychiatrist; and
- (c)** One clinical or rehabilitation staff person who shares case coordination tasks. The individual treatment team has continuous responsibility for:
 - i.** Assessing the person's status and needs and progress toward recovery;
 - ii.** Developing the recovery plan with the active participation of the person served, and with consent, the person's family and/or significant others ; and
 - iii.** Directing and providing most of the person's treatment, rehabilitation, and support services.

Individual treatment team members are assigned separate service roles with the person as specified in the service/recovery plan.

(32) Individual supportive therapy means verbal therapy, in the form of face-to-face and one-to-one conversations with the person and focuses on helping the person understand and identify symptoms, lessens distress and symptomatology, enhance opportunities for recovery, improves role interactions, and increase participation in and satisfaction with treatment and rehabilitative services.

(33) Initial assessment and recovery plan means the initial evaluation of a person's mental health status and his or her recovery and practical resource needs (e.g., housing, finances). The initial recovery plan is completed on the day of admission and guides team services until the comprehensive assessment and recovery plan are completed.

(34) Intentional care standards means standards that guide staff in working in ways that are empowering and that support individuals in their recovery process.

(35) Medication administration means the physical act of giving medication to

a person consistent with the prescription.

(36) Medication error means any error in prescribing or administering a specific medication, including errors in writing or transcribing the prescription, or in obtaining and administering the correct medication, in the correct dosage, in the correct form, and at the correct time.

(37) Medication monitoring means a person is observed to determine and identify both beneficial effects and inadvertent or undesirable effects secondary to psychotropic medications.

(38) Mental health professional means a person with a master's degree or above in one of the health or social science fields or a Florida Licensed Registered Nurse.

(39) Mental illness, as defined by Chapter 394.455(18), Florida Statutes, means "an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology. For the purposes of this part, the term does not include retardation or developmental disability as defined in Chapter 393, Florida Statutes (F.S.), intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment.

(40) MyFloridaMarketPlace means the system described in Rule 60A-1.030, Florida Administrative Code (F.A.C.) that requires, with few exceptions, vendor registration and payment of fess in order to do business in the state.

(41) Not guilty by reason of insanity means a ruling by a court acquitting a defendant of criminal charges because of a mental defect sufficient under the law to preclude conviction.

(42) Observation of self-administration means, for FACT purposes only, the act of physically observing an enrolled FACT person taking his or her own medication.

(43) PACT Manual means a manual published by NAMI for operating a model of community-based treatment for persons with severe and persistent mental illnesses, cited as, Deborah J. Allness, M.S.S.W., William H. Knoedler, M.D., the PACT Manual for PACT Start-up, June 2003 Edition, NAMI Campaign to End Discrimination, NAMI, Anti-Stigma Foundation, Arlington, Virginia

(44) People First language means written narrative and written communication that eliminates such terms as "client", "patient", or "consumer" and reflects a philosophy and value system that promotes person-centered services, recovery, empowerment, cultural competency and reduces stigma

(45) Performance measures means quantitative indicators, outcomes and outputs that can be used by the department to objectively measure a provider's performance.

(46) Person with psychiatric disability means individuals with a diagnosis of a psychiatric disability who are receiving services through Florida's adult mental health service delivery system.

(47) Primary case manager means, for FACT purposes only, the team member that coordinates and monitors the activities of the individual treatment team. The primary case manager has primary responsibility for:

- (a)** Writing the recovery plan;
- (b)** Providing individual supportive therapy;
- (c)** Ensuring immediate changes are made in the recovery plan as the person's needs change; and
- (d)** Advocate for their rights and preferences.

The primary case manager is the first staff person called on when a FACT enrolled person is in crisis. The primary case manager provides support and education, upon consent of the person served, to their family. The primary case manager shares these tasks with other members of the person's individual treatment team, who are responsible to perform them when the primary case manager is not working or not available.

(48) Professional services contract means a contract with a licensed mental health professional to perform the duties that fall within the scope of the person's license on behalf of the contracting FACT team.

(49) Psychiatric/social functioning history time line means the process that helps to organize, chronicle and evaluate information about significant events in a person's life, experience with mental illness, and treatment history.

(50) Psychotropic medication means any drug used to treat, manage, or control psychiatric symptoms or disordered behavior, including but not limited to antipsychotic, antidepressant, mood-stabilizing or anti-anxiety agents.

(51) Recovery means a personal process of overcoming the negative impact of a psychiatric disability despite its continued presence. The recovery process describes the manner in which hope, vision, meaning and purpose are restored, and connection to one's community is established or reinstated in spite of the effects of the illness.

(52) Recovery Plan means the culmination of a continuing process involving the person served, his or her family or other supports upon consent, and the FACT team. The plan reflects individualized service activity and intensity to meet person-specific treatment, rehabilitation, and support needs that promote recovery. The written recovery plan documents the person's goals and the services necessary to achieve them. The recovery plan must reflect and be consistent with the individual's preferences for services and choices in the selection of living arrangements. The plan also delineates the roles and responsibilities of the Individual Treatment Team members who will carry out the services.

(53) Recovery planning meeting means a meeting that must include the person served. The team leader supervises this weekly scheduled meeting that:

- (a)** Assesses the individuals' needs and problems;
- (b)** Establishes measurable long- and short-term treatment goals;
- (c)** Plans treatment and services interventions; and
- (d)** Assigns staff persons responsible for providing the services.

(54) Recovery Plan Review means a written summary describing the person's progress since the last recovery-planning meeting; it outlines interactional strengths and limitations at the time the recovery plan is rewritten.

(55) Rehabilitation means, for FACT purposes only, the process of helping individuals minimize the effects of the symptoms and impairments of mental illness on major role skills and develop greater competencies in employment, activities of daily living and social performance and promoting recovery.

(56) Representative payee means an entity that is legally authorized to receive Supplemental Security Income, Social Security Income, Veterans Administration benefits, or other federal benefits on behalf of an individual receiving services.

(57) SAMH means Substance Abuse and Mental Health.

(58) SAMHIS means the Substance Abuse and Mental Health Data Information System.

(59) Self-administration means, for FACT only, the physical act of taking one's own medication.

(60) Shift manager means the individual assigned by the team leader and is

in charge of developing and implementing the daily staff assignment schedule. This person is charged with:

- (a)** Making all daily assignments;
- (b)** Ensuring that all daily assignments are completed or rescheduled; and
- (c)** Managing all emergencies or crises that arise during the course of the day, in consultation with the team leader and the psychiatrist.

(61) Stakeholders mean individuals or organizations that share a mutual interest in improving quality mental health care in Florida.

(62) Support means providing practical, hands-on assistance to help persons meet the necessities of daily living that will assist a person in their recovery process.

(63) Team leader means the individual who is the licensed clinical and administrative supervisor of the team and also functions as a practicing clinician. This individual is charged with:

- (a)** Assigning the person's psychiatrist, primary case manager, and individual treatment team members within one week of admission;
- (b)** Assigning the Shift Manager;
- (c)** Assist in developing the Comprehensive Recovery Plan; and
- (d)** Other duties as described within this contract.

(64) Treatment means a systematic approach to relieving the primary manifestations of mental illness. Relieving the symptoms and minimizing the time individuals spend in psychiatric hospitals sets the stage for successful rehabilitation and recovery. Treatment is intended to lessen and remove the symptoms of mental illness, prevent later reoccurrence or worsening of symptoms and helping individuals cope with symptoms when medications and other treatments are only partially successful. Treatment for FACT contains four elements:

- (a)** Psychopharmacological treatment;
- (b)** Individual support therapy;
- (c)** Crisis interventions; and when necessary
- (d)** Psychiatric hospitalization

(65) Unit measurement means deliverables to be used in billing the department for services. There are nine (9) different unit measurements. The definition of each can be found in Rule 65E-14.021(5)(a), F.A.C.

(66) Verifiable service means documentation of service provision in compliance with the requirements contained in Rule 65E-14.021, F.A.C.

(67) Virtual private network (VPN) means a network that is constructed by using public wires to connect nodes. There are a number of systems that enable the creation of networks using the Internet as the medium for transporting data. These systems use encryption and other security mechanisms to ensure that only authorized users can access the network and that the data cannot be intercepted.

(68) Weekly schedule means a written schedule of the specific interventions or service contacts (i.e., by whom, when, for what duration, and where) that fulfills the goals and objectives in a given person's recovery plan. This schedule shall be developed and maintained for each person enrolled in FACT.

2. General Description

a. General Statement

The services provided under this contract are community-based mental health services provided to adults as authorized in section 394.74, F.S.

Florida assertive community treatment (FACT) teams provide intensive, assertive community-based treatment that includes rehabilitation and support services for persons with psychiatric disabilities. These disabilities are typically schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), mood disorders such as bipolar disorders and major depression, and personality disorders such as obsessive-compulsive disorders, posttraumatic stress disorders, anorexia nervosa, borderline personality disorders, and dissociative identity disorders. These individuals must first meet the definition of mental illness according to Chapter 394, Florida Statutes (F.S.), and be in one of the target groups that fall under the auspices of the departmental performance measures as required by the Government Performance and Accountability Act of 1994.

b. Authority

Chapters 39, 393, 394, 415 F.S., and General Appropriations Act 2004-2005 which can be found at:
<http://www.flsenate.gov/data/session/2004/house/appbills/pdf/confrept.pdf>

Chapter 394.457(3), Florida Statutes, authorizes the Department of Children and Families, Mental Health Program Office to contract with vendors to provide programs that are beneficial to persons with symptoms of mental illness and that ameliorate the associated symptoms. Section 287.057, and section 402.73(1), Florida Statutes, requires the competitive re-procurement of these programs.

c. Scope of Service

The provider is responsible for the administration and provision of FACT services in the following counties:

(Circuits Complete)

d. Major Program Goals

The major FACT program goals are to:

- (1)** Implement the FACT programs as described in this attachment, and
- (2)** Achieve measures of successful outcomes including the following:
 - (a)** Lessening or eliminating the debilitating symptoms of mental illness that the individual experiences, and minimize or prevent recurrent acute episodes of the illness, and promote recovery;
 - (b)** Meeting basic needs and enhance quality of life;
 - (c)** Improving interactions in adult social and employment roles and responsibilities;
 - (d)** Reducing hospitalization;
 - (e)** Increasing days in the community;
 - (f)** Collaborating with the criminal justice system to minimize or divert incarcerations; and
 - (g)** Lessening the families and significant others' role of providing care.

3. Individuals to Be Served

a. General Description

- (1)** Persons who receive FACT services have severe mental illness symptoms and impairments that are not adequately served in the traditional service delivery system. They are at high risk of repeated psychiatric hospital

admissions, prolonged inpatient psychiatric hospitalization, or repeated crisis stabilization unit use because of their severe psychiatric symptoms and significant interactional impairments and lack of available community-based services. Many may have co-occurring substance abuse disorders and some may have co-occurring mild mental retardation. Many may be homeless and/or involved with the local judiciary due to various misdemeanor violations.

(2) The provider shall serve one hundred (100) persons by enrolling thirty (30) people during the first six (6) months of operation, thirty (30) people during the second six (6) months of operation and forty (40) people during the second year of operation.

b. Service Eligibility

The provider shall provide supports and services in ways that recognize the cultural differences in persons who have long lasting psychiatric disabilities. The provider shall also provide services and supports that meet the needs of persons with severe and persistent mental illness. These same persons may be physically disabled, HIV positive or have AIDS and/or who may have co-occurring substance abuse disorders or co-occurring mild mental retardation.

c. Service Recipient Determination.

(1) The Department of Children and Families' circuit mental health program office where the team is contracted to provide services shall approve or disapprove all admissions to the FACT teams within five working days upon notification by the FACT team. The Department of Children and Families circuit mental health program offices shall also approve discharges, transfer or relocation of any person served by the FACT team within the same time frame. Each FACT provider must accept for enrollment all referrals made by the circuit mental health program office.

(2) The vendor shall be required to administer the Functional Assessment Rating Scale (FARS) consistent with the requirements contained in the Department of Children and Families Pamphlet 155-2. Vendors may be trained on administering the FARS through the Florida Mental Health Institute's web page at <http://outcomes.fmhi.usf.edu> A Manual can also be downloaded.

(3) Admission criteria to the FACT program contain three major areas:

(a) Threshold Requirements:

FACT teams must comply with the following parameters when at full capacity or while achieving full capacity:

- i. At least 50 percent (50%) of FACT members enrolled must be directly discharged from the state hospital serving the circuit if adequate referrals by the state hospital are made to the FACT team.
- ii. At least 60 percent (60%) of all persons served by the FACT program shall be eligible for Medicaid. As Health Maintenance Organizations (HMOs) are capitated for Community Behavioral Health Services and Targeted Case Management, FACT teams must be aware of Medicaid procedures for enrollment and disenrollment from managed care plans.
- iii. Enrollment into FACT: Once an individual enrolled as a member of a HMO, Prepaid Plan, or Provider Services Network is enrolled as a FACT member, the FACT teams shall fax a listing of the new enrollees monthly to the Medicaid Area Office. The Medicaid Area Office must fax the listing to the Agency for Health Care Administration (AHCA), Bureau of Managed Health Care (MHC). FACT members will be disenrolled from HMOs by MHC. Timely notification is important to avoid duplication of payment.
- iv. Disenrollment from FACT: All individuals who disenroll from FACT are placed back in the managed care assignment pool. They receive a letter informing them that they will be assigned to a specified plan unless they call Medicaid Options to choose the same plan they enrolled in prior to enrolling in FACT. However, persons assigned to a plan will be able to change plans or enroll in Medipass by calling Medicaid Options, the enrollment broker for Medicaid.

(b) Clinical Requirements:

The individual must have a diagnosis within one of the following categories as referenced in the American Psychiatric Association's Diagnostic and Statistical Manual-IV, 4th Edition or the latest revised edition thereof:

- i. Schizophrenia and Other Psychotic Disorders (295 series);
- ii. Mood Disorders (296 series);
- iii. Anxiety Disorders (300 series); and
- iv. Personality Disorders (301 series).
- v. Additionally, the individual must meet one of the following six criteria:

1. Demonstrate a high risk for hospital admission or readmission;
 2. Have prolonged inpatient days (more than 90 days within one calendar year);
 3. Have repeated (more than three (3) episodes per calendar year) local criminal justice involvement;
 4. Have been referred for aftercare services by one (1) of the state's correctional institutions;
 5. Referred from an inpatient detoxification unit and documented history of co-occurring disorders; or
 6. Have repeated (more than 3 admissions within one calendar year) crisis stabilization contacts; and
- vi. Meet at least three (3) of the following six (6) characteristics:
1. Inability to consistently perform the range of practical daily living tasks required for basic adult interactional roles in the community. These tasks include maintaining personal hygiene, meeting nutritional needs, or caring for personal business affairs. The tasks may also include obtaining medical, legal, and housing services, recognizing and avoiding common dangers or hazards to self and possessions. Persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others such as friends, family, or relatives also is considered to be part of the range of daily tasks required;
 2. Inability to be consistently employed at a self-sustaining level or inability to consistently carry out the homemaker role (e.g., household meal preparation, washing clothes, budgeting or child-care tasks and responsibilities);
 3. Inability to maintain a safe living situation (repeated evictions, loss of housing, or no housing);
 4. Coexisting substance use disorder of significant duration (greater than six months) or coexisting mild mental retardation;
 5. Destructive behavior to self or others; or
 6. High-risk or recent history of criminal justice involvement (arrest and incarceration).

(c) Forensic Requirements:

All persons enrolled in a forensic FACT team must first meet the eligibility criteria described above and, additionally, meet the following requirements:

i. Individuals eligible for services from the forensic FACT team must have a valid Chapter 916, Florida Statutes conditional release order. Individuals may be either incompetent to proceed or not guilty by reason of insanity and may be placed on conditional release as a discharge from a state mental health treatment facility in lieu of an involuntary commitment to a state mental health treatment facility.

ii. A circuit court may order a conditional release of an individual based on an approved plan for the FACT team providing appropriate supervision, community outpatient care and treatment. Individuals referred to or are participating in any departmentally-sponsored forensic program, either pre-booking or post-booking are eligible. The plan shall include:

1. Special provisions for residential care or adequate supervision of the defendant;
2. Provisions for FACT team mental health services; and
3. If appropriate, recommendations for auxiliary service such as vocational training, educational services or special medical care.

iii. In its order, the court must approve the conditions of the release plan. The FACT team must submit periodic reports to the court regarding the individual's compliance with the conditions of the release plan and progress in treatment. Copies of the reports must be sent to the State Attorney and the individual's attorney.

iv. The FACT team will assist in the design and implementation of an individualized recovery plan for each individual. Services will include the provision of the fifteen (15) specified mental health treatment, rehabilitation and support services as well as competency training for individuals adjudicated incompetent to proceed, and such other medical, vocational, social, educational and rehabilitative services the person's condition requires to assist in successful community living.

(4) Discharge criteria from FACT contain two major categories:

(a) Basis for discharge:

Discharges from the FACT team may occur when persons served by the

FACT team meet one of the following criteria:

- i. The person moves outside of the geographic areas of the FACT team's responsibility. In such cases, the FACT team shall notify the Department of Children and Families' Circuit Substance Abuse and Mental Health Program Office ___ of the pending relocation. The FACT team, in consultation with the Department of Children and Families' Circuit Substance Abuse and Mental Health Program Office ___, arranges for transfer of mental health service responsibility to a provider with a FACT team to where the person is moving if possible. The FACT team shall maintain contact with the person until this service transfer is completed;
- ii. The person moves outside of the geographic areas of the FACT teams' responsibility and moves outside of the State of Florida. In such cases, the FACT team will not administratively discharge the person until a period of sixty (60) days of moving has passed;
- iii. The person demonstrates an ability to perform on a continued basis in major role areas (i.e., work, social, and self-care) without requiring assistance from the program. This determination is to be made jointly by the person, the FACT team psychiatrist, the FACT Team Leader, team members and family members, upon consent;
- iv. The person requests discharge, despite the team's repeated efforts to develop a recovery plan acceptable to the person served by the team. When this criterion is used, documentation of the efforts to continue FACT services without success must be clearly described in the clinical record.
- v. The person has been admitted to a state mental health treatment facility and has remained in such facility for a period exceeding one year and after direct consultation with the individual's treatment team at the facility, it has been determined that there is no immediate, anticipated date of discharge; or
- vi. The person has been adjudicated guilty of a felony crime and subsequently sent to a state or federal prison for a sentence that exceeds one year.

There must be documentation in the clinical record that the person discharged was advised he or she may return to the FACT team if they desire and if space is available.

(b) Documentation of discharge process:

There must be documentation in the medical record of the following

discharge tasks:

- i. The reason(s) for discharge;
- ii. The person's status and condition at discharge and a written statement of concurrence from the circuit;
- iii. A written final evaluation summary of the person's progress toward the desired outcomes and goals set forth in the person's recovery plan;
- iv. A plan developed in conjunction with the person served by the FACT team for treatment upon discharge and for follow-up that includes the signature of the primary case manager, team leader and psychiatrist, the signature of the person or legal guardian, if appointed; and discharge planning activities including linkages and transitional plans to other providers; and
- v. Documentation of referral information made to other agencies upon discharge.

(5) Inter-Circuit Transfers of Persons Served:

(a) FACT teams will find that individuals may wish to move to another area of the state. When an individual plans to move out of the circuit served by the team, the team shall contact their circuit Substance Abuse and Mental Health Program Office and request their assistance in arranging for the transfer of services from the originating circuit to the new circuit. The originating circuit shall contact the receiving circuit to determine:

- i. If the receiving circuit team(s) have capacity to accept the transfer; and
- ii. A date of transfer.

(b) When it has been determined that space is available and a date of transfer has been established, the originating team must:

- i. Obtain consent to release information from the person being transferred;
- ii. Copy the clinical record;
- iii. Send the copy of the clinical record to the team that has agreed to accept the transfer on the last day of service to be provided to the transferring individual;

iv. Confirm that appropriate transportation arrangements have been made; and

v. Follow up with a phone call to the receiving team to confirm receipt of the copied clinical record.

(c) FACT teams are obligated to accept any transfers from other circuits if the team has remaining capacity. Upon arrival, the receiving team shall review the clinical record, conduct an initial assessment and admission process, assess the person's current medication regime, consult with the program psychiatrist and make a clinical determination as to the need to:

vi. Conduct a new comprehensive assessment; or

vii. Develop a new recovery plan.

(d) If a clinical determination is made to conduct a new comprehensive assessment and develop a new recovery plan, the same guidelines for completing the original comprehensive assessment and recovery plan shall be followed. If a determination has been made that it is not necessary to complete a new comprehensive assessment or recovery plan, the existing assessment and plan shall be placed in the new clinical chart in the sections identifying the location of the assessment and plan. When a new recovery plan is developed, the existing recovery plan that came from the originating team shall be placed in the correspondence section of the clinical record.

(e) The provider must accept and enroll all referrals exclusively from the Department of Children and Families' Substance Abuse and Mental Health Circuit Program Office ____.

d. Contract Limits:

(1) The provider shall serve, at a minimum, one hundred (100) persons.

(2) The Department of Children and Families' Circuit Substance Abuse and Mental Health Program Office ____ reserves the right to alter or adjust the number of persons enrolled by any amount.

(3) The provider shall submit a Monthly Enrollment Report, **Exhibit I, Monthly Enrollment Report** to notify the department monthly of its monthly enrollment levels. If the provider fails to meet the required enrollment levels as stated in **Exhibit C, Substance Abuse and Mental Health Required Outcomes and Outputs**, for thirty (30) calendar days, the department will require the provider to develop a corrective action plan stating how the provider plans to

comply with the enrollment requirement. Then, if the provider fails to remedy the situation within sixty (60) calendar days, the department will apply a financial penalty as stated in the department's Standard Contract, Section III, B., Section 402.73(1) F.S., and 6-29.001 F.A.C.

B. Manner of Service Provision

1. Service Tasks

a. Task List

(1) The FACT approach to performing services and administrative tasks must be implemented through the abiding belief in the dignity and worth of the individual. Services that are based on recovery and empowerment are more likely to support the goals of the individual and the Recovery Plan. This process can be described in a number of ways, but at a minimum must incorporate the following principles:

(a) Choice: Choice is more than given an opportunity to a yes/no or either/or circumstance. Meaningful choices mean having a range of options from which to choose. This is best demonstrated in decision-making. Individuals receiving mental health services have often in the past been viewed by professionals to lack the ability to make decisions, or to make correct decisions. Many programs assumed a paternalistic stance of limiting choices that individuals of service may make. To become independent and achieve recovery, it is important that individuals be given the opportunity to make important decisions about their life.

(b) Cultural Competence: In a mental health context, cultural competence means acknowledging and incorporating variances in normative acceptable behaviors, beliefs and values in determining an individual's mental wellness/illness and incorporating those variables into assessments and treatment that promote recovery.

(c) Person-Centered: A person-centered approach promotes individual service recipients and family as the most important participants in the service-providing process. People are unique in their individual needs and supports and services should be delivered accordingly, with assistance in achieving personal goals and outcomes. The system of care must recognize, respect and address the differences of gender, age, race, culture, and religion and deliver relevant services and supports.

(d) Rights of Persons Served: Recognizing that the rights of persons served go well beyond those rights specified in Chapter 394, F.S., and include basic human and civil rights. These rights should include a mechanism to strengthen an individual's confidence by assuring that the

system of care is fair and responsive to their needs; providing individuals credible and effective mechanisms for addressing their concerns; and reaffirming the importance of a strong relationship between individuals and their mental health professionals.

(e) Stakeholder inclusion: This can be demonstrated at the organizational level through board membership or at the service level through ad hoc committees such as the FACT Advisory Committees. Stakeholder inclusion ensures that organizational services and culture are reflective of the community's racial, cultural and economic composition.

(f) Voice: Individuals should have a say in the programs, policies, and the services designed to serve them; additionally

(2) The provider agrees to provide the following Treatment, Rehabilitation, and Support Services to all FACT individuals.

(a) Treatment Services:

i. The provider shall provide an initial assessment and recovery plan. The team leader and the psychiatrist, with the active participation of the person served and designated team members, shall do an initial assessment and recovery plan on the day of the person's admission to the FACT program. The required components of an initial assessment, at a minimum, include:

1. A mental status examination;
2. Assessment of symptoms;
3. An initial psychosocial history;
4. An initial health/medical assessment by a FACT team nurse;
5. A review of previous clinical information obtained at the time of admission; and
6. A preliminary identification of the person's housing, financial and employment status, and
7. A preliminary review of their strengths, challenges and preferences.
8. There must be documentation of task completion recorded in the person's clinical record.

ii. The provider shall provide a comprehensive assessment. The

comprehensive assessment shall be initiated and completed within sixty (60) days of the person's admission to the FACT program following these requirements:

1. Each assessment area shall be completed by the FACT team member with skill and knowledge in the area being assessed and shall be based upon all available information, including self-reports, reports of family members, upon consent, and other significant parties, and written summaries from other agencies, including police, courts, and outpatient and inpatient facilities where applicable.

2. The comprehensive assessment shall include an evaluation of the following areas:

- a.** Psychiatric history, mental status and a DSM-IV diagnosis,
- b.** Physical health assessment,
- c.** Assessment of the use of drugs or alcohol,
- d.** Assessment of education and employment,
- e.** Assessment of social development and functioning,
- f.** Assessment of activities of daily living, and
- g.** Assessment of family relationships.

3. The enrolled person's psychiatrist, primary case manager, and individual treatment team (ITT) will assume responsibility for preparing the written assessment, and the ITT will ensure that a Comprehensive Recovery Plan is developed upon completion of the comprehensive assessment.

4. The person's psychiatrist, primary case manager, and individual treatment team members shall be assigned by the team leader within a week of admission.

5. To supplement the comprehensive assessment, a psychiatric/social functioning history time line is to be completed. The time line is a form that helps to organize and evaluate information about significant events in the person's life, experience with mental illness and treatment history. When the time line is completed, it provides a picture that enables the team to understand how information and significant events are related.

The psychiatric/social functioning history time line is to be completed no later than one hundred twenty (120) days of the first day of admission.

6. There must be documentation of task completion recorded in the person's clinical record.

iii. The provider shall develop a Comprehensive Recovery Plan. The recovery plan is a reflection of the person's needs, strengths, and preferences. It identifies specific measurable long and short-term goals along with the specific services and activities necessary for the person to meet those goals and improve his or her capacity to interact in the community and achieve recovery. The Comprehensive Recovery Plan shall be completed within ninety (90) days of admission.

1. The recovery plan shall be developed in collaboration with the person, guardian, if any, and when feasible and upon consent, the person's family. The person's active participation in the development of the recovery plan shall be documented.

2. FACT team members shall meet at regularly scheduled times with the person for recovery planning meetings. At each meeting, the person, team leader, psychiatrist, primary case manager, individual treatment team members and all other FACT team members involved in regular tasks with the person shall be present.

3. The person shall have the option of asking others to attend the meeting.

4. Each recovery plan shall be based on the assessment findings and:

a. Identify the person's strengths, challenges, needs and limitations, their short-term and long-term goals, their choices and preferences of service, and specific measurable treatment objectives that clearly specify the services and activities necessary to meet their needs and who will be providing those services and activities;

b. Address symptom stability, symptom management and education, transportation, housing, activities of daily living, employment, daily structure, and family and social relationships; and

c. Be revised every six (6) months, unless clinically indicated earlier, by the primary case manager, individual treatment team, and the person receiving the services.

d. There must be documentation of task completion in the person's clinical record.

iv. The provider shall provide crisis assessment and intervention. Crisis assessment and intervention shall be provided on a twenty-four (24) hours per day, seven (7) days per week basis. These services will include telephone and face-to-face contact. This service requires the establishment of an on-call schedule to implement a crisis contingency plan. Mental health professionals, including the team leader, shall be available for on-call duty on a rotating basis. This service may be provided during normal operating hours or after hours. On call hours are in addition to regularly scheduled work hours. When used after hours, the assigned on-call staff must be available to respond either by telephone or by face-to-face intervention. On-call assignments are not expected to physically be at the FACT office during on-call nor are they expected to remain awake during the on-call duty.

v. The provider shall provide symptom assessment, management and individual supportive therapy. Symptom assessment, management, and individual supportive therapy help the person cope with and gain mastery over symptoms and impairments in the context of adult role activities. This therapy shall include, but not necessarily be limited to:

- 1.** Ongoing assessment of the person's symptoms of mental illness and response to treatment;
- 2.** Education of the person regarding his or her illness and the effects and side effects of prescribed medications, when applicable;
- 3.** Symptom management efforts directed to help each person identify the symptoms and occurrence patterns of his or her mental illness and develop internal, behavioral, or adaptive methods to help lessen their effects; and
- 4.** Generous psychological support to persons, both on a planned and as-needed basis, to help them accomplish their personal goals and to cope with the stresses of day-to-day living.

vi. The provider shall provide medication prescription, administration, monitoring and documentation. This task shall involve the team's psychiatrist:

1. Assessing each person's mental illness symptoms and behaviors and prescribing appropriate medication;
2. Regularly reviewing and documenting the person's symptoms of mental illness, as well as his or her response to prescribed medication treatment;
3. Educating the person regarding his or her mental illness and the effects and side effects of medication prescribed to regulate it; and
4. Monitoring, treating, and documenting any medication side effects.
5. Additionally, all FACT team members shall assess and document the person's symptoms of mental illness and behavior in response to medication and shall monitor for medication side effects; and
6. All FACT team members shall be aware of the availability of funds for medication supplementation for non-Medicaid persons enrolled.

vii. The provider hereby agrees to provide substance abuse services to persons with co-occurring mental health and substance use disorders. One or more mental health professionals with training and experience in substance abuse assessment and treatment shall be designated the role of substance abuse specialist. The most effective assessment and treatment approaches employ an integrated treatment model in which mental health and substance abuse treatment are provided simultaneously. The provision of a stage-based treatment model that is non-confrontational, considers interactions of mental illness and substance abuse, and has person-determined goals. This approach includes but is not limited to individual and group interventions settings. A stage-based approach involves:

1. Engagement (e.g., empathy, reflective listening, avoiding argumentation);
2. Assessment (e.g., state of readiness to change, person-determined problem identification);
3. Motivational enhancement (e.g., psychoeducation);
4. Active treatment (e.g., cognitive skills training, community

reinforcement); and

5. Continuous relapse prevention (e.g., trigger identification, building relapse prevention action plans).

(b) Rehabilitation Services

i. The provider hereby agrees to provide work-related services. Such services shall help persons find and maintain employment in community-based job sites and include:

1. Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs;
2. Assessment of the effect on the person's symptoms of mental illness on employment, with identification of specific behaviors that interfere with the person's work performance and development of interventions to reduce or eliminate those behaviors;
3. Development of an ongoing employment rehabilitation plan to help each person establish the skills necessary to find and maintain a job;
4. Individual supportive therapy to assist persons served to identify and cope with the symptoms of mental illness that may interfere with their work performance;
5. On-the-job or work-related crisis intervention;
6. Work-related supportive services, such as assistance with grooming and personal hygiene, securing of clothing, wake-up calls, and transportation; and
7. Educating the person enrolled as to work incentives such as the Social Security Administration's Ticket to Work and P.A.S.S. (Plans for Achieving Self Support). Work-related activities are a critical element toward recovery and achieving successful community tenure.

ii. The provider hereby agrees to provide support in activities of daily living. Such services shall support activities of daily living in community-based settings, typically in the person's home, and will include:

1. Individualized assessment;
2. Problem solving;
3. Side-by-side assistance and support;
4. Skill training;
5. Ongoing supervision such as prompting, assignments, monitoring, encouragement; and
6. Environmental adaptations to assist persons to gain or use the skills required to:
 - a. Carry out personal hygiene and grooming tasks;
 - b. Perform household activities including house cleaning, cooking, grocery shopping, and laundry;
 - c. Find and maintain or retain housing that is safe and affordable;
 - d. Develop or improve money-management skills;
 - e. Use available transportation; and
 - f. Have and effectively use a personal physician and dentist.

Activities of daily living are a critical element toward recovery and achieving successful community tenure.

iii. The provider hereby agrees to provide social, interpersonal relationship and leisure time training and support. Such services shall include:

1. Supportive individual therapy such as problem solving, role-playing, modeling, and support;
2. Social-skill teaching, and assertiveness training;
3. Planning;
4. Structuring and prompting of social and leisure-time activities;
5. Side-by-side support and coaching; and
6. Organizing individual and group social and recreational

activities to structure the persons' time, increase their social experience, and provide them with opportunities to practice social skills and receive feedback and support required to:

- a. Improve communication skills, develop assertiveness, and increase self-esteem as necessary;
- b. Develop social skills, increase social experiences, and where appropriate, develop meaningful personal relationships;
- c. Plan use of leisure time;
- d. Relate to landlords, neighbors, and others effectively; and
- e. Familiarize themselves with available social and recreational opportunities and increase their use of such opportunities.

(c) Support Services

- i. The provider shall provide FACT case management services. The primary case manager shall coordinate and monitor the activities of the individual treatment team. The primary case manager has primary responsibility to coordinate the development of the recovery plan, to provide individual supportive therapy, to ensure immediate changes are made in recovery plans as the persons' needs change, and to advocate for the person' rights and preferences. Additionally,
 1. The primary case manager is the first staff person called on when the person is in crisis and, upon consent, is the primary support person and educator to the individual persons' family.
 2. Mental health professionals on the FACT team have responsibility to provide case management services.
 3. Members of the persons' individual treatment team share these tasks with the case manager and are responsible to perform the tasks when the primary case manager is not working or not available.
- ii. The provider hereby agrees to provide supportive services. These services or direct assistance shall ensure that persons obtain the basic necessities of daily life and include, but are not necessarily limited to:
 1. Medical, dental and vision services;

2. Financial support;
3. Social services;
4. Transportation; and
5. Advocacy.

iii. The provider hereby agrees to provide and/or arrange for safe, decent, affordable living arrangements. This service shall ensure that a person is given the opportunity to obtain the type of living arrangement of his or her choice. This service requires that a FACT team member have knowledge about the housing resources within the community where the FACT program is located. The FACT Team member should also have knowledge and skills in accessing Section 8 rental vouchers from local housing authorities, have an awareness of Housing and Urban Development (HUD) housing availability and working with landlords in the community to secure a lease that specifies the terms and conditions of the rental and be aware of the program's housing subsidy.

iv. The provider hereby agrees to provide education, support and consultation services to the person's family and significant others. Such services shall be provided to family members and significant others, with the person's agreement or consent, and shall include:

1. Education about the person's illness and the role of the family in the recovery process;
2. Intervention to resolve conflict; and
3. Ongoing communication and collaboration, face-to-face and by telephone, between team members and the family.
4. The provider hereby agrees to provide other unique, person-specific services as necessary to implement a person's recovery plan. These unique, person-specific services are services that may be required to ensure a person's treatment and service needs are fully addressed. When using this service category, the specific service or services to be rendered must be identified with an estimation of the time frame the service or services will be provided.

(3) The provider shall also be responsible for performing the following administrative tasks:

- (a) The provider shall enforce staff communication and planning requirements of FACT.
- (b) The provider shall provide staff supervision.
- (c) The provider shall establish, maintain or comply with the FACT Operating Procedure for Management of Medications for Florida Assertive Community Treatment that is included herein as **Exhibit K, Medication Management Policy**.
- (d) The provider shall establish, maintain or comply with written admission and discharge policies and procedures consistent with Section B.4.b., of this Attachment I;
- (e) The provider shall establish, maintain or comply with written personnel policies and procedures; and
- (f) The provider shall maintain a personnel file on each FACT team member.
- (g) The provider shall establish and maintain written program organization policies and procedures including required hours of operation and coverage, service intensity, staff communication and planning, emphasis on teamwork approach, staff supervision, and place of treatment that includes a minimum of 75 percent (75%) of service delivery takes place out of the office.
- (h) The provider shall establish and maintain written policies and procedures governing assessments and recovery planning.
- (i) The provider shall establish and maintain written policies and procedures governing the provision of each of the following services:
- i. Initial assessment and initial recovery plans;
 - ii. Comprehensive assessments;
 - iii. Recovery planning;
 - iv. Case management;
 - v. Crisis assessment and intervention;
 - vi. Symptom assessment, management, and individual supportive therapy;

- vii.** Medication prescription, administration, monitoring, and documentation;
- viii.** Substance abuse services for persons with co-occurring substance abuse disorders;
- ix.** Work-related services;
- x.** Activities of daily living;
- xi.** Social, interpersonal relationship and leisure-time skill training;
- xii.** Support services;
- xiii.** Provisions or arrangements for safe, decent, affordable living arrangements; and
- xiv.** Education, support and consultation to the person's family and significant others.
- xv.** Other unique, person-specific services that may be necessary.

(j) The provider shall establish and maintain written medical records and records management policies and procedures:

i. The policy must ensure the record is to be confidential, complete, accurate, and contain up-to-date information relevant to the person's care and treatment. The policy must state that the record shall sufficiently document assessments, recovery plans, and the nature and extent of services provided, such that a person unfamiliar with the FACT team can identify the person's treatment needs and services received. The policy must indicate the team leader, and the program assistant shall be responsible for the maintenance and security of the medical record. The policy must ensure that records are to be kept in the FACT headquarters and kept in a locked file when not in use. The policy must also state that the disclosure of medical records is subject to all the provisions of applicable state and federal laws. The policy must also ensure that the record shall be available for review by the person served and the guardian, if any. The structure and order of the medical record shall be as follows:

- Tab I - Longitudinal Face Sheet
 - Identifying information
- Tab II - Problem List
 - Formulation and listing of the individual's problems

- Tab III - Physician Orders and Informed Consent for Medication
 - Record of the psychiatrist's orders; method of medication administration and laboratory tests
 - Informed consent for medication; the record that risks and benefits of the prescribed medication have been explained to the person/guardian
- Tab IV - Medication Administration Record (MAR)
 - Two forms
 1. A record of each medication a person receives including the dosage and the administration route, date, and time
 2. Chronological list of the person's medications
- Tab V - Recovery Plans and Recovery Plan Reviews
 - Initial recovery plan completed at enrollment
 - Comprehensive Recovery Plan completed by ITT within 60 days
 - Recovery plan reviews and revisions
- Tab VI - Progress Notes
 - A record of ALL staff contact and communications
 - Each progress note must be entitled as one of the 15 specific FACT services
- Tab VII - Assessments
 - Initial assessment upon enrollment
 - Comprehensive assessment within 60 days of enrollment that includes:
 - Part 1 Psychiatric history, mental status exam and diagnosis
 - Part 2 Physical health
 - Part 3 Use of alcohol and drugs
 - Part 4 Education and employment
 - Part 5 Social development and functioning
 - Part 6 Activities of daily living (e.g., self-care, living situation, nutrition, money management)
 - Part 7 Family structure and relationships
 - Psychiatric/Social Functioning History Time Line within 120 days of enrollment.
- Tab VIII - Consultation Reports
 - Evaluations made by other physicians, clinical specialists and outside entity reports as requested by the program psychiatrist
- Tab IX - Lab Reports
 - Diagnostic and laboratory data (hematology, chemistry, radiology, etc)
- Tab X - Referral Information and Correspondence
 - Referral information
 1. Source of referral
 2. Past records

(k) The provider shall establish and maintain a written Quality Assurance/Quality Improvement performance policy and procedure.

(l) The provider shall establish and maintain a written risk management policy and procedure; and

(m) The provider shall establish and maintain written policies and procedures on the rights of persons served by the FACT team.

(n) The provider shall keep accurate records reflecting the specific services offered to each person under this contract. All records of care, treatment, supervision and support created under this contract shall become part of the treatment records and made available to the Department of Children and Families' Mental Health Program Office and the Circuit ___ Mental Health Program Office upon request. Disclosure of treatment information by the provider, or to the provider by employees of the department, is subject to all the provisions of applicable state and Federal laws that are incorporated herein by reference. Each person's record shall be available for review at all times to department staff when requesting such in the regular performance of their duties. The records of any individual discharged from treatment with the provider shall be turned over to department staff to be transferred to the appropriate circuit when a FACT individual is transferring to another circuit or shall be maintained by the provider in accordance with existing rules.

(o) The provider shall coordinate services with other entities to ensure the needs of the person served are addressed at any given time. Coordination activities may include, but are not limited to, the following:

- i. United Way, county social services, state funded programs, faith-based organizations, neighborhood programs;
- ii. Law enforcement;
- iii. The business community;
- iv. Healthcare providers and social service agencies;
- v. Housing and employment agencies;
- vi. Local psychiatric and general hospitals;
- vii. Local jails as necessary;
- viii. Local public health offices; and

ix. Local Social Security Administration offices.

(p) The provider shall provide staff training, maintain personnel records and conduct supervision, to ensure staff are aware of their obligations as an employee. Activities may include, but not limited to, the following:

- i.** Providing an orientation to new employees;
- ii.** Reviewing administrative procedures;
- iii.** Reviewing confidentiality of treatment records; and
- iv.** Reviewing the rights of persons served.

b. Task Limits

The provider shall not perform any tasks related to the project other than those described in Section B.1, B.2, and B.3 of this attachment without the express written consent of the department.

2. Staffing Requirements

a. Staffing Levels

(1) The provider shall maintain an adequate administrative organizational structure and support staff sufficient to discharge its contractual responsibilities. The staffing composition is consistent with the PACT model as referenced in the NAMI-published PACT Start-Up Manual.

(2) The provider shall submit a Monthly Vacant Position Report, **Exhibit H, Monthly Vacant Position Report** to notify the department monthly of any existing staff vacancies. If the provider fails to meet the required staffing levels as stated in **Exhibit C, Substance Abuse and Mental Health Required Outcomes and Outputs**, for thirty (30) calendar days, the department will require the provider to develop a corrective action plan stating how the provider plans to comply with the staffing requirement. Then, if the provider fails to remedy the situation within sixty (60) calendar days, the department will apply a financial penalty as stated in the department's Standard Contract Section III, B., Section 402.73(1), F.S., and Rule 6-29.001, F.A.C.

(a) A position shall not be deemed vacant when an employee is temporarily absent due to paid vacation, paid sick leave, management and professional conferences, in-service training, or other temporary leave condition. Further, a position shall be deemed not to be vacant if filled through the use of overtime, contract services, or temporary employees.

- (b)** In any event, the provider must perform all functions and services specified in this agreement, regardless of whether these functions are performed by in-house employees, contracted professionals, or other similar contractual arrangements.
- (3)** The FACT team, with the exception of the program psychiatrist who may be employed or contracted by the team on a part-time basis, shall employ no clinical staff part-time without the written permission of circuit staff. Psychiatric services of 16 hours per week for every fifty (50) persons served by FACT must be available.
- (4)** The following is the minimum staffing configuration for each FACT team:
- (a)** A mix of individuals with clinical and rehabilitation training and experience;
 - (b)** Eighty (80) percent of all staff must be mental health professionals;
 - (c)** One (1) FTE Team Leader;
 - (d)** 0.8 FTE Program Psychiatrist for every 100 persons served by FACT;
 - (e)** At least one (1) Florida licensed Registered Nurse must be on duty each workweek day defined as Monday through Friday;
 - (f)** At least one (1) or more staff must serve as employment specialists;
 - (g)** At least one (1) or more staff must have training and experience in providing substance abuse services;
 - (h)** At least one (1) peer specialist must be employed;
 - (i)** At least one (1) program assistant must be employed; and
 - (j)** No more than 12.3 staff may be employed with FACT funds.
- (5)** The provider shall maintain a current organizational chart indicating required staff and displaying organizational relationships and responsibility, lines of administrative oversight and clinical supervision. Staff must conduct activities in accordance with their professional regulations and state law.

b. Professional Qualifications

- (1)** The provider shall document that all staff has adequate education and training to perform the duties for which they are assigned and meet all applicable licensing or certification requirements for their respective disciplines.

- (2)** The provider shall also ensure staff competence and sensitivity in providing treatment to persons of diverse cultural backgrounds. Every effort shall be made to hire staff that is responsive to the needs of minority individuals.
- (3)** The provider shall document its efforts to recruit and hire staff that has the expertise for providing Dialectical Behavior Therapy (DBT) for the treatment of individuals with Borderline Personality Disorders.
- (4)** All program staff will be required to participate in staff training authorized by the department.
- (5)** The following requirements apply to FACT Team positions:

(a) The Team leader

A full-time Florida-licensed mental health professional must be the team leader and is the clinical and administrative supervisor of the team and also functions as a practicing clinician. The team leader must possess a master's degree in nursing, social work, psychiatric rehabilitation, or be a psychologist, or psychiatrist. If the team leader is a registered nurse, it will not replace the requirement for a registered nurse on duty each day. The team leader is to receive clinical supervision from the program psychiatrist and administrative supervision from the FACT provider's Chief Executive Officer or designee.

(b) The Program Psychiatrist

A psychiatrist works on a full-time or part-time basis for a minimum of sixteen (16) hours per week for every fifty (50) persons served by the team. The psychiatrist provides clinical services to all persons served by the FACT team, works with the team leader to monitor each person's clinical status and response to treatment, assists in clinical supervision of staff delivery of services, and directs psychopharmacological and medical treatment. The program psychiatrist must be board certified or has access to a board certified psychiatrist for consultation.

(c) Peer Specialist

This is a person who is or has been a individual receiving mental health services for severe and persistent mental illness. Because of their life experience with mental illness and mental health services, the peer specialists provide expertise that professional training cannot replicate. Peer specialists are fully integrated team members who provide highly individualized services in the community and promote self-determination and decision-making. Peer specialists also provide essential expertise and consultation to the entire team to promote a culture in which each person's point of view and preferences are recognized, understood,

respected, and integrated into treatment, rehabilitation, and community self-help activities. Peer Specialists must meet the professional requirements and standards set forth by the Florida Certification Board and as such are certified by the state of Florida as a Certified Recovery Peer Specialist within one year of employment. The individual should also meet the other standard requirements for employment. Their special mental health professional qualification will be compensated on an equitable basis with other members of FACT.

(d) Registered and Licensed Practical Nurses

Preferred staffing for each FACT team would include three (3) RN's; however, one (1) RN and two (2) LPNs would be deemed an acceptable minimum. Registered and licensed practical nurses work closely with the program psychiatrist, monitor medication prescriptions, document effectiveness and response to medications or side effects and serve as members of individual treatment teams.

(e) Mental Health Professionals

There must be at least two Florida licensed mental health professionals on staff. One mental health professional, preferably with a master's degree in rehabilitation counseling, must be designated for the role of employment specialist. FACT staff members with training and experience in substance abuse disorders must provide substance abuse services to persons with co-occurring mental illness and substance abuse disorders. This person must have at least two (2) years experience in the field of substance abuse treatment.

(f) Case managers

These positions require a bachelor's degree in a behavioral science and work experience with adults with psychiatric disabilities. These workers carry out the rehabilitation and support functions under clinical supervision and are integral members of individual treatment teams.

(g) Program assistant

A program assistant equivalent to one (1) FTE or one (1) FTE plus a part-time (0.5) FTE is responsible for organizing, coordinating, and monitoring all non-clinical operations of FACT. This includes managing medical records; operating and coordinating the management information system; maintaining accounting and budgeting records for persons served by the team and program expenditures; and providing receptionist activities, including taking calls and coordinating communication between the team and persons served by the team.

- (6)** The provider shall provide Level II background screening for mental health personnel and all owners, directors, and chief financial officers of service providers in accordance with Chapter 435 and s. 408.809, F.S., and, as specified in s. 394.4572(1)(a)-(c), F.S. "Mental Health personnel" includes

all program directors, professional clinicians, staff members, and volunteers working in public or private mental health and substance abuse programs and facilities who have direct contact with or who are providing direct services to clients of mental health services. Additionally, the provider shall provide employment screening for substance abuse personnel using the standards set forth in Chapter 397, F.S.

c. Staffing Changes

The provider shall notify the contract manager, in writing, of staffing changes for the positions of Chief Executive Officer, Chief Operating Officer and Chief Financial Officer within seven (7) calendar days of any changes.

d. Subcontractors

No subcontracts with organizations to provide FACT services are permitted under this contract; however, professional service contracts with individual professionals are permitted.

3. Service Delivery Location & Equipment

a. Service Delivery Location

(1) The provider shall provide community-based psychiatric treatment, rehabilitation and support services in community-based settings. This means providing services in the person's home, on the street, on job sites, or wherever best meets the need of the person. At a minimum, seventy-five percent (75%) of all service provision must take place outside of the FACT program offices. Staff must ensure appropriate transportation, such as the purchase of vehicles, leasing vehicles, mileage, and insurance reimbursement and communication devices such as pagers and cellular phones are available to program staff to support community-based service delivery.

(2) The provider shall establish a central office site and may establish a satellite office site if deemed appropriate. The central office and satellite offices shall include an accessible and comfortable reception area for persons served and their families. It shall also include a team work/meeting room, a shared private room for conducting interviews as needed, a secure medication room and a safe or other locked means of securing an individual's funds and personal items.

(3) Each medication room shall have:

- a.** Locked areas (e.g. cabinets) where medication stocks, individual-specific medications and medication supplies (e.g., syringes and needles)

are kept;

- b.** Other storage areas for medication supplies and medical examination equipment;
- c.** Work areas where nurses can chart and perform other essential tasks; and
- d.** A faucet, sink and medication-dedicated refrigerator within close proximity to the medication room.

(4) The sites shall be accessible to public transportation and be safe, clean and well maintained. The offices shall conform to all applicable building codes and possess a current occupancy permit, a current Florida Fire Marshall Inspection and an evacuation plan. All offices offered for providing services under this contract shall be accessible to persons with mobility limitations consistent with the Rehabilitation of the Handicapped Act, P. L. 95-602, and section 504 of the Rehabilitation Act of 1973 as amended, 29 U.S.C. 794, which is incorporated herein by reference.

(5) The provider shall notify the contract manager, in writing, of changes to service delivery location within seven (7) calendar days.

b. Service Times

(1) Hours of operation and staff coverage shall be available to provide treatment, rehabilitation, and support activities seven (7) days per week; with two (2) overlapping eight (8) hour shifts and operate a minimum of twelve (12) hours per day on weekdays; and eight (8) hours each weekend day and every holiday. The FACT team shall operate an after-hours on-call system. All FACT team mental health professional staff shall rotate being on-call and available to respond to persons served by the team either by telephone or face-to-face. A mental health professional shall be on-call at all times. On call hours are in addition to regularly scheduled work hours. Psychiatric coverage may be provided by the program psychiatrist or by other psychiatrists in an approved psychiatric coverage rotation plan.

(2) The provider shall notify the contract manager, in writing, of any changes in days and times where services are being provided within seven (7) calendar days.

c. Changes in Location

The provider shall notify the contract manager, in writing, of any changes in locations where services are being provided within seven (7) calendar days.

d. Equipment

The provider will be responsible for supplying all equipment necessary to perform under this contract including, but not limited to, computers, telephones, copier and fax machine including supplies and maintenance, as well as needed office supplies.

4. Deliverables**a. Service Units**

(1) Service delivery costs are based on hours of staff availability. The provider will be paid on the basis of hours authorized FACT staff work during a normal work week. A staff hour includes time spent by FACT staff in direct and indirect care or program organization, administration or other FACT related duties such as FACT training. Non-reportable time includes time on leave, holiday, and on-call hours or in non-FACT training.

(2) FACT positions are budgeted by the department at 1,788 hours per Full Time Equivalent (FTE) per year or 149 hours per month. This total is derived by subtracting 120 hours annual leave, 60 hours sick leave, 72 hours holiday and 40 hours training from a total work year of 2,080 hours.

(3) Available staff hours shall be paid by the department at \$45.47 per staff hour. This is a blended rate that includes all personnel costs, including on-call hours and expense and applies to all FACT personnel.

b. Records and Documentation

(1) The provider shall protect confidential records from disclosure and protect an individual's confidentiality in accordance with subsections 397.501(7), 394.455(3), sections 394.4615, and 414.295, F.S. as well as 42 U.S.C. 132 and B.8.b.(10)

(2) The provider shall keep accurate clinical records reflecting the progress of each person served and any departmental performance standards required. These records shall contain uniform progress reports and documentation of any relevant data at the time of its occurrence.

(3) Documentation in the clinical record of admission tasks shall include:

(a) Referral information and reason(s) for admission including the transfer of information/records of past medications, service delivery, family information and other pertinent clinical information;

(b) A completed initial clinical assessment on the day of admission;

- (c) A completed comprehensive assessment within sixty (60) days of admission and a psychiatric/social functioning history time line within one hundred twenty (120) days of admission;
 - (d) A completed physical examination within sixty (60) days of admission;
 - (e) A DSM-IV Axis I diagnosis;
 - (f) FACT teams members who will make up the Individual Treatment Team;
 - (g) Assignment of a primary case manager; and
 - (h) A completed Comprehensive Recovery Plan must be in the record within ninety (90) days of admission.
- (4) Documentation in the clinical record of discharge tasks shall include:
- (a) The reason(s) for discharge;
 - (b) The person's status and condition at discharge and a written statement of concurrence from the circuit;
 - (c) A written final evaluation summary of the person's progress toward the desired outcomes and goals set forth in the recovery plan; and
 - (d) A plan developed in conjunction with the person served by the FACT team for treatment upon discharge and for follow-up that includes the signature of the primary case manager, team leader and psychiatrist, the signature of the person or legal guardian, if appointed; and discharge planning activities including linkages and transitional plans to other providers.
 - (e) Documentation of referral information made to other agencies upon discharge.

c. Reports

- (1) Chapter 394, F. S., requires all providers contracting with the department to comply with its uniform data specifications. Providers shall submit data that is used to assess their performance. Providers shall have the capability of transmitting required reports electronically and have a Virtual Private Network (VPN) connection through which they may submit personal protected information to the state. The provider shall submit to the department the reports specified below:

(2) FACT Enhancement Reconciliation Report: This report displays the provider’s expenditures of enhancement funds for each month of each quarter of the fiscal year. The report is segregated into three categories:

- (a)** Housing expenses;
- (b)** Medication expenses; and
- (c)** Flexible funding expenses.

(3) FACT Ad Hoc Report: This report displays the provider’s census, types of housing, employment, volunteering or educational pursuits. It also shows the number of local hospitalizations, number of state hospitalizations, and the types of discharges, and quarterly FACT team staffing levels.

(4) Incident Reports: The provider must comply with the reporting requirements of **Exhibit D**, "Incident Reporting and Risk Prevention" set out in Children and Families Operating Procedure (CFOP) 215-6 which can be found at: <http://www.dcf.state.fl.us/admin/publications/policies/215-6.pdf>.

(5) Monthly Vacant Position(s) Reports: The provider shall report monthly the positions required by this program and whether the positions were filled or vacant for the reporting month. The purpose of this report is to monitor and minimize staffing vacancies.

(6) Monthly Enrollment Reports: The provider shall report monthly the enrollment. The purpose of the report is to monitor and maximize operating capacity for the month.

(7) Operating and Capital Budget Reports: The provider shall submit to the department, financial and programmatic reports specified by the dates specified.

Report Title	Reporting Frequency	Report Due Date	Number of copies	DCF Office Address(es) to Receive Report
FACT Enhancement Reconciliation Report	Quarterly	15 days following end of each quarter	1 to Circuit & 1 to Program Office	Circuit SAMH Program Office
FACT Ad Hoc Report	Quarterly	15 days following end of each quarter	1 to Circuit & 1 to Program Office	Circuit SAMH Program Office
Incident Reports	Within 24 hours after occurrence	Within 24 hours after occurrence	1 to Circuit & 1 to Program Office	Circuit SAMH Program Office
Monthly Vacant Position(s)	Monthly	15 days following end of each month	1 to Circuit	Circuit SAMH Program Office

Report				
Monthly Enrollment Report	Monthly	15 Calendar days following the end of each month	1 to Circuit	Circuit SAMH Program Office
Operating and Capital Budget Report	By dates specified in Standard Contract, Exhibit Operating and Capital Budget Report	By dates specified in Standard Contract, Exhibit Operating and Capital Budget Report	1 to Circuit	Circuit SAMH Program Office

(8) The provider shall submit, pursuant to subsection 394.74(3)(e), F.S. and Rule 65E-14.022, F.A.C., demographic, admission, discharge, enrollment, placement, service, and performance outcome data electronically as specified in CFP 155-2.

(9) The provider shall ensure that its audit report will include the standard schedules that are outlined in Rule 65E-14.003, F.A.C.

(10) The provider shall ensure that the engagement of the independent audit contains a review of a SAMH contract.

(11) Delivery of reports shall not be construed to mean acceptance of those reports; acceptance of required reports shall constitute a separate act and shall be approved by the contract manager as such. The department reserves the right to reject reports as incomplete, inadequate or unacceptable.

5. Performance Specifications

a. Performance Measures

The provider shall meet the performance standards and required outcomes specified in **Exhibit C, Substance Abuse and Mental Health Required Outcomes and Outputs**.

b. Performance Measurement Terms

CFP 155-2 provides the definitions of the data elements used for various performance measures and contains policies and procedures for submitting the required data into the department data system.

c. Performance Evaluation Methodology

(1) Providers collect information and submit performance data and individual outcomes on FACT individuals, to the department data system in compliance with CFP 155-2 requirements. Performance outcome results are drawn from this system by department staff and are reported back to the provider monthly

via the circuit program office. The specific methodologies for each performance measure will be furnished upon request by the contract manager.

(2) By execution of this contract the provider hereby acknowledges and agrees that its performance under the contract must meet the standards set forth above and will be bound by the conditions set forth in this contract. If the provider fails to meet these standards, the department, at its exclusive option, may allow up to six (6) months for the provider to achieve compliance with the standards. If the department affords the provider an opportunity to achieve compliance, and the provider fails to achieve compliance within the specified time frame, the department must cancel the contract in the absence of any extenuating or mitigating circumstances. The determination of the extenuating or mitigating circumstances is the exclusive determination of the department. The contract manager will monitor the standards and outcomes specified in **Exhibit C, Substance Abuse and Mental Health Required Outcomes and Outputs**, during the contract period, to determine if the provider is achieving the levels that are specified.

6. Provider Responsibilities

a. Provider Unique Activities

(1) Hours of Operation and Staff Coverage

(a) The FACT team shall be available to provide treatment, rehabilitation, and support activities seven (7) days per week, with two (2) overlapping eight (8) hour shifts and operate a minimum of twelve (12) hours per day on weekdays; and eight (8) hours each weekend day and every holiday.

(b) The FACT team agrees operate an after-hours on-call system staffed by staff experienced and skilled in crisis-intervention procedures. Staff shall be on-call and available to respond to persons' needs by telephone or in person.

(c) Psychiatric backup shall also be available during all off-hours periods. If availability of the FACT team's psychiatrist during all hours is not feasible, alternative psychiatric backup should be arranged.

(2) Service Intensity

(a) The FACT team shall have the capacity to provide multiple contacts per week to persons experiencing severe symptoms or significant problems in daily living. These multiple contacts may be as frequent as two (2) to three (3) times per day, seven (7) days per week, depending on need. Many if not all staff shall share responsibility for addressing the

needs of all persons requiring frequent contacts.

(b) The FACT team shall have the capacity to rapidly increase service intensity to a person when his or her status requires it.

(c) The FACT team shall have contact with each person at least once per week with a mean (i.e., average) of three contacts per week for all persons.

(3) Place Of Treatment

The FACT team shall provide 75 percent (75%) of its service contacts in the community, from non-office or non-facility-based settings. The FACT team will maintain data to verify this requirement is being met.

(4) Staff Communication and Planning

(a) The FACT team shall conduct daily organizational staff meetings at regularly scheduled times per a schedule established by the team leader. These meetings will be conducted in accordance with the following procedures.

(b) The FACT team will maintain an electronic or manual record that will provide the following:

- i. A roster of the persons served in the program; and
- ii. For each person served, a brief documentation of any treatment or service contacts which have occurred during the day and a concise, behavioral description of the person's daily status.

(c) The daily organizational staff meeting will commence with a review of the daily log, to update staff on the treatment contacts which occurred the day before and to provide a systematic means for the team to assess the day-to-day progress and status of all persons served.

(d) The FACT team, under the direction of the team leader, shall maintain a weekly schedule for each person served. The weekly schedule is a written schedule of all treatment and service contacts, which staff must carry out to fulfill the goals and objectives in the person's recovery plan. The team will maintain a central file of all weekly schedules.

(e) The FACT team, under the direction of the team leader, shall develop a daily staff assignment schedule from the central file of all weekly schedules. The daily staff assignment schedule is a written timetable for all treatment and service contacts, to be divided and shared by the staff

working on that day.

(f) The daily organizational staff meeting will include a review by the shift manager of all the work to be done that day as recorded on the daily staff assignment schedule. During the meeting, the shift manager will assign and supervise staff to carry out the treatment and service activities scheduled to occur that day and the shift manager will be responsible for assuring that all tasks are completed.

(g) At the daily organizational meeting, the FACT team shall also revise recovery plans as needed, plan for emergency and crisis situations, and add service contacts to the daily staff assignment schedule per the revised recovery plans.

(h) The FACT team shall conduct recovery-planning meetings under the supervision of the team leader and psychiatrist. Recovery planning meetings shall:

- i. Convene at regularly scheduled times per a written schedule maintained by the team leader, and
- ii. Occur with sufficient frequency and duration to develop written individual recovery plans and to review and rewrite the plans every six months.

(5) Staff Supervision

The FACT team shall develop a written policy for clinical supervision of all staff providing treatment, rehabilitation, and support services. The team leader, or his or her clinical designee, or both shall assume responsibility for supervising and directing all FACT team staff activities. Clinical supervision provided to FACT team staff shall be documented in writing. The supervision and direction shall consist of:

(a) Individual, side-by-side sessions in which the supervisor accompanies an individual staff member to meet with individuals served in regularly scheduled or crisis meetings to assess performance, give feedback, and model alternative treatment approaches;

(b) Participation with team members in organizational staff meetings and regularly scheduled recovery planning meetings to review and assess staff performance and provide staff direction regarding individual cases; and

(c) Regular meetings with individual staff to review cases, assess performance, and give feedback.

(6) The provider will ensure that the invoices submitted to the department

reconcile with the amount of funding and services specified in this contract as well as the agency's audit report and the FACT individual's information system.

(7) The provider agrees to comply with all other applicable federal laws, state statutes and associated administrative rules as may be promulgated or amended. See **Exhibit B, Minimum Service Requirements**.

(8) If the provider is the representative payee for Supplemental Security Income, Social Security Administration, Veterans Administration, or other federal benefits on behalf of the individual, the provider agrees to comply with the applicable federal laws including the establishment and management of individual's trust accounts (20 CFR 416 and 31 CFR 240).

(9) Pursuant to section 402.73, F.S., the provider agrees to maintain data on the performance standards specified in **Exhibit C, Substance Abuse and Mental Health Outcomes and Outputs**, for the types of services provided under this contract and shall submit such data to the department upon request. Data submission requirements can be found in CFP 155-2.

(10) A provider that receives federal block grant funds from the Substance Abuse Prevention and Treatment or Community Mental Health block Grants agrees to comply with Subparts I and II of Part B of Title XIX of the Public Health Service Act, section 42 U.S.C. 300x-21 et seq. (as approved September 22, 2000) and the Health and Human Services (HHS) Block Grant regulations (45 CFR Part 96).

(11) The provider shall comply with the following provisions as required by HIPAA and 45 CFR Parts 160, 162, and 164::

(a) The provider hereby agrees not to use or disclose protected health information (PHI) except as permitted or required by this contract, state or federal law.

(b) The provider agrees to use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this contract or applicable law.

(c) The provider agrees to report to the department any use or disclosure of the information not provided for by this contract or applicable law.

(d) The provider hereby assures the department that if any PHI received from the department, or received by the provider on the department's behalf, is furnished to provider's subcontractors or agents in the performance of tasks required by this contract, that those subcontractors or agents must first have agreed to the same restrictions and conditions

that apply to the provider with respect to such information.

(e) The provider agrees to make PHI available in accordance with 45 CFR 164.524.

(f) The provider agrees to make PHI available for amendment and to incorporate any amendments to PHI in accordance with 45 CFR 164.526.

(g) The provider agrees to make available the information required to provide an accounting of disclosures in accordance with 45 CFR 164.528.

(h) The provider agrees to make its internal practices, books and records relating to the use and disclosure of PHI received from the department or created or received by the provider on behalf of the department available for purposes of determining the provider's compliance with these assurances.

(i) The provider agrees that at the termination of this contract, if feasible and where not inconsistent with other provisions of this contract concerning record retention, it will return or destroy all PHI received from the department or received by the provider on behalf of the department, that the provider still maintains regardless of form. If not feasible, the protections of this contract are hereby extended to that PHI which may then be used only for such purposes as to make the return or destruction infeasible.

(j) A violation or breach of any of these assurances shall constitute a material breach of this contract.

(12) The provider shall develop a summary plan for providing FACT services in case of disaster. The following elements shall be included in the plan:

(a) The plan shall describe how the provider would work with the circuit to assure the safety of the individual and to provide continuity of needed services and supports;

(b) The plan shall provide back-up contingencies for staff, medications, and other supports required; and

(c) The plan shall demonstrate how the provider will work with the local disaster response system to promote the best interest of the individuals being served.

(d) Within thirty (30) days of contract execution the provider shall submit a detailed disaster plan that includes the specifics on how the provider intends to support each individual enrolled in the FACT program in the

event of a disaster. The detailed plan shall be based upon the general description described in its summary plan. It shall include any specific assumptions being made by the provider upon which the plan is dependent. For example, the names of employees are not required in the plan. However, if additional employees were required for a short time to accommodate a more labor-intensive process, the numbers and classifications of the additional employees would be provided. The detailed plan shall include:

- i. A description of how the provision of FACT services would not be downgraded in the event of a disaster and what corrective remedies would be used to ensure continued operations.
- ii. A description of the provider's approach for addressing post-traumatic stress disorders and other post-disaster recovery-related activities.
- iii. A copy of the detailed plan shall be provided to the contract manager within sixty (60) days of the signed contract for review and approval.
- iv. The provider agrees to review and, if necessary, update annually.

(13) The provider will become familiar with and incorporate the principles of recovery into all service provision. Please see **Exhibit G, Principles of Recovery**.

b. Minimum Service Requirements

FACT providers must comply with all applicable Federal laws, regulations, action transmittals, program instructions, review guides, and similar documentation. See **Exhibit B, Minimum Service Requirements**.

7. Department Responsibilities

a. Department Obligations

The circuit will assign a contract manager to assure the provider will meet the required tasks in this contract and related departmental obligations.

b. Department Determinations

(1) The circuit reserves the exclusive right to make certain determinations in these specifications. The absence of the circuit setting forth a specific reservation of rights does not mean that all other areas of the contract are subject to mutual agreement. The circuit reserves the right to make any and

all determinations exclusively which it deems are necessary to protect the best interests of the State of Florida and the health, safety and welfare of persons served by the department either directly or through any one of its contracted providers.

(2) All referrals to the FACT teams shall be made through the Department of Children and Families' Circuit Mental Health Program Office _____. The Department of Children and Families' Circuit Mental Health Program Office _____ shall also approve admission, discharge, transfer or relocation of any persons served by the FACT team.

(3) A person cannot be discharged from the FACT team without the written concurrence of the Department of Children and Families' Circuit Mental Health Program Office _____.

c. Monitoring Requirements

The provider will be monitored in accordance with s. 394.741 F.S., and CFOP 75-8, Contract Monitoring Operating Procedures which can be found at: <http://www.dcf.state.fl.us/admin/publications/policies/075-8.pdf>.

C. Method of Payment

1. This is a fixed price (unit cost) contract. The department shall pay the provider for the delivery of service units provided in accordance with the terms of this contract for a total dollar amount not to exceed \$1,254,400 each fiscal year, which includes enhancement funds for those teams contracted to serve 100 individuals, subject to the availability of funds.
2. The provider must submit an invoice to the department each month for available FACT staff hours at the model FACT cost center rate of \$45.47 per hour subject to applicable requirements in Chapter 65E-14, F.A.C. All expenses, on call time, administrative costs, salary and benefits are included in this rate. This rate includes both Medicaid and departmental payments for these items. This hourly rate does not include enhancements for housing subsidies, pharmaceuticals, tangible items, or specialized treatment.
3. The provider must only use its allocation of enhancement funds to supplement housing costs, purchase pharmaceuticals for non-Medicaid eligible FACT individuals, purchase tangible items needed for employment/education or other meaningful activity, specialized treatment, or to provide temporary, flexible funding as a payment of last resort for the one-time purchase of commodities or services that are directly related to the person's ability to remain in the community.
4. The amount of \$212.00 per month per person is for budgeting purposes only and is not intended to prohibit the use of less or more funds for specific individuals as

clinically warranted by the FACT team. Enhancement fund expenditures must be consistent with the "Florida Assertive Community Treatment (FACT) Enhancement Guidelines, **Exhibit J**, revised January 2010, or the latest revised edition thereof", herein incorporated by reference.

5. The provider shall not bill the Medicaid for FACT services for persons who are enrolled in the FACT program.

6. Enhancement funds shall be billed via the Incidental Cost Center.

7. All expenses authorized through the Enhancement Guidelines that have been negotiated at the time of execution of this contract are specified in **Exhibit F, Incidental Expenses (Circuit generated)**. All other costs must have prior written authorization by the department's authorized staff representative.

8. Invoice Requirements

a. The total number of monthly service units paid under this contract can not exceed the total number of units as specified on **Exhibit A, Services to be Provided**.

b. The provider's final invoice must reconcile actual service units provided during the contract period with the amount paid by the department.

c. The provider shall request payment monthly through submission of a properly completed invoice, **Exhibit E, Substance Abuse and Mental Health Monthly Request for Payment/Advance** within thirty (30) days following the end of the month for which payment is being requested for the delivery of service.

d. If no services are due to be invoiced from the preceding month, the provider shall submit a written document to the department indicating this information within thirty (30) days following the end of the month.

9. Supporting Documentation

a. The provider agrees to maintain service documentation for each service billed to the department pursuant to this contract. Proper service documentation for each SAMH cost center is outlined in Rule 65E-14.021(7), F.A.C.

b. The department and the Office of the Chief Financial Officer reserve the right to request supporting documentation at any time after actual units have been delivered.

D. Special Provisions

1. Dispute Resolution

It is anticipated that the provider and department will agree to cooperate in resolving any differences concerning performance or in interpreting the contract. Within five (5) working days of the execution of this contract for FACT services, each party shall designate one person to act as its representative for dispute resolution purposes, and shall notify the other party of the person's name and business address and telephone number. Typically, these representatives are the department's contract manager and the FACT team leader's administrative supervisor. Within five (5) working days from delivery to the designated representative of the other party of a written request for dispute resolution, the representatives will conduct a face-to-face meeting to resolve the disagreement amicably. If the representatives are unable to reach a mutually satisfactory resolution, either representative may request referral of the issue to the Executive Director and the Circuit Substance Abuse and Mental Health Program Supervisor of the respective parties. Upon referral to this second step, the Executive Director and the Circuit Substance Abuse and Mental Health Program Supervisor shall confer in an attempt to resolve the issue.

If the second referral conference does not resolve the issue within ten (10) days, the parties appointed representatives shall meet within ten (10) working days and select a third representative. These three representatives shall meet within ten (10) working days to seek resolution of the dispute. If the representatives' good faith efforts to resolve the dispute fail, the representatives shall make written recommendations to the Secretary who has final authority to resolve the dispute. The parties reserve all their rights and remedies under Florida law. Venue for any court action shall be Leon County, Florida.

2. Collaboration Activities

The provider recognizes the FACT initiative is subject to the requirements of periodic re-procurement consistent with state law. As a requirement of providing FACT services, the provider agrees to conduct the following activities in the event of a change in providers as a result of the re-procurement process or due to the termination of an existing FACT contract:

- a.** Collaborating with the new FACT provider to assist in the transition of services including a census of all enrolled individuals that includes the name, any identification number, social security number, address, phone number and the primary case manager and phone number;
- b.** Assisting in the obtaining of signatures for the release of medical records pertaining to each enrolled individual;
- c.** Meeting with the new FACT provider to discuss individual case situations to identify treatment, rehabilitation and support needs requiring immediate attention;

- d. Providing a complete inventory of medications purchased with FACT funds including the name, address and phone number of the pharmacy serving the existing FACT team;
- e. Providing a complete inventory of FACT-purchased equipment and supplies for transfer to a new provider;
- f. Providing a complete directory of the FACT Advisory Committee membership including name, address and phone number; and
- g. Collaborating with the circuit to ensure a smooth transition of services and continuity of care.

3. Transportation Disadvantaged

The provider agrees to comply with the provisions of Chapter 427, F.S., Part I, Transportation Services, and Chapter 41-2, F.A.C., Commission for the Transportation Disadvantaged, if public funds provided under this contract will be used to transport individuals. The provider agrees to comply with the provisions of CFOP 40-5 if public funds provided under this contract will be used to purchase vehicles which will be used to transport individuals. CFOP 40-5 can be found at: <http://www.dcf.state.fl.us/admin/publications/policies/040-5.pdf>.

4. Renewal

This contract may be renewed for a period not to exceed 3 years or the term of the original contract, whichever period is longer. The total annual amount of the contract will not exceed \$1,254,400 which includes enhancement funds for those teams contracted to serve 100 individuals. Any such renewals shall be made by mutual agreement and shall be contingent upon satisfactory performance evaluations as determined by the department and shall be subject to the availability of funds. Any renewal shall be in writing and shall be subject to the same terms and conditions as set forth in the initial contract.

5. MyFloridaMarketPlace Transaction Fee

- a. The State of Florida, through the Department of Management Services, has instituted MyFloridaMarketPlace, a statewide eProcurement system. Pursuant to subsection 287.057(23), Florida Statutes (2002), all payments shall be assessed a Transaction Fee of one percent (1.0%), which the provider shall pay to the State.
- b. For payments within the State accounting system (FLAIR or its successor), the Transaction Fee shall, when possible, be automatically deducted from payments to the provider. If automatic deduction is not possible, the provider shall pay the Transaction Fee pursuant to Rule 60A-1.031(2), Florida

Administrative Code. By submission of these reports and corresponding payments, provider certifies their correctness. All such reports and payments shall be subject to audit by the State or its designee.

c. The provider shall receive a credit of any Transaction Fee paid by the provider for the purchase of any item(s) if such item(s) are returned to the provider through no fault, act, or omission of the provider. Notwithstanding the foregoing, a Transaction Fee is non-refundable when an item is rejected or returned, or declined, due to the provider's failure to perform or comply with specifications or requirements of the agreement.

d. Failure to comply with these requirements shall constitute grounds for declaring the provider in default and recovering procurement costs from the provider in addition to all outstanding fees. PROVIDERS DELINQUENT IN PAYING TRANSACTION FEES MAY BE EXCLUDED FROM CONDUCTING FUTURE BUSINESS WITH THE STATE.

6. Mandatory Reporting Requirements

a. The provider and any subcontractor must comply with and inform its employees of the following mandatory reporting requirements. Each employee of the provider, and of any subcontractor, providing services in connection with this contract who has any knowledge of a reportable incident shall report such incident as follows:

(1) Reportable incidents that may involve an immediate or impending impact on the health or safety of an FACT individual shall be immediately reported to the contract manager; and

(2) Other reportable incidents shall be reported to the department's Office of Inspector General by completing a Notification/Investigation Request (form CF 1934) and emailing the request to the Office of Inspector General at ig_complaints@dcf.state.fl.us. The provider and subcontractor may also mail the completed form to the Office of Inspector General, 1317 Winewood Boulevard, Building 5, 2nd Floor, Tallahassee, Florida, 32399-0700; or via fax at (850) 488-1428.

b. A reportable incident is defined in CFOP 180-4, which can be found at: <http://www.dcf.state.fl.us/admin/publications/policies/180-4.pdf>.

(Circuits may delete the MyFloridaMarketPlace Transaction Fee clause if not applicable to the provider)

E. List of Exhibits

1. Exhibit A, Services to be Provided

2. **Exhibit B**, Minimum Service Requirements
3. **Exhibit C**, Substance Abuse and Mental Health Required Outcomes/Outputs
4. **Exhibit D**, Unusual Incident Reporting and Risk Prevention
5. **Exhibit E**, Substance Abuse and Mental Health Monthly Request for Payment/Advance
6. **Exhibit F**, Incidental Expenses
7. **Exhibit G**, Principles of Recovery
8. **Exhibit H**, Monthly Vacant Position Report
9. **Exhibit I**, Monthly Enrollment Report
10. **Exhibit J**, Enhancement Guidelines
11. **Exhibit K**, Medication Management Policy
12. **Exhibit L**, FACT Advisory Committees: Authorities And Limitations

INSTRUCTIONS TO CIRCUITS: AFTER COMPLETING THIS DOCUMENT, DELETE ALL SPECIAL INSTRUCTIONS AND DIRECTIONS (MESSAGES IN BOLD AND ITALICS WITHIN PARENTHESES INCLUDING THIS MESSAGE). RENUMBER ALL PARAGRAPHS REORDERED BY THE PROCESS OF SELECTING CONTRACT OPTIONS.

EXHIBIT A SERVICES TO BE PROVIDED

Provider Name: _____

Amendment # : _____

Date: __/__/__

Activity / Cost Center 1	State Rate 2	Unit of Measure 3	# State Units 4	Contracted State Funds 5
TOTALS				\$ _____

Minimum Service Requirements

The provider and its subcontractors shall be knowledgeable of and fully comply with all applicable state and federal laws, rules and regulations, as amended from time to time, that affect the subject areas of the contract. Authorities include but are not limited to the following:

I. PROGRAMMATIC AUTHORITY (FEDERAL)

A. Mental Health

42 U.S.C. 300x to 300x-9 (*Block Grant for community Mental Health Services*)
<http://www4.law.cornell.edu/uscode/42/ch6AschXVIIpB.html>

B. Substance Abuse Prevention and Treatment Block Grant (SAPTBG)

42 U.S.C. 290kk, et seq. (*Limitation on use of funds for certain purposes*)
http://www4.law.cornell.edu/uscode/html/uscode42/usc_sec_42_0000029_0--kk000-.html

42 U.S.C. 300x-21 to 300x-35 and 300x-51 to 300x-66 (*SA Treatment & Prevention Block Grants*)
http://www4.law.cornell.edu/uscode/html/uscode42/usc_sup_01_42_10_6_A_20_XVII_30_B_40_ii.html

42 CFR, Part 54 (*Charitable choice*)
http://www.access.gpo.gov/nara/cfr/waisidx_03/42cfr54_03.html

45 CFR 96.120 – 137 (*SA Treatment & Prevention Block Grants*)
http://www.access.gpo.gov/nara/cfr/waisidx_03/45cfr96_03.html

Restrictions on expenditures of SAPTBG

45 CFR 96.135
http://www.access.gpo.gov/nara/cfr/waisidx_01/45cfr96_01.html

C. Substance Abuse-Confidentiality

42 CFR, Part 2
http://www.access.gpo.gov/nara/cfr/waisidx_03/42cfr2_03.html

D. Health Insurance Portability and Accountability Act (HIPAA)

45 CFR 164
http://www.access.gpo.gov/nara/cfr/waisidx_03/45cfr164_03.html

E. Social Security Income for the Aged, Blind and Disabled

20 CFR 416

http://www.access.gpo.gov/nara/cfr/waisidx_03/20cfr416_03.html**F. Endorsement and Payment of Checks Drawn on the United States Treasury**

31 CFR 240 relating to SSA

http://www.access.gpo.gov/nara/cfr/waisidx_03/31cfr240_03.html**G. Temporary Assistance to Needy Families (TANF)**

Part A, Title IV of the Social Security Act

45 CFR, Part 260

http://www.access.gpo.gov/nara/cfr/waisidx_03/45cfr260_03.html

Section 414.1585, F.S.

<http://www.leg.state.fl.us/statutes/index.cfm?Mode=ViewStatutes&Submenu=1>**H. Positive Alternatives to Homelessness (PATH)**

Public Health Services Act, Title V, Part C, Section 521, as amended

42 U.S.C. 290cc-21 et. seq.

<http://www4.law.cornell.edu/uscode/>

Stewart B. McKinney Homeless Assistance Amendments Act of 1990, Public Law 101-645

http://www4.law.cornell.edu/usc-cgi/get_external.cgi?type=pubL&target=101-645

42 CFR, Part 54

http://www.access.gpo.gov/nara/cfr/waisidx_03/42cfr54_03.html**I. Americans with Disabilities Act of 1990**

42 U.S.C. 12101 et seq.

<http://www4.law.cornell.edu/uscode/>**II. FLORIDA STATUTES**

All State of Florida Statutes can be found at the following website:

<http://www.leg.state.fl.us/statutes/index.cfm?Mode=ViewStatutes&Submenu=1>**A. Child Welfare and Community Based Care**

Chapter 39, F.S.	Proceedings Relating to Children
Chapter 119, F.S.	Public Records
Chapter 402, F.S.	Health and Human Services; Miscellaneous Provisions
Chapter 435, F.S.	Employment Screening
Chapter 490, F.S.	Psychological Services
Chapter 491, F.S.	Clinical, Counseling and Psychotherapy services
Chapter 1002, F.S.	Student and Parental Rights and Educational Choices
Section 402.3057, F.S.	Persons not required to be refingerprinted or rescreened
Section 414.295, F.S.	Temporary Cash Assistance; Public Records Exemptions

B. Substance Abuse and Mental Health Services

Chapter 381, F.S.	Public Health General Provisions
Chapter 386, F.S.	Particular Conditions Affecting Public Health
Chapter 395, F.S.	Hospital Licensing and Regulation
Chapter 394, F.S.	Mental Health
Chapter 397, F.S.	Substance Abuse Services
Chapter 400, F.S.	Nursing Home and Related Health Care Facilities
Chapter 435, F.S.	Employment Screening
Chapter 458, F.S.	Medical Practice
Chapter 459, F.S.	Osteopathic Medicine
Chapter 464, F.S.	Nursing
Chapter 465, F.S.	Pharmacy
Chapter 490, F.S.	Psychological Services
Chapter 491, F.S.	Clinical, Counseling and Psychotherapy Services
Chapter 499, F.S.	Drug, Cosmetic and Household Products
Chapter 553, F.S.	Building Construction Standards
Chapter 893, F.S.	Drug Abuse Prevention and Control
Section 409.906(8), F.S.	Optional Medicaid – Community Mental Health Services

C. Developmental Disabilities

Chapter 393, F.S.	Developmental Disabilities
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D. Adult Protective Services

Chapter 415, F.S.	Adult Protective Services
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E. Forensics

Chapter, F.S.916, F.S.	Mentally Deficient and Mentally Ill Defendants.
Chapter 985, F.S.	Juvenile Justice; Interstate Compact on Juveniles
Section 985.19, F.S.	Incompetency in Juvenile Delinquency Cases
Section 985.24, F.S.	Interstate Compact on Juveniles; Use of detention; prohibitions;

F. Florida Assertive Community Treatment (FACT)

General Appropriations Act

<http://www.flsenate.gov/Welcome/index.cfm?CFID=105701865&CFTOKEN=34016817>

G. State Administrative Procedures and Services

Chapter 120, F.S.	Administrative Procedures Act
Chapter 815, F.S.	Computer - Related Crimes
Section 112.061, F.S.	Per diem and Travel Expenses*
Section 112.3185, F.S.	Additional Standards for State Agency Employees
Section 215.422, F.S.	Payments, Warrants & Invoices; Processing Times
Section 216.181(16)(b), F.S.	Advanced funds invested in interest bearing accounts

*Travel Expenses are specified in the DFS Reference Guide for State Expenditures

http://www.myfloridacfo.com/aadir/reference%5Fguide/reference_guide.htm

III. FLORIDA ADMINISTRATIVE CODE (RULES)

A. Child Welfare and Community Based Care

All references to F.A.C. may be found at the following website:

<https://www.flrules.org/default.asp>

Rule 65C-12, F.A.C.	Emergency Shelter Care
Rule 65C-13, F.A.C.	Substitute Care of Children
Rule 65C-14, F.A.C.	Group Care
Rule 65C-15, F.A.C.	Child Placing Agencies

B. Substance Abuse and Mental Health Services

Rule 65C-12, F.A.C.	Emergency Shelter Care
Rule 65D-30, F.A.C.	Substance Abuse Services Office
Rule 65E-4, F.A.C.	Community Mental Health Regulation
Rule 65E-5, F.A.C.	Mental Health Act Regulation
Rule 65E-10, F.A.C.	Psychotic and Emotionally Disturbed Children Purchase of Residential Services Rules
Rule 65E-12, F.A.C.	Public Mental Health, Crisis Stabilization Units, Short Term Residential Treatment Programs
Rule 65E-14, F.A.C.	Community Substance Abuse and Mental Health Services-Financial Rules
Rule 65E-15, F.A.C.	Continuity of Care Case Management
Rule 65E-20, F.A.C.	Forensic Client Services Act Regulation

C. Financial Penalties

Rule 65-29, F.A.C. Penalties on Service Providers

Reduction/withholding of funds

Rule 65-29.001, F.A.C. Financial Penalties for a Provider’s Failure to Comply With a Requirement for Corrective Action

IV. MISCELLANEOUS

A. Department of Children and Families Operating Procedures

CFOP 155-10, Services for Children with Mental Health & Any Co-occurring Substance Abuse Treatment Needs In Out of Home Care Placements
<http://www.dcf.state.fl.us/publications/policies/cfop155-10.pdf>

CFOP 215-6, Incident Reporting and Client Risk Prevention
<http://www.dcf.state.fl.us/publications/policies/215-6.pdf>

B. Federal Cost Principles

OMB Circular A-21, Cost Principles for Educational Institutions
<http://www.whitehouse.gov/omb/circulars/a021/a021.html>

OMB Circular A-87, Cost Principles for State, Local and Indian Tribal Governments
<http://www.whitehouse.gov/omb/circulars/a087/a087-all.html>

OMB Circular A102, Grants and Cooperative Agreements with State and Local Governments
<http://www.whitehouse.gov/omb/circulars/a102/a102.html>

OMB Circular A-122, Cost Principles for Non-profit Organizations
<http://www.whitehouse.gov/omb/circulars/a122/a122.html>

C. Audits

OMB Circular A-133, Audits of States, Local Governments and Non-Profit Organizations
<http://www.whitehouse.gov/omb/circulars/a133/a133.html>

Section 215.97, F.S., Florida Single Audit Act
<http://www.leg.state.fl.us/statutes/index.cfm?Mode=ViewStatutes&SubMenu=1>

Comptrollers Memorandum #03 (1999-2000): Florida Single Audit Act Implementation

<http://www.fldfs.com/aadir/cmmaster9900.htm>

D. Administrative Requirements

45 CFR, Part 74 - Uniform Administration Requirements for Awards and Subawards to Institutions of Higher Education, Hospitals, other Non-Profit Organizations and Other Commercial Organizations

http://www.access.gpo.gov/nara/cfr/waisidx_06/45cfr74_06.html

45 CFR, Part 92 - Uniform Administration Requirements (State and Local Governments)

http://www.access.gpo.gov/nara/cfr/waisidx_06/45cfr92_06.html

OMB Circular A110, Uniform Administrative Requirements for Grants and Other Agreements

<http://www.whitehouse.gov/omb/circulars/a110/a110.html>

E. Data Collection and Reporting Requirements

Rule 65E-14.022, F.A.C.

<https://www.flrules.org/gateway/ruleNo.asp?ID=65E-14.022>

Section 397.321(3)(c), F.S., Data collection & dissemination system

http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=Ch0397/titl0397.htm

Section 394.74(3)(e), F.S., Data Submission

http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=Ch0394/titl0394.htm

Section 394.77, F.S., Uniform management information, accounting, and reporting systems for providers.

http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=Ch0394/titl0394.htm

CFP 155-2, Mental Health and Substance Abuse Data Measurement Handbook

<http://www.dcf.state.fl.us/mentalhealth/publications/index.shtml>

Substance Abuse and Mental Health Required Outcomes/Outputs

Provider: _____ Contract #: _____ Date: _____ Revision #: _____

FACT teams are required to meet the same numerical targets established in the working papers of the General Appropriations Act that are transmitted to the Department by the Executive Office of Governor for the target population referenced as "Adults with Serious and Persistent Mental Illness." These performance measures are:

1. Percent of adults with severe and persistent mental illnesses who live in stable housing environment that is *equal to or greater than* ninety (90) percent or the most current General Appropriations Act working papers transmitted to the Department of Children and Families; and
2. Average annual days worked for pay for adults with a severe and persistent mental illness that is equal to or greater than 40 days worked for pay or the most current General Appropriations Act working papers transmitted to the Department of Children and Families.

Additionally, the following performance measures will be incorporated into any contract awarded for the operation of a FACT team:

1. 90 percent of all initial assessments shall be completed on the day of the person's enrollment in FACT with written documentation of the service occurrence in the clinical record.
2. 90 percent of all comprehensive assessments shall be completed within 60 days of the person's enrollment in FACT with written documentation of the service occurrence in the clinical record.
3. 90 percent of all individuals enrolled in FACT shall have an individualized, comprehensive recovery plan within 90 days of enrollment with written documentation of the service occurrence in the clinical record.
4. 90 percent of all individuals enrolled in FACT shall have a completed psychiatric/social functioning history time line within 120 days of enrollment with written documentation of the service occurrence in the clinical record.
5. 50 percent of all individuals enrolled in FACT shall receive work-related services toward a goal of obtaining employment within one year of enrollment with written documentation of the service occurrence in the clinical record.
6. 90 percent of all individuals enrolled in FACT shall receive housing services toward a goal of obtaining independent, integrated living within one year of

enrollment with written documentation of the service occurrence in the clinical record.

7. 90 percent of staffing requirements as specified in Attachment I, Section B.2 of this contract, will be maintained monthly.
8. 5 percent or less of all individuals enrolled in FACT will be admitted to a state mental health treatment facility while receiving FACT services or within 30 days of discharge from the FACT program.
9. 75 percent of all individuals enrolled in FACT will maintain or show improvement in their level of functioning as measured by the Functional Assessment Rating Scale (FARS).
10. 95 percent of operating capacity will be maintained monthly.

EXHIBIT D INCIDENT REPORTING

1. Scope: Applies to all reportable events that occur related to adults and children served by the SAMH Programs of the Department of Children and Families as well as reportable events that occur in SAMH funded, contracted, or licensed programs including programs that are receiving funding from Medicaid for community substance abuse or mental health services. This reporting procedure does not replace other mandatory reporting requirements, i.e.:
 - a. The mandatory abuse, neglect, and exploitation reporting system;
 - b. The investigation and review requirements for child death review procedures;
 - c. Adult protective services reporting system;
 - d. The mandatory Medicare/Medicaid reporting of any death that occurs while a person is restrained or in seclusion
 - e. When a resident dies in a state (institution) treatment facility, the medical examiner will be notified.
 - f. The medical examiner will be notified when any person dies by accident; suicide; of criminal violence; suddenly, when in apparent good health; in any suspicious or unusually circumstance; or by disease constituting a threat to public health.
 - g. Facilities licensed under Chapter 395 F.S. Part 1: Hospitals and Other Licensed Facilities, shall report all incidents meeting the adverse incident criteria specified therein to AHCA.
 - h. All events of staff negligence and/or abuse that result in client injury or death, upon verification by the district/region or central program office, must be immediately reported to the department's Inspector General Office.
 - i. Facilities shall report an allegation of sexual activity between a resident and a licensed healthcare practitioner to the Department of Health.
2. Reportable Events:
 - a. Client Death. An individual receiving substance abuse and/or mental health services whose life terminates while receiving

department services or within thirty (30) days of discharge from a residential program or treatment facility. This includes adults and children receiving services from contracted, funded, or licensed substance abuse and mental health providers. This includes death by accident, homicide, natural expected, natural unexpected, suicide and unknown.

- b. Sexual Battery. An allegation of sexual battery by a client on a client, service provider employee or other individual on a client, or client on an employee, when there is either physical evidence or other findings upon medical examination or as a result of an investigation by law enforcement or the Office of the Inspector General. "Sexual battery" means oral, anal, or vaginal penetration by, or union with, the sexual organ of another or the anal or vaginal penetration of another by any other object; however, sexual battery does not include an act done for a bona fide medical purpose.
- c. Significant Injury. An injury to a client that requires admission to a community acute care medical facility.
- d. Suicide Attempt. A potential lethal act which reflects an attempt by an individual to cause his or her own death as determined by a licensed mental health professional or other licensed health care professional.
- e. Elopement.
 - (1) The unauthorized absence of a child or adolescent while in the care of a residential treatment center or therapeutic foster care program. Law enforcement and parents or guardian will be notified immediately if a child or adolescent elopes.
 - (2) The unauthorized absence of an adult during involuntary placement with a SAMH service provider of the department. If a person is at risk of hurting him/herself or others, law enforcement will be notified immediately. If the adult has freedom of movement on the grounds of the facility, notification of law enforcement may be delayed until a search has been conducted and it is determined the person has left the program.
 - (3) If an adult is a voluntary admission and chooses to leave a facility, notification of law enforcement is only necessary if the person has been determined to be a risk to self or others.

- f. **Escape.** The unauthorized absence of a person committed by the court to a secure forensic treatment, or a person with a forensic commitment who is in a civil step-down unit, or a person in the sexually violent predator civil commitment center. Escape is to be reported immediately to law enforcement. Escape of forensic clients who are residing in civil step-down units, or have been granted freedom of movement on the facility grounds will be reported to law enforcement if they are found to be missing from their program and are not located within 2 hours. If it is known that the person has left the facility grounds, immediate notification to law enforcement will be made.
 - g. **Other.** Any event not otherwise identified as a reportable significant event but has or is likely to have adverse impact for the provider and/or the Department.
3. It is the responsibility of all providers to:
- a. complete a comprehensive event report within 72 hours of the event or 24 hours if it is a potential news media event;
 - b. ensure event reports are updated as new information becomes available;
 - c. follow up on deaths that are medical examiner's cases until the final results of the autopsy and toxicology are obtained;
 - d. assess each reportable event to determine real and potential deficiencies; and
 - e. implement appropriate action plans if deficiencies are identified in service provision or procedures relative to the event.

EXHIBIT E
ADULT MENTAL HEALTH
Non-TANF
MONTHLY PAYMENT/ADVANCE REQUEST

a. AGENCY NAME: _____
b. CONTRACT NO.: _____
c. MONTH/YEAR OF: _____ 12 _____
d. "months remaining": _____
e. FEDERAL ID #: _____
f. Vendor No. if different from Federal ID#: _____

Part I Earnings ACTIVITY / Cost Centers	Non-TANF Funding for the Activity Only	YTD Total Non-TANF \$ Earned	YTD SAMH Non- TANF Paid for Earnings	Difference (YTD Unpaid Earnings)	Pro-rated Share For Activity only [(col. 2 - col. 4) / months remaining]*	Amount Due (Owed) The Total for each Activity is the lesser of Col. 5 or Col. 6.	Cost Center Unit Rate (col. C of Worksheet)	# of Non-TANF Units Paid for this Month (col. 7 / col. 8)	g. ADDRESS (Number, City, State, Zip):	
									1	2
R & R - FACT Teams 502018	(from Exh G)	(col. 1 of Worksheet)		(col. 3-col. 4)						
Fact Team	XXXXXXXX	#REF!		#REF!	XXXXXXXX		#REF!	#REF!		
R&R - Incidental Expenses	XXXXXXXX	#REF!	\$0.00	#REF!	\$0.00	\$0.00	#REF!	#REF!		
Incidental Expenses	XXXXXXXX	#REF!		#REF!	XXXXXXXX		#REF!	#REF!		
R&R Incidental Expenses Total =		#REF!	\$0.00	#REF!	\$0.00	\$0.00	#REF!	#REF!		
GRAND TOTAL =		#REF!	\$0.00	#REF!	\$0.00	\$0.00	#REF!	#REF!		

* Unless the contractor requests and the department approves payment in excess of the prorated share.
h. Less Recoupment of Interest = \$0.00
i. Less Recoupment of Advance = \$0.00
j. TOTAL AMOUNT OF STATE PAYMENT/ADVANCE = \$0.00

WORKSHEET FOR REQUEST FOR PAYMENT
Adult Mental Health

- a. AGENCY NAME: _____
- b. CONTRACT No.: _____
- c. FROM: _____ TO: _____
- d. PROGRAM: _____
- e. FEDERAL ID #: _____
- f. VENDOR ID (If different than Fed ID): _____
- g. ADDRESS (Number, City, State, Zip): _____

For cost centers paid for on the basis of utilization, Columns D & J MUST NOT BE > than, and Column E MUST NOT be < than, the # of units reported to the MHSA Data Warehouse

ACTIVITY Cost Center	Contracted Rate	YTD Total Units to Enrolled Clients & Non-Client-Specific Units	YTD Billable Medicaid Units to Enrolled Clients	YTD Local Match Units to Enrolled Clients & Non-Client-Specific Units	YTD Total Units Eligible to be Billed to SAMH D-(E+F)	Non-TANF- Units & Earnings		TANF -Units & Earnings	
						YTD Total Non-TANF Units Eligible to be Billed to SAMH	YTD Total Non-TANF \$ Amount for Eligible Units (CxH)	YTD Total TANF Units Eligible to be Billed to SAMH	YTD Total TANF \$ Amount for Eligible Units (CxJ)
A	B	D	E	F	G	H	I	J	K
Recovery & Resiliency - FACT Teams-502018									
Fact Team (No TANF)	\$0.00	0.00000	0.00000	0.00000	0.00000	0.00000	\$0.00		
Recovery & Resiliency -Incidental Expenses	\$0.00	0.00000	0.00000	0.00000	0.00000	0.00000	\$0.00	0.00000	\$0.00
Incidental Expenses									

**EXHIBIT E
ADULT SUBSTANCE ABUSE
Non-TANF
MONTHLY PAYMENT/ADVANCE REQUEST**

a. AGENCY NAME: _____
 b. CONTRACT No.: _____
 c. MONTH/YEAR OF: _____
 d. "months remaining": 12
 e. FEDERAL ID #: _____

f. Vendor No. (if different from Federal ID#): _____

g. ADDRESS (Number, City, State, Zip): _____

PART 1 - EARNINGS	Non-TANF Funding for the Activity Only	YTD Total Eligible Non-TANF \$ Earned	YTD SAMH Non-TANF Paid for Earnings	Difference (YTD Unpaid Earnings)	Prorated Share for Activity Only	Amount Due (Owed)	Cost Center Unit Rate	# of Non-TANF Units Paid for this Month
Budget Entity 60910603 ACTIVITY / Cost Centers	(from Exh G)	(col.1 of Wksh)		(col.3-col.4)	[(col. 2 - col 4) / months remaining]*	Each Activity is the lesser of Col.5 or Col.6.	(col.6 of Wksh)	(col.7 / col.8)
1	2	3	4	5	6	7	8	9
FACT Teams - xxxxxx	XXXXXXXX	#REF!		#REF!	XXXXXXXX		#REF!	#REF!
FACT Total =	XXXXXXXX	#REF!	\$0.00	#REF!	\$0.00		#REF!	#REF!
Incidental Expenses	XXXXXXXX	#REF!		#REF!	XXXXXXXX		#REF!	
Incidental Expenses Total =	\$0.00	#REF!	\$0.00	#REF!	\$0.00		#REF!	0.00000
TOTAL:	\$0.00	#REF!	\$0.00	#REF!	\$0.00			

* Unless the contractor requests and the department approves payment in excess of the prorated share.
 h. Less Recoupment of Interest = \$0.00
 i. Less Recoupment of Advance = \$0.00
j. TOTAL AMOUNT OF STATE PAYMENT/ADVANCE = \$0.00

WORKSHEET FOR REQUEST FOR PAYMENT
Adult Substance Abuse

- a. AGENCY NAME: _____
- b. CONTRACT NO.: _____ TO: _____
- c. FROM: _____
- d. PROGRAM: _____
- e. FEDERAL ID #: _____
- f. VENDOR ID (if different than Fed ID): _____
- g. ADDRESS (Number, City, State, Zip): _____
- h. _____

For cost centers paid for on the basis of utilization, Columns D & J MUST NOT BE > than, and Column E MUST NOT be < than, the # of units reported to the MHSA Data Warehouse

ACTIVITY	Cost Center	Contracted Rate	YTD Total Units to Enrolled Clients & Non-Client-Specific Units	YTD Billable Medicaid Units to Enrolled Clients	YTD Local Match Units to Enrolled Clients & Non-Client-Specific Units	YTD Total Units Eligible to be Billed to SAMH D-(E+F)	Non-TANF - Units & Earnings		TANF - Units & Earnings	
							YTD Total Non-TANF Units Eligible to be Billed to SAMH	YTD Total Non-TANF \$ Amount for Eligible Units (CxH)	YTD Total TANF Units Eligible to be Billed to SAMH	YTD Total TANF \$ Amount for Eligible Units (CxJ)
FACT Teams - xxxxxx	B									
Fact Team (No TANF)		\$0.00	0.000000	0.000000	0.000000	0.000000	0.000000	\$0.00		
Incidental Expenses		\$0.00	0.000000	0.000000	0.000000	0.000000	0.000000	\$0.00	0.000000	\$0.00

EXHIBIT F
INCIDENTAL EXPENSES
(placeholder)

This list of authorized incidental expenses shall be negotiated with the successful vendor and included as Exhibit F, prior to contract execution."

Principles of Recovery

1. The person directs the recovery process; therefore, the individual's input is essential throughout the process of providing treatment, rehabilitation and support services.
2. Any vendor submitting a proposal with the intent of operating a FACT team must be aware of the tendency to enable individual dependency.
3. Individuals are able to recover more quickly when their hope is encouraged, enhanced, and/or maintained; life roles with respect to work and meaningful activities are defined; spirituality is considered; culture understood; educational needs as well as those of their family/significant others are identified; and socialization needs are identified.
4. Individual differences are considered and valued across the life span.
5. Recovery from mental illness is most effective when a holistic approach is considered.
6. Medical, psychological, social and recovery models are merged.
7. The clinician's initial emphasis on "hope" and the ability to develop trusting relationships influences recovery.
8. Clinicians operate from a strengths/assets model.
9. Clinicians and the recipient collaboratively develop an individualized, comprehensive treatment plan. This plan focuses on the interventions that will facilitate recovery and the resources that will support the recovery process.
10. Family involvement may enhance the recovery process. The recipient defines his/her family unit.
11. Mental health services are most effective when delivery is within the context of the individual's community.
12. Community involvement as defined by the recipient is important to the recovery process.

EXHIBITS

H, I, J, K, L

Are included in the RFP Solicitation Document

Exhibit H, Monthly Vacant Position Report-----please see Appendix 14, page 116

Exhibit I, Monthly Enrollment Report----- please see Appendix 15, page 117

Exhibit J, Enhancement Guidelines----- please see Appendix 4, page 98

Exhibit K, Medication Management Policy----- please see Appendix 3, page 92

Exhibit L, FACT Advisory Committees: -----please see Appendix 2, page 84
Authorities And Limitations