MISSISSIPPI DEPARTMENT OF MENTAL HEALTH
SERVICE PROVIDER'S MANUAL

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I. Purpose

The Department of Mental of Health (DMH) obtains and distributes funds to its service providers in the form of grants and contracts. The funding for this assistance comes primarily from State General Fund revenues, state 3% Alcohol Tax revenues, and Federal grants.

Both Federal and State assistance programs impose requirements on the use of these funds and method of fund administration. The Federal Government's regulations concerning the administration of grants are, by far, the most demanding.

This manual explains the forms, instructions, and basic guidelines for the application, approval, and expenditure reimbursement from grant funds distributed by the DMH. Please review the grant reimbursement guidelines in Appendix 2 of this manual and the applicable federal guidelines explained on pages 48 and 49 of this manual prior to submitting expenses for reimbursement. Please note that general guidelines governing costs apply to both grants and contracts for services.

II. Forms and Instructions

A. Proposed Budget Summary - Form DMH-100-1

- "SERVICE PERIOD NUMBER": This item will be completed by the Department of Mental Health.
- "SERVICE PERIOD": Indicate the beginning and ending dates for the funds being requested.
- "SERVICE PROVIDER NAME": Indicate the name of the agency that will have the responsibility for administering the program.
- "ADDRESS": Indicate the address of the service provider.
- "PROPOSED BUDGET FOR FISCAL YEAR": Indicate the beginning and ending dates of the fiscal year (state or federal) during which the program will be operated.
- "CATEGORY OF EXPENSES":
  - "I. PERSONNEL": The total of this item must correspond with the total column (total year cost) of SECTION I - PERSONNEL (DMH 100-2), with corresponding totals per fund source.

- "II. TRAVEL": The total of this item must correspond with the total column, SECTION II - TRAVEL (DMH-100-3), with corresponding totals per fund source.

- "III. CONTRACTUAL SERVICES": The total of this item must correspond with the total column, SECTION III - CONTRACTUAL SERVICES (DMH-100-3), with corresponding totals per fund source.

- "IV. COMMODITES": The total of this item must correspond with the total column of SECTION IV - COMMODITIES (DMH-100-3), with corresponding totals per fund source.

- "V. EQUIPMENT": The total of this item must correspond with the total column of SECTION V - EQUIPMENT (DMH-100-3), with corresponding totals per fund source.

- "VI. INDIRECT COST": Indirect cost is limited to 8% of the direct program cost. Indicate any amount approved by DMH for indirect cost.

o "Submitted by": Indicate the person responsible for the program.

o "Title": Enter the name of the grant program.

o "Date": Enter the date this form is submitted to the DMH.

o "Telephone": Enter the telephone number of the person who completed the form.

DEPARTMENT OF MENTAL HEALTH

PROPOSED BUDGET

SERVICE PROVIDER NUMBER: _____

SERVICE PERIOD: _____

SERVICE PROVIDER NAME: _____

ADDRESS: _____

_____

PROPOSED BUDGET FOR FISCAL YEAR BEGINNING _____ AND ENDING _____

CATEGORY OF EXPENSE	TOTAL	FUND SOURCE		
		FEDERAL	STATE	LOCAL
I. PERSONNEL				
II. TRAVEL				
III. CONTRACTUAL SERVICES				
IV. COMMODITIES				
V. EQUIPMENT				
SUBTOTAL I - V				
VI. INDIRECT COST (limited to 8% of direct cost)				
TOTAL I - VI				

SUBMITTED BY: _____

TITLE: _____

DATE: _____

TELEPHONE: _____

PAGE _____ OF _____

DMH-100-1

B. Proposed Budget Personnel - Form DMH-100-2

- "SERVICE PROVIDER #": This item will be completed by the Department of Mental Health.

- "SERVICE PROVIDER": Indicate the name of the agency that is responsible for the program.

- "SECTION I – PERSONNEL":

  - "POS. #": Enter the identification numbers assigned by the service provider of each position.

  - "POSITION": Enter the position titles and the name of the individuals occupying the position in the program for which funds are being requested.

  - "% OF TIME": Enter the percentage of time that will be spent by each position on the program for which funds are being requested.

  - "MONTHLY SALARY": Enter the **gross** salary amounts requested for each position.

  - "SOC. SEC.", "RET.", "LIFE INS." "HEALTH INS." "UNEMP. INC." AND "WC": Enter either:

    - The fringe benefit percentage calculated using the instructions included on pages 18-20, "DMH Fringe Benefits Calculation Information/Instructions Sheet."

      OR:

    - Actual amounts of each fringe benefit that will be paid by the employer for each position not to exceed 28% of salaries requested as described on pages 18-30, "DMH Fringe Benefits Calculation Information/Instructions Sheet".

  - "TOTAL": Indicate the total amount of reimbursement requested for each position, with corresponding totals for each fund source.

- "SUBTOTAL MONTHLY COST": Indicate the total monthly cost of each column (if applicable).

- "TOTAL YEARLY COST": Indicate the total annual cost (12 months) of each column (if applicable).

DEPARTMENT OF MENTAL HEALTH -- PROPOSED BUDGET

SERVICE PROVIDER #: _____ SERVICE PROVIDER: _____

SECTION 1 - PERSONNEL

POS. #	POSITION	% OF TIME	MONTHLY SALARY	SOC. SEC.	RET.	LIFE INS.	HEALTH INS.	UNEMP. INS.	W/C	TOTAL	FUND SOURCE		
											FEDERAL	STATE	LOCAL
SUBTOTAL MONTHLY COST													
TOTAL YEAR COST													

C: Proposed Budget Line Item – Form DMH-100-3

- "SERVICE PROVIDER NO.": This item will be completed by the Department of Mental Health.

- "SERVICE PROVIDER": Indicate the name of the agency responsible for the program.

- "SECTION II –TRAVEL": Enter the total amount of funds requested for travel including in-state and out of state mileage, lodging, public carrier, meals, fees, etc.

- SECTION III – CONTRACTUAL SERVICES":

  - "Telephone": Enter proposed cost of telephone including services charge, long-distance, etc.

  - "Utilities": Enter proposed cost of electricity, water, gas, sewages, as applicable

  - "Postage": Enter proposed cost of postage, box rent, etc.

  - "Building Rent": Enter actual amount of rent to be paid during service period.

  - "Equipment Rent": Enter proposed amount to be expended including typewriter rentals, copy machine rentals, postage machine rentals, automobile rentals, etc.

  - "Repair and Maintenance": Enter proposed amount for repair maintenance or upkeep of property which neither adds to the permanent value of the property nor prolongs its intended life but keeps it in efficient operating condition. No renovation cost will be allowed.

  - "Insurance": Enter the proposed amount to be expended for bonding insurance, insurance on buildings and contents, vehicles, etc.

  - "Dues and Subscriptions": Enter the amount of funds to be expended for membership in professional organizations, publications, etc., necessary for the enhancement of the program.

  - "Professional Fees": Enter the total amount of funds proposed to be expended for any program/person providing medical services such as medical evaluations, psychological testing, etc.

- "Professional Fees Other": Enter the total amount of funds proposed to be expended for professional consultation, other than medical, such as contracts for food, pest control and transportation.

- "Medical Fees": Enter the proposed amount of funds to be expended for physical examinations, medical services, etc., both direct and consultative.

- "TOTAL": Enter total amount proposed to be expended for contractual services (Section III).

- "SECTION IV – COMMODITIES":

  - "Food": Enter proposed amount to be expended on food prepared for and consumed by clients.

  - "Office Supplies": Enter the proposed amount to be expended for office supplies. Equipment is not to be included in this line item.

  - "Program Supplies": Enter the proposed amount to be expended for materials to enhance client programs such as recreation, vehicle operating costs, etc.

  - "Janitorial Supplies": Enter the proposed amount to be expended for janitorial supplies.

  - "Household Supplies": Enter the proposed amount to be expended for household supplies.

  - "TOTAL": Enter total amount proposed to be expended for commodities (Section IV).

- "SECTION V – EQUIPMENT":

  - "Office Equipment": Enter the proposed amount to be expended for the purchase of equipment which may include computers, printers, copiers, etc.

  - "Program Equipment": Enter the proposed amount of funds to be expended for the purchase of equipment necessary to operate the programmatic segment of the program.

  - "Furniture": Enter the proposed amount of funds to be expended for furniture of group home, transition home, etc.

- "TOTAL": Enter total amount proposed to be expended for equipment (Section V).

- "TOTAL SECTIONS I THROUGH V": Enter total of line items I – V.

DEPARTMENT OF MENTAL HEALTH -- PROPOSED BUDGET

SERVICE PROVIDER NO. _____ SERVICE PROVIDER: _____

		FUNDING SOURCE		
		FEDERAL	STATE	LOCAL
	TOTAL			
SECTION II - TRAVEL				
SECTION III - CONTRACTUAL SERVICES				
Telephone				
Utilities				
Postage				
Building Rent				
Equipment Rent				
Repair & Maintenance				
Insurance				
Dues & Subsriptions				
Professional Fees				
Professional Fees, Other				
Medical Fees				
TOTAL				
SECTION IV - COMMODITIES				
Food				
Office Supplies				
Program Supplies				
Janitorial Supplies				
Household Supplies				
TOTAL				
SECTION V - EQUIPMENT				
Office Equipment				
Program Equipment				
Furniture				
TOTAL				
TOTAL SECTIONS I THRU V				

DMH-100-3 PAGE _____ OF _____

D. Notice of Proposed Budget – Form DMH-100-4

Form DMH-100-4 is provided for informational purposes only. **This form will be completed by the appropriate Bureau or Division within the Department.**

When the appropriate Bureau or Division of the DMH has received an application for a service program, a review will be made. As a result of this review there may be need for clarification, revisions, etc. to be made between the DMH and the Service provider. When the application has been approved by the DMH, a "Notice of Proposed Budget", Form DMH-100-4, will be forwarded to the service provider with any changes made by the DMH.

Please note that all budgets are subject to the availability of funds and on the optimal utilization of such funds. Budget awards are not guarantees for continued funding.

PROPOSED BUDGET
DEPARTMENT OF MENTAL HEALTH

PROGRAM	SERVICE PROVIDER NUMBER

SERVICE PERIOD: _____ THRU _____

SERVICE PROVIDER: NAME AND ADDRESS	PROGRAM ADMINISTRATOR: TELEPHONE:

PROPOSED BUDGET

CATEGORY OF EXPENSE	TOTAL	FUNDING SOURCE		
I. PERSONNEL				
II. TRAVEL				
III. CONTRACTUAL SERVICES				
IV. COMMODITIES				
V. EQUIPMENT				
SUBTOTAL I - V				
VI. INDIRECT COST (limited to 8%)				
TOTAL I - VI				
% OF TOTAL	100%			

REMARKS:

SIGNATURE, DIRECTOR, DIVISION OF	SIGNATURE, EXECUTIVE DIRECTOR,

E. DMH Budget Revision -Form DMH-100-5

Form DMH-100-5 is provided for informational purposes only. This form will be completed by DMH staff upon receipt and approval of a request for changes to be made to the original budget. Please note that most changes transferring money between line-items or transfers between categories **other than personnel** do not require formal budget revisions. Please check with the appropriate Bureau program staff prior to submission of this form.

SERVICE PROVIDER#:

PROGRAM:

REVISION#:

SERVICE PROVIDER:

DATE:

APPROVAL:

TITLE:

DIRECTOR:

BUDGET CATEGORY	PREVIOUS AUTHORIZATION			APPROVED CHANGE			REVISED BUDGET		
I. PERSONNEL									
II. TRAVEL									
III. CONTRACTUAL SERVICES									
IV. COMMODITIES									
V. EQUIPMENT									
SUBTOTAL									
VI. INDIRECT COST									
TOTAL									

DMH-100-5

F. Cash Request – Form DMH-100-6

NOTE: Cash Requests are due to the DMH on or before the 15th of each month following the month of expenditures. Final cash requests are due within 30 days following the end of the grant period.

- "SECTION I":
  - "Service Provider #": Enter the identification number assigned to the program.
  - "Program": Enter the particular work function or area for which funds are being requested.
  - "Service Provider": Enter the name of the funds recipient.
  - "Service Period": Enter the beginning and ending dates of the program.
- "SECTION II":
  - Month: Include the month for which funds are being requested and a categorical breakdown of the monthly expenditures. The category total must agree with the individual monthly expense reports (forms DMD-100-7-I-VI…personnel, contractual, commodities, etc.). These totals must be broken down by fund source (i.e. SAPT, State, Local) with fund source and year listed above the amounts requested (i.e. SA10, GF11, CM10, etc.) See approved budget for fund source.
  - YTD: The year-to-date (YTD) amounts should reflect the cumulative expenditures by category.
- "SECTION III":
  - Budget by Fund Source: Enter the approved budget by category and funding. This should remain the same for the grant period unless the Service Provider has received an approved budget revision.
- "SECTION IV":
  - Date: Enter the date of request
  - Funds Requested: Enter the amount of funds requested
  - Signature: Enter an approved signature, in ink.
- "SECTION V":
  - For DMH Use Only

DMH-100-6 (Revision 1)

DEPARTMENT OF MENTAL HEALTH
CASH REQUEST

SECTION I

SERVICE PROVIDER # _____ PROGRAM _____

SERVICE PROVIDER _____ SERVICE PERIOD _____

SECTION II — EXPENSE BY FUND SOURCE -- MONTH OF 20

CATEGORY:	TOTAL							
	MONTH	YTD	MONTH	YTD	MONTH	YTD	MONTH	YTD
PERSONNEL								
TRAVEL								
CONTRACTUAL SERVICES								
COMMODITIES								
EQUIPMENT								
INDIRECT COST								
TOTAL								

SECTION III — BUDGET BY FUND SOURCE

CATEGORY:	TOTAL			
PERSONNEL				
TRAVEL				
CONTRACTUAL SERVICES				
COMMODITIES				
EQUIPMENT				
INDIRECT COST				
TOTAL				

SECTION IV — DATE

FUNDS REQUESTED _____

SIGNATURE _____

SECTION V — DMH USE ONLY

AMOUNT APPROVED _____

PROGRAM APPROVAL _____

DIVISION APPROVAL _____

FISCAL APPROVAL _____

Monthly Expense Report (Forms DMH-100-7-I through DMH-100-7-VI) General Information:

These forms identify the actual expenditures, by expenditure categories, which constitute the totals requested for reimbursement. Expenditures should be properly coded categorically as well as being mathematically correct. Each applicable page should be subtotaled at the bottom for reference purposes. The last page should be the sum of the incremental categorical pages by the use of the individual subtotal lines.

The information entered on forms DMH-100-7-I-VI should be recalculated for accuracy prior to submitting to DMH. The amounts reimbursed should also be compared to the amounts requested to ensure that reimbursement does not cause an overpayment of funds in the category. Any over payment of funds will result in repayment at year end.

G. Personnel – Form DMH-100-7- I

- Enter all identification data.
- Number all pages.
- Enter the month and year of the expenditures that you are requesting to be reimbursed.
- "Check #": Enter the check numbers for all payments requested for reimbursement. If payroll checks are deposited directly into employee checking accounts, enter "DD" in check # column.
- "Paid to": Enter the name of the payee'.
- "Position #": Enter the employee position number.
- "Description": Enter the type of expenditure, such as payroll, fringes, etc., from form DMH-100-2 of the approved budget.
- "Total Amount of Check": Enter the total amount requested.
- "Fund Source": Enter Federal, State, and Local amounts by line item. The sum of these amounts should equal the "Total Amount of Check" column.

Note:

1) See pages 18-20 for instructions and worksheets for calculating fringe benefits.

SERVICE PROVIDER: _____

SERVICE PROVIDER #: _____

SIGNATURE: _____

DEPARTMENT OF MENTAL HEALTH

MONTHLY EXPENSE REPORT

MONTH OF _____ 20 _____

PAGE _____ OF _____

FUND SOURCE

CATEGORY	CHECK #	PAID TO	POS. #	DESCRIPTION	TOTAL AMOUNT OF CHECK			
I. PERSONNEL								

H. Fringe - Form DMH-Fringe:

Form DMH-Fringe is included for example purposes only. This form contains the necessary elements in estimating a percentage of fringe benefits based on total salaries. This information (whether using this form or a form of your own) should be kept on site for DMH review.

- Enter Service Provider identification information.

- Enter total salaries and wages for the last completed fiscal year, current fiscal year to date, projected current year to date, and proposed fiscal year.

  - The last completed fiscal year.
    Assuming a date of August 18, 2010, the last completed fiscal year would be the year ended September 30, 2009.

  - Current fiscal year to date.
    Assuming a date of August 18, 2010, this period would be from October 1, 2009 thru the current date August 18, 2010.

  - Projected Current year to date.
    Assuming a date of August 18, 2010, this period will be for the remainder of the fiscal year. This will be the current fiscal year cost up through August 18, 2010 plus the remaining 6 weeks up to September 30, 2010.

  - Proposed Fiscal Year.
    Assuming a date of August 18, 2010, this would be from October 1, 2010 through September 30, 2011 or whatever inclusive dates the next grant fiscal year would be.

- Enter employer fringe benefits including social security, retirement, health insurance, etc. for the last completed fiscal year, current fiscal year to date, projected current year to date, and proposed fiscal year.

- Enter the total fringe benefits

- Enter the percentage of fringe benefits to be used in requesting reimbursement. This amount is calculated by dividing the total fringe benefit amount by the total salaries and wages.

Notes:

1) Allowable fringe benefits will be those which meet the standard of being usual, customary, and reasonable, and which are allowed by the Internal Revenue Service. Some benefits which are **NOT** considered to be fringes are any cafeteria plan

deductions, vacation time, sick leave, administrative leave, or any other items that may be correctly considered as salary cost.

2) The fringe benefit rate will be applicable for the twelve (12) months of the grant year. As an example, should the rate be 27.88%, it will be used to calculate fringe benefits on all cash requests for that year. No mid year adjustments will be made. The rate will be used for all grants that the entity has in that fiscal year.

3) The fringe benefit percentage for employees earning a salary in excess of $40,000 is limited to 28%. If you are submitting a cash request for a grant that has no employees earning salaries in excess of these amounts, then you may use your actual fringe benefit rate for reimbursement under the grant. If any employees earn a salary that exceeds these amounts, then you are limited to 28% on those employees. It is the employee's total salary, not just the portion charged to the grant that applies. For example, if an employee with an annual salary of $45,000 is charged 50% on a grant, the salary charged to that grant is $22,500, but the 28% cap still applies because the employee's salary is more than $40,000. This does not apply if your actual fringe benefits percentage is 28% or less.

4) Fringe benefits cost should be claimed as a single line item in addition to the salary costs except in cases where an employee on the grant has an annual salary that exceeds $40,000 **AND** the claimed rate exceeds 28%. In these cases the fringe benefit for those employees is limited to 28%. Two fringe benefit line items will be required: one for all employees whose annualized salaries are $40,000 or less and another for those employees whose annualized salaries are more than $40,000.

5) An error rate of 5% may be allowed upon audit. For example, if the sub-grantee claims a fringe benefit rate of 29% and, upon audit, the actual rate is found to be no less than 27.55% (which is 5% below the claimed rate of 29%), an audit adjustment might not be proposed. If the actual rate in this example turns out to be 27%, then an adjustment down to the actual rate of 27% will be made.

DMH-FRINGE

Department of Mental Health
Fringe Benefit Rate Calculation

Service Provider:_____

Line No.	Category	Last Completed Fiscal Year (Actual) Yr. Ended_____	Current Fiscal Yr. To Date (Actual) Yr. Ending_____	Projected Current Fiscal Yr. (Actual + Estimated) Yr. Ending_____	Proposed Fiscal Year (Estimated) Yr. Ending_____
1	Total salaries and wages				
2	Employer Fringe benefits:				
3	Social Security (incl. Medicare)				
4	Retirement				
5	Health insurance				
6	Group term life insurance				
7	Unemployment tax				
8	Workers compensation				
9	Other: (list)				
10					
11					
12					
13					
14					
15	Total fringe benefits				
16	% fringes (line 15 divided by line 1)				

I. Travel-Form DMH-100-7-II

- Enter all identification data.
- Number all applicable pages.
- "Check #": Enter the check number of the expenses requested for reimbursement.
- "Paid To": Enter the payee to which funds were paid.
- "Description": Enter the explanation for disbursement of funds such as, local travel, conference fees, etc.
- "Total Amount of Check": Enter the full amount paid on that particular expense.
- "Fund Source": Enter Federal, State, and Local amounts by line item. The sum of these amounts should equal the "Total Amount of Check" column.

SERVICE PROVIDER #: _____ Page _____ of _____

FUND SOURCE

CATEGORY	CHECK #	PAID TO	DESCRIPTION	TOTAL AMOUNT OF CHECK			
II. TRAVEL							
SUBTOTAL -- TRAVEL							

DMH-100-7-II

J. Contractual-Form DMH-100-7-III

- Enter all identification data.
- Number all applicable pages.
- "Check #": Enter the check for which reimbursement is being requested.
- "Paid To": Enter payee to which funds were paid.
- "Description": Enter explanation for disbursement of funds. (I.e. utilities, rent, repair and maintenance, etc.)
- "Total Amount of Check": Enter full amount paid on that particular expense.
- "Fund Source": Enter Federal, State, and Local amounts by line item. The sum of these amounts should equal the "Total Amount of Check" column.

SERVICE PROVIDER #: _____ Page _____ of _____ **FUND SOURCE**

CATEGORY	CHECK #	PAID TO	DESCRIPTION	TOTAL AMOUNT OF CHECK			
II. CONTRACTUAL SERVICES							
SUBTOTAL -- CONTRACTUAL SERVICES							

DMH-100-7-III

K. Commodities-Form DMH-100-7-IV

- Enter all identification data.
- Number all applicable pages.
- "Check Number": Enter all check numbers for which reimbursement is being requested.
- "Paid To": Enter the name of the payee.
- "Description": Enter the explanation for disbursement of funds (i.e. office supplies, program supplies, food, etc.)
- "Total Amount of Check": Enter the full amount paid on that particular expense.
- "Fund Source" - Enter Federal, State, and Local amounts by line item. The sum of these amounts should equal the "Total Amount of Check" column.

SERVICE PROVIDER #: _____ Page _____ of _____

FUND SOURCE

CATEGORY	CHECK #	PAID TO	DESCRIPTION	TOTAL AMOUNT OF CHECK			
IV. COMMODITIES							
SUBTOTAL -- COMMODITIES							

DMH-100-7-IV

L. Equipment-Form DMH-100-7-V

- Enter all identification data.
- Number all applicable pages.
- "Check Number": Enter the check numbers for which funds are being requested.
- "Paid To": Enter the name of the payee.
- "Description": Enter a brief description of the equipment item purchased (i.e. refrigerator, computer, printer, etc.).
- "Total Amount of Check": Enter the full amount paid on that particular expense.
- "Fund Source": Enter Federal, State, and Local amounts by line item. The sum of these amounts should equal the "Total Amount of Check" column.

Notes:

1) The Equipment Data Report Form (DMH-101-01) on page 32 of this manual must also be completed and submitted to DMH for all equipment items purchased with grant funds.

2) Written approval from DMH and/or the county board of supervisors, depending on the original source of funding, must be obtained before disposing of all real and personal property purchased with state and/or county appropriated funds.

3) PROPERTY is defined as all furniture, vehicles, equipment and other state property having a useful life expectancy of at least one year and the cost of which is $1000 or more. It does not include carpeting (excluding area rugs), draperies, plants, installed floor-to-ceiling partitions, window shades or blinds, mattress/box springs, water heaters, installed drinking fountains, museum acquisitions, library books, films or archival collections. All items under $1000 in value are not required to be placed on inventory excluding specialty items. However, they are required to have an agency sticker applied.

4) The following property items shall be included on inventory regardless of the price paid to acquire the item or the fair market value of the item: **Weapons, camera and camera equipment (greater than $250), two-way radio equipment, televisions (greater than $250), lawn maintenance equipment,**

cellular telephones, computers and computer equipment (greater than $250), chain saws, air compressors, welding machines, generators, motorized vehicles.

SERVICE PROVIDER #: _____ Page _____ of _____ **FUND SOURCE**

CATEGORY	CHECK #	PAID TO	DESCRIPTION	TOTAL AMOUNT OF CHECK			
V. EQUIPMENT							
SUBTOTAL -- EQUIPMENT							

DMH-100-7-V

M. Equipment Data - Form DMH-101-01

When equipment is purchased with funds from the DMH, form DMH-101-01 is to be submitted to the DMH Audit Division to the attention of the Audit Director. Additionally, if equipment items purchased with grant funds from the DMH are broken or stolen, DMH 101-01 forms are required to be submitted to the DMH before these items can be removed from inventory. These property records are used to conduct annual audits of all equipment items of DMH service providers. Equipment items that were reimbursed with grant funds without submitting this form could result in a repayment of funds. Additionally, equipment items purchased with grant funds that are disposed of without submission of this form and approval by the audit division could also result in repayment of funds.

It is mandatory that the service provider keep detailed records of equipment including a master listing of fixed assets with corresponding inventory numbers assigned by the service provider, specific location of the property items, date the items were purchased, and any transfer information applicable (when equipment items are transferred to a different location within the facility or to a different DMH funded facility. Information submitted to the DMH must be accurate (i.e. serial numbers, locations, and inventory numbers) to prevent unnecessary payback of funds.

- Enter all identification data.
- Division and Grant Number: Enter the DMH division that funds the grant and the applicable grant number.
- Inv. #: Enter the inventory number of the equipment. This will be an inventory number that the funded program assigns.
- Description of item: Enter a description of the equipment item (i.e. Washer, computer, printer).
- Manufacturer: Enter the name of the manufacturer (i.e. Maytag, Dell, Hewlett Packard).
- Serial No.: Enter manufacturer's serial number, federal stock number, national stock number, or other identification number.
- Equipment Location: Enter the location and/or use of the equipment (i.e. Jackson St. Clubhouse).

- Total Cost: Enter the total cost charged to the grant and/or used to meet matching requirements.

- % FF – Enter the percentage of Federal participation in the cost of the project or program for which the property was acquired.

- Date Rec'd: Enter the date the equipment was received and put into inventory.

TO BE COMPLETED WHEN EQUIPMENT ITEMS NEED TO BE REMOVED FROM INVENTORY:

- Disposition Date: Enter the date that the inventory item was stolen or became unusable.

- Condition of Property: Enter the reason why the equipment item needs to be removed from inventory (i.e. broken, stolen, un-repairable).

Mississippi Department of Mental Health

Report of Non-Expendable Government Property Acquired by Grantee			Grantee Name, Address, and Authorized Representative Name: _____ Address: _____ Auth. Rep: _____
Date of Report	Division and Grant Number		

Inv.#	Description of Item	Manufactuerer	Serial No.	Equipment Location	Total Cost	%FF	Date Rec'd	Disposition Date	Condition of Property

DMH 101-01 (1/95)

N. Report Summary-Form DMH-100-7-VI

- Enter all identification data.

- "Subtotal I-V": Enter the combined totals of Forms DMH-100-7-1-V by Fund Source.

- "VI. Indirect Costs": Enter the amount by fund source allowed in the approved DMH budget (Form DMH-100-1, page 3 of this manual). Note that this amount is limited to 8% of direct costs.

- "Total 1-VI": Enter by fund source the total amounts requested for reimbursement. These amounts must agree with the amounts listed on the cash request (Form-DMH-100-6, page 15 of this manual).

SERVICE PROVIDER #: _____ Page _____ of _____

	FUND SOURCE		
SUBTOTAL I. - V.			
VI. INDIRECT COSTS			
TOTAL I. - VI.			

SERVICE PROVIDER: _____ SUBMITTED BY: _____

ADDRESS: _____ TITLE: _____

_____ DATE: _____

DMH 100-7-VI

O. CMHS – Form DMH-POS-1

DMH Form DMH-POS-1 is to be used to request funds during the application process and as part of the monthly reimbursement request to indicate units of services provided.

- Enter identification data.

- "Application": If this form is being used as part of the application process, enter the beginning and ending month, day, and year of the grant period for which funds are being requested.

- "Monthly Summary": If this form is being used as part of the monthly reimbursement request, enter the month and year for which the funds are being requested. The total is then transferred to DMH 100-6 as contractual funds requested.

- Service Categories 1-13: For the application process, the program should indicate the amount of funds that is being allocated to each service category. For the monthly reimbursement summary, the program should indicate by category the number of units provided and amount being requested.

- "Total": Enter the total amount of funds requested. The number of units does not have to be totaled.

- "Signature": Enter the signature of the individual completing this form.

- "Date": Enter the date submitted to the DMH.

CMHS PURCHASE OF MENTAL HEALTH SERVICES

Name of Provider_____

Contract Number_____ Application_____to_____

Month/Year_____ Monthly Summary_____

Service Categories		Unit Cost	Mental Health	
			Units	$$$
1	Intake/Bio-Psycho-social Assessment (1 hour)	$93.00		
2	Medication Evaluation & Monitoring (per service)	$46.88		
3	Individual Therapy (30 minutes)	$57.49		
4	Individual Therapy (50 minutes)	$81.09		
5	Individual Therapy (80 minutes)	$119.45		
6	Family Therapy (50 minutes)	$75.70		
7	Group Therapy (50 minutes)	$26.62		
8	Psychosocial Rehabilitation (Per 15 minute Unit)	$3.87		
9	Nursing Service (per 15 minute unit)	$18.45		
10	Injection of Psychotropic Meds (per injection)	$4.76		
11	Case Management (per 15 minute unit)	$14.88		
12	Family Education/Support	$16.00		
13	Consumer Education/Support	$16.00		
14	Emergency	$865.00		
		Total $		$
		Total Combined Reimbursement Request		$

Signature _____ Date _____

P. SAPT Dual Diagnosis– Form CMHS/SAPT-POS-1

CMHS/SAPT-POS-1 is completed in the budget request both as an initial request application for the expected number of units of services to be provided as well as a backup form to be included with the request for reimbursement for the actual number of units provided. The total is transferred to DMH 100-6 when requesting reimbursement.

- Enter identification data.
- "Application": Mark (X) this line if the form is being used as an initial request application for units of services to be provided.
- "Monthly Report": Mark (X) this line if the form is being used to request reimbursement.
- "SMI Adult Units/Total Cost": Enter the units of service and the corresponding dollar amounts for each service category for which funds are being requested. The dollar amount calculation should be equal to the number of units multiplied by the amounts listed in the unit cost column.
- "Total": Enter the total amount of funds requested, as well as the total number of units.
- "Signature": Enter the signature of the individual completing this form.
- "Date": Enter the date submitted to the DMH.

DIVISION OF COMMUNITY SERVICES

SAPT DUAL DIAGNOSIS PURCHASE OF MENTAL HEALTH SERVICES

Provider Name: _____

Contract: _____ **Application** _____

Month: _____ **Monthly Report** _____

SERVICE CATEGORIES	UNIT COST	SMI ADULT UNITS	TOTAL COST
1. Day Treatment	$8.00		
2. Engagement/Outreach Activities	Negotiable		
3. Intensive/Case Management	$14.88		
4. Nursing Care	$18.45		
5. Psychiatric Care	$46.88		
6. Specialized Group Therapy	$7.47		
7. Training/Educational Activities	Negotiable		
8. Transportation	Negotiable		
9. Aftercare	Negotiable		
10. Continuous Treatment Team Activities	Negotiable		
11. Family Education	$16.00		
12. Housing (temporary)	Negotiable		
13. Injections	$4.76		
14. Urine Drug Screens	Negotiable		
TOTAL			

*Negotiable - Data for these services must be established with the Department of Mental Health based on cost.

Signature: _____

Date: _____

CMHS/SAPT-POS-1
(Revised 7/10)

Q. SAPT Block Grant Funds - DMH Form DADA-POS-1

DADA-POS-1 is to be used to request funds during the application process and as part of the monthly reimbursement request to indicate units of services provided.

- Enter identification data.
- "Application": If this form is being used as part of the application process, enter the beginning and ending month, day, and year of the grant period for which funds are being requested.
- "Monthly Summary": If this form is being used as part of the monthly reimbursement request, enter the month and year for which the funds are being requested. The total is then transferred to DMH 100-6 as contractual funds requested.
- Service Categories 1-12: For the application process, the program should indicate the amount of funds that is being allocated to each service category. For the monthly reimbursement summary, the program should indicate by category the number of units provided and amount being requested.
- "Total": Enter the total amount of funds requested. The number of units does not have to be totaled.
- "Signature": Enter the signature of the individual completing this form.
- "Date": Enter the date submitted to the DMH.

Section A. Budget

MISSISSIPPI DEPARTMENT OF MENTAL HEALTH
DIVISION OF ALCOHOL AND DRUG ABUSE
PURCHASE OF SERVICES - SAPT BLOCK GRANT FUNDS

Name of Provider _____
Contract Number _____ **Application** _____ **to** _____
Month/Year _____ **Monthly Summary** _____

	Service Categories	Service/ Unit Cost	Alcohol		Drugs		Prevention	
			Units	$$$	Units	$$$	Units	$$$
1	Intake/Bio-psycho-social Assessment (1 Hour)	$ 93.00						
2	Individual Therapy (30 Minutes)	$ 57.49						
3	Individual Therapy (50 Minutes)	$ 81.09						
4	Individual Therapy (80 Minutes)	$ 119.45						
5	Family Therapy (50 Minutes)	$ 75.70						
6	Group Therapy (50 Minutes)	$ 26.62						
7	Prevention - Master's Level (1 hour Unit)	$ 62.00						
8	Prevention – Bachelor's Level (1 hour Unit)	$ 50.00						
9	Dual Diagnosis Prevention Master's Level (1 hour Unit)	$ 62.00						
10	Dual Diagnosis Prevention Bachelor Level (1 hour Unit)	$ 50.00						
		Total $		$		$	Combined Prevention Total $	$
		Total Reimbursement Request			$			

Signature_____ **Date**

DMH Form DADA-POS-!(BG)
(Revised 7/10)

Section A. Budget

MISSISSIPPI DEPARTMENT OF MENTAL HEALTH
DIVISION OF ALCOHOL AND DRUG ABUSE
PURCHASE OF SERVICES - SAPT BLOCK GRANT FUNDS

Name of Provider _____
Contract Number _____ **Application** _____ **to** _____
Month/Year _____ **Monthly Summary** _____

Service Categories		Service/ Unit Cost	Alcohol		Drugs		Prevention	
			Units	$$$	Units	$$$	Units	$$$
	Day Treatment (15 minute unit)	$ 3.25						
		Total $		$		$	Combined Prevention Total $	$
		Total Reimbursement Request			$			

Signature _____ **Date**_____

DMH Form DADA-POS-1(BG/DT)
Revised 7/10

Section A. Budget

MISSISSIPPI DEPARTMENT OF MENTAL HEALTH
DIVISION OF ALCOHOL AND DRUG ABUSE
PURCHASE OF SERVICES - SAPT BLOCK GRANT FUNDS

Name of Provider _____
Contract Number _____ **Application**
to _____
Month/Year _____ **Monthly Summary**
_____

Service Categories		Service/ Unit Cost	Alcohol		Drugs		Prevention	
			Units	$$$	Units	$$$	Units	$$$
	HIV Early Intervention Services (30 Minutes)	$ 31.00						
		Total $		$		$	Combined Prevention Total $	$
		Total Reimbursement Request			$			

Signature_____**Date**_____

DMH Form DADA-POS-1(BG/HIV)
(Revised 7/10)

R. MAP - CYS Services– Form DMH-POS-CYS

DMH-POS-CYS is completed in the budget request both as an initial request application for the expected number of units of services to be provided as well as a backup form to be included with the request for reimbursement for the actual number of units provided. The total is transferred to DMH 100-6 when requesting reimbursement.

- Enter identification data.

- "Monthly Summary": Mark (X) on this line if the form is being used to request reimbursement.

- "Total # Units/Total": Enter the units of service and the corresponding dollar amounts for each service category for which funds are being requested. The dollar amount calculation should be equal to the number of units multiplied by the amounts listed in the unit cost column.

- "Total": Enter the total amount of funds requested.

- "Signature": Enter the signature of the individual completing this form.

- "Date": Enter the date submitted to the DMH.

MISSISSIPPI DEPARTMENT OF MENTAL HEALTH
PURCHASE OF MENTAL HEALTH SERVICES FOR MAP TEAM GRANTEES

Name of Provider_____

Month of_____ Monthly Summary

Service Categories	Unit Cost	Mental Health	
		Total # Units	Total $
Individual Therapy (30 min.)	$57.49		
Individual Therapy (50 min.)	$81.09		
Individual Therapy (80 min.)	$119.45		
Group Therapy	$26.62 Adult $29.86 Children		
Family Therapy	$75.70 w/o client $93.83 w client		
Case Management	$14.88		
* School Based (Case Management) Services	$18.45		
* Mental Illness Management Services	$18.90		
Day Treatment	$32.00/hour		
* Individual Therapeutic Support	$9.52		
Respite: Individual one-on-one Group	 $40.00/hr $30.00/hr.per child		
Intensive Family Ed. and Training	$75.00/hr.		
Family Support Group (Maximum of one hour meeting per week)	Leader: $45/hr. Parent: $20/hr.		
	TOTAL $		$

* CMHCs must be certified to provide these services to children/youth with SED.

Signature_____ Date_____
FORM DMH-POS-CYS

S. Commitment Pre-Evaluation Screening/ Community Billing Form DMH-PES

DMH-PES is completed as backup for Reimbursement of Pre-Evaluation Screening expenses.

Expenses incurred in the Pre-Evaluation process resulting in recommending an individual for inpatient treatment or community maintenance are reimbursed at a rate of $15.50 per 15 minute unit. The maximum number of evaluation units that can be claimed per individual is 8 units or 2 hours.

Expenses incurred in the Pre-Evaluation process resulting in not recommending an individual for inpatient treatment and providing services to the individual to maintain him/her in the community are reimbursed at a rate of $250.00 per individual.

- Enter month of service
- Enter county
- Enter the total number of pre-evaluations recommended for inpatient treatment or community maintenance.
- Enter total number of pre-evaluation units for each county. This constitutes units involved in recommending a client for impatient treatment or community maintenance.
- Enter total dollar amount per county calculated by multiplying the total units by $15.50.
- Enter total number of individuals per county that were recommended for community maintenance
- Enter dollar amount per county of individuals recommended for community services. This number of individuals recommended for community maintenance multiplied by $250.00.
- Enter total amount per county for both individuals recommended for inpatient treatment and for individuals recommended for community maintenance.

NOTE: Documentation must be maintained on site for services provided to individuals receiving pre-evaluation screenings. Documentation include progress notes, service activity logs and, if applicable, case numbers.

Month_____

Commitment Pre-Evaluation Screening/ Community Billing

County	Number of Pre-Evaluations Recommended for Inpatient Treatment	Pre-Evaluation Units For Individuals Recommended For Inpatient Treatment or Community Maintenance	$ Amount Recommendations For Inpatient Treatment or Community Maintenance (maximum 8 units per individual) $15.50/unit	Number of Individuals Recommended for Community Maintenance	$ For Community Maintenance $250.00 per individual	Total
TOTAL						

Authorized Signature_____

CMHC_____

dmh-pes

III. DMH Standards/Guidelines for Grant Reimbursement

The DMH, through Section 41-4-7 of the Mississippi Code of 1972 Annotated, authorizes the Department "to supervise, coordinate, and establish standards for all operations and activities of the state, related to mental health and providing mental health services." Prior to final approval of grant awards to providers of mental health services, these providers must agree to adhere to DMH established guidelines and standards.

A. Independent Audit Guidelines

Programs funded by the DMH must agree to have an annual, independent audit, conducted in accordance with applicable federal and state requirements. The Independent Audit Guidelines define and explain the standards and legislation governing these audits. **These guidelines are included as Appendix 1 of this manual.**

B. Reimbursement Guidelines

Reimbursement Guidelines include general rules in determining the allowability of expenditures charged to DMH grants. **These guidelines are included as Appendix 2 of this manual.**

C. Certification Regarding Environmental Tobacco Smoke

Public Law 103-327, also known as the Pro-Children Act of 1994, prohibits smoking in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely for children services. This statement has to be signed by the subrecipients of applicable grants. **This certification is included as Appendix 3 of this manual.**

D. Assurances

An agreement, signed by the director of the subrecipient agency, which assures the DMH that specific federal and state rules and regulations, will be followed by the subrecipient. **DMH Assurances are included as Appendix 4 of this manual.**

E. Certification Regarding Drug-Free Workplace Requirements

An agreement, signed by an authorized representative of the agency, certifying that the agency will comply with regulations implementing the Drug-Free Workplace Act of 1988, 45 CFR Part 76, Subpart F. **This certification is included as Appendix 5 of this manual.**

F. Contract for the Purchase of Mental Health Services

An agreement between the agency requesting funding and the DMH must be signed by both parties prior to receiving final approval of grant awards. The Contract for the Purchase of Mental Health Services outlines the general agreements of the grantee agency and the DMH. **This contract is included as Appendix 6 of this manual.**

G. Appeals to the Board of Mental Health

This section contains instructions for appealing a DMH decision (i.e. to terminate grant funding, to request payback of funds, etc.). **The Appeals are included as Appendix 7 of this manual.**

H. Federal Standards/Guidelines for Federal, State and Local Governments Receiving Federal Grant Funds

The OMB provides guidance to Federal fund recipients through various "Circulars." The following "Circulars" govern the allowability of charges to Federal grants and prescribe audit requirements for recipients of such funds.

- OMB Circular A-87 – Cost Principles for State, Local and Indian Tribal Governments

  This circular establishes principles for determining the allowability of costs incurred by State, Local and Federally-recognized Indian tribal governments under grants, cost reimbursement contracts, and other agreements with the Federal government. **This circular would apply to costs incurred by state facilities and regional mental health centers funded by federal grants through the DMH.** This circular can be accessed online at: www.whitehouse.gov/omb/circulars/a087/a87_2004.html

- OMB Circular A-102 – Grants and Cooperative Agreements with State and Local Governments

  This Circular establishes consistency and uniformity among Federal agencies in the management of grants and cooperative agreements with State, Local, and federally recognized Indian tribal governments. **This circular would apply to costs incurred by state facilities and regional mental health centers funded by federal grants through the DMH.**

This circular can be accessed online at: www.whitehouse.gov/omb/circulars/a102/a102.html

- OMB Circular A-110 – Uniform Administrative Requirements for Grants and Agreements With Institutions of Higher Education, Hospitals and Other Non-Profit Organizations

  This Circular provides standards for obtaining consistency and uniformity among Federal agencies in the administration of grants and agreements with institutions of Higher Education, Hospitals, and Other Non-Profit organizations. **This circular would apply to costs incurred by independent, non-profit programs funded by federal grants through the DMH.** This circular can be accessed online at: www.whitehouse.gov/omb/circulars/a110/a110.html.

- OMB Circular A-122 – Cost Principles for Nonprofit Organizations

  This Circular establishes principles for determining the allowability of costs charged to federal grants through grants, contracts and other agreements with Non-Profit Organizations. **This circular would apply to costs incurred by independent, non-profit programs funded by federal grants through the DMH.** This circular can be accessed online at: www.whitehouse.gov/omb/circulars/a122/a122.html.

- OMB Circular A-133 – Audits of States, Local Governments and Non-Profit Organizations

  This Circular outlines establishes uniform audit requirements for Non-Federal entities that administer Federal awards and implements the Single Audit Act Amendments of 1996. **This Circular contains Federal independent audit requirements for service providers expending $500,000 in federal funds.** This circular can be accessed online at: www.whitehouse.gov/omb/circulars/a133/a133.html.

I. State of Mississippi Procurement Manual

The Procurement Manual sets form all laws and regulations along with other pertinent information that shall be in effect with the implementation of Title 31, Chapter 7, Mississippi Code of 1972, Annotated. The policies and procedures apply to the procurement of commodities and equipment bought, leased or rented with any funds, regardless of source, by those agencies which are required by the statute to be under the authority of the Department of Finance and Administration/Procurement Review Board. **These procurement requirements apply to purchases by state facilities and regional mental health centers and can be accessed through their Web Site at www.dfa.state.ms.us**

MISSISSIPPI DEPARTMENT OF MENTAL HEALTH
SERVICE PROVIDER'S MANUAL

Mississippi Department of Mental Health
Edwin C. LeGrand III
Executive Director
239 North Lamar
Suite 1101 Robert E. Lee Building
Jackson, Mississippi
(601) 359-1288

July, 2010 Revision

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I. Purpose

The Department of Mental of Health (DMH) obtains and distributes funds to its service providers in the form of grants and contracts. The funding for this assistance comes primarily from State General Fund revenues, state 3% Alcohol Tax revenues, and Federal grants.

Both Federal and State assistance programs impose requirements on the use of these funds and method of fund administration. The Federal Government's regulations concerning the administration of grants are, by far, the most demanding.

This manual explains the forms, instructions, and basic guidelines for the application, approval, and expenditure reimbursement from grant funds distributed by the DMH. Please review the grant reimbursement guidelines in Appendix 2 of this manual and the applicable federal guidelines explained on pages 48 and 49 of this manual prior to submitting expenses for reimbursement. Please note that general guidelines governing costs apply to both grants and contracts for services.

II. Forms and Instructions

A. Proposed Budget Summary - Form DMH-100-1

- "SERVICE PERIOD NUMBER": This item will be completed by the Department of Mental Health.
- "SERVICE PERIOD": Indicate the beginning and ending dates for the funds being requested.
- "SERVICE PROVIDER NAME": Indicate the name of the agency that will have the responsibility for administering the program.
- "ADDRESS": Indicate the address of the service provider.
- "PROPOSED BUDGET FOR FISCAL YEAR": Indicate the beginning and ending dates of the fiscal year (state or federal) during which the program will be operated.
- "CATEGORY OF EXPENSES":
  - "I. PERSONNEL": The total of this item must correspond with the total column (total year cost) of SECTION I - PERSONNEL (DMH 100-2), with corresponding totals per fund source.

- "II. TRAVEL": The total of this item must correspond with the total column, SECTION II - TRAVEL (DMH-100-3), with corresponding totals per fund source.

- "III. CONTRACTUAL SERVICES": The total of this item must correspond with the total column, SECTION III - CONTRACTUAL SERVICES (DMH-100-3), with corresponding totals per fund source.

- "IV. COMMODITES": The total of this item must correspond with the total column of SECTION IV - COMMODITIES (DMH-100-3), with corresponding totals per fund source.

- "V. EQUIPMENT": The total of this item must correspond with the total column of SECTION V - EQUIPMENT (DMH-100-3), with corresponding totals per fund source.

- "VI. INDIRECT COST": Indirect cost is limited to 8% of the direct program cost. Indicate any amount approved by DMH for indirect cost.

o "Submitted by": Indicate the person responsible for the program.

o "Title": Enter the name of the grant program.

o "Date": Enter the date this form is submitted to the DMH.

o "Telephone": Enter the telephone number of the person who completed the form.

DEPARTMENT OF MENTAL HEALTH

PROPOSED BUDGET

SERVICE PROVIDER NUMBER: _____

SERVICE PERIOD: _____

SERVICE PROVIDER NAME: _____

ADDRESS: _____

_____

PROPOSED BUDGET FOR FISCAL YEAR BEGINNING _____ AND ENDING _____

CATEGORY OF EXPENSE	TOTAL	FUND SOURCE		
		FEDERAL	STATE	LOCAL
I. PERSONNEL				
II. TRAVEL				
III. CONTRACTUAL SERVICES				
IV. COMMODITIES				
V. EQUIPMENT				
SUBTOTAL I - V				
VI. INDIRECT COST (limited to 8% of direct cost)				
TOTAL I - VI				

SUBMITTED BY: _____

TITLE: _____

DATE: _____

TELEPHONE: _____

PAGE _____ OF _____

DMH-100-1

B. Proposed Budget Personnel - Form DMH-100-2

- "SERVICE PROVIDER #": This item will be completed by the Department of Mental Health.

- "SERVICE PROVIDER": Indicate the name of the agency that is responsible for the program.

- "SECTION I – PERSONNEL":

  - "POS. #": Enter the identification numbers assigned by the service provider of each position.

  - "POSITION": Enter the position titles and the name of the individuals occupying the position in the program for which funds are being requested.

  - "% OF TIME": Enter the percentage of time that will be spent by each position on the program for which funds are being requested.

  - "MONTHLY SALARY": Enter the **gross** salary amounts requested for each position.

  - "SOC. SEC.", "RET.", "LIFE INS." "HEALTH INS." "UNEMP. INC." AND "WC": Enter either:

    - The fringe benefit percentage calculated using the instructions included on pages 18-20, "DMH Fringe Benefits Calculation Information/Instructions Sheet."

      OR:

    - Actual amounts of each fringe benefit that will be paid by the employer for each position not to exceed 28% of salaries requested as described on pages 18-30, "DMH Fringe Benefits Calculation Information/Instructions Sheet".

  - "TOTAL": Indicate the total amount of reimbursement requested for each position, with corresponding totals for each fund source.

- "SUBTOTAL MONTHLY COST": Indicate the total monthly cost of each column (if applicable).

- "TOTAL YEARLY COST": Indicate the total annual cost (12 months) of each column (if applicable).

DEPARTMENT OF MENTAL HEALTH -- PROPOSED BUDGET

SERVICE PROVIDER #: _____ SERVICE PROVIDER: _____

SECTION 1 - PERSONNEL

POS. #	POSITION	% OF TIME	MONTHLY SALARY	SOC. SEC.	RET.	LIFE INS.	HEALTH INS.	UNEMP. INS.	W/C	TOTAL	FUND SOURCE		
											FEDERAL	STATE	LOCAL
SUBTOTAL MONTHLY COST													
TOTAL YEAR COST													

C: Proposed Budget Line Item – Form DMH-100-3

- "SERVICE PROVIDER NO.": This item will be completed by the Department of Mental Health.

- "SERVICE PROVIDER": Indicate the name of the agency responsible for the program.

- "SECTION II –TRAVEL": Enter the total amount of funds requested for travel including in-state and out of state mileage, lodging, public carrier, meals, fees, etc.

- SECTION III – CONTRACTUAL SERVICES":

  - "Telephone": Enter proposed cost of telephone including services charge, long-distance, etc.

  - "Utilities": Enter proposed cost of electricity, water, gas, sewages, as applicable

  - "Postage": Enter proposed cost of postage, box rent, etc.

  - "Building Rent": Enter actual amount of rent to be paid during service period.

  - "Equipment Rent": Enter proposed amount to be expended including typewriter rentals, copy machine rentals, postage machine rentals, automobile rentals, etc.

  - "Repair and Maintenance": Enter proposed amount for repair maintenance or upkeep of property which neither adds to the permanent value of the property nor prolongs its intended life but keeps it in efficient operating condition. No renovation cost will be allowed.

  - "Insurance": Enter the proposed amount to be expended for bonding insurance, insurance on buildings and contents, vehicles, etc.

  - "Dues and Subscriptions": Enter the amount of funds to be expended for membership in professional organizations, publications, etc., necessary for the enhancement of the program.

  - "Professional Fees": Enter the total amount of funds proposed to be expended for any program/person providing medical services such as medical evaluations, psychological testing, etc.

- "Professional Fees Other": Enter the total amount of funds proposed to be expended for professional consultation, other than medical, such as contracts for food, pest control and transportation.

- "Medical Fees": Enter the proposed amount of funds to be expended for physical examinations, medical services, etc., both direct and consultative.

- "TOTAL": Enter total amount proposed to be expended for contractual services (Section III).

- "SECTION IV – COMMODITIES":

  - "Food": Enter proposed amount to be expended on food prepared for and consumed by clients.

  - "Office Supplies": Enter the proposed amount to be expended for office supplies. Equipment is not to be included in this line item.

  - "Program Supplies": Enter the proposed amount to be expended for materials to enhance client programs such as recreation, vehicle operating costs, etc.

  - "Janitorial Supplies": Enter the proposed amount to be expended for janitorial supplies.

  - "Household Supplies": Enter the proposed amount to be expended for household supplies.

  - "TOTAL": Enter total amount proposed to be expended for commodities (Section IV).

- "SECTION V – EQUIPMENT":

  - "Office Equipment": Enter the proposed amount to be expended for the purchase of equipment which may include computers, printers, copiers, etc.

  - "Program Equipment": Enter the proposed amount of funds to be expended for the purchase of equipment necessary to operate the programmatic segment of the program.

  - "Furniture": Enter the proposed amount of funds to be expended for furniture of group home, transition home, etc.

- "TOTAL": Enter total amount proposed to be expended for equipment (Section V).

- "TOTAL SECTIONS I THROUGH V": Enter total of line items I – V.

DEPARTMENT OF MENTAL HEALTH -- PROPOSED BUDGET

SERVICE PROVIDER NO. _____ SERVICE PROVIDER: _____

		FUNDING SOURCE		
		FEDERAL	STATE	LOCAL
	TOTAL			
SECTION II - TRAVEL				
SECTION III - CONTRACTUAL SERVICES				
Telephone				
Utilities				
Postage				
Building Rent				
Equipment Rent				
Repair & Maintenance				
Insurance				
Dues & Subsriptions				
Professional Fees				
Professional Fees, Other				
Medical Fees				
TOTAL				
SECTION IV - COMMODITIES				
Food				
Office Supplies				
Program Supplies				
Janitorial Supplies				
Household Supplies				
TOTAL				
SECTION V - EQUIPMENT				
Office Equipment				
Program Equipment				
Furniture				
TOTAL				
TOTAL SECTIONS I THRU V				

DMH-100-3 PAGE _____ OF _____

D. Notice of Proposed Budget – Form DMH-100-4

Form DMH-100-4 is provided for informational purposes only. **This form will be completed by the appropriate Bureau or Division within the Department.**

When the appropriate Bureau or Division of the DMH has received an application for a service program, a review will be made. As a result of this review there may be need for clarification, revisions, etc. to be made between the DMH and the Service provider. When the application has been approved by the DMH, a "Notice of Proposed Budget", Form DMH-100-4, will be forwarded to the service provider with any changes made by the DMH.

Please note that all budgets are subject to the availability of funds and on the optimal utilization of such funds. Budget awards are not guarantees for continued funding.

PROPOSED BUDGET
DEPARTMENT OF MENTAL HEALTH

PROGRAM	SERVICE PROVIDER NUMBER

SERVICE PERIOD: _____ THRU _____

SERVICE PROVIDER: NAME AND ADDRESS	PROGRAM ADMINISTRATOR: TELEPHONE:

PROPOSED BUDGET

CATEGORY OF EXPENSE	TOTAL	FUNDING SOURCE		
I. PERSONNEL				
II. TRAVEL				
III. CONTRACTUAL SERVICES				
IV. COMMODITIES				
V. EQUIPMENT				
SUBTOTAL I - V				
VI. INDIRECT COST (limited to 8%)				
TOTAL I - VI				
% OF TOTAL	100%			

REMARKS:

SIGNATURE, DIRECTOR, DIVISION OF	SIGNATURE, EXECUTIVE DIRECTOR,

E. DMH Budget Revision -Form DMH-100-5

Form DMH-100-5 is provided for informational purposes only. This form will be completed by DMH staff upon receipt and approval of a request for changes to be made to the original budget. Please note that most changes transferring money between line-items or transfers between categories **other than personnel** do not require formal budget revisions. Please check with the appropriate Bureau program staff prior to submission of this form.

SERVICE PROVIDER#:

PROGRAM:

REVISION#:

SERVICE PROVIDER:

DATE:

APPROVAL:

TITLE:

DIRECTOR:

BUDGET CATEGORY	PREVIOUS AUTHORIZATION			APPROVED CHANGE			REVISED BUDGET		
I. PERSONNEL									
II. TRAVEL									
III. CONTRACTUAL SERVICES									
IV. COMMODITIES									
V. EQUIPMENT									
SUBTOTAL									
VI. INDIRECT COST									
TOTAL									

DMH-100-5

F. Cash Request – Form DMH-100-6

NOTE: Cash Requests are due to the DMH on or before the 15th of each month following the month of expenditures. Final cash requests are due within 30 days following the end of the grant period.

- "SECTION I":
  - "Service Provider #": Enter the identification number assigned to the program.
  - "Program": Enter the particular work function or area for which funds are being requested.
  - "Service Provider": Enter the name of the funds recipient.
  - "Service Period": Enter the beginning and ending dates of the program.
- "SECTION II":
  - Month: Include the month for which funds are being requested and a categorical breakdown of the monthly expenditures. The category total must agree with the individual monthly expense reports (forms DMD-100-7-I-VI…personnel, contractual, commodities, etc.). These totals must be broken down by fund source (i.e. SAPT, State, Local) with fund source and year listed above the amounts requested (i.e. SA10, GF11, CM10, etc.) See approved budget for fund source.
  - YTD: The year-to-date (YTD) amounts should reflect the cumulative expenditures by category.
- "SECTION III":
  - Budget by Fund Source: Enter the approved budget by category and funding. This should remain the same for the grant period unless the Service Provider has received an approved budget revision.
- "SECTION IV":
  - Date: Enter the date of request
  - Funds Requested: Enter the amount of funds requested
  - Signature: Enter an approved signature, in ink.
- "SECTION V":
  - For DMH Use Only

DMH-100-6 (Revision 1)

DEPARTMENT OF MENTAL HEALTH
CASH REQUEST

SECTION I

SERVICE PROVIDER # _____ PROGRAM _____

SERVICE PROVIDER _____ SERVICE PERIOD _____

SECTION II — EXPENSE BY FUND SOURCE -- MONTH OF 20

CATEGORY:	TOTAL							
	MONTH	YTD	MONTH	YTD	MONTH	YTD	MONTH	YTD
PERSONNEL								
TRAVEL								
CONTRACTUAL SERVICES								
COMMODITIES								
EQUIPMENT								
INDIRECT COST								
TOTAL								

SECTION III — BUDGET BY FUND SOURCE

CATEGORY:	TOTAL			
PERSONNEL				
TRAVEL				
CONTRACTUAL SERVICES				
COMMODITIES				
EQUIPMENT				
INDIRECT COST				
TOTAL				

SECTION IV — DATE

FUNDS REQUESTED _____

SIGNATURE _____

SECTION V — DMH USE ONLY

AMOUNT APPROVED _____

PROGRAM APPROVAL _____

DIVISION APPROVAL _____

FISCAL APPROVAL _____

Monthly Expense Report (Forms DMH-100-7-I through DMH-100-7-VI) General Information:

These forms identify the actual expenditures, by expenditure categories, which constitute the totals requested for reimbursement. Expenditures should be properly coded categorically as well as being mathematically correct. Each applicable page should be subtotaled at the bottom for reference purposes. The last page should be the sum of the incremental categorical pages by the use of the individual subtotal lines.

The information entered on forms DMH-100-7-I-VI should be recalculated for accuracy prior to submitting to DMH. The amounts reimbursed should also be compared to the amounts requested to ensure that reimbursement does not cause an overpayment of funds in the category. Any over payment of funds will result in repayment at year end.

G. Personnel – Form DMH-100-7- I

- Enter all identification data.
- Number all pages.
- Enter the month and year of the expenditures that you are requesting to be reimbursed.
- "Check #": Enter the check numbers for all payments requested for reimbursement. If payroll checks are deposited directly into employee checking accounts, enter "DD" in check # column.
- "Paid to": Enter the name of the payee'.
- "Position #": Enter the employee position number.
- "Description": Enter the type of expenditure, such as payroll, fringes, etc., from form DMH-100-2 of the approved budget.
- "Total Amount of Check": Enter the total amount requested.
- "Fund Source": Enter Federal, State, and Local amounts by line item. The sum of these amounts should equal the "Total Amount of Check" column.

Note:

1) See pages 18-20 for instructions and worksheets for calculating fringe benefits.

SERVICE PROVIDER: _____

SERVICE PROVIDER #: _____

SIGNATURE: _____

DEPARTMENT OF MENTAL HEALTH

MONTHLY EXPENSE REPORT

MONTH OF _____ 20 _____

PAGE _____ OF _____

FUND SOURCE

CATEGORY	CHECK #	PAID TO	POS. #	DESCRIPTION	TOTAL AMOUNT OF CHECK			
I. PERSONNEL								

H. Fringe - Form DMH-Fringe:

Form DMH-Fringe is included for example purposes only. This form contains the necessary elements in estimating a percentage of fringe benefits based on total salaries. This information (whether using this form or a form of your own) should be kept on site for DMH review.

- Enter Service Provider identification information.

- Enter total salaries and wages for the last completed fiscal year, current fiscal year to date, projected current year to date, and proposed fiscal year.

  - The last completed fiscal year.
    Assuming a date of August 18, 2010, the last completed fiscal year would be the year ended September 30, 2009.

  - Current fiscal year to date.
    Assuming a date of August 18, 2010, this period would be from October 1, 2009 thru the current date August 18, 2010.

  - Projected Current year to date.
    Assuming a date of August 18, 2010, this period will be for the remainder of the fiscal year. This will be the current fiscal year cost up through August 18, 2010 plus the remaining 6 weeks up to September 30, 2010.

  - Proposed Fiscal Year.
    Assuming a date of August 18, 2010, this would be from October 1, 2010 through September 30, 2011 or whatever inclusive dates the next grant fiscal year would be.

- Enter employer fringe benefits including social security, retirement, health insurance, etc. for the last completed fiscal year, current fiscal year to date, projected current year to date, and proposed fiscal year.

- Enter the total fringe benefits

- Enter the percentage of fringe benefits to be used in requesting reimbursement. This amount is calculated by dividing the total fringe benefit amount by the total salaries and wages.

Notes:

1) Allowable fringe benefits will be those which meet the standard of being usual, customary, and reasonable, and which are allowed by the Internal Revenue Service. Some benefits which are **NOT** considered to be fringes are any cafeteria plan

deductions, vacation time, sick leave, administrative leave, or any other items that may be correctly considered as salary cost.

2) The fringe benefit rate will be applicable for the twelve (12) months of the grant year. As an example, should the rate be 27.88%, it will be used to calculate fringe benefits on all cash requests for that year. No mid year adjustments will be made. The rate will be used for all grants that the entity has in that fiscal year.

3) The fringe benefit percentage for employees earning a salary in excess of $40,000 is limited to 28%. If you are submitting a cash request for a grant that has no employees earning salaries in excess of these amounts, then you may use your actual fringe benefit rate for reimbursement under the grant. If any employees earn a salary that exceeds these amounts, then you are limited to 28% on those employees. It is the employee's total salary, not just the portion charged to the grant that applies. For example, if an employee with an annual salary of $45,000 is charged 50% on a grant, the salary charged to that grant is $22,500, but the 28% cap still applies because the employee's salary is more than $40,000. This does not apply if your actual fringe benefits percentage is 28% or less.

4) Fringe benefits cost should be claimed as a single line item in addition to the salary costs except in cases where an employee on the grant has an annual salary that exceeds $40,000 **AND** the claimed rate exceeds 28%. In these cases the fringe benefit for those employees is limited to 28%. Two fringe benefit line items will be required: one for all employees whose annualized salaries are $40,000 or less and another for those employees whose annualized salaries are more than $40,000.

5) An error rate of 5% may be allowed upon audit. For example, if the sub-grantee claims a fringe benefit rate of 29% and, upon audit, the actual rate is found to be no less than 27.55% (which is 5% below the claimed rate of 29%), an audit adjustment might not be proposed. If the actual rate in this example turns out to be 27%, then an adjustment down to the actual rate of 27% will be made.

DMH-FRINGE

Department of Mental Health
Fringe Benefit Rate Calculation

Service Provider:_____

Line No.	Category	Last Completed Fiscal Year (Actual) Yr. Ended_____	Current Fiscal Yr. To Date (Actual) Yr. Ending_____	Projected Current Fiscal Yr. (Actual + Estimated) Yr. Ending_____	Proposed Fiscal Year (Estimated) Yr. Ending_____
1	Total salaries and wages				
2	Employer Fringe benefits:				
3	Social Security (incl. Medicare)				
4	Retirement				
5	Health insurance				
6	Group term life insurance				
7	Unemployment tax				
8	Workers compensation				
9	Other: (list)				
10					
11					
12					
13					
14					
15	Total fringe benefits				
16	% fringes (line 15 divided by line 1)				

I. Travel-Form DMH-100-7-II

- Enter all identification data.
- Number all applicable pages.
- "Check #": Enter the check number of the expenses requested for reimbursement.
- "Paid To": Enter the payee to which funds were paid.
- "Description": Enter the explanation for disbursement of funds such as, local travel, conference fees, etc.
- "Total Amount of Check": Enter the full amount paid on that particular expense.
- "Fund Source": Enter Federal, State, and Local amounts by line item. The sum of these amounts should equal the "Total Amount of Check" column.

SERVICE PROVIDER #: _____ Page _____ of _____

FUND SOURCE

CATEGORY	CHECK #	PAID TO	DESCRIPTION	TOTAL AMOUNT OF CHECK			
II. TRAVEL							
SUBTOTAL -- TRAVEL							

DMH-100-7-II

J. Contractual-Form DMH-100-7-III

- Enter all identification data.
- Number all applicable pages.
- "Check #": Enter the check for which reimbursement is being requested.
- "Paid To": Enter payee to which funds were paid.
- "Description": Enter explanation for disbursement of funds. (I.e. utilities, rent, repair and maintenance, etc.)
- "Total Amount of Check": Enter full amount paid on that particular expense.
- "Fund Source": Enter Federal, State, and Local amounts by line item. The sum of these amounts should equal the "Total Amount of Check" column.

SERVICE PROVIDER #: _____ Page _____ of _____ **FUND SOURCE**

CATEGORY	CHECK #	PAID TO	DESCRIPTION	TOTAL AMOUNT OF CHECK			
II. CONTRACTUAL SERVICES							
SUBTOTAL -- CONTRACTUAL SERVICES							

DMH-100-7-III

K. Commodities-Form DMH-100-7-IV

- Enter all identification data.
- Number all applicable pages.
- "Check Number": Enter all check numbers for which reimbursement is being requested.
- "Paid To": Enter the name of the payee.
- "Description": Enter the explanation for disbursement of funds (i.e. office supplies, program supplies, food, etc.)
- "Total Amount of Check": Enter the full amount paid on that particular expense.
- "Fund Source" - Enter Federal, State, and Local amounts by line item. The sum of these amounts should equal the "Total Amount of Check" column.

SERVICE PROVIDER #: _____ Page _____ of _____

FUND SOURCE

CATEGORY	CHECK #	PAID TO	DESCRIPTION	TOTAL AMOUNT OF CHECK			
IV. COMMODITIES							
SUBTOTAL -- COMMODITIES							

DMH-100-7-IV

L. Equipment-Form DMH-100-7-V

- Enter all identification data.
- Number all applicable pages.
- "Check Number": Enter the check numbers for which funds are being requested.
- "Paid To": Enter the name of the payee.
- "Description": Enter a brief description of the equipment item purchased (i.e. refrigerator, computer, printer, etc.).
- "Total Amount of Check": Enter the full amount paid on that particular expense.
- "Fund Source": Enter Federal, State, and Local amounts by line item. The sum of these amounts should equal the "Total Amount of Check" column.

Notes:

1) The Equipment Data Report Form (DMH-101-01) on page 32 of this manual must also be completed and submitted to DMH for all equipment items purchased with grant funds.

2) Written approval from DMH and/or the county board of supervisors, depending on the original source of funding, must be obtained before disposing of all real and personal property purchased with state and/or county appropriated funds.

3) PROPERTY is defined as all furniture, vehicles, equipment and other state property having a useful life expectancy of at least one year and the cost of which is $1000 or more. It does not include carpeting (excluding area rugs), draperies, plants, installed floor-to-ceiling partitions, window shades or blinds, mattress/box springs, water heaters, installed drinking fountains, museum acquisitions, library books, films or archival collections. All items under $1000 in value are not required to be placed on inventory excluding specialty items. However, they are required to have an agency sticker applied.

4) The following property items shall be included on inventory regardless of the price paid to acquire the item or the fair market value of the item: **Weapons, camera and camera equipment (greater than $250), two-way radio equipment, televisions (greater than $250), lawn maintenance equipment,**

cellular telephones, computers and computer equipment (greater than $250), chain saws, air compressors, welding machines, generators, motorized vehicles.

SERVICE PROVIDER #: _____ Page _____ of _____ **FUND SOURCE**

CATEGORY	CHECK #	PAID TO	DESCRIPTION	TOTAL AMOUNT OF CHECK			
V. EQUIPMENT							
SUBTOTAL -- EQUIPMENT							

DMH-100-7-V

M. Equipment Data - Form DMH-101-01

When equipment is purchased with funds from the DMH, form DMH-101-01 is to be submitted to the DMH Audit Division to the attention of the Audit Director. Additionally, if equipment items purchased with grant funds from the DMH are broken or stolen, DMH 101-01 forms are required to be submitted to the DMH before these items can be removed from inventory. These property records are used to conduct annual audits of all equipment items of DMH service providers. Equipment items that were reimbursed with grant funds without submitting this form could result in a repayment of funds. Additionally, equipment items purchased with grant funds that are disposed of without submission of this form and approval by the audit division could also result in repayment of funds.

It is mandatory that the service provider keep detailed records of equipment including a master listing of fixed assets with corresponding inventory numbers assigned by the service provider, specific location of the property items, date the items were purchased, and any transfer information applicable (when equipment items are transferred to a different location within the facility or to a different DMH funded facility. Information submitted to the DMH must be accurate (i.e. serial numbers, locations, and inventory numbers) to prevent unnecessary payback of funds.

- Enter all identification data.
- Division and Grant Number: Enter the DMH division that funds the grant and the applicable grant number.
- Inv. #: Enter the inventory number of the equipment. This will be an inventory number that the funded program assigns.
- Description of item: Enter a description of the equipment item (i.e. Washer, computer, printer).
- Manufacturer: Enter the name of the manufacturer (i.e. Maytag, Dell, Hewlett Packard).
- Serial No.: Enter manufacturer's serial number, federal stock number, national stock number, or other identification number.
- Equipment Location: Enter the location and/or use of the equipment (i.e. Jackson St. Clubhouse).

- Total Cost: Enter the total cost charged to the grant and/or used to meet matching requirements.

- % FF – Enter the percentage of Federal participation in the cost of the project or program for which the property was acquired.

- Date Rec'd: Enter the date the equipment was received and put into inventory.

TO BE COMPLETED WHEN EQUIPMENT ITEMS NEED TO BE REMOVED FROM INVENTORY:

- Disposition Date: Enter the date that the inventory item was stolen or became unusable.

- Condition of Property: Enter the reason why the equipment item needs to be removed from inventory (i.e. broken, stolen, un-repairable).

Mississippi Department of Mental Health

Report of Non-Expendable Government Property Acquired by Grantee			Grantee Name, Address, and Authorized Representative Name: _____ Address: _____ Auth. Rep: _____
Date of Report	Division and Grant Number		

Inv.#	Description of Item	Manufactuerer	Serial No.	Equipment Location	Total Cost	%FF	Date Rec'd	Disposition Date	Condition of Property

DMH 101-01 (1/95)

N. Report Summary-Form DMH-100-7-VI

- Enter all identification data.

- "Subtotal I-V": Enter the combined totals of Forms DMH-100-7-1-V by Fund Source.

- "VI. Indirect Costs": Enter the amount by fund source allowed in the approved DMH budget (Form DMH-100-1, page 3 of this manual). Note that this amount is limited to 8% of direct costs.

- "Total 1-VI": Enter by fund source the total amounts requested for reimbursement. These amounts must agree with the amounts listed on the cash request (Form-DMH-100-6, page 15 of this manual).

SERVICE PROVIDER #: _____ Page _____ of _____

	FUND SOURCE		
SUBTOTAL I. - V.			
VI. INDIRECT COSTS			
TOTAL I. - VI.			

SERVICE PROVIDER: _____ SUBMITTED BY: _____

ADDRESS: _____ TITLE: _____

_____ DATE: _____

DMH 100-7-VI

O. CMHS – Form DMH-POS-1

DMH Form DMH-POS-1 is to be used to request funds during the application process and as part of the monthly reimbursement request to indicate units of services provided.

- Enter identification data.

- "Application": If this form is being used as part of the application process, enter the beginning and ending month, day, and year of the grant period for which funds are being requested.

- "Monthly Summary": If this form is being used as part of the monthly reimbursement request, enter the month and year for which the funds are being requested. The total is then transferred to DMH 100-6 as contractual funds requested.

- Service Categories 1-13: For the application process, the program should indicate the amount of funds that is being allocated to each service category. For the monthly reimbursement summary, the program should indicate by category the number of units provided and amount being requested.

- "Total": Enter the total amount of funds requested. The number of units does not have to be totaled.

- "Signature": Enter the signature of the individual completing this form.

- "Date": Enter the date submitted to the DMH.

CMHS PURCHASE OF MENTAL HEALTH SERVICES

Name of Provider_____

Contract Number_____ Application_____to_____

Month/Year_____ Monthly Summary_____

Service Categories		Unit Cost	Mental Health	
			Units	$$$
1	Intake/Bio-Psycho-social Assessment (1 hour)	$93.00		
2	Medication Evaluation & Monitoring (per service)	$46.88		
3	Individual Therapy (30 minutes)	$57.49		
4	Individual Therapy (50 minutes)	$81.09		
5	Individual Therapy (80 minutes)	$119.45		
6	Family Therapy (50 minutes)	$75.70		
7	Group Therapy (50 minutes)	$26.62		
8	Psychosocial Rehabilitation (Per 15 minute Unit)	$3.87		
9	Nursing Service (per 15 minute unit)	$18.45		
10	Injection of Psychotropic Meds (per injection)	$4.76		
11	Case Management (per 15 minute unit)	$14.88		
12	Family Education/Support	$16.00		
13	Consumer Education/Support	$16.00		
14	Emergency	$865.00		
		Total $		$
		Total Combined Reimbursement Request		$

Signature _____ Date _____

P. SAPT Dual Diagnosis– Form CMHS/SAPT-POS-1

CMHS/SAPT-POS-1 is completed in the budget request both as an initial request application for the expected number of units of services to be provided as well as a backup form to be included with the request for reimbursement for the actual number of units provided. The total is transferred to DMH 100-6 when requesting reimbursement.

- Enter identification data.
- "Application": Mark (X) this line if the form is being used as an initial request application for units of services to be provided.
- "Monthly Report": Mark (X) this line if the form is being used to request reimbursement.
- "SMI Adult Units/Total Cost": Enter the units of service and the corresponding dollar amounts for each service category for which funds are being requested. The dollar amount calculation should be equal to the number of units multiplied by the amounts listed in the unit cost column.
- "Total": Enter the total amount of funds requested, as well as the total number of units.
- "Signature": Enter the signature of the individual completing this form.
- "Date": Enter the date submitted to the DMH.

DIVISION OF COMMUNITY SERVICES

SAPT DUAL DIAGNOSIS PURCHASE OF MENTAL HEALTH SERVICES

Provider Name: _____

Contract: _____ **Application** _____

Month: _____ **Monthly Report** _____

SERVICE CATEGORIES	UNIT COST	SMI ADULT UNITS	TOTAL COST
1. Day Treatment	$8.00		
2. Engagement/Outreach Activities	Negotiable		
3. Intensive/Case Management	$14.88		
4. Nursing Care	$18.45		
5. Psychiatric Care	$46.88		
6. Specialized Group Therapy	$7.47		
7. Training/Educational Activities	Negotiable		
8. Transportation	Negotiable		
9. Aftercare	Negotiable		
10. Continuous Treatment Team Activities	Negotiable		
11. Family Education	$16.00		
12. Housing (temporary)	Negotiable		
13. Injections	$4.76		
14. Urine Drug Screens	Negotiable		
TOTAL			

*Negotiable - Data for these services must be established with the Department of Mental Health based on cost.

Signature: _____

Date: _____

CMHS/SAPT-POS-1
(Revised 7/10)

Q. SAPT Block Grant Funds - DMH Form DADA-POS-1

DADA-POS-1 is to be used to request funds during the application process and as part of the monthly reimbursement request to indicate units of services provided.

- Enter identification data.
- "Application": If this form is being used as part of the application process, enter the beginning and ending month, day, and year of the grant period for which funds are being requested.
- "Monthly Summary": If this form is being used as part of the monthly reimbursement request, enter the month and year for which the funds are being requested. The total is then transferred to DMH 100-6 as contractual funds requested.
- Service Categories 1-12: For the application process, the program should indicate the amount of funds that is being allocated to each service category. For the monthly reimbursement summary, the program should indicate by category the number of units provided and amount being requested.
- "Total": Enter the total amount of funds requested. The number of units does not have to be totaled.
- "Signature": Enter the signature of the individual completing this form.
- "Date": Enter the date submitted to the DMH.