

Behavioral Health System Baltimore

**SUBSTANCE USE DISORDERS (SUD)
BUDGET APPLICATION PACKET**

I N S T R U C T I O N M A N U A L

FY 2019

(Do not proceed before reading all instructions)

**SUBSTANCE USE TREATMENT, PREVENTION, RECOVERY SUPPORT SERVICES / GRANTS
FY 2019 INSTRUCTIONS FOR BUDGET APPLICATION PACKET**

You have received a Letter of Award requesting a budget application for funding of a Cost Reimbursement and/or Fee-For-Service Contract from Behavioral Health System Baltimore.

Providers must e-mail the budget forms in a PDF format to their Senior Contract Administrator by the specified date in your letter.

Providers can obtain electronic copies of budget forms at <http://www.bhsbaltimore.org/providers/forms-for-providers/budget-forms>.

The correct fiscal year budget forms located on the Behavioral Health System Baltimore website must be used in preparing the budget application. Budget applications submitted on incorrect forms will be returned.

I. SPECIFIC BUDGET PREPARATION INSTRUCTIONS

Buprenorphine Initiative Programs

Budget instructions specific to this program will be forthcoming.

Temporary Cash Assistance (TCA) (Addictions Program Specialists in local DSS Offices)

DHR/FIA will only reimburse BHA/BHSB up to the amount stated in the initial allocation letter. If the cost to support the position(s) exceeds the budget request ceiling amount, include only the percentage of the position(s) that can be provided for within the TCA grant. The remaining percentage of the position(s) to be funded should be included in another BHA/BHSB funded grant and clearly identified as the TCA assessor position

The only line items permitted for funding and reimbursement by DHR/FIA are Salary, Fringe, Urinalysis and Indirect Costs.

Any expenditure in line items other than those listed will not be permitted and will be the responsibility of the grantee.

Senate Bill 512 – Children In Need of Assistance (Assessor positions in Prince George’s, Washington, and Worcester Counties and Baltimore City Only)

The only allowable budget line items are: Salary, Fringe, Communications/ Telephones, Office Supplies, Staff Travel, Client Travel, Staff Training and Indirect Costs.

House Bill 7 – Integration of Child Welfare and Substance Abuse Treatment Service (Assessor Positions) (Baltimore City and Prince George’s County Only)

The only allowable budget line items are: Salary, Fringe, Training, Travel, Telephone, Office Supplies and Indirect Costs.

Recovery Support Service Expansion

Funds may only provide recovery support services and may not be used to provide treatment services.

Funds that were granted for special initiatives may not be reduced without prior approval from BHA/BHSB.

Drug Court Support Services

Funding may no longer provide for treatment services. Funds may only be used to provide “non-reimbursable” services delivered in ambulatory treatment settings to individuals actively being served in drug treatment court. Please contact your Program Lead for more information.

Prevention and Treatment Financial Reporting and Allocation Network (P.R.A.N. and T.F.R.A.N.) Forms

BHSB requires submission of these forms with the budget submission. See Addendum II for instructions and budget packet for forms.

In-Kind Contribution Forms

This form which is part of the budget packet should be completed to detail local in-kind contributions that provide support to prevention services.

II. **PROGRAM BUDGET INFORMATION – COST REIMBURSEMENT**

Cover Page – FORM (BHSB 432)

1. Program Title – Specific title indicating program.
2. Name of Organization – Enter formal, corporate or agency name
3. Name of Grant (Cost Center Name) – this is Funding Source on your Letter of Award
4. Period For Which Support Is Being Requested – Enter Fiscal Period or indicate if the request is for less than a 12-month period. This line must be in the format 7/1/18 – 6/30/19.
5. Grant Number – Leave blank
6. Fiscal Year – State Fiscal Year for which funds are requested – e.g., 2019
7. Submission Date – Enter date you are submitting grant application to BHSB

Vendor Information Page (BHSB 432A)

Complete entire form. Do not leave any items blank.

Note:

BHSB formulas will automatically enter most vendor information from the COVER PAGE; however Providers must review and complete any remaining sections.

1. Organization Address
2. Executive Director’s Name, telephone number and e-mail address
3. Finance Contact Name, telephone number and e-mail address
4. Mailing Address (if other than shown above)
5. Federal Employer Identification – This number is required. Payments will not be made to vendors without this number.
6. Minority Enterprise - If your organization meets the definition per the Annotated Code of Maryland mark “Yes”. If not, mark “No”.
7. National Provider Identifier – Please provide us with your NPI.
8. Agency Number – Please provide us with your Agency Number *(formerly the Substance Abuse Management Information Systems number – SAMIS)* as listed on your current DHMH certification for Levels of Care for which your program is certified.
9. Period for which funds are requested – *(Automatically entered from Cover Page)*
10. Area/Jurisdiction to be served – List local jurisdiction where services will be rendered, e.g. Baltimore City.
11. Does the Organization do Fundraising? – Enter Yes or No
12. Are any of the State supported costs being used to generate fundraising dollars? – Enter Yes or No

13. **Type of Proposal** – See below
 - a) NEW – First time application under this funding
 - b) ONE-TIME-ONLY – One time only application for funding applicable to one fiscal year only
 - c) Renewal – Initial application for continuing funding for new fiscal year
 - d) Supplement/(Reduction)– Grant application for additional funding or for the reduction of funding

Vendor Information Page (BHSB 432B)

Complete entire form. Do not leave any items blank.

1. I-SAT Identification Number – Please provide assigned Federal Inventory of Substance Abuse Treatment Services (I-SATS) ID unique to each physical location where services are being provided. *A separate Treatment F.R.A.N. form must be completed for each location.*
2. Facility Name/Address – Please provide the Facility Name and Address for each physical location where services are being provided.
3. Level(s) of Care to be funded – Use American Society of Addiction Medicine (ASAM) Levels of Care.
4. Number of Treatment Slots – Enter number of treatment slots/beds if applicable for each location and Level of Care for this grant. Do not assign treatment slots to Methadone, Buprenorphine and Detox categories.
5. Number of Clients to be Served (Treatment Episodes) – Enter the number of Clients to be served annually by location and Level of Care for this grant.

Program Budget Summary Sheet (BHSB 432C)

Expenditures for the program should include costs supported by fee collections such as client fees. Third party income, Medicare and Medicaid collections are no longer required to be included in the budget. Do not include "Other" funding such as other state or federal awards etc.

Section I

1. Only Complete Vendor Information that was not copied from COVER PAGE and VENDOR INFORMATION PAGE.
2. Chargeable Services – Indicate "Yes" or "No" as to whether your program charges patients all or a co-pay portion for services.
3. BHSB provides 50% or more of funding – Indicate Yes or No

Section II

Complete with information regarding the level of care, number of slots/beds, and number of estimated clients.

Section III

Grant Name will automatically transfer from the Cover Page.

Section IV

Enter all costs associated with program services to be delivered under this application (Column B).

Note:

DO NOT CHANGE LINE ITEM TITLES. Additional line items must be totaled under "Other". Include a detailed breakdown of "Other" in the Line Item Budget Narrative section.

1. **INDIRECT COSTS.** Indirect costs are limited to an amount not to exceed 10% of salary and fringe. A description of the expenditure items included under indirect costs must be in Section AB of the line item budget narrative. Indirect costs are costs which have been incurred for multiple or common objectives; shared costs or those costs associated with more than one cost within that part of the provider's operation which is both funded by BHSB and which are not readily identifiable as direct costs without effort disproportionate to the results achievable. Indirect costs are not administrative or overhead costs per se. Such costs should be identified as direct costs unless they meet the forgoing criteria. All costs must be reasonable and necessary.
2. **UNALLOWABLE COSTS** - (this list is not all inclusive). Refer to DHMH Human Services Agreement Manual, Section 2150.09.
 1. Staff licensure fees
 2. Gifts, contributions, donations
 3. Lobbying or advocacy costs
 4. Malpractice Insurance for consultants
 5. Losses on other grants and contracts
 6. Bad debts
 7. Fines, Claims, Awards, Judgments, or Penalties
 8. Vehicle purchase or leasing costs are allowable if the purchase or lease is approved by BHSB and if the vehicle is for transportation of recipients of grant/contract services to or from service locations or for the transportation of service personnel and/or supplies from one service site to another or to home-bound clients for the purpose of delivering services.

Schedule of Salary Costs (BHSB 432D)

You will need the Attachment A in order to fill in this form. If you don't have one please contact your Program Lead.

1. Merit System - Indicate if salaries are based on the State Merit System. If not based on the State Merit, leave this section blank.
2. Job Identification Number for each position, full-time and/or part time. Each position must have an assigned "job number". This number indicates the position, not the individual hired for that position.
3. Job Title / Position Name – List positions in groups using the following categories:
 - a) Level 0.5 – Early Intervention
 - b) Level 1 a – Outpatient – Adolescent
 - c) Level 1 – Outpatient – Adult
 - d) Level 2.1 – Intensive Outpatient – Adult

- e) Level 2.5 – Partial Hospitalization
- f) Level 3.1 – Halfway House
- g) Level 3.3 – Long Term Residential Care
- h) Level 3.5 – Therapeutic Community
- i) Level 3.7 – Medically Monitored Inpatient (ICF)
- j) Level 3.7.D – Medically Monitored Inpatient (ICF) – Detox
- k) OMT – Opioid Maintenance Therapy
- l) OMT.D – Opioid Maintenance Therapy – Detox
- m) Administrative

Note:

Any position split between levels of care within the same grant should be preceded by a plus sign (+). Show percentage of position under each category.

Any position funded in more than one BHSB grant should be preceded by an asterisk (*).

4. Name of Person Filling Position – Names must match names entered on the Organizational Chart. If a name is not provided for each position i.e. the position is vacant, you must indicate the anticipated date of hire in the "name of person" column.
5. Certification/Licensure – Updated certification/licensure must be entered for each position where certification/licensure is required.
6. Type of Service – Indicate the type of service provided by each clinical position using any of the following categories:
 - a) Adult
 - b) Men Specific Adult
 - c) Women Specific Adult
 - d) Adolescent
 - e) Co-Occurring
 - f) Criminal Justice
 - g) Homeless
 - h) Women and Children
7. Slot Allocation – the number of slots allocated to this position must be entered. The number of slots should be proportionate to the FTE. The total number of slots allocated must equal the total slots funded by the grant.
8. Hours per week – It is required that you list number of total hours worked for BHSB under this grant for each staff member. Part time and temporary positions for replacement of persons on leave should be identified.
9. FTE % - The percentage of Full Time Equivalency devoted to the BHSB funded program is calculated automatically by a formula using 40 hour work week.
10. Annual Salary – You must indicate each employee's annualized salary. This is the salary that your agency would pay annually if this position is/was full time and is a basis for calculation of the total funded salaries under this grant.
11. BHSB Funded Salaries - Amount funded by BHSB is calculated automatically. For positions that are funded partial year, make sure the salary is prorated for the months for which the funding is requested. The total amount for this schedule must equal the salary line item on the Program Budget page in the "Total Program Budget" column, Form BHSB 432C.

Schedule of Consultant Costs (BHSB 432E)

List the individual's name. If payment will be made to a business, list the firm's name also. List only the highest applicable degree held. Total costs must equal the hourly rate times the total number of hours. The total amount of "BHSB Funded" for this schedule must equal the consultant line item in the BHSB Program Budget Summary Sheet.

Note:

The consultant-contractor relationship is defined as individual, personal delivery of service where the format has a high degree of autonomy over use of time, selection of process, and utilization of resources (See Addendum I).

Legal, accounting, or audit services, should not be entered on this schedule but should be identified on the specific line items indicated in the Program Budget Summary page.

Nursing agency costs can be listed under either "Purchase of Services" or "Consultant". The appropriate category used should be based on your consistent treatment of the costs in your accounting records.

Schedule of Equipment Costs (BHSB 432F)

This schedule is to be used to identify each piece of equipment and the sources of funding used to purchase equipment. Indicate if this is an Equipment Replacement or Additional Equipment item by using the appropriate column. List the total cost of equipment and the amount being funded by BHSB. The justification column is to be used to describe the need for the item to be purchased and its proposed usage.

Line Item Budget Narrative pages (BHSB 432G)

Provide a cost breakdown and justification for each BHSB funded line item shown on section 432C Program Budget Summary Page. The justification should reflect the basis for the amount requested to be funded by BHSB.

- a) Client Incentives – must provide a detailed breakdown and justification
- b) Fee Collections – must include a detailed breakdown of the collections and calculation of estimated amount of the fees.

Financial Records Check List (BHSB 432H)

Indicate the financial records your organization maintains. Signature in blue ink of the certifying official is required on this page.

Budget Packet Check List and Signature Page

Place a check mark next to each completed item in Budget Application Packet. The certifying officer (chief executive or director) must sign (in blue ink) this page prior to the submission of this application.

III. PROGRAM BUDGET INFORMATION–FEE FOR SERVICE

Cover Page (BHSB 432 FFS)

Follow Instructions included in completion of BHSB 432 application.

Vendor Pages (BHSB 432A FFS and BHSB 432B FFS)

Follow Instructions included in completion of BHSB 432 application.

Program Budget Summary (BHSB 432C FFS)

List the total cost to provide service on Line 31: **FEE-FOR-SERVICE**

Line item Budget Narrative (BHSB 432D FFS)

Provide level of care, contractual rate, bed days and number of clients to be served.

Financial Records Check List (BHSB 432E FFS)

Indicate the financial records your organization maintains.

Signature of the certifying official is required on this page.

Budget Packet Check List and Signature

Follow Instructions included in completion of BHSB 432 application.

Addendum I

Description of Contractual Employee and Consultant

"Contractual Employee" or "Consultant"

A- **Contractual Employee** is defined in Section 4401 (C-1) of the Federal Employee Tax Regulations to include every individual performing service under the terms of an employee-employer relationship. In general, this relationship exists if the person for whom services are performed has control or direction of the individual performing the services. This applies not only to the result of the service but may extend to the means by which that result is attained.

- Guidelines which may be used to identify a Contractual Employee:
 - 1- If the Provider has a right to control and direct the performance of services not only as to the results, but also as to the details and means.
 - 2- If the Provider has the right to discharge.
 - 3- If the Provider furnished a place for work.
 - 4- If the degree to which the individual has become integrated into the Provider's operation for which services are performed is significant.

Contractual Employees must abide by the Federal Employee Tax Regulations. The Provider shall deduct from the Contractual Employee's wages such withholding and FICA social security taxes and pay the employer contribution as required by applicable Federal and State law.

B- **Consultant** is a person engaged in the presentation of independent work, business or trade in which they offer services to the public.

Addendum II

COMPLETING T.F.R.A.N. / P.F.R.A.N. FORMS

SPECIFIC GUIDELINES:

TREATMENT PROVIDERS:

A separate F.R.A.N form must be completed for each I-SAT ID (i.e. facility location)

Information on the F.R.A.N. form should reflect number slots to be funded, number of patients expected to be served, and amount of funds expected to be used for the services. The "slot" category is to be used only when the purchase agreement is via cost reimbursement. If services are purchased via a fee-for-service payment mechanism leave the "slot" category blank.

F.R.A.N. Form and Performance Measures Page

Slot and client information reported for each facility (I-SAT ID) must match the information contained on your Vendor Information Page – Part II.

PREVENTION PROVIDERS:

NREPP Programs:

List each program from the SAMHSA National Registry of Evidence-based Programs and Practices (NREPP), the number served, the number of cycles and amount of funds for each program for the fiscal year.

Non-NREPP Program:

Enter any non-evidence-based recurring prevention programs under the "Non-NREPP Program" field. Enter the number served, number of cycled and the amount of funds for each.

Single Services

Enter all funded single service prevention activities in the "Single Services" field. Enter the number served, and the amount of funds associated with those services. Single services are defined as non-recurring one time prevention services, events or activities.

Center Top Heading:

Utilize a drop down box to select type of document: Original, Modification, Supplement or Reduction.

Column Heading:

Replace <Organization Name> with legal name for your organization (*i.e. ABC, Inc.*)

Replace <Grant Name> with the appropriate name of the funding source (*i.e. Block Grant*).

Replace <Facility Name> with the appropriate name of the facility if applicable (*i.e. Tulip House*)
Note: each facility location must have a separate F.R.A.N. form.

Replace <I-SAT #> with the number assigned to the location of the facility where the services are being provided. Every certified Provider location in Maryland is assigned a unique Inventory of Substance Abuse Treatment Services (ISATS) ID. A separate Provider location F.R.A.N. form must be completed for each ISATS ID under the grant. If you are a Prevention Provider leave this space blank.

Levels of Care

Funds allocated to a Level of Care (LOC) that's being funded must be categorized. Use drop down boxes by clicking on the arrow at the right of the cell directly beneath each LOC section to identify specific type of population.

Types of population to choose from are:

Adults	Drug Court - Men
Adolescents	Drug Court - Women
Co-Occurring	Drug Court - Women & Children
Criminal Justice	Homeless
Drug Court	Men
Drug Court - Adolescents	Women
Drug Court - Adults	Women & Children

Enter slots, number of clients served and funding amount including any fee collections into white cells only. All light gray cells have been formatted to total the data you have entered. Do not enter anything into dark gray cells.

"Other" Category

Utilize this category for services that do not fall under individual Levels of Care. An example could be Recovery Housing, Assessments, and Care Coordination etc. Use drop down boxes to select from the following pre-populated descriptions or enter your own.

Adolescent Clubhouse	Case Management
Assessments - Block	Intensive Dual Diagnosis Treatment
Assessments - CINA (SB512)	Outreach
Assessments - Court Based	SBIRT Recovery Coaches
Assessments - ICW (HB7)	Urinalysis - TCA
Assessments - TCA	

Contact your Grants Accountant if you need additional assistance.