Behavioral Health Care Services

Funding Request for FY _____

Org / Provider Name: _____ **Org #:** _____ **Request Date:** _____

RU # (if applicable) _____ **Submitted by:** _____

Name of Program: _____ **Phone No:** _____

Budget Request Amount: **$**_____ ☐ **New Program**

☐ **Revised Program**

☐ **Augmentation to Existing** ☐ **Match Required $**_____

Purpose or description of Request (attach Program Description and/or list of new positions or reclasses if necessary)

_____

_____

_____

Appropriation: Revenue:

Acct No	Acct Description	Program Code	Amount	Acct No	Acct Description	Program Code	Amount	One Time (Y/N)

Reviewed by Finance Director: _____ **Date:** _____

Reviewed by Executive Admin: _____ **Date:** _____

Admin Action: ☐ **Approved** ☐ **Approved as modified** ☐ **Denied** ☐ **Hold** **Action Date:** _____

Modification / Reason for Denial: _____

_____

Distribution		
CBO:	**Civil Service Positions:**	**Other:**
SOC/Program Director Program Liaison Fiscal Liaison Finance Requestor	SOC/Program Director Human Resources Finance Requestor	SOC/Program Director Finance Requestor

Internal Finance Use

Board Letter Required	Yes ☐ No ☐
Financial Recommendation	Yes ☐ No ☐
Org Bud Updated:	
Updated by:	
Comments:	

Rev 9/24/2009

BHCS Cross-Agency/Cross-County/Community Provider Project Grid

Your Name:

Position:

BHCS Organizational Unit:

1. Activity Name: _____

Lead: _____

_____

(project lead name/dept/agency)

- Project ☐
- Work Group ☐
- Committee ☐
- Other ☐ _____

2. Project Purpose

- Advisory ☐
- Coordination/Oversight ☐
- Policy Development ☐
- Start-up/Developmental/Program Design ☐
- Implementation ☐

Functional Area (check all that apply)

- Operations ☐
- Administrative ☐
- Mgmt/Business Processes ☐

3. Collaborative Partners (Agency, County &/or Community Providers)

Please list all participating partners below

List: _____ List: _____

_____ _____

_____ _____

_____ _____

_____ _____

4. Timeframe

Estimated end date (mo/yr)

- Short-term (3 - 6 months) ☐ _____
- Mid-term (6 months—1 year) ☐ _____
- Longer term (>1 year) ☐ _____
- Ongoing ☐

Frequency of Meetings

- Weekly ☐
- Every other week ☐
- Monthly ☐
- Quarterly ☐

Questions? Call Sean Jara, QI Coordinator, at tieline 31776 or sjara@acbhcs.org. Please submit completed grids to Sean by January 30, 2013.

BHCS
Operational Program Summary Template
Final Draft

The template's purpose is to:

- Provide consistent, accessible information to the Executive/System of Care Teams on BHCS program design/development; redesign; budget modifications; evaluation reports and decision-making.
- Develop a systematic process/approach for program descriptions and review that captures key information and is accessible to all Executive/System of Care Team members.
- Serve as a guide for managers and staff presenting at Executive/SOC meetings to maximize the effectiveness and utility of their presentations.
- Provide information for program/system redesign and service mapping.
- Align with and support the Network Office Exhibit As and RFPs, rather than duplicate these documents.

PROGRAM TEMPLATE

BHCS Unit, Contract Community Based-Provider or Primary Care Clinic:
Program Name:
Program Lead: Name, title, contact info (email and phone)

Program Summary

1. **Program "Mission" or Purpose:** a short statement describing the overall goal of this effort, one or two sentences, including the desired outcome
2. **Program Objective(s):** 3-5 measurable objectives that the program will meet in order to accomplish its mission/purpose
3. **Population to be Served/Eligibility Criteria:** Age, diagnosis, stage of recovery, functionality, current health status, co-occurring conditions, homeless, integrated care
4. **Primary Referral Source(s):** Front door/emergency services (i.e. ACCESS, CRP, JGP, Sausal Creek, Cherry Hill Detox and Willow Rock); specific County or CBO programs; primary care providers; community-based agencies or other settings
5. **Setting/Site/Length of Stay:** Front door/emergency services; hospital-based and subacute services; full service partnerships; Level 1 service teams; Level 2, 3 & 4 services; wellness centers; integrated care clinics; school-based services; etc.
6. **Capacity:** Number of clients enrolled/served by this program or served in different levels of care within the program
7. **Services Clients and Families Will Receive:** Brief, bulleted descriptions
8. **Workforce Requirements and Staffing Plan:** Expertise required; license requirements, i.e. clinical supervisor, specific licensed providers; case managers, consumer and family providers; bi-lingual, bi-cultural staff
9. **Outcome Measures to Support Program Objectives:** TBD by SOC Directors, operational leads, Management Support Services staff and program managers, with technical assistance and support provided by the QI Unit.
10. **Transition and/or Exit Criteria:** TBD as above

FINANCIAL TEMPLATE

We will use a Finance Unit Budget Modification for this section that will incorporate the following information:

1. **Annual Operating Budget**:
2. **Funding Stream/Mechanism**: Medi-Cal, Medi-Medi, MHSA, EPSDT, TCM, MAA, HealthPAC, FQHC, Contracts, Grants, others?
3. **Revenue Generation Expectations**: MAA, TCM, other
4. **Estimated Cost Per Unit of Service**:
5. **Estimated Cost Per Outcome**: (i.e. estimated cost of $25,000 to house a homeless person)