

# **Section 5**

## **Attachments**

- A. Proposal Application Checklist**
- B. Sample Table of Contents**
- C. Draft Special Conditions**
- D. Consumer Rights**
- E. Division P & P Regarding Consumer Grievances**  
**Division P & P Regarding Consumer Appeals**
- F. QMHP and Supervision**
- G. Certifications**
- H. Form SPO-H-205A Instructions**

# **Attachment A**

## **Competitive POS Application Checklist**

## Proposal Application Checklist

Applicant: \_\_\_\_\_ RFP No.: HTH 420-2-08

The applicant's proposal must contain the following components in the order shown below. This checklist must be signed, dated and returned to the purchasing agency as part of the Proposal Application. SPOH forms are on the SPO website. See Section 1, paragraph II Website References.\*

Item	Reference in RFP	Format/Instructions Provided	Required by Purchasing Agency	Completed by Applicant
<b>General:</b>				
Proposal Application Identification Form (SPO-H-200)	Section 1, RFP	SPO Website*	<b>X</b>	
Proposal Application Checklist	Section 1, RFP	Attachment A	<b>X</b>	
Table of Contents	Section 5, RFP	Section 5, RFP	<b>X</b>	
Proposal Application (SPO-H-200A)	Section 3, RFP	SPO Website*	<b>X</b>	
Tax Clearance Certificate (Form A-6)	Section 1, RFP	Dept. of Taxation Website (Link on SPO website)*		
Cost Proposal (Budget)				
SPO-H-205	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-205A	Section 3, RFP	SPO Website* Special Instructions are in Section 5	<b>X</b>	
SPO-H-205B	Section 3, RFP,	SPO Website* Special Instructions are in Section 5		
SPO-H-206A	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206B	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206C	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206D	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206E	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206F	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206G	Section 3, RFP	SPO Website*		
SPO-H-206H	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206I	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206J	Section 3, RFP	SPO Website*	<b>X</b>	
<b>Certifications:</b>				
<b>Federal Certifications</b>		Section 5, RFP		
Debarment & Suspension		Section 5, RFP	<b>X</b>	
Drug Free Workplace		Section 5, RFP	<b>X</b>	
Lobbying		Section 5, RFP	<b>X</b>	
Program Fraud Civil Remedies Act		Section 5, RFP	<b>X</b>	
Environmental Tobacco Smoke		Section 5, RFP	<b>X</b>	
<b>Program Specific Requirements:</b>				

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

# **Attachment B**

## **Sample Table of Contents for the POS Proposal Application**

## Proposal Application Table of Contents

<b>I.</b>	<b>Program Overview.....</b>	<b>1</b>
<b>II.</b>	<b>Experience and Capability .....</b>	<b>1</b>
	A. Necessary Skills .....	2
	B. Experience.....	4
	C. Quality Assurance and Evaluation.....	5
	D. Coordination of Services.....	6
	E. Facilities.....	6
<b>III.</b>	<b>Project Organization and Staffing .....</b>	<b>7</b>
	A. Staffing.....	7
	1. Proposed Staffing.....	7
	2. Staff Qualifications .....	9
	B. Project Organization .....	10
	1. Supervision and Training.....	10
	2. Organization Chart (Program & Organization-wide) (See Attachments for Organization Charts)	12
<b>IV.</b>	<b>Service Delivery.....</b>	<b>12</b>
<b>V.</b>	<b>Financial.....</b>	<b>20</b>
	See Attachments for Cost Proposal	
<b>VI.</b>	<b>Litigation.....</b>	<b>20</b>
<b>VII.</b>	<b>Attachments</b>	
	A. Cost Proposal	
	SPO-H-205 Proposal Budget	
	SPO-H-206A Budget Justification - Personnel: Salaries & Wages	
	SPO-H-206B Budget Justification - Personnel: Payroll Taxes and Assessments, and Fringe Benefits	
	SPO-H-206C Budget Justification - Travel: Interisland	
	SPO-H-206E Budget Justification - Contractual Services – Administrative	
	B. Other Financial Related Materials	
	Financial Audit for fiscal year ended June 30, 1996	
	C. Organization Chart	
	Program	
	Organization-wide	
	D. Performance and Output Measurement Tables	
	Table A	
	Table B	
	Table C	
	E. Program Specific Requirement	

# **Attachment C**

## **Draft Special Conditions**

## SPECIAL CONDITIONS

1. Option to Extend Agreement. Unless terminated, this Agreement may be extended by the STATE for specified periods of time not to exceed three (3) years or for not more than three (3) additional twelve (12) month periods, without resolicitation, upon mutual agreement and the execution of a supplemental agreement. This Agreement may be extended provided that the Agreement price shall remain the same or is adjusted per the Agreement Price Adjustment provision stated herein. The STATE may terminate the extended agreement at any time in accordance with General Conditions no. 4.

2. Agreement Price Adjustment. The Agreement price may be adjusted prior to the beginning of each extension period and shall be subject to the availability of state funds.

3. Federal Citation. Pursuant to the Public Health Service Act, Title XIX, Part B, Subparts I and III, as amended, Public Law 106-310, 42 U.S.C. 300X, and the implementing Federal regulations 45 C.F.R. Part 96, the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration of the United States Department of Health and Human Services has granted federal funds to the STATE under a Community Mental Health Services Block Grant by Grant No. 3B09SM010015-0753, dated July 30, 2007, for the block grant period from October 1, 2006 through September 30, 2008, Catalog of Federal Domestic Assistance No. 93.958, which notice of award, grant application, and other applicable documents and conditions are hereinafter collectively referred to as the "Federal Grant."

4. Audit Requirements.

a. Nonprofit organizations that expend \$500,000 or more in a year of federal funds from any source shall have a single audit conducted for that year in accordance with the Single Audit Act Amendments of 1996, Public Law 104-156.

b. If the preceding condition applies, the PROVIDER shall conduct a financial and compliance audit in accordance with the guidelines identified in Exhibit “\_” attached hereto and made part hereof. Failure to comply may result in the withholding of payments to the PROVIDER.

c. Nonprofit organizations that expend less than \$500,000 a year in federal funds are exempt from federal audit requirements for that year; however, records shall be available for review or audit by appropriate officials of the federal awarding agency, the STATE, or General Accounting Office.

d. If the PROVIDER is exempt from federal audit requirements in accordance with subparagraph c., above, the cost of any audit conducted on behalf of the PROVIDER shall not be charged to the federal portion of this Agreement.

5. Certification Regarding Environment Tobacco Smoke. The PROVIDER shall comply with the requirements of the Pro-Children Act of 1994 and by signing the “Certification Regarding Environmental Tobacco Smoke,” attached as Exhibit “\_” and made a part of this Agreement, acknowledges that is a subgrantee of federal funds to be received under the Federal Grant.

6. If this Agreement is terminated with cause or without cause or at the scheduled expiration of the time of performance specified in this Agreement, all equipment and unused supplies and materials leased or purchased with funds paid to the PROVIDER under this Agreement shall become the property of this STATE as it so specifies and shall be disposed of as directed by the STATE, except as otherwise may be provided under the Federal Grant. The PROVIDER shall have bylaws or policies that describe the manner in which business is conducted and policies that relate to nepotism and management of potential conflicts of interest.

7. The PROVIDER shall have bylaws or policies that describe the manner in which business is conducted and policies that relate to nepotism and management of potential conflicts of interest.

# **Attachment D**

## **Consumer Rights**

## ADULT MENTAL HEALTH DIVISION

### POLICY AND PROCEDURE MANUAL

AMHD Administration

SUBJECT: Consumer Rights

REFERENCE:

**Number: 60.909**

Effective Date: 10/29/04

History: New

Page: 1 of 7

APPROVED:

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Title: Chief, AMHD

### PURPOSE

To ensure that specified rights of each consumer are protected.

### POLICY

- A. Each provider shall have a statement designed to protect consumer's rights. The statement shall be:
  - 1. Consistent with Federal and State laws and regulations; and
  - 2. Posted in strategic and conspicuous areas to maximize consumer, family and staff awareness.
- B. Each consumer shall have a consumer rights statement that complies with AMHD consumer rights requirements. The statement shall be:
  - 1. Signed and dated by the consumer prior to treatment; and
  - 2. Maintained in the treatment records of consumers.

### PROCEDURE

- A. The statement given to consumers must include at the minimum the following language:
  - 1. You have rights no matter what your situation is. Adult Mental Health Division (AMHD) and all its providers will uphold these rights. You have these rights regardless of your:

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- Age
  - Race
  - Sex
  - Religion
  - Culture
  - Amount of education
  - Lifestyle
  - Sexual orientation
  - National origin
  - Ability to communicate
  - Language spoken
  - Source of payment for services
  - Physical or mental disability
2. You have the right to be treated with respect and dignity, and to have your right to privacy respected.
  3. You have the right to know about the AMHD and the services available to you. You have the right to know who will provide the services you use, their training, and experience.
  4. You have the right to know as much information about your treatment and service choices as you need so you can give an informed consent or refuse treatment. This information must be told to you in a way you can understand. Except in cases of emergency services, this information shall include a description of the treatment, medical risks involved, any alternate course of treatment or no treatment and the risks involved in each.

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5. You have a right to information about your medications; up to and including your right not to take them, what they are, how to take them, and known side effects.
6. You have a right to be informed of continuing care following discharge from the hospital or outpatient services.
7. You have a right to look at and get an explanation of any bills for non-covered services, regardless of who pays.
8. You have a right to receive emergency services when you, as a prudent layperson, acting reasonably, would believe that an emergency medical condition existed. Payment for emergency services will not be denied in cases when you go for emergency services.
9. You have a right to receive emergency services when traveling outside the State of Hawaii when something unusual prevents you from getting care from an AMHD provider.
10. You have a right to usually have the same provider when you get services.
11. You have a right to an honest discussion with your providers of the options for your treatment, regardless of cost and benefit coverage.
12. You have a right to be advised if a provider wants to include you in experimental care or treatment. You have the right to refuse to be included in such research projects.
13. You have a right to complete an advance directive, living will, psychiatric advance directive, medical durable powers of attorney or other directive to your providers.
14. You have a right to have any person who has legal responsibility make decisions for you regarding your mental health care. Any person with legal responsibility to make health care decisions for you will have the same rights as you would.
15. You have the right to know all your rights and responsibilities.
16. You have the right to get help from AMHD in understanding your services.
17. You are free to use your rights. Your services will not be changed and you will not be treated differently if you use your rights.

## ADULT MENTAL HEALTH DIVISION

### POLICY AND PROCEDURE MANUAL

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18. You have the right to receive information and services in a timely way.
19. You have the right to be a part of all choices about your treatment. You have the right to have a copy of your written Individual Service Plan.
20. You have the right to disagree with your treatment or to ask for changes in your Individual Service Plan.
21. You have the right to ask for a different provider or case manager. If you want a different provider or case manager, we will work with you to find another one in the AMHD network. There is no guarantee that you will be provided a new case manager right away, however.
22. You have the right to refuse treatment or medication, or both, to the extent allowed by the law. You are responsible for your actions if you refuse treatment or if you do not follow your providers' advice.
23. You have the right to receive services that are responsive to your racial and ethnic culture including language, histories, traditions, beliefs, and values.
24. You have the right to an interpreter, if needed, to help you speak to AMHD or your providers. You have the right to have an interpreter in the room when your provider sees you.
25. You have the right to ask us to send you mail and call you at the address or telephone number of your choice, in order to protect your privacy. If we cannot honor your request, we will let you know why.
26. You have a right to a second opinion when deciding on treatment.
27. You have the right to expect that your information will be kept private according to the Privacy law.
28. You have the right to complain about your services and to expect that no one will try to get back at you. If you complain, your services will not stop unless you want them to.

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29. You have the right to be free from being restrained or secluded unless a doctor or psychologist approves, and then only to protect you or others from harm. Seclusion and restraints can never be used to punish you or keep you quiet. They can never be used to make you do something you don't want to do. They can never be used to get back at you for something you have done.

If you have any questions or concerns about these rights, you can speak to the Rights Advisor at your Community Mental Health Center or call the AMHD Consumer Advisor at (808) 586-4688.

- B. Each consumer must be provided an orientation to the program at a level educationally appropriate for the consumer, communicated in either the consumer's native language or sign language, as is appropriate for the individual. Documentation of the orientation must be kept in the consumer's treatment record and signed and dated by the consumer. If a consumer who received the orientation refuses to sign the form acknowledging that he/she received information regarding his/her rights, the staff shall document on the form that the consumer refuses to sign and the date that the information was provided to the consumer. At a minimum such orientation must include:
1. An explanation of the:
    - a) Rights and responsibilities of the consumer,
    - b) Grievance and appeal procedures
    - c) Ways in which input is given regarding:
      - the quality of care
      - achievement of outcomes
      - satisfaction of the consumer
  2. An explanation of the organization's:
    - a) Services and activities
    - b) Expectations
    - c) Hours of operation

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- d) Access to after-hour services
  - e) Code of ethics
  - f) Confidentiality policy
  - g) Requirements for follow-up for the mandated consumer served, regardless of his or her discharge outcome
3. An explanation of any and all financial obligations, fees, and financial arrangements for services provided by the organization
  4. Familiarization with the premises, including emergency exits and/or shelters, fire suppression equipment, and first aid kits
  5. The program's policies regarding:
    - a) Use of seclusion or restraint
    - b) Smoking
    - c) Illicit or licit drugs brought into the program
    - d) Weapons brought into the program
  6. Identification of the person responsible for case management
  7. A copy of the program rules to the consumer, that identifies the following:
    - a) Any restrictions the program may place on the consumer
    - b) Events, behaviors, or attitudes that may lead to the loss of rights or privileges for the consumer
    - c) Means by which the consumer may regain rights or privileges that have been restricted
  8. Education regarding advance directives, when legally applicable
  9. Identification of the purpose and process of the assessment

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10. A description of how the Individualized Service Plan (ISP) or other plan will be developed and the consumer's participation
11. Information regarding transition criteria and procedures
12. When applicable, an explanation of the organization's services and activities will include:
  - a) Expectations for consistent court appearances
  - b) Identification of therapeutic interventions, including:
    - Sanctions
    - Interventions
    - Incentives
    - Administrative discharge criteria

Date of Review: \_\_\_/\_\_\_/\_\_\_; \_\_\_/\_\_\_/\_\_\_; \_\_\_/\_\_\_/\_\_\_; \_\_\_/\_\_\_/\_\_\_

Initials: [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_]

# **Attachment E**

**Division P&P Regarding  
Consumer Grievances**

**Division P&P Regarding  
Consumer Appeals**

## ADULT MENTAL HEALTH DIVISION

### POLICY AND PROCEDURE MANUAL

AMHD Administration

SUBJECT: Consumer Grievances

REFERENCE: Consumer Appeals, Consumer Rights,  
Recovery Guide

Number: 60.906

Effective Date: 10/26/04

History: New

Page: 1 of 6

APPROVED:

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Title: Chief, AMHD

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### PURPOSE

To outline the internal process and procedure for reviewing and resolving consumer grievances or any expressions of dissatisfaction.

### POLICY

The grievance process is administered by Adult Mental Health Division's (AMHD) Office of Consumer Affairs.

A description of AMHD's grievance process is included in the Recovery Guide, which is distributed to all consumers within ten (10) days of entry into the AMHD service system. There is no punitive or retaliatory action taken against a consumer, consumer advocate or provider, acting on behalf of the consumer, for filing a grievance.

### DEFINITIONS

- Action – The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, unreasonable delays in services, or grievances not acted upon within prescribed timeframes.
- Appeal – A request for review of an action made by AMHD, as “action” is defined. Consumer Appeals are discussed in a separate policy and procedure.

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- Consumer – Anyone who is receiving services or potentially could be eligible to receive services.
- Grievance – An expression of dissatisfaction from a consumer or provider, or any authorized representative on behalf of the consumer about any matter other than an action, as “action” is defined.
- Grievance Review – A review process for grievance resolutions. A consumer may request a “grievance review” by AMHD if they do not agree with a provider’s resolution of a grievance.
- Inquiry – A contact from a consumer, or on behalf of the consumer, that questions any aspect of AMHD’s or a provider’s operations, activities, or behavior, or to request change to another provider, and does not express dissatisfaction.

### PROCEDURE

1. Inquiry
  - A. Consumers should call their Case Manager for any inquiry or question regarding any aspect of AMHD or a provider’s operations, activities, or behavior, or request to change to another provider.
  - B. If during the contact, the consumer expresses dissatisfaction of any kind, the inquiry becomes an expression of dissatisfaction and becomes a Grievance or Appeal (see Grievance and Appeal process below).
2. Grievance
  - A. Consumers may file a grievance to express any dissatisfaction in regards to the following:
    - AMHD or provider’s operations
    - AMHD or provider’s activities
    - AMHD or provider’s failure to respect the consumer’s rights

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- AMHD or provider's behavior
  - Provider or AMHD employee is rude
  - Provider quality of care
  - AMHD or provider's privacy practices – copies of these grievances are also forwarded to AMHD's Privacy Officer.
- B. A consumer, provider or a consumer's authorized representative, acting on behalf of the consumer, may file a grievance orally or in writing.
- (1) For oral filing of grievance, the consumer may call the Office of Consumer Affairs and a Consumer Specialist will assist the consumer in writing the grievance by completing an AMHD Consumer Grievance Form (see Attachment A), however, any AMHD staff may assist the consumer to complete the Grievance Form. The Consumer will be given an option to receive a copy of the written grievance. The form is forwarded to the individual responsible for tracking grievances within the Office of Consumer Affairs who is defined as the Grievance Coordinator.
  - (2) If a provider or an authorized representative on behalf of the consumer files the grievance orally, the consumer must give their written authorization.
  - (3) The Grievance Coordinator directs the grievance to the appropriate individual within AMHD for investigation and resolution of the grievance. That individual forwards the written results of their investigation and resolution to the Grievance Coordinator for data entry and tracking.
  - (4) All written grievances should be submitted to:

Adult Mental Health Division  
Office of Consumer Affairs  
Grievance Coordinator  
P.O. Box 3378  
Honolulu, Hawaii 96801-3378
  - (5) Within five (5) working days of the receipt date, the grievant will be informed by letter that the grievance has been received.

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- (6) Each grievance will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory, and contractual provisions, as well as AMHD's policies and procedures.
  - (7) AMHD will render a resolution of the grievance within thirty (30) calendar days of the receipt date. If the thirtieth (30<sup>th</sup>) day falls on a Saturday, Sunday, or State holiday, a resolution will be rendered the next working day. A letter of resolution will be mailed to the grievant and copies are sent to all parties whose interest has been affected by the decision. If the grievant has requested not to be identified, consumer identifying information will be left off other parties' letters.
  - (8) The effective date of the decision will be the date of personal delivery, or if mailed, the postmarked date of the mailing.
- C. The resolution letter includes and describes the following details:
- Nature of the grievance
  - Issues involved
  - Actions AMHD has taken or intends to take
  - Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures.
  - A statement that AMHD's resolution of the grievance is final, unless the consumer requests an appeal by contacting the Office of Consumer Affairs.
- D. AMHD may grant an extension of the resolution deadline of up to fourteen (14) calendar days if the consumer requests an extension or if additional information is needed. In this case, a letter will be sent to the grievant. The content of the notification will include the following details:
- Nature of the grievance
  - Reason for the extension of the decision and how the extension is in the consumer's interest

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### 3. Appeals

A. Consumers may file an appeal for the following actions or decisions made by AMHD:

- Prior authorization for a service is denied or limited
- The reduction, suspension, or termination of a previously authorized service
- The denial, in a whole or in part, of payment for a service
- The denial of eligibility
- Failure to provide services in a timely manner
- Unreasonable delays in services, or appeals not acted upon within prescribed timeframes
- Not satisfied with resolution of grievance

B. The appeal process is discussed in a separate policy and procedure.

### 4. Other Requirements

A. The AMHD Grievance Coordinator shall compile an aggregate quarterly grievance report and submit such report to the Quality Improvement Committee in the required format no later than forty-five (45) days from the end of each quarter.

The Aggregate Grievance Report shall at a minimum include the following elements:

- (1) Number of grievances sorted by date, nature of the grievance, county, and provider of services, if applicable;
- (2) Status of Resolution and if resolved, result including feedback, and
- (3) Turn-around times.

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- B. An Aggregate Annual Grievances Report shall be prepared and presented to the Quality Improvement Committee within sixty (60) days of the last quarter of the calendar year. The report shall contain an aggregate data report, analysis by county, and recommendations for improvement of clinical and service areas.
  
- C. Privacy of the grievance records is maintained at all times, including the transmittal of medical records.
  
- D. All grievances and related documentation are maintained in a secure, designated area and retained for a period of seven (7) years following the final decision, or closure of grievance.
  
- E. All grievances that concern provider organization actions and are proven quality of care or non-compliance with AMHD contracts or policies and procedures will be forwarded and collated by AMHD Performance Management and used in certification and contract review activities.

**ATTACHMENTS**

Consumer Grievance Form

Date of Review: \_\_\_/\_\_\_/\_\_\_; \_\_\_/\_\_\_/\_\_\_; \_\_\_/\_\_\_/\_\_\_; \_\_\_/\_\_\_/\_\_\_

Initials: [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_]





## ADULT MENTAL HEALTH DIVISION

### POLICY AND PROCEDURE MANUAL

AMHD Administration

SUBJECT: Consumer Appeals

#### REFERENCE:

Plan for Community Mental Health Services IV, B, 1, a, i,  
Consumer Grievances, Denial Letter,  
Recovery Guide  
HRS 91

Number: 60.903

Effective Date: 05/01/03  
History: Rev. 10/04, 05/05

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APPROVED:

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Title: Chief, AMHD

### PURPOSE

To outline the process by which a consumer may appeal an action or decision made by Adult Mental Health Division (AMHD).

### POLICY

The consumer appeals process is administered by the Office of Consumer Affairs.

A description of AMHD's appeals process is included in the Consumer Handbook, which is distributed to all consumers within ten (10) days of entry into the AMHD service system. There is no punitive or retaliatory action taken against a consumer, consumer advocate or provider, acting on behalf of the consumer, for filing an appeal.

Medicaid eligible consumers also have the right to request a Fair Hearing for appeals related to Medicaid reimbursable services provided by AMHD. This process does not require a Medicaid eligible consumer to appeal to AMHD first.

### DEFINITIONS

- Action – The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, unreasonable delays in services, or appeals not acted upon within prescribed timeframes.
- Appeal – A request for review of an action made by AMHD, as “action” is defined.

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- Consumer – Anyone who is receiving services or potentially could be eligible to receive services.
- Grievance – An expression of dissatisfaction from a consumer or provider, or any authorized representative on behalf of the consumer about any matter other than an action, as “action” is defined.
- Grievance Review - A review process for grievance resolutions. A consumer may request a “grievance review” by AMHD if they do not agree with a provider’s resolution of a grievance.
- Inquiry – A contact from a consumer, or on behalf of the consumer, that questions any aspect of AMHD’s or a provider’s operations, activities, or behavior, or to request change to another provider, and does not express dissatisfaction.
- Medicaid – A federal program administered by the Department of Human Services, Med-QUEST Division which provides medical coverage. Medicaid recipients can receive services from the Fee-for-service program or QUEST managed care health plans.

### PROCEDURE

1. Inquiry
  - A. Consumers should call their Case Manager for any inquiry or question regarding any aspect of AMHD or a provider’s operations, activities, or behavior, or request to change to another provider.
  - B. If during the contact, the consumer expresses dissatisfaction of any kind, the Inquiry becomes an expression of dissatisfaction and becomes a Grievance (see Grievance and Appeal process below).
2. Grievance
  - A. Consumers may file a grievance if they express any dissatisfaction in regards to the following:
    - AMHD or provider’s operations
    - AMHD or provider’s activities

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- AMHD or provider failure to respect the consumer's rights
  - AMHD or provider's behavior
  - Provider or AMHD employee is rude
  - Provider quality of care
  - AMHD or provider's privacy practices – copies of these grievances are also forwarded to AMHD's Privacy Officer.
- B. The grievance process is administered by the Office of Consumer Affairs as delineated in the Consumer Grievances Policy and Procedures.
3. Appeals
- A. Consumers may file an appeal for the following actions or decisions made by AMHD:
- Prior authorization for a service is denied or limited
  - The reduction, suspension, or termination of a previously authorized service
  - The denial, in a whole or in part, of payment for a service
  - The denial of eligibility
  - Failure to provide services in a timely manner
  - Unreasonable delays in services, or appeals not acted upon within prescribed timeframes
  - Not satisfied with resolution of grievance
- B. AMHD Utilization Management shall notify consumers about their appeal rights and processes at the time of denial of eligibility or service request. Consumers shall have access to consumer advocacy and AMHD shall assure that any consumer who requests an advocate for this process shall be linked to this assistance.

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- C. Consumers who wish to appeal a decision regarding a Medicaid reimbursable service provided by AMHD and who are Medicaid recipients have the right to ask for a Fair Hearing from the Department of Human Services. These appeals do not have to go through the AMHD appeals process first. Medicaid recipients are directed to contact their Department of Human Services worker for information and assistance.
- D. A consumer, provider or a consumer's authorized representative, acting on behalf of the consumer with the consumer's written consent or if documentation is available to demonstrate the consumer is incapacitated, may file an appeal orally or in writing.
- E. For oral filing of appeal, the consumer (or consumer's representative with the written consent of the consumer or if documentation is available to demonstrate the consumer is incapacitated), may call the Office of Consumer Affairs and must also submit a follow-up written appeal.
- F. The designated case manager, or the designated crisis support manager, may appeal on behalf of the consumer without written consent if documentation is available to demonstrate the consumer is incapacitated. The case manager or crisis support manager shall provide specified clinical information to support the appeal request.
- G. An AMHD Consumer Appeal Form (see Attachment A) may also be completed on behalf of the consumer or consumer's representative. In this case, the completed Consumer Appeal Form will be sent to the consumer or the consumer's authorized representative if a written authorization has been received for review and signature.
- H. The consumer or the consumer's authorized representative must submit the follow-up written appeal or return the signed Consumer Appeal Form to the AMHD Office of Consumer Affairs which is designated as the AMHD Consumer Appeals Coordinator within one (1) week from the receipt date of the oral appeal. If the follow-up written appeal or the signed Consumer Appeal form is not received within the allotted timeframe, a follow-up call will be made to the consumer or the consumer's representative. If the consumer requests an extension for the filing deadline of the written appeal, AMHD will grant another one (1) week to submit the written appeal.
- I. If a written follow-up is not received, the appeal will be closed after thirty (30) calendar days without further action or investigation. The consumer will receive written notification of this.

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J. If a provider files a written appeal on behalf of a consumer, it will be initially designated as a Provider Complaint unless accompanied by the consumer's written consent. If the written appeal is filed with the consumer's written consent, AMHD will contact the provider to determine if consent was given. If the written consent is received, AMHD will transfer the Provider Complaint to a Consumer Appeal.

K. All written appeals should be submitted to:

Adult Mental Health Division  
Office of Consumer Affairs  
Consumer Appeal  
P.O. Box 3378  
Honolulu, Hawaii 96801-3378

#### 4. First Level Appeal

- A. The appeal must be filed within thirty (30) days from the date of the initial action or decision made by AMHD. Exceptions to this deadline may be granted if details regarding extenuating circumstances are provided. At no time will an appeal be considered that is 180 days from the date of the initial action or decision made by AMHD.
- B. Within five (5) working days of receipt of the written appeal, the consumer, provider, or the consumer's authorized representative will be informed by letter that the appeal has been received.
- C. The consumer or authorized representative of the consumer may request to examine the consumer's case file, including medical records and any other documents considered during or before the appeal process by contacting the AMHD Consumer Appeals Coordinator in accordance with federal and state privacy regulations.
- D. All appeals will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory, and contractual provisions, as well as AMHD's policies and procedures.
- E. For appeals regarding reduction, suspension, or termination of a previously authorized service such care will be continued until resolution of the appeal.
- F. The AMHD Medical Director shall review the denial and shall make a determination (overturning or ratifying the denial). The AMHD Medical Director has the option of obtaining a second physician opinion prior to rendering an appeal decision.

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- G. AMHD will render a resolution of the appeal within thirty (30) calendar days of the receipt date except in the case of an expedited appeal. If the thirtieth (30<sup>th</sup>) day falls on a Saturday, Sunday, or State holiday, a resolution will be rendered by the next working day. A letter of resolution will be mailed to the provider and copies are sent to all parties whose interest has been affected by the decision. The effective date of the decision will be the date of personal delivery, or if mailed, the postmarked date of the mailing.
- H. The resolution letter includes and describes the following details:
- Nature of the appeal
  - Issues involved
  - Actions AMHD has taken or intends to take
  - Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures
  - Process for a second level appeal if appeal denied
- I. AMHD may grant an extension of the resolution deadline of up to fourteen (14) calendar days if the consumer requests the extension or if additional information is needed. In this case, a letter will be sent to the consumer. The content of the notification will include the following details:
- Nature of the appeal
  - Reason for the extension of the decision and how the extension is in the best interest of the consumer
5. Expedited Appeals
- A. Any AMHD consumer (or provider acting on behalf of the consumer with the consumer's written authorization) may request an expedited appeal.
- B. An expedited appeal may be authorized if the standard review time frame of AMHD's appeal process may:
- Seriously jeopardize the life or health of the consumer

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- Seriously jeopardize the consumer's ability to access services with limited availability with a resulting loss of function
- C. All expedited appeals will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory and contractual provisions, as well as AMHD's policies and procedures.
- D. The AMHD Medical Director will review all expedited appeals.
- E. A decision will be rendered within forty-eight (48) working hours of receipt of the request for an expedited appeal.
- F. The decision will be phoned by the AMHD Consumer Appeals Coordinator to the consumer and provider.
- G. The resolution letter includes and describes the following details:
- Nature of the appeal
  - Issues involved
  - Actions AMHD has taken or intends to take
  - Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures
  - Process for a second level appeal if appeal denied
6. Second Level Appeal
- A. The consumer or appealing party may proceed with a written second level appeal within thirty (30) calendar days from the date of the first level appeal determination letter.
- B. The second level appeal letter along with any additional clinical information shall be sent to the AMHD Chief who shall obtain all relevant documentation from the AMHD UM Coordinator and the AMHD Medical Director. The second level appeal will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory, and contractual provisions, as well as AMHD's policies and procedures.

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- C. For appeals regarding reduction, suspension, or termination of a previously authorized service such care will be continued until resolution of the appeal by the AMHD Chief.
- D. Expedited appeals which result in an expedited second level appeal shall be reviewed and a decision rendered within forty-eight (48) working hours of receipt of the request for an expedited second level appeal if the request has been designated as such. The decision shall be phoned by the AMHD Consumer Appeals Coordinator to the consumer and provider.
- E. Within five (5) working days of receipt of the written non-expedited second level appeal, the consumer, provider, or the consumer's authorized representative will be informed by letter that the appeal has been received.
- F. AMHD will render a resolution of the appeal for non-expedited appeal within thirty (30) calendar days of the receipt date except in the case of expedited appeal. If the thirtieth (30<sup>th</sup>) day falls on a Saturday, Sunday, or State holiday, a resolution will be rendered by the next working day. A letter of resolution will be mailed to the consumer and copies are sent to all parties whose interest has been affected by the decision. The effective date of the decision will be the date of personal delivery, or if mailed, the postmarked date of the mailing.
- G. The resolution letter includes and describes the following details:
- Nature of the appeal
  - Issues involved
  - Actions AMHD has taken or intends to take
  - Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures
  - Statement concerning any other avenues of appeal, if any, available to the appellant.
- H. Consumers or their legal representatives who wish to appeal further must follow the Department of Health administrative appeals process, HR91f, or pursue through the legal system.

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7. Other Requirements

- A. The AMHD Consumer Appeals Coordinator shall compile a quarterly aggregate appeal report and submit such report to the AMHD Quality Council in the required format no later than forty-five (45) days from the end of each quarter.

The aggregate Appeals Report shall include at a minimum include the following elements:

- (1) Number of appeals sorted by date, nature of the appeal, county level of appeal, and provider of services, if applicable,
  - (2) Number of decisions upheld,
  - (3) Number of decisions overturned, and
  - (4) Turn-around times.
- B. An aggregate Annual Appeals Report shall be prepared and presented to the AMHD Quality Council within sixty (60) days of the last quarter of the calendar year. The report shall contain an aggregate data report, analysis, and recommendations for improvement of clinical and service areas.
  - C. Privacy of the appeal records is maintained at all times, including the transmittal of medical records.
  - D. All appeals and related documentation are maintained in a secure, designated area and retained for a period of seven (7) years following the final decision, or closure of appeal.
  - E. All appeals that concern provider organization actions and are proven quality of care matters or non-compliance with the terms and conditions of AMHD contracts or policies and procedures will be forwarded and collated by AMHD Performance Management and used in certification and contract review activities.

**ATTACHMENT**

Consumer Appeal Form

Date of Review: \_\_\_/\_\_\_/\_\_\_; \_\_\_/\_\_\_/\_\_\_; \_\_\_/\_\_\_/\_\_\_; \_\_\_/\_\_\_/\_\_\_

Initials: [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_] [\_\_\_\_\_]

**Attachment A**

**Consumer Appeal Form**

Print Name of Consumer:	_____
AMHD ID#:	_____
Mailing Address:	_____
Island:	_____
Phone Number:	_____
Signature of Consumer:	_____ Date Signed: _____
<i>Note to Consumer: By signing this form, you as a consumer are authorizing your provider or any representative (if there's any) to file this appeal on your behalf.</i>	

<b>** Please fill out this section if a provider or a representative is filing the appeal on behalf of the consumer**</b>	
Print Name of Representative:	_____
Relationship to Consumer:	_____
Phone Number:	_____
Mailing Address:	_____
Signature of Representative:	_____ Date Signed: _____

Description of Service: \_\_\_\_\_

Date(s) of Service: \_\_\_\_\_



# **Attachment F**

## **QMHP AND SUPERVISION**

## **Definition and Role of the Qualified Mental Health Professional and Mental Health Professional**

### **Qualified Mental Health Professional (QMHP)**

A Qualified Mental Health Professional (“QMHP”) is defined as a Licensed Psychiatrist, Licensed Clinical Psychologist (Ph.D. or Psy.D.), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), or Licensed Advanced Practice Registered Nurse (APRN) in behavioral health currently licensed in the State of Hawaii.

The QMHP shall oversee the development of each consumer’s treatment plan to ensure it meets the requirements stated in the Community Plan 2003 and sign each treatment plan.

The QMHP shall serve as a consultant to the treatment team.

The QMHP shall serve as the LOCUS expert.

The QMHP shall provide oversight and training.

The QMHP shall review and sign each authorization request for clinical services prior to submittal to ensure that the services requested are medically necessary.

The QMHP shall provide clinical consultation and training to team leaders and/or direct care providers as needed.

Additionally, for Specialized Residential Treatment Programs, the QMHP shall provide day-to-day program planning, implementation, and monitoring.

### **Mental Health Professional (MHP)**

Except for Assertive Community Treatment (“ACT”), the team leader is not required to be a QMHP. Non-QMHP team leaders shall be clinically supervised by a QMHP.

Non-QMHP team leaders are defined as Mental Health Professionals (“MHP”) and shall meet the following minimum requirements:

- Licensed Social Worker (LSW); or
- Master of Science in Nursing (MSN); or
- APRN in a non-behavioral health field; or
- Master’s degree from accredited school in behavioral health field
  - a) Counseling, or
  - b) Human Development, or
  - c) Marriage, or
  - d) Psychology, or
  - e) Psychosocial Rehabilitation, or
  - f) Criminal Justice.

- Master's degree in health related field with two (2) years experience in behavioral health; or
- Licensed Registered Nurse with two (2) years experience in behavioral health.

The MHP may supervise para-professional staff if the MHP is clinically supervised by a QMHP.

The MHP may function as the DIVISION Utilization Management Liaison.

**Supervision:**

Clinical supervision of all staff is ongoing and shall be sufficient to ensure quality services and improve staff clinical skills and is according to community standards, scope of license as applicable, and agency policies and procedures. Treatment team meetings are consumer focused whereas clinical supervision is staff focused. Therefore, treatment team meetings do not need to meet clinical supervision requirements.

One-on-one clinical supervision of MHP team leaders and direct care providers, if there is no MHP team leader, shall be performed by the QMHP at a minimum of once per month. If a MHP is the team leader, the MHP shall provide one-on-one monthly clinical supervision of non-MHP and non-QMHP staff.

The supervision shall be documented in writing, legible, signed and dated by the QMHP or MHP as directed by the provider agency's policies and procedures.

The DIVISION funded PROVIDER shall have policies and procedures to select and monitor the MHP team leaders if non-QMHP team leaders are used.

The QMHP and non-QMHP staff does not have to work in the same physical setting but shall have routine meetings as defined in the PROVIDER's policies and procedures.

# **Attachment G**

# **Certifications**

## CERTIFICATIONS

### 1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

### 2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about--
  - (1) The dangers of drug abuse in the workplace;
  - (2) The grantee's policy of maintaining a drug-free workplace;
  - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  - (1) Abide by the terms of the statement; and
  - (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--
  - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management  
Office of Grants Management  
Office of the Assistant Secretary for Management and Budget  
Department of Health and Human Services  
200 Independence Avenue, S.W., Room 517-D  
Washington, D.C. 20201

### 3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under-

signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

### 4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

**5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE**

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE	
APPLICANT ORGANIZATION		DATE SUBMITTED

# **Attachment H**

## **Form SPO-H-205A Instructions**

**Instructions for Completing  
FORM SPO-H-205A ORGANIZATION - WIDE BUDGET BY  
SOURCE OF FUNDS**

<b>Applicant/Provider:</b>	Enter the Applicant's legal name.
<b>RFP#:</b>	Enter the Request For Proposal (RFP) identifying number of this service activity.
<b>For all columns (a) thru (d)</b>	<p>Report your total organization-wide budget for this fiscal year by <b>source of funds</b>. Your organization's budget should reflect the total budget of the "organization" legally named. Report each source of fund in separate columns, by budget line item.</p> <p>For the first column on the first page of this form, use the column heading, "Organization Total".</p> <p>For the remaining columns you may use column headings such as: Federal, State, Funds Raised, Program Income, etc. If additional columns are needed, use additional copies of this form.</p>
<b>Columns (b), (c) &amp; (d)</b>	Identify sources of funding in space provided for column titles.
<b>TOTAL (A+B+C+D)</b>	Sum the subtotals for Budget Categories A, B, C and D, for columns (a) through (d).
<b>SOURCE OF FUNDING: (a) (b) (c) (d)</b>	Identify all sources of funding to be used by your organization.
<b>TOTAL REVENUE</b>	Enter the sum of all revenue sources cited above.
<b>Budget Prepared by:</b>	Type or print the name of the person who prepared the budget request and their telephone number. If there are any questions or comments, this person will be contacted for further information and clarification. Provide signature of Applicant's authorized representative, and date of approval.

Special Instructions by the State Purchasing Agency: