



**MILWAUKEE COUNTY**  
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Behavioral Health Division**  
**Delinquency and Court Services Division**  
**Disabilities Services Division**  
**Economic Support Division**

**YEAR 2008**  
**PURCHASE OF SERVICE GUIDELINES**  
**PROGRAM REQUIREMENTS**

Issued July 2007

Ver-7/16/07

## Table of Contents

Page #

### RECOMMENDED PROGRAMS and TENTATIVE ALLOCATIONS

|  |            |
|--|------------|
| <b>BEHAVIORAL HEALTH SERVICES DIVISION</b>     | <b>3-4</b> |
| <b>DELINQUENCY AND COURT SERVICES DIVISION</b> | <b>5</b>   |
| <b>DISABILITIES SERVICES DIVISION</b>          | <b>6-7</b> |
| <b>ECONOMIC SUPPORT DIVISION</b>               | <b>8</b>   |

### PROGRAM REQUIREMENTS

**Program Name**

**Page #**

|   |             |
|---|-------------|
| <b>BEHAVIORAL HEALTH SERVICES DIVISION</b>                        | <b>9-58</b> |
| Service Access and Prevention                                     | 10          |
| Inpatient and Institutional Care: Secure Emergency Detoxification | 12          |
| Outpatient Treatment Program                                      | 18          |
| Employment Programs   | 27          |
| <u>Community Living Support Programs</u>                          |             |
| <i>Protective Payee</i>   | 29          |
| <i>Drop in Center</i>   | 30          |
| <i>Psychosocial Rehabilitation Program (Clubhouse Model)</i>      | 31          |
| Community Based Residential Programs                              | 32          |
| Community Support Program (CSP)                                   | 35          |
| Targeted Case Management Program (TCM)                            | 40          |
| Central Intake Unit (CIU)   | 43          |
| Information Systems Requirements                                  | 48          |

|  |              |
|--|--------------|
| <b>DELINQUENCY AND COURT SERVICES DIVISION</b> | <b>59-82</b> |
| Family Connections Program                     | 64           |
| Level 2 In-Home Monitoring Services            | 68           |
| Serious Chronic Offender Program               | 72           |
| Adolescent Sex Offender Treatment Program      | 77           |
| Shelter Care                                   | 80           |

|                                       |               |
|---------------------------------------|---------------|
| <b>DISABILITIES SERVICES DIVISION</b> | <b>83-111</b> |
|---------------------------------------|---------------|

**Developmental Disabilities**

Advocacy

|                                     |    |
|-------------------------------------|----|
| <i>Advocacy/ Consumer Education</i> | 87 |
|-------------------------------------|----|

Community Living Support

|                                    |    |
|------------------------------------|----|
| <i>Recreation</i>                  | 89 |
| <i>Respite</i>                     | 90 |
| <i>Corporate Guardianship</i>      | 91 |
| <i>Assertive Case Intervention</i> | 92 |

Community Residential

|                                  |     |
|----------------------------------|-----|
| <i>Supportive Living Options</i> | 96  |
| <i>Supported Parenting</i>       | 97  |
| <i>Person-Centered Planning</i>  | 100 |
| <i>Targeted Case Management</i>  | 103 |

|                                     |     |
|-------------------------------------|-----|
| <u><i>Fiscal Agent Services</i></u> | 106 |
|-------------------------------------|-----|

|                                  |                |
|----------------------------------|----------------|
| <b>ECONOMIC SUPPORT DIVISION</b> | <b>112-122</b> |
|----------------------------------|----------------|

|                   |     |
|-------------------|-----|
| Energy Assistance | 113 |
|-------------------|-----|

---

## 2008 TENTATIVE CONTRACT ALLOCATIONS

---

### BEHAVIORAL HEALTH DIVISION

---

| <u>Recommended Programs</u>  | <u>2008*<br/>Tentative<br/>Allocations</u> |
|--|--|
| Service Access and Prevention <sup>C2</sup>  | \$TBD                                      |
| Inpatient and Institutional Care: Secure Emergency Detoxification <sup>C3</sup>  | \$TBD                                      |
| Outpatient Treatment Program <sup>C2</sup>   | \$TBD                                      |
| Employment Programs <sup>C2</sup>  | \$TBD                                      |
| Community Living Support Services <sup>C1</sup><br>Protective payee<br>Drop in Center<br>Psychosocial Rehabilitation Program (Clubhouse Model) | \$TBD                                      |
| Community Based Residential Programs <sup>C3</sup>   | \$TBD                                      |
| Targeted Case Management Program (TCM) <sup>C1</sup>   | \$TBD                                      |
| Community Support Program (CSP) <sup>C2</sup>  | \$TBD                                      |

Behavioral Health Division has three-year program contract cycles. They are as follows:

|   |                  |
|---|------------------|
| CYCLE I                                   | OPEN BID PROCESS |
| Community Living Support Programs         | 2009-2010        |
| Targeted Case Management                  | 2009-2010        |
| <br>CYCLE II                              |                  |
| Central Intake Unit                       | 2007-2008**      |
| Community Support Programs                | 2007-2008        |
| Outpatient Programs                       | 2007-2008        |
| Service Access Prevention – Mental Health | 2007-2008        |
| Service Access Prevention – AODA          | 2007-2008**      |

\*\* (These programs are not part of the voucher services in the Wiser Choice Provider Network)

### CYCLE III

|  |           |
|--|-----------|
| Community Based Residential Facilities | 2008-2009 |
| Secure Emergency Detoxification        | 2008-2009 |
| Employment Programs                    | 2008-2009 |

All programs are required to submit full applications annually. However, only Cycle II programs are open for competitive bid in the 2008 contract process. New applications will be accepted for Cycle II programs only.

An abbreviated review will be performed on Cycle I and Cycle III programs.

**\*Final 2008 allocations are contingent on the 2008 adopted budget.**

**DELINQUENCY AND COURT SERVICES DIVISION**

---

| <b><u>Recommended Programs</u></b>                   | <b><u>2008*<br/>Tentative<br/>Allocations</u></b> |
|--|---|
| DCSD 002 – Family Connections Program                | \$60,000  |
| DCSD 008 – Level 2 In-Home Monitoring Services       | \$1,125,737                                       |
| DCSD 009 – Serious Chronic Offender Program          | \$544,575   |
| DCSD 010 – Adolescent Sex Offender Treatment Program | \$134,912   |
| DCSD 011 – Shelter Care                              | \$2,146,289                                       |
|  | <b>GRAND TOTAL =====</b>                          |
|  | \$4,011,513                                       |

**\*Final 2008 allocations are contingent on the 2008 adopted budget.**

**DISABILITIES SERVICES DIVISION**

---

| <b><u>Recommended Programs</u></b>                                   | <b><u>2008*<br/>Tentative<br/>Allocations</u></b> |
|--|---|
| <b><u>ADVOCACY</u></b>   |   |
| Advocacy/Consumer Education <sup>C1</sup>                            | \$186,043**                                       |
| <br><b><u>COMMUNITY LIVING SUPPORT AND COMMUNITY RESIDENTIAL</u></b> |   |
| <b><u>COMMUNITY LIVING SUPPORT</u></b>                               |   |
| Recreation <sup>C1</sup>   | \$173,516   |
| Respite <sup>C1</sup>  | \$338,095   |
| Corporate Guardianship <sup>C1</sup>                                 | \$10,000  |
| Assertive Case Intervention <sup>C1</sup>                            | \$59,680  |
|  | <b>\$581,291</b>                                  |
| <br><b><u>COMMUNITY RESIDENTIAL</u></b>                              |   |
| Supportive Living Options <sup>C1</sup>                              | \$627,419   |
| Supported Parenting <sup>C1</sup>                                    | \$91,815  |
| Person-Centered Planning*** <sup>C1</sup>                            | \$51,581  |
| Targeted Case Management*** <sup>C1</sup>                            | \$60,000  |
|  | <b>\$830,815</b>                                  |
| <br><b><u>FISCAL AGENT SERVICES</u></b> <sup>C1</sup>                | <br><b>N/A</b>                                    |
| <br><b>GRAND TOTAL</b> <b>\$1,598,149</b>                            |   |

\*Final 2008 allocations are contingent on the 2008 adopted budget.

\*\*Funding for the Advocacy program has been recommended for reduction in the Department's 2008 budget. It is possible that funding for this program may not be available in the final adopted budget.

\*\*\*2008 is the last year that funding will be available for Person-Centered Planning and Targeted Case Management programs.

Disabilities Services Division has three-year program contract cycles. Only Cycle 1<sup>(C1)</sup> programs are open for competitive bid in the 2008 contract process. New applications will be accepted for Cycle 1 programs only.

All agencies that are in the second or third year of a multi-year contract cycle (non-cycle 1 programs) in 2008 are not open for competitive bid. Agencies that are currently in a multi-year contract cycle (do not require a competitive, panel review), but **must** submit **all** the items listed under FINAL SUBMISSION, **plus** the Authorization To File (Item 3) as found in the Application Contents section of the *Purchase of Service Guidelines - Technical Requirement*. The following programs are currently in a multi-year contract cycle:

- Day Services
- Work Services
- Employment Programs
- Early Intervention – Birth to Three
- Service Access & Prevention - Emergency Shelter Care
- Service Access & Prevention - Battered Women's Counseling
- Service Access & Prevention - Coordinated Community Housing

All submissions, regardless of contract cycle year, must be received by the DHHS **no later than 4:30 p.m. on Tuesday, September 4, 2007.**

## ECONOMIC SUPPORT DIVISION

---

| <u>Recommended Programs</u>   | <u>2008***<br/>Tentative<br/>Allocations</u> |
|---|--|
| <b>Community Information Line (211)*</b><br>Centralized 24-hour information and referral service.   | \$ 46,958                                    |
| <b>Low Income Home Energy Assistance Program (LIHEAP)</b><br><br>Administration of the application process of regular and emergency energy assistance, and the provision of crisis and supportive case management.<br><br>Provision of case management services to LIHEAP (see below) recipients who have difficulty paying for utility and heating services, as well as presentation of workshops to the Department's customers with energy assistance issues. | \$2,300,000                                  |
| <b>Drop-In Child Care Center – Marcia P. Coggs Human Services Ctr.*</b><br>Administration of the drop-in childcare center at 1220 W. Vliet St., providing care for the children of the childcare, food stamp, medical assistance, and energy assistance applicants/recipients who are in the building taking care of their cases.   | \$ 128,750                                   |
| <b>Child Care Certification Intake*</b><br>Intake services to enable the certification/recertification of family childcare providers.   | \$ 87,794                                    |
| <b>GRAND TOTAL: \$2,563,502***</b>  |  |

\*New applications are not accepted for these programs as they are purchased from designated service agencies. **The designated provider agencies are required to apply according to the *Year 2008 Purchase of Service Guidelines Technical Requirements*.**

\*\*\*Final 2008 allocations are contingent on the 2008 adopted budget.

# **Section 1**

## **Behavioral Health Division Program Descriptions**

---

---

---

**Service Access and Prevention  
Program #A001<sup>¶</sup>**

---

---

Two programs will be funded in this area.

This program area consists of a variety of services designed to increase the community's understanding of substance abuse issues, prevention, and intervention strategies. Applicants applying for this program must meet the requirements of HFS 75.04 (see Program Definitions).

1) A program will be funded that has an emphasis in the Category of "Selective Measures" with a primary focus on adolescents.

The program will solicit vendors to plan and implement prevention programs that build on the public health framework and understand the relationship between substance abuse problems, the individual, and the environment.

The proposed programs will incorporate researched prevention strategies in their program and design. The programs will fund projects that clearly target the juvenile population relative to AODA prevention and specific interventions.

- **Primary Interventions** should target general population groups, mass media, school-based health curriculum, without reference to those at particular risk. All members of a community, not just specific individuals or groups within a community, benefits from a universal prevention effort.
- **Selective Interventions** should target those who are at greater-than-average risk for substance use, mentoring programs aimed at children with school performance or behavioral problems. Targeted individuals are identified on the basis of the nature and number of risk factors of substance use to which they may be exposed.
- **Other Selective Interventions** should be focused on juveniles who may already display signs of substance use or alcohol abuse. The other selective interventions should be designed to prevent the onset of regular or heavy substance use via utilizing parenting programs and other interventions.

Services proposed, including methods for measuring outcomes, must meet the requirements of HFS 75.04 (1) – (5).

---

<sup>¶</sup> Program description revised and replaced on 07/16/07

The second program funded must have an extensive history working with HIV prevention, care, treatment and research programs.

2) A second program will be funded that has a focus in the Category of “Indicated Measures,” with an identified “high-risk group that require assistance in accessing the appropriate AODA treatment or service.

The program must be able to provide service to thousands of people with HIV/AIDS and conduct thousands of prevention contacts.

### **Care and Treatment Programs:**

- Medical Care – Operate outpatient HIV medical clinics led by Board Certified Infectious Disease physicians and health care professionals. The medical clinics must be able to serve hundreds of HIV positive patients.
- Dental Care – Operate HIV-dedicated dental clinic, led by dentists and dental professionals who provide comprehensive care to hundreds of patients.
- Mental Health Therapy – Operate a mental health clinic, led by therapists who provide counseling and psychotherapy to consumers.
- Social Work Case Management – Case management program must serve hundreds of HIV/AIDS clients through a statewide team of social workers.
- Housing – Provide residential housing, rent assistance, and housing counseling. Provide housing counseling service to hundreds of clients and rent subsidy and utility assistance and resources to HIV clients across Wisconsin.
- Legal Assistance – The legal program should be led by attorneys who can provide legal representation and consultation for hundreds of clients.
- Food Service - Assist with food program that includes pantries and voucher services to assure access to nutritional foods and provide HIV-positive clients and their households with food services.
- Transportation Assistance – Provide transportation assistance to people living with HIV and AIDS in the form of bus tickets, bus passes, and gift cards.

### **HIV Prevention Programs:**

- Clean Needle Exchange for injection drug users (IDUs) – Operate a clean needle exchange program in seven communities statewide – Madison and Beloit in the southern region, Milwaukee, Kenosha and Racine in the southeast region, Appleton and Green Bay in the northeast region, and Wausau in the northern

region, - serving thousands of injection drug users and exchanging thousands of needles.

- Provide prevention outreach, individual and group interventions for these populations at high risk for HIV.
- Alcohol and Drug Treatment –Operate a state-licensed alcohol and drug treatment program utilizing a harm reduction model.

This program area should be able to assist hundreds of people at any given time throughout the year

## **Service Access and Prevention**

---

### **Program # M001**

This program consists of a variety of services designed to increase the community's awareness and understanding of chronic mental illness, and to provide information on what resources are available to assist and support individuals and families. There are four main service areas.

### **Advocacy**

---

#### **Program # M001-A**

---

These are services designed to assist individuals and their families obtain or maintain access to appropriate community resources.

### **Information And Referral Services**

#### **Program # M001-IR**

---

These are services designed to assist individuals and their families in obtaining information and linking them with appropriate public and private resources.

### **Prevention Services**

#### **Program # M001-P**

---

These are services designed to provide information, education and training to individuals, their families, and the general public in regard to the causes of disabling conditions, and the means to prevent or ameliorate their causes.

### **Intake & Assessment Services**

#### **Program # M001-IA**

---

These are services designed to screen and assess individuals for mental health problems, to make treatment recommendations, and to provide short-term counseling interventions

---

## **Inpatient and Institutional Care: Secure Emergency Detoxification Program #A007**

---

The purpose of the Secure Emergency Detoxification (SED) program is to provide detoxification services in a non-hospital-based facility to persons who are in withdrawal, are intoxicated, or are physically debilitated through the use of substances. The detoxification program is a basic component of the substance abuse treatment system. Persons intoxicated by or in withdrawal from substances and for whom it is inadvisable to return home, or whose medical and psychiatric status does not indicate a need for emergency or inpatient hospital treatment, are appropriate for the detoxification program. The program provides appropriate care and treatment in a medically supervised environment, and at the same time, offers the opportunity for further help with the substance abuse problem.

Persons who exhibit homicidal or suicidal ideation due to mental illness or substance abuse are brought to the Milwaukee County Behavioral Health Division Psychiatric Crisis Service (PCS) for assessment, evaluation, and treatment. It is clear that for many persons the homicidal or suicidal ideation is brought on because of the use of substances, and that they do not have a mental illness that requires acute care mental health treatment, yet they still remain in need of secure emergency detoxification services. Persons who come to PCS may be brought by family or friends, but most often are brought by law enforcement, either as an Emergency Detention or other police hold.

### **Target Population**

The primary target population includes Milwaukee County residents who meet the admission criteria for the Secure Emergency Detoxification Program. It is anticipated that a large cross-section of individuals will seek services and will be provided with a medical screen to determine their suitability for admission to the Detoxification Program. Such clients might include:

- a. individuals brought to the unit in police custody;
- b. persons referred by hospitals including PCS, community agencies, or family members;
- c. homeless individuals referred by community agencies; and
- d. self-referrals.

The target population includes adults who initially present to the Milwaukee County Behavioral Health Division Psychiatric Crisis Service (PCS) with substance abuse or substance abuse with mental illness. It will be the responsibility of PCS to evaluate the mental and physical status of all patients referred directly from PCS and determine that they can be safely transferred to the Secure Emergency Unit. Symptoms associated with mental illness include anxiety, depression, psychosis, mania, and personality

problems. Common mental illness diagnosis may include depression, personality disorders, adjustment reactions, and occasionally psychotic episodes. It is not always possible to determine those persons with a primary mental illness diagnosis, those patients with long-term mental illness or primary functional psychosis (schizophrenia, bipolar illness), and those with major depression. Therefore, it may be more appropriate to admit those persons to the Mental Health Complex or to transfer them to the Mental Health Complex if previously admitted to the Secure Emergency Detoxification Program.

It is anticipated that those patients who present a danger to themselves or others because of primary substance abuse will be considered appropriate for admission to the Secure Emergency Detoxification Service.

### **Intended Service Response of the Contracted Secure Drug Detoxification Service Provider**

In order to provide optimum care, the program should meet the following objectives:

1. Provide an appropriate secure environment and services to address the needs of clients admitted to the program.
2. Ensure appropriate clients are served by establishing a mechanism for the detailed assessment of each client entering the program through use of the ASAM PPC-2R and CIWA. This would entail utilizing both physiological and psycho-social measures for evaluating the level of intoxication, the mental status, and physical status (e.g. trauma) of a new client. Data derived from the assessment would be used:
  - a. for determining the suitability of a client's admission to the facility;
  - b. in determining a medical emergency;
  - c. in the planning and managing of a client's detoxification; and
  - d. in motivating a client to change the drinking behavior.
3. Create a positive, supportive environment that can motivate the client toward a positive change in his/her lifestyle while respecting individual differences in client value systems, behaviors, and lifestyles.
4. Link the detoxifying client to the Behavioral Health Division's contracted program providers in the substance abuse treatment and human service system. The necessity of networking with Recovery Support Coordinators, case management and other service providers is a requirement for the detoxification program in order to minimize service gaps for the client.
5. Ensure that linkages with community programs, health care institutions, and law enforcement are in place. Linkages should include:
  - a. community (municipal) law enforcement organizations;

- b. Milwaukee County Corporation Counsel;
  - c. community hospitals;
  - d. community AODA treatment providers; and
  - e. linkages with the Milwaukee County Behavioral Health Division's Mental Health Complex for emergency services.
6. Utilize the CMHC client monitoring or tracking system pertaining to a client's interaction with treatment resources for purposes of:
- a. crisis intervention;
  - b. program planning; and
  - c. verifying the agency's efforts in following up referrals to other programs without compromising the confidentiality of clients.

Persons who are stabilized to the point of not needing inpatient psychiatric care but still in need of detoxification/stabilization services would be transferred to the Secure Emergency Detoxification Program. Such transfers may continue to have symptoms of emotional illness but their AODA treatment will be the primary concern. Specific procedures detailing the relationship between the detoxification provider and the BHD will be addressed through a Memorandum of Understanding.

Consumers admitted to the Secure Emergency Detoxification Program will continue to be monitored for symptoms of the emotional illness, drug abuse, and other medical problems. Consumers transferred to the Secure Emergency Detoxification Program may, while at PCS, have been administered antidepressant, anti-psychotic, anti-anxiety, or mood stabilizing medication. Continued administration and monitoring is required.

It is the expectation that the Secure Emergency Detoxification Program will work with consumers while in treatment to identify ongoing treatment or service needs, complete detoxification, refer them to the appropriate service providers and insure linkage with the provider. Use of the AODA system's "Central Intake Unit" sites will be required.

It is also anticipated that some consumers transferred to the Secure Emergency Detoxification Program may require transfer back to the Mental Health Complex should it be determined that the symptoms of any related emotional illness cannot be ameliorated in the Secure Emergency Detoxification Program setting.

### **Design Specifications**

The Secure Emergency Detoxification Program will consist of two components, as described below.

#### ***1. Sobering-Up Services - Fifteen (15) Client Slots***

This service is required to be licensed under HFS 75.09

The sobering-up component is designed to assist intoxicated clients in achieving an acceptable level of sobriety. The sobering-up component is designed to be a

safe place for intoxicated clients to stabilize before returning home or to other programs or facilities. It is anticipated that the average length of stay in this component will be 8 to 12 hours.

Persons referred to the sobering-up component must be screened to determine the presence of medical problems. All persons admitted to the sobering-up component that request further assistance in addressing their alcohol or sedative related problem will be offered assistance.

Clients will not be admitted to this component if their level of intoxication requires medical supervision. If at any time during the course of the client's stay in this component complications arise requiring admission to the detox services component or to a hospital, that transfer shall be accommodated by staff, and transportation arranged, if necessary. The registered nurse available on the premises shall make decisions regarding client's medical needs.

## **2. Detoxification Services – Forty-three (43) Beds**

This service is required to be licensed under HFS 75.07

The length of stay in this component will be approximately three to five days. Clients may remain longer if medical complications arise, or if the client is awaiting admission into a particular treatment setting in the community (as determined in the discharge planning meeting).

This component of the program shall offer clients an array of therapeutic interventions including AODA education, recreational therapy, group therapy, and exposure to self-help groups, in preparation for a referral to a treatment program.

The staffing levels and therapeutic interventions will be consistent with an ASAM III.7-D level of care. The Secure Emergency Detoxification Program must have the capacity to provide ongoing monitoring of the consumer's physical condition, to administer medications, to assess the consumer's ongoing service support needs, and to refer and link to other components of the AODA or mental health system. Patients will be evaluated 7 days a week and discharges will occur based on patient readiness including Saturdays and Sundays.

Clients who through their abusive use of alcohol pose a danger to themselves or others and refuse to seek appropriate treatment of their own volition should be evaluated for possible Wisconsin Statutes 51.45 alcohol involuntary commitment proceedings. The applicant agency will be responsible for initiating such proceedings when indicated.

Transportation: Transfers may occur at any time during a 24-hour period. For the purpose of this initiative, the applicant must build into the program and budget

the capacity to provide transportation for this population to and from the Psychiatric Crisis Service and the Secure Emergency Detoxification Program.

Transportation shall be provided 24 hours/day, 7 days/week. The contracted secure emergency detoxification program shall respond to the BHD transportation requests within one hour of the request. Options for conveyance shall include non-secure vehicle, secure vehicle with two staff, or ambulance. BHD PCS staff will indicate the type of conveyance required. Clients shall not be left unattended for any reason.

Legal: Persons within the target population are often brought to PCS by law enforcement agencies, most often as a result of an emergency detention (ED), re-detention for violation of a stipulation and, at times, as a result of a three-party petition for involuntary commitment. An individual's continued detention under an emergency detention status is subject to the PCS physician's determination. A physician may discharge the person from the ED status, permit the individual to sign a voluntary admission or maintain the ED even if the individual is transported to the Secure Emergency Detoxification Services setting. Similarly, a person detained under a three-party petition or re-detained as a violation of a stipulation may be transferred to the Secure Emergency Detoxification Services Program. It is likely that a person transferred to the Secure Emergency Detoxification Services Program on ED status may have the ED removed prior to a probable cause hearing. However, a person detained through a three-party petition is subject to probable cause proceedings.

In each case -- Emergency Detention, Treatment Director's Supplement (TDS), re-detention, three party petition or Protective Custody under 51.45 -- there are certain procedures and time lines that must be followed. The secure emergency detoxification service provider will be responsible for complying with all requirements related to legal disposition. Therefore, a thorough knowledge of Wis. Statutes Chapter 51 detention and commitment procedures as they are enacted in Milwaukee County is required.

Note: As indicated persons transferred to the Secure Emergency Detoxification Services program may have been administered medication while receiving services from PCS. Continued prescription and administration of medications may be required. It is the responsibility of the detoxification services provider to maintain a stock supply of medication used in the detoxification process as well as commonly used psychotropic medications. Further, it may be necessary for the physician of the detoxification services provider to prescribe and provide medications to be used by the patient subsequent to discharge from the detoxification service for a short period of time until such time the client is linked up with a community treatment provider. The applicant should include projected medication costs into the proposed budget.

Memorandum of Understanding: Due to the direct interrelationship between the contracted agency and the Behavioral Health Division's Psychiatric Crisis Service, a Memorandum of Understanding (MOU) will be developed. The purpose of the MOU

will be to clearly define roles and responsibilities for each party. Issues to be addressed in the MOU will include: clinical and treatment expectations, referral and transportation mechanisms between BHD and the contracted provider, contract monitoring, and legal responsibilities of BHD and the contracted agency with regard to Wis. Statutes, Chapter 51, civil detention and commitment proceedings.

### **Accessibility**

The program shall be included in the telephone directory and have an information number listed in order to describe the scope of services available to the public. Brochures on the detoxification program shall be distributed to general hospitals, community agencies and to other potential referral agents (e.g. general practitioners). The program must facilitate access for physically handicapped persons and be accessible to non-English speaking clients.

### **Citizens Advisory Committee**

To ensure that the needs of residents are being sufficiently met, and that resources are being efficiently utilized, a Citizens Advisory Committee shall be established. Members of the committee may include representatives from self-help groups, police, and judicial, correctional, social service and health care systems. Other relevant persons can be added to the committee as particular issues or problems arise in administering the emergency detoxification program. The applicant should include current or proposed members of the Committee, as well as scheduled meeting dates for the term of the contract.

---

---

## **Outpatient Treatment Program Program #M002**

---

---

### **Introduction:**

It is the intent of the Behavioral Health Division to expand, diversify and modify the provision of mental health outpatient treatment services to include additional providers, modify intake and treatment practices/protocols and to ensure that the providers have the capacity to provide substance abuse treatment services to persons presenting with a serious and persistent mental illness and a co-occurring substance abuse disorder.

The development of integrated services is an expectation of outpatient providers. Further, the development of COD capacity among outpatient as well as among other “level of care” providers will occur through a collaborative approach that will emphasize “Best Practices” within the field. It is our expectation that outpatient providers will engage with BHD in the development of COD capacity shortly after initiation of a purchase of service contract.

### **Eligibility Standards**

- Milwaukee County Resident
- Age 18 or older
- Are indigent or without current insurance benefits and are determined eligible for services as determined through application of Wisconsin Health and Family Services Administrative Rule, HFS 1.1001 Without current insurance benefits for mental health outpatient services
- Meets criteria for DSM IV mental health diagnosis

### **Referral Process**

- For the purposes of this application, all referrals for outpatient treatment will emanate from either and only from the Behavioral Health Division’s (BHD) Acute Inpatient services or Crisis Walk-in Clinic.

### **Target Population**

- These are individuals who need varying levels of service. Individuals in need of adult mental health outpatient have an array of diagnoses including the majority of individuals experiencing affective disorders such as major depression, bipolar disorder, and some situational depressions. The remaining individuals are persons who experience major thought disorders such as schizophrenia. Many individuals served in outpatient have an accompanying substance abuse

disorder. Individuals having a mental health disorder, as described above, may have a co-occurring substance abuse disorder (COD). Although not known with certainty, it is estimated that 60% of all individuals having a mental illness also have a substance use disorder.

Individuals having a mental health disorder, as described above, may have a co-occurring substance abuse disorder (COD). Although not known with certainty, it is estimated that 60% of all individuals having a mental illness also have a substance use disorder.

## **Services**

- Diagnostic evaluation
- Documentation of ongoing assessment, treatment planning and evaluation
- Medication prescription, monitoring and teaching
- Individual, group and family therapy: (Note: We believe that therapy, in addition to medication prescription and management is an important adjunct in the treatment of many persons having a serious mental illness or co-occurring disorder). In addition to therapy groups are included educational groups such as symptom and medication management as well as AODA education groups.
- Psychological evaluation and assessment when indicated
- Treatment for consumers with co-occurring MH/AODA diagnoses
- Situational case management: This type of office-based case management is intended to 1. be brief interventions of short duration to engage and assist consumers in resolving immediate situation events in their life, such as loss of housing, obtaining income and coordinating appointments. 2. Services that are intended to improve client compliance with intake and ongoing appointments (Note: The applicant is encouraged to demonstrate, through their application, suggested methods that can be applied to reduce intake and on-going appointment “no-shows”. The current rate for intake appointment “no-shows” is approximately 50% whereas the estimated “no-show” rate for regularly scheduled ongoing appointments is estimated to be 30-35%).
- Scheduled “Walk-in” times for enrolled service recipients who have missed their scheduled appointment.
- Intramuscular medication injections
- Clozaril management
- Acquisition and use of Sample medications to the extent possible.
- Patient Assistance Program (PAP) management: Pharmacy support services to promote
- client eligibility for low or no cost medications.
- “Winged Victory”, a benefit advocacy and acquisition program (SSI, T-19) contracted to BHD, currently provides these services to currently contracted BHD Outpatient service provider. Winged Victory, in collaboration, with the contracted outpatient service providers, will continue to do so. If the client is approved for SSI s/he will immediately receive T-19. If the client is approved for SSDI, the client may immediately apply for T-19, but in order to receive

Medicare, the client must have a demonstrated disability lasting two years. If the client receives T-19, the contracted outpatient provider may elect to continue to provide services to the client outside of the BHD contract or seek to transfer the client to a provider accepting and providing behavioral health services to T-19 recipients. The contracted outpatient provider must assist the client in transferring to a T-19 provider and ensure, to the best of their ability, continuity in care.

- Laboratory services, to ensure that the prescribed medication(s) are maintained within therapeutic levels, are provided through licensed facilities.
- Other services as listed in the accompanying CPT Service Code Chart

All services are to be provided through empathic, hopeful and integrated relationships utilizing a team approach that emphasizes the incorporation of recovery oriented principles into all aspects of care.

**Service Reporting  
Data**

**2006 Service Volume**

|   |        |
|---|--------|
| FAMILY PSYCHOTHERAPY (Hourly)   | 1      |
| GROUP PSYCHOTHERAPY (Hourly)  | 298    |
| MEDICATION INJECTION (15 minutes)   | 1,445  |
| MEDICATION MANAGEMENT (15 minutes)  | 10,044 |
| OP INDIVIDUAL PSYCHOTHERAPY 20-30 Minutes                                     | 898    |
| OP INDIVIDUAL PSYCHOTHERAPY 20-30 WITH MED MGMT                               | 2,177  |
| OP INDIVIDUAL PSYCHOTHERAPY 45-50 Minutes                                     | 1,900  |
| OP INDIVIDUAL PSYCHOTHERAPY 45-50 WITH MED MGMT                               | 67     |
| OP INDIVIDUAL PSYCHOTHERAPY 75-80 Minutes                                     | 10     |
| PRESCRIPTION ASSISTANCE PROGRAM MANAGEMENT (15 minutes) *<br>Captured in 2006 | Not    |
| PSYCHIATRIC DIAGNOSTIC INTERVIEW (Hourly)                                     | 1,137  |
| PSYCHOLOGICAL TESTING (Hourly)<br>Captured in 2006                            | Not    |
| SITUATIONAL CASE MANAGEMENT (15 minutes) **                                   | 3,101  |
|   |        |
|   |        |

\* Prescription Assistance Program Management: Pharmacy support services to promote client eligibility for low or no cost medications

\*\* Situation case management: This type of office-based case management is intended to be brief interventions of short duration to assist consumers in resolving immediate situation events in their life, such as loss of housing, obtaining income and coordinating appointments.

**Note:** Contractor must also be, or become, an approved Wisser Choice provider in order to fulfill the requirement to deliver substance abuse services to those clients in need of them. The client would need to be Wisser Choice eligible and this will be done through the CIU/Comprehensive Screening process. The contractor will then utilize the existing Wisser Choice mechanisms for authorization and payment under the voucher system.

### Descriptive/Demographic Information-2006 Outpatient Program Data

3477 Open cases

#### Average Age

| Outpatient Program | Average Age |
|--------------------|-------------|
|                    | 44.6        |
|                    |             |

#### Gender

| Gender |      |             |
|--------|------|-------------|
| F      | M    | Grand Total |
| 1673   | 1804 | 3477        |

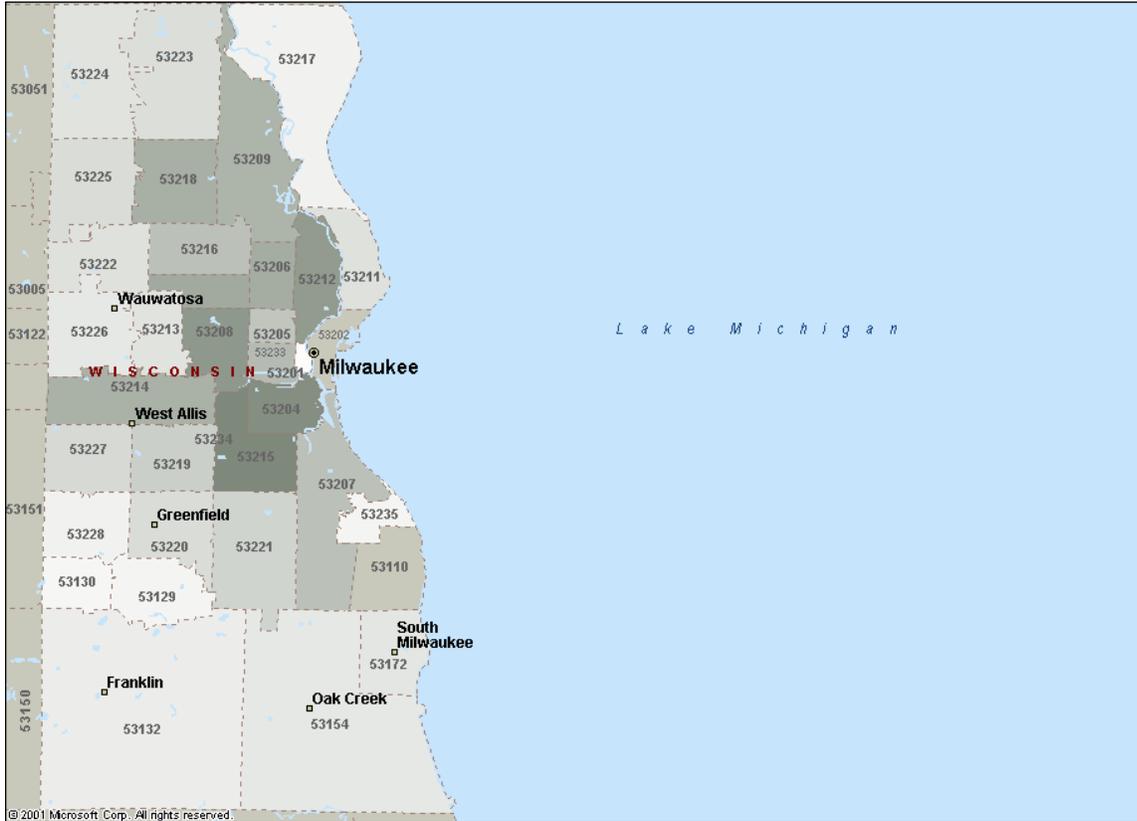
#### Ethnicity

| AFRICAN AMERICAN | AMERICAN INDIAN | ASIAN | HISPANIC | UNKNOWN | WHITE | Grand Total |
|------------------|-----------------|-------|----------|---------|-------|-------------|
| 1183             | 16              | 24    | 277      | 39      | 1938  | 3477        |

Diagnosis Axis I Categories

|      |  |
|------|--|
| 32   | Adjustment Disorders                       |
| 313  | Anxiety Disorders                          |
| 3    | Dissociative Disorders                     |
| 1    | Eating Disorders                           |
| 11   | Impulse-Control Disorders                  |
| 1699 | Mood Disorders                             |
| 16   | Personality Disorders                      |
| 906  | Psychotic Disorders                        |
| 1    | Sexual Disorders, Gender Identity Disorder |
| 1    | Sexual Disorders, Paraphilias              |
| 10   | Somatoform Disorders                       |
| 173  | Substance Related Disorders                |
| 311  | None Recorded                              |
| 3477 | Grand Total                                |

## Zip Code Counts Current Caseloads



|       |     |       |     |
|-------|-----|-------|-----|
| 53110 | 60  | 53217 | 23  |
| 53129 | 22  | 53218 | 164 |
| 53130 | 17  | 53219 | 99  |
| 53132 | 37  | 53220 | 69  |
| 53154 | 48  | 53221 | 86  |
| 53172 | 51  | 53222 | 59  |
| 53201 | 8   | 53223 | 64  |
| 53203 | 5   | 53224 | 54  |
| 53204 | 232 | 53225 | 71  |
| 53205 | 115 | 53226 | 44  |
| 53206 | 170 | 53227 | 77  |
| 53207 | 127 | 53228 | 26  |
| 53208 | 208 | 53233 | 136 |
| 53209 | 155 | 53234 | 2   |
| 53210 | 172 | 53235 | 22  |
| 53211 | 59  |       |     |
| 53212 | 203 |       |     |
| 53213 | 54  |       |     |
| 53214 | 158 |       |     |
| 53215 | 242 |       |     |
| 53216 | 129 |       |     |

## **Service Access**

- Appointments for persons referred by BHD's Acute Inpatient services must be scheduled for an intake appointment within two (2) weeks after the referral from the acute inpatient service.
- Appointments for persons referred by BHD's Crisis Walk-in Clinic (CWIC) shall be scheduled for an intake appointment within thirty (30) days of referral from CWIC.
- Provide emergency telephone "on-call" services 24/7/365
- Provide services in a culturally competent environment for the population to be served; ensure that the facility(ies) are ADA compliant with regard to access.
- The current process for outpatient referrals is for the referrant, i.e., BHD Acute Inpatient or CWIC, to call the outpatient clinic selected and to schedule an intake appointment. Historically, fifty percent (50%) of all scheduled intake appointments have resulted in a "no show" for the appointment on the part of the client. This, most often, results in a return to CWIC for further service and re-referral for another intake appointment.

The high "no-show" rate for intake appointments is problematic for the referrant, the receiving outpatient clinic and, of course, the client. Over the years, several strategies have been employed to reduce the intake appointment "no-show" rate. These strategies have not proven successful. Regularly scheduled ongoing appointments subsequent to intake also have a "no-show" rate that is excessive, but not nearly as high as for the initial intake appointment. This suggests that if clients keep their scheduled intake appointments, there is less probability that the client will miss regular ongoing appointments. It also suggests that the initial engagement of the client plays a significant role in retaining the client in service.

The applicant is encouraged, through their narrative response, to suggest methodologies that may be successfully employed to reduce the "no-show" rate of intake and regularly scheduled ongoing appointments.

## **Recovery**

The concept of "Recovery", when applied to persons having a serious mental illness, simply means that individuals can achieve a productive and fulfilling life; that they, in conjunction with others, including providers of mental health treatment, can achieve "more meaning, more purpose, more success and more satisfaction" in their lives.

In response to this RFP, the applicant should demonstrate in the proposal narrative their knowledge of recovery principles and how it will integrate the principles of recovery into the provision of outpatient treatment and how the provider will partner with the consumer in the attainment of recovery. For example, the applicant may demonstrate a partnership with the consumer in the development of a recovery oriented treatment plan or include consumers in the process of ongoing program development.

## **Communication**

- Monthly participation in SAIL outpatient operations meetings
- Consultation to ensure continuity of patient care with BHD inpatient medical staff regarding common patients.
- Upon notification of patient hospitalization by SAIL, the outpatient clinic will fax the outpatient treatment plan, current medication list and last three (3) progress notes to the Acute Inpatient Service within on (1) business day.
- Outpatient prescriber to contact and collaborate with the inpatient treating team within 72 hours of admission.
- Outpatient clinic staff to collaborate with primary care, external case management and other significant providers in the development of outpatient plan of care.
- On-going communication with SAIL, Crisis Service & Inpatient Service to address any system issues or related concerns in a timely manner.
- Professional disagreement between BHD and clinic providers to be decided by the medical directors of the two programs

## **Information Management**

- •The contractor is required to submit accurate and timely information on patient demographics, episode and service data as described in this RFP. This information supports all state and county reporting requirements related to performance monitoring, service reporting, service payment as well as HSRS. Contractor must monitor service utilization at the client level and it is expected that episodes of care will be closed on those clients without contact for six (6) months. Monitoring mechanisms must be in place to assure this activity is carried out.

## **Documentation**

- •All services must be documented through an entry in the case record. The documentation must include:
  - date of service;
  - type of service;
  - length of service contact;
  - who the service contact was with;
  - location of service; and
  - description of the contact.
- Treatment plans specify measurable target goals and case notes reflect interventions and progress toward accomplishment of these goals and are regularly adjusted as client circumstances warrant. Treatment plans updated in accordance with Administrative Rule.
- Informed consent for any financial obligations under HFS 1 relating to treatment at the agency

## **Certifications/Licensure/Compliance**

- All applicants must be currently certified as a state approved mental health outpatient treatment provider under Wisconsin Health and Family Services Administrative Rule HFS 61, (61.91, Outpatient Psychotherapy Clinic).
- All applicants must be currently certified as a state approved substance abuse treatment provider under Wisconsin Health and Family Services Administrative Rule HFS 75 OR indicate that it will achieve such certification within six (6) months of contract award.
- Compliance with Health Insurance Portability and Accountability Act of 1996 (HIPPA), privacy rule 45 CFR Parts 160 and 164.
- Compliance with HFS 94, Patient Rights.

## **Medication**

- Informed consent obtained and teaching documented
- Monitoring to include blood pressures, weights, and lab tests when appropriate
- Prescription renewal for stable clients through use of medication groups when possible

## **Contract Management**

- Service management through BHD SAIL unit, Outpatient Services Manager
- Cooperation with SAIL utilization review process
- Updating of consumers status relative to eligibility criteria at each appointment
- All services reported according to requirements specified elsewhere in the mental health RFP

## **Reimbursement**

During the initial year of the contract, mental health treatment services will be reimbursed on a net expense basis up to one-twelfth of the contract amount each month. New providers may request, as part of their application, start-up cost reimbursement. A separate "Start-up" budget must be included as part of the application submission. A narrative explanation of the need for and use of start-up funds must also be included. While start-up costs, combined with program operation costs, may exceed one-twelfth of the contract, the amount paid for start-up are part of the total contract award made to the outpatient provider.

Alcohol and other drug abuse services shall be reimbursed on a fee-for-service basis separate from the mental health contract amount (See Information Management Section).

It is the intent of the Behavioral health Division to change reimbursement mechanisms from a net expense payment system in 2007 to a fee-for-service payment mechanism for mental health services in 2009. CY 2008 will be used to collect sufficient accurate data necessary to establish reimbursement rate for the various CPT codes to be utilized in 2008.

---

## **Employment Programs Program #M004**

---

As part of the recovery process, employment opportunities can give meaning and hope for people recovering from the impact of a severe mental illness. The Behavioral Health Division provides funding for Community Employment for persons who have had a serious and persistent mental illness.

The Behavioral Health Division provides employment services for mental health consumers who may need more support and supervision to secure employment. Community Employment Programs (CEP) assists mental health consumers who may not otherwise be employed in more traditional settings. The Community Employment Programs assist mental health consumers with preparation for employment, and provide an important role with the consumer to assure a successful job placement.

### **Community Employment Program Requirements**

- 1) Refer potential Community Employment Program (CEP) enrollees to the Behavioral Health Division's Service Access to Independent Living (SAIL) unit. The SAIL unit will assess the need for CEP services and make referrals to the contracted provider. Upon acceptance by the CEP the service provider will request a Prior Authorization from SAIL to provide service for an estimated time period.
- 2) Assist consumers to obtain instruction on job preparedness, job seeking skills, and job retention skills. Secure competitive employment.
- 3) Provide job coaching and other means of supporting the consumer while seeking employment and while employed. (e.g. mobility training) Provide technical assistance/support to employers.
- 4) Assist the consumer to obtain community employment within a three-month period following enrollment in the community employment program. If consumers do not obtain employment within three months, the case should be closed by the employment program and re-referred by the case manager.
- 5) Provide ongoing support to the consumer for a period of three months after acquisition of employment, if needed.
- 6) Request prior authorization from SAIL prior to the end of the authorization period. If additional time in the program is indicated, in order to determine the appropriateness of continuation in the program.
- 7) Coordinate services and assist in transitioning of CEP referrals with case management staff, in order to assure on going support with case management staff after the program participant's case is closed.

### **Consumer-Based Program Outcomes**

Community employment program participants' progress reports should be submitted on a monthly basis. A summary of the monthly reports should be submitted on a quarterly basis.

Key statistical reporting should:

- Identify consumers who have been employed for 90 days or longer
- Specify the type of employment.
- Track the numbers of hours consumers work.
- Identify the number of individuals maintained during the current year who were placed the previous year.

Semi-annually the provider must submit a report identifying various consumer outcomes as a result of their participation in community employment. (e.g. increase wages, positive pathways to new job skills, indicators of consumers' choice and achievement of their goals.) Providers must also submit three personal participant surveys on a quarterly basis.

### **Unit of Service for Community Employment Programs**

For Community Employment, a unit of service is one-quarter hour of direct service time. **Direct service time** is staff time spent in providing services to the program participants, which includes face-to-face contacts (office or field), collateral contacts, telephone contacts, client staffing sessions, and time spent in documentation of service provision. (Direct service does not include indirect time such as that spent at staff meetings, in-service training, vacations, etc.)

**Collateral contacts** are face-to face or telephone contacts with persons other than the program participants who are directly related to providing service. Collateral contacts should include contacts with family members, other service providers, physicians, school personnel, clergy, etc.

---

## Community Living Support Services Program

---

### **PROTECTIVE PAYEE PROGRAM #M013**

---

Protective payee programs provide services to individuals who have a primary mental illness and require assistance with financial management in order to live independently in the community. They do not require residential or case management services but may need representative payeeships, financial counseling, budget teaching and referral for any additional entitlement.

Protective payee programs are expected to work toward having consumers gradually assume more control over their own finances, with the goal of eventual independence in financial management, in keeping with the skills and abilities of the individuals. The program is also expected to document the anticipated outcomes and monitor progress toward those outcomes.

#### **Access**

Access to contracted payee ship services is achieved through referral from SAIL-Service Access to Independent Living. For agencies with existing caseloads, SAIL will use the referral process to fill cases lost to attrition or division.

#### **Unit of Service**

The unit of service for protective payee services is one-quarter hour of direct service time. Direct service time is staff time spent in providing service to the program participants, which includes face-to-face contacts (office or field), and time spent in documenting services. Not included in direct service time are staff meetings, in-services, etc. Direct service time also includes collateral contacts which are face-to-face or by phone. Collateral contacts are those individuals involved by virtue of their relationship to the program participant, i.e., family, physician, and other service providers.

#### **Documentation**

Service time must be documented through an entry in the case notes. All records for individuals served must be kept in a central file with documentation, which includes: date of contact, type of contact (face-to-face, phone, collateral, etc.) and length of contact. A case plan must include income, monthly budget and disbursements, anticipated outcomes and methods used to attain outcomes, as well as progress towards achievement of outcomes.

## **PSYCHOLOGICAL DROP IN CENTER #M014**

---

Psychosocial clubs serve as points of soft entry for individuals experiencing severe and persistent mental illness. They are based on the concept of involvement and acceptance as a required component of engagement in broader community membership. Clubs are meant for individuals with severe and persistent mental illness living in the community and in need of social experiences and movement toward recovery.

Members of the club volunteer their time to participate in the planning and carrying out of club activities, which include: social/recreational groups, community outings, and travel/tour activities. While members are free to select elements of the offerings, they are encouraged to be an integral part of the planning and growth of meaningful activities, as well as providing mentorship for new members. The club also needs to contain some elements of prevocational activity, i.e., a job club, so that individuals have an opportunity for enhanced movement toward recovery.

In order to ensure that individuals experiencing severe and persistent mental illness are welcome within the club, and that adequate numbers of members are served, it is essential that outreach be done to programs serving that population, i.e., CSP and TCM. Vendors are encouraged to explore transportation options to make programs more accessible. They are also encouraged to have Board members who can assist with fund raising, legal issues and community support.

### **Target Population**

The primary population to be considered for this program is persons with severe and persistent mental illness; in particular those referred by Behavioral Health Division providers.

### **Unit of Service**

Vendors will be reimbursed for expenses up to 1/12(one-twelfth) of the annualized contract per month. The reimbursement will be for actual expenses or 1/12(one-twelfth) of the contract amount; whichever is lower, based upon a review of the vendor's monthly billing statement. The format of the billing statement will be determined by Behavioral Health Division and may include program, occupancy costs, equipment costs and other expenses found to be appropriate. The billing statement shall be submitted on a monthly basis.

### **Documentation**

Financial records/ CPA audit, annual report of numbers of members served and sources of referrals.

## **PSYCHOLOGICAL REHABILITATION PROGRAM (CLUBHOUSE MODEL) #M015**

The Clubhouse Psychosocial Rehabilitation Program is a model of psychiatric rehabilitation, which operates as a club with participants as members, rather than clients. Central to its philosophy is the belief that work is important for all people and that people experiencing mental illness, even severe illness, have potential to grow and develop and to make productive contributions to the community. Parallel to the importance of work, individuals have a need to have opportunities for socialization. The clubhouse provides a place for social interchange, relationships and social support in the evenings, on weekends and especially on holidays.

The clubhouse is to have significant representation of their membership on the Board. It is also expected that members will have full membership in the planning processes and all other operations of the club. Because entry to a club may be difficult for some potential members, it is important that there are other members available and able to mentor incoming members. It is also important to have a flexible entry process, allowing for individualized needs to be met.

While work is an essential part of the clubhouse model, prevocational and engagement efforts need to be available and tailored to the individual's needs. It is anticipated that with increased socialization opportunities, individual isolation will decrease, members will be more willing to consider the other opportunities the club has to offer and begin the journey toward recovery and full community membership.

### **Target Population**

The primary population to be considered for this program is persons with severe and persistent mental illness; in particular those referred by Behavioral Health Division providers.

### **Unit of Service**

The vendor will be reimbursed for expenses up to 1/12(one-twelfth) of the annualized contract per month. The reimbursement will be for the actual expenses of the 1/12(one-twelfth) or the contract amount; whichever is lower, based upon a review of the vendor's monthly billing statement. The format of the billing statement will be determined by the Behavioral Health Division and may include program staff, occupancy costs, equipment costs and other expenses found to be appropriate. The billing statement shall be submitted on a monthly basis.

### **Documentation**

Financial records/CPA audit, annual report of numbers of members served and sources of referrals.

---

---

**Community Based Residential Programs  
Program # M011**

---

---

Community based residential programs provide services to persons having a serious and persistent mental illness with a living environment that: 1) provides the support necessary for an individual to live as independently as possible in a structured group residential setting; 2) continually promotes the acquisition of skills necessary for the consumer to transition to more independent living; and 3) actively pursues movement to a more independent living environment in conjunction with the consumer and other members of the consumer's support network.

While residing in the community based residential facility consumer will actively participate in development of his/her service plan, goals and means to achieve them. It is also expected that the community based residential facility (CBRF) staff and other members of the consumer's support network will offer the consumer the means to acquire or further develop the skills necessary to function more independently.

Services provided by CBRFs will include the provision of twenty-four hour supervision, the provision of meals and dietary management, individual counseling, support groups, medication education and monitoring, financial management (benefit advocacy and representative payee-ship), care coordination, and crisis prevention. These services will be provided by the community-based residential facility staff in conjunction with other members of the consumer's support network.

If a CBRF resident is assigned to a case management agency, the group home staff will collaborate with the case manager when developing the individual service plan. A copy of the case management agency treatment plan will be readily available to group home staff (in the consumer's CBRF record) and all treatment plans will identify agency/individual accountabilities. The CBRF staff will be responsible for a minimum of one contact with case manager, or assigned agency representative, per week to discuss issues related to consumer's treatment.

In addition to these services, CBRF providers will develop programming for a minimum of five groups, which will be made available to consumers. Staff will be trained to facilitate these groups and choice of groups will be determined by the needs of consumers residing in the individual agency's community-based residential facilities. Suggestions for groups would include, but are not limited to, life skills, anger management, dual diagnosis, spirituality, stress management, recovery, medication education/symptom management, leisure skills, and social skills.

Upon admission to the group home and at Individual Service Plan Evaluations, a set of discharge criteria must be established. It is important that this set of discharge criteria be specific as to the level of functioning the resident must obtain in order to live in a less restrictive setting in the community. This criterion needs to outline the steps that the individual must achieve in order for discharge to take place. Criterion must be

individualized and measurable. This criterion must be established and maybe included in the individual service plan and reviewed at the same interval as this plan.

### **Community-Based Residential Program – Other Requirements**

1. Enrollment into a community-based residential program is implemented through a referral from the Behavioral Health Division's Service Access to Independent Living (SAIL) Unit. The SAIL Unit will assess the need for community-based residential care and make referrals to contracted service provider. When a consumer is in an acute care setting, the residential provider agency will do a face-to-face assessment within 72 hours after receipt of the referral packet from SAIL.
2. All Behavioral Health Division contracted community-based residential facilities must be licensed by the State of Wisconsin under Wisconsin Administrative Code HFS 83.
3. Consumers residing in a community-based residential facility are subject to the ability to pay provisions of Wisconsin Administrative Code HFS 1, Uniform Fee System, which requires that consumers in a non-medical residential program are liable for the cost of their care based upon their ability to pay CBRF Program Requirements

### **CBRF Admission Policy**

It is the policy of the BHD that individuals referred for CBRF placement by SAIL will have an evaluation completed and a decision regarding admission will be reported to SAIL (per HFS 83 Guidelines) within three business days of receipt of that referral.

### **CBRF Inpatient Contact Policy**

It is the policy of the BHD that, when a CBRF resident is admitted to a psychiatric inpatient unit, the CBRF residential coordinator responsible for that client must contact the appropriate inpatient team within one business day of the admission in order to develop a plan of discharge.

### **CBRF Service Utilization Policy**

It is the policy of the BHD that CBRFs have a service utilization review process to identify consumers who might be candidates to transition to less intensive models of community support (in accordance with HFS 83 Standards) and when appropriate to effect these changes.

### **Unit of Service**

One day of care in a community-based residential facility equals a unit of service.

### **Documentation**

1. Resident case records maintained by the agency shall include daily attendance logs.
2. All case records must maintain the Individual Service Plan for each individual.
3. Participation in planned treatment groups must be documented within the client record and include the type of group and duration of time provided.
4. Individual Service Plans must be completed within 30 days of admission to the group home.
5. Client files must demonstrate coordination with the assigned case manager.

---

---

**Community Support Program (CSP)  
Program # M012**

---

---

## **General Proposal Requirements**

### **Definition**

This program represents the most comprehensive and intensive community treatment service model. A Community Support Program or "CSP" is a coordinated care and treatment program that provides a comprehensive range of treatment, rehabilitation and support services through an identified treatment program and staff to ensure ongoing therapeutic involvement individualized participant centered treatment, rehabilitation and support service in the community where participants live, work, and socialize. Treatment and rehabilitation services are individually tailored with each participant through relationship building, individualized assessment and planning, and active involvement with participants to achieve individual goals, to better manage symptoms, to maintain hope and optimism, and to live and work in community settings of their choice.

### **Target Population**

- be a Milwaukee county resident;
- be at least 18 years of age and under the age of 60;
- meet the diagnostic and functional criteria outlined in Wisconsin Administrative Code HFS 63;

### **Program Requirements**

#### CSP Admission Policy

It is the policy of the BHD that individuals hospitalized on psychiatric inpatient units and referred to a CSP by SAIL will be admitted (per HFS 63 guidelines) to that CSP within three working days of receipt of that referral.

#### CSP Inpatient Contact Policy

It is the policy of the BHD that, when a CSP client is admitted to a psychiatric inpatient unit, the CSP which serves that client must contact the appropriate inpatient treatment team within 24 hours of notification of the admission by the treatment team in order to develop a plan of discharge.

#### CSP Service Utilization Policy

It is the policy of the BHD that Community Support Programs have a service utilization review process to identify consumers who might be candidates to transition to less intensive models of community support and in accordance with CSP discharge criteria and HFS 63 standards to effect those transitions when appropriate. To include a policy and process for identifying and referring individuals who turn 60 years of age to Family Care. Community Support Programs that have CSP consumers also residing in a CBRF are to have a service utilization review process to identify goals of the CBRF

placement, length of placement and identify candidates to transition to less intensive models of housing when appropriate.

### **Case Management No Contact Policy**

It is the policy of the BHD that Community Support Programs utilize a risk management framework and assessment procedure in the event a consumer misses an appointment or is unable to be reached, as to assess and determine the appropriate course of action. These case management practice guidelines are to incorporate clinical consultation, communication, client preference and documentation as required elements.

### **Experience and Qualifications of the Organization**

Within each proposal, relative to experience and qualifications of the organization:

- a. Explain how the delivery of CSP services relates to the mission of the organization and commitment to providing this type of comprehensive community based services
- b. Describe the organization's experience and capabilities in providing Community Support Programs within a state certified CSP as defined in HFS 63, Wisconsin Administrative Code. Emphasize experiences in providing core psychiatric services as provided by an interdisciplinary team including assessment and the provision of comprehensive community based services in keeping with HFS 63 specifications
- c. Describe how HFS 63 and C.S.P. Medicaid billing requirements will be met and maintained.

### **Program Content and Methodology**

Describe throughout the treatment program narrative how HFS 63, HFS 94, Medicaid billing and HIPAA standards will be met in the development, implementation, evaluation and monitoring of the provision of C.S.P. services.

Within each proposal, relative to treatment methodology:

- a. Describe how comprehensive assessment and treatment of all psychiatric needs, including primary and secondary diagnoses will be implemented.
- b. Describe how the program will work collaboratively with the participants toward the goals of achieving greater levels of independence through a better understanding of and self management of the symptoms, increasing problem solving abilities, expanding the use of natural supports, and supporting wellness activities.
- c. Describe the composition of the proposed treatment team, the respective roles they will be performing, how teaming will occur, amount of psychiatric time available to serve participants, and the case management staff to participant ratio.

- d. Describe how the participants symptom status and psychotropic medications will be monitored along with the ability to provide higher level of responses as needed in a timely manner. Include a discussion as to how advance directives and crisis planning in keeping with the participants' preferences could be implemented.
- e. Explain how crisis responses will occur during regular working hours and after hours.
- f. Describe how the inclusion of comprehensive treatment of individuals with co-occurring mental illness and substance abuse disorders will occur.
- g. In conjunction with the participant, explain how active collaboration will occur as needed with all other essential providers outside of the CSP, such as with primary health (including dental care whenever possible); inpatient, nursing home, and correctional settings; supervised living; psychotherapy; work services; etc.
- h. Explain how productive and meaningful roles such as paid and volunteer work, supported education, parenting and parenting assistance, and other fulfilling activities will be facilitated in keeping with the desires, skills, and abilities of the participants.
- i. Describe how assistance will be provided to participants in housing, social relationships, and activities of daily living, leading towards a greater sense of personal well being and community inclusion.
- j. Describe how participants residing in supervised living arrangements will receive assistance leading towards more independent living.
- k. Specify how recovery and the incorporation of recovery principles in all treatment services will be implemented. Address the following areas:
  - (1) Developing and implementing consumer centered treatment plans with full participants' involvement and input throughout the process including the participants' signing the plan.
  - (2) Having participants and family members involved on committees and boards, paying for their involvement as appropriate, and providing the training and mentoring to facilitate more fully their participation in these roles.
  - (3) Inclusion of participants' families as valued, respected, and integral parts of the overall treatment in accordance with desires of the participants.
  - (4) Helping to foster personal recovery for each participant by providing messages of hope and inspiration, affording choices, and understanding

the importance of personal responsibility and accountability throughout the treatment process.

- (5) Developing peer and natural supports with family members and significant others.
  - (6) Assuring participants involvement in program evaluation that includes satisfaction and participant outcomes.
  - (7) Working in conjunction with participants to reduce stigma in all of the forms it is manifested.
  - (8) Providing education and training to enhance participation in these various capacities and roles.
  - (9) Hiring participants as providers.
- l. Project how much staff time will be spent in face-to-face clinical contact in the community.
  - m. Describe how accommodations will be made to work with people who are deaf or hard of hearing in keeping with their special developmental and communication needs.
  - n. Describe how the delivery of culturally competent services will be provided.

### **Quality Assurance and Quality Improvement**

Within each proposal, applicants will be required to:

- a. Explain how the organization will provide leadership and will monitor the program's day to day operation providing sufficient staff, training and clinical expertise, and participant and family support.
- b. Describe the organization's performance indicators for this program and how they will be evaluated.
- c. Describe how consumer and family satisfaction with the program will be evaluated.
- d. Explain what experience the bidder can demonstrate in providing an effective quality assurance and improvement program.
- e. Describe the areas to be addressed in an ongoing quality improvement plan.

### **Mandatory Requirements**

The following general requirements are mandatory and must be complied with.

- a. HFS 63, Wisconsin Administrative Code
  - b. HFS 94 (Patients Rights), Wisconsin Administrative Code
  - c. Wisconsin Medical Assistance Provider Handbook, Mental Health and Alcohol and Other Drug Abuse Services Handbook, Part H, Division II
  - d. Health Insurance Portability and Accountability Act of 1996 (HIPAA), privacy rule 45 CFR Parts 160 and 164.
- e. Be able to achieve CSP certification in keeping with HFS 63 and in a timely manner.

### **Unit of Service**

A unit of service is one-quarter (1/4) hour of direct service time. Direct service is the time spent providing services to consumers, which include face-to-face contact (office or community) collateral contacts, telephone contacts, consumer staffings, and time spent in service documentation. Direct service time does not include indirect time such as that spent in staff meeting, in-service training, etc.

### **Documentation**

The agency must collect information required for the BHD data reporting structures. The information required related to demographics, episode of care, State's Human Service Reporting System (HSRS), and service information. See File Layout For Contract Agency Interface.

Assessments and treatment plans must be present in the case record maintained by the agency.

Services must be documented through an entry in the case record. The documentation must include:

- (a) date of service;
- (b) type of service;
- (c) length of service contact;
- (d) who the service contact was with;
- (e) location of service; and
- (f) description of the contact.

---

---

## Targeted Case Management Program (TCM) #M0013 & #M0014

---

---

### Definition

Targeted case management is a modality of mental health practice which addresses the overall maintenance of a person with mental illness including his / her physical, psychological and social environment with the goal of facilitating physical survival, personal health, community participation and recovery from or adaptation to mental illness. Targeted case management puts primary emphasis on a therapeutic relationship and continuity of care.

### Target population

Persons served by TCM services have Axis I and / or Axis II diagnoses without the severity or persistence that qualifies them for a CSP and yet have a disorder requiring more than outpatient or ambulatory therapy. The target population is at high risk for re-hospitalization or for drifting into the chronic young adult population and/ or often have concomitant substance abuse, developmental disorders, organic illness and homelessness. Persons who are served by the program must:

- Be a Milwaukee county resident;
- Be at least 18 years of age **and if over the age of 60 have been screened for Family Care;**
- Have an Axis I diagnosis with either psychotic or major affective disorder or an Axis II diagnosis in cluster A or B, based on DSM-IV;
- Have demonstrated functional limitation in the last six months in one or more of the following areas: housing, employment, medication management, court mandated mental health services, money management, or symptom escalation to the point of requiring emergency intervention or hospitalization; and
- Be screened and found eligible for services through a SAIL assessment.

### Program levels

There are two levels of targeted case management services:

1. **Level I** (standard) TCM, **Program #M013**. Applicants are expected to provide outreach case management and must refer to the “Behavioral Health Division’s Standards of Practice for Targeted Case Management (TCM)” for further information regarding TCM program requirements, e.g., admission timeliness, staff to client ratios, services to be provided, billing and staff professional requirements. The Standards of Practice are available at the BHD Service Access to Independent Living (SAIL) office, 9201 Watertown Plank Road, (414)-257-8095.
2. **Level II** (clinic-based) TCM, **Program #M014**. Applicants are expected to provide primary clinic-based mental health services to individuals who are not appropriate for primary outreach case management services. Individuals served in this program will

have a primary serious and persistent mental illness. Programs must meet the following requirements:

- Case managers will maintain a caseload of sixty (60) consumers;
- Case managers will practice with a team approach to assure adequate coverage, team collaboration and provider support;
- Services need to be available forty (40) hours per week with on-call coverage after regular hours; and
- All documentation must meet the requirement.

In addition to mental health services, the program will provide:

- Essential payee ship and money management services
- Linkage to other health and social services
- A minimum of four outreach (in-home) visits and eight face-to-face visits per year

### **Program Requirements**

Please include specifics in the narrative on how the following would be met:

#### **Service Access**

- SAIL referrals on individuals hospitalized on BHD **inpatient** units will have service initiated **within 24, working, day hours**.
- SAIL referrals on individuals in the **community** will have service initiated within **72, working day, hours** unless otherwise indicated on the referral.
- In cases where there is **difficulty accessing** an individual the case manager will **contact the SAIL Care Coordinator** to develop strategies on how to meet and serve the consumer.
- **Within 24, working day, hours of notification of a consumer admission** to the BHD, the program is expected to contact the respective inpatient or Observation unit to collaborate on a discharge plan.
- Emergency on-call services 24/7/365.

#### **Case Management No Contact Policy**

- **Programs are required to follow the protocol identified in the “BHD Case Management No Contact Policy” developed and adopted in June 2007 in situations when a consumer misses an appointment or is unable to be reached. These practice guidelines incorporate clinical consultation, communication, client preference, and documentation and provide a risk management framework and assessment procedure for case managers to utilize for the determination of the appropriate course of action.**

#### **Utilization Review**

- Policy and process to identify consumers who are candidates to transition to less intensive as well as more intensive models of service or support in accordance with TCM discharge criteria as established by SAIL and the TCM network.
- Policy and process for identifying and **referring individuals who turn 60 years of age** to Family Care.

## **Contract Management**

- Programs are expected to maximize third party revenue, including billing for Crisis Case Management services.

## **Crisis Case Management**

- Staff capability, infrastructure, and financial resources to provide “Crisis Case Management Services (CCM)”, known as “Linkage and Coordination Services” under HFS 34, “Emergency Mental Health Service Programs”.
- Plan and process for identification of persons who are experiencing a mental health crisis or are in a situation likely to turn into a mental health crisis if more intensive supportive services are not provided.
- Submission of Prior Authorizations for the provision of CCM services to individuals who are in need of crisis services.
- Plan for following billing guidelines as described in Wisconsin Medicaid Provider Handbook Part H, Division VI for “crisis intervention services”.

## **Units of Service (UOS)**

A unit of service is one quarter hour (1/4) of direct service time. Direct service is the time spent providing service to program participants, which includes: face-to-face contacts (office or community), collateral contacts telephone contacts, consumer staffing sessions, and time spent in service documentation. Direct service time does not include indirect time such as that spent in staff meetings, in-service training, etc.

## **Documentation**

Direct service time must be documented through an entry in case notes, or narrative, for units billed. The narrative entry must include: the date of the contact, the type of the contact (face to face, collateral, phone, etc.), who the contact was with, the content of the contact, and the number of units (the length of contact). The case narrative must be contained in the case chart records maintained by the agency. In addition documentation should include the following:

- Comprehensive assessment
- Case plan per clinical standards, collaboration and identification of those involved, including **signature of the consumer**.
- Integration between the assessment, treatment plan, service delivery and progress reporting
- Evidence of a strength assessment and strength based service approach
- Stated consumer preference(s)
- Evidence of recovery focused goals, treatment plan and service delivery
- Evidence that a method is in place to assure that all services submitted for payment have met corresponding requirements and are present in the chart.

---

**Intake and Assessment: Central Intake Unit (CIU)  
Program #A005**

---

**PROGRAM DESCRIPTION: Central Intake Unit**

**Client Eligibility**

The Central Intake Unit screens individuals to determine if they meet the eligibility criteria for BHD AODA services. Services can be provided to individuals who:

- Reside in Milwaukee County;
- Are at least 18 years of age (with the exception that pregnant females of any age are eligible);
- Meet diagnostic criteria (as specified by BHD) for a substance use disorder;
- Are part of the target population; and
- Are screened and authorized for services by a BHD Central Intake Unit.

**Target Population**

BHD is targeting two populations:

1. The General Population of Milwaukee County.
2. Criminal Justice Population:
  - a) incarcerated individuals that are reentering the Milwaukee community from prison and
  - b) persons on probation or parole supervision who are facing revocation proceedings and imprisonment, and who can be safely supervised in the community while benefiting from AODA treatment and recovery support services as an alternative to revocation, and.
  - c) individuals considered for pre-charging diversion, deferred prosecution and deferred sentencing options; persons reentering the Milwaukee community from jail confinement; and those involved in the Milwaukee County felony drug court alternative to prison programs.

**Definition of Central Intake Unit Services**

1. Deliver Central Intake Unit services according to BHD policies and procedures and consistent with federal and State confidentiality and patient rights laws and regulations.
2. Oversee the operation of all CIU sites, including the provision of mobile capacity. The selected agency may be required to subcontract with BHD-specified providers for the target criminal justice population and for the general population. The vendor will assure that all sites, including those operated by the subcontractors, operate according to the same BHD policies and procedures.
3. Identify, secure (purchase or lease), furnish and equip three CIU sites.

4. Provide intake/screening services for all individuals seeking County-funded AODA services. Annual volume is projected at approximately 3,390 intake/screenings per year.
5. Conduct a computer-assisted interview in real time (expected to not exceed 2 hours per client) with each client to:
  - a) provide an orientation about AODA system services;
  - b) advise the client of the provisions of HFS 1, HFS 92, HFS 94, the federal Health Insurance Portability and Accountability Act (HIPAA), Confidentiality of Drug and Alcohol Patient Records (42 CFR Part 2) and rules related to county funding;
  - c) determine eligibility for Milwaukee County funded AODA treatment, which includes a preliminary Temporary Assistance for Needy Families (TANF) screen;
  - d) provide referral to other community resources if the client does not have a need for AODA services or is ineligible for Milwaukee County funding.
  - e) if the client meets technical eligibility criteria, perform a comprehensive screening for AODA clinical and recovery support needs in order to determine:
    - if there is a need for AODA treatment and if so;
    - the most appropriate level of treatment; and
    - what other services may be needed to support recovery.
6. Enter client data into the BHD computerized information system in real time and update as necessary.
7. Assist each client, to make an informed choice of a BHD-approved provider for clinical treatment and recovery support coordination. Choice will be informed by data shared with the client from the comprehensive screening, as well as profiles of individual providers. Under the terms of the Milwaukee Wiser Choice program, The CIU must help each client choose from among two or more providers qualified to render each service needed by the client, among them at least one provider to which the client has no religious objection. If no provider is available, the CIU will follow BHD's wait list process.
8. Obtain the client's signature on the appropriate consent forms.
9. Schedule an appointment with the BHD-approved AODA treatment provider chosen by the client.
10. Connect the client with the selected recovery support coordination agency at the time of screening, if so indicated per established criteria.
11. In the case of a client with emergent needs, work closely with the recovery support coordinator to assure that appropriate services are accessed immediately.
12. For each identified service, enter a request via the computerized BHD information system for the issuance of a voucher to pay for the service. Upon confirmation from the provider that the client has presented for service, submit the request to BHD for approval.
13. Manage the BHD wait list according to BHD policies and procedures, and in collaboration with BHD and service providers.
14. Provide initial and ongoing training for CIU employees to include instruction on the administration of the ASI, ASAM and CIU clinical

- policies and procedures. **Describe in detail the agency capability and training plan for all new hires and existing employees (if applicable)**
15. Attend all BHD-mandated related trainings and meetings.
  16. Participate in the continuing development of policies and procedures for the operation of the CIU.
  17. Develop and implement procedures that have been approved by Milwaukee County including:
    - a. Emergency procedures for the conveyance of persons to emergency medical facilities when necessary;
    - b. Management of belligerent and aggressive persons; and
    - c. Procedures to implement BHD's Appeal Processes for both clients and treatment providers.
  18. Receive data from the State-approved vendor for IDP assessments (expected volume of 1,100 per year) and enter it into BHD's information system. It is estimated that entry for each assessment will take approximately 15 minutes.

## **REQUIREMENTS OF THE CENTRAL INTAKE UNIT PROVIDER**

### **Operations**

1. **Operations.** Manage the operations of the Central Intake Unit according to BHD policies and procedures. Assure consistent business processes across all sites;
2. **Subcontracts.** Oversee the operation of all CIU sites, including the provision of mobile capacity. The selected agency may be required to subcontract with BHD-specified providers for the target criminal justice population and for the general population. The vendor will assure that all sites, including those operated by the subcontractors, operate according to the same BHD policies and procedures.;
3. **Sites.** Identify, secure (purchase or lease), furnish and equip three CIU sites (including the sub-contracted criminal justice site). Locations of sites will be based on the historical distribution of persons accessing CIU services. A north side site for the general population will be located no further north than Capitol Dr., no further south than Walnut St., no further west than Sherman Blvd. and no further east than Holton St. A south side site for the general population will be located no further north than National, no further south than Morgan Ave., no further west than 35<sup>th</sup> St. and no further east than 6<sup>th</sup> St. All sites are to be on a bus line, and facilities must meet Americans with Disabilities Act (ADA) requirements. Each site must provide interview areas that assure privacy and confidentiality.
4. **Mobile Capacity.** In order to maximize system access for clients, the agency will have mobile capacity for conducting intake and screening at locations throughout Milwaukee. Through discussion with BHD, the agency will develop a plan to allocate mobile services to fixed-site locations convenient for clients.
5. **Equipment.** The CIU must have adequate TDD/TTY, phone system, fax capability and computer equipment sufficient to meet the IT requirements, and laptop computer(s) to support mobile capacity.

6. Hours of Operation. In addition to normal, weekday hours of operation (e.g. 8:00 a.m. to 4:30 p.m.), the applicant may be required to have hours of operation at the two general population sites that provide for access at least one evening a week and Saturday mornings. Mobile Capacity must be available during normal, weekday business hours. Intake services are available on a walk-in basis.
7. Use of Best Practices for Comprehensive Screening. The CIU Operations Management Agency will use instruments and processes approved by BHD for conducting the comprehensive screening. At this time, screening protocol includes the Addiction Severity Index (ASI) with Supplemental Items followed by application of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC-2R); as well as the Clinical Institute Withdrawal Assessment (CIWA), if needed.
8. Staffing. The CIU agency will implement a staffing plan sufficient for conducting 3,990 intake/screenings annually for the hours of operation listed above. The Central Intake Unit's staff must reflect the cultural, ethnic, gender and linguistic characteristics of the community area it serves. A minimum of one staff must be English/Spanish bilingual, and as needed, provision must be made to communicate with Limited English Proficiency (LEP) clients. All CIUs must have means for communicating with vision impaired and with Deaf and Hard of Hearing clients
9. Staff Qualifications.
  - a. Persons conducting the comprehensive screening must possess:
    - a minimum of a Bachelor's degree in Social Work, Psychology, Nursing or a related human services field, and two years full-time work experience and demonstrated competencies in clinical interviewing, assessment and knowledge of substance use disorders;
    - alternatively, a minimum of a Certified Alcohol and Drug Counselor II (CADC-II) certification or equivalent from the Department of Regulation and Licensing with at least three years of experience as an AODA counselor and demonstrated competencies in clinical interviewing, assessment and knowledge of substance use disorders;
    - in addition to the demonstrated competencies for substance use disorders, knowledge and experience of mental health disorders is preferred.
    1. The clinical ability to effectively administer and interpret instruments used in the comprehensive screening; and
    2. sufficient computer skills to administer the computer-assisted interview and to enter data into the BHD information system.
  - b. At least one staff person, in a supervisory position, must be a licensed Master's level behavioral health professional with a degree in Social Work, Psychology, Nursing or other human service profession with experience and demonstrated competencies in clinical interviewing and assessment and knowledge of substance use disorders (knowledge and experience of mental health disorders is preferred). **For this position, describe in detail the capability and plan for the provision of direct supervision of screeners.**

10. Client Choice. Under the terms of the Access to Recovery program, SAMHSA requires that clients be ensured “genuine, free and independent choice” of provider for all clinical treatment and recovery support services. For the purposes of the Access to Recovery program, choice is defined as “a client being able to choose from among two or more providers qualified to render the services needed by the client, among them at least one provider to which the client has no religious objection.” The CIU Operations Management Agency and its staff must implement practices to assure that clients have informed choice. CIU staff must take all measures to assure that the assistance they provide clients in the selection process is based entirely on the client’s reported needs and preferences, rather than on any bias in favor of or against any particular provider. Acceptance of any form of compensation, monetary or other, in return for steering a client toward choosing a particular provider is prohibited.
11. Confidentiality. The CIU agency and its staff must have a thorough understanding of and policies/procedures to comply with Wisconsin patient rights (Wisconsin Administrative Code HFS 94) and confidentiality regulations (HFS 92); the Code of Federal Regulations, 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records; and the Privacy and Security Rules of the federal Health Insurance Portability and Accountability Act (HIPAA)

---

## **Behavioral Health Division Information Systems Requirements**

### **Data Requirements**

The selected contractor will be required to comply with the Behavioral Health Division's (BHD) Management Information System data needs. This data includes, but is not limited to, consumer registration data, service data, agency financial data, performance measurement data and data required by the State of Wisconsin, including Human Services Reporting System (HSRS), etc. The contractor will have the sufficient technological capacity to adapt agency data systems as necessary to accommodate any and all changes to data reporting requirements as required by BHD. Changes have included, but are not limited to, compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards and the Remote Access Project data collection and reporting requirements.

All electronic data files required will meet BHD file format requirements (in the development phase). Should modifications to these requirements be necessary, the contractor will comply with any required modifications to meet these requirements as requested by BHD within 90 days of written notification. Failure to comply with required reporting requirements will result in withholding of payment.

The contractor will be required to report all necessary information in a timely manner consistent with the needs of BHD.

### **Hardware, Software and Procedural Requirements**

The contractor will also need to meet the minimum computer hardware and software standards as specified by both the BHD and the Milwaukee County Information Management Services Division.

Our current usage of web based access to the CMHC MIS in both mental health and substance abuse the minimum requirements are that all personal computer equipment used to access CMHC should be at least a Pentium IV or Athlon XP Pro, 512 MB of memory, CD-ROM drive or access to network CD-ROM for installation, 300 MB of free disk space or higher for installation and working space during processing, 800 x 600 SVGA display with 256 colors and 16MB of video RAM, Parallel port, TCP/IP Ethernet connection of 10BT, 14" color monitor capable of SVGA display running Windows 2000 Professional or Windows XP Professional. Microsoft Internet Explorer 6.0 or higher.

Each computer should also have a 56K modem installed but broadband access is recommend for best performance. Required software includes Microsoft Office.

The contractor will also be required to obtain communication software necessary, i.e., PC Anywhere 11.0 or above, to access the BHD local area network as well as BHD's primary database.

The contractor will be required to complete and submit a User Login Request form and Confidentiality Statement for each agency employee requiring access to the BHD primary database or local area network. BHD will provide the technical support to establish connectivity to the BHD local area network and primary database. The contractor will be solely responsible for subsequent technical support. **BHD Management Information Staff will not provide on-going technical support to contract agencies.**

Please complete the [Information System Requirement Checklist](#) and attach to your proposal.

## Outpatient Reporting Requirements

The following three files are to be submitted once a month for all clients served under the vendor's contract with the Milwaukee County Behavioral Health Division (MCBHD). The files are due on the 8<sup>th</sup> of the month and must contain all clients served during the previous month (files 1 and 2) and all services provided during the previous month (file 3). The files should be delimited text files (a separate delimited text file for each of the three files). The files must be transmitted to MCBHD electronically to MCBHD's secure server.

### FILE 1: DEMOGRAPHIC INFORMATION (1 record per client)

| Item                                  | Data Type | Length | Format   | Required?                                     |
|---------------------------------------|-----------|--------|--|---|
| Agency's unique client ID             | Alpha     | 20     | Right-justify  | Y   |
| MHD's unique medical record number    | Numeric   | 9      | Include leading zeroes   | N   |
| Date of last contact                  | Date      | 10     | MM/DD/YYYY   | Y   |
| Client last name                      | Alpha     | 20     |  | Y   |
| Client first name                     | Alpha     | 20     |  | Y   |
| Client middle name                    | Alpha     | 20     |  | N   |
| Street address                        | Alpha     | 26     |  | N   |
| Additional address info (apt. #, etc) | Alpha     | 26     |  | N   |
| City                                  | Alpha     | 20     |  | N   |
| State                                 | Alpha     | 2      |  | N   |
| Zip code                              | Alpha     | 10     |  | N   |
| County                                | Alpha     | 2      | 01-Milwaukee<br>02-Ozaukee<br>03-Racine<br>04-Walworth<br>05-Washington<br>06-Waukesha<br>98-Other<br>99-Unknown | N (We will default to 01 if none is supplied) |
| Birth date                            | Date      | 10     | MM/DD/YYYY   | Y   |
| Sex                                   | Alpha     | 1      | M or F   | Y   |
| Ethnic code                           | Alpha     | 2      | A-Asian<br>B-African American<br>H-Hispanic<br>I-American Indian<br>W-White                                      | N   |
| Social Security number                | Alpha     | 11     | 999-99-9999  | Y   |
| Marital status                        | Alpha     | 1      | D-Divorced<br>M-Married<br>S-Single<br>W-Widowed<br>X-Separated<br>U-Unknown                                     | N   |
| Medical Assistance Number             | Numeric   | 10     |  | N   |

FILE 2: EPISODE OF CARE/HSRS INFORMATION (1 record per client)

| Item                               | Data Type | Length | Format  | Required?                                     |
|------------------------------------|-----------|--------|---|---|
| Agency's unique client ID          | Alpha     | 20     | Right-justify   | Y   |
| Service open date                  | Date      | 10     | MM/DD/YYYY  | Y   |
| Reporting Unit                     | Numeric   | 3      | xxx   | Y   |
| Discharge date                     | Date      | 10     | MM/DD/YYYY  | Yes if Client is discharged.<br>Otherwise No  |
| Client characteristic 1            | Alpha     | 2      | See table below for list of valid values  | N (We will default to 99 if none is supplied) |
| Client characteristic 2            | Alpha     | 2      | See table below for list of valid values  | N   |
| Client characteristic 3            | Alpha     | 2      | See table below for list of valid values  | N   |
| Commitment status                  | Alpha     | 2      | 01-Voluntary<br>02-Voluntary w/Settlement Agreement<br>03-Involuntary Civil - Ch. 51<br>04-Involuntary Civil - Ch. 55<br>05-Involuntary Criminal                | Y   |
| Number of children                 | Numeric   | 2      |   | N (We will default to 0 if none is supplied)  |
| Number of children living w/client | Numeric   | 2      |   | N (We will default to 0 if none is supplied)  |
| Severity/BRC Target Population     | Alpha     | 2      | H- In Need of Ongoing, High Intensity, Comprehensive Services<br>L- In Need of Ongoing, Low Intensity Services<br>S- In Need of Short-term Situational Services | Y   |

|                                      |       |   |   |   |
|--------------------------------------|-------|---|---|---|
| Presenting problem 1                 | Alpha | 3 | ABU-<br>Abuse/assault/ra<br>pe victim<br>ACT-Activity<br>level difficulties<br>ADL-Problems<br>coping w/daily<br>activity<br>AFF-Affective<br>disturbance<br>ALC-Alcohol<br>CJS-Criminal<br>justice system<br>involvement<br>DAO-Dangerous<br>to others<br>DRU-Drugs<br>ED-Emergency<br>detention<br>FAM-<br>Marital/family<br>problem<br>NTR-Nutritional<br>PHY-<br>Medical/somatic<br>RUN-Runaway<br>behavior<br>SI -Suicide<br>attempt/threat/da<br>nger<br>SOC-<br>Social/interperso<br>nal<br>THO-Thought<br>disturbance | Y   |
| Presenting problem 2                 | Alpha | 3 | Same codes as<br>above  | N   |
| Presenting problem 3                 | Alpha | 3 | Same codes as<br>above  | N   |
| DSM IV Axis I Primary<br>Diagnosis   | Alpha | 5 | No decimal  | Either Axis I<br>primary or Axis II<br>primary is<br>required |
| DSM IV Axis I Secondary<br>Diagnosis | Alpha | 5 | No decimal  | N   |
| DSM IV Axis I Tertiary<br>Diagnosis  | Alpha | 5 | No decimal  | N   |
| DSM IV Axis II Primary<br>Diagnosis  | Alpha | 5 | No decimal  | Either Axis I<br>primary or Axis II                           |

|                                     |       |   |  |  |
|-------------------------------------|-------|---|--|--|
|                                     |       |   |  | primary is required  |
| DSM IV Axis II Secondary Diagnosis  | Alpha | 5 | No decimal   | N  |
| DSM IV Axis II Tertiary Diagnosis   | Alpha | 5 | No decimal   | N  |
| DSM IV Axis III Primary Diagnosis   | Alpha | 5 | No decimal   | N  |
| DSM IV Axis III Secondary Diagnosis | Alpha | 5 | No decimal   | N  |
| DSM IV Axis III Tertiary Diagnosis  | Alpha | 5 | No decimal   | N  |
| Closing Reason                      | Alpha | 2 | 01-Completed Treatment - Major Improvement<br>02-Completed Treatment - Moderate Improvement<br>03-Completed Treatment - No positive change<br>04-Transferred to another community based resource<br>05- Administratively discontinued service (no contact with agency for 90 days)<br>06-Referred<br>07-Withdrew against staff advise<br>08- Funding/Authorization expired<br>09-Incarcerated (local jail or prison)<br>10-Entered Nursing Home or Institutional Care (IMD, CCI, etc.)<br>11-No Probable | Yes when discharge date is present (Client is discharged).<br>Otherwise No |

|  |  |  |                   |  |
|--|--|--|-------------------|--|
|  |  |  | Cause<br>99-Death |  |
|--|--|--|-------------------|--|

FILE 3: EVENT INFORMATION (1 record per service provided)

| Item                      | Data Type | Length | Format  | Required? |
|---------------------------|-----------|--------|---|-----------|
| Agency's unique client ID | Alpha     | 20     | Right-justify   | Y         |
| Staff ID                  | Numeric   | 6      | 9902 for MCW<br>9927 for<br>Recovery  | Y         |
| Staff type                | Alpha     | 2      | 01-Psychiatrist<br>02-Physician<br>03-Psychologist<br>04-Psych Social<br>Worker<br>05-Case Worker<br>06-M/H Assistant<br>07-O/T<br>Registered<br>08-O/T Assistant<br>09-Recreation<br>Therapist<br>10-Music<br>Therapist<br>11-Cert. O/T<br>Assistant<br>12-Psych<br>Resident<br>13-Registered<br>Nurse<br>14-Registered<br>Nurse Master<br>15-AODA<br>Counselor<br>16-Rehab<br>Counselor | Y         |
| Reporting unit            | Numeric   | 3      | 610,611-MCW<br>625-Recovery   | Y         |
| Date of service           | Date      | 10     | MM/DD/YYYY  | Y         |
| Time of service           | Time      | 5      | HH:MM (time of<br>day - military)   | Y         |
| Service code              | Alpha     | 6      | <b>90782</b> -Injection<br><b>90801</b> -Psych<br>Diagnostic<br><b>90804</b> -Ind.<br>Therapy 20-30<br>min.<br><b>90805</b> -Ind.<br>Therapy w/E&M,   | Y         |

|                |         |   |   |                          |
|----------------|---------|---|---|--------------------------|
|                |         |   | 20-30 min.<br><b>90806</b> -Ind.<br>Therapy 45-50 min.<br><b>90807</b> -Ind.<br>Therapy w/E&M, 45-50 min.<br><b>90808</b> -Ind.<br>Therapy 75-80 min.<br><b>90809</b> -Ind.<br>Therapy w/E&M, 75-80 min.<br><b>90847</b> -Family Therapy<br><b>90853</b> -Group Therapy<br><b>90862</b> -Medication Mgmt<br><b>96100</b> -Psych. Testing<br><b>99361</b> -Case Management |                          |
| Duration       | Time    | 5 | HH:MM (length of time)  | Y                        |
| Location code  | Numeric | 1 | 1-At Center<br>2-Client's Home<br>3-Other Hospital<br>4-Court/Jail<br>5-School<br>6-EAP Client's Office<br>7-Community<br>9-Other Location  | N (We will default to 1) |
| Recipient code | Numeric | 1 | 1-Client Only<br>2-Collaterals Only<br>3-Family Member(s) Only<br>4-Client and Collateral(s)<br>5-Client and Family Member(s)<br>6-Client & Family & Collaterals<br>7-Telephone Contact<br>8-Staff Only   | N (We will default to 1) |

|  |  |  |                |  |
|--|--|--|----------------|--|
|  |  |  | 9-No Recipient |  |
|--|--|--|----------------|--|

**Requirements for Mental Health Contracts Only  
Residential, Work, Case Management and  
Community Support Programs**

On the 6th of each month after 1:00 PM, BHD will provide for contract agencies a list, in the form of a text file, of Client/Patient/Consumer that have an open episode on CMHC with that agency. A separate list will be provided for each provider/site/funding source combination for each Client/Patient/Consumer both in a file on diskette and electronically on a BHD file Server, to be retrieved by whichever method best fits a particular contract agency's needs. This information will be updated by the SAIL staff from Registration and Assessment Packet (RAP) Forms (both new and updates) submitted to them by the contract agency. The text file created for each contract agency each month will contain:

| Item                      | Data Type | Length |
|---------------------------|-----------|--------|
| SCRIPTS Case Number       | Alpha     | 10     |
| Client Last Name          | Alpha     | 26     |
| Client First Name         | Alpha     | 26     |
| Social Security Number    | Numeric   | 9      |
| MHC Medical Record Number | Numeric   | 9      |
| CMHC Staff ID             | Numeric   | 4      |
| CMHC Reporting Unit       | Numeric   | 4      |

**SCRIPTS Case Number** - this is the ID that contract agencies previously used to identify client to SAIL.

**MHC Medical Record Number** - CMHC/MIS system of identifying the client. This field is provided on the file to enable the contract agency to include it in their file to us thus tying the service information to the correct client in the CMHC/MIS system.

**Staff ID**- Required by CMHC/MIS and will be used as a generic staff ID to indicate that the service was provided by a contract agency. Contract agencies will not have to indicate specifically which staff member provided the service.

**Reporting Unit** - Required by CMHC/MIS. Indicates where (i.e. under what provider/site/funding source) the service was provided. One or more reporting units have been set up for each contract agency in the system.

On the 11th of each month before 4:00 PM, the contract agencies use the above text file of Client/Patient/Consumer, add the service information, and return a text file to BHD. Service information is reported in summary rather than detail - i.e. the agency reports total number of units for the month, using the last day of the month as Date of Service. The information **must** be in the following format. All fields are required.

| Item                      | Data Type | Length |
|---------------------------|-----------|--------|
| MHC Medical Record Number | Numeric   | 9      |
| CMHC Staff ID             | Numeric   | 4      |

|                     |         |   |
|---------------------|---------|---|
| CMHC Reporting Unit | Numeric | 4   |
| Date of Service     | Date    | MMDDYYYY  |
| Service Duration    | Numeric | In days, hours or 15-minute increments, depending on the service. |
| Service Code        | Alpha   | 3   |

The first three fields are the information that the MHD text file originally provided. The remaining fields must be filled in by the agency:

**Date of Service** - The last day of the reporting month.

**Service Duration** - Equals number of units of service. This should be entered as whole number units of service, i.e., units = days for residential services; hours for day treatment and work services; quarter-hour increments for CSP's and other outpatient services.

**Service Code** - Service codes as assigned by BHD – SAIL Service Manager – Information Services

BHD encourages the agencies to report electronically and will work with each agency to facilitate this process. Contract Agencies will have a variety of options available to them for completing this process. The only requirement is that the returned file must have the format outlined above.

#### **Option 1: Use a spreadsheet**

Import the provided text file into a spreadsheet, add the service information in the spreadsheet and create a file to be returned to us. The Behavioral Health Division (BHD) Information Systems staff will provide a standard spreadsheet for agency use.

#### **Option 2: Use database software**

Import the provided text file into a database application, add the service information in the database application and create a text file to be returned.

#### **Option 3: Create an extract file from their own computer system**

Extract the service information from a contract agency computer system into a file to be sent to BHD. The agency must develop their own extract and must be able to provide the data in the format described in the table above.

---

**BEHAVIORAL HEALTH DIVISION**  
**Information System Requirement Checklist**

---

Agency Name \_\_\_\_\_

Person filling out form \_\_\_\_\_

Contact Number \_\_\_\_\_

Contact E-mail \_\_\_\_\_

As of \_\_\_\_\_ (date) the agency computers have...

- Processors
  - Pentium IV or Athlon XP Pro or better
  - Less than Pentium IV or Athlon XP Pro
- Memory
  - 512 MB or more
  - Less than 512 MB
- Internet Connectivity
  - Broadband Internet access
  - 56K modem
  - Both (56K modem and Broadband)
  - Less than 56K modem, or no Internet connectivity

As of \_\_\_\_\_ (date) the agency computers use...

- Web Browser
  - Internet Explorer 6.0 or higher
  - Less than Internet Explorer 6.0 or another web browser
- Software
  - Microsoft Office
  - Not Microsoft Office

*Signed* \_\_\_\_\_

*Dated* \_\_\_\_\_

## **Section 2**

# **Delinquency & Court Services Division Program Descriptions**

---

## **DELINQUENCY AND COURT SERVICES DIVISION**

### **INTRODUCTION AND INSTRUCTIONS**

The Delinquency and Court Services Division's mission is to promote community safety through the reduction of juvenile crime by providing intake, probation, and intervention services to youth, and their families, who are the subjects of Milwaukee County delinquency proceedings.

The Delinquency and Court Services Division (DCSD) provides direct services and contracts for specific programs and services that meet the needs of juveniles, ages 10 through 16, who enter the Juvenile Court system. The primary goals for these programs and services are: (1) to provide for the community's safety by reducing the risk factors associated with delinquent behavior; (2) to ensure that juveniles are held accountable for their behaviors and court expectations; and (3) to build systems and programs that cultivate life skills and personal responsibilities within our youth. In meeting these goals we create the opportunity for every youth to become a healthy and contributing member of the community.

Services that are purchased by the Delinquency and Court Services Division are allocated to match the priorities of our service area and to manage the available resources. Substantial effort has gone into applying for grants that supplement state and county funding. The Division attempts to utilize its funds to provide a broad continuum of services for juveniles. Services range from early intervention programs, including the First Time Juvenile Offender Program, to community-based alternatives that can divert juveniles from a commitment to the State's Juvenile Correctional Institutions. The Division will continue to develop and support service models that are culturally competent, culturally diverse, and will meet the needs of our youth and their families.

For calendar year 2008, we have placed multiple programs within the RFP for Delinquency and Court Services. The remaining programs fall within multi-year contracting cycles and, based upon service needs and priorities, will be included in the RFP for a subsequent contract year.

#### **Special Instructions:**

These program elements should be addressed within Item 29b, Program Description, of your overall Program Design if applicable.

**Service/Treatment Process:**

1. List and define the program activities, purpose of the activity, and the anticipated size, structure, and schedule of the activity.
2. Describe the sequence of program activities, including counseling and treatment, if applicable. Indicate the length of time in each phase of the activity and the criteria used to move youth from one phase to the next.
3. If counseling or treatment is a program component:
  - Describe how and when individualized plans, goals, and operationalized strategies are developed and reviewed. Identify by position who is involved in this process.
  - Provide a detailed description of the issues and topics to be addressed in counseling.
  - Provide a description of the theory of change or treatment model that will be utilized. Address specific service needs of dual-diagnosis youth.
4. Describe agreements and working collaborations with other community agencies that will provide services to the target population. Describe the qualifications of the agencies and service providers. Include any letters of agreement.

**Admissions:**

1. Describe the process for screening (if applicable) and admitting youth to the program. Begin with the initial contact and include all activities that occur.
2. Describe in detail the program's intake and assessment process. If applicable, describe the involvement of any specialists such as a medical director, psychologist, or clinicians.
3. Identify program referral sources other than Milwaukee County Children's Court. Indicate the anticipated number of referrals each source will generate.

## **Discharges:**

1. If discharge decisions are made by anyone other than Children's Court staff, identify the decision-maker by position and describe the proposed basis for discharge decisions.
2. Describe the discharge process. Address aftercare services and post-discharge monitoring, if applicable.
3. Identify community-based services with which discharged youth may be connected.

## Important Note Regarding Program Evaluations:

If applying as an incumbent, summarize the process and results of your 2006-2007 program evaluation. Discuss any changes made to the program as a result of the evaluation.

For agencies under contract in 2008, Delinquency and Court Services Division requires a single, annual program evaluation report for the period July 1, 2007 – June 30, 2008. The report is due August 1, 2008.

*For Delinquency and Court Services, the evaluation reports should be submitted to:*

David Emerson, Contract Services Coordinator  
Milwaukee County Children's Court Center  
10201 Watertown Plank Road  
Wauwatosa, WI 53226

## Funding Note for 2008:

As in recent years, the uncertainties of funding for 2008 may result in significant changes in the structure or funding of our programs by the time the applications are due for submission in September. Applicants should contact the Division to check for updates to the RFP prior to writing and submitting a proposal. Inquiries should be made to Eric Meaux at telephone 414-257-7789 or email [emeaux@milwcnty.com](mailto:emeaux@milwcnty.com)

## 2008 Application Requirements and Uniform Program Numbers

### Delinquency and Court Services Division (DCSD)

The following list includes the programs for which DCSD is issuing a Request For Proposal (RFP) for contract year 2008. Agencies seeking to contract for the provision of these programs are required to submit a **complete application** package that includes all of the documents and formats as defined in the *Year 2008 Purchase of Service Guidelines – Technical Requirements* and the *Year 2008 Purchase of Service Guidelines – Program Requirements*.

New applicants should include an action plan and time frame for program start-up as part of the Program Design section of the application.

- DCSD 002 – Family Connections Program
- DCSD 008 – Level 2 In-Home Monitoring Services
- DCSD 009 – Serious Chronic Offender Program
- DCSD 010 – Adolescent Sex Offender Treatment Program
- DCSD 011 – Shelter Care

**Important:** The following programs currently fall within a multi-year contracting cycle and **are not open** to new provider agencies. The current provider agencies for these services must file a **partial application for each program** that includes all the items listed under FINAL SUBMISSION plus the Authorization To File for 2008. Please refer to the *Year 2008 Purchase of Service Guidelines – Technical Requirements*.

- DCSD 001 – Day Treatment
- DCSD 003 – Firearms Program
- DCSD 004 – First Time Juvenile Offender Program (FTJOP) - Tracking
- DCSD 005 – Foster Home Recruitment, Licensing and Case Management
- DCSD 006 – Group Care
- DCSD 007 – In-Home Monitoring

Partial applications for programs that fall within a multi-year contracting cycle are due the same date as the complete application for programs that are included in the 2008 RFP.

## **FAMILY CONNECTIONS PROGRAM**

**Program #DCSD 002**

The Family Connection Program began in April of 2005. The program was originally funded in large part through an Office of Justice Assistance grant. Although that funding will end in 2007, the Division does plan to continue the services in 2008 through other funding sources and local funding if necessary.

This program is intended to serve alleged and/or delinquent adolescent girls and their families in a curriculum based group process entitled "Creating Lasting Family Connections". This is a research-based program for strengthening families, and providing substance abuse and violence prevention services.

The Division initiated extensive research and discussions during 2004, during which time issues concerning this target group were explored and clarified. The following premises and issues emanated from that research:

1. Drug and alcohol use is endemic to delinquent girls.
2. Delinquent girls report being extremely vulnerable to the influence of older men who involve them in alcohol and drug use, as well as sexual activity.
3. Sexual activity and concern about sexually transmitted diseases are major concerns for this group.
4. Anger issues are often at the root of girl's delinquency.
5. Family relationships are very important.

More information regarding this program is available at the following link:

<http://www.copes.org/include/clfc.htm>

The original project demonstrated the unique challenge of coordinating and recruiting this type of group process for this target population. In addition, the Division has found it a challenge to ensure that a regular number of female youth would be available to reach that critical mass of participants that is essential to realizing the full impact of the group process.

As a result the Department is requesting proposals from multiple providers that can demonstrate an ability to have on-going groups (minimum goal of 8 families per group) using this model without the Department being the sole referral source. Ideally, providers would have collaborate agreements with other agencies such as municipal courts, school systems, and other social service agencies that would serve as additional sites of recruitment to ensure the routine ability to provide scheduled female groups. While female specific group proposals will be given greater consideration, the Division is willing to consider non-gender specific proposals.

## **PROGRAM DESIGN**

Applicants must address all program elements listed in the following two places:

1. Section 3, Program Design, located in the *Year 2008 Purchase of Service Guidelines - Technical Requirements*.
2. “Introduction and Instructions”, located in the front of the Delinquency and Court Services Division’s section of the *Year 2008 Purchase of Service Guidelines - Program Requirements*.

The following outline includes program specific information and responses required by the Delinquency and Court Services Division. This information should be addressed in the appropriate section of your application.

### **Program Description**

Creating Lasting Family Connections is identified as a model program by OJJDP and other federal agencies and has demonstrated significant impact on participants relative to: youth use of drugs and alcohol, increased parent-youth communication and bonding, improved use of community resources to solve family problems, and decreased violence. Specific anticipated outcomes of the program include:

- a) Improved parenting skills and family functioning among parents who complete the program.
- b) Improved youth attitudes relative to school, AODA, sexual activity, and violence among girls who complete the program.

Referral to the program will be made based on an initial screening and recommendation from Delinquency Services staff .

### **Needs and Problems**

Girls represent one-fifth (19.1%) of the referrals to Children's Court on felony or misdemeanor charges but they have longer average lengths of stay in the Detention Center than boys and are considerably more likely to have a history of involvement in the child welfare system. The confluence of delinquency and child welfare involvement often results in a pattern of multiple, unsuccessful out of home placements, repeated instances of running away, and successive, more restrictive placements, including, for some, placement in juvenile corrections.

Please provide a description of the needs and problems to be addressed by your program. This should include how your agency will coordinate and provide services to this population. The description should address how your coordinated efforts will address the issues outlined by this RFP.

### **Target Population**

The target population is intended to include girls charged with disorderly conduct and/or battery (50%) and other offenses (50%) who have had multiple referrals to Milwaukee County Children's Court. Further, the project is targeted to girls, ages 10-16, who are at an early stage in their delinquency experience (3 or fewer referrals), are living in the community with their birth/adoptive family or in long term foster care, with no prior experience in a juvenile corrections facility.

## **Specific Program Activities:**

**In addition, to the program elements contained within the published CLFC curriculum the following Specific Activities or exceptions to be performed under this proposal include the following:**

1. Providers will publish a current group schedule indicating times and locations of scheduled group start dates.
2. Providers will document youth participation or non-participation, including provider's efforts to recruit, retain, and engage youth and families in group activities.
3. Each group will meet weekly for a total of 12 weeks. The final week will consist of the one-day retreat.
4. Each group session will begin with a meal shared by girls and their parents. (The family meal has been shown to be an essential component of a successful CLFC program.)
5. Trained facilitators will facilitate each group.
6. Each group will receive 3 program modules: Module 1: Personal and Family Responsibilities; Module 2: Substance Abuse; and Module 3: "Getting Real".

## **Goals**

CLFC services are expected to provide a structured intervention to reduce a youth's risk of re-offense by addressing factors identified and potentially contributing to the youth's presenting behavior.

## **Expected Outcomes**

Outcome: Program Completion

Indicator: Number and percent of youth that complete the program.

Indicator: Number and percent of families that complete the program.

Indicator: Number and percent of youth that attend each weekly session.

Indicator: Number and percent of families that attend each weekly session.

Outcome: Improved youth behavior and attitudes.

Indicator: Number and percent of youth that demonstrate responsibility for their behavior.

Indicator: Number and percent of youth that can recognize high-risk behaviors.

Outcome: Improved family understanding of offense dynamics and ability to manage youth behavior.

Indicator: Number and percent of families that can recognize high-risk behaviors of their youth.

Indicator: Number and percent of families that show improvement in understanding family dynamics and functioning.

Indicator: Number and percent of families that increase their knowledge of available community resources.

## **Agency Experience**

In addition to your agency's overall experience in serving the target population, you must address your agency's experience with, and training in, the "Creating Lasting

Family Connections” curriculum. Either verification of CLFC certification or a plan to receive the verification within 30 days of proposal submittal is required. Details on CLFC and necessary training can be obtained at [www.copes.org](http://www.copes.org).

### **Staffing Pattern**

The successful community-based agency applying for this proposal must be able to demonstrate a plan to have certified CLFC facilitators and/or have a Master Trainer designation that would allow training of additional facilitators. Agencies may subcontract for the services of a Master Trainer if not employed by the Agency. There will be a need for 2 trained facilitators for each session.

### **Documentation**

Documentation requirements will be determined by Milwaukee County.

Individual case files must include:

- Service Authorization and referral forms.
- Initial client and family intake forms.
- Initial client and family assessments and service plans.
- Counseling notes or contact sheets to include the date of contact, the name of person contacted, services provided, the type of the contact (e.g. face-to-face, phone, collateral, etc.), times and duration of service, and the provider’s signature.
- Consent forms.
- Incident reports.
- Discharge summaries.

### **Reimbursement**

Monthly reimbursement will be fee-for-service based for a total maximum reimbursement per youth of \$650. At this time, the Department anticipates the following reimbursement for intake and group attendance. Attendance will be based on either youth or parent participation.

- Intake and Recruitment activities: \$100 per youth
- Documented 75 % attendance groups 1-4: \$150 per youth
- Documented 75% attendance groups 5-8: \$150 per youth
- Documented 75% attendance groups 9-12: \$250 per youth

## **LEVEL 2 IN-HOME MONITORING SERVICES**

**Program #DCSD 008**

The Level 2 In-Home Monitoring Program is a pre-dispositional monitoring program that is designed to serve both male and female youth. The program will primarily serve youth pending court for alleged delinquency. As requested by the Division, other youth involved in Children's Court Center matters may be placed at the discretion of the Division. The program provides intensive in-home services to youth and their families in an effort to support parental home supervision, to avoid additional offenses and to appear for their court hearings. Youth are court ordered into this program and remain until the time of disposition or discontinuation of services is deemed appropriate by the court. The program is based on the belief that juveniles who remain connected with their families, schools, peers, employers, and with other community resources, have an increased opportunity to avoid further contact with the juvenile justice system. This is accomplished through structured supervision, program support and counseling, advocacy and the availability of 24-hour crisis intervention.

The 2008 program is designed to cover 96 youth at any one time.

This program may be divided between two vendors.

### **PROGRAM DESIGN**

Applicants must address all program elements listed in the following two places:

1. Section 3, Program Design, located in the *Year 2008 Purchase of Service Guidelines - Technical Requirements*.
2. "Introduction and Instructions", located in the front of the Delinquency and Court Services Division's section of the *Year 2008 Purchase of Service Guidelines - Program Requirements*.

The following outline includes "program" specific information and responses required by the Delinquency and Court Services Division. This information should be addressed in the appropriate section of your application.

### **Program Description**

The service delivery system should include the number and type of staff used to provide program services. The design should also include a daily/weekly schedule to show that all program components are addressed and include parent participation.

## **Needs and Problems**

Provide a detailed description of how your program will address the special needs of this target population. This should include direct service activities that at a minimum must include the required components (listed in the Specific Activities section). Youth generally identified as appropriate for this program are those who have not committed a serious offense such as sexual assault, homicide or drug dealing and are not considered a significant runaway risk.

## **Specific Program Activities**

A brief description of minimum required components is described below. The scope of services is not limited to these specific descriptions.

### ***Supervision/Tracking***

The supervision component of the program provides the foundation from which all other services are delivered. Two contacts per day are expected and are to be face-to-face unless otherwise described or approved.

- The provider must perform at least one school contact per day (employment contact if not attending school) on weekdays and a home contact during the day on weekends.
- The provider must know the whereabouts of youth at all times making necessary the development of a reporting/call-in plan to ensure the adequate tracking of youth under supervision.

### ***Counseling***

Counseling services, including individual, group and family counseling, or the combination thereof, should be based on the youth's needs. Counseling services should be a minimum of five (5) hours per week.

- Individual counseling should be available to all youth. It may be in the form of structured counseling sessions or integrated into any of the other program components. Counseling can include anger management, communication skills, appropriate decision-making and self-esteem.
- Family counseling should be available to all families. The need for family counseling can be addressed in several ways, including scheduled private family sessions with the Clinician, referral to a community resource, or spontaneous sessions with the Caseworker as the result of a particular problem or issue.
- Group counseling should be available to all youth. Youth should participate in a minimum of two (2), one-hour group counseling sessions per week. The Clinician and Caseworkers must facilitate the groups. Group sessions should deal with a variety of issues such as anger management, adolescent sexuality, problem solving, appropriate decision-making and self-esteem. The primary goal of group counseling should be to develop positive behavioral changes.

### ***Crisis Intervention***

Crisis intervention services must be provided 24 hours a day on a daily basis. Clinicians or Caseworkers may provide the crisis intervention services, with oversight and guidance provided by the Clinician. The agency under contract should maintain a relationship with local law enforcement and the Mobile Urgent Treatment Team to properly respond to any crisis that creates a risk of harm or safety.

### ***Family Dynamics***

The entire family should have some involvement with the program in order to make the youth's experience more successful. The goal is to help families meet their own needs by improving interpersonal relationships and the parenting skills of the parents.

### ***Educational Services***

For youth enrolled in an educational program, the Caseworker will be responsible for meeting with the appropriate school representatives in order to build a positive working relationship and to better serve the academic needs of the youth. The Caseworker must visit the assigned school daily as part of the required face-to-face contact. If the youth is not enrolled in school when placed in the program, the agency under contract must work closely with the school system to transition the youth back into an educational program.

The agency under contract should also provide one-on-one tutoring services to youth who require these services.

### ***Pre-Vocational Services***

Pre-vocational services should be available for youth who would benefit from them. Life skills and job readiness training should be offered to increase participants' chances of finding employment.

### ***Recreational Programming***

All youth in the program should be required to participate in structured therapeutic recreational activity at least once per week. Youth should be exposed to various activities to learn alternative ways to spend their free time and promote engagement with the program.

### ***Transportation***

The agency under contract must provide transportation for youth to and from counseling sessions, court, educational and medical appointments and recreational activities.

### ***Staffing Pattern***

The Caseworker staff shall meet the criteria required by Milwaukee County DHHS for Human Service Worker and the Clinician must be licensed by the State of Wisconsin. A written description of the agency's initial orientation plan and ongoing staff development activities should be included with the application.

### ***Written Reports and Documentation***

Documentation requirements will be determined by Milwaukee County.

The provider shall maintain an accurate daily census of all active youth and discharges as requested by Division staff.

A progress report on each youth placed in the program must be submitted to the Children's Court Center on a weekly basis. In addition, a detailed report to the court must be completed for each youth and submitted in advance of the scheduled court hearing. The formats for progress reports and for reports to the court will be determined by Milwaukee County.

The agency will maintain individual case files. An initial case plan/contract will be developed with the participation of the youth and their family.

### **Goals**

The goal of the Level 2-In-Home Monitoring Program is to maintain youth within their parental or relative home, ensure court appearances, and reduce the likelihood of re-offense.

### **Expected Outcomes**

Outcome: Program Completion

Indicator: Number and percent of youth that complete the program.

Indicator: Number and percent of youth that participate in at least 5 hours of counseling per week.

Indicator: Number and percent of youth that engage in at least one recreational activity per week.

Outcome: Compliance with Court Conditions

Indicator: Number and percent of active youth that attend all scheduled court hearings.

Indicator: Number and percent of youth discharged as a result of the issuance of a warrant.

### **Reimbursement**

Reimbursement is based on actual program expenses and paid monthly. Monthly reimbursement will be limited to a cumulative 1/12 of the 2008 Milwaukee County approved contract allocation. Annual reimbursements may not exceed actual program expenses or the total contract allocation. A program specific Revenue and Expense Statement must be submitted following the end of each calendar month according to Milwaukee County DHHS policy.

This contract will be for calendar year 2008, with the option to extend the contract for two additional years.

## **SERIOUS CHRONIC OFFENDER PROGRAM**

**Program #DCSD 009**

The Serious Chronic Offender Program is designed to provide neighborhood-based mentoring and advocacy services to 45 youth who have been adjudicated delinquent and who are on stayed orders of commitment. The program employs an advocate or advocate team to work with each youth. The program will provide substantial intervention in the youth's life, will occupy a substantial amount of otherwise unsupervised time, and will provide enough supervision to protect the community.

The Serious Chronic Offender Program reflects a belief that even the most troubled youth have compensating strengths and capabilities that can be developed and enhanced through supervision, structure, and support. A major program objective is to help youth and their families develop their ability to function without routine contact with law enforcement and to live a positive life within their home and community.

The program is a collaboration that includes the courts, probation staff, and other community-based organizations. It is essential that all components work together to ensure that youth remain in compliance with the program. Communication between involved agencies is essential to ensure the program's effectiveness.

This contract will be awarded to a single vendor.

### **PROGRAM DESIGN**

Applicants must address all program elements listed in the following two places:

1. Section 3, Program Design, located in the *Year 2008 Purchase of Service Guidelines - Technical Requirements*.
2. "Introduction and Instructions", located in the front of the Delinquency and Court Services Division's section of the *Year 2008 Purchase of Service Guidelines - Program Requirements*.

The following outline includes program specific information and responses required by the Delinquency and Court Services Division. This information should be addressed in the appropriate section of your application.

### **Program Description**

Discuss the service delivery model to be used in serving 45 youth that have been identified by the courts as potentially requiring removal from the community for placement in corrections. Please address the following:

- How will your program complete the intake process and complete the initial assessment and service plan document?
- What is the role of the advocate or mentor with the family and other community agencies and resources?
- How will the agency address any supplementary service needs?

- How will client employment training and employment searches be conducted?
- How will inherent transportation issues be managed or coordinated?
- What experience does your agency have with background checks and the recruitment and employment of mentors? How have problems been resolved?
- How is staff training to be provided by your agency? What topics and certifications will be included in your employee in-service training program?
- What other components will be included in your program design (e.g. Group Counseling, Case Staffing, Crisis Intervention, etc.)?
- How will the program utilize the supplemental funds identified in “specific program activities” below? Applicants must provide a separate budget itemizing their anticipated expenses.

### **Needs and Problems**

Identify and discuss the issues surrounding youth that are identified in this target population and in need of close supervision. How will your program’s design address these issues to avoid the need for a more restrictive placement?

### **Target Population**

The youth are adjudicated delinquent and ordered to community supervision including probation supervision. The majority of the youth, either by the severity of their behavior or the reoccurrence of behavior, have been determined to be a high enough risk to warrant placement within a correctional facility. Based upon previous experience, approximately 95% of the youth served will be male minorities.

### **Agency Experience**

Discuss your agency’s experience in providing mentoring services and in providing the described services to the target population. Include any documentation that demonstrates the effectiveness of the delivery model.

### **Specific Program Activities**

An individual assessment and service plan document is to be developed on each youth and family.

Service plan reviews should occur at minimum of every 90 days by the Program Supervisor at a scheduled in-home or office conference with appropriate agency staff in attendance.

Youth referred to the program will receive an average of 13 hours of face-to-face contact weekly that includes group services provided to the youth as part of the program.

A minimum of one face-to-face contact with the youth or family should occur daily.

Advocates and mentors will be responsible for the following activities:

- Enrolling the youth in school and monitoring school attendance and progress.
- Involving the youth in positive activities that will assist in keeping the youth out of trouble.

- Engaging the youth and family in program activities and providing the required hours of face-to-face contact.
- Assisting the youth with the development of job-seeking skills and in obtaining employment.
- Providing supportive services to the parents.
- Attending all court hearings involving the youth.
- Providing 24 hour, seven days per week crisis intervention, either by pager or telephone.

In addition to the core program activities described above, the program has available separate funds in the amount of \$60,000 that may be used to provide supplemental services or personnel that directly support the youth and their families in their successful completion of the program. These services include, but are not limited to:

- Job Preparation and Employment skills building.
- Family Assistance Funds to stabilize basic needs.
- Parenting Assistance to develop parenting skills and knowledge.
- Child Care to support engagement in therapeutic services and/or activities.

### **Agreement With Other Community Agencies**

If this program is to be operated in collaboration with another agency, please supply complete information about the agency and how they will be involved in the delivery of services. Please include signed letters of agreement.

### **Staffing Pattern**

The Program Supervisor must have a Bachelor's Degree in Social Work, Criminal Justice, or related field (a waiver may be requested). The ideal candidate will have at least 2 years of experience working with delinquent youth.

The Program Supervisor will be responsible for the operation of the program and provide coordination with the Children's Court Liaison assigned to the program.

Youth advocates and mentors should be experienced in the delivery of social services to youth and families. Individual advocates and mentors may reflect various specialized skills. Advocates and mentors are required to have a high school degree or equivalent and have additional training or certification in youth care or social work.

At least one of the advocates must reside in the youth's zip code or neighborhood.

### **Admission and Discharge Procedures:**

Milwaukee County staff determines program referrals and discharges. Referrals will originate with the assigned Probation Officer or Intake Specialist (subject to an appropriate court order). A copy of the court report, along with the dispositional order or docket sheet, will be provided to the contract agency.

The program staff is to contact the youth and family within two business days of a referral. The program is expected to actively attempt to complete the intake through both face-to-face and telephone contacts.

Youth who do not comply with the program or conditions of probation established by the court may be returned to court. Probation staff may file a petition that requests a revision of the order, sanctions, or a lift of the stayed order for correctional placement. Program staff will provide written documentation and maintain ongoing communications with probation staff.

### **Documentation**

Documentation and data collection requirements will be determined by the Division.

Individual case files must include:

- Service Authorization and referral forms.
- Initial client and family intake forms.
- Initial client and family assessments and service plans.
- Counseling notes or contact sheets to include the date of contact, the name of person contacted, services provided, the type of the contact (e.g. face-to-face, phone, collateral, etc.), times and duration of service, and the provider signature.
- Consent forms.
- Incident reports.

Please include copies of proposed forms and document formats with your application.

## **Goals**

The Serious Chronic Offender Program services are expected to be an intensive alternative to a correctional placement by holding youth accountable and minimizing a youth's risk for re-offense. These services are a targeted enhancement to regular probation services.

## **Expected Outcomes**

Outcome: Program Completion

Indicator: Number and percent of youth that complete the program.

Indicator: Number and percent of youth that complete service plan goals.

Outcome: Improved school attendance and performance.

Indicator: Number and percent of youth that demonstrate an improvement in school attendance.

Indicator: Number and percent of youth that demonstrate an improvement in school performance.

Outcome: Improved youth behavior, attitudes, and understanding of offense dynamics.

Indicator: Number and percent of youth that demonstrate improved accountability.

Indicator: Number and percent of youth that can demonstrate recognition of high-risk behaviors.

Indicator: Number and percent of youth that demonstrate improved decision-making.

Outcome: Improved family functioning and understanding of offense dynamics.

Indicator: Number and percent of families that can recognize high-risk behaviors of their youth.

Outcome: Compliance with Court Conditions

Indicator: Number and percent of active youth that do not have a subsequent referral to Children's Court.

Indicator: Number and percent of active youth that do not have a request to lift a stay of corrections filed.

## **Reimbursement**

Reimbursement is based on actual program expenses and paid monthly. Monthly reimbursement will be limited to a cumulative 1/12 of the 2008 Milwaukee County approved contract allocation. Annual reimbursements may not exceed actual program expenses or the total contract allocation. A program specific Revenue and Expense Statement must be submitted following the end of each calendar month according to Milwaukee County DHHS policy. This contract will be for calendar year 2008, with the option to extend the contract for two additional years.

The Adolescent Sex Offender Treatment Program (ASOTP) serves the needs of adolescent children whose treatment needs can be met in a structured, community-based setting. Proposals will be assessed, in part, on the agency's ability to determine the child's appropriate sub-group as an offender. In addition, the program should be able to provide, on a case-specific basis, various treatment modalities and service options.

Children who are referred to this program reside throughout Milwaukee County. Therefore preference will be given to agencies that offer multiple service sites or who are able to collaborate with other agencies to provide neighborhood-based services. In addition, preference will be given to agencies that utilize 3rd party payees including private insurance, T-19, or grant money to expand services or to offset Milwaukee County's allocation.

This contract will be awarded to a single vendor.

### **PROGRAM DESIGN**

Applicants must address all program elements listed in the following two places:

1. Section 3, Program Design, located in the *Year 2008 Purchase of Service Guidelines - Technical Requirements*.
2. "Introduction and Instructions", located in the front of the Delinquency and Court Services Division's section of the *Year 2008 Purchase of Service Guidelines - Program Requirements*.

The following outline includes specific information and responses required by the Delinquency and Court Services Division. This information should be addressed in the appropriate section of your application.

### **Program Description**

Discuss the service delivery model to be used in serving 80 adolescent sex offenders. If the model uses a phase system, define who will be responsible for services during each phase and the amount of direct service time afforded each youth. Include a discussion of the curriculum to be used and include any appropriate supporting documents. The program design should also address its ability to deal with age differences and the different types of sexual assault.

### **Needs and Problems**

Describe the difficulties inherent in treating juvenile sex offenders and discuss your agency's philosophy towards treatment. Include an outline of the proposed treatment modalities (e.g. In-Patient, Group, Individual, and Family treatment) and describe the specific therapeutic models being proposed and to be used for the majority of youth.

Agencies under consideration should demonstrate their understanding of the community's need for safety.

### **Target Population**

Discuss the program's target population within the context of the ages, severity of the offenses, and various family histories and dynamics. Discuss strategies for overcoming the inherent difficulties in engaging individual children and families in the treatment process.

### **Agency Experience**

Discuss the agency's experience in providing services to the target population and in treating emergent or established disorders. Include data or reports that demonstrate the effectiveness of the delivery model.

### **Program Activities**

1. Assessment of the child and family to identify the child's sub-group as an offender.
2. Group, Individual, and Family therapy as determined to meet the treatment needs of the specific child and family.  
Note: Please list and discuss the group counseling activities included in your treatment model.
3. Relapse Prevention programming and implementation of an individualized Safety Plan that is specific to the needs of each child. Safety Plans involve the family, are regularly reviewed and updated and are written. An initial Safety Plan will be completed within 30 days of intake into the program. A final Safety Plan will be in place upon discharge from the program.
4. Bilingual capability to work with Spanish speaking families.
5. Home visits when necessary to engage the family in treatment services.
6. Access to community-based mentoring programs where available.
7. Transportation planning (may include public transportation).
8. Bi-monthly staffing of currently active cases.
9. Ongoing consultation and communication with Probation Officers and/or Care Coordinators.

### **Documentation**

Individual case files must include:

- Initial family and child assessments
- Individualized treatment plans
- Operationalized treatment goals
- Client staffing reports and treatment plan updates

- Counseling notes or contact sheets to include the date of contact, the name of person contacted, services provided, the type of the contact (e.g. face-to-face, phone, collateral, etc.), times and duration of service, and the provider's signature.
- Written Safety Plan including final plan
- Court and referral documents
- Incident reports

## **Goals**

ASOTP services are expected to provide a structured intervention to reduce a youth's risk of re-offense by addressing factors identified and potentially contributing to the youth's presenting behavior.

## **Expected Outcomes**

Outcome: Program Completion

Indicator: Number and percent of youth that complete the program.

Indicator: Number and percent of youth that have an initial safety plan in place within 30 days of intake.

Indicator: Number and percent of youth that have a final safety plan in place at the time of discharge.

Indicator: Number and percent of youth that complete treatment plan goals.

Outcome: Improved youth behavior and reduction of risk.

Indicator: Number and percent of youth that accept responsibility for their behavior.

Indicator: Number and percent of youth that demonstrate empathy for their victims.

Indicator: Number and percent of youth that can recognize high-risk behaviors.

Outcome: Improved family understanding of offense dynamics and ability to manage youth behavior.

Indicator: Number and percent of families that can recognize high-risk behaviors of their youth.

Indicator: Number and percent of families that engage in and understand their youth's safety plan.

## **Reimbursement**

Reimbursement is based on actual program expenses and paid monthly. Monthly reimbursement will be limited to a cumulative 1/12 of the 2008 Milwaukee County approved contract allocation. Annual reimbursements may not exceed actual program expenses or the total contract allocation. A program specific Revenue and Expense Statement must be submitted following the end of each calendar month according to Milwaukee County DHHS policy.

This contract will be for calendar year 2008, with the option to extend the contract for two additional years.

## **SHELTER CARE**

**Program #DCSD 011**

Shelter care is a short-term (typically 30 days) non-secure, supervised residential program as defined and regulated under HFS 59. The program will primarily serve youth pending court for alleged delinquency. As requested by the Division, other youth involved in Children's Court Center matters may be placed at the discretion of the Division.

In addition to the above-described services, providers must be able to demonstrate the ability and willingness to enter into the following collaborative agreements.

- Providers must lease facility space located at 9501 West Watertown Plank Road, Buildings D and E, which is part of the Milwaukee County Behavioral Health Division (BHD) complex, formerly known as CATC. This facility is currently licensed for 64 shelter care beds.
- Providers must be willing to work with the Wauwatosa School District that provides on-grounds educational programming for youth temporarily housed on county grounds.

This contract will be awarded to a single vendor.

## **PROGRAM DESIGN**

Applicants must address all general program elements listed in the following two places:

1. Section 3, Program Design, located in the *Year 2008 Purchase of Service Guidelines - Technical Requirements*.
2. "Introduction and Instructions", located in the front of the Delinquency and Court Services Division's section of the *Year 2008 Purchase of Service Guidelines - Program Requirements*.

The following outline includes "program" specific information and responses required by the Delinquency and Court Services Division. This information should be addressed in the appropriate section of your application.

### **Program Description**

#### **Shelter Care for 44 Males and 20 Females**

The provider must be able to provide 24-hour supervised care.

Each unit is capable of housing up to 24 youth. Lease costs, available from Milwaukee County DHHS, include utilities, grounds maintenance, major equipment and building repair costs, overhead and depreciation costs (building, equipment and furniture amortization cost), use of the gym and employee parking. The cost of meals and laundry are not included. The vendor will also be responsible for coordinating the use of common-use areas with the BHD-CATC Administrator.

The provider proposing to provide temporary shelter as described above must demonstrate the ability to have a license to provide shelter from the State Department of Health & Social Services.

### **Education**

The Wauwatosa School System will provide a school program on the former CATC premises. The provider will be responsible for supervision of the youth during the noon lunch hour and other periods when school is not in session. Provider staff must also provide crisis intervention assistance when requested, handle acute disruptive problems, participate in school conferences, attend school orientation, and be available to school authorities when requested.

### **Placement Criteria**

Youth can only be placed in the program if they are referred and approved for placement by the Division and if one of the following criteria is met:

1. There is a court order for custody under s. 938.19(1)(c) or s. 938.21(4)(b) Wis. Stats.;
2. An intake worker placement decision is made pursuant to s. 938.205 Wis. Stats.;
3. There is an emergency change of placement under s. 938.357(2) Wis. Stats., subject to further court action for placement elsewhere;
4. There is an emergency change of placement under s. 48.357(2) Wis. Stats., subject to further court action for placement elsewhere;
5. There is a signed voluntary placement agreement.

### **Specific Program Activities**

- The provider must accept youth for placement 24 hours a day, seven days a week.
- The provider must have the ability to be on-call and available to transport youth to and from the Detention Center/Court Center at all times and to a medical provider as necessary.
- The provider must fully comply with all current provisions and revisions of “The Temporary Shelter Care Policy and Procedures” published by Milwaukee County DHHS that is available from Division staff.
- The provider must have staff members awake and alert throughout the night.
- The provider shall have responsibility to directly notify the Bureau of Milwaukee Child Welfare if any abuse is suspected either within the Shelter, or upon return of a youth from the outside and shall be responsible for reporting missing/runaway youth to appropriate law enforcement.

- The provider shall maintain an accurate daily census of all active youth and discharges as requested by Division staff.
- The provider must report on a monthly basis any changes in staff providing direct care.

### **Staffing Pattern**

Direct service staff must possess a high school diploma and have three years experience working with juveniles. Four years experience with programs serving juveniles may be substituted for a high school degree. The provider must be able to document staff experience at the request of the Division. The application should include a written description of the provider's orientation plan for new staff and ongoing staff development programs.

### **Documentation**

Documentation requirements will be determined by Milwaukee County and will include any requirements of the State of Wisconsin's regulatory guidelines.

### **Goals**

Shelter care services are expected to provide a safe, monitored environment for youth awaiting court hearings, placement in foster care, group care, residential treatment care, or pending return home.

### **Expected Outcomes**

Outcome: Program Completion

Indicator: Number and percent of youth that complete the program.

Indicator: Number and percent of critical incidents filed

(Number of critical incidents / Total actual days of care).

Outcome: Compliance with Court Conditions

Indicator: Number and percent of active youth that attend all scheduled court hearings.

Indicator: Number and percent of youth discharged as a result of AWOL.

### **Reimbursement**

Reimbursement is based on actual program expenses and paid monthly. Monthly reimbursement will be limited to a cumulative 1/12 of the 2008 Milwaukee County approved contract allocation. Annual reimbursements may not exceed actual program expenses or the total contract allocation. A program specific Revenue and Expense Statement must be submitted following the end of each calendar month according to Milwaukee County DHHS policy.

This contract will be for calendar year 2008, with the option to extend the contract for two additional years.

# **Section 3**

## **Disabilities Services Division Program Descriptions**

---

## **VISION, MISSION & GUIDING PRINCIPLES**

### **Vision for the Milwaukee County Disabilities Services Division**

All persons with disabilities and their support networks will have maximum individual choice and access to resources leading to full participation in all aspects of community life.

### **Mission of the Milwaukee County Disabilities Services Division**

Our mission is to enhance the quality of life for all individuals with physical, sensory and developmental disabilities and their support networks living in Milwaukee County by addressing their needs and providing individualized opportunities for persons to participate in the community with dignity and respect, while acknowledging their cultural differences and values.

### **Guiding Principles**

Independence: Everyone has a right to do what they want and need to do to function in society.

Achievement of the highest level of independence

Continuum: Need to provide a continuum of services

Real Choice: Self Determination

Nurturing Relationships/Friendships

Strengths Based vs. Needs Based

Respectful and Fully Accessible

Equality and Rights for All

Participation in the Mainstream

High Quality staff, providers, services, options

Maximum flexibility

Individualized, Person-Centered, Culturally Competent

Collaboration and Partnership

Values cultural and ethnic diversity

Emphasizes Home and Community Based programs and services

People have the ability to live where they want to live, and have opportunities to work and recreate

Total acceptance in the community, no stigma

Involvement of consumers in the planning process

Comprehensive grievance system, systemic method to resolve issues

Continuing grievance system, systemic method to resolve issues

Continuing community education and advocacy

All stakeholders as advocates

Allocation of sufficient resources

Successful outcomes for each individual

The premise of this approach rests on flexible supports for individuals with disabilities changing through life stages, starting at birth through childhood, adult living and senior years. Services and supports at these critical stages require unique consideration, assessment, planning and intervention to offer appropriate supports to the individuals and families. Providing flexible supports and allowing for changes through life's stages promotes a continued presence in the community, encourages higher achievement levels and successful outcomes for each individual served.

Developmental Disabilities staff expect all providers of services to be familiar with, and aware of, the following in regards to service delivery:

**Selected Providers:**

- must be familiar with developmental disabilities condition and have a basic understanding of the cognitive issues and current service philosophy;
- should be knowledgeable in the person-centered and/or person-directed service planning model;
- must strive for cultural and social competencies, i.e., ethnic, religious or gender factors;
- should be open and seek to address stated preferences of consumer/guardian family;
- should have knowledge of the inclusion philosophy;
- should have knowledge of program design and service implementation in natural environments;
- must be interested in and willing to support or provide reasonable flexibility in service to meet the different consumer needs of the population;
- must be interested in seeking utilization of generic resources for community awareness and participation on behalf of the consumer;
- must be able to plan, coordinate and/or provide transportation services to meet transportation needs (to include the use of family, friends, public transportation, specialized service, or leasing of a vehicle;)
- must be able to plan and collaborate services with other providers and exhibit a cooperative spirit.
- All providers must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in the Medicaid Waivers Manual, Chapter IX.

## **PROGRAM DESCRIPTIONS**

---

### **PROPOSAL SUBMISSION REQUIREMENTS (Applies to all DSD programs up for competitive bid):**

#### **Service/Treatment Process**

#### **For each program for which you are submitting a competitive proposal:**

- (1) List and define each program's activities, purpose of the activity, and the usual size, structure, and schedule of activities or groups.
- (2) Describe the sequence of program activities, including counseling and/or treatment, if applicable. Indicate the phases of service/treatment, the length of time in each phase, and the criteria used to determine movement from one phase to another.
- (3) Describe how and when individualized client treatment plans, goals, and objectives are developed, monitored, and reviewed. Identify by position categories, staff that is involved in this process.

Describe formal relationships and informal arrangements used to leverage resources with other community agencies or programs providing services to the target population. Describe the qualifications of agencies and other professionals. Include copies of letters of agreements, as applicable.

If applying as an incumbent, summarize the process and results of the previous year's evaluation report submitted to DSD. Include any changes made in the program as a result of the evaluation.

---

---

## ADVOCACY

---

### **ADVOCACY/CONSUMER EDUCATION #DSD005\***

---

Services are designed to assist individuals and their families speak for their interest and needs, and to promote community sensitivity and responsiveness to disability issues. Self-advocacy, parental, guardian and/or significant other advocacy should promote opportunities to share experiences, learn client/disability rights information, and work on self-expression of disability issues. These areas focus on obtaining or maintaining access to community resources to enhance community living, acquire specialized services, in addition to addressing service needs and gaps. Advocacy effort is also intended to be a support network to, and for, adults with disabilities and their families aiding with system change initiatives.

Service emphasis should reflect a shift to self-advocacy. Program designs must include elements of training and support to persons with disabilities in person directed and centered planning, fundamentals of self-determination, social/peer relationship building, and self and system advocacy. Parental and family linkages are anticipated to continue through support groups, or through focus group discussions.

Secondly, of equal importance is consumer education. This area seeks to provide training to participants in adult services, waitlisted and/or transitioning from school services on information regarding understanding adult service systems, identification of how to share their respective interest, needs, abilities and challenges in order to express and participate in supports/services on their behalf. Furthermore, the agency is expected to provide or coordinate training forums on self-determination and person directed supports, community education, core service areas, and personal safety, with the goal of enabling the consumer to engage in a self-directed support model.

#### **Advocacy Service Requirements:**

##### **1. Advocacy**

The agency will provide or coordinate self-advocacy training for individuals with developmental disabilities, coordinate parental, guardian and significant other advocacy training on behalf of consumers with DD.

Two (2) times per year the agency will provide or coordinate system advocacy training for consumers and significant others.

---

**Note: Funding for the Advocacy program has been recommended for reduction in the Department's 2008 budget. It is possible that funding for this program may not be available in the final adopted budget**

Two (2) times per year the agency will facilitate person-directed education and training to self-advocates, and their families, agency staff providing services to persons with disabilities.

Two (2) times per year the advocacy agency (ies) will participate in a DD system discussion session with DSD staff to review consumer issues, discuss service outcomes/satisfaction, unmet and under-served consumer needs.

Two (2) times yearly the agency will produce a summary report on activities implemented over the year.

## **Consumer Education**

The agency will provide training with emphasis on self-expression, choice, person-centered services and elements of self-determination.

The agency will issue a participant survey to measure the progression of person directed approach to services.

Two (2) times per year the advocacy agency (ies) will participate in a DD system discussion session with DSD staff to review the progress of consumer education sessions, discuss service outcomes, and unmet consumer needs.

Two (2) times yearly the agency will produce a summary report on activities implemented over the year.

---

---

## COMMUNITY LIVING SUPPORT

---

---

### **RECREATION #DSD011**

---

Recreation programming for developmentally disabled children and adults provides integrated or specialized opportunities for social interaction, self-expression and entertainment. Programs should be designed to maintain motor skills and develop recreational interest of consumers. Consumers are offered opportunities to socialize with peers and other people who are not disabled while increasing recreational experiences. Participants receive an individualized screening and thus, participate in independent and/or group activities accordingly. Activities are selected based on personal choice or skill.

The goal of recreational resources is to introduce the consumers to a variety of activities and experiences with the intent of these experiences being transferred to general community living activities by the person with their peers, families or other significant individuals.

Recreational services also design and facilitate integrative recreation. For several consumers this service focuses on assessing and enrolling their participation in generic recreation and educational activities in the community. Services are provided on a one to one or a small group basis, and implemented based on a personal assessment.

#### **Recreation Administrative Service Requirements:**

Three (3) times per year the recreational provider and administrative entity will provide an in service to community providers on recreational activities in the Milwaukee community, leisure skill development and implementation, and facilitating integrated recreation.

Two (2) times per year the recreation agency (ies) will participate in a DD system discussion session with DSD staff to review consumer issues, discuss service outcomes, unmet and under-served consumer needs, and future service planning.

#### **Unit of Service**

The vendor will be reimbursed for expenses up to 1/12 (one-twelfth) of the annualized contract per month. The reimbursement will be for the actual expenses or 1/12 (one-twelfth) of the contract amount, whichever is lower, based upon a review of the vendor's monthly billing statement. The format of the billing statement will be determined by the Disabilities Services Division and may include program staff, occupancy costs, equipment costs and other expenses found to be appropriate. The billing statement shall be submitted on a monthly basis.

#### **Documentation**

Financial records/CPA audit.

## **RESPITE CARE #DSD012**

---

Respite care is designed to provide for a substitute caregiver when an interval of rest or relief is needed by the primary care giver. Respite may be provided in the family's home, in a licensed foster home for children, or in a certified adult family home.

### **Agency Requirement-Respite Care**

- 1) Semi-annually, the provider will produce a survey on un-met family/individual needs, in addition to, other service trends or needs identified.
- 2) Semi-annually, the provider will submit a report indicating service utilization and program participants' satisfaction.
- 3) Agency must identify and submit three (3) personal stories identifying service outcome and client benefit.

### **Unit of Service**

**A unit of service is one hour of direct service time.**

**Direct service time** is staff time spent in providing service to the program participants which includes face-to-face contacts (office or field), collateral contacts, travel time, telephone contacts, client staffings and time spent in documentation of service provision. (Direct service time does not include indirect time such as that spent at staff meetings, in service training, vacation, etc.)

**Collateral contacts** are face-to-face or telephone contacts with persons other than the program participants, who are directly related to providing service to the person and need to be involved by virtue of their relationship to the program participant. Collateral contacts could include contacts with family members, other service providers, physicians, school personnel, clergy, etc.

Reimbursement for group services is based on one-hour units of direct service time. The total time must be equally divided between each group participant and recorded in the case record of the participant.

### **Documentation**

**Direct service time** must be documented through an entry in the case notes or narrative for units billed. The narrative entry must include (a) the date of the contact, (b) the type of contact (face-to-face, collateral, phone, etc.), (c) who the contact was with, (d) the content of the contract, and (e) the number of units (the length of the contact). The case narrative must be contained in the case record maintained by the agency.

## **CORPORATE GUARDIANSHIP #DSD013**

---

Corporate Guardianship provides guardianship services for adults between the ages of 18 and 59 years who are found incompetent under Chapter 880 by a court of law and for whom family are unsuitable or unavailable. The purpose of this service is to provide intensive and short-term guardianship until the ward's situation and or behaviors have stabilized.

Services include, but are not limited to making personal decisions regarding health care, housing, nutrition, social needs, etc., on behalf of the ward, and ensuring that all benefits due the ward are applied for and provided. Disabilities Services staff are the fixed point of referral and the agency must state in writing that they agree to cooperate with Adult Services to accept, substitute and/or transfer wards via the successor guardianship process, when deemed appropriate by Adult Services.

### **Corporate Guardianship Requirements**

Contract agencies will provide a quarterly report indicating the number and names of clients served and a brief narrative on status (concerns, critical issues, charges etc.) of their case-monitoring role.

### **Agency Requirement-Corporate Guardianship**

Agency must provide a quarterly report on the status of assigned consumers and service operations.

### **Unit of Service**

#### **A unit of service is one-quarter hour of direct service time.**

**Direct service time** is staff time spent in providing service to the program participants including face-to-face contacts (office or field), collateral contacts, travel time, telephone contacts, client staffing and time spent in documentation of service provision. (Direct service time does not include indirect time such as time spent at staff meetings, in service training, vacation, etc.)

**Collateral contacts** are face-to-face or telephone contacts with persons other than the program participants, who are directly related to providing service to the person and need to be involved by virtue of their relationship to the program participant. Collateral contacts could include contacts with family members, other service providers, physicians, school personnel, clergy, etc. Reimbursement for group services is based on one-hour units of direct service time. The total time must be equally divided between each group participant and recorded in the case record of the participant.

## Documentation

**Direct service time** must be documented through an entry in the case notes or narrative for units billed. The narrative entry must include (a) the date of the contact, (b) the type of contact (face-to-face, collateral, phone, etc.), (c) who the contact is with, (d) the content of the contact, (e) the number of units (the length of the contact). The case narrative must be contained in the case record maintained by the agency.

### **ASSERTIVE CASE INTERVENTION SERVICES #DSD014**

---

Assertive Case Intervention Services for adults with developmental disabilities provides short and long term intervention services. Assertive Case Intervention is a component within the core group of Diversion Services. Support services are designed to address a wide range of behavioral challenges exhibited by consumers with DD and have a high range of support needs in the mental health area in order to function successfully in the community. Through a process of intervention and pro-active case involvement, this service is planned to guide consumers on a daily basis, and collaborate with other professionals through high-risk periods to reduce the loss of residential and /or day activity due to instability in social behavior. The goal is to foster manageability by the person in typical daily living experiences to reduce high-risk periods of emotional instability. Families and significant others to the client may also be assisted with education and support on an ongoing basis and especially in times of turmoil or crisis. Adults in this service are developmentally disabled who also are dual diagnosed with a major mental health diagnosis, or who have problematic mental health or behavioral patterns. These characteristics present significant barriers to their successful community living status.

Assertive Case Intervention services provide the monitoring link with community providers and the home environment through direct community intervention and support to the individual. Communication among the intervention team members and with the client is paramount.

DSD staff serves as the fixed point of referral for all identified consumers. Referrals to the provider are directed by DD staff. DD staff holds regular case review meetings with the provider to monitor progress and provide technical assistance.

Individuals and families in Diversion Services are treated with dignity and respect. Although a variety of behavioral challenges exist, staff strives to provide reasonable assurances of personal safety and guide the person through opportunities to express interests, desires, and preferences. The consumer must have choice and flexibility in the services and supports they receive. All parties, the consumer, DSD and the provider staff work as partners in shaping the delivery of services and supports.

#### **Assertive Case Intervention services offer four major service components;**

1. Intervention/Functional Daily Living Component
2. Health and Wellness Monitoring
3. Guidance and Counseling
4. Social Supports

### **Through these service components the provider staff will:**

1. Implement a service plan designed to address the consumers needs in daily living tasks. This would include stable and safe housing, a daily activity, training program or job and free time structure. The plan should compare closely to the life values and culture of each individual. The focus is to assist the consumer to live in, learn, and cope with the community through functional tasks and social relationships.
2. Monitor health and safety in the living environment. The consumer's preferred health and personal habits should be accepted or their development guided. Interventions may be necessary to assist consumers with the maintenance of regular health care provider visits for physical health and mental/behavioral health visits, or with money management.
3. Offer an informal counseling and support service through individual contacts or in a group setting. The service should be offered according to the guidelines of the licensing and professional standards of the field. This service may be extended to family or other living environments to foster their ability to address crises. In accordance with the consumer's needs and wishes, referrals may be made to outside providers. Coverage from benefits should be taken into consideration.
4. Utilize a system of social supports to guide opportunities for meaningful and trusting relationships that is core to the measure of a functional life. Additionally, the provider will offer service that will feature a consumer run set of services. The provider functions as the facilitator of space, equipment, the structure of services and the variety of programs. This should include activities facilitating personal growth and opportunities that permit attendance at events and public resources.

### **Agency Requirements - Assertive Case Intervention Services**

1. Assess and submit an initial plan within ten working days on all referrals. The final plan must be submitted within 30 days and include objectives. In this process each consumer should be given respect, their dignity a priority and their opinion included in the planning. The elements of self-determination must be implemented. This would include helping the person choose their own goals, choose what kind of help is needed to achieve them, and how to get that help.
2. Produce written reports every month and submit to DSD. The report should include a statement of progress and challenges toward the goals and any recommendations for changes in the service plan.
3. Attend regular meetings with DSD DD staff for the purpose of joint case review and to provide a time for administrative review and case processing.
4. Agency must identify and submit three (3) personal stories identifying service outcome and client benefit.
5. A Consumer Satisfaction Survey must be issued and a written summary of the results forwarded to the Contract Supervisor.

## **Expected Outcomes**

Developmental Disabilities expects the following outcomes:

Decrease in the number of repeat inpatient psychiatric admissions of 3 or more days per calendar year. **Indicator:** Number of inpatient psychiatric admissions of 3 or more days during the year preceding the program evaluation.

Increase attendance of adults who are in structured day services or work options. **Indicator:** Number and percent of adults who are in structured day services or work options at the time of the program evaluation.

Decrease the number of adults with DD in crisis hospitalization during contract year. **Indicator:** Number of adults with DD who required crisis hospitalization during the year preceding the program evaluation.

### **Key supporting process and output measures include:**

Number of repeat inpatient psychiatric admissions of 1 or 2 days for medication adjustment per calendar quarter for the consumers served that quarter.

Number of consumers receiving diversion services who participated in consumer run services.

Number of people maintained in or those assisted to move into stable housing.

Number of people participating in the development and implementation of their service plans.

Number of people referred and participating in a new service program.

Number of Families, Guardians and/or Significant others receiving education and support.

The agency must prepare a report on client outcomes acquired as a result of their participation in this service.

## **Unit of Service**

### **A unit of service is one-quarter hour of direct service time.**

**Direct service time** is staff time spent in providing service to the program participants which includes face to-face contacts (office or field), collateral contacts, travel time, telephone contacts, client staffing and time spent in documentation of service provision. (Direct service time does not include indirect time such as that spent at staff meetings, in-service training, vacation, etc.)

**Collateral contacts** are face-to-face or telephone contacts with persons other than the program participants, who are directly related to providing service to the person and need to be involved by virtue of their relationship to the program participant. Collateral contacts could include contacts with family members, other service providers, physicians, school personnel, clergy, etc. Reimbursement for group services is based on one-hour units of direct service time. The total time must be equally divided between each group participant and recorded in the case record of the participant.

## **Documentation**

**Direct service time** must be documented through an entry in the case notes or narrative for units billed. The narrative entry must include (a) the date of the contact, (b) the type of contact (face-to-face, collateral, phone, etc.), (c) who the contact is with, (d) the content of the contact, (e) the number of units (the length of the contact). The case narrative must be contained in the case record maintained by the agency.

---

## COMMUNITY RESIDENTIAL PROGRAMS

---

Community living supports is a broad term that represents an array of supports or services to individuals with disabilities who are in the community. Participants or applicants reside independently, with family or significant others and need supports or intervention to enable their success, full participation or advance in skills for adult living.

### **SUPPORTIVE LIVING OPTIONS #DSD015**

---

The Supportive Living Options Program provides individually tailored training, support and supervision to individual adults to promote, maintain, and maximize independence in community living. The premise of the program is that adults with disabilities can live independently or semi-independent in settings provided the appropriate support arrangements and home can be identified and acquired on behalf of the participant. Program participants are assessed for their abilities, needs, and family or significant other assistance in order to clarify the appropriate service components needed in the supportive living service structure. The goal of the program is to enable the participant to experience a safe, supported, and positive living experience while enhancing their understanding, access and utilization of community. Participants receive guidance with interpersonal relationships and supervision from various agency staff that fosters personal growth. The program model includes four service components: Case Management, Daily Living Skills Training, Daily Living – Maintenance Service, and Supportive Home Care Services.

Agencies interested in applying for this services in this program area must be able to provide the full array of services.

**Case Management Services:** Assessing, planning, monitoring, locating and linking an individual to supports and/or services. Supports needed generally reflect health care services, social services, benefits, or fundamental supports (e.g. housing). Case manager may assist with setting appointments, providing intervention with problems, documenting supports received and aiding through informal counseling or guidance with interpersonal problems or people relationships.

**Daily Living Skills Training:** Training or teaching an individual a skill to develop greater independence. Skill training is task-oriented and time-limited with pre- and post assessment. Areas of focus typically include: personal care, grooming, dressing, food preparation, money transactions, budgeting, home upkeep, use of community resources, community-travel training safety issues.

**Daily Living Skills Maintenance:** Assisting/accompanying an individual with typical day-to-day functions that enable community living. This service typically includes functional training, general guidance and supervision of instrumental ADLs, informal intermittent, monitoring critical appointments to lessen vulnerability and increase or maintain success in community living. DL-Maintenance fosters the individual retaining their functional level and generally learning new tasks over time. It is likely that the individual in this category may always require the same level of support to maintain community living.

**Supported Home Care:** Instrumental ADL tasks performed by care workers, or care workers accompany an individual in functions related to personal care, grooming, shopping, medication set-up, mobility in the home and in community, home care and household chores, social activities, health care appointments and other daily living tasks. These tasks are actually hands-on activities performed by personal care workers.

## **SUPPORTED PARENTING #DSD016**

---

Supported Parenting is a sub category of the supportive living program service or case monitoring service. This service provides training, counseling and intervention to adults with developmental disabilities who are also parents. The focus of this service is to offer guidance in community living and parenting. Participants are encouraged to identify their needs, routines, challenges, as well as family needs. Training and supports in personal skills and parenting skills vary. Guidance on how to support the family unit is provided on an individual and/or a group basis.

Persons receiving this service generally lack a natural support network or the extended family and friends are unable to assist at the level needed for successful family community living. Subsequently, staff seeks mentors and uses the mentoring approaches to foster learning. Staff provide practical and functional training in daily living skills, decision-making, social and community training, in addition to informal child rearing counseling, parenting skills and service coordination. The goal is to teach adult community living skills and promote stability in the family unit through guiding the parent to learn about and understand the parental role. Staff also functions as advocates for the parent on educational, medical and social service issues where the child is involved.

### **Agency Service Requirements - Supported Living: Supported Living and Parenting Programs**

For Supported Parenting providers must produce a quarterly summary report including information on persons served, needs identified-addressed, progress made and unmet needs, and submit it to DD management staff.

Agency must submit a semi-annual update on the services provided, frequency and identify the general goals of the participants and progress made.

Agency must provide training in self-advocacy on elements of self-determination.

A Consumer Satisfaction Survey must be issued and a written summary of the results forwarded to the Contract Supervisor.

Representation at the Supported Living Service Meetings scheduled by Disabilities Services staff is required.

Agency must identify and submit three (3) personal stories identifying service outcome and client benefit.

### **Supportive Living Programs Service Requirements**

All agencies seeking to provide Supportive Living Programs must comply with the following requirements:

1. Develop a comprehensive Living Plan (LP) with each SLP participant based on an assessment that addresses his/her needs and specifies responsibilities, methods to be used, and time frames for completion. Provide ongoing monitoring of progress towards attaining LP goals and recommend changes, including discharge planning as needed. Visit the program participant with frequency sufficient to insure progress in the LP. Coordinate semiannual staffing with appropriate parties to review status. The LP should provide or arrange for training or support in the following areas as determined by the initial assessment and progress:
  - a. housekeeping and home maintenance skills
  - b. mobility and community transportation skills
  - c. interpersonal skills and relationships
  - d. health maintenance
  - e. safety practices
  - f. financial management
  - g. problem solving and decision-making
  - h. self-advocacy and assertiveness training
  - i. utilization of community resources and services
  - j. recreational and leisure skills
  - k. basic self-care skills
  - l. menu planning and meal preparation
  - m. communication skills
  - n. time management
  - o. coping with crises
  - p. forming natural support systems
2. Maintain written documentation in case files of contacts, visits, and telephone conversations with program participants, service providers, and significant others.
3. Provide case management and informal counseling for individuals as needed. Case management services include but are not limited to:

- a. Ensure referral and follow-through to needed community services including vocational, educational, medical, psychological, alcohol and drug abuse and other specialized services, as appropriate. Maintain communication and coordination with other service providers.
  - b. Provide prompt intervention to resolve interpersonal and community living problems.
  - c. Encourage and support the individual's involvement in community life, activities, self-help, and advocacy programs.
  - d. Assist individuals in applying for benefits as appropriate and securing needed documentation to resolve problems concerning those benefits.
  - e. Assist the individual in screening, hiring and training attendant and respite workers as required. Help the individual understand their responsibilities as employers.
  - f. Lead in the development of a support network for the individual which will include the resident and significant others who will contribute to the training, support and service plan of the individual.
  - g. Complete a community-based social/recreational Personal Planning Inventory (PPI) on all residents to enhance community integrative programming.
4. Maintain a 24-hour coverage plan to respond to residents when ill or in case of emergency. The agency must maintain a log of the emergency calls and the response time to an emergency call.
  5. Provide initial and ongoing training to program staff, including attendant and respite staff, regarding the concerns of residents.
  6. Notify Adult Services verbally and in writing of significant problems and submit discharge/termination summary.
  7. Provide consultation on community resources and service options in order to facilitate the development of consumer choice in service planning.
  8. Develop and review a "Safeguard Program Checklist" that identifies items/services or procedures critical for the care, stability or service need of the program participants, and review the list with participants/guardian, where appropriate.

The agency must prepare and submit a report indicating various client outcomes acquired as a result of their participation in this service (e.g. increase wages, acquire new job skill, individuals' goal achieved).

### **Unit of Service**

**A unit of service is one-quarter hour of direct service time.**

**Direct service time** is staff time spent in providing service to the program participants which includes face to-face contacts (office or field), collateral contacts, travel time, telephone contacts, client staffing and time spent in documentation of service provision. (Direct service time does not include indirect time such as that spent at staff meetings, in-service training, and vacation.

**Collateral contacts** are face-to-face or telephone contacts with persons other than the program participants, who are directly related to providing service to the person and need to be involved by virtue of their relationship to the program participant. Collateral contacts could include contacts with family members, other service providers, physicians, school personnel, clergy, etc. Reimbursement for group services is based on one-hour units of direct service time. The total time must be equally divided between each group participant and recorded in the case record of the participant.

## **PERSON-CENTERED PLANNING #DSD017**

---

**Note: 2008 is the last year that funding will be available for the Person-Centered Planning programs.**

Person-Centered planning services provides a “skilled facilitator” to guide the parent, guardian and significant others, with the consumer through a process of identifying current and futures supports, in addition to planning future goals. The intent of the Person-Centered process is to identify the needs, interest and positive support elements to work collaboratively to accomplish desired consumer and family goals by engaging all parties in the planning and implementation process.

Disabilities Services staff interest in this method is to provide a vehicle that begins the “get-acquainted process” of individuals and their family with professionals in the field to recognize and utilize their strengths in navigating adult services and systems important to community living for the adult with a disability. Addressing needed supports through a family and significant other process provides the opportunity to capitalize on utilizing stable supports, who have a vested interest in the adult with the disability to assist in life planning and life services.

The trained staff providing person-centered services will be expected to possess the knowledge, and skill of person-centered planning approaches, upon contract award. In addition staff will need current understanding and familiarity of the adult systems to inform and guide family members. It is expected that staff will encourage and guide the person with family, primary caregiver and other interested parties to engage in functional skill building activities, social/peer relationship development, community activities, assistance with benefit counseling and develop future plans and goals that will aid the individual and their support network. The planning sessions are planned to occur, at minimum one to two times monthly, per person and as needed to accomplish the objectives.

Disabilities Services is the fixed point of referral and enrollment for this service.

## **Agency Service Requirements - Person-Centered Planning Programs**

For Person-Centered Planning, providers must produce a quarterly summary report including information on persons served, needs identified-addressed, progress made and unmet needs, and submit it to DD management staff.

Agency must submit a semi-annual update on the services provided, frequency and identify the general goals of the participants and progress made.

Agency must provide training in self-advocacy on elements of self-determination.

A Consumer Satisfaction Survey must be issued and a written summary of the results forwarded to DSD management personnel.

Representation at the Person-Centered Providers Group Meetings scheduled by Disabilities Services staff is required, quarterly.

Agency must identify and submit three (3) personal stories identifying service outcome and client benefit.

## **Person-Centered Planning Services Requirements**

All agencies seeking to provide Person-Centered Planning services must comply with the following requirements:

1. Develop a service/support plan with each participant based on assessing the individual. Provide monitoring of progress towards attaining the goals and recommend changes. Contact the program participant and family with frequency sufficient to insure progress. Coordinate semiannual staffing with appropriate parties to review status. Areas to focus on are:
  - a. housekeeping and home maintenance skills
  - b. mobility and community transportation skills
  - c. interpersonal skills and relationships
  - d. health maintenance
  - e. safety practices
  - f. financial management
  - g. problem solving and decision-making
  - h. self-advocacy and assertiveness training
  - i. utilization of community resources and services
  - j. recreational and leisure skills
  - k. basic self-care skills
  - l. menu planning and meal preparation
  - m. communication skills
  - n. time management
  - o. coping with crises
  - p. forming natural support systems
2. Maintain written documentation in case files of contacts, visits, and telephone conversations with program participants, service providers, and significant others.

3. Provide case management and informal counseling for individuals as needed. Case management services include but are not limited to:
  - a. Insure referral and follow-through to needed community services including vocational, educational, medical, psychological, alcohol and drug abuse and other specialized services, as appropriate. Maintain communication and coordination with other service providers.
  - b. Encourage and support the individual's involvement in community life, activities, self-help, and advocacy programs.
  - c. Assist individuals in applying for benefits as appropriate and securing needed documentation to resolve problems concerning those benefits.
  - d. Lead in the development of a support network for the individual that will include the resident and significant others who will contribute to the training, support and service plan of the individual.
  - e. Complete a community-based social/recreational Personal Planning Inventory (PPI) on all residents to enhance community integrative programming.
4. Provide consultation on community resources and service options in order to facilitate the development of consumer choice in service planning.

The agency must prepare and submit a report indicating various client outcomes acquired as a result of their participation in this service (e.g. increase wages, acquire new job skill, individuals' goal achieved)

### **Unit of Service**

#### **A unit of service is one-quarter hour of direct service time.**

**Direct service time** is staff time spent in providing service to the program participants which includes face to-face contacts (office or field), collateral contacts, travel time, telephone contacts, client staffing and time spent in documentation of service provision. (Direct service time does not include indirect time such as that spent at staff meetings, in-service training, and vacation.

**Collateral contacts** are face-to-face or telephone contacts with persons other than the program participants, who are directly related to providing service to the person and need to be involved by virtue of their relationship to the program participant. Collateral contacts could include contacts with family members, other service providers, physicians, school personnel, clergy, etc. Reimbursement for group services is based on one-hour units of direct service time. The total time must be equally divided between each group participant and recorded in the case record of the participant.

## **TARGETED CASE MANAGEMENT (TCM) #DSD018**

---

**Note: 2008 is the last year that funding will be available for the Targeted Case Management program.**

Targeted case management (TCM) is a service/practice which addresses the overall maintenance of a person including his / her physical, psychological and social environment with the goal of facilitating physical survival, personal health, community participation and recovery from or adaptation to mental illness. Targeted case management puts primary emphasis on a support professional- consumer therapeutic relationship and intervention to facilitate a continuity of care and promote successful community living experiences.

### **Target population**

Persons served by TCM services have a diagnosis of a developmental disability and are typically at-risk for loss of stability in the community leading to an in-patient hospitalization or rehabilitation period and/or homelessness. This factor occurs due to the lack of family or significant adult instrumental in directing or guiding their care and support. Persons who are served by the program must:

- Be a Milwaukee county resident;
- Be at least 18 years of age up to 59;
- Active on Title 19; and
- Have demonstrated functional limitation in one or more of the following areas: housing, employment, medication or health care management, court mandated services, money management, community problem due to decision-making or symptom escalation to the point of requiring inpatient care

### **Targeted Case Management (DD target group) offers three major service components;**

1. Health and Wellness Monitoring
2. Guidance and Informal counseling with daily functions
3. Social Supports/relationships

### **The service components the provider staff will:**

1. Implement a service plan designed to address the consumers needs in daily living tasks. This would include stable and safe housing, productive and meaningful activity, and ideas for leisure or recreation time. The plan should identify and complement the life relationships, activities, values and culture of each individual. The focus is to assist the consumer to live in, learn, and participate in community.
2. Collaborate on health and safety in the community living. The consumer's preferred health and personal habits should be accepted or their development guided. Assistance may be necessary with the maintenance of regular health care provider visits for physical health and mental/behavioral health visits, or with money management.

3. Offer guidance and informal counseling/support through assistance with decision-making, individual contacts or in a group setting. This service may be extended to family or other living environments to foster productive living experience. In accordance with the consumer's needs and wishes, referrals may be made to outside providers for formal counseling.
4. Provide guidance with social supports and build meaningful and trusting relationships that are core to a functional and productive life. This should include activities facilitating personal growth and opportunities that permit attendance at events and utilize public resources.

### **Agency Requirements – Targeted Case Management Services DD**

1. Assess and submit an initial plan within twelve working days of all referrals. The final plan must be submitted within 30 days and include objectives. In this process each consumer should be given respect and priority to their views and opinion included in the planning. This would include helping the person choose their own goals, choose what kind of help is needed to achieve them, and how to get that help.
2. Agency must produce a semi-annual report on the services provided, frequency and identify the general goals of the participants and progress made. The document should be submitted to DSD staff. The report should include a statement of progress and challenges toward the goals for each participant and, any recommendations for changes in the service plan.
3. Agency must provide training in self-advocacy on elements of self-determination.
4. A Consumer Satisfaction Survey must be issued and a written summary of the results.

### **Unit of Service**

#### **A unit of service is one-quarter hour of direct service time.**

**Direct service time** is staff time spent in providing service to the program participants which includes face to-face contacts (office or field), collateral contacts, travel time, telephone contacts, client staffing and time spent in documentation of service provision. (Direct service time does not include indirect time such as that spent at staff meetings, in-service training, vacation, etc.)

**Collateral contacts** are face-to-face or telephone contacts with persons other than the program participants, who are directly related to providing service to the person and need to be involved by virtue of their relationship to the program participant. Collateral contacts could include contacts with family members, other service providers, physicians, school personnel, clergy, etc. Reimbursement for group services is based on one-hour units of direct service time. The total time must be equally divided between each group participant and recorded in the case record of the participant.

## **Documentation**

**Direct service time** must be documented through an entry in the case notes or narrative for units billed. The narrative entry must include (a) the date of the contact, (b) the type of contact (face-to-face, collateral, phone, etc.), (c) who the contact is with, (d) the content of the contact, (e) the number of units (the length of the contact). The case narrative must be contained in the case record maintained by the agency.

---

---

## FISCAL AGENT SERVICES

---

### FISCAL AGENT SERVICES #DSD021

---

The Milwaukee County Department of Health and Human Services Disability Services Division administers several federal and state client-specific long term support funding sources. These funding sources include the Community Options Program (COP), COP Waiver, Community Integration Program (CIP II), the Community Integration Program - IA and IB (CIP IA, CIP IB), Brain Injury Waiver (BIW), Children's Long Term Support Programs (CLTS) and the Family Support Program.

CIP IA, CIP IB, COP Waiver and CIP II, are Medicaid funds provided through a federal home and community-based state waiver. The waiver programs provide services to adults and children with chronic disabilities to assist them with living in the community. The Community Options and Family Support programs are funded with State General Purpose Revenue. COP provides funds for the same purposes as CIP IA and CIP IB, COP Waiver and CIP II. The Family Support Program provides funds only to families with severely disabled children to keep their own from being institutionalized.

Milwaukee County has, for several years, given the client COP funds to purchase Supportive Home Care services. The client, in turn, pays a provider for that service. When funds are paid directly to the client, the client becomes the provider's employer. The client directs their own care and is responsible for hiring, supervising and training the provider. If Milwaukee County were to pay providers directly, Milwaukee County would be deemed the provider's employer in any Unemployment Compensation action.

Act 31 (1989-1991 State Budget) added a provision to COP statute s. 46.27(5)(i), allowing counties to serve as fiscal agents for purposes of paying Unemployment Compensation taxes when COP recipients serve as the employer of their Supportive Home Care or respite provider. This statute applies only where the COP recipient receives direct cash payments from the county. Federal law prohibits the direct pay of Medicaid Waiver dollars (CIP IA; CIP IB, COP Waiver and CIP II) to Waiver recipients, spouses, or parents of minors. All Medicaid Waiver payments must be made to the providers of care.

Given that Milwaukee County administers funding sources, which have these specific requirements, we have chosen to contract for the services of a fiscal agent to comply with the Medicaid provisions and the new provision in the COP statute. We are also extending these requirements to other long-term support funding sources operated by the county; i.e., Family Support.

Through this request for proposals, it is our intent to contract with an entity to purchase the services of a fiscal agent. The primary purpose of the fiscal agent is to provide payroll services to clients who employ providers of in-home supportive services. The County would provide funds to the fiscal agent to meet payroll requirements of supportive home care providers.

The functions of the fiscal agent also include cutting checks, preparing reports, and creating accounts with unemployment compensation. For providing these payroll services, the fiscal agent will be compensated by Milwaukee County on an agreed upon rate per check fee. That activity will be included as a service cost to each client as part of the case plan. By using the fiscal agent, the County accomplishes two objectives:

1. The County is not the employer of this group of service providers.
2. It allows clients to choose, hire, and train their own attendants within the framework of Medicaid Waiver and State guidelines.

### **Program Requirements**

The provider agency will be under contract with the Disability Services Division. The contract will include an agreed upon rate for reimbursement of fiscal agent services up to a maximum contract amount.

1. The number of clients will vary from 200 to a possible 800.
2. The cost for this service will be added to each individual client service plan. Therefore, the provider agency should calculate its cost based on each individual client transaction, including activities of check writing, mailings, processing tax forms, etc.
3. The actual client payments that will be transferred from the County to the fiscal agent will range from \$65,000/month to \$500,000.
4. Agency will quote a maximum fee per check (physical) and also quote a rate per direct deposit payment in lieu of a check. Agency should also provide a quote for Administrative cost for "Stop Payment" order and a separate quote for providing a manual or out of sequence or special check or direct deposit.
5. The agency may charge the market bank rate for processing of a client stop payment order
6. Disability Services shall provide a monthly early payment to the fiscal agent to avoid disrupting of the agency's processing the client payroll. The early payment to the fiscal agent will equal the actual reporting statement from the fiscal agent for the most recent month of available data. Upon the discretion of Disability Services, the early payment can be increased to meet changing workload (for example, if a large group of clients are about to be added to the Fiscal Agent process).

### **Audit Requirements**

The fiscal agent shall submit to County, on or before June 30, 2009 or such later date that is mutually agreed to by Contractor and County, two (2) original copies of a certified program-specific audit report of the Fiscal Agent Program. The audit shall be performed by an independent certified public accountant (CPA) licensed to practice by the State of Wisconsin.

The audit shall be conducted in accordance with the State of Wisconsin Department of Health and Family Services *Provider Agency Audit Guide*; 1999 revision, the provisions of *Government Auditing Standards* (GAS) most recent revision published by the Comptroller General of the United States; and, Generally Accepted Auditing Standards (GAAS) adopted by the American Institute of Certified Public Accountants (AICPA).

The CPA audit report shall contain the following Financial Statements and Auditors' Reports:

**1. Financial Statements for the Fiscal Agent Program prepared on a Modified Cash Basis as defined in the Fiscal Agent Program Purchase Contract.**

- a. Comparative Statements of Financial Position – Modified Cash Basis.
- b. Comparative Statements of Activities – Modified Cash Basis.
- c. Cash basis revenue and expenditures must be reported on **Comparative Statements of Cash Flows** for the calendar years under audit regardless of the fiscal agent program years to which they are related. (Note, comparative statements of cash flows are required because fiscal agent program financial statements are not prepared on the pure cash basis of accounting.)
- d. Notes to financial statements, **including total units of service provided under contract** (if not disclosed on the face of the financial statements).
- e. Schedule of expenditures of federal and state awards broken down by contract year. The schedule shall identify the contract number and the program number from the Exhibit I of the contract, and contain the information required by the *Provider Agency Audit Guide*, 1999 revision.

**2. Auditors Reports for the Fiscal Agent Program**

- a. Opinion on Financial Statements and Supplementary Schedule of Expenditures of Federal and State Awards.
- b. Report on Compliance and Internal Control over Financial Reporting Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards (GAS), and the Provider Agency Audit Guide, 1999 revision, testing and reporting on items of compliance based on samples and directions contained in exhibit A.
- c. A copy of any management letter issued in conjunction with the audit shall be provided to County. If no management letter was issued, the Schedule of Findings and Questioned Costs shall state that no management letter was issued.

- d. Schedule of Findings and Questioned Costs including a summary of auditor's results.
- e. A report on the status of action(s) taken on prior audit findings.
- f. Corrective action plan for all current year audit findings.
- g. Management's response to each audit comment and item identified in the auditor's management letter.

Regardless of status or format, all CPA audit reports and financial statements referenced above shall be prepared on a modified cash basis of accounting. **For purposes of this contract modified cash basis is defined as follows:**

1. Expenses are recognized when paid, with the exception of payroll taxes, which are accrued for wages and salaries, earned and paid.
2. Revenue is recognized when earned, which is upon issuance of paychecks for the related pay period; therefore, there will be a matching of revenue and related modified cash basis expenses for the same fiscal agent program calendar year. Audited revenue reported should correspond to DHS payments made for the contracted calendar year under review, including the final year-end adjusting payment made after the calendar year end for the prior contract year.

### **Fiscal Agent Service Provision Responsibilities and Requirements**

1. The fiscal agent shall develop and implement a fiscal agent system for providers of supportive home care services funded with long-term support funds. Duties of a fiscal agent include the issuance of:
  - Wage payments;
  - Social Security and benefit payments and deductions;
  - Tax payments and tax withholding;
  - W-2 forms and tax statements;
  - Recipient cost share statements.
2. The provider shall function as the federal and IRS fiscal agent, handling provider payments and deductions, and reporting and tax withholding responsibilities for the consumer, who is the employer.
3. The fiscal agent issues bimonthly payroll checks/Direct deposit made out to the provider (supportive home care worker). The checks are mailed to the client, who turns them over to the provider or with proper documentation set up a system of direct deposit. The fiscal agent makes deductions for Social Security, Unemployment Compensation, and other deductions as necessary, and makes these payments.

4. The fiscal agent shall submit on or before the fifth (5<sup>th</sup>) working day of the month following the month in which service payments were made, a report of all payments made on behalf of clients served for the month. The reports will be in the format designated by Adult Services, and at a minimum contain the following: client name, address, provider, S.S. #, funding source of payment, payroll deductions, service coding, maximum authorized cost per case, payments to each provider, and total provider cost per client.
5. The fiscal agent will receive, review, complete and submit all forms, reports, and other documents required by Department of Industry, Labor and Human Relations or the Internal Revenue Service for Unemployment Compensation proposed on behalf of the client. The fiscal agent will also serve as the representative of the client in any investigation, hearing, meeting, or appeal involving an Unemployment Compensation tax question or benefits claim in which the client is a party.
6. The fiscal agent shall comply with all Disability Services fiscal and program reporting requirements. This includes the submittal of monthly expense and revenue forms.
7. The fiscal agent shall work with County staff to develop reports to meet federal and state reporting requirements.
8. The fiscal agent must be an entity, which offers similar services as part of its normal business, and may not be a relative or friend of the service provider acting on behalf of a single individual. Examples include:
 

|                            |                        |
|----------------------------|------------------------|
| Independent Living Centers | Consumer Organizations |
| Banks                      | Hospitals              |
| Accounting Firms           | Nursing Homes          |
| Law Firms                  | Home Health Agencies   |
9. Disability Services will require that the fiscal agent be bonded.
10. The fiscal agent shall assist clients in understanding payroll processing, filling out time cards, and in submitting time cards to in a timely fashion.
11. The fiscal agent shall provide for an emergency payroll processing service that can handle emergency payroll processing needs outside of the normal.
12. The fiscal agent is responsible to provide all supplies, forms, etc., necessary to provide their services.

## EXHIBIT A

### REQUIRED AUDIT PROCEDURES FOR FISCAL AGENT AUDIT REQUIREMENTS

The auditor will, at a minimum, examine and report on the following internal control and compliance matters.

1. Recalculation of at least one month payroll, payroll taxes, reimbursable expenses and processing fees, and reconciliation to the monthly billing submitted to DHHS. *Any discrepancy, regardless of materiality, shall be reported as a finding.*
2. Reconcile annual payroll and payroll taxes to relevant payroll tax returns filed with Internal Revenue Service, Social Security Administration, and Wisconsin Department of Workforce Development. *Any discrepancy, regardless of materiality, shall be reported as a finding.*
3. Examine insurance coverages. *Any discrepancy from the insurance requirements shall be reported as a finding.*
4. Test internal controls over reporting, to include at a minimum,
  - a. Testing of at least 100 payroll checks, recalculating gross payroll and calculation of employee and employer payroll taxes;
  - b. Testing the calculation of processing and stop payment fees charged, including examination of the underlying supporting documentation for the fees; and
  - c. Testing reimbursable expenses charged, including examination of the underlying supporting documentation for the expenses.

# **Section 4**

## **Economic Support Division Program Description**

---

---

---

**ENERGY ASSISTANCE  
Program #ESD 001**

---

---

**TENTATIVE BUDGET:**     \$2.3 million, pending state notification of funding level  
Note – see #s 1 – 4 in “Use of Funds” section for specific breakdown. Separate Budgets for each section are required.

**TARGET GROUP:**

Low and Fixed Income Milwaukee County residents, including the elderly and disabled, who are eligible for energy assistance.

**PROGRAM GOALS:**

- Administer the Milwaukee County Wisconsin Home Energy Assistance Program in compliance with all federal, state and local laws, rules and requirements.

**GENERAL INFORMATION:**

The Wisconsin Home Energy Assistance Program (WHEAP) administers the federally funded Low Income Home Energy Assistance Program (LIHEAP) and Public Benefits Energy Assistance Program. LIHEAP and its related services help approximately 140,000 Wisconsin households annually. In addition to regular heating and electric assistance, specialized services include:

- Emergency fuel assistance,
- Counseling for energy conservation and energy budgets,
- Pro-active co payment plans,
- Targeted outreach services,
- Emergency furnace repair and replacement

**HEATING ASSISTANCE**

WHEAP heating assistance is a one-time benefit payment per heating season (October 1 through May 15). It is intended to help pay a portion of a household’s heating costs, not the entire annual cost of heating a home.

The amount of heating assistance benefit depends on the household’s size, income and heating costs. In most cases the heating assistance benefit is applied directly to the household’s bill with the fuel supplier.

### ELECTRIC ASSISTANCE

WHEAP electric assistance is a one-time benefit payment per heating season to eligible households. It is intended to help pay a portion of a household's electrical costs.

The amount of the electrical assistance benefit depends on the household's size, income, and electric costs. In most cases the electrical assistance benefit is applied directly to the household's electric account.

### CRISIS ASSISTANCE

A household may be eligible for crisis assistance if it has no heat, received a disconnect notice from its heating fuel dealer, if it is nearly out of heating fuel and does not have any way to pay for its heating needs, or if a heating emergency can be avoided. WHEAP crisis assistance provides both emergency and proactive services.

Emergency services may help a household during the heating season from October 1 through May 15. These services can include the purchasing of heating fuel, providing a warm place for a household to stay for a few days, or needed furnace repair or replacement.

Proactive WHEAP services are available through the entire year to avoid future emergencies. Proactive services include training and information on how to reduce fuel costs, counseling on money management, providing payments to fuel suppliers when a household agrees to a co-payment, and other actions to help avoid future emergencies.

### **SERVICE DESCRIPTION:**

The following minimal levels of service must be provided

1. Public Information
  - a. Identify the program as being administered by the State of Wisconsin Home Energy Assistance Program in all program materials prepared and published by the vendor.
  - b. Establish and publicize a telephone number where persons can call year-round for WHEAP information.
  - c. Provide information on transportation to application sites.
  - d. Publicize eligibility requirements, how to apply, location of application sites, times to apply, etc.
  - e. Publicize the availability of home energy assistance, crisis assistance and weatherization services.
2. Outreach
  - a. Provide outreach services to targeted population groups, high-risk households, the elderly, disabled persons, households with children under six.
  - b. Provide assistance with the preparation and submittal of applications by persons who are homebound.
  - c. Provide for an alternate outreach agency.
  - d. In cooperation with Milwaukee County, submit to the state by October 1 a written "Outreach Plan and Strategy" explaining how your agency will reach targeted households.

- e. Subcontract a portion of outreach funding to other organizations for outreach, to total at least as large a portion of total outreach dollars and utilizing at least as many other outreach organizations as were used in 2006.
3. Intake
- a. Establish a central location for the distribution and receipt of applications.
  - b. Provide flexible office hours to accommodate clients who cannot apply during normal business hours.
  - c. Ensure that application sites are physically and geographically available for all potential applicants throughout Milwaukee County.
  - d. Ensure that all outreach sites are accessible to persons with physical disabilities.
  - e. Provide for an alternate intake site (as required by federal law). An alternate application site is a site that is not administered by a TANF agency.
  - f. The state/Milwaukee County will provide weatherization agencies with a weekly list of clients who have received home energy benefits and/or a furnace replacement:
    - i. Vendor should develop a working relationship with area weatherization operators to take advantage of the additional services they may be able to offer clients.
    - ii. Vendor should provide the client the name, phone number and address of the weatherization operator for their area.
4. Eligibility Determination
- a. Verify application information and supporting documents and certify the application is accurate.
  - b. Enter applications into the energy system within 30 days of the application
  - c. All applications need to be entered in chronological (date) order. Applications will be paid on first chronological application taken.
  - d. Applications should be complete, unless applicant withdraws or fails to provide required information.
  - e. Resolve application and check issuance problems.
  - f. If the applicant is an employee of the vendor or a relative or household member of a vendor employee, the person certifying/entering the application must be at the level of supervisor or higher.
5. Crisis Assistance
- Provide emergency and pro-active crisis services to assist clients with home energy costs. The vendor shall develop a "Crisis Plan" to guide the in managing funds and distributing benefits and services. The plan must be submitted to Milwaukee County two weeks prior to the date it is due to the state.

Crisis services include but are not limited to the following

- a. Respond to requests for emergency assistance within 48 hours of receiving the request.
- b. If a situation is life threatening, respond within 18 hours of receiving the request
- c. Provide emergency services during the heating season.
- d. Provide pro-active services year-round.

## 6. Coordination

- a. Coordinate with other local agencies serving low-income persons, especially those providing energy related services. This includes, but is not limited to, community action agencies, weatherization agencies, agencies on aging, social security offices, housing authorities, and special purpose agencies providing energy assistance.
- b. In cooperation with Milwaukee County, prepare a local coordination plan to be submitted to the state by the first of September.
- c. Coordinate services with utility programs that provide services to low-income persons.
- d. Coordinate with registered fuel suppliers.

## 7. Staffing

Staffing must be adequate, both in terms of numbers and experience and training, to provide the following:

- a. Program information year-round on both Home Energy Assistance and Crisis Assistance
- b. Ability to take applications throughout the calendar year to assist clients with home energy needs.
- c. Outreach activities throughout the calendar year.
- d. Crisis Emergency Services during the heating season.
- e. Crisis Proactive Services year-round.

The vendor will demonstrate the ability to provide the appropriate number of managerial and supervisory staff with appropriate knowledge and experience to adequately manage the program.

## 8. Records

Milwaukee County will maintain a record management system that retains applications and supporting documents for a period of five years from the date the application is submitted. It is the responsibility of the vendor to send a vendor employee to Milwaukee County during the first five business days of every month to file energy records from the previous month in the Milwaukee County energy file storage room:

- a. Files on all Applicants including signed and certified application form(s) DOA-9549.
- b. If the application is completed interactively, the client signature form must be in the client's file.
- c. All records associated with the Quality Assurance/Quality Control requirements in Chapter 7 of the Wisconsin Home Energy Assistance Program – Program and Operations Manual.
- d. Electronic files of the following are maintained on the WHEAP System:
  - Registered fuel suppliers
  - Weekly check registers for payments through the heating, public benefits and crisis programs.

9. The vendor must provide the following information to Milwaukee County and the state:

- a. Name, address, phone numbers and e-mail addresses of persons responsible for administration and operation of the various components of the program.
  - b. Address(s) and telephone number(s) for client contacts and for computer-generated client notification letters.
  - c. Other general information which may be requested by Milwaukee County or the state relative to the administration of the program.
  - d. Any changes to the above information must be submitted by email to Milwaukee County and the state.
10. Fraud  
If fraud is suspected, collect all information available about the case. Present this to the authority in Milwaukee County who handles fraud cases.
11. The vendor must provide access to energy assistance in at multiple sites dispersed throughout Milwaukee County.
12. The vendor must offer non-English language/culturally competent programs as required by the Milwaukee County resident population.

**USE OF FUNDS:**

1. LIHEAP General Operations      **tentative budget: \$312,000**  
Administrative funds may be used to pay the cost of WHEAP staff and associated costs.
  - a. Allowable Costs Include:
    - Staff time to accept and process applications throughout the calendar year.
    - Verifying application information
    - Processing applications, including entering data into the energy system.
    - Processing benefit payments and denial letters
    - Other costs not covered by crisis assistance or outreach funds.
  - b. Administrative Activities:
    - Supervisor and coordinator salary and fringe
    - Travel for meetings and training
    - Clerical support salary and fringe
    - Supplies, services and equipment
    - Indirect program charges
  - c. Out of State Travel Costs:  
If the vendor wishes to have staff attend out of state conferences or training, they must obtain prior approval from Milwaukee County. The vendor must submit a request at least six weeks in advance identifying the staff person(s) they wish to send and a justification for their attendance. The justification must include estimated total costs, reference to the specific workshops/programs they plan to attend and an explanation of how this knowledge will contribute to the agency's performance or quality of work.
  
2. Public Benefits Operations      **tentative budget: \$403,000**  
Public Benefit Operations should be used for costs of services associated with processing non-heating energy benefits.
  - a. Allowable Costs Include:

- Staff time to accept and process applications throughout the calendar year
- Verifying application information
- Processing applications, including entering data into the energy system
- Processing benefit payments and denial letters
- Other costs not covered by crisis assistance or outreach funds

NOTE: Administrative activities may NOT be charged to Public Benefit Operations

3. LIHEAP Crisis Client Services **tentative budget: \$1,250,000**

The vendor may charge to LIHEAP Crisis Assistance funds the cost of staff salaries, fringe benefits, travel associated with providing crisis services and other costs directly related to providing crisis services.

When charging staff costs to LIHEAP Crisis Assistance funds, agencies must document staff time spent providing crisis services to clients.

Documentation must include:

- The name(s) of staff person(s) providing the service
- Case names(s) and case Numbers(s) of eligible household(s) receiving the service
- Type of assistance provided
- Date and amount of time spent by staff person(s) to provide the service.

Non-staff costs may also be charged to Crisis Assistance funds, including educational or informational materials or services provided to clients. These costs must be directly related to the provision of emergency or proactive services to eligible households.

All non-staff costs require documentation to include:

- Description of item or service provided
- Why the item or service is needed, including how it is used such as weatherization kits, blankets etc.
- Date and cost of item or service

NOTE: Administrative activities may NOT be charged to LIHEAP Crisis Services.

4. Outreach **tentative budget: \$347,000**

Agencies may charge to Outreach the cost of staff salaries, fringe benefits and travel associated with staff time spent on outreach activities.

Agencies must document the use of outreach funds in one of the following ways:

- Job Descriptions. These must clearly state that the person will be performing outreach activities for a specific portion of their time, e.g., 100%, 50%, etc. Agencies may then charge the appropriate percentage of the staff costs, including support costs to outreach.
- Documentation of Outreach Activities Performed.

Documentation must include:

- Name(s) of staff person(s) providing outreach activities
- Type of outreach provided
- Dates and amounts of time spent by staff person(s) to provide outreach services

Outreach activities include but are not limited to:

- Providing energy information to potentially eligible groups or individuals through home visits, site visits, group meetings, etc.
- Distributing posters, flyers or other informational material when available to potentially eligible persons
- Providing information on eligibility criteria, application sites, etc. to local media
- Producing and mailing information to potentially eligible persons, ensuring that the State of Wisconsin, Department of Administration, Home Energy Assistance Program is referenced on any published material.
- Coordinating with other local program offices servicing persons in targeted low-income groups, including arranging for WHEAP information and/or application intake to be provided in conjunction with other programs.

Note: Administrative activities may NOT be charged to Outreach.

5. Public Benefits Crisis Client Services

When funding is made available, the use is the same as for LIHEAP Crisis Client Services. Additionally, these funds may be only used for those clients whose electric utility participates in the State Public Benefits program.

Note: Administrative activities may NOT be charged to Public Benefit Crisis Client Services.

6. Crisis Benefits

Crisis Benefit allocations (LIHEAP and Public Benefits) are not included in the contract budget because they are tracked on the WHEAP system. The state makes crisis allocations to each WHEAP agency which usually include two parts, Crisis Client Services funds and Crisis Benefit funds.

7. Budget Transfers

Transfers of funds from one budget line to another are not allowed, except as detailed below.

The vendor may request to transfer funds from LIHEAP Crisis Services to LIHEAP Crisis benefits. The vendor may request to transfer funds from Public Benefit Crisis Services to Public Benefits Crisis Benefits. All requests to transfer funds must be in writing, email is acceptable, and approved by Milwaukee County.

## **FAIR HEARINGS:**

The client has the right to apply for Energy Assistance benefits and to receive a payment of a letter of explanation within 45 days from the date the client completes the application process. If the client believes his/her application has been incorrectly denied or his/her payment is incorrect, the client may request a fair hearing by contacting Milwaukee County Economic Support Division or by writing to:

Wisconsin Department of Administration  
Division of Hearing and Appeals  
PO Box 7875  
Madison, WI 53707-7875

If the client believes he/she has been discriminated against in any way, the client may file a complaint by contacting the 504 Coordinator at Milwaukee County or any person authorized by the Milwaukee County to receive discrimination complaints. The law prohibits discrimination based on: race, color, national origin, sex, age or disability.

The vendor will receive any and all client discrimination complaints brought to the attention of any of their staff at any of their locations and forward them to Milwaukee County. The vendor will also assist Milwaukee County in the resolution of fair hearing complaints prior to a fair hearing occurring. In the event that resolution does not occur, the vendor will assist Milwaukee County in preparing for the fair hearing and will have the appropriate staff present at the hearing.

## **MONITORING:**

WHEAP monitoring of heating and non-heating assistance, crisis assistance, furnace replacement and repairs, outreach, and alternate intake and outreach is conducted on both the local agency level and the state level.

## **LOBBYING RESTRICTIONS:**

WHEAP funds may not be used to influence federal contracting nor financial transactions. This restriction includes, but is not limited to the following activities:

- The vendor may not use federal funds (including LIHEAP) to pay a person(s) to lobby on their behalf with the Executive or Legislative Branch in connection with the award of a specific contract, grant or loan.
- The vendor must file with the US Department of Health and Human Services an annual statement certifying that they will abide by these restrictions.
- The web site for form for vendor to disclose lobbying activities:  
[www.whitehouse.gov/omb/grants/sfillin.pdf](http://www.whitehouse.gov/omb/grants/sfillin.pdf).
- The vendor must disclose any payments made to a person(s) lobbying, as defined above, even if no federal funds are used to make the payment.

## **PAYMENT METHOD:**

Cost reimbursement of actual expenses incurred based on the vendor's budgets approved by DHHS. **Separate budgets must be submitted for each of the following**

**areas:** LIHEAP General Operations, Public Benefits Operations, LIHEAP Crisis Client Services, and Public Benefits Outreach

Please note that Administrative Activities are **only** an allowable cost under, and may be charged to, LIHEAP General Operations.

### **REPORTING REQUIREMENTS:**

Vendor will provide a monthly activity report, due the 7<sup>th</sup> of each month. Each monthly report must include the following:

- Number of households requesting service in the previous month by type of service
- Number of households approved for service in the previous month by type of service
- Total benefits provided in the previous month
- Number of non-English speaking households served by language
- Year-to-date figures should also be provided on the above categories

Vendor will provide a final report, due the 15<sup>th</sup> of January 2009.

Vendor will cooperate with any other special reports and/or evaluation activities as requested by Milwaukee County.

#### **Performance Standards:**

- All aspects of the program will be conducted in accord with federal, state, and local laws, rules and guidelines.
- Vendor will meet with Milwaukee County staff as needed to discuss program and performance standards.
- Vendor will participate in a six month and 12 month review of contract accomplishments with Milwaukee County.
- All reporting is accomplished on a consistent and timely basis.
- Vendor will cooperate with any special reports, training and/or evaluation activities as required by Milwaukee County.

### **MILWAUKEE COUNTY RESPONSIBILITIES:**

- Milwaukee County will forward to the vendor all documents and messages (including electronic messages) from the state
- State/federal forms, pamphlets and other material from the state will be forwarded to the main office of the vendor, when received by Milwaukee County.
- Milwaukee County will provide assistance to the vendor to verify required income information through the CARES system.
- Milwaukee County will provide assistance to the vendor in verifying Social Security and SSI income through TPQY (Third Party Query).
- Milwaukee County will provide assistance to the vendor in verifying TANF/W2 income and other Income Maintenance program documentation.

- Milwaukee County will provide procedures to the vendor for applicants to use in applying for SSNs.
- Milwaukee County will provide procedures to the vendor for verification of Alien status through INS.