Attachment I

MD Role in Crisis Services for Medications / Pick-Up of Medications when in a Licensed Crisis Residential

MD Role in Crisis Services for Medications		
Situation	Issues / Concerns	Recommendations
Unknown to AMHD or other private psychiatrist	Use of ER regardless of need to check client out	Crisis Services MD.
Previous history of crisis services only	May have no other linkages with psychiatry	If has a psychiatrist, that psychiatrist should be notified. Otherwise Crisis Services MD.
Private psychiatrist or provider	Need to notify private psychiatrist or provider upon admission to LCRS	Private psychiatrist should Rx. If cannot be reached, Crisis Services MD should be called.
CSM services while awaiting linkage with ongoing case management	CSM has no MD back-up. The wait for ongoing case management services depends on availability of case management. May or may not have been seen for meds only in CMHC.	If seen in the CMHC for meds the CMHC MD who prescribed the meds should be notified. If after business hours the Crisis Services MD should be called.
Known to CMHC as ICM or TCM or Care Coordination	Need to notify CMHC MD of admission if admission occurs during business hours.	Responsible CMHC MD is called during business hours, otherwise the on-call CMHC MD is called for after hours. If no response within 1 hour the Crisis Services MD is called.
Known to POS as ACT	Pay for 24/7 ACT services	ACT MD. If no response within 1 hour the Crisis Services MD is called.
Known to POS as ICM	ICM clients have CMHC MD assigned.	Responsible CMHC MD is called during business hours, otherwise the on-call CMHC MD is called for after hours. If no response within 1 hour the Crisis Services MD is called.

Pick-up of Medications When in a Licensed Crisis Residential		
Situation	Issues / Concerns	Disposition
Unknown to AMHD, or Previous history of crisis services only	Licensed Crisis Residential staffing (1 RN and 1 mental health worker) is mandated to stay in the residence when there are consumers in the home. Consumers may enter without medications. Once determined what the consumer is on, or needs there is concern as to obtaining the needed meds to stabilize in the Licensed Crisis Residential.	Medication management is required for crisis services. The required Licensed Crisis Residential staffing cannot be used for medication errands. Sample drugs at the Licensed Crisis Residential can be used or Rx with use of the recovery fund to pay for medication, if no insurance, or the consumer is unable to pay the co-payment.
Private psychiatrist or provider, or Crisis Support Management Services while awaiting linkage with ongoing case management	Same as above	Individuals should be encouraged to bring their meds. If there are med changes or no meds are brought in, the Licensed Crisis Residential needs to call Crisis Mobile Outreach who arranges for pick-up.
Known to CMHC as ICM or TCM or Care Coordination	Same as above. Case management could be used to pick-up meds if on duty.	If there are med changes or no meds are brought in, the Licensed Crisis Residential needs to call Crisis Mobile Outreach who arranges for pick-up. e.g., ICM, TCM, family.
Known to POS as ACT or, Known to POS as ICM	Same as above. Case management could be used to pick-up meds since service is 24/7.	If there are med changes or no meds are brought in, the Licensed Crisis Residential needs to call Crisis Mobile Outreach who arranges for pick-up. e.g., ICM, TCM, family.

Attachment J

Comprehensive, Continuous, Integrated System of Care Model by Kenneth Minkoff, M.D.

Comprehensive, Continuous, Integrated System of Care Model

By Kenneth Minkoff, M.D.

The eight research-derived and consensus-derived principles that guide the implementation of the CCISC are as follows:

1. *Dual diagnosis is an expectation, not an exception:* Epidemiologic data defining the high prevalence of comorbidity, along with clinical outcome data associating individuals with co-occurring psychiatric and substance disorders ("ICOPSD") with poor outcomes and high costs in multiple systems, imply that the whole system, at every level, must be designed to use all of its resources in accordance with this expectation. This implies the need for an integrated system planning process, in which each funding stream, each program, all clinical practices, and all clinician competencies are designed proactively to address the individuals with co-occurring disorders who present in each component of the system already.

2. *All ICOPSD are not the same; the national consensus four quadrant model for categorizing co-occurring disorders (NASMHPD, 1998) can be used as a guide for service planning on the system level.* In this model, ICOPSD can be divided according to high and low severity for each disorder, into high-high (Quadrant IV), low MH – high SA (Quadrant III), high MH – low SA (Quadrant II), and low-low (Quadrant I). High MH individuals usually have SPMI and require continuing integrated care in the MH system. High SA individuals are appropriate for receiving episodes of addiction treatment in the SA system, with varying degrees of integration of mental health capability.

3. *Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting; provision of continuous integrated treatment relationships is an evidence based best practice for individuals with the most severe combinations of psychiatric and substance difficulties.* The system needs to prioritize a) the development of clear guidelines for how clinicians in any service setting can provide integrated treatment in the context of an appropriate scope of practice, and b) access to continuous integrated treatment of appropriate

intensity and capability for individuals with the most complex difficulties.

4. *Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting.* Each individual client may require a different balance (based on level of functioning, available supports, external contingencies, etc.); and in a comprehensive service system, different programs are designed to provide this balance in different ways. Individuals who require high degrees of support or supervision can utilize contingency based learning strategies involving a variety of community based reinforcers to make incremental progress within the context of continuing treatment.

5. *When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended.* The system needs to develop a variety of administrative, financial, and clinical structures to reinforce this clinical principle, and to develop specific practice guidelines emphasizing how to integrate diagnosis-specific best practice treatments for multiple disorders for clinically appropriate clients within each service setting

6. *Both mental illness and addiction can be treated within the philosophical framework of a "disease and recovery model" (Minkoff, 1989) with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery), in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change.* Literature in both the addiction field and the mental health field has emphasized the concept of stages of change or stages of treatment, and demonstrated the value of stagewise treatment (Drake et al, 2001.)

7. *There is no single correct intervention for ICOPSD; for each individual interventions must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and (in a managed care system) multidimensional assessment of level of care requirements.* This principle forms the basis for developing clinical practice guidelines for assessment and treatment matching. It also forms the basis for designing the template of the CCISC, in which

each program is a dual diagnosis program, but all programs are not the same. Each program in the system is assigned a "job": to work with a particular cohort of ICOPSD, providing continuity or episode interventions, at a particular level of care. Consequently, all programs become mobilized to develop cohort specific dual diagnosis services, thereby mobilizing treatment resources throughout the entire system.

8. *Clinical outcomes for ICOPSD must also be individualized, based on similar parameters for individualizing treatment interventions.* Abstinence and full mental illness recovery are usually long term goals, but short term clinical outcomes must be individualized, and may include reduction in symptoms or use of substances, increases in level of functioning, increases in disease management skills, movement through stages of change, reduction in "harm" (internal or external), reduction in service utilization, or movement to a lower level of care. Systems need to develop clinical practice parameters for treatment planning and outcome tracking that legitimize this variety of outcome measures to reinforce incremental treatment progress and promote the experience of treatment success.

Attachment K

Dual Diagnosis Philosophy and Treatment Guidelines

DUAL DIAGNOSIS
PHILOSOPHY AND TREATMENT GUIDELINES

GUIDING PRINCIPLES:

- We agree that psychiatric and substance disorders tend to be persistent and recurrent, and that co-occurrence of these disorders occurs with sufficient frequency in both systems that a continuous and integrated approach to assessment and treatment is required.
- We agree that individuals with co-occurring serious and persistent mental illness and substance disorders should be regarded as having two (or more) co-occurring primary disorders, each of which requires specific assessment and diagnosis, and appropriately intensive treatment. The presence of co-occurring disorders makes each disorder more difficult to treat.
- We agree that the recommended treatment approach for individuals with co-occurring serious and persistent mental illness and substance disorders is an integrated dual primary treatment in which:
    - Each individual has a primary treatment relationship with a clinician, or team of clinicians.
    - Each individual receives specific, and appropriately intensive, primary treatment for each disorder that takes into account the complications resulting from the co-occurring disorder.
    - Each individual receives integrated and coordinated treatment for both disorders in a single setting.
- We agree that because the underlying goal of working together is to improve consumer outcomes, any successful program must be consumer-centered. A consumer-centered system is one in which dual diagnosis consumers and their families are actively involved, not only in treatment decisions, but also in program design, administration and evaluation. The role of consumers in advancing care for people with serious and persistent mental illness should be the cornerstone in program planning.

TREATMENT PHILOSOPHY:

- Serious, persistent psychiatric disorders and substance disorders are both examples of primary psychiatric or behavioral illness that can utilize a disease and recovery model for conceptualizing assessment, treatment, and rehabilitation.
- The program must incorporate the recovery model. Recovery is defined as an ongoing personal process of empowerment by which an individual overcomes the negative impact of a psychiatric disability (and other co-occurring disabilities), regains hope, self-esteem, self-worth, pride, dignity and meaning by acquiring increasing ability to maintain stabilization or remission of the disorder, and maximizing functioning with appropriate supports despite the possible ongoing constraints of the disorder.
- Every individual, regardless of the severity and disability associated with each disorder, is entitled to experience the promise and hope of dual recovery, and considered to have the potential to achieve dual recovery.

- Bringing optimism to the treatment process creates consumer motivation. Treatment success derives from the implementation of an empathic, hopeful, continuous treatment relationship, which takes place over time and often in multiple treatment episodes.

PSYCHOPHARMACOLOGY GUIDELINES:

- Initial psychopharmacologic evaluation in mental health should not require consumers to be abstinent.
- Initial psychopharmacologic evaluation in substance disorder treatment should occur as early in treatment as possible, and incorporate capacity to maintain existing non-addictive psychotropic medication during detoxification and early recovery.
- Psychopharmacology with individuals with co-occurring disorders is not an absolute science. It is best performed in the context of an ongoing, empathic clinical relationship. Treatment should emphasize a continuous re-evaluation of diagnosis and medication, and artful utilization of medication strategies to promote outcome of both disorders.

The applicant must have expertise in Best Practices and Evidenced Based Practices in the area of treatment for individuals with serious and persistent mental illness and a co-occurring substance use disorder defined in the literature by a variety of authors, including but not limited to, Robert E. Drake, Ken Minkoff, JO Prochaska. The applicant shall also provide a listing of verifiable experience with projects or contracts for the most recent five years that are pertinent to the proposed services.

Attachment L

Treatment Services Definitions

Diagnostic/Functional Assessment. Intensive clinical and functional evaluation which results in a treatment plan that documents and identifies needed services and supports, goals and objectives related to the provision of these services and supports, and methods for achieving the objectives. Required components include: (1) evidence that an interdisciplinary team process was conducted; (2) evidence of consumer participation including families and/or guardians where required; (3) assessment of a person's psychological, neuropsychological, psychiatric, psychosocial, and physical health (including nutrition) associated with a person's mental health, as well as conducting a risk and developmental assessment; and (4) periodic review of the treatment plan which shall occur no less frequently than every ninety (90) days. This service also includes the assessment of the need for psychiatric hospitalization for persons being referred to psychiatric inpatient services to assure less restrictive alternatives are considered and evaluated when appropriate.

Biopsychosocial Rehabilitative Programs. A set of therapeutic and rehabilitative social skill building services which promotes resiliency and recovery and which allows children with serious emotional or behavioral disturbance and adults with serious mental illness to gain the necessary social, independent living, work-related, and communication skills necessary to allow them to remain in or return to communities of their choice and access naturally occurring community supports. Services include, but are not limited to: individual or group skill building activities that focus on the development of problem-solving techniques, independent living skills, social skills, medication management, and recreational activities that improve self-esteem.

Crisis Management. This service provides mobile assessment for children or adults in an active state of crisis twenty-four (24) hours per day, seven (7) days per week and can occur in a variety of settings including the consumer's home, local emergency departments, etc. It does not include transportation time to and from clinic/hospital and community settings. Immediate response is provided to conduct a thorough assessment of risk, mental status, and medical stability, explore service options in the community, and assure immediate crisis resolution and de-escalation as applicable. The presenting crisis situation is one where it is medically necessary to deliver the services in the consumer's home or natural environment setting as the consumer does not have the resources to present at the clinic for crisis services.

Licensed Crisis Residential Services. This service offers short-term, acute interventions to individuals experiencing crisis. This is a structured residential alternative or diversion from psychiatric inpatient hospitalization. Licensed Crisis Residential Services are for individuals who are experiencing a period of acute stress that significantly impairs the capacity to cope with normal life circumstances. The program provides psychiatric services that address the psychiatric, psychological, and behavioral health needs of the individuals. Specific services are: psychiatric medical assessment, crisis stabilization and intervention, medication management and monitoring, individual, group and/or family counseling, daily living skills training, and linkage to other services, as needed.

Counseling and Psychotherapy Services. Individual, group or family face-to-face services include symptom/behavior management, development, restoration, or enhancement of adaptive behaviors and skills, enhancement or maintenance of daily living skills. These skills include those necessary to access community resources and support systems, interpersonal skills, and restoration or enhancement of the family unit and/or support of the family.

Medication/Somatic Treatment. Medical interventions include: physical examinations; prescription, supervision or administration of psychoactive medications; monitoring of diagnostic studies; and medical interventions needed for effective mental health treatment provided as either an individual or group intervention. Activities include promoting compliance, evaluating the clinical effectiveness of the medication, monitoring and treating the side effects of medication and any adverse reactions, and providing education and direction for symptom and medication self-management. Group treatment is always therapeutic, educational, and interactive with a strong emphasis on group member selection, peer interaction, and support as specified in the treatment plan.

Assertive Community Treatment (ACT). ACT is an intensive case management community service for adults discharged from the state or community hospitals after multiple or extended stays. Intensive, integrated rehabilitative, crisis, treatment, and community support services provided by an interdisciplinary staff team is available twenty-four (24) hours per day, seven (7) days per week. Services offered by the ACT team must be documented in a treatment plan and must include (in addition to those provided by other systems): some medication prescription, administration, and monitoring medication and self medication; crisis assessment and intervention; symptom assessment, management, and individual supportive therapy; substance abuse and co-occurring disorders treatment; psychosocial rehabilitation and skill development; personal, social, and interpersonal skill training; consultation, education, and support for individuals, families, and their support systems; representative payee and money management; and general client support services.

Intensive Case Management. This is an intensive community rehabilitation service for adults at-risk of hospitalization, or for crisis residential or high acuity substance abuse services. Treatment and restorative interventions assist individuals to gain access to necessary services to reduce psychiatric and addiction symptoms and to develop optimal community living skills. Services can be provided by a team or an individual case manager and documented in a treatment plan. Services provided by the intensive case management team or individual include: assistance and support for the individuals in crisis situations; service coordination; consultation, education, and support for individuals, families, and their support systems; individual restorative interventions for the development of interpersonal, community coping, and independent living skills; development of symptom monitoring and management skills; medication prescription, administration, and monitoring medication and self medication; representative payee and money management; and treatment for substance abuse or other co-occurring disorders.

Screening. Determination of an individual's need and eligibility for psychiatric services, as well as registration for psychiatric evaluation and treatment.

Targeted Case Management. The least intensive model of case management and it is generally used in conjunction with at least one additional community mental health service. Interventions employed to assist eligible individuals in gaining access to needed medical services, including psychiatric, social, educational, vocational, and other services. Services include, but are not limited to, maintenance of a supportive relationship to assist with problem solving and development of necessary skills to sustain recovery; regular contact for the purpose of assessing or reassessing needs for planning or monitoring services; contact with collaterals (family and agency) to mobilize services and provide support and education; advocacy on behalf of the individual; coordination of services specified in the plan, such as medication management and rehabilitation activities; and some limited crisis intervention.

Treatment Planning. Development of a comprehensive, individualized document specifying treatment modalities and interventions to be provided for the consumer that is approved by a licensed psychiatrist, licensed psychologist, or licensed advanced psychiatric practice nurse. The plan is derived from the assessment and includes:

1. DSM – IV, five axes diagnoses;
2. Signs and symptoms expressed in measurable terms;
3. Specification of needs or problems which are barriers to consumer's enhancement of independent psychosocial functioning;
4. Integration of consumer's preferences, expectations, strengths, and expressed goals;
5. Clearly stated measurable, output performance, and outcome measurements;
6. Intervention and treatment methods which specifically address identified needs or problems;
7. Identification of staff, community supports, other professionals responsible for treatment or interventions;
8. Medications prescribed;
9. A prognosis expressed in expected length of stay in current level of care.

Licensed psychiatrists shall approve treatment plans for consumers who have prescribed medications. Licensed psychologists and licensed advanced practice psychiatric nurses may approve treatment plans for consumers who have not been prescribed medications. There should be some cooperation between all three on all treatment plans in case some consumers have unidentified needs.

Supported Housing Program. This program provides housing for persons who are able to live in the community with appropriate supports. This type of housing is directed to those individuals who desire, and are capable of, living independently with flexible tailored services in accordance with their needs. Services are provided, with prior authorization from the Adult Mental Health Division ("DIVISION"), to targeted consumers and include, but are not limited to, assisting consumers in search of housing,

developing and sustaining working relationships with local landlords and property managers, working collaboratively with DIVISION-designated case managers regarding consumer/tenant status, and assisting consumers/tenants in meeting tenancy requirements under the Supported Housing Program.

Pharmaceuticals. As defined in Chapter 10 of the Medicaid Provider's Manual, "pharmacy services as allowed by the Medicaid program pays for medically necessary and non-experimental drugs and pharmacy services with certain limitations." The dispensement and drug formulary shall be in accordance with the guidelines as specified in Chapter 19 of the Medicaid Provider Manual Pharmacy Services (Date issued: November 15, 2001; Date revised: November 5, 2001).

Medical Supplies. As defined in Chapter 10 of the Medicaid Provider Manual, "durable medical equipment, prosthetic and orthotic devices and medical supplies (DMEPOS) include medically necessary equipment/appliances/items provided either through purchase or rental and prescribed by a physician for the maximum reduction of medical disability and for the restoration or maximum improvement in the patient's functional level."

Ancillary Services. Not considered as a main part of a patient's treatment milieu. Services are regarded as supportive services which may include durable medical equipment and medical supplies, as defined in Chapter 10 of the Medicaid Provider Manual.

Attachment M

Mental Health Worker Definitions

Mental Health Worker

Definition

A mental health worker may:

- Provide all direct treatment services to consumers that do not require a licensed qualified mental health professional,
- Provide specialized services in conjunction with other professionals,
- Coordinate services,
- Make referrals,
- Develop treatment plans,
- Monitor and evaluate progress,
- Provide ongoing support,
- Provide intake and assessments, and
- Make changes to treatment plans.

Educational and Experience Requirement

Mental health workers shall meet the following minimum requirements:

- Bachelor's degree with a minimum of twelve (12) semester credit hours in courses such as counseling, criminal justice, human services, psychology, social work, social welfare, sociology, or other behavioral sciences and one and one-half (1 ½) years of specialized experience.

Grandfathering Existing Staff Who Provide Case Management

Existing staff with these qualifications may be grandfathered as case managers for the duration of the current contract award:

- Registered nurse with a current Hawaii license,
- Certified Substance Abuse Counselor (CSAC) with a current Hawaii certification,
- Adult Mental Health Division (AMHD) Certified Peer Specialist, and
- High school diploma or GED with two (2) years of experience providing case management services to adult mentally ill consumers in Hawaii's public health system.

Definition of Experience

Specialized experience is progressively responsible professional work experience that involved helping individuals and their families find satisfactory ways of identifying their problems, coping with their conditions, and functioning effectively within their environments. This experience may include identification and evaluation of the consumer's problems and needs the development of a service or treatment plan the initiation and implementation of the treatment plan monitoring of services and evaluation/assessment of the consumer's progress.

Levels of Supervision

I. <u>Requires a minimum of individual one-on-one monthly clinical supervision by the team leader.</u>

Bachelor's prepared Mental Health Worker, CSAC or registered nurse with a minimum of one and a half (1 ½) years of specialized experience with this population. Worker provides the full range of core human services work appropriate for the agency. Consumers served represent the full range of cases the agency serves. Work is under general supervision, in accordance with established agency policies and procedures. The expectation is that the worker will seek guidance from the supervisor if unusual case complexities arise.

<u>II. Requires a minimum of individual one-on-one weekly clinical supervision by the team leader and direct supervision by the team leader:</u>

Registered nurse without specialized experience, case manager with a high school diploma or GED, or AMHD Certified Peer Specialist. Cases may be fewer in number. Cases are assigned with orientation and training. Problems may be limited in scope and complexity, or may require only short-term intervention. Supervision is close and immediate with work assignments closely monitored and critically reviewed.

Supervision

A mental health worker's clinical supervisor is the team leader who is a QMHP or MHP.

Attachment N

Certifications

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

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

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

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

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

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

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

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
   (1) The dangers of drug abuse in the workplace;
   (2) The grantee's policy of maintaining a drug-free workplace;
   (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
   (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   (1) Abide by the terms of the statement; and
   (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

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

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

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

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

3. CERTIFICATION REGARDING LOBBYING

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

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

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

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

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

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

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

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

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
APPLICANT ORGANIZATION	DATE SUBMITTED

Attachment O

Form SPO-H-205A Instructions

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

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

Special Instructions by the State Purchasing Agency:

Provide a budget by source of funds for this specific service activity.