

NETWORK SERVICE PROVIDER PROGRAM DESCRIPTION



The service provider shall submit the proposed Program Description to the department or Managing Entity, as applicable, for approval prior to the start of the contract or subcontract period. Once a contract or subcontract has been signed, the service provider shall submit a final version of the Program Description.

The Network provider shall complete a Program Description form for each program/activity funded by this contract.

SERVICE DELIVERY SITES			
Organization Name:			
Program Name:			
Address(es): (Insert additional rows as needed)			
Days of Operation:		Hours of Operation:	
Facility Licenses (Attach a copy of all applicable licenses)			

Program Director:			
Email:		Phone:	

TARGET POPULATION			
Adults		Children	
<input type="checkbox"/> Client Specific	<input type="checkbox"/> Non-Client Specific	<input type="checkbox"/> Client Specific	<input type="checkbox"/> Non-Client Specific
<input type="checkbox"/> Mental Health <input type="checkbox"/> Severe & Persistent Mental Illness <input type="checkbox"/> Serious & Acute Episodes of Mental Illness <input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Forensic Involvement <input type="checkbox"/> Other population served (specify): Click here to enter text.	<input type="checkbox"/> Mental Health <input type="checkbox"/> Serious Emotional Disturbance <input type="checkbox"/> Emotional Disturbance <input type="checkbox"/> Risk of Emotional Disturbance <input type="checkbox"/> Other population served (specify): Click here to enter text.	<input type="checkbox"/> Substance Abuse <input type="checkbox"/> Other population served (specify): Click here to enter text.	<input type="checkbox"/> Substance Abuse <input type="checkbox"/> Other population served (specify): Click here to enter text.

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COVERED SERVICES		
<input type="checkbox"/> Aftercare <input type="checkbox"/> Assessment <input type="checkbox"/> Case Management <input type="checkbox"/> Crisis Stabilization <input type="checkbox"/> Crisis Support/Emergency <input type="checkbox"/> Day Treatment <input type="checkbox"/> Drop-In/Self Help Centers <input type="checkbox"/> FACT <input type="checkbox"/> Incidental Expenses <input type="checkbox"/> Information and Referral <input type="checkbox"/> In-Home and Onsite <input type="checkbox"/> Inpatient <input type="checkbox"/> Intensive Case Management <input type="checkbox"/> Intervention	<input type="checkbox"/> Medical Services <input type="checkbox"/> Medication-Assisted Treatment <input type="checkbox"/> Mental Health Clubhouse <input type="checkbox"/> Outpatient <input type="checkbox"/> Outreach <input type="checkbox"/> Prevention <ul style="list-style-type: none"> <input type="checkbox"/> Universal-Direct <input type="checkbox"/> Universal-Indirect <input type="checkbox"/> Selective <input type="checkbox"/> Indicated <input type="checkbox"/> Recovery Support <input type="checkbox"/> Residential <ul style="list-style-type: none"> <input type="checkbox"/> Level I <input type="checkbox"/> Level II <input type="checkbox"/> Level III <input type="checkbox"/> Level IV 	<input type="checkbox"/> Respite Services <input type="checkbox"/> Room & Board w/ Supervision <ul style="list-style-type: none"> <input type="checkbox"/> Level I <input type="checkbox"/> Level II <input type="checkbox"/> Level III <input type="checkbox"/> Short-term Residential Treatment <input type="checkbox"/> Inpatient Detoxification <input type="checkbox"/> Outpatient Detoxification <input type="checkbox"/> Supported Employment <input type="checkbox"/> Supportive Housing/Living <input type="checkbox"/> Treatment Alternatives for Safer Communities (TASC)

SERVICE STAFFING LEVELS			
	Position Title	Position Type <small>(Select from drop-down list)</small>	Total FTE's
		Choose an item.	
		Choose an item.	
		Choose an item.	
		Choose an item.	
		Choose an item.	
Totals			

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SERVICE DELIVERY STRATEGIES

Describe the organization's specific service delivery strategies for providing individual services/care. Service delivery strategy descriptions should separately address those strategies as applied to the general SAMH target populations served and any special population groups. This description should address:

The specific services that will be provided within each covered service

The means by which individual and family needs will be evaluated and re-evaluated throughout the episode of care

Major referral sources

The processes employed to match individuals and families to services and ensure that services are consistent with the individuals' and families' individual recovery and resiliency needs;

Any science-based or evidence-based models employed or practices utilized

The service capacity proposed for funding

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Admission and discharge criteria

Average length of participation for persons served

Use of Incidental funds

CONTINUING CARE STRATEGIES

Identify the major continuing care strategies for individuals and families completing services. Address placement and referral activities specific to the general SAMH target populations served and any Special Populations. This description should address:

The processes by which individuals and families are prepared for and transitioned to continuing care services,

The major continuing care strategies, best practice models, and community housing/living options alternatives for individuals and families completing services in this Activity (within the organization and within the community system of care)

A description of any Activity funded cost centers and related services utilized to affect the transition

How Incidental funds and any applicable, restricted funding are used to support individual transitions

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SIGNATURES			
Individual Completing the Document:			
Name:		Title:	
Phone:		Fax:	
		Email:	
Submitted by:			
Provider Representative Signature		Date	
Approved by:			
CFCHS Representative Signature		Date	