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** | |
| ☐ Client Specific | ☐ Non-Client Specific | Client Specific | Non-Client Specific |
| **Mental Health**  Severe & Persistent Mental Illness  Serious & Acute Episodes of Mental Illness  Mental Health Problems  Forensic Involvement  Other population served (specify): Click here to enter text. | | ☐ **Mental Health**  Serious Emotional Disturbance  Emotional Disturbance  Risk of Emotional Disturbance  Other population served (specify): Click here to enter text. | |
| **Substance Abuse**  Other population served (specify): Click here to enter text. | | **Substance Abuse**  Other population served (specify): Click here to enter text. | |

|  |  |  |
| --- | --- | --- |
| **Covered Services**  **Refer to 65E-14 F.A.C. for descriptions of the services**  **(**[**65E-14 : COMMUNITY SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES - FINANCIAL RULES - Florida Administrative Rules, Law, Code, Register - FAC, FAR, eRulemaking**](https://flrules.org/gateway/ChapterHome.asp?Chapter=65E-14)**)** | | |
| Aftercare  Assessment  Case Management  Care Coordination  Crisis Stabilization  Crisis Support/Emergency  Day Treatment  Drop-In/Self Help Centers  FACT  HIV Early Intervention  Incidental Expenses  Information and Referral  In-Home and Onsite  Inpatient  Intensive Case Management  Intervention | Medical Services  Medication-Assisted Treatment  Mental Health Clubhouse  Outpatient  Outreach  Prevention  Universal-Direct  Universal-Indirect  Selective  Indicated  Recovery Support  Residential  Level I  Level II  Level III  Level IV | Respite Services  Room & Board w/ Supervision  Level I  Level II  Level III  Short-term Residential Treatment  Inpatient Detoxification  Outpatient Detoxification  Supported Employment  Supportive Housing/Living  Treatment Alternatives for Safer  Communities (TASC) |

|  |  |  |  |
| --- | --- | --- | --- |
| Service Staffing Levels  *(List only the positions that will be funded by CFC)* | | | |
|  | Position Title | Position Type  (Select from drop-down list) | Total FTE’s |
|  |  | Choose an item. |  |
|  |  | Choose an item. |  |
|  |  | Choose an item. |  |
|  |  | Choose an item. |  |
|  |  | Choose an item. |  |
| Totals |  | |  |

|  |
| --- |
| **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  *(Provide a summary of the specific services that will be provided. This may include a brief job description for each service staff)* |
|  |
| 1. **The means by which individual and family needs will be evaluated and re-evaluated throughout the episode of care** |
|  |
| **Major referral sources** *(List agencies expected to refer to program)* |
|  |
| **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** (Projected annual number of individuals served) |
|  |
| **Admission and discharge criteria** |
|  |
| **Average length of participation for persons served** |
|  |
| **Use of Incidental funds** *(Type N/A if funding will not be utilized for non-treatment expenses- i.e. rental assistance)* |
|  |

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| **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, |
|  |
| 1. **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 | | | | |