

State Community Mental Health Allocation Report F-01684 2018 - DRAFT

Welcome to the 2018 State Community Mental Health Allocation (SCMHA) Report.

Please refer to DCTS Numbered Memo 2016-13 for details regarding reporting requirements and allowed expenditures.

The following are the core areas of this report.

1. SCMHA expenditures in calendar year 2017
2. The number of individuals served in 2017 using the allocation
3. Capital expenses using the 2017 allocation
4. Narrative description of allocation utilization

Please note the following instructions for completing the survey.

Users will be asked to provide the information listed above.

Data may be entered, saved, and accessed or modified later using your Anonymous Login Code at the top of this page. Please record your Anonymous Login Code now. Data can be modified or entered in stages; however, the same Anonymous Login Code must be used to access the information that was previously entered. If logging off the survey tool prior to completing the survey, be sure to click SAVE to ensure your data is recorded thus far.

Upon completing the report, users must certify the accuracy of the information (Question 16) and click the DONE button.

After submitting the final survey, users will receive an email confirming the report was successfully completed and users will be provided a copy of the data that was entered.

If you have any questions or difficulties with this report, contact Ron Bonlender at Ronald.Bonlender@dhs.wisconsin.gov or 608-267-9864.

Click NEXT to begin the report.

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Contact Information

Please provide the below contact information for both your county's main contact for the Mental Health Block Grant Community aids reporting and the person responsible for completing this report.

1. County Name (or Counties if reporting for a consortium)*

2. Agency Name*

3. Name--County Contact (Please enter the name of the main county or agency contact regarding the funding source).*

4. County Contact's Title*

5. County Contact's Email Address*

6. County Contact's Mailing Address*

7. County Contact's Telephone Number*

8. Name of Person Completing Survey (If different from above)

9. Email Address of Person Completing Survey (If different from above)

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Expenditures

10. Please provide the following information regarding 's use of the 2017 State Community Mental Health Allocation.

In the table below, report what spent in CY 2017 in each program area with the allocation.

Note: You do not need to include the \$ symbol when entering data.

2017 Expenditures

Assistance for People
Relocating from an
IMD/Medicaid-Certified
Skilled Nursing Facility to
Adult Family Home

Case Management

Certified Community
Support Program (CSP)

Certified Comprehensive
Community Services (CCS)

Certified Peer Specialists	<input type="text"/>
Community-Based Residential Facility	<input type="text"/>
Community Placement	<input type="text"/>
Community Recovery Services (CRS)	<input type="text"/>
Coordinated Services Team (CST)	<input type="text"/>
Counseling/Therapeutic Resources	<input type="text"/>
Crisis Intervention	<input type="text"/>
Day Center Services—Non Medical	<input type="text"/>
Day Treatment—Medical	<input type="text"/>
Group Home	<input type="text"/>
Information and Referral	<input type="text"/>
Intake Assessment	<input type="text"/>
Medication Management	<input type="text"/>
Outreach	<input type="text"/>
Supported Employment	<input type="text"/>
Supportive Community Services (Excluding Case Management)	<input type="text"/>
Transportation	<input type="text"/>
Work-Related Services	<input type="text"/>
	<input type="text"/>

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Numbers Served

In the below table indicate the number of individuals who received services in 2017 via a program or service funded in part by the State Community Mental Health Allocation. If exact counts are not known, estimates should be provided. Place numbers in the appropriate column, actual or estimated.

11.

	CY 2017 Number Served — Actual Count	CY 2017 Number Served — Estimated Count
Assistance for People Relocating from an IMD/Medicaid-Certified	<input type="text"/>	<input type="text" value="0"/>

Skilled Nursing Facility to
Adult Family Home

Case Management

		0
--	--	---

Certified Community
Support Program (CSP)

		0
--	--	---

Certified Comprehensive
Community Services (CCS)

		0
--	--	---

Certified Peer Specialists

		0
--	--	---

Community-Based
Residential Facility

		0
--	--	---

Community Placement

		0
--	--	---

Community Recovery
Services (CRS)

		0
--	--	---

Coordinated Services
Team (CST)

		0
--	--	---

Counseling/Therapeutic
Resources

		0
--	--	---

Crisis Intervention

		0
--	--	---

Day Center Services—Non
Medical

		0
--	--	---

Day Treatment—Medical

		0
--	--	---

Group Home

		0
--	--	---

Information and Referral

		0
--	--	---

Intake Assessment

		0
--	--	---

Medication Management

		0
--	--	---

Outreach

		0
--	--	---

Supported Employment

		0
--	--	---

Supportive Community
Services (Excluding Case
Management)

		0
--	--	---

Transportation

		0
--	--	---

Work-Related Services

		0
--	--	---

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Capital Expenses

12. Was any equipment purchased using the 2017 State Community Mental Health Allocation?

Yes No

13. If yes, describe below the item(s) that were purchased and provide a rationale for their purchase. Equipment purchase

expenditures must be related to the achievement of appropriate program goals, and be allowable under the State Community Mental Health Allocation.

Describe the item	<input type="text"/>
Item Cost	<input type="text"/>
Rationale	<input type="text"/>

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Highlights

This page asks counties to report on accomplishments in 2017 using the State Community Mental Health Allocation. This information may either be provided in the dialogue box below (Question 14), or uploaded as a Word document or PDF below (Question 15).

14. Please describe the Program Highlights with outcomes achieved through the use of the State Community Mental Health Allocation in CY 2017 in . Describe program accomplishments, innovations, and outcomes of community mental health services through the use of the funds. Program highlights should be provided in the text box below, or uploaded as a Word document or PDF below.

15.

Select file to upload:

(click "Browse" button below to locate file)

File size restricted to: 4194304 KB

File type restricted to: No file type restrictions.

No file chosen

File Name: (limit 255 characters)

File Description: (limit 255 characters)

Files Uploaded:

Certification

16. CERTIFICATION: I certify that the information reported here is accurate and complete to the best of my knowledge. I also certify that I am authorized on behalf of the above county to certify this report.*

Yes No

17. If you have any comments on this report or suggestions on how to improve the reporting process, leave your comments below.