



Date: February 19, 2018

DCTS Action Memo 2018-03
Replaces 2016-13

To: County Departments of Community Programs
County Departments of Community Services
County Departments of Health and Human Services
County Departments of Human Services

From: Patrick Cork, Administrator

Community Mental Health Allocation CY 2018

Document Summary

This memo references Profile #516 of the State and County Contract for Social and Community Programs, outlines the reporting requirements for the Community Mental Health Allocation for Calendar Year 2018 (CY 2018), and includes expenditure requirements for the use of CY 2018 funds. This memo is distributed at this time to foreshadow reporting requirements for CY 2018 mental health services. Counties must comply with the reporting requirements in the Program Participation System (PPS). This includes the reporting of consumer functional outcomes every six months through the consumer status data set in PPS.

NOTE: This memo, Community Mental Health Allocation CY 2018, is distinct and separate from the annual Community Mental Health Services Block Grant Community Aids Formula Allocation and Reporting Requirements memo. Counties must comply with the reporting requirements outlined in both memos.

Background

The 2015-2017 state budget included a provision to consolidate base funding for several community mental health program funding allocations to a single allocation for community programs under the state's community aids program. This measure combined two mental health institutional relocation programs, one psychosocial rehabilitation program (Community Support Programs (CSP) Waitlist), and one program supporting development and operations of certified CSP, Comprehensive Community Services (CCS), Community Recovery Services (CRS), and/or crisis services into a community aids program for community mental health services. In addition, funding was transferred from the Community Options Program in an amount that approximates the annual use of Community Options Program funding for program participants receiving community-based mental health and substance use services.

The Department of Health Services (DHS), Division of Mental Health and Substance Abuse Services (now known as the Division of Care and Treatment Services [DCTS]) convened an advisory group to review and comment on internal workgroup documents and consolidation plans, and inform the division on how the consolidation plans may impact counties and constituents. The group included various

community stakeholders who were interested in the consolidation of contracts and its impact on mental health services.

DCTS, as required by [Wis. Stat. § 46.40\(7m\)](#), annually obligates \$24,348,700 of community mental health funding to all counties within the state.

Community Mental Health Reporting for 2018

Community mental health funding carries reporting requirements on how the allocation is spent. As a result, DCTS requires counties to report how much of their formula allocation was spent and for what purposes.

Counties will want to be tracking the consumers served by this allocation throughout the year to assist with end-of-year reporting requirements. The deadline for reporting expenditures and outcomes for the 2017 Community Mental Health Allocation is April 2, 2018. Use the State Community Mental Health Allocation Report, [F-01684](#), to record county expenditures in the 22 allowable expenditure categories and the associated outcomes for those expenditures.

Mental health Community Options Program reporting requirements are no longer necessary due to the consolidation of funds; however, counties should carefully review and consider each program priority area and the reporting requirements listed in this memo. Should counties have additional questions after reviewing the instructions, they should contact the contract administrator. Counties must use the instructions in this memo to correctly complete [F-01684](#).

Community Mental Health Allocation Expenditures for 2018

DCTS will allocate an estimated \$24,348,700 in funding for federal fiscal year 2018. Allocations for CY 2018 must be spent by December 31, 2018, and the associated expenditure reports are due to the Community Aids Reporting System within 90 days of the expenditure deadline. Please check your current expenditure level to ensure your county is on track to spend its formula allocation by December 31, 2018. If you have questions, contact Heather Leach at heather.leach@dhs.wisconsin.gov or 608-267-9741

The following is more information on the federal and state requirements associated with the expenditure of the community mental health funds for CY 2018.

Some of these requirements include:

- Funds must be used for activities associated with community mental health services.
- Funds must be used for services to adults or children with a mental health diagnosis who have or are at risk of having a serious mental illness or a serious emotional disorder.
- DCTS has identified 22 areas to which counties can apply these funds CSP, CCS, CRS, crisis intervention, certified peer specialists, case management, counseling/therapeutic resources, medication management, day treatment-medical, outreach, information and referral, intake assessment, supported employment, day center services-nonmedical, work-related services, supportive community services (excluding case management), adult family home, group home, community-based residential facility, transportation for mental health services, assistance for people relocating from an institute for mental disease or Medicaid-certified skilled nursing facility to community placement, and Coordinated Services Teams Initiatives (CST).

Action Summary

Counties are required to report data, summarize activities, expenditures, and outcomes related to community mental health funding in CY 2018 following these requirements.

A. Definition of Adults with a Serious Mental Illness and Children with Serious Emotional Disorders

"Adults with a serious mental illness" are people: (1) age 18 and over; (2) who currently have, or at any time during the past year, had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 or their ICD-10 equivalent (and subsequent revisions) with the exception of DSM-5 codes, substance use disorders, and developmental disorders that are excluded unless they co-occur with another diagnosable serious mental illness that has resulted in functional impairment, which substantially interferes with or limits one or more major life activities. Pursuant to Section 1911(c) of the Public Health Service Act, children with a serious emotional disorder are (1) from birth up to age 18; and (2) currently have, or at any time during the last year, had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5. (Federal Register, Volume 58 No. 96 published Thursday, May 20, 1993, pages 29,422 through 29,425).

B. Allowable Services

The purpose of these funds is to expand the county-operated or contracted system of community-based services for adults with a serious mental illness and children with a serious emotional disorder. These funds must be used to initiate new programs or significantly strengthen existing programs for these population categories.

Program Priority Areas. These funds shall be used by the county only to pay for the cost of community-based care and services provided to any person who has a mental illness in the following program priority areas:

- CSP
- CCS
- CRS
- Crisis intervention
- Certified peer specialists
- Case management
- Counseling/therapeutic resources
- Medication management
- Day treatment-medical
- Outreach
- Information and referral
- Intake assessment
- Supported employment
- Day center services-nonmedical
- Work-related services
- Supportive community services (excluding case management)
- Adult family home
- Group home
- Community-based residential facility

- Transportation for mental health services
- Assistance for people relocating from an institute for mental disease or Medicaid-certified skilled nursing facility to community placement
- CST

The following section defines allowable uses of the funds for each of the 22 priority areas and presents information on how funds may be used. Use of the funds in these priority areas must be reported through PPS as a service. Each of the descriptions of the program priority areas below is followed by its associated standard program category (SPC) code, which counties should use when recording data in PPS.

For further descriptions of each allowable use of funds, refer to the [PPS Mental Health Module Handbook](#). Service definitions are listed in Appendix 2 of the handbook.

CSP is the provision of a network of coordinated care and treatment services to adults with serious and persistent mental illness in a natural or supportive service setting by an identified provider and staff to ensure ongoing therapeutic involvement and individualized treatment in the community for the purpose of reducing the disabling effects of their mental illness and assisting clients to access and participate in the community.

- The service of case planning, monitoring, and review, as well as the activities involved in case management/service coordination, are a required part of this program for every client.
- Funds may be used only by a certified CSP for the following activities associated with community mental health services: assessment and diagnosis, eligibility determination, advocacy, education and training, counseling and psychotherapy, person locating, medical support, referral, and transportation. This includes identifying people in need of services, assisting with and training clients in all aspects of community functioning, crisis consultation, assistance with learning and performing daily living tasks, supervision of community work or educationally related activities, assistance with obtaining health care, assistance with acquiring and maintaining adequate housing, social and recreational activities, and coordinating services delivered by both CSP and other human service programs.

All services delivered as a component of a CSP with these funds should be reported using the **509 Community Support** SPC code in PPS.

CCS programs are certified per the requirements of Wis. Admin. Code ch. DHS 36 and provide a flexible array of individualized, community-based, psychosocial rehabilitation services authorized by a licensed mental health professional under Wis. Admin. Code § DHS 36.15 and provided to consumers with mental health or substance use issues across the lifespan who qualify based on level of need through a completed Mental Health/Alcohol and Other Drug Abuse Functional Screen.

Funds may be used only by certified CCS counties for the following activities: assessment, recovery and service planning, service facilitation, and individually authorized psychosocial rehabilitation services, when such services are not covered by medical assistance.

All services delivered as a component of a CCS benefit with these funds should be reported using the **510.10 Comprehensive Community Services—Hours (per diem code is no longer available)** SPC code in PPS.

CRS is a non-waiver, state Medicaid plan amendment benefit provided by a certified county, tribe, or vendor. The goal of CRS is to provide services that enable mental health consumers to live in the least restrictive community environment available. CRS offers three services: community living supportive services (activities necessary to allow individuals to live with maximum independence in community integrated housing), supported employment (activities necessary to assist individuals to obtain and maintain competitive employment), and peer supports (advocacy, information, and support provided by certified peer specialists).

- Funds may only be used by certified CRS counties for the following activities: Funds may be used to cover the county match of the Federal Financial Participation for the CRS Program.
- Funds may be used to cover administrative county overhead to support CRS, to include CRS coordinator role, quality assurance activities in support of CRS, and fiscal activities in support of CRS.

All services delivered as a component of the CRS benefit should be reported using the **511 Community Recovery Services** SPC code in PPS.

Crisis intervention is the provision of services to individuals in the general public who are experiencing emergencies that require an immediate response by the human service system (including those activities necessary to prepare for responding to conditions that are an immediate threat to a person's life or well-being) for the purpose of removing or improving these conditions and linking the individual with appropriate human services.

- Funds may be used for counseling and psychotherapy, supervision, emergency transportation, and referral. Includes 24-hour hotlines, crisis response teams, and extra-hour staffing for handling emergencies only when the program provider is specially organized for this purpose, and are designed to serve the general public rather than specific client groups.
- The provision of services following an initial crisis contact that are follow-up responses described on a response plan or crisis plan. These can include linkage and coordination or follow-up services provided in-person, in a mobile contact, or over the telephone.
- This excludes services delivered under emergency conditions that are an integral, but subordinate, part of other standard programs (e.g., emergency inpatient care is to be classified as part of the inpatient program).

Services delivered with these funds should be reported using the following SPC codes in PPS:

501.00 Crisis Intervention – Hours

501.10 Crisis Intervention – Days

501.20 Crisis Intervention Follow-up

Certified peer specialists and peer support services. Individuals with experience in the mental health and substance use services system or peer-run organizations provide self-help, peer-to-peer support, and peer support to families of adults with severe mental illness or children/adolescents with severe emotional disturbance. Certified peer specialists function as role models demonstrating techniques in recovery and providing ongoing recovery and resiliency support. Peer supports lend their unique insight into mental health and substance use and what makes recovery possible. Peer specialists include parents or other adult family caregivers of children with behavioral health disorders providing peer services to other families with a youth with behavioral health disorders.

- Funds may be used to hire individuals with lived experience to provide peer support including assistance in the development of goals; serve as an advocate, mentor, or facilitator for resolution of issues; and teach skills necessary to improve coping abilities to assist consumers and/or families in regaining control over their lives and over their own recovery process.
- Funds may be used to hire individuals with lived experience to attend treatment team and crisis plan development meetings to promote consumer's use of self-directed recovery tools; inform consumers about community and natural supports and how to utilize these in the recovery process; and assist consumers in developing empowerment skills.
- Funds may be used to develop peer support and self-help programs, including clubhouses, drop-in centers, supported telephone lines, crisis alternatives, housing referral and support, employment referral, etc.
- Funds may be used to hire consumers or family members to provide assistance to other clients and family members in dealing with the mental health system during a crisis, when there is a complaint, etc.

No SPC codes are available to record for this program priority area.

Case management is the provision of services by providers whose responsibility is to enable clients and, when appropriate, their families to gain access to and receive a full range of appropriate services in a planned, coordinated, efficient, and effective manner. Funds may be used for assessment; case planning, monitoring, and review; advocacy; and referral.

Services delivered with these funds should be reported using the **604 Case Management SPC** codes in PPS.

Counseling and therapeutic resources is the provision of treatment-oriented services to clients needing treatment for a personal, social, behavioral, mental, or alcohol and drug abuse disorder to maintain and improve effective functioning.

- Funds may be used for assessment and diagnosis; case (treatment) planning, monitoring, and review; counseling and psychotherapy; therapy services; physical health services; and medical support services. Includes divorce and family counseling and counseling for students experiencing behavioral problems at school.
- This includes intensive home and community treatment services when provided by people other than those responsible for probation, juvenile supervision, or aftercare supervision. Includes methadone maintenance activities.
- This excludes work-related services and treatment services provided to residents of an alternate living setting or in a day center by staff or providers of those settings.

Services delivered with these funds should be reported using the **507 Counseling/Therapeutic Resources SPC** code in PPS.

Medication management. Medication management includes the prescription, directions on the use of, and review of medication, with not more than minimal psychotherapy. This service should be recorded in PPS regardless of whether it's provided by a psychiatrist, advanced practice nurse practitioner, or any other authorized prescriber.

Services delivered with these funds should be reported using the **507.10 Medication Management** SPC code in PPS.

Day treatment-medical. A day treatment program is a nonresidential program in a medically supervised setting that provides case management, counseling, medical care, and therapies on a routine basis for a scheduled portion of a 24-hour day and a scheduled number of days per week to alleviate those problems.

Funds may be used for individual, family, and group counseling. Aftercare services are not included under this billing provision.

Services delivered with these funds should be reported using the **704 Day Treatment—Medical** SPC code in PPS.

Outreach is the provision of services that are designed to result in the locating of people likely to have a problem that can potentially be alleviated by the delivery of human services.

- Funds may be used for case finding and referral.
- This excludes assessment and diagnosis associated with a formal application process, which should be classified as intake assessment; assessments that are an integral but subordinate part of admission to another program; health screening activities that should be classified under the program of that name; and services for agency clients.

Services delivered with these funds should be reported using the **601 Outreach** SPC code in PPS.

Information and referral is the provision of public information and referral services to satisfy individual inquiries for specific information about a particular aspect of the human service delivery system or community resources and ensure linkage to needed resources.

- Funds may be used for referral to legal resources for activities associated with community mental health services or related to mental health symptoms and maintaining and summarizing records of information and referral contacts.
- This excludes public information and referral when provided as a subordinate part of the intake process or when part of other programs.

Services delivered with these funds should be reported using the **602 Information and Referral** SPC code in PPS.

Intake Assessment is the provision of services in a natural or supportive service setting to people who are or may become clients for purposes of determining the existence of, and the nature of, a specific problem or group of problems.

- Funds may be used for assessment and diagnosis and referral (Intoxicated Driver Program assessments and child abuse and neglect investigations); activities associated with the process and screenings of prospective nursing home admissions per Wis. Admin. Code § DHS 132.51(2)(d)(1); the development of an initial case service or treatment plan if done as part of a general client intake process; intake activities that occur prior to the establishment of client status; and activities of centralized intake units.

- Assessment/diagnosis that is an integral, but subordinate, part of another standard program should be classified to that program. Investigations or assessments for the court are part of the Court Intake and Studies Program.

Services delivered with these funds should be reported using the **603 Intake Assessment SPC** code in PPS.

Supported employment is competitive work in an integrated work setting for individuals who, because of their disability, need ongoing and/or intensive support services to find and perform this work. An integrated work setting is defined as no more than eight people with a disability in one work area. This service area excludes sheltered workshop settings.

Services delivered with these funds should be reported using the **615 Supported Employment SPC** code in PPS.

Day center services-nonmedical. A day treatment program is a nonresidential program in a nonmedically supervised setting that provides case management, counseling on a routine basis for a scheduled portion of a 24-hour day, and a scheduled number of days per week to alleviate those problems.

Funds may be used for individual, family, and group counseling but not aftercare services.

Services delivered with these funds should be reported using the **706 Day Center Services—Non-Medical SPC** code in PPS.

Work-related services is the provision of services in integrated community work settings or other settings for purposes of enabling clients to participate in work, develop work and related abilities, improve work performance, and/or remove obstacles to gainful employment.

- Funds may be used for: education and training; work-related transportation; assessment and diagnosis; case planning, monitoring, and review when done by work-related service providers; and supervision.
- This excludes supported employment as defined in the SPC of that name and sheltered workshop settings.

Services delivered with these funds should be reported using the **108 Work-Related Services SPC** code in PPS.

Supportive community services includes respite care, housing, daily living skills training, family support, interpreter services, adaptive equipment, and representative payee fees. Note that monies can only be used for the identified purposes if the client is not eligible for CCS, CRS, or CSP. Please utilize the aforementioned program priority codes if a client is eligible for services under that program and a service is available under the applicable program. Case management is not to be reported as a component of supportive community services for the purposes of this project. Case management should be reported separately under SPC code 604.

- **Respite care:** The provision of services to clients who are either caregivers or their dependents for the purposes of providing the primary caregiver temporary relief, relieving the primary caregiver of the stress of giving continuous support, providing the dependent client adequate care

and supervision in a home-like environment (unlicensed), and reducing the need for placement of the dependent person outside the home. Funds may be used for services to the primary caregiver, which may include case planning, monitoring, and review, and services for the dependent person, which may include personal care and supervision.

- **Housing:** The provision of services to clients in a stable, community setting for the purpose of enabling people to obtain safe, healthful, and affordable housing. Funds may be used for: a variety of housing and services including transitional and permanent supportive housing, rapid re-housing, street outreach, client assessment, and other housing first approaches. Includes the purchase of necessary furniture, kitchen appliances not furnished by the landlord in the housing arrangement, cooking/serving utensils, basic cleaning equipment, household supplies, and bathroom and bedroom furnishings. Includes the payment of a security deposit, limited-term rent (up to three months) and heating/electric/water utility connection costs. The provision of services to help families access and sustain housing includes working with the client to identify affordable units, access housing subsidies, and negotiate leases. Clients may require assistance to overcome barriers, such as poor tenant history, credit history, and discrimination based on ethnicity, gender, family make-up, and income source. Providers may need to develop a roster of landlords willing to work with the program and engage in strategies to reduce disincentives to participate.
- **Daily living skills:** The provision of services to clients whose health or well-being is at risk of deteriorating or for whom development is delayed due to inadequate knowledge or skills in routine daily living tasks. Services are intended to improve a client's or caretaker's ability to perform routine daily living tasks and utilize community resources. Services that are educationally focused and are not primarily designed to provide substitute task performance include, but are not limited to: education and training; assessment and diagnosis; and case planning, monitoring, and review. This category excludes intensive home services, community treatment services, supportive home care, and recreational activities.
- **Family support:** The provision of a material benefit to the caregivers of disabled children that enables the caregivers to obtain needed material benefits or services, consistent with provisions of the family support plan for the purposes of enabling disabled children to maintain a natural living arrangement, preventing institutional placement, alleviating family stress, and/or preventing family dysfunction. Services purchased by caretakers with approval of the county agency include, but are not limited to, personal care, household care, assessment and diagnosis, and therapy.
- **Interpreter services and adaptive equipment:** The provision of services and material benefits to clients whose ability to access, participate, and function in community mental health services is limited by physical, sensory, or speech impairments, or lack of ability to effectively communicate in English. Services include the purchase or direct provision of bilingual interpreters for people with limited English skills or interpreters capable of facilitating communication for the deaf or those with hearing loss. Types of items include adaptive household modifications, including ramps, vehicle modifications, prosthetic or orthotic devices, communication devices, special safety equipment, special clothing, etc. This excludes training of service providers for purposes of developing or improving the ability of their bilingual or signing staff to deliver services. This excludes the activities of staff that possess bilingual or signing skills functioning in other programs.
- **Representative payee fees:** The provision of services to people who have demonstrated a lack of ability to use their funds properly by a person or authorized agency responsible for managing the client's money or supervising the client's use of funds. Funds may be used for reimbursement

for fee-for-service payeeship as authorized by the Social Security Administration. Funds cannot be used to reimburse fees set above those approved by the Social Security Administration.

Includes the services of a representative payee in SSI/Social Security Administration cases in which representative payees are required. To qualify, an organization must:

- Either be a community-based, nonprofit social service organization, bonded and licensed in the state in which it serves as payee, OR a state or local government agency responsible for income maintenance, social service, health care, or fiduciary duties.
- Regularly serve as a payee for at least five beneficiaries.
- Not be a creditor of the beneficiary.
- Submit an application to collect a fee to the Social Security Administration.
- Be authorized in writing by the Social Security Administration to collect a customary fee.

Services delivered with these funds should be reported using the following SPC codes in PPS:

103 Respite care

106 Housing

110 Daily living skills training

111 Family support

112 Interpreter services and adaptive equipment

406 Representative payee fees

Adult family home is the provision of a structured residential living arrangement for the purpose of providing care and support to adult clients whose physical, developmental, and emotional functioning is likely to be maximized in a family or other home-like living arrangement for less than five adults. Funds may be used for supervision, dietary, personal care, and education/training. Please utilize the aforementioned program priority codes if a client is eligible for services under that program and a service is available under the applicable program.

Services delivered with these funds should be reported using **the 202 Adult Family Home** SPC code in PPS.

Group home is the provision of services in a community-based group living setting to children for whom a living arrangement with peers or siblings is judged to be most beneficial. Funds may be used for supervision, dietary, and personal care. Please utilize the aforementioned program priority codes if a client is eligible for services under that program and a service is available under the applicable program.

Services delivered with these funds should be reported using the **204 Group Home** SPC code in PPS.

Community-based residential facility. This is the provision of services to clients in a community-based residential facility for purposes of providing needed care or support and/or improving personal, social, behavioral, mental, developmental, or alcohol and drug abuse disorders. Funds may include supervision, dietary, counseling and psychotherapy. Please utilize the aforementioned program priority codes if a client is eligible for services under that program and a service is available under the applicable program. This excludes residential care for the primary purpose of detoxification. This excludes unlicensed living arrangements even if supervision is provided or live-in staff are present. This excludes alcohol and other drug abuse residential care in nursing homes. This excludes alcohol and other drug abuse residential inpatient programs in community-based

residential facilities. This excludes homes serving three or four residents that are licensed as community-based residential facilities when the home is also the residence of the sponsor and homes certified under Wis. Admin. Code ch. DHS 82.

Services delivered with these funds should be reported using the **506 Community-Based Residential Facility** SPC code in PPS.

Transportation for mental health services. Resources for transportation must be directly related to accessing mental health services that are not able to be accessed or reimbursed elsewhere. Transportation expenses are not allowable if conveyance is reimbursable through Medicaid. Exceptions can be made only if Medicaid-reimbursed services could not be reasonably scheduled to provide for safe and timely transport to mental health services. Moreover, transportation expenses must not supplant what is an allowable transportation expense within a DHS-regulated program (for example, CSP, crisis) and must be related to the prevention, assessment, diagnosis, or treatment of a serious mental illness or serious emotional disorder (excluding primary substance use disorders).

Transportation services may include the purchase or provision of such items as tickets, passes, vouchers, or other fare medium, or may include a direct payment to providers covering the cost of conveyance. Transportation for recreational purposes or for reasons other than being directly related to accessing mental health services is not allowable. Transportation resources may not be used to pay for an attendant or accompanying staff or volunteer rider.

Use of transportation funds must adhere to safety and accessibility standards. Mass transit carriers are regulated under [Wis. Stat. § 85.20](#), and the provision of specialized transportation is regulated under [Wis. Stat. § 85.21](#). Other individual providers or volunteers providing transportation must be able to provide documentation of a valid driver's license and proof of liability insurance and attest to the fact that the vehicle is mechanically sound with safety and comfort systems functioning properly. The county should have a written policy to ensure that community criteria are consistently and equitably applied.

Services delivered with these funds could be reported using the **107 Specialized Transportation** SPC code in PPS.

Assistance for people relocating from an institute for mental disease or Medicaid-certified skilled nursing facility to community placement. This is the provision of community-based care and services provided to any person who has a mental illness and is 22 through 64 years of age at the time the person is relocated from an institute for mental disease or a Medicaid-certified nursing facility.

- These funds may be used for services that assist in the recovery process of the individual and are not billable under medical assistance.
- Funds may be used for the provision of essential items needed to establish a community living arrangement for people who are relocating from an institution or who are moving from a congregate living environment or out of homelessness in order to establish an independent living arrangement.
- Funds cannot be used for start-up or relocations to licensed or certified facilities.

No standard program categories are available to record a relocation from an institute for mental disease or nursing home, but any of the other allowable services in this list of program priority areas may be funded and reported for relocated clients.

CST is based on the traditional wraparound philosophy emphasizing a collaborative system change approach for youth. CST is an intervention and support model that offers a collaborative, team-centered, strengths-based assessment and planning process.

No SPC code exists for a CST, but any services in the list of allowable services should be recorded in PPS if provided to youth. For example, case management (SPC code 604) and counseling (SPC code 507) would be typical mental health services provided to youth in a CST.

In addition, enrollment in a CST must be recorded in PPS. Within this module, CST must be selected as the program in which the youth is enrolled followed by an enrollment date, disenrollment date, and disenrollment reason.

C. Guidance on Uses of Expenditures

- Agencies may not expend the community mental health allocation to pay for the federal share of the Federal Financial Participation for medical assistance programs when billing has, or will be, claimed for the federal share. Monies may be used to cover the county match to the federal share.
- Agencies may not utilize funding for CCS for clients receiving medical assistance or private insurance with the exception of services associated with CCS that are not eligible for medical assistance reimbursement. Funding may be utilized to provide services to CCS clients who are in the process of being approved for medical assistance, private insurance, or insurance via the marketplace.
- Funds may be utilized to provide nonmedical assistance reimbursable services approved by DHS.
- Funds may be used for development (start-up costs), expansion, or build-out of certified programming, such as CSP, CCS, or crisis services. Sources and uses of funds must be clearly identified and reported in the Cost Reporting Tool if using funds to pay the nonfederal share of Medicaid services.
- County or agency shall not expend the monies to provide inpatient or institute for mental disease or nursing facility services.
- Counties must comply with all reporting requirements included in this memo, regardless of their choice on use of expenditures (matching, expansion, etc.).

For additional information and questions regarding this memo:

REGIONAL OFFICE CONTACT

[Area Administrators](#)

CENTRAL OFFICE CONTACT

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Community Mental Health Formula Allocation – CY 2018

ADAMS COUNTY	116,366
ASHLAND COUNTY	47,129
BARRON COUNTY	94,627
BAYFIELD COUNTY	44,967
BROWN COUNTY	1,773,216
BUFFALO COUNTY	80,576
BURNETT COUNTY	84,179
CALUMET COUNTY	36,297
CHIPPEWA COUNTY	135,032
CLARK COUNTY	146,955
COLUMBIA COUNTY	171,255
CRAWFORD COUNTY	167,216
DANE COUNTY	1,076,985
DODGE COUNTY	127,391
DOOR COUNTY	103,623
DOUGLAS COUNTY	139,471
DUNN COUNTY	117,808
EAU CLAIRE COUNTY	530,430
FLORENCE COUNTY	10,568
FOND DU LAC COUNTY	342,213
FOREST, ONEIDA, VILAS (HUMAN SERVICES CENTER)	318,339
GRANT-IOWA UNIFIED BOARD	244,771
GREEN COUNTY	101,971
GREEN LAKE COUNTY	35,029
IRON COUNTY	27,167
JACKSON COUNTY	72,014
JEFFERSON COUNTY	97,609
JUNEAU COUNTY	24,055
KENOSHA COUNTY	708,894
KEWAUNEE COUNTY	50,359
LA CROSSE COUNTY	343,078
LAFAYETTE COUNTY	16,299
NORTH CENTRL COMM SERVICES PROGRAM	389,355
MANITOWOC COUNTY	426,416
MARINETTE COUNTY	240,078
MARQUETTE COUNTY	14,091
MENOMINEE COUNTY	138,442
MILWAUKEE COUNTY	7,780,317
MONROE COUNTY	179,509
OCONTO COUNTY	220,546
OUTAGAMIE COUNTY	268,642
OZAUKEE COUNTY	43,530
PEPIN COUNTY	13,692
PIERCE COUNTY	133,782
POLK COUNTY	137,286

PORTAGE COUNTY	202,057
PRICE COUNTY	86,319
RACINE COUNTY	963,375
RICHLAND COUNTY	124,228
ROCK COUNTY	821,034
RUSK COUNTY	100,374
SAUK COUNTY	197,417
SAWYER COUNTY	47,502
SHAWANO COUNTY	240,467
SHEBOYGAN COUNTY	1,088,859
ST. CROIX COUNTY	458,680
TAYLOR COUNTY	137,088
TREMPEALEAU COUNTY	55,093
VERNON COUNTY	47,056
WALWORTH COUNTY	189,215
WASHBURN COUNTY	100,213
WASHINGTON COUNTY	229,643
WAUKESHA COUNTY	603,712
WAUPACA COUNTY	56,069
WAUSHARA COUNTY	111,973
WINNEBAGO COUNTY	834,687
WOOD COUNTY	282,064
TOTAL	\$24,348,700