DAUPHIN COUNTY MH/MR PROGRAM
POLICY AND PROCEDURE

<table>
<thead>
<tr>
<th>Department</th>
<th>MH</th>
<th>Policy No.</th>
<th>02-09</th>
</tr>
</thead>
<tbody>
<tr>
<td>MR</td>
<td></td>
<td>Effective Date</td>
<td>July 1, 2002</td>
</tr>
<tr>
<td>Admin</td>
<td></td>
<td>Revision Date</td>
<td></td>
</tr>
<tr>
<td>Crisis</td>
<td></td>
<td>Approved</td>
<td></td>
</tr>
</tbody>
</table>

Note: This policy, together with Policy Number 02-08 titled Fee-for-Service Billing, replaces Policy Number 98-08 concerning claims for services rendered.

**Title:** Program Funded Billing

**Policy:** The Program Funded Billing Request is utilized to reflect the total GROSS revenues and expenses of the provider’s program and to establish the amount of financial participation due from the Dauphin County MH/MR Program.

**Procedure:**

1. The Dauphin County MH/MR Program will pay the provider via the Program Funded Billing form only after MH/MR has approved the required Program Funded Contract Materials including: The Program Funding Budget Request Form, The Roster of Personnel (Program Services), and the Roster of Personnel (Administration). Please refer to the Program Funding Budget Request Instructions included with the MH/MR Contract Submission Instructions which is distributed annually (not included).

2. The Provider will also be required to complete a MCR (Modified Classification Review) Agency Roster Form, which is to be completed for each agency with program-funded employees. MH/MR will mail each Provider approved for a Program Funded contract the required forms and instructions (not included) for submission to the State. The instructions will include the Adjustments to Local Government Allowable Salary Maximums, which is effective July 1, of each new fiscal year.

3. In determining expenses please utilize the following expense categories:

   A. Wages and Salaries: wages and salaries paid to employees of the program. Include the allowable amount as determined through the MCR process. Attach the Roster of Personnel – Program Services (included).
B. Employee Benefits: costs included as the employer’s share of social security (FICA), retirement, pension funds, employee health insurance, employee term life insurance coverage, worker’s compensation insurance and unemployment insurance.

C. Purchased Personnel Services: costs incurred for personnel hired on a temporary basis through a contract but not on the payroll, fees and expenses of professional consultants who are not regular employees but are engaged on a contract basis (attorneys, accountants, auditors, etc.)

D. Occupancy Charges: costs of rent, utilities, insurance (fire, liability, auto, etc.) and contract maintenance and housekeeping.

E. Communications: costs of telephone service, postage, printing, audio-visual materials and advertising.

F. Office Supplies: costs of all office supplies and minor equipment, which are consumed or used in day-to-day operations of the office.

G. Treatment and Supportive Supplies: costs of all medical supplies, RX drugs, food and clothing used by clients, and supplies purchased for activities related to social or vocational rehabilitation or recreational purposes which are not deemed fixed assets.

H. Transportation: costs of all transportation provided to clients and employee travel allowances.

I. Administrative: allocate administrative costs on a pro-rata basis to each program, as applicable. Include administrative personnel on the Roster of Personnel – Administrative (included).

J. Miscellaneous: include other operating expenses that cannot be properly allocated elsewhere.

K. Purchase of Fixed Assets: costs of capital purchases of equipment or furnishings. Attach list of assets showing description, purchase date and cost.

L. Repairs/Maintenance of Fixed Assets: include necessary repairs and maintenance of fixed assets.

4. In determining revenue include Total Non-MH/MR Income not limited to: Medical Assistance, CBHN, Third Party Insurance, Client Fees, United Way, Private Contributions, etc.

5. The Dauphin County MH/MR Funding request will be the Gross Expenses less the Total Non-MH/MR Income.
6. The Program Funded Invoice (attached) must contain the appropriate provider signature, title, and date.

7. The Program Funded Invoice is due to MH/MR by the 15th of the month following the month in which the service was provided.
DAUPHIN COUNTY MH/MR
PROGRAM FUNDED INVOICE

FROM: ___________________________________________  Provider Number ____________

_________________________________________  For Month/Year of ____________

_________________________________________  REVISED: 7/01/02

Program No. and Description
(Per Appendix A of the Contract)
_________________________________________

<table>
<thead>
<tr>
<th>EXPENSES:</th>
<th>CURRENT MONTH</th>
<th>YEAR-TO-DATE ACTUAL</th>
<th>YEAR-TO-DATE BUDGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel Services:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wages and Salaries (Attach Roster)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchased Personnel Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Expenses:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Supplies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment &amp; Supportive Supplies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative (Attach Roster for Wages &amp; Salaries)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equipment/Fixed Assets:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Purchase of Fixed Assets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repairs/Maintenance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GROSS EXPENSES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>REVENUE:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income (Non-MH/MR):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Assistance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Third Party Insurance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client Fees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Way</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Contributions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL NON-MH/MR INCOME</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DAUPHIN COUNTY MH/MR FUNDING
_________________________________________

*Attach List of Assets showing description, purchase date and cost

SUBMITTED BY:  ___________________________________________

(PROVIDER SIGNATURE)  (TITLE)  (DATE)

DAUPHIN COUNTY MH/MR APPROVAL:

(SIGNATURE)  (DATE)
DAUPHIN COUNTY MENTAL HEALTH/MENTAL RETARDATION
PROGRAM

ROSTER OF PERSONNEL

ADMINISTRATION

Program Name: ________________________________

<table>
<thead>
<tr>
<th>Staff Name</th>
<th>Hours Worked</th>
<th>Hours Worked in this Program</th>
<th>Total Salary</th>
<th>Salary Charged to this Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DAUPHIN COUNTY MENTAL HEALTH/MENTAL RETARDATION
PROGRAM

ROSTER OF PERSONNEL

PROGRAM SERVICES

Program Name: ________________________________________________________________

<table>
<thead>
<tr>
<th>Staff Name</th>
<th>Hours Worked</th>
<th>Hours Worked in this Program</th>
<th>Total Salary</th>
<th>Salary Charged to this Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>