DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Bowling	1-23-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 060477	[X] Prepare reply for the Director's signature DATE DUE 1-30-07
2. DATE SIGNED BY DIRECTOR cc: Wells cleared 1/23/07, letter attached.	[ ] Prepare reply for appropriate signature DATE DUE [ ] FOIA DATE DUE [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

Log. Bowling
"Robby's Sign"
cc: wkl

DEPARTMENT OF HEALTH & HUMAN
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-2
Baltimore, Maryland 21244-1850

CMS
MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

DEC 13 2006

RECEIVED
JAN 22 2007
Department of Health & Human Services
OFFICE OF THE DIRECTOR

Ms. Sheila Mills
South Carolina Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

Dear Ms. Mills:

I am pleased to inform you of your award of a FY2007 Community Alternatives to Psychiatric Residential Treatment Facilities Demonstration Grant. Congratulations on your successful application!

We at the Centers for Medicare & Medicaid Services (CMS) thank you for your efforts in preparing the application and look forward to our work together throughout the grant period. We expect these demonstration grants will increase the opportunities for children and youth with mental illness to return to the community from psychiatric residential treatment and provide an array of services that will offer an alternative to admission to these facilities.

Your first year award is in the amount of $741,584. Your projected five year funding request of $8,125,494 will be awarded in succeeding fiscal years dependent on the approval of a revised Implementation Plan and a Continuation Grant award. Continuation awards will be made based on your progress in meeting your implementation timeline, the number of enrollees and the service plans.

Please examine this offer and respond back to both your CMS Grants Officer and CMS Project Officer with notice of your acceptance of the award and of the terms and conditions no later than January 23, 2007. In addition to the general terms and conditions, this grant award has special terms and conditions that you will need to review. The enclosed award profile provides all necessary contact information for your CMS partners.

If you accept this award, you may begin immediately to work with CMS and the CMS Evaluation Contractor to develop your Implementation Plan.

Enclosed are four important documents regarding your Psychiatric Residential Treatment Facilities Demonstration Grant Program Award:

1. **Award Profile** – The award profile is a quick reference list for your grant and includes the grant award number, amount of the grant and contact information for the officers within

CMS including, the Grants Management Specialist and Project Officer. Official correspondence should be directed to the CMS Grants Management Specialist with a copy to your CMS Project Officer. Any questions and correspondence regarding programs or initiatives under your grant should be directed to your CMS Project Officer.

2. **Terms and Conditions** - This is the legal document that cites the regulations governing this grant and sets forth the general requirements, assurances, reporting requirements, and other terms and conditions that apply specifically to the grant.

3. **Financial Assistance Award** – This document is the "official" notification of your award from the CMS Office of Acquisition and Grants Management.

4. **Letter of Acceptance (recommended format)** – A letter of acceptance of the grant award serves as official acceptance. Please submit your letter of acceptance to your CMS Grants Management Specialist and send a copy to your CMS Project Officer by close of business on Tuesday, January 23, 2007. If you do not plan to accept the grant award, please send a letter of declination to the CMS Grants Management Specialist and send a copy to the CMS Project Officer by close of business on Friday, January 5, 2007.

Thank you again for your commitment to increasing the opportunities for children to receive home and community-based services as an alternative to psychiatric residential treatment facilities.

Sincerely,

Dennis G. Smith

Dennis G. Smith
Director

Enclosures
cc: Project Officer
Robert Kerr

AWARD PROFILE
FY 2007 REAL CHOICE SYSTEMS CHANGE GRANTS PROGRAM

CMS GRANT NO.	**602823**
TYPE OF GRANT	Community Alternatives to Psychiatric Residential Treatment Facilities Demonstration
AWARDEE	South Carolina Department of Health and Human Services
AUTHORITY	Section 6063 of the Deficit Reduction Act of 2005
AMOUNT OF AWARD	(Project Period December 20, 2006 –December 19, 2011) **$741,584**
CMS GRANT MANAGEMENT SPECIALIST	Nicole Nicholson Grants Management Specialist Centers for Medicare & Medicaid Services Office of Acquisition and Grants Management Mail Stop: C2-21-15, Central Building 7500 Security Boulevard Baltimore, MD 21244-1850 Phone: 410.786.5158 Email: nicole.nicholson@cms.hhs.gov **Official correspondence regarding the award should be submitted to the CMS Grants Management Specialist. Copies of such material should also be sent to the CMS Project Officer and the CMS Regional Office Coordinator.**
CMS PROJECT OFFICER	Sona Stepp Centers for Medicare & Medicaid Services Center for Medicaid and State Operations Disabled and Elderly Health Programs Group Mail Stop: S2-14-26 7500 Security Boulevard Baltimore, MD 21244-1850 Phone: 410.786.6815 Fax: (410) 786.9004 E-mail: sona.stepp@cms.hhs.gov **Communication regarding program matters should be addressed to the CMS Project Officer.**

Grant Specific Special Terms & Conditions

State of South Carolina
Department of Health and Human Services

In developing your Implementation Plan, you must address the following issues:

1. Insure that adequate oversight is provided through a project director and additional staff that has sufficient time devoted to the project to coordinate, manage, and report as required by CMS.
2. Insure that the funds awarded in this demonstration do not supplant other funding resources such as social services, juvenile justice or education.
3. Work very closely with our National Evaluator to insure your evaluation plan meets the requirements of participation and the requirements of Section 6063 and the data required is submitted timely.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Community Alternatives to Psychiatric Residential Treatment Facilities Grant Demonstration

GENERAL TERMS AND CONDITIONS

In addition to any programmatic Special Terms and Conditions of the award, the following General Terms and Conditions will apply. Where there are inconsistencies, the Programmatic Special Terms and Conditions will take precedence. Additionally, the attached Grant Award is subject to Federal legislation and to DHHS and CMS regulations and policies. Either 45 CFR Part 74 or 45 CFR Part 92 will apply to this award:

45 CFR Part 74 "Uniform Administrative Requirements for Awards and Sub-awards to Institutions of Higher Education, Hospitals, and other Non-Profit Organizations, and Commercial Organizations; and certain grants and agreements with States, Local Government and Indian Tribal Governments."

45 CFR Part 92 "Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments."

45 CFR Part 74 and Part 92 may be accessed from the DHHS GrantsNet at:
http://www.hhs.gov/grantsnet/adminis/fedreg45.htm

Other DHHS regulations codified in 45 CFR:

Part 16	-	Procedures of the Departmental Grants Appeals Board
Part 30	-	Claims Collection
Part 46	-	Protection of human subjects
Part 76	-	Government-wide debarment and suspension (non-procurement) and Government-wide requirements for drug-free workplace (grants)
Part 80	-	Nondiscrimination under programs receiving Federal assistance through the Department of Health and Human Services effectuation of Title VI of the Civil Rights Act of 1964
Part 81	-	Practice and procedure for hearings under Part 80 of this title
Part 84	-	Nondiscrimination on the basis of handicap in programs and activities receiving Federal financial assistance
Part 86	-	Nondiscrimination on the basis of sex in education programs and activities receiving or benefiting from Federal financial assistance
Part 91	-	Nondiscrimination on the basis of age in HHS programs or activities receiving Federal financial assistance

Part 93 - New restrictions on lobbying
Part 100 - Intergovernmental Review of Department of Health and Human Services programs and activities

Applicable cost principles are as follows:

OMB Circular A-21, Cost Principles for Educational Institutions
OMB Circular A-87, Cost Principles for State, Local and Indian Tribal Governments
OMB Circular A-122, Cost Principles for Non-Profit Organizations
OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations.

The OMB Circular website is: www.whitehouse.gov/omb/circulars.

The recipient organization must carry out the project according to the application as approved by the Centers for Medicare & Medicaid Services (CMS) including the proposed work program and any amendments, all of which are incorporated by reference in these terms and conditions.

Reporting Requirements

Financial Reports - The Grantee agrees to submit financial status reports (SF-269 or SF-269A) to the CMS Grants Management Officer with a copy to the CMS Project Officer as stipulated in the Special Terms and Conditions. Unless specified as quarterly or semi-annual in the Special Terms and Conditions, financial reports are due annually and at the end of the project. This financial status report will account for all uses of grant monies during the previous period and project uses of grant money for the ensuing period. Quarterly and semi-annual reports are due 30 days after the end of the reporting period. Annual reports are due 90 days after the budget period ending date.

Progress Reports – The Grantee agrees to submit progress reports to the CMS Grants Management Officer with a copy to the CMS Project Officer as stipulated in the Special Terms and Conditions. Unless specified as quarterly or semi-annual in the Special Terms and Conditions, progress reports are due annually. These reports are to be consistent with a format and content specified by CMS. CMS reserves the right to require the grantee to provide additional details and clarification on the content of the report. Quarterly and semi-annual reports are due 30 days after the end of the reporting period. Annual reports are due 90 days after the budget period ending date.

Final Report – The Grantee agrees to submit a final report to the CMS Grants Management Officer with a copy to the CMS Project Officer within 90 days after the final CMS-64 form and final SF269 is submitted with all claims remaining to be reimbursed by the demonstration grant. The Grantee may use the CMS' "Author's Guidelines: Grants and Contracts Final Report" in the preparation of the final report. This document can be found at the following website: http://www.cms.hhs.gov/ResearchDemoGrantsOpt/Downloads/authorsguidelines.pdf

A draft final report should be submitted to the CMS Project Officer for comments. CMS's comments should be taken into consideration by the Grantee for incorporation into the final

report. CMS reserves the right to require the Grantee to provide additional details and clarification on the content of the report.

The final report may not be released or published without permission from the CMS Project Officer within the first four (4) months following the receipt of the report by the CMS Project Officer.

The final report will contain a disclaimer that the opinions expressed are those of the Grantee and do not necessarily reflect the opinion of CMS.

Failure to submit reports (i.e., financial, progress, or other required reports) on time may be basis for withholding financial assistance payments, suspension, termination or denial of refunding. A history of such unsatisfactory performance may result in designation of "high risk" status for the recipient organization and may jeopardize potential future funding from DHHS.

Use of Grant Funds

At the conclusion of this Grant, Grantees shall submit all claims for reimbursement as required within the Medicaid reimbursement regulations time requirement. Any request for reimbursement after the required submittal time will not be considered for payment from the Grant award.

The Grantee will take all necessary affirmative steps to ensure that small, minority and woman-owned business firms are utilized when possible as sources of supplies, services, and equipment. To the extent practicable, all equipment and products purchased with grant funds made available through this award should be American-made.

When issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with Federal money, all Grantees receiving Federal funds, including but not limited to State and local governments and recipients of Federal research grants shall clearly state (1) the percentage of total costs of the program or project which will be financed with Federal money, (2) the dollar amount of Federal funds for the program or project, and (3) the percentage and dollar amount of the total costs or the program or project that will be financed by nongovernmental sources.

Project Oversight

CMS may suspend or terminate any project in whole, or in part, at any time before the date of expiration, whenever it determines that the Grantee has materially failed to comply with the terms and conditions of the project. CMS will promptly notify the grantee in writing of the determination and the reasons for the suspension or termination, together with the effective date.

At any phase of the project, if so requested, the CMS Project Officer will be available for technical consultation at the convenience of the Grantee.

Certain key personnel, as designated by the CMS Project Officer, are considered to be essential to the work being performed on specific activities. Prior to altering the levels of effort of any of the key personnel among the various activities for this project, or to diverting those individuals to other projects outside of the scope of this award, the Grantee shall notify the CMS Project Officer reasonably in advance and shall submit a justification (including name and resume of proposed substitution) in sufficient detail to permit evaluation of the impact of the project. No alteration or diversion of the levels of effort of the designated key personnel for the specified activities for this project shall be made by the Grantee without the approval of the CMS Project Officer.

Project and Data Integrity

The Grantee shall develop and submit detailed plans to protect the confidentiality of all project-related information that identifies individuals. The plan must specify that such information is confidential, that it may not be disclosed directly or indirectly except for purposes directly connected with the conduct of the project; and that informed written consent of the individual must be obtained for any disclosure. The plan is subject to CMS approval and must be submitted within 60 days of receipt of this letter.

The Grantee shall assume responsibility for the accuracy and completeness of the information contained in all technical documents and reports submitted. The CMS Project Officer shall not direct the interpretation of the data used in preparing these documents or reports.

At any phase in the project, including the project's conclusion, the Grantee if so requested by the Project Officer, must deliver to CMS materials, systems, or other items applied, developed, refined or enhanced in the course of or under the award. The Grantee agrees that CMS shall have royalty-free, nonexclusive and irrevocable rights to reproduce, publish, or otherwise use and authorize others to use the items for Federal government purposes.

Use of Data and Work Products

At any phase of the project, including the project's conclusion, the Grantee, if so requested by the CMS Project Officer, shall submit copies of analytic data file(s) with appropriate documentation, representing the data developed/used in end-product analyses generated under the award. The analytic file(s) may include primary data collected, acquired or generated under the award and/or data furnished by CMS. The content, format, documentation, and schedule for production of the data file(s) will be agreed upon by the Principal Investigator and the CMS Project Officer. The negotiated format(s) could include both file(s) that would be limited to CMS's internal use and file(s) that CMS could make available to the general public.

All data provided by CMS will be used for the research described in this grant only. The Grantee will return any data provided by CMS or copies of data at the conclusion of the project.

For 6 months after completion of the project, the Grantee shall notify the CMS Project Officer prior to formal presentation of any report or statistical or analytical material based on information obtained through this award. Formal presentation includes papers, articles,

professional publication, speeches, and testimony. In the course of this research, whenever the Principal Investigator determines that a significant new finding has been developed, he/she will communicate it to the CMS Project Officer before formal dissemination to the general public.

Charitable Choice

Charitable Choice is a legislative provision designed to remove unnecessary barriers to the receipt of certain Federal funds by "faith-based" organizations. Under the Department of Health and Human Services implementation, 45 CFR Part 87 (including Parts 74, 92, and 96 as amended) "faith-based" organizations are eligible to compete for funding on the same basis and under the same eligibility requirements as other organizations.

Religiously affiliated ("faith-based") organizations under 45 CFR Part 87 (including Parts 74, 92, and 96 as amended) may not use direct financial assistance from this grant, as well as from State and local governments or intermediate organizations administering funds under the Department of Health and Human Services programs, to support inherently religious activities, such as worship, religious instruction, or proselytization. If the organization engages in such activities, it must offer them separately, in time or location, from programs or services funded with direct Department assistance or required matching funds, and participation must be voluntary for the beneficiaries of the Department-funded program or services. All rules and revision under 45 CFR Parts 74, 87, 92, and 96 are hereby incorporated by reference.

Community Alternatives to Psychiatric Residential Treatment Facilities Grant Demonstration

Programmatic Special Terms & Conditions

1. Implementation Plans (IP/AP) must be completed within 9 months of the date of award. The format of the IP will be the new web-based 1915 (c) waiver template. Training on the new web-based 1915 (c) Template will be provided shortly after the receipt of the award package.

   IP/APs will address the components listed below in the design, operation, and administration of the demonstration project:

   - **Demonstration Administration and Operation.** States will be required to specify the administrative and operation structure of the demonstration.

   - **Participant Access and Eligibility.** Specify the target group(s) of individuals who are served under the demonstration, the number of participants that the State expects to serve during each year that the demonstration is in effect, applicable Medicaid eligibility requirements, and procedures for the evaluation and re-evaluation of level of care.

   - **Participant Services.** Specify the services that are furnished through the demonstration, including applicable limitations on such services.

   - **Participant Direction of Services.** When the State provides for participant direction of services, specify the supports provided in the demonstration to support participant direction of demonstration services.

   - **Participant Rights.** Specify how the State informs participants of the Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

   - **Participant Safeguards.** Describe the safeguards that the State has established or will establish to ensure the health and welfare of participants.

   - **Quality Management Strategy.** Describe the process, procedures, and strategies employed by the State to discover, remedy, and improve the overall operation and administration of the demonstration project. The description should provide information detailing the frequency of which information is tracked, trended, and reported out, as well as those individuals and groups that receive such information.

   - **Financial Accountability.** Describe the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable Federal requirements concerning payments and Federal financial participation.

- **Financial Neutrality.** Your demonstration of cost-neutrality will be reported using the following forms:

  CMS-372(S) The annual report that a State must submit to CMS following the completion of each demonstration year that details: (a) the number of unduplicated individuals who participated in a waiver during the waiver year; (b) the unduplicated number of persons who utilized each waiver service and the amount of funds expended for each service; (c) expenditures for Medicaid State plan services on behalf of waiver participants; and, (d) information concerning assuring the health and welfare of waiver participants. The information submitted via the CMS-372(S) provides evidence of the waiver's cost-neutrality on an ongoing basis. The CMS-372(S) was formerly known as Form HCFA-372. The CMS-372(S) simplified the information that States previously reported on Form HCFA-372. This form may be modified for the demonstration

  CMS-373 (S) The report that will replace the financial and statistical portion of the CMS-372(S) in the future.

  CMS-373 (Q) The report that will replace the health and welfare part of the CMS-372(S) in the future. The CMS-373Q will provide for the reporting of State performance in meeting the waiver assurances and for updates to the waiver Quality Management Strategy.

  CMS-64 Quarterly Expense Report-Modified: This report will provide actual expenses per quarter for all services provided through the demonstration. This form will be modified to allow for recording expenses for each service category.

2. **Financial Status Report Form (SF-269) with the Modified Form CMS-64,** are required to be submitted quarterly. This financial status report required by the Office of Acquisition and Grants Management, will account for all uses of grant monies during each reporting period. The Modified form 64 is described above.

3. **Federal fund reimbursable claims:** All claims will be coded and identified as PRTF Demonstration claims.

4. **Bundling of services:** CMS permits states to bundle services as long as the health and welfare of demonstration participants is not compromised. When bundling services, unskilled providers may not provide skilled services, such as physical therapy or other services that require the judgment of a certified or licensed professional. Additionally, the rate(s) established for bundled services shall be derived in manner or with a methodology that is appropriate and reasonable for such bundled services. Services must be fully described. Also, States must provide a detailed list of all services to be bundled for review and approval by CMS.

5. **Annual Progress Reports:** Annual reports, in a format to be determined, are required to be submitted within 30 days of the close of the grant year. The submission of the finalized

Implementation Plan, due no later than 9 months after receipt of the Notice of Financial Assistance Award will be considered the First annual report due under this demonstration.

6. **Administrative Costs will be eligible for Federal Financial Participation (FFP) under the authority of CFR42 433.15 (7):** "All other activities the Secretary finds necessary for the proper and efficient administration of the State Plan." Since the administrative costs associated with implementation of the PRTF demonstration will: (1) be billed against the grantee's total grant award; and (2) operate under the auspices of a 1915 (c), but also include additional requirements (such as participation in a national evaluation); CMS maintains discretion as to what are reimbursable costs under the demonstration. Awardees are expected to submit proposed administrative and service budgets as part of the Implementation Plan and these budgets will serve as upper limits on the initial grant award and expenditures under the demonstration. The administrative budgets will be examined by the CMS to determine whether the proposed demonstration costs supplant existing State administrative costs, and/or are excessive based on the applicant's Implementation Plan.

6. **Continuing Grant Awards and Award Funding:** For up to 9 months you will be developing the Implementation Plan/1915 (c) web-based wavier application (IP/AP). The remaining 3 months of the first year, and the following 12 months of the award period will be considered the first period of the grant reflected in the initial 1915 (c) web-based waiver application submission. For years three through year five, awards amounts will be determined through a request for additional funding using a continuation award process and an amended IP/AP. Awards in succeeding fiscal years are dependent on the approval of a revised IP/AP and a Continuation Grant Award. Continuation awards will be made based on your progress in meeting your implementation timeline, the number of enrollees and the service plans. **Any unliquidated award funds at the end of an award year may be carried over into the succeeding award year through the 5 year award period.** Continuation award funding will affect the amount of funds to be carried over from the preceding grant year award.

7. **Governing Requirements:** Section 6063 of the Deficit Reduction Act of 2005. All the requirements in the solicitation, Medicaid Program Demonstration Project: Community-based Alternatives to Psychiatric Residential Treatment Facilities CFDA 93.789, as well as all additional information in the form of Questions and Answers posted on the CMS website are components of this award.

8. **CMS will be contracting for a National Demonstration Evaluation:** All awardees must cooperate with the National Evaluation Contractor in the development of your State's Evaluation Plan development and the National Evaluation Plan. The following are required:

   - Monthly Calls Working with the Contractor for Evaluation Plan Development: The Grantee will participate in monthly calls with Contractor for national evaluation plan development.

   - Development of Minimum Data Set (MDS) and Mode of Transmission: The Grantee will submit their evaluation plan to CMS and the Contractor who will then provide

recommendations on any refinements necessary. The Grantee will participate in meetings/conference calls conducted by the Contractor to determine the MDS.

- Quarterly Calls on Research Activities: The Grantee will participate in quarterly calls with CMS, conducted by the Contractor, on its research activities that will include (a) a description of data gathering, evaluation, and analysis activities for that quarter; (b) an analysis of the State's adherence to its timeline and work plan; (c) information on the data gathered in that quarter; (d) descriptions of the evaluation and analyses performed in that quarter; (e) a discussion of barriers to the project's implementation or success; and (f) recommendations for refinements of the research project.

- Submission of Data to CMS: The evaluator will include a description of the process for forwarding its research data to CMS in a timely manner. This includes individually identifiable files including name, date of birth, and Social Security number.

- Confidentiality: The Grantee will develop and submit detailed plans to protect the confidentiality of all project-related information that identifies individuals. The plan must specify that such information is confidential, that it may not be disclosed directly or indirectly except for purposes directly connected with the conduct of the project; and that informed written consent of the individual must be obtained for any disclosure. The plan is subject to CMS approval and must be submitted within 60 days of receipt of this letter.

- The State will be expected to provide a finder file to CMS, or its appointed representative, for each participant and an extract file of individual-level data for the demonstration enrollees during the Demonstration period. The PRTF Grantees will be expected to use existing Medicaid reporting systems including Medicaid Management Information System (MMIS). The information in the extract files will be used to effectively monitor the utilization and costs of services by participants. The extract file is necessary in order to avoid the time delays involved in the MMIS quality reviews.

- The information needed for the PRTF evaluation will generally come from official administrative records and not from self-reported information. The finder file shall include Medicaid enrollment information such as name, address, Social Security number, date of birth, race, ethnicity, disabling condition(s), and service utilization. Use and access to these data will be limited to the specific research purposes of these projects and shall adhere to all CMS provisions concerning data release policies, the Privacy Act of 1974, and the Health Insurance Portability and Accountability Act of 1996.

7. **Final Report:** The Grantee will be required to work with the evaluation contractor on the National Evaluation until the completion of the evaluation. The contractor will also provide a final report, in a format to be determined, at the conclusion of the demonstration grant project.

1.RECIPIENT

Department of Health and Human Services
Centers For Medicare Medicaid Services
Notice of Award (NOA)

SAI NUMBER:

PMS DOCUMENT NUMBER:
1S0CMS300131A

1. AWARDING OFFICE:	2. ASSISTANCE TYPE:	3. AWARD NO.:	4. AMEND. NO.:
Centers For Medicare & Medicaid Services	Discretionary Grant	1S0CMS300131/01	

5. TYPE OF AWARD:	6. TYPE OF ACTION:	7. AWARD AUTHORITY:
DEMONSTRATION	New	Section 8063 of the DRA 05

8. BUDGET PERIOD:	9. PROJECT PERIOD:	10. CAT NO.:
12/20/2006 THRU 12/19/2007	12/20/2006 THRU 12/19/2011	93789

11. RECIPIENT ORGANIZATION:
South Carolina Department of Health and Human Services
PO Box 8206
Columbia SC 29202 8602
Robert Kerr, Director

12. PROJECT / PROGRAM TITLE:
Community Based Alternatives to Psychiatric Residential Treatment Facilities

13. COUNTY:	14. CONGR. DIST:	15. PRINCIPAL INVESTIGATOR OR PROGRAM DIRECTOR:
		Sheila Mills , PI

16. APPROVED BUDGET:

Personnel	$	0
Fringe Benefits	$	0
Travel	$	0
Equipment	$	0
Supplies	$	0
Contractual	$	0
Facilities/Construction	$	0
Other	$	741,584
Direct Costs	$	741,584
Indirect Costs At % of $	$	0
In Kind Contributions	$	0
Total Approved Budget(**)	$	741,584

17. AWARD COMPUTATION:

A. NON-FEDERAL SHARE	$	0	0.00 %
B. FEDERAL SHARE	$	741,584	100.00 %

18. FEDERAL $HARE COMPUTATION:

A. TOTAL FEDERAL SHARE	$	741,584
B. UNOBLIGATED BALANCE FEDERAL SHARE	$	
C. FED. SHARE AWARDED THIS BUDGET PERIOD	$	741,584

19. AMOUNT AWARDED THIS ACTION:	$	741,584
20. FEDERAL $ AWARDED THIS PROJECT PERIOD:	$	741,584

21. AUTHORIZED TREATMENT OF PROGRAM INCOME:

22. APPLICANT EIN:	23. PAYEE EIN:	24. OBJECT CLASS:
1-576000286-A8	1-576000286-A8	41.45

25. FINANCIAL INFORMATION:

ORGN	DOCUMENT NO.	APPROPRIATION	CAN NO.	NEW AMT.	UNOBLIG.	NONFED %
CMS	1S0CMS300131A	75-7/1-0515	2007 5992054	$741,584		

26. REMARKS: (Continued on separate sheets)

Paid by DHHS Payment Management System (PMS), see attached for payment information.
This award is subject to the requirements of the HHS Grants Policy Statement (HHS GPS) that are applicable to you based on your recipient type and the purpose of this award.
This includes requirements in Parts I and II (available at http://www.acf.hhs.gov/grants/grants_resources.html) of the HHS GPS. Although consistent with the HHS GPS, any applicable statutory or regulatory requirements, including 45 CFR Part 74 or 92, directly apply to this award apart from any coverage in the HHS GPS.
This grant is subject to the requirements set forth in 45 CFR part 74 (for non-profit organizations and educational institutions) or 45 CFR Part 92 (for state, local, and federally recognized tribal governments).
Initial expenditure of funds by the grantee constitutes acceptance of this award.

27. SIGNATURE - CMS GRANTS OFFICER	DATE:	28. SIGNATURE(S) CERTIFYING FUND AVAILABILITY
Judith L. Norris	DEC 13 2006	Signature Not Required

29. SIGNATURE AND TITLE - PROGRAM OFFICIAL(S) DATE:

Sona Stepp, Signature Not Required

1.RECIPIENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE &MEDICAID SERVICES
FINANCIAL ASSISTANCE AWARD

SAI NUMBER:

PMS DOCUMENT NUMBER:
1S0CMS300131A

1. AWARDING OFFICE:	2. ASSISTANCE TYPE:	3. AWARD NO.:	4. AMEND. NO.
Centers For Medicare & Medicaid Services	Discretionary Grant	1S0CMS300131/01	

5. TYPE OF AWARD:	6. TYPE OF ACTION:	7. AWARD AUTHORITY:
DEMONSTRATION	New	Section 6063 of the DRA 05

8. BUDGET PERIOD:	9. PROJECT PERIOD:	10. CAT NO.:
12/20/2006 THRU 12/19/2007	12/20/2006 THRU 12/19/2011	93789

11. RECIPIENT ORGANIZATION:
South Carolina Department of Health and Human Services

28. REMARKS: (Continued from previous page)

Future support is anticipated.
(**) Reflects only federal share of approved budget.There are special conditions attached to this award.
For CMS Purposes Only: Transmittal Number: BOAX720541 / 7527205401
APPROPRIATION NUMBER: 75 7711 0516

By January 23, 2007, the grantee agrees to provide to the CMS Grants Management Specialist and CMS Project Officer a hardcopy of a revised budget equal to the amount of the grant award on Standard Form 424A, Section B and the approved Indirect Cost Rate Agreement used in calculating the budget, if applicable.

Please remember to include your award number on all correspondence.

For administrative assistance, please contact your Grants Management Specialist: Nicole Nicholson at 410 786-5158 or Nicole.Nicholson@cms.hhs.gov.

For programmatic assistance, please contact your Project Officer: Sona Stapp at 410 786-6815 or Sona.Stapp@cms.hhs.gov .

LETTER OF GRANT AWARD ACCEPTANCE

Due on or before January 23, 2007
(Recommended Format)

Please submit your letter of acceptance on your agency's letterhead stationery.

Date

(Insert the name of your Grants Management Specialist)
Grants Management Specialist
Centers for Medicare & Medicaid Services
Office of Acquisition and Grants Management
Mail Stop: C2-21-15, Central Building
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Grants Management Specialist:

This letter serves as formal acceptance of FY 2007 Community Alternatives to Psychiatric Residential Treatment Facilities Demonstration Grant, **Grant No., type of grant award)** and its accompanying terms and conditions. We understand that the grant award is **(insert amount of grant award)** and that the grant period is from December 20, 2006 through December 19, 2007.

Sincerely,

Your name
Title
Phone number
Fax number

cc: CMS Project Officer

#477

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

January 23, 2007

Robert M. Kerr
Director

Ms. Nicole Nicholson, Grants Management Specialist
Centers for Medicare and Medicaid Services
Office of Acquisition and Grants Management
Mail Stop: C2-21-15, Central Building
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Nicholson:

This letter serves as formal acceptance of FY 2007 Community Alternatives to Psychiatric Residential Treatment Facilities Demonstration Grant, Grant No., 1SOCMS300131/01 Demonstration and its accompanying terms and conditions. We understand that the grant award is $741,584 and that the grant period is from December 20, 2006 through December 19, 2007.

We have enclosed a copy of the South Carolina Department of Health and Human Services' confidentiality plan for individual health records. If you have any questions, please contact Ms. Sheila Mills at (803) 898-2555.

Sincerely,

Robert M. Kerr
Director

RMK/mbc

Enclosures

cc: Sona Stepp, CMS Project Officer

Office of the Director
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2504 • Fax (803) 255-8235

Community Alternatives to Psychiatric Residential Treatment Facilities Demonstration
Award No. 1SOCMS300131/01

Confidentiality Plan

Safeguarding Information

The South Carolina Department of Health and Human Services shall safeguard the use and disclosure of information concerning applicants for or recipients of Title XIX services in accordance with 42 CFR Part 431, Subpart F, (2000, as amended), SCDHHS's regulations R. 126-170, et seq., Code of Laws of South Carolina (1976), Volume 27, as amended, and all other applicable state and federal laws and regulations and shall restrict access to, and use and disclosure of, such information in compliance with said laws and regulations. Further, all use and disclosure shall comply with the "HIPAA Manual of Policies and Procedures for South Carolina Department of Health and Human Services, Effective April 14, 2003."

SCDHHS Authorization To Disclose Health Information

Enclosed SCDHHS HIP-02 Revised 03/06

SCDHHS AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name: _____ Date of Birth: _____

Record #: _____ Client SS #: _____

I _____ hereby authorize
(Client or Personal Representative)

_____ to disclose specific health information
(Name of Provider/Plan/Agency)

from the records of the above named client to: _____
(Recipient Name/Address/Phone/Fax)

_____

_____

for the specific purpose(s):_____

_____

Specific information to be disclosed: _____

_____

_____

I understand that this authorization will expire on the following date, event or condition: _____

_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that refusal to sign this authorization will not condition or limit my access to treatment, payment, enrollment or eligibility for benefits available to me.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I further understand that I may request a copy of this signed authorization.

_____	_____	_____
(Signature of Client)	*(Date)*	*(Witness-If Required)*
_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

****

NOTE: This Authorization was revoked on _____	_____
(Date)	*(Signature of Staff)*

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Client)

signed by _____ on _____
(Enter Name of Person Who Signed Authorization) *(Enter Date of Signature)*

be rescinded, effective _____. I understand that any action taken on this authorization prior to the
(Date)

rescinded date is legal and binding.

_____ _____ _____ _____
(Signature of Client) *(Date)* *(Signature of Witness)* *(Date)*

_____ _____ _____
(Signature of Personal Representative) *(Date)* *(Personal Representative Relationship/Authority)*

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by _____
(Name of Client or Personal Representative)

on _____. The client or his personal representative has been informed that any
(Date)

action taken on this authorization prior to the rescinded date is legal and binding.

_____ _____ _____ _____
(Signature of Staff) *(Date)* *(Signature of Witness)* *(Date)*

ATTN: SONA

410-786-9004

TRANSMISSION VERIFICATION REPORT

TIME : 01/23/2007 14:25
NAME : DHHS
FAX : 803-898-4511
TEL :
SER.# : BROL5J367220

DATE,TIME	01/23 14:24
FAX NO./NAME	914107869004
DURATION	00:00:40
PAGE(S)	05
RESULT	OK
MODE	STANDARD ECM

SC Department of Health and Human Services
Transmittal for Director's Signature

Item(s) to be signed: Letter to Nicole Nicholson, Grants Management specialist regarding-DHHS formal acceptance of the FY 2007 Community alternatives Psychiatric Residential Treatment Facililites Demonstration Grant No 1SOCMS300131/01 and a copy of DHHS's confidentiality plan for individual health records.

Indicate reason Director's signature is needed: ASAP

DATE REQUESTED BY:	CONTACT PERSON & PHONE #:
ASAP	Sheila L. Mills- 8-3018

APPROVALS

1) DIVISION DIRECTOR/BUREAU CHIEF SIGNATURE: / Sheila L. Mills SLM	Date: 1/22/07
2) DEPUTY DIRECTOR'S SIGNATURE: Susan B. Bowling SBB	Date: 1/22/07
3) OTHER (Please indicate)	Dates:

FOR DIRECTOR'S USE ONLY

DATE RETURNED:	___ APPROVED	___ DISAPPROVED

Rev: 07/03

DATE: 1-23-07

TO: Sona Step, Project Mgr.
Telephone #: 410-786-6815
Fax #: 410-786-9004

FROM: MARY Cooper for Sheila Mills

Total Number of Pages Transmitted: 5 (Including Cover Sheet)

COMMENTS:

Confidentiality Note

This message is intended for the use of the person or entity to which it is addressed and may contain information, including health information, that is privileged, confidential, and the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this in error, please notify us immediately and destroy the related message. Thank you.

Bureau of Rehabilitative and Medical support Services
P. O. Box 8206 Columbia South Carolina 29202-8206
898-2555 Fax 255-8205

Rev: 4/03

DATE,TIME	01/23 12:27
FAX NO./NAME	914107869004
DURATION	00:00:36
PAGE(S)	05
RESULT	OK
MODE	STANDARD ECM

TRANSMISSION VERIFICATION REPORT

TIME : 01/23/2007 12:28
NAME : DHHS
FAX : 803-898-4511
TEL :
SER.# : BROL5J367220

Community Alternatives to Psychiatric Residential Treatment Facilities Demonstration
Award No. 1SOCMS300131/01

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(Recipient Name/Address/Phone/Fax)

_____

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for the specific purpose(s):_____

_____

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I further understand that I may request a copy of this signed authorization.

_____	_____	_____
(Signature of Client)	*(Date)*	*(Witness-If Required)*
_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

****

NOTE: This Authorization was revoked on _____	_____
(Date)	*(Signature of Staff)*

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(Name of Client)

signed by _____ on _____
(Enter Name of Person Who Signed Authorization) *(Enter Date of Signature)*

be rescinded, effective _____. I understand that any action taken on this authorization prior to the
(Date)

rescinded date is legal and binding.

_____ _____ _____ _____
(Signature of Client) *(Date)* *(Signature of Witness)* *(Date)*

_____ _____ _____
(Signature of Personal Representative) *(Date)* *(Personal Representative Relationship/Authority)*

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by _____
(Name of Client or Personal Representative)

on _____. The client or his personal representative has been informed that any
(Date)

action taken on this authorization prior to the rescinded date is legal and binding.

_____ _____ _____ _____
(Signature of Staff) *(Date)* *(Signature of Witness)* *(Date)*