Amendment No. 6
to
Contract No. G040079
For
HIV Social Services

Between

City of Austin
and
Austin Travis County MHMR Center

TERMS:

Contract Amendment

1.0 On March 20, 2008, the City Council approved an extention to the above-referenced contract for an additional 12 month period from March1, 2008 to February 28, 2009 and hereby agrees to amend the current contract to reflect the additional funding of $ 51,858 for a total contract amount of $ 51,858. The contract term will be March1, 2008 through February 28, 2009.

2.0 The total Contract amount is recapped below.

Term	Contract Change Amount	Total Contract Amount
Basic Term: 03/01/04 – 02/28/05	$ 47,000	$ 47,000
Amendment No. 1: 03/01/05 – 02/28/06 Renewal Option #1	$ 47,000	$ 94,000
Amendment No. 2: 3% Cost of Living: 03/01/05 – 02/28/06	$ 588	$ 94,588
Amendment No. 3: 03/01/06 – 02/28/07 Renewal Option # 2	$ 48,410	$ 142,998
Amendment No. 4: 03/01/06 – 02/28/07 Option #2 contract decrease	($21,000)	$121,998
Amendment No.5: 12-month contract extension 03/01/07 – 02/29/08	$ 30,233	$ 152,231
Amendment No. 6: one 12-month extension: 03/01/08 – 02/28/09	$ 51,858	$ 204,089

3.0 The following terms and conditions have been amended and attached.

4.1	Attachment A-6	Statement of Work
4.2	Attachment B-6	Performance Measures
4.3	Attachment C-6	Budget – Cost Allocation

4.0 Minority Business Enterprises/Women's Business Enterprises (MBE/WBE) goals do not apply to this contract.

5.0 By signing this Amendment the Contractor certifies that the Contractor and its principals are not currently suspended or debarred from doing business with the Federal Government, and Non-Procurement Programs, the State of Texas, or the City of Austin.

6.0 All other terms and conditions remain the same.

BY THE SIGNATURES affixed below, Amendment No.6 is hereby incorporated into and made a part of the above-referenced contract.

CONTRACTOR

David Evans
Executive Director
Austin Travis County MHMR Center
1430 Collier Street
Austin, Texas, 78704
(512) 440-4030

_____
Signature

_____
Date

CITY

Lynn Mueller
Contract Compliance Manager
P.O. Box 1088
Austin, Texas 78767
(512) 972-4011

_____
Signature

_____
Date

ATTACHMENT A-6

STATEMENT OF WORK

City of Austin and Travis County
Austin Travis County MHMR C.A.R.E. Program
2008 HIV Social Services Contract
March 1, 2008– February 28, 2009

1. Executive Summary

The Austin Travis County MHMR C.A.R.E. Program provides services to HIV positive men and women via a grant by the Community Action Network (CAN), which is managed by the Austin/Travis County Health and Human Services. A service overview is presented in the following table.

Service	Units	People	Budget
Case Management			
Special Needs – Mental Health	**3,040**	**33**	**$51,858**

Case Management Services – Mental Health: The C.A.R.E. Program will provide case management for HIV positive men and women with serious and persistent mental illness or episodic depression. The case management model is intensive, includes all case management functions, and incorporates clinical attention to mental health needs. A licensed, credentialed professional provides the service.

The goals for this service are:

Goal 1. To utilize case management functions to support the stabilization of mental health.

Goal 2. To utilize case management functions to support access to appropriate psychiatric services and medications so that engagement in primary health care or substance abuse services is not compromised.

Goal 3. To utilize case management functions to assist clients in acquiring other resources to support successful personal management.

Work Statement for Program

a) Service Category: Mental Health Case Management

The Austin Travis County MHMR C.A.R.E. Program will provide **case management services for HIV positive men and women with serious and persistent mental illness or episodic depression.**

Service Category	Target	Units of Service	People
Case Management	Clients identified by diagnostic screening with a mental illness or episodic depression	3,040	33

b) Program Name: Austin Travis County MHMR C.A.R.E. Program

c) Program Goals: Case management includes a range of client-centered services that link clients with primary medical care, psychosocial and other services. The service ensures timely, coordinated access to medically appropriate levels of health and support services, continuity of care, through ongoing assessment of the client's and other family members' needs and personal support systems. Key activities include initial assessment of the client's service needs; development of a comprehensive, individualized service plan; coordination of the services required to implement the plan; client monitoring to assess the efficacy of the plan' and periodic reevaluation and revision of the plan as necessary over the life of the client or until discharged from services. The service may include client-specific advocacy and/or review of service utilization.

d) Program Activities: The Mental Health Case Manager will provide intensive case management that includes the following activities:

Assessment and ongoing re-assessment: Each client will participate in an extensive psychosocial assessment to be updated at a minimum of six months or sooner if indicated.

Service planning: All client wills participate in service planning with the MH Case Manager. Goals will include engaging or remaining in primary medical care, treatment adherence for psychiatric care and accessing stable housing.

Referrals to community resources: When appropriate, the CM will refer clients to other community resources for additional support. The Case Management will support the client in preparing for the referral and will follow-up to see that a successful referral has been made. All referrals are logged and monitored for successful completion.

Referral and assistance to accessing other treatment services: When indicated, the Case Manager will refer the client to other types of treatment services including substance abuse.

e) Staffing

The CAN Mental Health Case Manager is Mary Newton, MSW. Caseload standards per case manager range from 20-25; however, the more intensive needs of the target population indicate a caseload of 15-18 for the mental health case manager.

This position reports to the Clinical Supervisor, Rosella Garcia-Batot, LPC. Rosella previously held this and other positions in her 10 years with the CARE program.

f) Targeted Populations

Service Category	Gender	Race/Ethnicity	Co-Morbidities	Resident Geographical Area	Total Served
Case Mgt. – Mental Health	8 Women 25 Men	**Women**: 4Afr/American 2 Hispanic 2 white **Men:** 12 Afr/ American 3 Hispanic 10 white	Hepatitis – 70% STD's - 20% TB – 10% Drug use – 100%	Any zip code within Travis County	**33**
TOTAL	**33**	16 Afr/American 5 Hispanic 12 White			**33**

Following the HIV Planning Council guidance about heavily impacted areas in the Austin EMA, the CARE program does extensive outreach in the targeted zip codes. These zip codes represent high concentrations of HIV infection and/or drug use in the EMA. Additionally, the CARE program provides through Outreach and the RWIII funded Jail Liaison, comprehensive services to the incarcerated or recently incarcerated PLWHAs. The CARE Street Outreach team provides a specialized service to female crack cocaine users as well as to IDU's in an effort to reach these underserved groups. Through community based and intra-unit referrals, the CARE program provides easy access to services for PLWHAs seeking mental health services.

All CARE services are provided without regard to sexual orientation and the program has successfully served a number of transgendered persons over the years.

g) Client Access: Eligible clients access mental health case management through a variety of strategies. The C.A.R.E. Program outreach team targets the incarcerated, users of crack cocaine, and persons at risk of HIV infection because of injection or other drug use. Among this group is a high incidence of co-occurring disorders. Prevention counseling and partner elicitation activities provide another doorway to an on-going continuum of care. Clients can access the case management services by working through the outreach team, by calling the C.A.R.E. office, by walking into the C.A.R.E. office or any of the other C.A.R.E. Program sites, or from the adult mental health service components.

The Mental Health Case Manager sees clients by appointment however; she is often readily available for simple drop-in visits. Other C.A.R.E. Program staff can refer a client directly to the mental health case manager by walking with the client to the case manager's office or by arranging the referral process. If referred by other C.A.R.E. staff, clients receive follow-up within 3 working days.

Barriers to service that might hinder or prevent clients from accessing services include: transportation, lack of knowledge about mental illness or the specialized case management available for HIV positives, denial, desire to remain confidential, and shame. For those who do engage in services, barriers continue to be transportation, access to medications, and procurement of other basic needs such as housing, food and clothing.

Barrier reduction strategies include bus passes and taxi service for critical needs (provided through fund-raising; bus passes from the City of Austin); assessment for placement in substance abuse treatment services that specialize in treatment of co-occurring disorders; availability of psychiatrist 8 hours per week at the program site and access to additional mental health services through the Center's Behavioral Health Division; support and peer group support for specialized needs including Journey I, a substance abuse support group for the target population who are struggling with medication issues and daily living; and a commitment to confidentiality in each client engagement.

Once engaged in services, clients can receive transportation assistance, can participate in the C.A.R.E. Emergency Community Medication Program and the Center's pharmacy program for mental health formulary medications, and can engage in food bank and clothing from donations to C.A.R.E. or through other community providers. Regardless of service engagement, individuals have access to the Center's 24-Hour Hotline for emergencies or assistance after program hours or on weekends.

h) Hard-to-Reach Populations: Interventions utilized by the C.A.R.E. Program and designed to address the needs of populations at greatest risk or most severely impacted by the HIV/AIDS epidemic include:

- Jail Program services to educate and identify HIV positives, then link inmates to medical services
- HIV antibody counseling, testing, and partner elicitation services provided on-demand at all program locations and at the street outreach van; providing a confidential and convenient setting for HIV antibody testing
- Street outreach with prevention materials about primary medical care and substance abuse treatment options, designed to provide simple, direct information
- Choice in service plan development, allowing client directed goals and objectives
- Harm reduction model of care in the Journey Outpatient Treatment Program, keeping the client engaged in managing their substance use
- Harm reduction approach to service delivery, assisting the client in identification and control of actions associated with increased HIV risk
- Utilization of Prochaska DiClementi's Stages of Change Theory, which helps the client identify steps to behavior change
- Utilization of Motivational Interviewing techniques which elicits information without judgment
- Walk-in policy to access staff; ready to serve the client when the client is ready
- Cultural and holiday events participation at the community level
- Collaboration with other providers of street outreach or services designed for underserved or hard-to-reach populations
- Licensed Nurse available thru the Street Outreach Program to engage underserved and hard-to-reach men and women in health screenings (blood pressure, glucose testing, etc.), which provide opportunities for continued contact and trust building.
- Abbreviated intake procedures so that service connection can be established as soon as the individual seeks assistance
- Long-term established relationships and co-location with mental health providers.

This case management proposal will serve 33 HIV positive individuals: sixty four percent (64%) are from communities of color. Fifty one percent (51%) of those served will be new clients, from hard-to-reach or out-of-care populations.

i. Client Eligibility

Persons who are eligible for Mental Health services are those PLWHAs living in the EMA with mild to moderate diagnoses as well as the more psychotic manifestations of mental illness. A mental health diagnosis is documented through assessment by the psychiatrist and/or mental health counselor. Clients may also be referred from his/her case manager or counselor, or may be clients referred from other service providers. The CARE program encourages referrals from the David Powell Clinic for those PLWHAs who have both substance abuse and mental illness diagnoses. These referrals are especially appropriate because of the need for individuals to be psychiatrically stable in order to remain engaged in primary medical care.

The CARE program serves the homeless and the uninsured. Financial assessments demonstrate that the client meets the guidelines for having an income less than or equal to 200% above the Federal Poverty Guidelines. Experience since 1988 indicates that few CARE clients are eligible for or are receiving Medicaid nor do they have third-party payers. The Center utilizes financial assessment information to bill those clients who have third-party payers.

HIV status is documented by medical records. If medical records are not available, CARE has both rapid and standard testing procedures to verify a clients HIV status.

j. Standards of Care Compliance

CARE Mental Health Case Management services currently meet 100% of the Austin EMA Standards of Care (SOC). The Center provides a credentialing specialist who ensures that licensure is current for all staff. All staff receives annual training on the Center's and HIPPA confidentiality requirements. All charts and files are kept in a secured file room with limited access by key. Clients sign consent for disclosure of any information regarding treatment. Qualified mental health professionals provide all psychosocial assessments for mental health services.

In addition to the SOC, the mental health case manager is expected to adhere to his/her respective professional standards of care and Best Practices.

k. Quality Management Plan

The Center's "Quality Management Program Plan for fiscal year 2007" is on file with the administrative agent. The CARE program implements this process at program level and is responsible to the Director of Behavioral Health Services for compliance to the plan. At the CARE program, consumer surveys are reviewed on a quarterly basis and focus groups are held to provide direct client input to programming when possible. Data is gathered both from ARIES and the Center's Anasazi software. The Clinical Supervisor helps to monitor quality improvement. The Senior Program Manager is responsible for ensuring that corrective action is taken when quality issues have been identified.

ATTACHMENT B-6

PERFORMANCE MEASURES

ATCMHMR C.A.R.E. PROGRAM
City County HIV Services
May 1, 2008 – February 28, 2009

OUTCOME Performance Measures

Agency Name: ATCMHMR C.AR.E. Program

Service Category: Case Management – Social

OUTCOME MEASURE # 1:
Eighty Five percent (80%) of clients receiving mental health case management services who participate in client satisfaction surveys will report satisfaction with overall quality of services received.

What data will be collected analyzed and reported in order to assess this outcome?
Client satisfaction surveys will be given to each client receiving advocacy services.

# of clients reporting satisfaction with services provided (26)
# of clients receiving mental health case management services (33)

How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?
Data collected and compiled for outcome will originate from: client satisfaction surveys, complaints related to service delivery and filed with consumer rights officer and Incident Reports listing consumer abuse or neglect.

At what point(s) or time(s) in the service delivery sequence will the data be collected and evaluated?
Data is collected on a monthly basis and reported quarterly. Surveys are evaluated on a quarterly basis by the Unit Manager and the Mental Health Case Manager for areas of improvement.

What resources and tools will be used?
Data collected and compiled for outcome will originate from: treatment plans, Anasazi data base and in ARIES.

How will the data be analyzed/verified?
The data will be analyzed/verified using ARIES reporting tools. The program utilizes monthly performance measures reviews to insure outcome measures are met.

How will the outcome data be used to assess and improve the services delivery system?
The program manager, clinical supervisor and staff will utilize the data to create corrective plans of action if necessary.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Specify Reporting Dates
33	26	80%	June 20, 200\8 September 20, 2008 December 20, 2008 March 20, 2009

OUTCOME Performance Measures

Agency Name: ATCMHMR C.AR.E. Program

Service Category: Case Management - Social
OUTCOME MEASURE # 2: Pregnant woment are not part of our target population and will be referred elsewhere for proper services.
What data will be collected analyzed and reported in order to assess this outcome?
How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?
At what point(s) or time(s) in the service delivery sequence will the data be collected and evaluated?
What resources and tools will be used?
How will the data be analyzed/verified?
How will the outcome data be used to assess and improve the services delivery system?

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Specify Evaluation Dates
N/A	N/A	N/A	N/A

OUTCOME Performance Measures

AGENCY NAME: Austin Travis County MHMR C.A.R.E. Program

Service Category: Case Management - Social

OUTCOME MEASURE # 3:
A. Eighty percent (80%) of the 33 unduplicated clients receiving mental health case management services will make progress on their service plan objectives.

# of clients making progress on their service plan (26)
# of clients working on service plans (33)

What data will be collected analyzed and reported in order to assess this outcome?
Data will be collected and analyzed using ARIES and Anasazi data base. Data will be collected from clients treatment plans, client satisfaction surveys and client case notes.

How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?
Data collected and compiled for outcome will originate from: Anasazi data base and in ARIES using treatment plans.

At what point(s) or time(s) in the service delivery sequence will the data be collected and evaluated?
Data will be collected and evaluated on a monthly basis.

What resources and tools will be used?
Data collected and compiled for outcome will originate from: treatment plans, Anasazi data base and in ARIES.

How will the data be analyzed/verified?
The data will be analyzed/verified using ARIES reporting tools. The program utilizes monthly performance measures reviews to insure outcome measures are met.

How will the outcome data be used to assess and improve the services delivery system?
The program manager, clinical supervisor and staff will utilize the data to create corrective plans of action if necessary.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Specify Reporting Dates
33	26	80%	June 20, 2008 September 20, 2008 December 20, 2008 March 20, 2009

OUTCOME Performance Measures

AGENCY NAME: Austin Travis County MHMR C.A.R.E. Program

Service Category: Case Management - Social

OUTCOME MEASURE # 4:
One hundred percent (100%) of clients receiving primary medical care based on in-care criteria on the "In Care Verification" form with exceptions noted

# of client receiving primary medical care (33)
# of clients receiving mental health services (33)

What data will be collected analyzed and reported in order to assess this outcome?
Data will be collected and analyzed using the "In Care Verification" form as well as case notes on ARIES and Anasazi data base.

How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?
Data collected and compiled for outcome will originate from: In Care Verfication Form, client treatment plan(s), Anasazi data base and in ARIES.

At what point(s) or time(s) in the service delivery sequence will the data be collected and evaluated?
Data will be collected and evaluated on a monthly basis.

What resources and tools will be used?
Data collected and compiled for outcome will originate from: treatment plans, Anasazi data base and in ARIES.

How will the data be analyzed/verified?
The data will be analyzed/verified using ARIES reporting tools. The program utilizes monthly performance measures reviews to insure outcome measures are met.

How will the outcome data be used to assess and improve the services delivery system?
The program manager, clinical supervisor and staff will utilize the data to create corrective plans of action if necessary.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Specify Reporting Dates
33	33	100%	June 20, 2008 September 20, 2008 December 20, 2008 March 20, 2009

OUTPUT Peformance Measures

NOTE: Complete one Output Performance Measure form for each Output. An Output is a Unit of Service.

Agency Name: ATCMHMR C.A.R.E. Program

Service Category: Case Management - Social
OUTPUT/Unit of Service #1: 3,040 units of case management service will be delivered to HIV positive men and women with serious and persistent mental illness or episodic depression between March 1, 2008 and February 28, 2009.
Describe what data will be collected in order to assess this output? The data collected will be from services entered into the Anasazi data base and ARIES. Data will include the number of visits and the services provided during these visits.
How will the data be collected and compiled for this output measure? The data will be collected and compiled in report form from Anasazi and ARIES.
What resources and tools will be used? Data collected and compiled for outcome will originate from: Anasazi and ARIES data bases
How will the data be analyzed/verified? The data will be analyzed/verified using ARIES reporting tools. The program utilizes monthly performance measures reviews to insure outcome measures are met.
How will the output data be used to adjust the service delivery system? The program manager, clinical supervisor and staff will utilize the data to create corrective plans of action if necessary.

ATCMHMR C.A.R.E. PROGRAM
City County HIV Services
May 1, 2008 – February 28, 2009

OUTPUT Performance Measure

NOTE: Complete one Output Performance Measure form for each Output. An Output is a Unit of Service.

Agency Name: ATCMHMR C.A.R.E. Program

Service Category: Case Management Social
OUTPUT/Unit of Service #2: Number of unduplicated clients served A. Number of new clients 17new clients B. Number of continuing clients: 20 continuing clients
Describe what data will be collected in order to assess this output? The data collected will be collected from Anasazi using and unduplicated and duplicated reporting function and from ARIES reporting.
How will the data be collected and compiled for this output measure? The data will be collected and compiled in report form from Anasazi and ARIES.
What resources and tools will be used? Data collected and compiled for outcome will originate from: Anasazi and ARIES data bases
How will the data be analyzed/verified? The data will be analyzed/verified using Anasazi and ARIES reporting tools. The program utilizes monthly performance measures reviews to insure outcome measures are met.
How will the output data be used to adjust the service delivery system? The program manager, clinical supervisor and staff will utilize the data to create corrective plans of action if necessary.

Projected Units of Service to be Delivered

Month	Mar 2006	Apr 2006	May 2006	Jun 2006	Jul 2006	Aug 2006	Sep 2006	Oct 2006	Nov 2006	Dec 2006	Jan 2007	Feb 2007		Total
Total		276	276	276	276	276	276	276	276	276	276	280		2,280

NOTE: Please explain any significant seasonal or monthly fluctuation

ATTACHMENT C-6

BUDGET- COST ALLOCATION

FORM: Projected Program Cost Allocation Plan for Year 2008-2009

Program : Mental Health Case Management

Please complete one worksheet per program using March 1, 2008 through February 28, 2009 awarded or projected figures.

Cost Category	FTE	Hourly Rate	Annual Cost (Including Fringe For Personnel)	%	City/County HIV Social Services Program Costs	%	City/County HIV Social Services Admin Costs	%		Total Program Costs	Total Admin Costs	TOTAL	%
OPERATING COSTS													
Personnel: Name & Position Title													
Mary Newton, MH Case Manager	1.00	14.97	40,188	100%	40,188	0%	0	0%		40,188	0		100%
Vacant, Program Manager	1.00	24.53	63,184	2.0%	1,264	0%	0	0%		1,264	0		2%
Beverly Charlton, Admin Supervisor	1.00	15.46	41,366	2.0%	827	0%	0	0%		827	0		2%
Rosella Garcia Batot, Clinical Supv	1.00	22.95	59,384	2.0%	1,188	0%	0	0%		1,188	0		2%
Crstal Torres, Admin Support	1.00	11.89	32,779	2.0%	656	0%	0	0%		656	0		2%
				0.0%	0	0%		0%		0			0%
Utilities			10,723	3.0%	322	0%	0	0%		322	0		3%
Equipment Rental			3,300	3.0%	99	0%	0	0%		99	0		3%
Minor Equipment Purchases				0.0%	0	0%	0	0%		0	0		0%
Office Rent			40,622	3.0%	1,219	0%	0	0%		1,219	0		3%
Postage			1,836	0.0%	0	0%	0	0%		0	0		0%
Telephone			14,037	3.0%	421	0%	0	0%		421	0		3%
Staff Travel			5,180	3.0%	155	0%	0	0%		155	0		3%
Printing/Duplication			1,260	3.0%	38	0%	0	0%		38	0		3%
Office Supplies			13,800	1.0%	138	0%	0	0%		138	0		1%
Medical Supplies			12,000	0.0%	0	0%	0	0%		0	0		0%
Other Program Supplies			31,800	0.0%	0	0%	0	0%		0	0		0%
Audit				0.0%	0	0%	0	0%		0	0		2%
Accounting			47,135	0.0%	0	11%	5,185	0%		0	5,185		11%
Conferences/Seminars			2,820	0.0%	0	0%	0	0%		0	0		0%
Insurance/Bonding			4,357	3.0%	131	0%	0	0%		131	0		3%
Building Maintenance/Repair			945	3.0%	28	0%	0	0%		28	0		3%
Subcontractors			45,000	0.0%	0	0%	0	0%		0	0		0%
Subscriptions/Memberships			20,500	0.0%	0	0%	0	0%		0	0		0%
Other:F&E Maint, IT Replacement, Hardware Maint., Landscaping, Bldg Security, F			38,795	0.0%	0	0%	0	0%		0	0		0%
TOTAL OPERATING COST			$531,011	9%	$46,673	1%	$5,185	0%	10%	$46,673	$5,185		$51,858
											Math Check		$51,857
Units of Service Delivered					3,040						Total Units		3,040
Operating Unit Cost											$17.06		

Projected 2008-2009 City/County HIV Social Services Categorical Budget	
Program Name: Mental Health Case Management	
Budget Period: March 1, 2008 through February 28, 2009	
The agency total annual HIV budget for Mental Health Case Management will be funded as follows:	
HIV Social Services $51,858	
TOTAL $51,858 100%	
Direct Service Costs	**Total**
PERSONNEL (Salary and Fringe Benefits)	
Mental Health Case Manager, Mary Newton	
1.0 FTE x 12 mths x $3,349 monthly salary and fringe	$40,188
Provides direct care to clients. Case Management includes services that link clients with primary medical care, psychococial and other services.	
Vacant, Sr. Program Manager	
.02 FTE x 12 mths x $5,265.33 monthly salary and fringe	$1,264
Manages contracts, oversees program management, reporting and and internal monitoring	
Rosella Garcia-Batot, Clinical Supervisor	
.02 FTE x 12 mths x $4948.66 monthly salary and fringe benefits	$1,188
Provides clinical supervision with staff on clinical issues. Provides back-up assessment service for clients wanting treatment.	
Beverly Charlton, Admin Supevisor	
.02 FTE x 12 mths x $6448.166 monthly salary and fringe benefits	$827
Responsible for data collection necessary for reporting, supervises administrative staff responsible for reception area, inventory and filing, works with Center administration on	
Administrative Support, Crystal Torres	
.02 FTE x 12 mths x $2731.58 monthly salary and fringe benefits	$656
Provides administrative support for front office and phones. Maintains inventory for client charts and supplies	
Personnel Subtotal	$44,123
TRAVEL	

Local Mileage: Reimbursement to mental health case manager for use of privately owned vehicles in the performance of grant duties over a five (5) county area. 34 mi/mo x 10 months x 0.455/mile = $155 times 100% = $298	$155
Travel Subtotal	$155
SUPPLIES	
Office supplies to include pens, pencils, paper, staplers, etc. - 1% of total office supply budget of $13,800 = $138 times 100% = $138	$138
Supplies Subtotal	$138
CONTRACTUAL (Subcontractor Data Sheets attached)	**$0**
Contractual Subtotal	$0
OTHER	
Telephone (local, long distance, computer and fax), dedicated for staff use - 3% of $14,037 annual cost = $421times 100% - $421	$421
Rent, mental health case management facility is 224 of 3,460 sq.ft., 3% of $40,622 total annual rent = $1,219, times 100% = $1,219	$1,219
Utilities, mental health case management facility is 3% of total sq. ft. times $10,723 total annual utilities = $322 times 100% = $322	$322
Copier rental and operating expenses. Mental Health Case Management usage estimated at 3%, times $3,300 total annual expense = $99 times 100% = $99	$99
Printing and Duplicating expenses. Mental Health Case Management usage estimated at 3% times $1,260 total annual expense = $38 times 100% = $38	$38
Insurance and Bonding. Mental Health Case Management allocation of 3% times $4,357 annual expense = $131 times 100% = $131	$130
Building Maintenance and Repair is 3% of total annual cost of $945 = $28 times 100% = $28	$28
Other Subtotal	$2,257

TOTAL DIRECT SERVICES COSTS - 90%	**$46,673**
Administrative Costs	
Administrative costs includes support services of Human Resources, Facilities Maintenance, Business Office and Directors Office. The approved single audit rate is 16.43%	$5,185
TOTAL ADMINISTRATIVE COSTS - 10%	$5,185
TOTAL DIRECT SERVICES COSTS - 90%	$46,673
TOTAL SERVICES COSTS	$51,858