



Promoting wellness and recovery

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OhioMHAS 2014-2015

Adult Care Facilities (ACF)/Adult Foster Home (AFoH)

Home Operator Incentive Program

WELCOME!



Theresa M Rohrbaugh
Housing Policy and Resource
Administrator

What is the ACF/AFoH Program?

The Adult Care Facilities (ACF)/Adult Foster Home (AFoH) Home Operator Incentive Program provides a cash supplement to ACF and AFoH operators who facilitate the linkage of the homes' residents with local Mental Health and/or Substance Use Disorder providers according to their service needs.

The purpose of the program is to improve behavioral & physical health outcomes for residents by encouraging utilization of community resources while increasing revenue for home operators. Eligible operators will receive \$72.00 per resident/per quarter. As an additional resource, our ACF/AFoH web site can be found at the link below:

<http://mha.ohio.gov/Default.aspx?tabid=572#2092430-what-is-the-adult-care-facilityadult-foster-home-acfafoh-incentive-program>.

WHO IS ELIGIBLE TO PARTICIPATE?

All Adult Family, Foster, and Group Home operators licensed by the Ohio Department of Mental Health & Addiction Services (the Department) through the Office of Licensure & Certification. Only home operators whose licensure is in good standing may participate in the ACF/AFoH Home Operator Incentive Program. The program does not provide housing assistance for individual residents.

Please contact the Office of Licensure & Certification if you have questions about your licensure status at 614-752-8880.



What is the Application Process?

- ❖ Completion of the ACF/ AFoH Home Operator Incentive Program Form (see Example) 
- ❖ Where do I get the form?
http://mha.ohio.gov/Portals/0/assets/Supports/Housing/ACF-Incentive-Form_Final.pdf.
- ❖ Complete one form per licensed home.
- ❖ How often do I complete the form(s)?
At the end of every quarter. Forms submitted prior to the end of the quarter will not be processed.
- ❖ How do I submit the form(s)?
Email, fax to the information at the bottom of the form, OR send U.S. Mail to my attention (referenced at the end of this presentation).



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EXAMPLE

Adult Care Facility (ACF)/Adult Foster Home (AFoH) Home Operator Incentive Form

Please complete information below verifying all residents linked with Mental Health (MH) and/or Substance Use Disorder (SUD) services on the last day of the Quarterly Reporting Period (see quarterly due dates noted below).

	OAKS Vendor #: (i.e., 0000299777)
	0 0 0 0 299777

ACF or AFoH Information
You may submit one form per facility per quarter

NOTE: Payment is issued by the Office of Budget and Management, Ohio Shared Services (OSS). You must register with OSS and receive an OAKS Vendor Number in order to receive payment. Applications that do not have the OAKS Vendor Number will not be processed. More information can be found at <http://ohiosharedservices.ohio.gov/VendorsForms.aspx>.

ACF/AFoH Name	Operator Name	ACF/AFoH Address
Rohrbaugh Adult Home	Theresa Rohrbaugh	30 East Broad Street Columbus, OH 43215

License Type	Facility License #	Facility Contact #	Facility Contact Email	ACF/AFoH County
<input type="radio"/> Foster Home (1 - 2)	(i.e., 09-3377)			
<input type="radio"/> Family Home (3 - 5)	093377	614-466-4061	ACF- AFoHIncentive@Franklin	Franklin
<input checked="" type="radio"/> Group Home (6 - 16)			mha.ohio.gov	

Please **mark** the box for the quarter you are requesting participation:

Quarterly Reporting Period(s)	Total # of Licensed Beds	# of Residents linked on last day of Quarter
<input checked="" type="radio"/> 1st Quarter (Jul. 1 - Sept. 30, 2014)	15	10
<input type="radio"/> 2nd Quarter (Oct. 1 - Dec. 31, 2014)		
<input type="radio"/> 3rd Quarter (Jan. 1 - Mar. 31, 2015)		
<input type="radio"/> 4th Quarter (Apr. 1 - Jun. 30, 2015)		

By voluntarily signing this form, you affirm that all residents included in the quarterly count(s) are currently residing in this facility on the end date(s) of the quarter(s) you are requesting participation. I hereby declare, certify and affirm that the information I have provided on this application, including all attachments and supporting documentation, is true and accurate to the best of my knowledge and belief. I further affirm that this agreement is voluntary and is entered into in good faith; therefore, any misleading or fraudulent activities will forfeit my ability to receive additional funding.

Last day of the quarter or after

X Theresa Rohrbaugh	X Signature
PRINT - ACF/AFoH Home Authorized Name - PRINT	ACF/AFoH Home Authorized (Signature) Date

The quarterly form may not be signed, dated or submitted prior to the end date of each quarter.

This form may be emailed to OhioMHAS's Housing Policy and Resource Administrator at ACF-AFoHIncentive@mha.ohio.gov or sent via fax at 614-485-9747

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Adult Care Facility (ACF)/Adult Foster Home (AFoH) Home Operator Incentive Form

Please complete information below verifying all residents linked with Mental Health (MH) and/or Substance Use Disorder (SUD) services on the last day of the Quarterly Reporting Period (see quarterly due dates noted below).

OAKS Vendor #: (I.e., 0000299777)

0 0 0 0

ACF or AFoH Information

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ACF/AFoH Name		Operator Name	ACF/AFoH Address		
License Type	Facility License #	Facility Contact #	Facility Contact Email	ACF/AFoH County	
<input type="radio"/> Foster Home (1 - 2) <input type="radio"/> Family Home (3 - 5) <input type="radio"/> Group Home (6 - 16)	(I.e., 09-3377)			<input type="text"/>	

Please mark the box for the quarter you are requesting participation:

Quarterly Reporting Period(s)	Total # of Licensed Beds	# of Residents linked on last day of Quarter
<input type="radio"/> 1st Quarter (Jul. 1 - Sept. 30, 2014)		
<input type="radio"/> 2nd Quarter (Oct. 1 - Dec. 31, 2014)		
<input type="radio"/> 3rd Quarter (Jan. 1 - Mar. 31, 2015)		
<input type="radio"/> 4th Quarter (Apr. 1 - Jun. 30, 2015)		

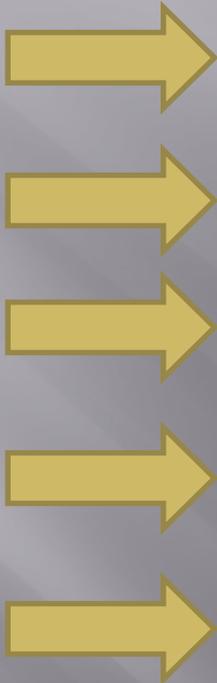
By voluntarily signing this form, you affirm that all residents included in the quarterly count(s) are currently residing in this facility on the end date(s) of the quarter(s) you are requesting funding participation. I hereby declare, certify and affirm that the information I have provided on this application, including all attachments and supporting documentation, is true and accurate to the best of my knowledge and belief. I further affirm that this agreement is voluntary and is entered into in good faith; therefore, any misleading or fraudulent activities will forfeit my ability to receive additional funding.

X _____ X _____

PRINT - ACF/AFoH Home Authorized Name - PRINT ACF/AFoH Home Authorized (Signature) Date

The quarterly form may not be signed, dated or submitted prior to the end date of each quarter.

This form may be emailed to OhioMHAS's Housing Policy and Resource Administrator at ACF-AFoHIncentive@mha.ohio.gov or sent via fax at 614-485-9747



What are the Program Rules?

In addition to submission of the application, there are additional program rules to comply with for home operators to participate in the ACF/ AFoH Home Operator Incentive Program.

- ❖ Home operators should only count those linked residents *living in the home on the last day of the Quarterly Reporting Period* on the Incentive Verification Form.
- ❖ Home operators must maintain records of Mental Health Plans for Care for residents in order for the Department to verify linkage with local Mental Health and/or AOD providers.
- ❖ If it is determined during the verification process that the home's license is not in good standing, then the operator must comply with the requirements established by the Office of Licensure & Certification in order to receive the ACF/ AFoH Home Operator Incentive payment.

Please note: The Department may request verification of resident linkage with local Mental Health and/or Substance Use Disorder providers at any time. If it is determined during the verification process that the home operator provided incorrect information regarding resident linkage, all ACF/ AFoH Home Operator Incentive payments must be returned to the Department.

How is the ACF/AFoH Incentive Payment Determined?

- ❖ Payments will be based on the number of residents regardless of how many services they utilized during the quarter, i.e., the home operator will receive the same payment amount for one (1) resident utilizing four (4) Mental Health and AOD services as one (1) resident utilizing one (1) service.
- ❖ All requested documentation must be submitted as instructed prior to the home operator receiving payment through the program.
- ❖ Payments will be distributed on a quarterly basis. The Home Operator will receive \$72.00 per resident/per quarter if all requirements are met. Payments will be processed on or about the 15th and 30th of each month. Distribution will take approximately four to six weeks.

Additional Information

Theresa M Rohrbaugh

Housing Policy and Resource Administrator

30 E. Broad Street, 36th Floor

Columbus, Ohio 43215

- ☐ Phone: (614) 466-4061
- ☐ Email: ACF-AFoHIncentive@mha.ohio.gov
- ☐ ACF/AFoH Confidential Fax: (614) 485-9747

ACF/AFoH web site: <http://mha.ohio.gov/Default.aspx?tabid=572>

ACF/AfoH Frequently Asked Questions:

<http://mha.ohio.gov/Default.aspx?tabid=572#2092898-frequently-asked-questions>.

Office of Licensure & Certification: (614) 752-8880

Ohio Shared Services 1-877-644-6771