SECTION 2 – PLAN AND BUDGET SUBMISSION

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General Instructions

Submit one original and three copies of the CMS plan and budget package to your CMS Regional Administrative Consultant. The plan is composed of the documents that are required for submission. Programs will be notified on an annual basis on the submission due date for budgets.

Individual CCS, CHDP, and HCPCFC budgets will be approved only when all required documents have been submitted and reviewed by the appropriate regional office staff. Unless specified, counties should submit one package for all three CMS programs. Beginning with Fiscal Year (FY) 2006-07, the CMS Branch requires counties to submit two separately signed Certification Statements, one for CHDP and another for CCS. The Certification Statements and Interagency Agreement, however, may be sent under separate cover after other documents have been submitted. **All pages must be numbered and dated.** After assembling the plan and budget package, complete the Checklist and include the Checklist in the plan and budget package.

The following are required documents of the CMS plan and budget package for Fiscal Year (FY) 2009-10:

I. Checklist (see page 7)

The CMS Plan and Budget Required Documents Checklist assists in identifying the contents and sequence of the documents for submission in the plan package. The contents of the package must be submitted in the sequence reflected on the checklist.

II. Agency Information sheet (see page 9)

Complete the Agency Information Sheet with **all of the following:**

A. Official name and address of the county/city agency in which the CCS, CHDP, and HCPCFC programs are organizationally located. Name and contact information for the County/City Health Officer.

B. Name and contact information of the CMS Director, if any

C. Name and contact information of the CCS Administrator

D. Name and contact information of the CHDP Director (must be a physician)

E. Name and contact information of the CHDP Deputy Director

F. Name and contact information of the Clerk of the County Board of Supervisors or City Council

G. Name and contact information of the Director of Social Services Agency for the HCPCFC Program

H. Name and contact information of the Chief Probation Officer for the HCPCFC Program

III. Certification Statements (see pages 10 and 11)

A. For the CHDP Certification Statement, obtain current signatures, including the dates signed, of the CHDP Director, Director/Health Officer, and the chairperson of the local governing body, as required.

B. For the CCS Certification Statement, obtain current signatures, including the dates signed, of the CCS Administrator, Director/Health Officer, and the chairperson of the local governing body, as required.

C. Submit the CHDP and CCS original Certification Statements (with signatures) and one photocopy to the Regional Office. The Certification Statements are valid for one year.

D. The citations of current federal and state legislation and regulations for the CCS, CHDP, and HCPCFC programs are listed in Section 9 - References.

E. An additional line for the signature of any other person with fiscal or programmatic responsibility is included for optional use.

IV. Agency Description

A. Describe in brief narrative:

1. The structure of the agencies in which, CHDP, programs are located;

2. The current organizational structures of the, CHDP, programs within the local agencies (Health and/or Social Services);

3. The integration of the CHDP, and HCPCFC programs within the agency and county structure; and

4. Briefly outline the accomplishments for the last fiscal year and any anticipated changes for the current fiscal year for, CHDP programs.

B. Retain current organizational charts for CHDP, HCPCFC and CCS with names of incumbent staff using the **same job titles** as listed on the budget worksheets.

C. Retain a copy of the CCS County Staffing Standards Profile (Section 6, page 94) and highlight the caseload category for your county/city. For counties with total caseloads below 500, write the words "Below 500" at the top of the CCS Staffing Standards Profile and highlight those words only.

D. Retain Incumbent List (see pages 12 through 14) for CCS, CHDP, and HCPCFC programs using the same job titles as listed on the organizational chart and budget detail worksheet.

E. Retain civil service classification statements for newly established, proposed, or revised classifications.

F. Retain duty statements for all staff budgeted to the programs **if there are changes from the previous year** (see pages 12 through 14).

1. Changes are defined as:

   a. Changes in job duties or activities, or

   b. Changes in percentage of time allotted for each activity.

   c. Changes in percentages of time allotted for enhanced and non-enhanced activities.

2. Include in the duty statement **all of the following:**

   a. Position title,

   b. Civil service classification,

   c. Percent FTE in CCS, CHDP, and/or HCPCFC program(s) and percent FTE in other program(s) if applicable, and

   d. Actual job duties appropriate and specific to the CCS, CHDP, and/or HCPCFC program **with an estimated percentage of time allocated to each activity** (see Documentation of Staff and Time for more information (see Section 8, page 8).

e. If staff work in multiple programs, retain separate job duty statements for each program.

V. Implementation of Performance Measures (see Section 3 – Scope of Work and Performance Measures)

A. CCS, CHDP, and HCPCFC programs under joint administrations should submit joint Performance Measures when reporting to the CMS Branch.

B. CCS, CHDP, and HCPCFC programs under separate administrations should collaborate to ensure coordination of services and resources and cooperatively submit one package when reporting Performance Measures to the CMS Branch.

C. Performance Measures should be reported in the appropriate reporting format, except for those Performance Measures that specifically require a county tracking system.

D. Data collection for these Performance Measures began with Fiscal Year 2002-03. **Reporting on these Performance Measures is due November 30, 2009 for Fiscal Year (FY) 2008-09.**

VI. Data Forms

A. CCS Caseload Summary Form (see Section 4, page 7).

B. CHDP Program Referral Data (see Section 4, pages 11-12).

VII. Memoranda of Understanding (MOU) and Interagency Agreements (IAA)

A. Retain a list of all current MOU and IAA

B. Retain all MOU and IAA that are new, renewed, or have been revised since the prior fiscal year.

1. Retain CHDP IAA with DSS biennially.

2. Retain Interdepartmental MOU for HCPCFC biennially.

B. Retain Memoranda of Understanding/Interagency Agreements List (Section 2, page 15).

VII. Budgets

A. CHDP Administrative Budget (No County/City Match)

Budget Summary

Budget Worksheet

Budget Justification Narrative

B. CHDP Administrative Budget (County/City Match) – **Optional**

Budget Summary

Budget Worksheet

Budget Justification Narrative

C. CHDP Foster Care Administrative Budget (County/City Match) – **Optional**

Budget Summary

Budget Worksheet

Budget Justification Narrative

D. HCPCFC Administrative Budget

Budget Summary

Budget Worksheet

Budget Justification Narrative

E. CCS Administrative Budget

Budget Summary

Budget Worksheet

Budget Justification Narrative

Plan and Budget Required Documents Checklist

MODIFIED FY 2009-2010

County/City: _____ **Fiscal Year: 2009-10**

	Document	Page Number
1.	**Checklist**	Yes
2.	**Agency Information Sheet**	Yes
3.	**Certification Statements**	
	A. Certification Statement (CHDP) – Original and one photocopy	Yes
	B. Certification Statement (CCS) – Original and one photocopy	Yes
4.	**Agency Description**	
	A. Brief Narrative	Yes, CHDP
	B. Organizational Charts for CCS, CHDP, and HCPCFC	Retain locally
	C. CCS Staffing Standards Profile	Retain locally
	D. Incumbent Lists for CCS, CHDP, and HCPCFC	Retain locally
	E. Civil Service Classification Statements – Include if newly established, proposed, or revised	Retain locally
	F. Duty Statements – Include if newly established, proposed, or revised	Retain locally
5.	**Implementation of Performance Measures** – Performance Measures for FY 2008-09 are due November 30, 2009.	**N/A**
6.	**Data Forms**	
	A. CCS Caseload Summary	Yes
	B. CHDP Program Referral Data	Yes
7.	**Memoranda of Understanding and Interagency Agreements List**	
	A. MOU/IAA List	Retain locally
	B. New, Renewed, or Revised MOU or IAA	Retain locally
	C. CHDP IAA with DSS biennially	Retain locally
	D. Interdepartmental MOU for HCPCFC biennially	Retain locally
8.	**Budgets**	
	A. CHDP Administrative Budget (No County/City Match)	
	1. Budget Summary	Yes

County/City: _____ **Fiscal Year: 2009-10**

Document	Page Number
2. Budget Worksheet	Yes
3. Budget Justification Narrative	Yes
B. CHDP Administrative Budget (County/City Match) - Optional	
1. Budget Worksheet	Yes
2. Budget Justification Narrative	Yes
3. Budget Justification Narrative	Yes
C. CHDP Foster Care Administrative Budget (County/City Match) - Optional	
1. Budget Summary	Yes
2. Budget Worksheet	Yes
3. Budget Justification Narrative	Yes
D. HCPCFC Administrative Budget	
1. Budget Summary	Yes
2. Budget Worksheet	Yes
3. Budget Justification Narrative	Yes
E. CCS Administrative Budget	
1. Budget Summary	Yes
2. Budget Worksheet	Yes
3. Budget Justification Narrative	Yes
G.. Other Forms	
1. County/City Capital Expenses Justification Form	Yes, only if applicable
2. County/City Other Expenses Justification Form	Yes, only if applicable

Agency Information Sheet

County/City: **Fiscal Year:** 2009-10

Official Agency

Name:		Address:	
Health Officer			

CMS Director (if applicable)

Name:		Address:	
Phone:			
Fax:		E-Mail:	

CCS Administrator

Name:		Address:	
Phone:			
Fax:		E-Mail:	

CHDP Director

Name:		Address:	
Phone:			
Fax:		E-Mail:	

CHDP Deputy Director

Name:		Address:	
Phone:			
Fax:		E-Mail:	

Clerk of the Board of Supervisors or City Council

Name:		Address:	
Phone:			
Fax:		E-Mail:	

Director of Social Services Agency

Name:			
Phone:			
Fax:		E-Mail:	

Chief Probation Officer

Name:			
Phone:			
Fax:		E-Mail:	

Certification Statement - Child Health and Disability Prevention (CHDP) Program

County/City: _____ Fiscal Year: 2009-10

I certify that the CHDP Program will comply with all applicable provisions of Health and Safety Code, Division 106, Part 2, Chapter 3, Article 6 (commencing with Section 124025), Welfare and Institutions Code, Division 9, Part 3, Chapters 7 and 8 (commencing with Section 14000 and 14200), Welfare and Institutions Code Section 16970, and any applicable rules or regulations promulgated by DHCS pursuant to that Article, those Chapters, and that section. I further certify that this CHDP Program will comply with the Children's Medical Services Plan and Fiscal Guidelines Manual, including but not limited to, Section 9 Federal Financial Participation. I further certify that this CHDP Program will comply with all federal laws and regulations governing and regulating recipients of funds granted to states for medical assistance pursuant to Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.). I further agree that this CHDP Program may be subject to all sanctions or other remedies applicable if this CHDP Program violates any of the above laws, regulations and policies with which it has certified it will comply.

Signature of CHDP Director	Date Signed
Signature of Director or Health Officer	Date Signed
Signature and Title of Other – Optional	Date Signed

I certify that this plan has been approved by the local governing body.

Signature of Local Governing Body Chairperson	Date

Certification Statement - California Children's Services (CCS)

County/City: _____ Fiscal Year: 2009-10

I certify that the CCS Program will comply with all applicable provisions of Health and Safety Code, Division 106, Part 2, Chapter 3, Article 5, (commencing with Section 123800) and Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000-14200), and any applicable rules or regulations promulgated by DHCS pursuant to this article and these Chapters. I further certify that this CCS Program will comply with the Children's Medical Services Plan and Fiscal Guidelines Manual, including but not limited to, Section 9 Federal Financial Participation. I further certify that this CCS Program will comply with all federal laws and regulations governing and regulating recipients of funds granted to states for medical assistance pursuant to Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.) and recipients of funds allotted to states for the Maternal and Child Health Services Block Grant pursuant to Title V of the Social Security Act (42 U.S.C. Section 701 et seq.). I further agree that this CCS Program may be subject to all sanctions or other remedies applicable if this CCS Program violates any of the above laws, regulations and policies with which it has certified it will comply.

Signature of CCS Administrator	Date Signed
Signature of Director or Health Officer	Date Signed
Signature and Title of Other – Optional	Date Signed

I certify that this plan has been approved by the local governing body.

Signature of Local Governing Body Chairperson	Date

State of California - Health and Human Services Agency Department of Health Care Services - Children's Medical Services Branch

Incumbent List - California Children's Services

For FY 2009-10, complete the table below for all personnel listed in the CCS budgets. Use **the same** job titles for both the budget and the incumbent list. Total percent for an individual incumbent should **not be over 100 percent**.

Specify whether job duty statements or civil service classification statements have been revised or changed. Only submit job duty statements and civil service classification statements that are new or have been revised. This includes (1) changes in job duties or activities, (2) changes in percentage of time spent for each activity, and (3) changes in percentage of time spent for enhanced and non-enhanced job duties or activities.

Identify Nurse Liaison positions using: **MCMC** for Medi-Cal Managed Care; **HF** for Healthy Families; **IHO** for In-Home Operations, and; **RC** for Regional Center.

County/City: **Fiscal Year: 2009-10**

Job Title	Incumbent Name	FTE % on CCS Admin Budget	Have Job Duties Changed? (Yes or No)	Has Civil Service Classification Changed? (Yes or No)

State of California - Health and Human Services Agency Department of Health Care Services - Children's Medical Services Branch

Incumbent List - Child Health and Disability Prevention Program

For FY 2009-10, complete the table below for all personnel listed in the CHDP budgets. Use **the same** job titles for both the budget and the incumbent list. Total percent for an individual incumbent should **not be over 100 percent**.

Specify whether job duty statements or civil service classification statements have been revised or changed. Only submit job duty statements and civil service classification statements that are new or have been revised. This includes (1) changes in job duties or activities, (2) changes in percentage of time spent for each activity, and (3) changes in percentage of time spent for enhanced and non-enhanced job duties or activities.

County/City: _____ **Fiscal Year: 2009-10**

Job Title	Incumbent Name	FTE % on CHDP No County/ City Match Budget	FTE % on CHDP County/City Match Budget	FTE % in Other Programs (Specify)	Have Job Duties Changed? (Yes or No)	Has Civil Service Classification Changed? (Yes or No)

State of California - Health and Human Services Agency Department of Health Care Services - Children's Medical Services Branch

Incumbent List - Health Care Program for Children in Foster Care

For FY 2009-10, complete the table below for all personnel listed in the HCPCFC and CHDP Foster Care Administrative (County/City) budgets. Use **the same** job titles for both the budget and the incumbent list. Total percent for an individual incumbent should **not be over 100 percent**.

Specify whether job duty statements or civil service classification statements have been revised or changed. Only submit job duty statements and civil service classification statements that are new or have been revised. This includes (1) changes in job duties or activities, (2) changes in percentage of time spent for each activity, and (3) changes in percentage of time spent for enhanced and non-enhanced job duties or activities.

County/City: _____ **Fiscal Year: 2008-09**

Job Title	Incumbent Name	FTE % on HCPCFC Budget	FTE % on FC Admin County/City Match Budget	FTE % in Other Programs (Specify)	Have Job Duties Changed? (Yes or No)	Has Civil Service Classification Changed? (Yes or No)

State of California - Health and Human Services Agency Department of Health Care Services - Children's Medical Services Branch

Memoranda of Understanding/Interagency Agreement List

List all current Memoranda of Understanding (MOU) and/or Interagency Agreements (IAA) in California Children's Services, Child Health and Disability Prevention Program, and Health Care Program for Children in Foster Care. Specify whether the MOU or IAA has changed. Submit only those MOU and IAA that are new, have been renewed, or have been revised. For audit purposes, counties and cities should maintain current MOU and IAA on file.

County/City: _____ **Fiscal Year: 2009-10**

Title or Name of MOU/IAA	Is this a MOU or an IAA?	Effective Dates From/To	Date Last Reviewed by County/ City	Name of Person Responsible for this MOU/IAA?	Did this MOU/IAA Change? (Yes or No)