

Health, Human and Social Services Committee
Mental Health/Office of Community Services
AGENDA - AMENDED
11/20/18

Committee Members:

- Chairwoman Frasier
- Supervisor McDevitt
- Supervisor Braymer
- Supervisor Leggett
- Supervisor Loeb
- Supervisor Diamond
- Supervisor Hyde
- Supervisor Magowan
- Supervisor Sokol

I. Action Agenda/New Business

1. Resolution request to approve 2019 contracts with community mental health, substance abuse and developmental disability services provider agencies, consistent with/contingent upon amounts approved in the 2019 Warren County budget
2. Resolution request to approve 2019 contracts for youth mental health respite services, consistent with/contingent upon amounts approved in the 2019 Warren County budget
3. Resolution request to reappoint Community Services Board member
4. Resolution request for authorization to enter into 3-year lease agreement for office space
5. Resolution request to transfer funds: Increase Psychiatric Evaluation/Criminal appropriation
6. Informational: PFC Joseph P. Dwyer Veterans Peer-to-Peer program

II. Motion to adjourn

Attachments:
Resolution Request forms

RESOLUTION REQUEST FORM NO. 3

Request for New Contract

DEPARTMENT NAME: Mental Health/Office of Community Services

DATE: 11/20/18

- (a) Is this a Result of a Bid or Request for Proposal? **Yes -- PEOPLE, Inc. No for the remainder, which are on-going services authorized by the Warren County Community Services Board.**
- (b) Purpose of Contract: **To provide community mental health, substance abuse and developmental disability services pursuant to provisions of NYS Mental Hygiene Law, Article 41, for amounts not to exceed the amounts set forth on the attached Schedule A.**
- (c) Name of Contractor: **See attached Schedule A.**
- (d) Address of Contractor:
- (e) Contractor's Contact Person and Telephone Number:
- (f) Has or will the Contract be provided, if so, please attach:
- (g) Commencement Date of Contract: **1/1/2019**
- (h) Termination Date of Contract: **12/31/2019**
- (i) Payment Provisions: i) lump sum amount
ii) hourly rate amount
iii) total amount not to exceed
iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc. **Quarterly advances**)
- (j) Where are the Funds for this Contract? List Budget Code, Object Code, Full Title* and Amount: **OR Capital Project OR Capital Reserve Project Number, Title, and Amount: See attached Schedule A.**

Sample: A.1010 470 Legislative Board – Contract Sxx.xx
Capital Project No. H289.9550 480 – Old Jail Renovations Sxx.xx

*as listed in budget and LOGOS

Schedule A – 2018 OCS Contract Agencies

<u>Provider Agency</u>	<u>Amount</u>	<u>Budget Code</u>
<u>Mental Health Assn</u>	\$938,261.00	A.4320.0120
<u>BHS of G.F. Hosp.</u>	\$635,299.00	A.4320.0080
<u>Liberty House</u>	\$269,106.00	A.4320.0090
<u>C.W.I., Inc.</u>	\$45,680.00	A.4320.0070
<u>Council for Prevention</u>	\$349,987.00	A.4320.0110
<u>Addictions Care Center of Albany (ACCA)</u>	\$511,447.00	A.4320.0145
<u>Parson's Child & Family</u>	\$1,401,959.00	A.4320.0165
<u>PEOPLE, Inc.</u>	\$143,027.00	A.4320.0065

RESOLUTION REQUEST FORM NO. 3

Request for New Contract

DEPARTMENT NAME: Mental Health/Office of Community Services

DATE: 11/20/2018

- (a) Is this a Result of a Bid or Request for Proposal? **No, these are ongoing mental health services funded by the NYS Office of Mental Health and not subject to re-bidding or RFP processes.**
- (b) Purpose of Contract: **To provide specialized mental health crisis respite services for youth, for amounts not to exceed the amounts listed on attached Schedule A.**
- (c) Name of Contractor: **See attached Schedule A.**
- (d) Address of Contractor:
- (e) Contractor's Contact Person and Telephone Number:
- (f) Has or will the Contract be provided, if so, please attach: **New contracts will be written for 2019, modeled after existing 2018 contracts.**
- (g) Commencement Date of Contract: **1/1/2019**
- (h) Termination Date of Contract: **12/31/19**
- (i) Payment Provisions: i) lump sum amount
ii) hourly rate amount **Yes, per contract specifications**
iii) total amount not to exceed
iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc. **Monthly, per vouchered services.**
- (j) Where are the Funds for this Contract? List Budget Code, Object Code, Full Title* and Amount: **OR Capital Project OR Capital Reserve Project Number, Title, and Amount: A.4310-470 - Contract -- \$59,396 (100% State Aid).**

Sample: A.1010 470 Legislative Board – Contract Sxx.xx
Capital Project No. H289.9550 480 – Old Jail Renovations Sxx.xx

*as listed in budget and LOGOS

Schedule A – 2019 OCS Respite Contracts
(100% State Aid – NYS OMH)

<u>Provider Agency</u>	<u>Amount</u>	<u>Budget Code</u>
<u>Northeast Parent & Child</u>	\$20,000	A.4310-470
<u>Wait House</u>	\$33,352	A.4310-470
<u>Capital District</u>	As needed, not to exceed \$6,044	A.4310-470
<u>Vanderheyden Hall</u>	As needed, not to exceed \$6,044	A.4310-470

RESOLUTION REQUEST FORM NO. 1

Request to Appoint or Reappoint Member of Committee, Board or Agency*

****If more than one person is being appointed, please attach additional sheets***

DEPARTMENT NAME: Mental Health

DATE: 11/20/18

- (a) Name of Appointee: **Joan Grishkot**
- (b) Is this a Reappointment? **yes** If so, please provide the Resolution No. which authorized the last appointment of this individual **Reso #64 of 2015.**
- (c) If a Certificate of Appointment applies, please provide a copy of the prior certificate of appointment, if possible.
- (d) If person is being Appointed as a Representative of a Specific Group/Agency, please list their Affiliation and Title
- (e) Address of Appointee: **Glens Falls, NY**
- (f) Title of Appointment: **Warren County Community Services Board**
- (g) Effective Date of Appointment: **1/1/2019**
- (h) Termination Date of Appointment: **12/31/2022**
- (i) Name of Person Being Replaced (if applicable):
- (j) Reason for Replacement:

RESOLUTION REQUEST FORM NO. 20

MISCELLANEOUS

**Please List All Other Requests Not Covered by Previous Resolution Request Forms Here.
Please attach any backup information available and be as detailed as possible.*

DEPARTMENT NAME: Mental Health/Office of Community Services

DATE: 11/20/18

- (a) Purpose of Request: To authorize the Director of Community Services for Warren and Washington Counties to enter into a three-year lease agreement for office space.
- (b) Details: Three year lease agreement with the Warren-Washington Association for Mental Health, Inc. for office and conferencing space for the Office of Community Services for Warren and Washington Counties. Monthly rent expense for 2019 will be \$2,425.33, with 2% annual increase for each year the remainder of the term. Leased space contains five offices for six staff, two file rooms, and use of two conference rooms. Office and file space totals 1020 sq. ft. Square footage with conferencing space included totals 1720 sq. ft.
- (c) Previous Resolution Number: Resolution #116 of 2016
- (d) Where are the Funds (if required)? List Budget Code, Object Code, Full Title* and Amount: A.4310-411, Rent

Sample: A.8021 470 Planning & Community Development – Contract

* as listed in budget and LOGOS

RESOLUTION REQUEST FORM NO. 10

Request for Transfer of Funds

TO: AMANDA ALLEN, CLERK, WARREN COUNTY BOARD OF SUPERVISORS

DEPARTMENT NAME: Mental Health/Office of Community Services for Warren and Washington Counties

SIGNED: 

DATE: 11/20/18

<u>FROM CODE</u>	<u>TITLE</u>	<u>TO CODE</u>	<u>TITLE</u>	<u>AMOUNT</u>
A.4310 444	Travel	A.4390 435	Psychiatric Eval/Criminal	\$1,000
A.4310 435	Psych Eval/Non-Criminal	A.4390 435	Psychiatric Eval/Criminal	\$500
A.4310 130	Salaries - Part-Time	A. 4390 435	Psychiatric Eval/Criminal	\$1,000

Please state reason for transfers requested: Transfer of funds to cover NYS mandated chargeback expenses for Warren County defendants found not competent to stand trial pursuant to the NYS CPL 730 statute.

CONTINGENT FUND TRANSFER REQUESTS

<u>FROM CODE</u>	<u>TITLE</u>	<u>TO CODE</u>	<u>TITLE</u>	<u>AMOUNT</u>
A.1990 469	Contingent Account- Other Payments/Contributions			

Please state reason for transfer request:

Please file original request with Clerk of the Board and retain copy for your records.

RESOLUTION REQUEST FORM NO. 10

Request for Transfer of Funds

TO: AMANDA ALLEN, CLERK, WARREN COUNTY BOARD OF SUPERVISORS

DEPARTMENT NAME: Mental Health/Office of Community Services for Warren and Washington Counties

SIGNED:



DATE: 11/20/2018

<u>FROM CODE</u>	<u>TITLE</u>	<u>TO CODE</u>	<u>TITLE</u>	<u>AMOUNT</u>
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Please state reason for transfers requested:

CONTINGENT FUND TRANSFER REQUESTS

<u>FROM CODE</u>	<u>TITLE</u>	<u>TO CODE</u>	<u>TITLE</u>	<u>AMOUNT</u>
A.1990 469	Contingent Account- Other Payments/Contributions	A.4390 435	Psychiatric Eval/Criminal	\$35,500

Please state reason for transfer request: Transfer of funds to cover NYS mandated chargeback expenses for Warren County defendants found not competent to stand trial pursuant to the NYS CPL 730 statute.

Please file original request with Clerk of the Board and retain copy for your records.