

5122-26-01 Purpose.

The purpose of this chapter is to state the requirements for policies and procedures for operation of agencies that provide mental health services and activities.

R.C. [119.032](#) review dates: 11/29/2010 and 11/29/2015

Promulgated Under: [119.03](#)

Statutory Authority: 5119.61(A), 5119.611(C)

Rule Amplifies: 5119.61(A), 5119.611(C)

Prior Effective Dates: 1/1/91

5122-26-02 Applicability.

The provisions of the rules contained in this chapter are applicable to each agency subject to certification by the department.

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Rule Amplifies: 5119.61(A), 5119.611(C)

Prior Effective Dates: 1/1/91, 10/1/03

5122-26-03 Governing body and governance.

(A) Each agency shall have a leadership structure. . The leadership structure shall identify who is responsible for:

- (1) Governance;
- (2) Agency administration, i.e. planning, management and operational activities; and
- (3) Provision of clinical services.

(B) Each corporation for non-profit shall have a governing body. For the purposes of this rule, governing body shall have the same meaning as governing board. The governing body shall guide, plan and support the achievement of the agency's mission, vision and goals. The governing body shall develop written by-laws, a code of regulation, or policies for the following:

- (1) Selection of members of the governing body. The composition of the governing body shall reflect the demographics of the community it serves.
- (2) The number of members of the governing body needed for a quorum;
- (3) Terms of office for the members of the governing body; and
- (4) Provisions guarding against the development of, and prohibiting the existence of, a conflict of interest between a governing body member and the agency.

(C) The governing body shall:

- (1) Provide for orientation of its new members, including providing information about governing structure, duties, responsibilities and operations of the organization;
- (2) Provide financial oversight and approve the annual budget and plan for services;
- (3) Conduct meetings of the governing body at least quarterly, which shall include:
 - (a) Review an annual summary of quality assurance and risk management activities and document governing body actions taken as a result of this review; and
 - (b) Review an annual summary of client rights activities and document governing body actions taken as a result of this review.
- (4) Maintain minutes of meetings of the governing body including, but not limited to:
 - (a) Date, time and place of the meeting;
 - (b) Names of members who attended; and
 - (c) Topics discussed and actions taken.
- (5) Establish procedures for selecting the chief executive officer or executive director;
- (6) Establish duties and responsibilities of the executive director;

- (7) Select the executive director;
 - (8) Conduct an annual review and evaluation of the executive director;
 - (9) Identify responsibility for leadership in the absence of the executive director;
 - (10) Establish, review and update as necessary the agency's policies, and document that this review has occurred. The policies shall be reviewed in accordance with the schedule established by the agency's national accrediting body, if applicable, or a minimum of every five years;
 - (11) Ensure adequate malpractice and liability insurance protection for its corporate membership, governing body, advisory board if applicable, agency and agency staff, and review such protection annually;
 - (12) Ensure that opportunity is offered for input regarding the planning, evaluation, delivery, and operation of mental health services, which shall include but not be limited to the opportunity to participate in the activities of or participate on the governing body, advisory groups, committees, or other agency bodies, to:
 - (a) Persons who are receiving or have received mental health services, and their family members; and
 - (b) Persons who collectively represent a wide range of community interests and demographic characteristics of the service district in categories such as race, ethnicity, primary spoken language, gender and socio-economic status;
 - (13) Ensure that the hours of operation for services and/or activities accommodate the needs of persons served, their families and significant others; and
 - (14) Ensure that all services provided and employment practices are in accordance with non-discrimination provisions of all applicable federal laws and regulations.
- (D) A government agency shall identify its governance structure for the purpose of meeting the requirements of this rule. Each agency which is not a corporation for non-profit and therefore not subject to the provisions of paragraphs (B) and (C) of this rule shall have a written description of its governance structure, and identify whether the owner shall assume sole responsibility for the activities required in this rule, or whether the agency is governed by a governing body, board of directors, or other governance body. Agency governance shall:
- (1) Provide financial oversight and develop an annual budget and plan for services;
 - (2) At least annually:
 - (a) Review an summary of quality assurance and risk management activities and document governing body actions taken as a result of this review; and
 - (b) Review client rights activities and document governing body actions taken as a result of this review;
 - (3) Establish duties and responsibilities of the executive director;
 - (4) Select the executive director;
 - (5) Conduct an annual review and evaluation of the executive director;
 - (6) Identify responsibility for leadership in the absence of the executive director;
 - (7) Establish, review and update as necessary the agency's policies, and document that this review has occurred. The policies shall be reviewed in accordance with the schedule established by the agency's national accrediting body, if applicable, or a minimum of every five years;

(8) Ensure adequate malpractice and liability insurance protection for its corporate membership, advisory board if applicable, agency and agency staff, and review such protection annually;

(9) Ensure that opportunity is offered for input regarding the planning, evaluation, delivery, and operation of mental health services, which shall include but not be limited to the opportunity to participate in the activities of or participate on the governing body, advisory groups, committees, or other agency bodies, to

(a) Persons who are receiving or have received mental health services, and their family members; and

(b) Persons who collectively represent a wide range of community interests and demographic characteristics of the surrounding community, such as race, ethnicity, primary spoken language, gender, and socio-economic status;

(10) Ensure that the hours of operation for services and/or activities accommodate the needs of persons served, their families and significant others; and

(11) Ensure that all services provided and employment practices are in accordance with non-discrimination provisions of all applicable federal laws and regulations.

(E) Each agency shall maintain a written table of organization or organization chart which documents the lines of responsibility of:

(1) Governing body, if applicable;

(2) Executive director;

(3) Administrative leadership; and

(4) Clinical oversight.

Replaces: 5122-26-03, 5122-26-05

Effective: 07/01/2011

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Prior Effective Dates: 5/10/79, 1/1/91

5122-26-04 Policy and procedure manual.

(A) Each agency shall develop a written manual of policies and procedures regarding all services and activities of the agency.

(B) The policy and procedure manual shall be available for review by staff, persons served and their family and significant others.

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Prior Effective Dates: 1/1/91

5122-26-06 Human resources management.

(A) The purpose of this rule is to ensure that each agency has a human resources management program, and develops written personnel policies and procedures which include the provisions of this rule.

(B) In addition to the definitions in rule 5122-24-01 of the Administrative Code, the following definition shall apply to this rule:

"Personnel" means any paid or unpaid person, volunteer, contract worker, student intern or other person who is a part of an agency's workforce, including but not limited to those who perform management, clinical, operations, clerical, or other functions in support of the agency's mission, vision and goals. Contract worker does not include an individual or company with whom the agency contracts to perform occasional maintenance such as lawn care, snow removal, painting, etc. Staff shall have the same meaning as personnel.

(C) Each agency shall ensure that it has the necessary staff to support the agency's mission, vision and goals, and to provide services to persons served

(D) Each agency shall ensure that its personnel policies and procedures include the following provisions:

(1) Prohibit discrimination in employment, training, job duties, compensation, evaluation, promotion, and any other term or condition of employment based on race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws;

(2) Describe a formal process to express and process employee grievances;

(3) Establish recruitment and hiring practices;

(4) Establish skills, qualifications and competencies required for each position, based on mission of organization, services provided and characteristics and needs of population(s) served. The agency shall maintain a written job description for each position.

All personnel for whom licensure is required by law shall maintain current licensure by the appropriate body in the state of Ohio, and shall practice only within the scope of their license.

(5) Verify staff credentials, including licensure, certification or registration, education, and experience;

(6) Develop and maintain a staff orientation program, which shall include training on:

(a) Employee and client safety;

(b) Agency's mission, vision and goals;

(c) Characteristics of the population served;

(d) Sensitivity to cultural diversity;

(e) Agency policies and procedures, including personnel policies, and those specific to individual job duties;

(f) Confidentiality;

(g) Reporting abuse and neglect; and

(h) Client rights.

(7) Ensure direct service and supervisory staff participate in education and training. Training may be provided by direct supervision, attendance at conferences and workshops internal and external to the agency, on-line training, educational coursework, etc. Training shall:

(a) Maintain or increase competency;

(b) Include topics specific to population served; and

(c) Ensure culturally competent provision of service.

(8) Ensure each staff providing direct services receives documented supervision appropriate to his/her skill level and job duties, and in accordance with the requirements of his/her license, certificate or registration, if applicable.

Supervision may be provided in individual and group sessions, including supervisor participation in treatment plan meetings.

(9) Evaluate staff performance at a frequency required by its accrediting body, if applicable, or for an agency without behavioral health accreditation, annually.

The agency shall establish a system and frequency for evaluating volunteers, based on job duties, scope of responsibility, and frequency of service.

(E) A copy of the written personnel policies and procedures shall be available to each employee. Employees shall be notified of changes in personnel policies and procedures.

(F) Personnel files.

(1) The agency shall maintain a person file on each staff person, who shall have access to his/her own personnel file.

(2) Personnel files shall be stored in such a manner as to maintain the privacy of each staff person. Agency policies shall describe who shall have access to the various information contained within the file.

(3) Each personnel file shall include the following content:

(a) Identifying information and emergency contacts;

(b) Application for employment or resume;

(c) Verification of credentials, if applicable;

(d) Documentation of education, experience and training;

(e) Verification of references, if required for position;

(f) Job description;

(g) Compensation documentation, if applicable;

(h) Performance evaluations;

(i) Documentation of orientation;

(j) Documentation of on-going training, as required by position, state law and agency policy;

(k) Commendations or awards, if applicable; and

(l) Disciplinary actions, if applicable.

(G) The agency shall have policies and written procedures for handling cases of staff neglect and abuse of persons served, and documentation that each employee has received a copy of these policies and procedures.

(H) The agency shall have a policy that appropriate disciplinary action, up to and including dismissal from employment, shall be taken regarding any employee misconduct or criminal conviction that bears a direct and substantial relationship to that employee's position.

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Prior Effective Dates: 5/10/79, 10/14/82, 1/1/91, 10/1/93

5122-26-08 Drug theft in agencies.

(A) The agency shall have a policy on employee drug theft and shall inform all employees concerning this policy.

(B) An employee or volunteer with knowledge of drug theft by an employee or any other person shall report such information to the executive director of the agency. If the executive director of the agency is suspected of drug theft, the employee or volunteer shall notify the department.

(C) Suspected drug theft shall be reported to the Ohio board of pharmacy. For controlled substances, suspected drug theft shall also be reported to the federal drug enforcement administration. For agencies participating in drug services with the Ohio department of mental health central pharmacy and/or pharmacy service center, these offices shall also be notified of suspected drug theft.

(D) The agency shall take all reasonable steps to protect the confidentiality of the information and the identity of the person furnishing the information.

(E) Failure to report information of drug theft shall be considered in determining the eligibility of the employee to continue to work in a secure area where drugs are stored.

(F) If an employee violates the agency's drug theft policies, the agency shall assess the seriousness of the employee's violation, whether the violation has a direct and substantial relationship to that employee's position, the past record of employment, and other relevant factors in determining whether to suspend, transfer, terminate, or take other action against the employee.

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Statutory Authority: 5119.61(A), 5119.611(C)

Rule Amplifies: 5119.61(A), 5119.611(C)

Prior Effective Dates: 1/1/91

5122-26-09 Agency service plan.

(A) The purpose of this rule is to ensure that the agency plans and develops services to meet the needs of the population served.

(B) The agency shall define in writing its mission, vision and goals.

(C) The agency shall develop a written description of each service provided, which shall include:

(1) The description of the service;

(2) Schedule of the days the service is available, and hours of operation;

(3) Needs and characteristics of the population served;

(4) Goals and scope of service; and

(5) Description of services which are offered through referral or affiliations with other providers, and the responsibilities of each agency or provider.

(D) The agency shall revise and update the service description when any of the information required in paragraph (C) of this rule changes.

(E) The agency service plan shall be available for review by persons served, their family, significant others and the public.

Replaces: 5122-26-09

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Rule Amplifies: [5119.61\(A\)](#), [5119.611\(C\)](#)

Prior Effective Dates: 5/10/79, 1/1/91, 10/1/93

5122-26-11 Affiliation agreements.

(A) Each agency shall ensure that any residential facility subject to licensure by the department in which persons served by the agency reside is affiliated with a mental health agency or the local community mental health board.

(B) Each agency designated by the community mental health board to screen, refer, and/or admit persons to a state-operated psychiatric hospital shall have a signed continuity of care agreement describing the roles and responsibilities of the community mental health board, hospital, agency and department.

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Rule Amplifies: [5119.22](#), [5119.61\(A\)](#), [5119.611\(C\)](#)

Prior Effective Dates: 1/1/1991

5122-26-12 Environment of care and safety.

(A) The purpose of this rule is to ensure that each agency maintains a clean, safe environment which supports the provision of quality mental health services and minimizes the risk of harm to clients, staff, visitors, and others.

(B) Each agency shall designate the personnel who are responsible for implementing and oversight of the provisions of this rule.

(C) Each agency shall develop written policies and procedures to address emergency situations, including:

(1) Fire, including the requirement that fire exit doors shall remain unlocked and clearly marked unless a variance has been granted by a certified authority of the division of state fire marshal of the department of commerce;

(2) Bomb threat;

(3) Natural disaster;

(4) Utility outage or malfunction, e.g. a gas leak; and

(5) Other potential threats which may be applicable based upon location, e.g. nuclear power plant leak.

(D) Each agency shall conduct emergency drills and evaluate the effectiveness of the drill to ascertain the need for performance improvement:

(1) Fire drills shall be conducted at least once every twelve months.

(2) The agency shall evaluate and determine the need to conduct other drills, and the frequency. This shall be included in its policies and procedures.

(E) Each agency shall have written policies and procedure, which incorporate any applicable local, state or federal laws for:

(1) Safe handling, storage and disposal of hazardous materials.

(2) Safe handling and disposal of infectious waste materials, including applicable specifications of the occupational health and safety administration and the Ohio department of health.

(3) Infection control, including applicable specifications of the occupational health and safety administration and the Ohio department of health.

(4) Hazardous areas of the agency.

(F) The agency's policies and procedures shall include the requirement that each staff receives training during orientation on the safety procedures identified in paragraphs (C), (D) and (E) of this rule. The agency shall identify in its policies and procedures the need for on-going training on each emergency or safety procedure, and the frequency of such training.

(G) Each agency shall meet local, state and federal laws regarding accessibility.

Whenever it identifies a structural or other barrier which limits access to or within the building, the agency shall develop a plan to remove the barrier.

(H) The agency shall conduct regular safety inspections at least every six months, or more often as identified by the agency's policies and procedure or its accrediting body. Inspections shall include attention to:

- (1) Physical structure;
 - (2) Electrical systems;
 - (3) Heating and cooling systems;
 - (4) Warning devices, e.g. exit lights, alarm systems, etc.;
 - (5) Fire suppression equipment;
 - (6) Lighting;
 - (7) Food preparation areas, if applicable; and
 - (8) Any other areas or systems as needed and identified in agency policies and procedures.
- (I) Each agency shall ensure it obtains inspections and permits in accordance with local, state or federal laws.

(1) At a minimum, the agency shall obtain the following inspections every twelve months:

(a) Fire inspection by a certified fire authority, or where there is none available, by the division of the state fire marshal of the department of commerce, to include testing of fire alarm systems.

(b) Water supply and sewage disposal inspection for facilities in which these systems are not connected with public services to certify compliance with rules of the department of health and any other state or local regulations, rules, codes or ordinances.

(2) The agency shall ensure that it obtains inspections and/or maintains current permits as required by law, if applicable:

(a) Elevator inspection.

(b) Boiler inspection.

(c) Food service.

(d) Any other as required by local, state or federal law.

Replaces: 5122-26-12, 5122-26-14

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5122-26-13 Incident notification and risk management.

(A) This rule establishes standards to ensure the prompt and accurate notification of certain prescribed incidents. It also requires the agency to review and analyze all incidents so that it might identify and implement corrective measures designed to prevent recurrence and manage risk.

(B) Definitions

(1) "County community mental health board of residence" means the mental health board that is responsible for referring and/or paying for the client's treatment.

(2) "Incident" means an event that poses a danger to the health and safety of clients and/or staff and visitors of the agency, and is not consistent with routine care of persons served or routine operation of the agency.

(3) "Reportable Incident" means an incident that must be submitted to the department, including an incident that must then be forwarded by the department to the Ohio legal rights service pursuant to section [5123.604](#) of the Revised Code. As referenced in division (C) of section [5119.611](#) of the Revised Code, "Major Unusual Incident" has the same meaning as "Reportable Incident."

(4) "Six month reportable incident" means an incident type of which limited information must be reported to the department. A six month reportable incident is not the same as a reportable incident.

(5) "Six month incident data report" means a data report which must be submitted to the department.

(C) The agency shall develop an incident reporting system to include a mechanism for the review and analysis of all reportable incidents such that clinical and administrative activities are undertaken to identify, evaluate, and reduce risk to clients, staff, and visitors. The agency shall identify in policy other incidents to be reviewed and analyzed.

(1) An incident report shall be submitted in written form to the agency's executive director or designee within twenty-four hours of discovery of a reportable incident.

(2) As part of the agency's performance improvement process, a periodic review and analysis of reportable incidents, and other incidents as defined in agency policy, shall be performed. This shall include a review of all incident reports received from licensed type 2 and type 3 residential facilities regarding persons served by the agency, and any action taken by the agency, as appropriate.

(3) The agency shall maintain an ongoing log of its reportable incidents for departmental review.

(D) Any person who has knowledge of any instance of abuse or neglect, or alleged or suspected abuse or neglect of:

(1) Any child or adolescent, shall immediately notify the county children's services board, the designated child protective agency, or law enforcement authorities, in accordance with section [2151.421](#) of the Revised Code; or

(2) An elderly person, shall immediately notify the appropriate law enforcement and county department of jobs and family services authorities in accordance with section [5101.61](#) of the Revised Code.

(E) Each agency shall submit reportable incidents and six month reportable incidents as defined by and according to the schedule included in appendix A to this rule.

(F) Each reportable incident shall be documented on form "DMH-LIC-015" as required by the department. Form "DMH-LIC-015" shall include identifying information about the agency, date, time and type of incident, and client information that has been de-identified pursuant to the HIPAA privacy regulations, [45

C.F.R.164.514(b)(2)].

(1) The agency shall file only one incident form per event occurrence and identify each incident report category, if more than one, and include information regarding all involved clients, staff, and visitors; and

(2) The agency shall forward each reportable incident to the department and to the county community mental health board of residence within twenty-four hours of its discovery, exclusive of weekends and holidays; and

(G) Each agency shall submit a six month incident data report to the department and to the community mental health board utilizing the form that is in appendix B to this rule.

The six month incident data report must be submitted according to the following schedule:

(1) The six month incident data report for the period of January first to June thirtieth of each year shall be submitted no later than July thirty-first of the same year; and

(2) The six month incident data report for the period of July first to December thirty-first of each year shall be submitted no later than January thirty-first of the following year.

(H) The department may initiate follow-up and further investigation of a reportable incident and six month reportable incidents, as deemed necessary and appropriate, or may request such follow-up and investigation by the agency, regulatory or enforcement authority, and/or the community mental health board.

Replaces: 5122-26-13

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Prior Effective Dates: 1/1/04

**Certified Community Mental Health Agency
Reportable and Six Month Reportable Incidents**

In addition to the definitions in rule 5122-24-01 and 5122-26-16 of the Administrative Code, the following definitions are applicable to Ohio Administrative Code (OAC) rule 5122-26-13 "Incident Notification and Risk Management":

- (1) "Emergency/Unplanned Medical Intervention" means treatment required to be performed by a licensed medical doctor, osteopath, podiatrist, dentist, physician's assistant, or certified nurse practitioner, but the treatment required is not serious enough to warrant or require hospitalization. It includes sutures, staples, immobilization devices and other treatments not listed under "First Aid", regardless of whether the treatment is provided in the agency, or at a doctor's office/clinic/hospital ER, etc. This does not include routine medical care or shots/immunizations, as well as diagnostic tests, such as laboratory work, x-rays, scans, etc., if no medical treatment is provided.
- (2) "First Aid" means treatment for an injury such as cleaning of an abrasion/wound with or without the application of a Band-aid, application of a butterfly bandages/Steri-Strips™, application of an ice/heat pack for a bruise, application of a finger guard, non-rigid support such as a soft wrap or elastic bandage, drilling a nail or draining a blister, removal of a splinter, removal of a foreign body from the eye using only irrigation or swab, massage, drinking fluids for relief of heat stress, eye patch, and use of over-the-counter medications such as antibiotic creams, aspirin and acetaminophen. These treatments are considered first aid, even if applied by a physician. These treatments are not considered first aid if provided at the request of the client and/or to provide comfort without a corresponding injury.
- (3) "Hospitalization" means inpatient treatment provided at a medical acute care hospital, regardless of the length of stay. Hospitalization does not include treatment when the individual is treated in and triaged through the emergency room with a discharge disposition to return to the community, or admission to psychiatric unit.
- (4) "Injury" means an event requiring medical treatment that is not caused by a physical illness or medical emergency. It does not include scrapes, cuts or bruises which do not require medical treatment.
- (5) "Sexual Conduct" means as defined by Section 2907.01 of the Ohio Revised Code, vaginal intercourse between a male and female; anal intercourse, fellatio, and cunnilingus between persons regardless of sex; and, without privilege to do so, the insertion, however slight, of any part of the body or any instrument, apparatus, or other object into the vaginal or anal opening of another. Penetration, however slight, is sufficient to complete vaginal or anal intercourse.
- (6) "Sexual Contact" means as defined by Section 2907.01 of the Ohio Revised Code, any touching of an erogenous zone of another, including without limitation the thigh, genitals, buttock, pubic region, or, if the person is a female, a breast, for the purpose of sexually arousing or gratifying either person.

Reportable Incidents

The following lists and defines each event category which must be reported per incident in accordance with paragraph (F) of rule 5122-26-13 of the Administrative Code.

Category	Reportable Incident Definition
Suicide	The intentional taking of one's own life by a client.
Homicide by Client	The alleged unlawful killing of a human being by a client.
Homicide of Client	The alleged unlawful killing of a client by another person.
Accidental Death	Death of a client resulting from an unusual and unexpected event that is not suicide, homicide or natural, and which happens on the grounds of the agency or during the provisions of care or treatment, including during agency off-grounds events.
Verbal Abuse	Allegation of staff action directed toward a client that includes humiliation, harassment, and threats of punishment or deprivation.
Physical Abuse	Allegation of staff action directed toward a client of hitting, slapping, pinching, kicking, or controlling behavior through corporal punishment or any other form of physical abuse as defined by applicable sections of the Revised or Administrative Code.
Sexual Abuse	Allegation of staff action directed toward a client where there is sexual contact or sexual conduct with the client, any act where staff cause one or more other persons to have sexual contact or sexual conduct with the client, or sexual comments directed toward a client. Sexual conduct and sexual contact have the same meanings as in Section 2907.01 or the Revised Code.
Neglect	Allegation of a purposeful or negligent disregard of duty imposed on an employee by statute, rule, organizational policy, or professional standard and owed to a client by that staff member.
Defraud	Allegation of staff action directed toward a client to knowingly obtain by deception or exploitation some benefit for oneself or another or to knowing cause, by deception or exploitation, some detriment to another.
Involuntary Termination Without Appropriate Client Involvement	Discontinuing services to a client without informing the client in advance of the termination, providing a reason for the termination, and offering a referral to the client. This does not include situations when a client discontinues services without notification, and the agency documents it was unable to notify the client due to lack of address, returned mail, lack of or non-working phone number, etc.
Sexual Assault by Non-staff, Including a Visitor, Client or Other	Any allegation of one or more of the following sexual offenses as defined by Chapter 2907 of the Revised Code committed by a non-staff against another individual, including staff, and which happens on the grounds of the agency or during the provisions of care or treatment, including during agency off-grounds events: Rape, sexual battery, unlawful sexual conduct with a minor, gross sexual imposition, or sexual imposition.

Reportable Incidents

The following lists and defines each event category which must be reported per incident in accordance with paragraph (F) of rule 5122-26-13 of the Administrative Code (continued).

Category	Reportable Incident Definition
Physical Assault by Non-staff, Including Visitor, Client or Other	Knowingly causing physical harm or recklessly causing serious physical harm to another individual, including staff, by physical contact with that person, which results in an injury requiring emergency/unplanned medical intervention or hospitalization, and which happens on the grounds of the agency or during the provision of care or treatment, including during agency off-grounds events.
Medication Error	Any preventable event while the medication was in the control of the health care professional or client, and which resulted in permanent client harm, hospitalization, or death. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication, product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.
Adverse Drug Reaction	Unintended, undesirable or unexpected effect of a prescribed medication(s) that results in permanent client harm, hospitalization, or death.
Medical Events Impacting Agency Operations	The presence or exposure of a contagious or infectious medical illness within an agency, whether brought by staff, client, visitor or unknown origin, that poses a significant health risk to other staff or clients in the agency, and that requires special precautions impacting operations. Special precautions impacting operations include medical testing of all individuals who may have been present in the agency, when isolation or quarantine is recommended or ordered by the health department, police or other government entity with authority to do so, and/or notification to individuals of potential exposure. Special precautions impacting operations does not include general isolation precautions, i.e. suggesting staff and/or clients avoid a sick individual or vice versa, or when a disease may have been transmitted via consensual sexual contact or sexual conduct.
Temporary Closure of One or More Agency Sites Subcategory (check one)	The agency ceases to provide services at one or more locations for a minimum period of more than seven consecutive calendar days due to: <ol style="list-style-type: none">1. Fire2. Disaster (flood, tornado, explosion, excluding snow/ice)3. Failure/Malfunction (gas leak, power outage, equipment failure)4. Other (name)

Continued On Page 4 & 5 for Seclusion and Restraint & Use of Force Related Incidents

Continued On Page 6 for Six Month Reportable Incident Instructions

Reportable Incidents

The following lists and defines each event category which must be reported per incident in accordance with paragraph (F) of rule 5122-26-13 of the Administrative Code (continued).

Category	Reportable Incident Definition
Inappropriate Use of Seclusion or Restraint	Seclusion or restraint utilization that is not clinically justified, or mechanical seclusion or restraint employed without the authorization of staff permitted to initiate/order mechanical seclusion or restraint
Subcategory (check all that apply)	<ol style="list-style-type: none">1. Seclusion2. Mechanical restraint3. Physical restraint4. Transitional hold
Total Minutes	The total number of minutes of the seclusion or restraint.
Inappropriate Restraint Techniques and other Use of Force	Staff utilize one or more of the following methods/interventions prohibited by paragraph (D)(2) of rule 5122-26-16 of the Administrative Code:
Subcategory (check all that apply)	<ol style="list-style-type: none">1. Behavior management interventions that employ unpleasant or aversive stimuli such as: the contingent loss of the regular meal, the contingent loss of bed, and the contingent use of unpleasant substances or stimuli such as bitter tastes, bad smells, splashing with cold water, and loud, annoying noises2. Any technique that restricts the client's ability to communicate3. Any technique that obstructs vision4. Any technique that obstructs the airways or impairs breathing5. Use of mechanical restraint on a client under age 186. A drug or medication that is used as a restraint to control behavior or restrict the client's freedom of movement and is not a standard treatment or dosage for the client's medical or psychiatric condition or that reduces the client's ability to effectively or appropriately interact with the world around him/her7. The use of handcuffs or weapons such as pepper spray, mace, nightsticks, or electronic restraint devices such as stun guns and tasers
Seclusion/Restraint Related Injury to Client	Injury to a client caused, or it is reasonable to believe the injury was caused by being placed in seclusion/restraint or while in seclusion/restraint, and first aid or emergency/unplanned medical intervention was provided or should have been provided to treat the injury, or medical hospitalization was required. It does not include injuries which are self-inflicted, e.g. a client banging his/her head, unless the agency determines that the seclusion/restraint was not properly performed by staff, or injuries caused by another client, e.g. a client hitting another client.
Subcategory (check one)	<ol style="list-style-type: none">1. Injury requiring first aid2. Injury requiring unplanned/emergency medical intervention3. Injury requiring hospitalization

Reportable Incidents

The following lists and defines each event category which must be reported per incident in accordance with paragraph (F) of rule 5122-26-13 of the Administrative Code (continued).

Category	Reportable Incident Definition
Seclusion/Restraint Related Injury to Staff	Injury to staff caused, or it is reasonable to believe the injury was caused as a result of placing an individual in seclusion/restraint, and first aid or emergency/unplanned medical intervention was provided or should have been provided to treat the injury, or medical hospitalization was required. It does not include injuries which occur prior to, or are the rationale for, placing an individual in seclusion or restraint.
Subcategory (check one)	<ol style="list-style-type: none">1. Injury requiring first aid2. Injury requiring emergency/unplanned medical intervention3. Injury requiring hospitalization
Seclusion/Restraint Related Death	Death of a client which occurs while a client is restrained or in seclusion, within twenty-four hours after the client is removed from seclusion or restraint, or it is reasonable to assume the client's death may be related to or is a result of seclusion or restraint
Subcategory (check one)	<ol style="list-style-type: none">1. Death during seclusion or restraint2. Death within twenty-four hours of seclusion or restraint3. Death related to or result of seclusion or restraint

Continued On Page 6 for Six Month Reportable Incident Instructions

Six Month Reportable Incidents

The following lists and defines the incident data which must be reported every six months in accordance with paragraph (G) of rule 5122-26-13 of the Administrative Code.

Category	Six Month Reportable Incident Definition
Seclusion	A staff intervention that involves the involuntary confinement of a client alone in a room where the client is physically prevented from leaving.
Age 17 and Under	The aggregate total number of all episodes of seclusion and aggregate total minutes of all seclusion episodes.
Age 18 and Over	The aggregate total number of all episodes of seclusion and aggregate total minutes of all seclusion episodes.
Mechanical Restraint	A staff intervention that involves any method of restricting a client's freedom of movement, physical activity, or normal use of his or her body, using an appliance or device manufactured for this purpose.
Age 18 and Over	The aggregate total number of all episodes of mechanical restraint and aggregate total minutes of all mechanical restraint episodes.
Physical Restraint excluding Transitional Hold	A staff intervention that involves any method of physically (also known as manually) restricting a client's freedom of movement, physical activity, or normal use of his or her body without the use of mechanical restraint devices
Age 17 and Under	The aggregate total number of all episodes of physical restraint and aggregate total minutes of all physical restraint episodes, excluding transitional hold.
Age 18 and Over	The aggregate total number of all episodes of physical restraint and aggregate total minutes of all physical restraint episodes, excluding transitional hold.
Transitional Hold	A staff intervention that involves a brief physical (also known as manual) restraint of a client face-down for the purpose of quickly and effectively gaining physical control of that client, or prior to transport to enable the client to be transported safely.
Age 17 and Under	The aggregate total number of all episodes of transitional hold and aggregate total minutes of all transitional hold episodes.
Age 18 and Over	The aggregate total number of all episodes of transitional hold and aggregate total minutes of all transitional hold episodes.

**Community Mental Health Agency
Six Month Reportable Incident Data Report Form****Instructions:**

Please complete the Agency Information on this page. If agency policy prohibits the use of seclusion or restraint, please check the box in Part A below. If agency policy permits the use of seclusion or restraint, please skip Part A and complete Parts B, C & D, beginning on Page 4. *Please complete Parts B, C & D if agency policy allows the use of seclusion or restraint, even if the agency did not utilize seclusion or restraint during the reporting period.* Definitions are found on Page 2.

You may submit this form by fax, e-mail or mail. Address and fax number information is available on the Ohio Department of Mental Health website.

Please submit this report by the following deadline:

- For the incident reporting period of January 1 through June 30, by July 31 of the same year
- For the incident reporting period of July 1 through December 31, by January 31 of the following year

Community Mental Health Agency Information

Agency Name: _____ ODMH Certification Number: _____

Person completing report: _____ Title: _____

Phone _____ E-mail: _____

Reporting Period (please include year): January 1 – June 30, 20____ Report is due by July 31 of this year
 July 1 – December 31, 20____ Report is due by January 31 of the following year

Part A

Agency policy prohibits the use of seclusion and restraint in all certified services, and the agency did not utilize seclusion and restraint during the reporting period.

**If Box in Part A is checked, you are finished.
Please return report.**

If not, please skip to and complete Parts B, C and D

Definitions. Please utilize the following definitions for completing this report:

“Hours of Service” means the total number of hours of service provided to all clients.

“Mechanical Restraint” means staff intervention that involves any method of restricting a client’s freedom of movement, physical activity, or normal use of his or her body, using an appliance or device manufactured for this purpose.

“Physical Restraint” means a staff intervention that involves any method of physically (also known as manually) restricting a client’s freedom of movement, physical activity, or normal use of his or her body without the use of mechanical restraint devices.

“Seclusion” means a staff intervention that involves the involuntary confinement of a client alone in a room where the client is physically prevented from leaving.

"Transitional hold" means a staff intervention that involves a brief physical (also known as manual) restraint of a client face-down for the purpose of quickly and effectively gaining physical control of that client, or prior to transport to enable the client to be transported safely.

“Unduplicated Clients Served” means the number of clients served during a specified timeframe. Each person can only be counted once, regardless of the number of services he or she receives.

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Part B. Crisis Intervention Mental Health Service. Please check the appropriate answer, and then follow the instructions.

- Agency is not certified for Crisis Intervention Mental Health Service. Please continue to Part C.
- Agency policy prohibits the use of seclusion and restraint in Crisis Intervention Mental Health Service, and the agency did not utilize seclusion or restraint during the reporting period. Please continue to Part C.
- Agency did not utilize seclusion or restraint in Crisis Intervention Mental Health Service during the reporting period. Please complete Table B1, and then continue to Part C.
- Seclusion or restraint was utilized in Crisis Intervention Mental Health Service. Please complete Tables B1 & B2, and then continue to Part C.

Table B1. Seclusion and Restraint in Crisis Intervention Service

Service Utilization	January/ July	February/ August	March/ September	April/ October	May/ November	June/ December
Total Number of Unduplicated Crisis Intervention Mental Health Clients Served						
Total Hours of Crisis Intervention Mental Health service						

Table B2. Seclusion and Restraint in Crisis Intervention Service

	January/ July	February/ August	March/ September	April/ October	May/ November	June/ December
Seclusion for Ages ≤17 <input type="checkbox"/> None						
Number of episodes of seclusion for ages ≤17						
Total minutes of all seclusion episodes for ages ≤17						
Seclusion for Ages ≥18 <input type="checkbox"/> None						
Number of episodes of seclusion for ages ≥18						
Total minutes of all seclusion episodes for ages ≥18						
Mechanical Restraint for Ages ≥18 <input type="checkbox"/> None						
Number of episodes of mechanical restraint for ages ≥18						
Total minutes of all mechanical restraint episodes for ages ≥18						
Physical Restraint for Ages ≤17 <input type="checkbox"/> None						
Number of episodes of physical restraint, excluding transitional hold, for ages ≤17						
Total minutes of all physical restraints episodes, excluding transitional hold, for ages ≤17						
Physical Restraint for Ages ≥18 <input type="checkbox"/> None						
Number of episodes of physical restraint, excluding transitional hold, for ages ≥18						
Total minutes of all physical restraints episodes, excluding transitional hold, for ages ≥18						
Transitional Hold for Ages ≤17 <input type="checkbox"/> None						
Number of episodes of transitional hold for ages ≤17						
Total minutes of all transitional hold episodes for ages ≤17						
Transitional Hold for Ages ≥18 <input type="checkbox"/> None						
Number of episodes of transitional holds for ages ≥18						
Total minutes of all transitional hold episodes for ages ≥18						

Please Continue to Part C

Part C. Partial Hospitalization Service. Please continue to Part D when completed.

- Agency is not certified for Partial Hospitalization Service. Please continue to Part D.
- Agency policy prohibits the use of seclusion and restraint in Partial Hospitalization Service, and the agency did not utilize seclusion and restraint during the reporting period. Please continue to Part D.
- Agency did not utilize seclusion or restraint in Partial Hospitalization Service during the reporting period. Please complete Table C1, and then continue to Part D.
- Seclusion or restraint was utilized in Partial Hospitalization Service. Please complete Tables C1 & C2, and then continue to Part D.

Table C1. Seclusion and Restraint in Partial Hospitalization Service

Service Utilization and Partial Hospitalization Length	January/ July	February/ August	March/ September	April/ October	May/ November	June/ December
Total Number of Unduplicated Partial Hospitalization Clients Served						
Total Hours of Partial Hospitalization Service						
Length of Partial Hospitalization Day ____ Hours						

Table C2. Seclusion and Restraint in Partial Hospitalization Service

	January/ July	February/ August	March/ September	April/ October	May/ November	June/ December
Seclusion for Ages ≤17 <input type="checkbox"/> None						
Number of episodes of seclusion for ages ≤17						
Total minutes of all seclusion episodes for ages ≤17						
Seclusion for Ages ≥18 <input type="checkbox"/> None						
Number of episodes of seclusion for ages ≥18						
Total minutes of all seclusion episodes for ages ≥18						
Mechanical Restraint for Ages ≥18 <input type="checkbox"/> None						
Number of episodes of mechanical restraint for ages ≥18						
Total minutes of all mechanical restraint episodes for ages ≥18						
Physical Restraint for Ages ≤17 <input type="checkbox"/> None						
Number of episodes of physical restraint, excluding transitional hold, for ages ≤17						
Total minutes of all physical restraints episodes, excluding transitional hold, for ages ≤17						
Physical Restraint for Ages ≥18 <input type="checkbox"/> None						
Number of episodes of physical restraint, excluding transitional hold, for ages ≥18						
Total minutes of all physical restraints episodes, excluding transitional hold, for ages ≥18						
Transitional Hold for Ages ≤17 <input type="checkbox"/> None						
Number of episodes of transitional hold for ages ≤17						
Total minutes of all transitional hold episodes for ages ≤17						
Transitional Hold for Ages ≥18 <input type="checkbox"/> None						
Number of episodes of transitional holds for ages ≥18						
Total minutes of all transitional hold episodes for ages ≥18						

Please Continue to Part D

Part D. All Other Certified Mental Health Services, excluding Crisis Intervention Mental Health & Partial Hospitalization Service

- Agency policy prohibits the use of seclusion other than in Crisis Intervention Mental Health and/or Partial Hospitalization Service, and the agency did not utilize seclusion and restraint in other certified services during the reporting period. You are finished. Please return report.
- Agency did not utilize seclusion or restraint in All Other Certified Mental Health Services during the reporting period. You are finished. Please return report.
- Seclusion or restraint was utilized in mental health services other than Crisis Intervention Mental Health and Partial Hospitalization Service. Please complete Table D1 on the next page and then return report.

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Table D1. Seclusion and Restraint in All Other Certified Mental Health Services, Except Crisis Intervention Mental Health Service and Partial Hospitalization Service

	January/ July	February/ August	March/ September	April/ October	May/ November	June/ December
Seclusion for Ages ≤17 <input type="checkbox"/> None						
Number of episodes of seclusion for ages ≤17						
Total minutes of all seclusion episodes for ages ≤17						
Seclusion for Ages ≥18 <input type="checkbox"/> None						
Number of episodes of seclusion for ages ≥18						
Total minutes of all seclusion episodes for ages ≥18						
Mechanical Restraint for Ages ≥18 <input type="checkbox"/> None						
Number of episodes of mechanical restraint for ages ≥18						
Total minutes of all mechanical restraint episodes for ages ≥18						
Physical Restraint for Ages ≤17 <input type="checkbox"/> None						
Number of episodes of physical restraint, excluding transitional hold, for ages ≤17						
Total minutes of all physical restraints episodes, excluding transitional hold, for ages ≤17						
Physical Restraint for Ages ≥18 <input type="checkbox"/> None						
Number of episodes of physical restraint, excluding transitional hold, for ages ≥18						
Total minutes of all physical restraints episodes, excluding transitional hold, for ages ≥18						
Transitional Hold for Ages ≤17 <input type="checkbox"/> None						
Number of episodes of transitional hold for ages ≤17						
Total minutes of all transitional hold episodes for ages ≤17						
Transitional Hold for Ages ≥18 <input type="checkbox"/> None						
Number of episodes of transitional holds for ages ≥18						
Total minutes of all transitional hold episodes for ages ≥18						

You are finished. Please return report.

Thank you.

5122-26-15 Medication handling.

(A) The agency shall have written policies and procedures regarding the purchasing, receipt, storage, distribution, return, and destruction of medication that include accountability for and security of medications located within any of its facilities. These policies and procedures shall include, but not be limited to the requirements that agencies handling medications shall:

(1) Hold a valid and current terminal distributor of dangerous drugs license from the Ohio board of pharmacy if maintaining a stock supply of medications and/or if participating with the department's central pharmacy to receive dispensed prescriptions.

(2) Locate all medications and prescription blanks in a locked, secure area;

(3) Designate a person(s) having access to or authorized to handle medication and shall maintain a current list of these persons, their credentials and their medication handling responsibilities.

(4) Provide a method to record and follow the medications from the time of receipt to the time of distribution, return to central pharmacy, or destruction. This record shall be retained by the agency for three years and shall include, but not be limited to the following information:

(a) The date and time the medication was received by the agency, distributed to persons served, returned to central pharmacy or, if appropriate, destroyed;

(b) The name(s), credentials and signature of all persons handling the medications; and

(c) The provision that unused medication prescribed for a person shall be appropriately destroyed or returned to central pharmacy, and that, under no circumstances shall the unused medication be issued to another individual. (Return of unused medication prescribed to a person is only allowed when the return is to central pharmacy in accordance with rule 4729-9-04 of the Administrative Code).

(5) Ensure that:

(a) Individuals providing information about the use of medications shall be educated regarding medication issues for groups such as minority-specific populations and children and youth in order to provide appropriate information to these populations, and

(b) All staff handling medications have basic and ongoing instruction and training in safe and effective handling of medications.

(6) Ensure that medications are handled only by authorized persons and that others do not have access to the medications; and

(7) Ensure that controlled substances may be destroyed only by an agent of the Ohio board of pharmacy, or the federal drug enforcement agency, or by transfer to persons registered under Chapters 3719. and 4729. of the Revised Code and according to rule 4729-9-06 of the Administrative Code.

(B) Agencies maintaining a limited stock supply of medications shall:

(1) Allow only a physician or pharmacist to dispense medication, although the following individuals may personally furnish samples of some medications if issued a certificate to prescribe:

(a) Certified nurse practitioner and clinical nurse specialist in accordance with division (D) of section [4723.481](#) of the Revised Code; and

(b) Physician's assistant in accordance with division (A) of section [4730.43](#) of the Revised Code.

(2) Have visibly posted the phone number of the nearest poison control center.

Replaces: 5122-26-15

Effective: 07/01/2011

R.C. [119.032](#) review dates: 01/04/2011 and 07/01/2016

Promulgated Under: [119.03](#)

Statutory Authority: [5119.61\(A\)](#), [5119.611\(C\)](#)

Rule Amplifies: [5119.61\(A\)](#), [5119.611\(C\)](#)

Prior Effective Dates: 1/1/91, 10/1/93

5122-26-16 Seclusion, restraint and time-out.

(A) The provision of a physically and psychologically safe environment is a basic foundation and requirement for effective mental health treatment. Adopting trauma informed treatment practices, creating calm surroundings and establishing positive, trusting relationships are essential to facilitating a person's treatment and recovery.

The goal of reducing and minimizing the use of seclusion and restraint is one that must be shared and articulated by the organization's leadership. The elevation of oversight by leadership of each use of seclusion or restraint in order to investigate causality, ascertain relevancy of current policies and procedures, and identify any associated workforce development issues, is core to the successful achievement of this goal.

These methods are very intrusive techniques to be used by trained, qualified staff as a last resort in order to control dangerous and potentially harmful behaviors and to preserve safety. Best practices include careful early assessment of a person's history, experiences, preferences, and the effectiveness or ineffectiveness of past exposure to these methods.

Use of seclusion or restraint must be subject to performance improvement processes in order to identify ways in which the use of these methods can be decreased/avoided and more positive, relevant and less potentially dangerous techniques used in their place.

When individuals experience repeated or sustained use of these methods, leadership should evaluate all causative factors and consider alternative treatment interventions and/or possible transfer to/placement in a more structured treatment setting with the capacity to meet individual needs with reduced exposure to these intrusive interventions.

(B) The purpose of this rule is to state the general requirements applicable to the use of seclusion and restraint, and to the adoption of processes to reduce their utilization.

(C) The following definitions shall apply to rules 5122-26-16 to [5122-26-16.2](#) of the Administrative Code and supersede those contained in rule [5122-24-01](#) of the Administrative Code:

(1) "Advance directives" means a legal document an adult can use to direct in advance the decisions about his or her mental and/or physical health treatment, if in the future he/she lacks the capacity to make his/her own health care decisions. Two types of advance directives related to mental health treatment are: a "Declaration for Mental Health Treatment" subject to the requirements of Chapter 2135. of the Revised Code, and a "Durable Power of Attorney for Health Care" subject to the requirements of sections [1337.11](#) to [1337.17](#) of the Revised Code.

(2) "Behavior management" means the utilization of interventions that are applied in a systematic and contingent manner in the context of individual or group programs to change or manage behavior or facilitate improved self-control. The goal of behavior management is not to curtail or circumvent an individual's rights or human dignity, but rather to support the individual's recovery and increase his/her ability to exercise those rights.

(3) "Comfort rooms", (formerly known as quiet or time-out rooms), are adapted sensory rooms that provide sanctuary from stress and/or can be places for persons to experience feelings within acceptable boundaries.

(4) "Individual crisis plan" means a written plan that allows the person to identify coping techniques and share with staff what is helpful in assisting to regain control of his/her behavior in the early stages of a crisis situation. It may also be referred to as a "behavior support plan."

(5) "Mechanical restraint" means any method of restricting a person's freedom of movement, physical

activity, or normal use of his or her body, using an appliance or device manufactured for this purpose.

(6) "Physical restraint", also known as "manual restraint", means any method of physically restricting a person's freedom of movement, physical activity, or normal use of his or her body without the use of mechanical restraint devices.

(7) "PRN (pro re nata)" means as the situation demands.

(8) "Prone Restraint" means all items or measures used to limit or control the movement or normal functioning of any portion, or all, of an individual's body while the individual is in a face-down position for an extended period of time. Prone restraint may include either physical (also known as manual) or mechanical restraint.

(9) "Qualified person" means an employee and/or volunteer who carries out the agency's tasks under the agency's administration and/or supervision, and who is qualified to utilize or participate in the utilization of seclusion or restraint by virtue of the following: education, training, experience, competence, registration, certification, or applicable licensure, law, or regulation.

(10) "Seclusion" means the involuntary confinement of a person alone in a room where the person is physically prevented from leaving.

(11) "Sensory rooms" means appealing physical spaces painted with soft colors with the availability of furnishings and objects that promote relaxation and/or stimulation.

(12) "Time-out" means an intervention in which a person is required to remove him/herself from positive reinforcement to a specified place for a specified period of time. Time-out is not seclusion.

(13) "Transitional hold" means a brief physical (also known as manual) restraint of an individual face-down for the purpose of quickly and effectively gaining physical control of that individual, or prior to transport to enable the individual to be transported safely.

(14) "Vital signs" means the rates or values indicating an individual's blood pressure, pulse, temperature, and respiration.

(D) General requirements

(1) Seclusion or restraint shall not be used unless it is in response to a crisis situation, i.e., where there exists an imminent risk of physical harm to the individual or others, and no other safe and effective intervention is identified.

(a) They shall not be used as behavior management interventions, to compensate for the lack of sufficient staff, as a substitute for treatment, or as an act of punishment or retaliation.

(b) Absent a co-existing crisis situation that includes the imminent risk of physical harm to the individual or others, the destruction of property by an individual, in and of itself is not adequate grounds for the utilization of these methods.

(2) The following shall not be used under any circumstances:

(a) Behavior management interventions that employ unpleasant or aversive stimuli such as: the contingent loss of the regular meal, the contingent loss of bed, and the contingent use of unpleasant substances or stimuli such as bitter tastes, bad smells, splashing with cold water, and loud, annoying noises.

(b) Any technique that restricts the individual's ability to communicate, including consideration given to the communication needs of individuals who are deaf or hard of hearing;

- (c) Any technique that obstructs vision;
- (d) Any technique that obstructs the airways or impairs breathing;
- (e) Use of mechanical restraint on individuals under age eighteen;
- (f) A drug or medication that is used as a restraint to control behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's medical or psychiatric condition or that reduces the individual's ability to effectively or appropriately interact with the world around him/her; and
- (g) The use of handcuffs or weapons such as pepper spray, mace, nightsticks, or electronic restraint devices such as stun guns and tasers.

The presence of weaponry in an agency poses potential hazards, both physical and psychological, to clients, staff and visitors. Utilization by the agency of non-agency employed armed law enforcement personnel (e.g., local police) to respond to and control psychiatric crisis situations, shall be minimized to the extent possible.

(3) Position in physical or mechanical restraint.

(a) An individual shall be placed in a position that allows airway access and does not compromise respiration.

(i) The use of prone restraint is prohibited.

(ii) A transitional hold shall be limited to the minimum amount of time necessary to safely bring the person under control, at which time staff shall either terminate the transitional hold, and begin the post-restraint process required by this rule, or, if the individual cannot safely be released from the transitional hold, re-position the individual into an alternate restraint position.

(b) The use of transitional hold shall be subject to the following requirements:

(i) Applied only by staff who have current training on the safe use of transitional hold techniques, including how to recognize and respond to signs of distress in the individual.

(ii) The weight of the staff shall be placed to the side, rather than on top of the individual. No transitional hold shall allow staff to straddle or bear weight on the individual's torso while applying the restraint, i.e. no downward pressure may be applied that may compromise the individual's ability to breathe.

(iii) No transitional hold shall allow the individual's hands or arms to be under or behind his/her head or body. The arms must be at the individual's side.

(iv) No soft device, such as a pillow, blanket or other item, shall be used to cushion the client's head, since such a device may restrict the individual's ability to breathe.

(v) All staff involved in the procedure must constantly observe the individual's respiration, coloring, and other signs of distress, listen for the individual's complaints of breathing problems, and immediately respond to assure safety.

(4) The choice of the least restrictive, safe and effective use of seclusion or restraint for an individual is determined by the person's assessed needs, including a consideration of any relevant history of trauma and/or abuse, risk factors as identified in paragraph (G)(3) of this rule, the effective or ineffective methods previously used with the person and, when possible, upon the person's preference.

(a) Upon admission/intake and when clinically warranted, the person and his/her parent, custodian or guardian, as appropriate, shall be informed of the agency's philosophy on the use of seclusion or restraint as well as of the presence of any agency policies and procedures addressing their use by the agency. Such policies and procedures shall be made available to the person and/or to his/her parent, custodian or guardian

upon request.

Adult clients shall be offered the opportunity to give consent for the notification of their use to a family member or significant other.

(5) Within twenty-four hours of the initiation of seclusion or restraint, the agency shall notify the following individuals:

(a) For children/adolescents, the client's parent, custodian or guardian;

(b) For adults, the client's guardian, when applicable, or family or significant other when the client has given his/her consent for such notification.

(6) Following the conclusion of each incident of seclusion or restraint, the client and staff shall participate in a debriefing(s).

(a) The debriefing shall occur within twenty-four hours of the incident unless the client refuses, is unavailable, or there is a documented clinical contraindication.

(b) The following shall be invited to participate unless such participation is clinically contraindicated and the rationale is documented in the clinical record:

(i) For a child/adolescent client, the family, or custodian or guardian, or

(ii) For an adult client, the client's family or significant other when the client has given consent in accordance with paragraph (D)(4)(a) of this rule, or an adult client's guardian, if applicable.

(7) A thorough review and analysis of each incident of the use of seclusion or restraint shall be undertaken in order to use the knowledge gained from such analysis to inform policy, procedures, and practices to avoid repeated use in the future and to improve treatment outcomes. Secondly, such analysis should help to mitigate, to the extent possible, the adverse and potentially traumatizing effects of a seclusion or restraint event for involved staff, clients, and for all witnesses to the event.

(8) The inclusion of clients (including children), families, and external advocates in various roles and at all agency levels to assist in reducing the use of seclusion or restraint shall be considered.

(E) Policies and procedures

(1) The agency shall establish policies and procedures that reflect how the utilization of seclusion or restraint is reviewed, evaluated, and approved for use. The agency shall document if and how the inclusion of clients and families in the development of such policies occurred.

(2) Policies and procedures governing the use of seclusion or restraint shall include attention to preservation of the person's health, safety, rights, dignity, and well-being during use. Additionally:

(a) Respect for the person shall be maintained when such methods are utilized;

(b) Use of the environment, including the possible addition of comfort and sensory rooms, shall be designed to assist in the person's development of emotional self-management skills; and

(c) The number of appropriately trained staff available to apply or initiate seclusion or restraint shall be adequate to ensure safety. The use of non-agency employed law enforcement personnel, e.g., local police, to substitute for the lack of sufficient numbers of appropriately trained staff in such situations is prohibited.

(F) Staff training.

(1) The agency shall ensure that all direct care staff and any other staff involved in the use of seclusion or restraint receive initial and annual training designed to minimize their use.

(a) Staff shall be trained and demonstrate competency in the correct and appropriate use of non-physical techniques for intervention, such as mediation and conflict resolution, and de-escalation of disruptive or aggressive acts, persons and/or situations; and

(b) Staff shall be trained in understanding how their behavior can affect the behavior of clients.

(2) The agency shall identify, educate and approve staff members to use seclusion or restraint. Competency of staff in the use and documentation of seclusion or restraint methods shall be routinely evaluated. The results of evaluations shall be maintained by the agency for a minimum of three years for each staff member identified.

(a) Staff shall have appropriate training prior to utilizing seclusion or restraint, and, at a minimum, annually thereafter. The exception to annual training is a first aid and/or CPR training/certification program of a nationally recognized certifying body, e.g. the American Red Cross or American Heart Association, when that certifying body establishes a longer time frame for certification and renewal.

(i) Staff shall be trained in and demonstrate competency in the identification and assessment of those possible risk factors identified in paragraph (G) of this rule and to understand how these may impact the way a client responds to seclusion or restraint, and place an individual at greater risk to experience physical or psychological trauma during an episode of seclusion or restraint;

(ii) Staff shall be trained in and demonstrate competency in choosing the least restrictive intervention based on an individualized assessment of the client's behavioral and/or medical status or condition;

(iii) Staff shall be trained in and demonstrate competency in the safe application of all seclusion or restraint interventions he or she is authorized to perform, including specific training in utilization of transitional hold, if applicable;

(iv) Staff shall be trained and certified in first aid and CPR;

(v) Staff shall be trained in and demonstrate competency in recognizing and responding to signs of physical distress in clients who are being secluded or restrained;

(vi) Staff authorized to take vital signs and blood pressure shall be trained in and demonstrate competency in taking them and understanding their relevance to physical safety and distress;

(vii) Staff shall be trained in and demonstrate competency in assessing circulation, range of motion, nutrition, hydration, hygiene, and toileting needs; and

(viii) Staff shall be trained in and demonstrate competency in helping a client regain control to meet behavioral criteria to discontinue seclusion or restraint.

(b) Leadership shall maintain a current list of staff authorized to utilize seclusion or restraint interventions which is readily available to all agency staff who may be asked to participate in these interventions; and

(c) The curriculum used to train staff shall be documented and shall be made available to ODMH upon request.

(G) Documentation.

(1) The presence of advance directives or client preferences addressing the use of seclusion or restraint shall be determined and considered, and documented in the ICR. If the agency will be unable to utilize seclusion or

restraint in a manner in accordance with the person's directives or preferences, the agency shall notify the individual, including the rationale, and document such in the ICR.

(2) In conjunction with the person's active participation, an individual crisis plan shall be developed at the time of admission and incorporated in the person's ISP for each child/adolescent resident of an ODMH licensed residential facility, for each client known to have experienced seclusion or restraint, and when otherwise clinically indicated.

The plan shall be based on the initial mental health assessment, and shall include and be implemented, as feasible, in the following order:

(a) Identification of the methods or tools to be used by the client to de-escalate and manage his or her own aggressive behavior;

(b) Identification of techniques and strategies for staff in assisting the person to maintain control of his or her own behavior; and

(c) Identification, in order of least restrictive to most restrictive, of the methods/tools to be used by staff to de-escalate and manage the client's aggressive behavior.

(3) Initial and ongoing identification of individual-specific contraindications to the use of seclusion or restraint shall be documented. Consideration of the use of such methods shall take into account the following which may place the person at greater risk of physical or psychological injury as a result of the use of seclusion or restraint:

(a) Gender;

(b) Age;

(c) Developmental issues;

(d) Culture, race, ethnicity, and primary language;

(e) History of physical and/or sexual abuse, or psychological trauma;

(f) Medical and other conditions that might compromise physical well-being, e.g., asthma, epilepsy, obesity, lung and heart conditions, an existing broken bone, pregnancy, and drug/alcohol use; and

(g) Physical disabilities.

(4) Debriefings following the conclusion of each incident of seclusion or restraint shall be documented, and shall include, at a minimum:

(a) The incident and antecedent behaviors which lead to the use of seclusion or restraint;

(b) What actions might have prevented the use of seclusion or restraint; and what techniques and tools might help the individual manage his or her own behavior in the future;

(c) The person's reaction to the method, including whether there is any need for counseling or other services related to the incident; and

(d) Whether any modifications to the person's ISP or individual crisis plan are needed.

(5) Each incident of seclusion or restraint shall be clinically and/or administratively reviewed. Such review shall be documented.

(H) Logs and notifications.

(1) A log shall be maintained for department review of each incident of mechanical restraint, seclusion, and physical restraint, and for time-outs exceeding sixty minutes per episode. The log shall include, at minimum, the following information:

(a) The person's name or other identifier;

(b) The date, time and type of method or methods utilized, i.e., seclusion, mechanical restraint, physical restraint and/or transitional hold, or time-out. The log of physical and mechanical restraint shall also describe the type of intervention as follows:

(i) For mechanical restraint, the type of mechanical restraint device used;

(ii) For physical restraint, as follows:

(a) Transitional hold, and/or

(b) Physical restraint; and

(c) The duration of the method or methods.

If both transitional hold and physical restraint are utilized during a single episode of restraint, the duration in each shall be included on the log. For example, a physical restraint that begins with a one minute transitional hold, followed by a three minute physical restraint shall be logged as one restraint, indicating the length of time in each restraint type.

(2) Pursuant to rules [5122-26-13](#) and [5122-30-16](#) of the Administrative Code, the agency shall notify ODMH of each:

(a) Instance of physical injury to a client/resident that is restraint-related, e.g., injuries incurred when being placed in seclusion or restraint or while in seclusion or restraint, with the exception of injury that is self-inflicted, i.e. a client/resident banging his/her own head;

(b) Death that occurs while a person is restrained or in seclusion;

(c) Death occurring within twenty four hours after the person has been removed from restraints or seclusion, and

(d) Death where it is reasonable to assume that a person's death may be related to or is a result of such seclusion or restraint.

(l) Performance improvement.

(1) The agency shall collect data on all instances of the use of seclusion or restraint and integrate the data into performance improvement activities.

(2) Data shall be aggregated and reviewed at least semi-annually by agencies and at least quarterly by ODMH licensed residential facilities. The minimum data to be collected for each episode shall include:

(a) Staff involved, including staff member(s) who initiated the seclusion or restraint;

(b) Duration of the method;

(c) Date, time and shift each method was initiated;

(d) Day of week;

(e) Type of method, including type of physical hold or mechanical restraints utilized;

- (f) Client age, race, gender and ethnicity;
 - (g) Client and/or staff injuries;
 - (h) Number of episodes per client; and
 - (i) Use of psychotropic medications during an intervention of seclusion or restraint.
- (3) Data shall be reviewed:
- (a) For analysis of trends and patterns of use; and
 - (b) To identify opportunities to reduce the use of seclusion or restraint.
- (4) The agency shall routinely compare how its practices compare with current information and research on effective practice.
- (5) The results of data reviews and performance improvement activities shall be shared with staff at least semi-annually with the goal of reducing the use of seclusion or restraint.
- (J) Plan to reduce seclusion or restraint.
- (1) An agency which utilizes seclusion or restraint shall develop a plan designed to reduce its use. The plan shall include attention to the following strategies:
- (a) Identification of the role of leadership;
 - (b) Use of data to inform practice;
 - (c) Workforce development;
 - (d) Identification and implementation of prevention strategies;
 - (e) Identification of the role of clients (including children), families, and external advocates; and
 - (f) Utilization of the post seclusion or restraint debriefing process.
- (2) A written status report shall be prepared annually, and reviewed by leadership.
- (K) Staff actions commonly known as therapeutic, supportive or directional touch, utilized to direct an individual to another area without the use of force and which do not restrict an individual's freedom of movement, are not considered restraint and are not subject to the provisions of this rule.

Replaces: 5122-26-16, Part of 5122-26-16.1, Part of 5122-26-16.2, Part of 5122-26-16.3

Effective: 01/01/2012

R.C. [119.032](#) review dates: 01/01/2017

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Statutory Authority: [5119.22](#), [5119.61](#), [5119.611](#)

Rule Amplifies: [5119.22](#), [5119.61](#), [5119.611](#)

Prior Effective Dates: 1/1/91, 4/6/01

5122-26-16.1 Mechanical restraint and seclusion.

(A) The purpose of this rule is to state the specific requirements applicable to mechanical restraint and seclusion.

(B) The requirements for the use of mechanical restraint or seclusion do not apply:

(1) To restraint use that is only associated with medical, dental, diagnostic, or surgical procedures and is based on standard practice for the procedure. Such standard practice may or may not be described in procedure or practice descriptions (e.g., the requirements do not apply to medical immobilization in the form of surgical positioning, iv arm boards, radiotherapy procedures, electroconvulsive therapy, etc.);

(2) When a device is used to meet the assessed needs of an individual who requires adaptive support (e.g., postural support, orthopedic appliances) or protective devices (e.g., helmets, tabletop chairs, bed rails, car seats). Such use is always based on the assessed needs of the individual. Periodic reassessment should assure that the restraint continues to meet an identified individual need;

(3) To forensic and corrections restrictions used for security purposes, i.e., for custody, detention, and public safety reasons, and when not involved in the provision of health care.

(C) Mechanical restraint or seclusion shall not be used unless it is in response to a crisis situation, i.e., where there exists an imminent risk of physical harm to the individual or others, and no other safe and effective intervention is possible. It shall be employed for the least amount of time necessary in order that the individual may resume his/her treatment as quickly as possible.

(D) Implementation of mechanical restraint or seclusion.

(1) Authorized staff may implement mechanical restraint or seclusion at the direction and in the presence of an individual with specific clinical privileges/authorization granted by the agency to authorize mechanical restraint or seclusion, and who is a psychiatrist or other physician, physician's assistant, certified nurse practitioner, clinical nurse specialist, or registered nurse.

(2) Upon any implementation of mechanical restraint or seclusion, an individual with specific clinical privileges/authorization granted by the agency shall:

(a) Perform an assessment and document it in the clinical record. This assessment shall include, at minimum:

(i) The reason for the utilization of mechanical restraint or seclusion;

(ii) All prior attempts to use less restrictive interventions;

(iii) Notation that any previously identified contraindication(s) to the use of mechanical restraint or seclusion were considered and the rationale for continued implementation of mechanical restraint or seclusion despite the existence of such contraindications(s); and

(iv) A review of all current medications.

(b) Assess and document vital signs; and

(c) Explain to the individual the reason for mechanical restraint or seclusion, and the required behaviors of the individual which would indicate sufficient behavioral control so that mechanical restraint or seclusion can be discontinued.

(3) For adults in mechanical restraint, an assessment shall include health and related safety concerns including body positioning, comfort and circulation.

(E) Ordering mechanical restraint or seclusion.

(1) Orders shall be written only by an individual with specific clinical privileges/authorization granted by the agency to order mechanical restraint or seclusion, and who is a:

(a) Psychiatrist or other physician; or

(b) Physician's assistant, certified nurse practitioner or clinical nurse specialist authorized to order restraint or seclusion in accordance with his or her scope of practice and as permitted by applicable law or regulation.

(2) Orders may be written for a maximum of:

(a) Two hours for mechanical restraint or seclusion of adults eighteen years of age or older;

(b) One hour for seclusion of children and adolescents age nine through seventeen; or

(c) Thirty minutes for seclusion of children under age nine.

(3) Prn orders are prohibited, whether individual or as a part of a protocol.

(4) When indicated, a verbal order from an individual with specific clinical privileges/authorization granted by the agency to order mechanical restraint or seclusion, and who is a psychiatrist or other physician, physician's assistant, certified nurse practitioner, or clinical nurse specialist shall be obtained by a registered nurse upon implementation of mechanical restraint or seclusion, or within one hour. Such order shall be signed within twenty four hours by an individual with specific clinical privileges/authorization granted by the agency to order mechanical restraint or seclusion, and who is a psychiatrist or other physician, physician's assistant, certified nurse practitioner, or clinical nurse specialist.

(5) After the original order for mechanical restraint or seclusion expires, the individual shall receive a face-to-face reassessment, as described in subsection five of this paragraph. The reassessment shall be performed by an individual with specific clinical privileges/authorization granted by the agency to order mechanical restraint or seclusion, and who is a psychiatrist or other physician, physician's assistant, certified nurse practitioner, or clinical nurse specialist, who shall write a new order if mechanical restraint or seclusion is to be continued. However, agency policy and the original order may permit a registered nurse to perform such reassessment and make a decision to continue the original order for an additional:

(a) Two hours for mechanical restraint or seclusion of adults eighteen years of age or older up to a maximum of twenty-four hours;

(b) One hour for seclusion of children and adolescents age nine through seventeen up to a maximum of twenty-four hours; or

(c) Thirty minutes for seclusion of children under age nine up to a maximum of twelve hours.

(6) Continuation of orders cannot under any circumstances exceed the maximums stated in this paragraph without a face-to-face reassessment and a new written order. The reassessment shall be performed and new order written by an individual with specific clinical privileges/authorization granted by the agency to order mechanical restraint or seclusion, and who is a psychiatrist or other physician, physician's assistant, certified nurse practitioner, or clinical nurse specialist.

Such assessment shall be documented in the clinical record. It shall address the need for continued mechanical restraint or seclusion. It shall include a mental status examination, physical assessment, gross neurological assessment, and an assessment of the individual's verbal statements, level of behavioral control, and responses to stimuli and treatment interventions, unless contra-indicated for clear treatment reasons which shall be documented in the clinical record.

(7) Mechanical restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

(F) Continuous monitoring of persons in mechanical restraint or seclusion.

(1) While in mechanical restraint or seclusion, persons shall be continuously monitored, i.e., constant visual observation by staff in a manner most conducive to the situation and/or person's condition.

(2) Documentation of the condition of the person shall be made in the clinical record at routine intervals not to exceed fifteen minutes or more often if the person's condition so warrants. Such documentation shall address attention to vital signs, circulation, range of motion, nutrition, hydration, hygiene, toileting, the need for continued mechanical restraint or seclusion, and other needs as necessary, and the appropriate actions taken.

(3) Upon conclusion of the mechanical restraint or seclusion, the results of a check of injuries shall be conducted and documented.

The appropriate actions taken for any injuries noted shall also be documented.

(G) Seclusion room requirements.

(1) The type of room in which seclusion is employed shall ensure:

(a) Appropriate temperature control, ventilation and lighting;

(b) Safe wall and ceiling fixtures, with no sharp edges;

(c) The presence of an observation window and, if necessary, wall mirror(s) so that all areas of the room are observable by staff from outside of the room; and

(d) That any furniture present is removable or is securely fixed for safety reasons.

(H) Clinically appropriate reason(s) for the inability to implement any portion of this rule shall be documented in the clinical record, and shall be addressed in any staff de-briefing of the episode and in the agency's performance improvement process.

Replaces: 5122-26-16.1

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Rule Amplifies: [5119.22](#), [5119.61](#), [5119.611](#)

Prior Effective Dates: 1/1/91, 4/16/01

5122-26-16.2 Physical restraint.

(A) The purpose of this rule is to state the specific requirements applicable to physical restraint.

(B) Physical restraint shall not be used unless it is in response to a crisis situation, i.e., where there exists an imminent risk of physical harm to the individual or others, and no other safe and effective intervention is possible. It shall be employed for the least amount of time necessary in order that the individual may resume his/her treatment as quickly as possible..

(C) Implementation of physical restraint.

(1) Physical restraint must be authorized by a trained, qualified staff member in accordance with the requirements of the agency's behavioral health accrediting body; or

(2) For an agency who has not achieved appropriate behavioral health accreditation, the agency must identify and approve staff who are qualified to authorize physical restraint.

Staff approved by the agency must have received all training in accordance with paragraph (F) of rule [5122-26-16](#) of the Administrative Code.

(D) Documentation of each episode of the use of physical restraint shall be made in the clinical record and shall include:

(1) The reason for implementation of the physical restraint;

(2) All prior attempts to use less restrictive interventions;

(3) Notation that any previously identified contraindication(s) to the use of physical restraint were considered and the rationale for continued implementation of physical restraint despite the existence of such contraindication(s);

(4) A review of all current medications;

(5) Explanation to the person for the reason for implementation of physical restraint and the required behaviors of the person which would indicate sufficient behavioral control so that the physical restraint could be discontinued;

(6) The condition of the person at routine intervals not to exceed fifteen minutes or more often if the person's condition so warrants. Such documentation shall address attention to vital signs, circulation, range of motion, nutrition, hydration, hygiene, toileting, need for continued restraint, and other needs as necessary, and the appropriate actions taken; and

(7) Upon conclusion of the physical restraint, the results of a check of injuries shall be conducted.

The appropriate actions taken for any injuries noted shall also be documented.

(E) Clinically appropriate reason(s) for the inability to implement any portion of this rule shall be documented in the clinical record, and shall be addressed in any staff de-briefing of the episode and in the agency's performance improvement process.

Replaces: 5122-26-16.2

Effective: 01/01/2012

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Prior Effective Dates: 1/1/91, 4/16/01

5122-26-17 Accessibility, availability, appropriateness, and acceptability of services.

(A) Agency services shall be accessible, available, appropriate and acceptable to the persons served.

(B) Minimum criteria for accessibility of services shall include but not be limited to:

(1) Evening and/or weekend hours to meet the needs of persons receiving services;

(2) Compliance with relevant federal and state regulations, including "section 504" of the "Rehabilitation Act of 1973" (29 U.S.C. Section 794 et seq.); and

(3) Geographical access to services for persons served.

(C) Minimum criteria for availability of services shall include, but not be limited to:

(1) Coordinating discharge planning and mental health services for persons leaving state operated inpatient settings and participating in discharge planning for persons leaving private psychiatric inpatient settings and referred to the agency;

(2) Assuring continuity of care for persons discharged from psychiatric inpatient settings and referred to the agency through the provision of necessary services as determined by the agency in consultation with the person served and the referral source. Such necessary services shall be provided upon discharge whenever possible and no later than two weeks post discharge if it has been concluded that these services are required within two weeks;

(3) Providing assistance, as appropriate according to the person's needs, at no additional cost to persons served, to persons requesting or receiving services, and their families or significant others, who speak a language other than standard English as a primary means of communication, or who have a communication disorder, such as deafness or hearing impairment. Such assistance shall include availability of appropriate communication devices, including telecommunication devices for the deaf ("TDD" aka "TTY"), or publishing service access via use of Ohio relay service or other similar communication interpreter services, according to 29 U.S.C. 794, 29 U.S.C. 45 CFR part 84 et seq. In situations when a client expresses a preference to communicate by use of a TDD/TTY, then the agency shall ensure one is available at the agency.

Other assistance to be provided according to the needs of persons served shall apply to all forms of communication and shall include:

(a) Interpreters fluent in the first vernacular language of the person served, and with demonstrated ability and/or certification;

(b) Services provided by a professional who is able to communicate in the same vernacular language as the person served; and

(c) Referral to a service that provides interpreters.

(4) Providing culturally sensitive and responsive treatment planning and service delivery; and

(5) Addressing mental health service needs of the relevant community(ies) as described in the community plan(s) of the community mental health board(s).

(D) Minimum criteria for acceptability of services shall include, but not be limited to:

(1) Sensitivity to ethnic and cultural differences among people;

- (2) Promoting freedom of choice among therapeutic alternatives for the person receiving services; and
- (3) Provision that no person served shall be denied access to any service based on their refusal to accept other services recommended by the agency.
- (E) Minimum criteria for appropriateness of services shall include, but not be limited to:
- (1) Provision of services in the least restrictive setting;
 - (2) Delivery of service in the natural environment of the person receiving services as appropriate;
 - (3) Continuity of therapeutic relationships;
 - (4) Perceived needs of the person receiving services; and
 - (5) Culturological assessment.
- (F) Minimum criteria for appropriateness of services for persons with a severe mental disability or children with severe emotional disturbance shall also include referral to other systems or organizations to meet identified needs if the agency does not provide such services.
- (G) The agency shall review annually the effectiveness of its efforts to ensure accessibility, availability, appropriateness, and acceptability of services.

Effective: 02/17/2012

R.C. [119.032](#) review dates: 11/30/2011 and 02/17/2017

Promulgated Under: [119.03](#)

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Rule Amplifies: [5119.61\(A\)](#), [5119.611\(C\)](#)

Prior Effective Dates: 1-1-1991; 10-1-1993

5122-26-18 Client rights and grievance procedure, and abuse.

(A) Each agency shall develop policies and procedures regarding staff neglect and abuse of persons served including, but not limited to, the following requirements:

(1) Each allegation of neglect and/or abuse by agency staff of a person served, regardless of the source, shall be investigated. The written results of an investigation into an allegation of neglect and/or abuse of persons served shall be reviewed by the executive director of the agency. The agency shall keep documentation of the findings of the investigation and of actions taken as a result of the investigation.

(2) The agency shall report any allegation of staff neglect or abuse to the community mental health board within twenty-four hours of the event occurring and shall communicate the results of the investigation to the community mental health board.

(3) In situations that involve child abuse or adult abuse, any notification required by law shall be made to the appropriate authorities.

(B) Each agency shall have written policies and procedures that are consistent with state law and with the Ohio department of health's and the department's guidelines regarding rights of persons served, such as persons with human immunodeficiency virus ("HIV").

(C) Each agency shall develop a policy on the rights of persons receiving services and a grievance policy for those persons according to relevant federal, state, and local statutes. The following definitions are in addition to or supersede the definitions in rule [5122-24-01](#) of the Administrative Code:

(1) "Client" means an individual applying for or receiving mental health services from a board or mental health agency.

(2) "Client rights specialist " means the individual designated by a mental health agency or board with responsibility for assuring compliance with the client rights and grievance procedure rule as implemented within each agency or board. For these purposes the individual holds the specific title of client rights officer.

(3) "Contract agency" means a public or private service provider with which a community mental health board enters into a contract for the delivery of mental health services. A board which is itself providing mental health services is subject to the same requirements and standards which are applicable to contract agencies, as specified in rule [5122:2-1-05](#) of the Administrative Code.

(4) "Grievance" means a written complaint initiated either verbally or in writing by a client or by any other person or agency on behalf of a client regarding denial or abuse of any client's rights.

(5) "Reasonable" means a standard for what is fair and appropriate under usual and ordinary circumstances.

(6) "Services" means the complete array of professional interventions designed to help a person achieve improvements in mental health such as counseling, individual or group therapy, education, community psychiatric supportive treatment, assessment, diagnosis, treatment planning and goal setting, clinical review, psychopharmacology, discharge planning, professionally-led support, etc.

(D) Client rights.

Except for clients receiving forensic evaluation service as defined in rule [5122-29-07](#) of the Administrative Code, from a certified forensic center, each client has all of the following twenty-five rights as listed in paragraphs (D)(1) to (D)(15) of this rule. Rights of clients receiving only a forensic evaluation service from a certified forensic center are specified in paragraph (E) of this rule.

(1) All who access mental health services are informed of these rights:

- (a) The right to be informed of the rights described in this rule prior to consent to proceed with services, and the right to request a written copy of these rights;
 - (b) The right to receive information in language and terms appropriate for the person's understanding; and
 - (c) The right to be fully informed of the cost of services.
- (2) Services are appropriate and respectful of personal liberty:
- (a) The right to be treated with consideration, respect for personal dignity, autonomy, and privacy, and within the parameters of relevant sections of the Ohio Revised Code and the Ohio Administrative Code;
 - (b) The right to receive humane services;
 - (c) The right to participate in any appropriate and available service that is consistent with an individual service plan (ISP), regardless of the refusal of any other service, unless that service is a necessity for clear treatment reasons and requires the person's participation;
 - (d) The right to reasonable assistance, in the least restrictive setting; and
 - (e) The right to reasonable protection from physical, sexual and emotional abuse, inhumane treatment, assault, or battery by any other person.
- (3) Development of service plans:
- (a) The right to a current ISP that addresses the needs and responsibilities of an individual that specifies the provision of appropriate and adequate services, as available, either directly or by referral; and
 - (b) The right to actively participate in periodic ISP reviews with the staff including services necessary upon discharge.
- (4) Declining or consenting to services:
- (a) The right to give full informed consent to any service including medication prior to commencement and the right to decline services including medication absent an emergency;
 - (b) The right to be advised of and refuse observation by techniques such as one-way vision mirrors, tape recorders, televisions, movies, or photographs, or other audio and visual technology. This right does not prohibit an agency from using closed-circuit monitoring to observe seclusion rooms or common areas, which does not include bathrooms; and
 - (c) The right to decline any hazardous procedures.
- (5) Restraint, seclusion or intrusive procedures:
- The right to be free from restraint or seclusion unless there is imminent risk of physical harm to self or others.
- (6) Privacy:
- The right to reasonable privacy and freedom from excessive intrusion by visitors, guests and non agency surveyors, contractors, construction crews or others.
- (7) Confidentiality:
- (a) The right to confidentiality unless a release or exchange of information is authorized and the right to request to restrict

treatment information being shared; and

(b) The right to be informed of the circumstances under which an agency is authorized or intends to release, or has released, confidential information without written consent for the purposes of continuity of care as permitted by division (A) (7) of section [5122.31](#) of the Revised Code.

(8) Grievances:

The right to have the grievance procedure explained orally and in writing, the right to file a grievance, with assistance if requested; and the right to have a grievance reviewed through a grievance process, including the right to appeal a decision.

(9) Non-discrimination:

The right to receive services and participate in activities free of discrimination on the basis of race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws.

(10) No reprisal for exercising rights:

The right to exercise rights without reprisal in any form including the ability to continue services with uncompromised access. No right extends so far as to supersede health and safety considerations.

(11) Outside opinions:

The right to have the opportunity to consult with independent specialists or legal counsel, at one's own expense.

(12) No conflicts of interest:

No agency employee may be a person's guardian or representative if the person is currently receiving services from said facility.

(13) The right to have access to one's own psychiatric, medical or other treatment records, unless access to particular identified items of information is specifically restricted for that individual client for clear treatment reasons in the client's treatment plan. If access is restricted, the treatment plan shall also include a goal to remove the restriction.

(14) The right to be informed in advance of the reason (s) for discontinuance of service provision, and to be involved in planning for the consequences of that event.

(15) The right to receive an explanation of the reasons for denial of service.

(E) Client rights.

Each client receiving a forensic evaluation service from a certified forensic center has the rights specified in paragraphs (E) (1) to (E)(12) of this rule.

(1) The right to be treated with consideration and respect for personal dignity;

(2) The right to be evaluated in a physical environment affording as much privacy as feasible;

(3) The right to service in a humane setting which is the least restrictive feasible if such setting is under the control of the forensic center;

(4) The right to be informed of the purpose and procedures of the evaluation service;

- (5) The right to consent to or refuse the forensic evaluation services and to be informed of the probable consequences of refusal;
- (6) The right to freedom from unnecessary restraint or seclusion if such restraint or seclusion is within the control of the forensic center;
- (7) The right to be advised of and refuse observation by techniques such as one-way vision mirrors, tape recordings, televisions, movies, or photographs, or other audio and visual technology, unless ordered by the court, in which case the client must be informed of such technique. This right does not prohibit an agency from using closed-circuit monitoring to observe seclusion rooms or common areas, which does not include bathrooms;
- (8) The right not to be discriminated against in the provision of service on the basis of race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws;
- (9) The right to be fully informed of all rights;
- (10) The right to exercise any and all rights without reprisal in any form;
- (11) The right to file a grievance; and
- (12) The right to have oral and written instructions for filing a grievance including an explanation that the filing of a grievance is exclusively an administrative proceeding within the mental health system and will not affect or delay the outcome of the criminal charges.

(F) Client rights procedures.

(1) Each agency must have a written client rights policy which contains the following:

- (a) Specification of the client rights as listed in paragraphs (D)(1) to (D)(15) and/or (E)(1) to (E)(12) of this rule; and
- (b) Assurance that staff will explain any and all aspects of client rights and the grievance procedure upon request.

(2) Each agency policy shall specify how explanation of client rights shall be accomplished, and shall include:

- (a) Provision that in a crisis or emergency situation, the client or applicant shall be verbally advised of at least the immediately pertinent rights, such as the right to consent to or to refuse the offered treatment and the consequences of that agreement or refusal. Full verbal explanation of the client rights policy may be delayed to a subsequent meeting; and
- (b) Provision that clients or recipients of information and referral service, consultation service, mental health education service, and prevention service as described in Chapter 5122-29 of the Administrative Code may have a copy and explanation of the client rights policy upon request.

(3) A copy of the client rights policy shall be posted in a conspicuous location in an area of each building operated by the agency that is accessible to clients and the public. It shall also include the name, title, location, hours of availability, and telephone number of the client rights officer with a statement of that person's responsibility to accept and oversee the process of any grievance filed by a client or other person or agency on behalf of a client (4) Each agency shall provide that every staff person, including administrative and support staff, is familiar with all specific client rights and the grievance procedure.

(G) Grievance procedure.

(1) Each agency must have a written grievance procedure which provides for the following:

(a) Assistance in filing the grievance if needed by the grievor, investigation of the grievance on behalf of the grievor, and agency representation for the grievor at the agency hearing on the grievance if desired by the grievor. The grievance procedure shall clearly specify the name, title, location, hours of availability, and telephone number of the person(s) designated to provide the above activities;

(b) An explanation of the process from the original filing of the grievance to the final resolution, which shall include reasonable opportunity for the grievor and/or his designated representative to be heard by an impartial decision-maker;

(c) A specification of time lines for resolving the grievance not to exceed twenty working days from the date of filing the grievance;

(d) A specification that written notification and explanation of the resolution will be provided to the client, or to the grievor if other than the client, with the client's permission;

(e) Opportunity to file a grievance within a reasonable period of time from the date the grievance occurred;

(f) A statement regarding the option of the grievor to initiate a complaint with any or all of several outside entities, specifically the community mental health board, the Ohio department of mental health, the Ohio legal rights service, the U.S. department of health and human services, and appropriate professional licensing or regulatory associations. The relevant addresses and telephone numbers shall be included; and

(g) Provision for providing, upon request, all relevant information about the grievance to one or more of the organizations specified in this paragraph to which the grievor has initiated a complaint.

(2) Each agency shall make provision for posting the grievance procedure in a conspicuous place and for distributing a copy of the written grievance procedure to each applicant and each client, upon request.

(3) Each agency shall make provision for prompt accessibility of the client rights officer to the grievor.

(4) Each agency shall provide alternative arrangements for situations in which the client rights officer is the subject of the grievance.

(5) Each agency shall provide that every staff person, including administrative, clerical, and support staff, has a clearly understood, specified, continuing responsibility to immediately advise any client or any other person who is articulating a concern, complaint, or grievance, about the name and availability of the agency's client rights officer and the complainant's right to file a grievance.

(6) Each agency shall provide for the client rights officer to take all necessary steps to assure compliance with the grievance procedure.

(H) Implementation and monitoring.

(1) An agency may accomplish its responsibilities in regard to the provisions of this rule through utilization of its own staff or board members as appropriate, or through agreement with outside staff, agencies, or organizations, except that:

(a) Each agency must assure prompt accessibility of the client rights officer.

(b) The utilization of outside persons must be clearly explained to clients, applicants, and grievors.

(2) The agency client rights officer shall assure the keeping of records of grievances received, the subject matter of the grievances, and the resolution of the grievances, and shall prepare an annual summary for review by agency governance in accordance with rule [5122-26-03](#) of the Administrative Code. The annual summary shall include the number of grievances received, type of grievances, and resolution status of grievances, and shall be forwarded to the mental health board. The agency records shall be available for review by the community mental health board and the department of mental health

upon request.

(3) Each agency shall maintain a client rights policy and grievance procedure that is approved by the department of mental health. Subsequent substantive changes to such written policy and procedure shall also be submitted to and approved by the department before enactment.

Replaces: 5122-26-18, 5122:2-1-02 (part)

Effective: 03/01/2012

R.C. [119.032](#) review dates: 07/28/2011 and 03/01/2017

Promulgated Under: [119.03](#)

Statutory Authority: [5119.61\(A\)](#), [5119.611](#), [5119.613](#)

Rule Amplifies: [5119.61\(A\)](#), [5119.611](#), [5119.613](#)

Prior Effective Dates: 5-10-1979, 1-1-1991

5122-26-19 Uniform cost reporting.

(A) Definitions

(1) The following definitions apply to this rule:

(a) "ADAMHS board" means an alcohol, drug addiction and mental health services board as defined in Chapter 340. of the Revised Code.

(b) "CMH agency" means any community mental health agency as defined in section 5122.01 of the Revised Code which has been certified by the Ohio department of mental health in accordance with the requirements of section 5119.611 of the Revised Code.

(c) "CMH board" means a community mental health board as defined in Chapter 340. of the Revised Code.

(d) "CMS" means the "Centers for Medicare and Medicaid Services."

(e) "ODMH" means the Ohio department of mental health.

(f) "OMB A-87" means the most current version of the office of management and budget circular "A-87, Cost Principles for State, Local, and Indian Tribal Governments". This can be found at the following internet site: <http://www.whitehouse.gov/omb/circulars/index.html>.

(g) "OMB A-122" means the most current version of the office of management and budget circular "A-122, Cost Principles for Non-Profit Organizations". This can be found at the following internet site: <http://www.whitehouse.gov/omb/circulars/index.html>.

(h) "PRM, Part 1" means the most current version of the provider reimbursement manual, part 1 as published by CMS. This can be found at the following internet site: <http://www.cms.hhs.gov/Manuals/PBM/list.asp>.

(i) "SFY" means state fiscal year. This is the time period commencing on July first of any given calendar year and completing on June thirtieth of the following calendar year.

(j) "UCR" means uniform cost report. The form is designated as "ODMH-FIS-047" in appendix A to this rule. When completed on a prospective basis using budget cost information for a SFY, it is considered a budgeted UCR. When completed on a retrospective basis using actual cost information for a SFY, it is considered an actual UCR.

(k) "UFMS" means uniform financial management system. Appendix A of this rule in its entirety, including the UCR.

(l) "UPI" means unique provider identification number. This number represents an ODMH certified community mental health agency and owner (indicated by a single federal tax identification number) operating at a discrete physical location.

(B) Beginning with SFY 2012 cost reporting, the principles set forth in this rule are applicable to all UCRs filed with ODMH for the purpose of reporting costs associated with providing mental health services as defined in Chapter 5122-29 of the Administrative Code. All UCRs must be completed by utilizing generally accepted accounting principles and all costs must be allocated, either directly or indirectly, to the services that benefit from the cost.

(C) All mental health agencies must use the uniform cost report to report all costs associated with providing mental health services regardless of anticipated or actual payor source(s).

(1) The three options for completion and filing of UCRs are:

- (a) By discrete UPIs;
- (b) By bundling costs from multiple physical locations and reporting these under a single UPI; or
- (c) At the corporate level by reporting all service costs associated with multiple physical locations under a single UPI and federal tax identification number combination.
- (D) Any community mental health agency not receiving funding from an ADAMHS board, a CMH board, or directly from ODMH, may file the following statement in lieu of an actual UCR:
- "I do hereby certify that my agency has not received any funding from an ADAMHS board, a CMH board, or directly from ODMH, in the past SFY and am filing this statement in lieu of an actual UCR."
- This statement must be submitted on agency letterhead and signed by the agency director.
- (E) All programs must file an actual UCR or the statement in lieu of an actual UCR with ODMH within one hundred eighty days of the close of a SFY. Any ODMH certified CMH agency failing to file an actual UCR or the statement in lieu of an actual UCR with ODMH, and sending a copy to the local ADAMHS/CMH board in which the agency's primary place of business is located, within one hundred eighty days after the close of a SFY may have its ODMH certification status terminated in accordance with rule [5122-25-07](#) of the Administrative Code.
- (F) When an incomplete or inadequate actual UCR is filed with ODMH within the prescribed time period, ODMH will notify the ODMH certified CMH agency of the discrepancy(ies) and send a copy of the notification to the local ADAMHS/CMH board in which the agency's primary place of business is located. The ODMH certified CMH agency has forty-five days from the date of the notification of the discrepancy(ies) to re-file a complete and adequate UCR with ODMH, including sending a copy to the local ADAMHS/CMH board in which the agency's primary place of business is located. Failure to re-file a complete and adequate UCR may result in ODMH proposing that the agency's certification status be terminated in accordance with rule [5122-25-07](#) of the Administrative Code.
- (G) All cost data must be reported using the accrual basis of accounting.
- (H) Cost categories
- (1) Allowable costs – for privately owned and/or operated not-for-profit programs, allowable costs shall be determined in accordance with 42 CFR 413 and OMB A-122 . For governmentally owned and/or operated programs, allowable costs shall be determined in accordance with 42 CFR 413 and OMB A-87 . For privately owned and/or operated for-profit programs, allowable costs shall be determined in accordance with 42 CFR 413 and the PRM, Part 1.
- (2) Unallowable costs – for privately owned and/or operated not for profit programs, unallowable costs shall be determined in accordance with 42 CFR 413 and OMB A-122 . For governmentally owned and/or operated programs, unallowable costs shall be determined in accordance with 42 CFR 413 and OMB A-87 . For privately owned and/or operated for-profit programs, unallowable costs shall be determined in accordance with 42 CFR 413 and the PRM, Part 1.
- (3) Direct service personnel costs – direct service personnel costs shall represent the full salary and benefit costs of those personnel who provide direct services to the clients.
- (4) Support service personnel costs – support service personnel costs shall represent the full salary and benefit costs of those personnel who directly support a specific mental health service or services.
- (5) Nonpersonnel costs – are those costs necessary for, and allocated to, specific direct services.

(6) Administrative overhead costs – administrative overhead costs are those personnel and nonpersonnel costs that benefit the agency as a whole and cannot be allocated to a specific service or services.

(I) An actual UCR must be audited in accordance with the UCR audit requirements and procedures as set forth in rules established by ODMH.

(J) Certified CMH agencies must keep all actual UCRs and the supporting documentation necessary to fully disclose the extent of services provided and costs associated with providing those services for a period of seven SFYs from the date a service is rendered, or until all financial reporting obligations which or rely upon include data contained in the UCR and/or the supporting documentation have been completed, whichever is longer.

[Click to view Appendix](#)

Effective: 07/01/2012

R.C. [119.032](#) review dates: 12/30/2011 and 07/01/2017

Promulgated Under: [119.03](#)

Statutory Authority: [5119.61\(A\)](#), [5119.611\(C\)](#)

Rule Amplifies: [5119.61\(A\)](#), [5119.611\(C\)](#)

Prior Effective Dates: 7/22/04, 2/24/05, 7/1/05, 01/09/2006

5122-26-19

Appendix A-1

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Form A-1 Uniform Cost Report (UCR) DMH-FIS-047

MACSIS UPL Reporting Period: From To

Agency Name : Budget Actual Agency Address: Agency Telephone No: Owner Federal Tax I.D. Number:

Table with 12 columns: 1. Type of Service, 2. HCPCS / Procedure Code, 3. Unit Definition, 4. No. of Units, 5-6. Personnel Costs (Direct Support Service (A/B)), 7. Non-Personnel Costs, 8. Service Total Costs, 9. \$ Allocation of Admin. Overhead, 10. Total Costs, 11. Cost/ Unit, 12. Unallowable Costs, 13. Total Allowable Cost, 14. Allowable Cost/Unit

I certify that this UCR and all supporting documentation (including Forms A-2, A-3 and A-4 or their equivalents) have been completed in accordance with OAC 5122-26-19

Name/Title: Date:

**Mental Health Services
 PERSONNEL SERVICES COSTS WORKSHEET**

Agency Name and MACSIS UPI:	Prepared By:
	Date:

Column 1 Position Title	Column 2 Position Number (optional)	Column 3 Annual Salary/Wages/Fringe	Column 4 Annual Hours	Column 5 (a) Service: Administration				Column 5 (a) Service:					
				DIRECT SERVICE		SUPPORT SERVICE		DIRECT SERVICE		SUPPORT SERVICE			
				(b) COST	(c) HOURS	(d) COST	(e) HOURS	(b) COST	(c) HOURS	(d) COST	(e) HOURS		
TOTALS													

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Appendix

1

FORM A-4
MENTAL HEALTH SERVICES
ADMINISTRATIVE OVERHEAD
COST DISTRIBUTION WORKSHEET

Agency Name and MACSIS UPI:	Prepared by:
	Date:

Step 1:
Determine Base

Step 2:
Calculate % of Base per
service/total Base

Step 3:
Column 3 multiplied by total
Administration costs from UCR, column 6
Transfer administration allocation result
by service to UCR column 7

Column 1	Column 2	Column 3	Column 4	Column 5
TYPE OF SERVICE	BASE VALUE FOR EACH SERVICE	% OF TOTAL BASE	TOTAL ADMINISTRATION ALLOCATION	UNALLOWABLE ALLOCATION
TOTALS				

- CHECK METHOD USED:**
- Service Total Costs () UCR Column 6
 - Direct Service Personnel Costs () UCR Column 4 (a)
 - Total Personnel Costs () UCR Column 4 (a)+4 (b)
 - Total Direct Service FTEs () UCR Column 3 (a)
 - Total Direct and Support FTEs () UCR Column 3 (a) + 3 (b)

5122-26-19

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Appendix A
Ohio Department of Mental Health
Uniform Cost Reporting

I. INTRODUCTION

The purpose of this appendix is to detail the cost finding principles that must be followed when a UCR is being completed. Also included are the recommended forms to be used when completing a UCR and the format in which the UCR must be submitted. This appendix will provide instructions for the proper completion of all forms.

The UCR has been designed to report all costs, regardless of payor/program. When costs associated with a particular service (e.g., room and board) benefit multiple programs, an allocation methodology must be used to prevent duplicating reporting of those costs. For example, a program provides room and board service to children. If, historically, 25% of those children received the room and board service as part of a mental health residential program and 75% of those children received the room and board service through the Title IV-E program, then when completing a UCR, 25% of the room and board service costs and units should be reported on the mental health service line and 75% of the room and board service costs should be reported on the Title IV-E services line.

II. GENERAL PRINCIPLE

“Form A-1, Uniform Cost Report (UCR)” is the summary of the entire cost reporting process. The UCR has been designed to calculate an allowable cost of providing a unit of service. This is found in column 12. The following represents the formula for this calculation for each service being expensed:

Allowable Cost per Unit (Column 12) =

Total Allowable Costs (column 11)
Divided by the Number of Units (column 2)

III. INSTRUCTIONS

A. Reporting Service Volume, (i.e. number of units by service).

The cost reporting process is essentially composed of two separate components which include the proper allocation of all Agency

costs into the various service categories, and the documentation of service volume, (i.e. the type of services and the number of units for each service type), that were produced by the allocated costs.

Types of Services – All mental health services provided by an agency and funded by public funds must be certified by ODMH. The services that are subject to certification are defined in O.A.C. Section 5122-29 and are listed in column 1 of the DMH-FIS-047. This report also contains a place where non-mental health services (e.g. Alcohol and Drug Addiction Services, Title IV-E services, etc.), should be reported.

Unit Definitions – On the DMH-FIS-047, the duration of the units for each service is located to the right of the “type of service”, and “procedure code” columns.

The first step in completing a UCR is to document the number of service units anticipated to be provided or actually provided for each service during the SFY the UCR is covering.

When completing a budgeted UCR, the units are established according to historical data in conjunction with service planning activities. These unit totals should be entered into column 2 “number of units” of the UCR.

When completing an actual UCR, it is recommended that all mental health agencies have a management information system that tracks the number of units produced (by service) throughout the SFY regardless of the anticipated or actual payor source of the units in order to produce a report that documents the total number of units for all service types provided in the SFY being expensed. The results of this report should be entered into column 2 “number of ~~unit~~ units” of the UCR.

B. Determining and Allocating Direct Service Costs, Support Service Costs and Administrative Personnel Costs

1. General information

[When completing a UCR, either budget or actual, all cost information should be rounded to the nearest hundredth \(penny\).](#)

Payroll information, or other supporting documentation, must be able to capture and allocate personnel costs into the following cost categories:

Direct Service Personnel Costs – Direct service personnel costs shall represent the full salary and benefit cost of those personnel who provide direct services to the clients. The costs would include the total paid time for each position, minus the value of any time allocated to the provision of clinical supervision, program oversight or administration, or quality assurance by a clinician who has primary or significant responsibility in these areas (which are items that require the expertise of a licensed clinical person; but which also represent staff time that is not available for direct client care). Total paid time includes that time spent in delivering a unit of service as well as the time for that position which may be devoted to paperwork, vacation, meetings, etc.

Support Service Personnel Costs – Support service personnel costs are those personnel costs that directly support a specific mental health service or services. Examples of these costs include, but are not limited to, clerical staff for a partial hospitalization program, or dietary staff for a residential care facility. Support service personnel costs also include the value of any direct care staff time allocated to the provision of clinical supervision, program oversight or administration, or quality assurance by a clinician who has primary or significant responsibility in these areas.

Administrative Overhead Costs - Administrative overhead costs are those personnel and nonpersonnel costs that benefit the agency as whole and can not be allocated to a specific service or services. Examples of administrative overhead costs specific to personnel include, but are not limited to, the personnel costs of the chief financial officer and the personnel costs of the maintenance staff for the entire agency.

These personnel cost categories are defined in paragraphs (H)(3), (H)(4), and (H)(6) of this rule.

In addition to separating the costs into the above cost categories, the payroll documentation must also accurately allocate the Direct Service Personnel Costs and Support Service Personnel Costs among the various mental health services for the SFY being expensed.

2. Personnel Services Costs Worksheet, Form A-2

The “Mental Health Services Personnel Services Costs Worksheet”, Form A-2 of this appendix or its equivalent (e.g., a spreadsheet containing the same information), must be completed for the reporting and allocating of all personnel costs during the SFY being expensed.

This form provides a method for allocating personnel time and costs among the direct and support service categories for all services being expensed. Note that at this step in the reporting of the costs, the administrative personnel hours and costs are treated in the same manner as Support Service costs.

3. Instructions for completion of Form A-2

When completing Form A-2 for budgeting purposes, historical payroll and contract service records should be used to create the report. When completing Form A-2 for actual purposes, the actual payroll and contract service records for the SFY being expensed should be used.

From payroll and contract service records, it is recommended a report be produced that accounts for total incurred costs and hours paid for each employee. The total personnel costs must agree with the financial statements and will be used to verify that all costs have been allocated among the various cost categories in the cost reporting process.

From either the report referenced above, or some other supporting documentation, the hours and costs of each employee must be separated into direct service or support service hours and costs (as defined in paragraphs (H)(3) and (H)(4) of this rule) remembering

that administrative personnel costs must be classified as support service costs at this point in the cost reporting process.

The next step is that all direct and support hours paid and costs incurred are required to be further allocated to the various services that are included in the cost report.

Once this information has been documented, complete Form A-2 by following these steps:

The position title of each employee is entered into column 1 of Form A-2. If there are multiples of the same position, enter the position title as many times as necessary (i.e. If there are three community psychiatric supportive treatment workers, enter community psychiatric supportive treatment workers on three rows in column 1.)

The agency must keep sufficient documentation to be able to track each "position title" to a specific employee and that employee's payroll records.

Column 2 is ~~optional and, if used, must reflect the position number or other internal position identification number~~ [the minimum educational level necessary to perform the duties of the position. Acceptable entries are: ND for non-degreed; B for a Bachelor's Degree; M for a Master's Degree; and PH.D for a Doctoral Degree.](#)

Utilizing a report that accounts for total incurred costs and hours paid for each employee for the SFY being expensed, the total incurred personnel costs, including fringe benefits is entered into column 3 for each position listed.

Utilizing the payroll records for the SFY being expensed, enter the total hours, including overtime, to be paid or actually paid (calculated using the accrual method of accounting) for each position into column 4.

For each service that is being expensed, place the name of the service at the top of a separate column 5. These names must match the service names in column 1 of the UCR. Make as many column 5s as are necessary for the services

being expensed, including administration as a service.

The total costs, [unallowable costs, and allowable costs](#) and the total hours should be allocated among the various services by cost category, (i.e. direct service or support service). Be certain that all of the hours and all of the costs have been allocated.

The final step in the completion of Form A-2 is to sum columns 3, 4, and the ~~four~~ [eight sub](#) columns in all column 5s. Place these sums in the appropriate space on the “TOTALS” row.

4. Reporting of Personnel hours and costs on the UCR

The sum of column 3 of Form A-2 represents the total personnel costs and must balance to the financial statements. The sum of column 4 of Form A-2 divided by the total hours (using the accrual method of accounting) a FTE should work during the SFY being expensed, represents the total FTEs and must equal the sum of columns 3 (a) and (b) of the “AGENCY TOTAL” row on the UCR.

The sum of the [total](#) costs for each direct service (column 5, sub column (b) of Form A-2) is transferred to the appropriate column 4, sub column (a) of the UCR.

The sum of the [total](#) costs for each support service (column 5, sub column ~~(d)~~ [\(f\)](#) of Form A-2) is transferred to appropriate column 4, sub column (b) of the UCR.

The sum of the hours for the direct (each column 5, sub column [e](#)) of Form A-2) service is divided by the total hours (using the accrual method of accounting) a FTE should work during the SFY being reported and the resulting FTE amount is transferred to column 3, sub column (a) of the appropriate service on the UCR.

The sum of the hours for the support (each column 5, sub column ~~(e)~~ [\(i\)](#) of Form A-2) service for each service (column 5) is divided by the total hours (using the accrual method of accounting) a FTE should work during the SFY, being reported and the resulting FTE

amount is transferred to column 3 sub column (b) of the appropriate service on the UCR.

C. Determining and Allocating Non-personnel Costs

After allocating all personnel costs among the various services, the non-personnel costs must be determined and allocated among the services. Non-personnel costs are those costs defined in paragraph (H) 5 of this rule. An example of this type of cost includes, but is not limited to, the cost of supplies needed for the delivery of a partial hospitalization service. These costs also include those costs which benefit the agency as a whole and can not be directly allocated to one or more services. An example of this type of non-personnel costs includes, but is not limited to, utility costs that are allocated to all services on the basis of square footage. Non-personnel costs must be allocated to the services that they benefit.

1. Allocation Methods for Non-personnel Costs

Direct Allocation – This method is used when the entire cost category benefits one service. An example of a direct allocation is the depreciation costs of a van that is used exclusively for a partial hospitalization service. In this case, the entire cost of the depreciation must be allocated to the partial hospitalization service and must not be shared among any of the other services.

Allocation by square footage – This method is used in the allocation of non-personnel costs that are driven by the physical area that a service utilizes. Examples of these types of non-personnel costs are utility and maintenance related costs. When this type of allocation base is used, the physical area of the facility that is used by each service, including administration, must be documented in square feet. The percentage of the square footage for each service is multiplied by the total non-personnel cost for that cost category and the result will be that service's allocated cost for that category.

Allocation by total FTEs assigned to each service – This allocation base is used for non-personnel costs that are driven by staff usage. An example where this allocation base is used is the costs of general office supplies. When this allocation base is used, columns 3 (a) and 3 (b) of the UCR should be summed for each service and

the resulting percentage of the total FTEs must be multiplied by the total cost of that non-personnel item of expense, such as office supplies, to arrive at each service's allocation of these costs.

Allocation by Direct Service FTEs assigned to each service - This allocation base is used for non-personnel costs that are driven by direct care staff usage. An example where this allocation base is used is the costs of clinical liability insurance. When this allocation base is used, the percentage of column 3(b) of the UCR compared to the total direct care FTEs on the UCR for each service must be multiplied by the total cost of that non-personnel item of expense, such as liability insurance, to arrive at each service's allocation of these costs.

Allocation by the Number of Units Produced for each service - This allocation base is used for non-personnel costs that are driven by units produced for each service. An example where this allocation base is used is the non-personnel claims processing costs. When this allocation base is used, the percentage of the units documented in column 2 of the UCR for each service is multiplied by the total cost of that non-personnel cost category, such as claims processing costs, to arrive at each service's allocation of these costs.

2. Non-personnel Cost ~~Report~~ [Worksheet](#), Form A-3

The "Mental Health Services Non-personnel Costs ~~Report~~ [Worksheet](#)", Form A-3 of this appendix or its equivalent (e.g., a spreadsheet containing the same information), must be completed for the reporting and allocating of all non-personnel costs anticipated to be incurred or actually incurred during the SFY being expensed.

This form provides documentation of the method or methods used for allocating non-personnel costs for all services being expensed including "administration" as a service.

3. Instructions for the completion of Form A-3

The first step is to obtain [all](#) cost information concerning all service non-personnel costs, and combine the costs into like

categories, (e.g. natural gas costs, electric costs, liability insurance costs, etc.). The ~~Objects~~ objects of expense are documented in column 1 “object of expense” of Form A-3.

These costs must be separated into allowable and unallowable categories in order to complete form A-3.

The total costs identified for each object of expense documented in column 1 must be entered into the appropriate column 4 of Form A-3.

Once the method of allocation (i.e. the allocation base) has been determined for each object of expense, document this in column 2 of Form A-3.

For each service being expensed on the uniform cost report, including administration, a separate column 3, including sub columns (a), (b), and (c) must be made on Form A-3 and the name of the each service must be placed at the top of each column 3 of Form A-3. These service names must match the service taxonomy located in column 1 of the UCR.

The allocated unallowable and allowable costs, using calculations defined above must then be placed into the appropriate sub columns (b) and (c) of each column 3 on form A-3. Each sub column (b) and (c), by object of expense, is then summed and entered in the appropriate sub column (a) of each column 3.

Once all ~~necessary~~ sub columns (a), (b) and (c) of each column 3s have been completed for all appropriate objects of expense, sum the total, unallowable and allowable costs, including administration, by object of expense and compare the resulting number to column 4 “Object of Expense Total” to ensure they are the same.

Each sub column (a), (b), and (c) of all column 3s and column 4 should then be summed and the resulting number documented in the “totals” row.

4. Reporting of Non-personnel Costs on the UCR

The totals documented [in each sub column \(a\) of each column \(3\)](#) on Form A-3 must be transferred to the appropriate row, by service taxonomy, in column 5 “service non-personnel costs” of the UCR.

D. Determining Service Total Costs

Columns 2 through 5 of the UCR have been completed. The values in columns 4 (a), 4 (b) and 5 should be summed by service and the total for each service placed in the appropriate place of column 6 “service total costs” of the UCR.

E. Determining And Allocating Administrative Overhead Costs

1. General Information

The purpose of this step is to equitably allocate all administrative overhead costs among the various mental health services as well as non-mental health services, (e.g. alcohol and other drug services, Title IV-E services, etc.). Up to this point, personnel and non-personnel costs have been allocated to administrative overhead as a discrete service as well as the other mental health services. The personnel and non-personnel costs that were allocated to administrative overhead have been documented on the UCR in the row titled “administrative overhead”. Columns 4 (b) and 5 of the “administrative overhead” row need to be summed and the result placed in column 6 of the “administrative overhead” row on the UCR.

2. Administrative Overhead Cost Distribution Worksheet, Form A-4

The “Administrative Overhead Cost Distribution Worksheet”, Form A-4 of this appendix or its equivalent (e.g., a spreadsheet containing the same information), must be completed for the reporting and allocation of all administrative costs anticipated to be incurred or actually incurred during the SFY being expensed.

This form provides documentation of the method used for allocating administrative costs among the services.

3. Instructions for the completion of the “Administrative Overhead Cost Distribution Worksheet”, Form A-4.

In column 1 “type of service”, enter the names of all mental health services that contain a value in column 6 of the UCR. The number of and names of the services reported on Form A-4 must be identical to those found in column 1 of the UCR.

At this point, decide which allocation base will be used for the distribution of all administrative overhead costs across all services being expensed. The only acceptable allocation bases are:

Service Total Costs, (column 6 of the UCR)
Direct Service Personnel Costs, (column 4a of the UCR)
Total Personnel Costs, (columns 4a plus 4b of the UCR)
Total Direct Service FTEs, (column 3a of the UCR)
Total Direct and Support FTEs, (columns 3a plus 3b of the UCR)

Place a check mark in the appropriate place on the bottom of Form A-4 in the “check method used” area.

The allocation base for each service must be entered into column 2 “base value for each service” of Form A-4. For example, if the allocation base used is service total costs, the values in column 6 of the UCR are entered into column 2 for each service on Form A-4.

Column 2 is then summed and the result entered in the “totals” row of Form A-4.

For each service in column 1, the value in column 2 is divided by the value in column 2 in the “totals” row. The result of this calculation is a percentage of the total and is placed in column 3 “% of total base”. For example, if the value in column 2 is \$25,000 for assessment, and the sum of column 2 is \$100,000, then the percent of the total allocation is .25 (25,000 divided by 100,000). The values in column 3 should be rounded to two decimal points.

Column 3 is summed and the result must be 1.00. If not, the calculations must be rechecked.

At this point, the total administrative overhead costs, (found in column 6 in the “administrative overhead” row of the UCR) ~~are~~ is entered in the “totals” row of column 4.

The total administration value found at the bottom of column 4 should be multiplied by each value in column 3. The result is entered into the appropriate service row of column 4. For example, if the percent of total allocation for mental health assessment is .25 and the total administration is \$100,000, then the administration allocation for mental health assessment is \$25,000. The amount of \$25,000 would be entered in column 4 “administration allocation” of the mental health assessment row on form A-4.

All Column 4 values should be totaled to verify that the sum is equal to the amount previously entered in the “totals” row of column 4. If not, the calculations must be rechecked.

Column 5 is now to be completed. The value from the “totals” row of form A-3, column 3, service: administration, sub column (b) and the value from the “totals” row of form A-2, column 5, (a) service: administration, sub column (g) are summed together and the resulting value is entered into the “Totals” row of column 5. This total unallowable allocation should be multiplied by each value in column 3. The result is entered into the appropriate service row of column 5.

All column 5 values should be totaled to verify that the sum is equal to the amount previously entered in the “Totals” row of column 5. If not, the calculations must be rechecked.

~~Finally, the~~ The values in column 4 of Form A-4 are transferred to the appropriate column 7 of the UCR and the values in column 5 of form A-4 are transferred to the appropriate column 10 of the UCR.

F. Calculating Total Costs for Each Service on the UCR

The total costs for a service is calculated by adding the value in column 6 “service total costs” and the value in column 7 “allocation of administrative overhead”. The sum is entered into column 8 “total costs”.

G. Calculating the Cost Per Unit of Each Service on the UCR.

For each service being expensed on the UCR, the total costs in column 8

must be divided by the number of units in column 2. This results in a cost per unit for each service and this value is entered in column 9 “cost per unit” of the UCR.

~~H. Identification and Documentation of Unallowable Costs:~~

~~For each service being expensed on the UCR, any unallowable costs as defined in this rule must be documented in column 10 of the service in which the unallowable cost was originally allocated. After all such costs are documented and placed in column 10, the column should be summed.~~

~~H.~~ H. Calculating the Total Allowable Costs

For each service being expensed which has documented unallowable costs, subtract the amount in column 10 from the amount in column 8. This results in a total allowable cost and this value is entered in column 11 “total allowable costs” of the UCR.

For each service being expensed, which has no documented unallowable costs, enter the value from column 8 in column 11.

~~H.~~ H. ~~I.~~ I. Calculating The Allowable Cost Per Unit Of Service

For each service being expensed on the UCR, the total allowable costs in column 11 must be divided by the number of units in column 2. This results in an allowable cost per unit for each service and this value is entered in column 12 “allowable cost per unit” of the UCR.

~~K.~~ J. Reporting Of Costs For “Other” In The Service Taxonomy

The following four services are considered as “Other” in the ODMH Service Taxonomy:

Administrative Overhead – This represents administrative costs that benefit the agency as whole and can not be allocated to a specific service or services.

Ohio Department of Alcohol and Drug Addiction Services – This represents the total costs associated with alcohol and other drug services.

These values should exactly match the values in the “Total for AoD Services” service line of the ODADAS-FIS-047.

Title IV-E Services – This represents costs associated with all services provided under the Title IV-E program. Costs reported in columns 4a, 4b, 5 and 7 of the UCR must exactly match the costs as reported on the JFS 02911, Total Agency Cost-Summary” IV-E service line.

Other non-Mental Health/AoD/IV-E Services – This represents costs associated with any services not already classified.

L.K. Totals for MH services

In each area indicated in this row, total all values entered into each column excluding the values for “Administrative Overhead, “~~ODADAS~~” [“Ohio Department of Alcohol and Drug Addiction Services”](#), “Title IV-E Services” and “Non MH/AOD/Title IV-E Services”. This will report the total column values for all MH specific services.

M.L. Totals for Agency

In each area indicated in this row, total all values entered into each column including the values for “Administrative Overhead, “~~ODADAS~~” [“Ohio Department of Alcohol and Drug Addiction Services”](#), “Title IV-E Services” and “Non MH/AOD/Title IV-E Services”. This will report the total column values for all services.

5122-26-19.1 Actual uniform cost report (AUCR) agreed upon procedures and report submission requirement.

(A) This rule establishes the requirement for each Ohio department of mental health (ODMH) certified community mental health (CMH) agency required to submit an actual uniform cost report (AUCR) in accordance with rule [5122-26-19](#) of the Administrative Code to have the AUCR examined by an independent audit firm using the agreed upon procedures contained in the appendix to this rule prior to submission to ODMH. The ODMH certified CMH agency shall assure any recommendations contained in the agreed upon procedures report are made and a new original AUCR is completed and submitted.

(B) The CMH agency shall submit the following to ODMH within one hundred eighty days after the end of a state fiscal year (SFY):

(1) The originally prepared AUCR which was completed prior to the agreed upon procedures review and in accordance with rule [5122-26-19](#) of the Administrative Code;

(2) A copy of the agreed upon procedures review report completed in accordance with the appendix to this rule and issued by the independent audit firm; and

(3) A new original AUCR adjusted based upon the recommendations of the independent audit firm as documented in the agreed upon procedures review report. If there are no recommendations in the agreed upon procedures review report, then only the requirements of paragraphs (B)(1) and (B)(2) of this rule shall be met.

(C) A CMH agency reporting costs on the AUCR's "Ohio Department of Alcohol and Drug Addiction Services" line will also need to submit a copy of its information as required in rule [3793:2-1-10](#) of the Administrative Code.

(D) A CMH agency that is also subject to rule [5101:2-47-26.2](#) of the Administrative Code may submit the information required in paragraph (C)(2) of rule 5101:2-47-26.2 of the Administrative Code in place of the information required by paragraph (B) of this rule with the following exception: the CMH agency is responsible for complying with the requirements of paragraph (B)(3) of this rule.

(E) The CMH agency shall send the AUCR agreed upon procedures report and, if applicable, the new, original AUCR to the Ohio department of mental health. A copy of the documents in paragraph (B) of this rule shall be sent to the local alcohol, drug addiction and mental health services or mental health board where the agency's primary place of business is located.

[Click to view Appendix](#)

Effective: 07/01/2012

R.C. [119.032](#) review dates: 12/30/2011 and 07/01/2017

Promulgated Under: [119.03](#)

Statutory Authority: [5119.61\(A\)](#), [5119.611\(C\)](#)

Rule Amplifies: [5119.61\(A\)](#), [5119.611\(C\)](#)

Prior Effective Dates: 06/30/2006

5122-26-19.1

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Appendix

Actual Uniform Cost Report (AUCR) Agreed Upon Procedures and Report Submission Requirement

(A) An independent public accounting (IPA) firm shall use the following procedures when performing an Actual Uniform Cost Report (AUCR) in order to:

- (1) report on the accuracy of the data reported on the AUCR;
- (2) report on the allocation methods used for actual cost reporting;
- (3) report on the allowability and unallowability of the cost data reported on the AUCR;
- (4) determine if the data reported on the AUCR is in accordance with the applicable federal and state resources as stated in rule 5122-26-19 of the Administrative Code, as in effect for the State Fiscal Year (SFY) being reported; and
- (5) report on the consistency between the first budget uniform cost report (BUCR) and the AUCR.

(B) Work completed in other areas or during other agreed upon procedures reviews may be used to satisfy these procedures as long as it is documented by the independent audit firm how the work satisfies these procedures. Work completed during a review required by rule 5101:2-47-26.2 of the Ohio Administrative may be used for completing the review required by this rule. If reliance is placed upon work completed by an independent audit firm from another engagement, such as an Office of Management and Budget (OMB) circular A-133 audit, a financial statement audit, or other such audit or review, or some other auditor's work, it must be documented in the [AUCR](#) agreed upon procedures report required by this rule, how the work being relied upon meets the requirements contained in these procedures.

(C) If it is available, the previous SFY AUCR, AUCR report, and independent financial audit report are to be reviewed to determine if any management comments and/or findings will impact the current actual uniform cost report data.

(D) Obtain and inspect the program's chart of accounts, including all revenue and expense accounts.

(E) Obtain and ~~inspect~~ [review](#) a copy of rule 5122-26-19 of the Administrative Code as in effect for the SFY AUCR being reviewed.

(F) Obtain and inspect the first BUCR and all supporting documentation.

(G) Agreed Upon Procedures

(1) Procedure One – Mathematical Accuracy Testing

(a) Obtain a reconciliation of the total costs reported on the AUCR to the general ledger and/or the independent audited financial statements for the SFY being verified. Compare the amounts listed on the reconciliation to the amounts listed on the general ledger and/or the independent audited financial statements for the SFY being verified. Identify and document any material variances (variances greater than plus or minus two percent) and obtain management's explanation of the material variance(s) for inclusion in the actual uniform cost report agreed upon procedures (AUP) report.

(b) For and by each service with costs being reported on the AUCR:

(i) sum the values reported in columns 4[\(a\)](#), 4**(b)** and 5 to verify the result is equal to the value reported in the corresponding column 6;

(ii) sum the values reported in columns 6 and 7 to verify the result is equal to the value reported in the corresponding column 8;

(iii) verify the value reported in column 9 is equal to the result of dividing the value in column 9 by the value in column 2;

(iv) verify the value reported in column 11 is equal to the result of subtracting the value in column 10 from the value in column 8;

(v) verify the value reported in column 12 is equal to the result of dividing the value in column 11 by the value in column 2;

(vi) verify the values reported in the "Total MH Services" are equal to the sum of the values reported in the corresponding column [excluding the values for "Administrative Overhead", "Ohio Department of Alcohol and Drug Addiction Services",](#)

“Title IV-E Services” and “Other Non-Mental Health/AoD/IV-E Services”; and

(vii) verify the values reported in the “Agency Total” are equal to the sum of the values reported in the corresponding column excluding “Total MH Services”.

(2) Procedure Two – Personnel Costs Verification

(a) Compare the personnel costs reported in ~~column~~ columns 4(a) and 4(b) of the AUCR to the salaries, wages, and fringe benefits reported on the independently audited financial statements or Federal Internal Revenue Service Employer Form 941 for the SFY. Identify and document any material variances (variances greater than plus or minus two percent) and obtain management’s explanation of the material variance(s) for inclusion in the actual uniform cost report agreed upon procedures (AUP) report.

(b) From the personnel costs reported in column 4 of the AUCR, select ten employees whose personnel costs roll-up to those costs. Either for one pay period or on the year end totals, perform the following procedures on the sample by inspecting the following supporting documentation:

(i) compare the costs for allowability and unallowability as defined in ~~sections~~ paragraphs (H)(1) and (H)(2) ~~of paragraph (H) of rule~~ 5122-26-19 of the Administrative Code;

(ii) compare the allocation methods used to determine whether the costs are documented as direct service (column 4a) or support service (column 4b) costs;

(iii) compare the allocation methods used to determine which service personnel costs have been allocated to;

(iv) verify any unallowable costs are allocated in the same manner they were originally allocated and are documented accordingly on Form A-2 and in the appropriate service row of column 10 of the AUCR; and

(v) identify and document any material variances (variances greater than plus or minus two percent) and obtain management’s

explanation of the material variance(s) for inclusion in the ~~actual uniform cost report~~ [AUCR](#) agreed upon procedures (AUP) report.

(3) Procedure Three – Non-Personnel Costs Verification

(a) From the non-personnel costs reported in column 5 of the AUCR, select a haphazard sample (as defined in the American Institute of Certified Public Accountants audit sampling guide); of checks and/or electronic funds transfer (EFT) disbursements, equal to twenty percent or forty checks and/or EFT disbursements, whichever is less. Perform the following procedures on each selected check or EFT disbursement:

(i) compare the costs the check or EFT disbursement is for to the appropriate allowability or unallowability criteria listed in ~~sections paragraphs (H)(1) and (H)(2) of paragraph (H) of rule 5122-26-19 of the Administrative Code;~~ [paragraphs \(H\)\(1\) and \(H\)\(2\)](#) of ~~paragraph (H) of rule 5122-26-19 of the Administrative Code;~~

(ii) verify the allocation method or methods used for the sampled non-personnel costs have been made in accordance with the procedures outlined in the Appendix to rule 5122-26-19 of the Administrative Code;

(iii) verify any unallowable costs are allocated in the same manner as they were originally allocated and are documented in the appropriate service row of column 10 of the AUCR; and

(iv) identify and document any material variances (variances greater than plus or minus two percent) and obtain management's explanation of the material variance(s) for inclusion in the actual uniform cost report agreed upon procedures (AUP) report.

(4) Procedure Four – Administrative Overhead Costs Verification

(a) From the administrative overhead costs reported in column 7 of the AUCR, select a haphazard sample (as defined in the American Institute of Certified Public Accountants audit sampling guide) of checks and/or electronic funds transfer (EFT) disbursements, equal to ten percent or twenty checks and/or EFT disbursements, whichever is less. Perform the following procedures on each selected check or EFT disbursement:

(i) compare the costs the check or EFT disbursement is for to the appropriate allowability or unallowability criteria listed in ~~sections paragraphs (H)(1) and (H)(2) of paragraph (H)~~ paragraphs (H)(1) and (H)(2) of paragraph (H) of rule 5122-26-19 of the Administrative Code;

(ii) determine if the administrative overhead costs were allocated using only one of the allowable methods described in the Appendix to rule 5122-26-19 of the Administrative Code;

(iii) verify that any unallowable costs are allocated in the same manner they were originally allocated and are documented accordingly on Form A-4 and in the appropriate service row of column 10 of the AUCR; and

(iv) identify and document any material variances (variances greater than plus or minus two percent) and obtain management's explanation of the material variance(s) for inclusion in the actual uniform cost report agreed upon procedures (AUP) report.

(5) Procedure Five – Units of Service Verification

(a) From and by each service with costs reported on the AUCR, select a haphazard sample (as defined in the American Institute of Certified Public Accountants audit sampling guide) of the reported units of service, equal to twenty percent or forty total units, whichever is less. Perform the following procedures on the selected units:

(i) verify documentation exists in client records to support the number of units selected ;

(ii) compare the type of service selected to determine it is reported in the appropriate service line of column 2; and

(iii) identify and document any material variances (variances greater than plus or minus two percent) and obtain management's explanation of the material variance(s) for inclusion in the actual uniform cost report agreed upon procedures (AUP) report.

(6) Procedure Six – First BUCR to AUCR Comparison

- (a) Compare the first BUCR to AUCR and verify that the methods of cost reporting selected for the first BUCR are the same as the methods used when completing the AUCR.

(H) Actual Uniform Cost Report Agreed Upon Procedures Report

(1) A written report on the findings of these agreed upon procedures shall be completed by the independent public accounting (IPA) firm for the ~~Ohio Department of Mental Health (ODMH)~~ certified CMH agency to submit to ODMH. The report shall be completed in accordance with the American Institute of Certified Public Accountants Statement on Standards for Attestation Engagements Statement number 11, 12 or its successor, and the work papers shall be completed in accordance with Government Auditing Standards. At a minimum, the report shall include the following:

- (a) [a summary of](#) the procedures performed and the findings;
- (b) a schedule listing the number of variances, if any, per procedure and a list of unallowable costs noted during the agreed upon procedures (AUP);
- (c) the completed copy of the AUCR, including an original signature; and
- (d) any other observations and/or comments of note the auditor, using his/her professional judgment, deems relevant.

(I) The AUCR agreed upon procedures report shall be given to the ODMH certified CMH agency.