



The Florida Senate

Local Funding Initiative Request

Fiscal Year 2024-2025

LFIR # 1458

1. Project Title

2. Senate Sponsor

3. Date of Request

4. Project/Program Description

Short-term residential treatment beds are utilized by individuals with a primary mental health disorder with possible cooccurring issues while they await placement in a state mental health treatment hospital. The funds will be used to contract for the operation of 12 short-term community-based residential treatment beds and community-based services for post discharge. In some instances, individuals who receive treatment in a short-term residential treatment facility may end up being diverted from placement in state hospitals and instead receive treatment in the local community.

5. State Agency to receive requested funds

State Agency contacted?

6. Amount of the Nonrecurring Request for Fiscal Year 2024-2025

| Type of Funding | Amount |
|------------------------------------|------------------|
| Operations | 1,584,000 |
| Fixed Capital Outlay | 0 |
| Total State Funds Requested | 1,584,000 |

7. Total Project Cost for Fiscal Year 2024-2025 (including matching funds available for this project)

| Type of Funding | Amount | Percentage |
|--|------------------|-------------|
| Total State Funds Requested (from question #6) | 1,584,000 | 100% |
| Matching Funds | | |
| Federal | 0 | 0% |
| State (excluding the amount of this request) | 0 | 0% |
| Local | 0 | 0% |
| Other | 0 | 0% |
| Total Project Costs for Fiscal Year 2024-2025 | 1,584,000 | 100% |

8. Has this project previously received state funding?

| Fiscal Year (yyyy-yy) | Amount | | Specific Appropriation # | Vetoed |
|--------------------------|-----------|--------------|-----------------------------|--------|
| | Recurring | Nonrecurring | | |
| 2023-24 | 0 | 1,584,000 | 378 | No |

9. Is future funding likely to be requested?

a. If yes, indicate nonrecurring amount per year.

b. Describe the source of funding that can be used in lieu of state funding.

There is no other funding in lieu of state funding.

10. Has the entity requesting this project received any federal assistance related to the COVID-19 pandemic?



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If yes, indicate the amount of funds received and what the funds were used for.

Complete questions 11 and 12 for Fixed Capital Outlay Projects

11. Status of Construction

a. What is the current phase of the project?

- Planning
 Design
 Construction
 N/A

b. Is the project "shovel ready" (i.e permitted)?

c. What is the estimated start date of construction?

d. What is the estimated completion date of construction?

12. List the owners of the facility to receive, directly or indirectly, any fixed capital outlay funding. Include the relationship between the owners of the facility and the entity.

13. Details on how the requested state funds will be expended

| Spending Category | Description | Amount |
|--|--|------------------|
| Administrative Costs: | | |
| Executive Director/Project Head Salary and Benefits | | 0 |
| Other Salary and Benefits | | 0 |
| Expense/Equipment/Travel/Supplies/Other | | 0 |
| Consultants/Contracted Services/Study | Total funds are contracted through the Managing Entity (CFBHN) with BayCare Behavioral Health - Northside, for the daily operation of the Short Term Residential Facility. | 1,584,000 |
| Operational Costs: Other | | |
| Salary and Benefits | | 0 |
| Expense/Equipment/Travel/Supplies/Other | | 0 |
| Consultants/Contracted Services/Study | | 0 |
| Fixed Capital Construction/Major Renovation: | | |
| Construction/Renovation/Land/Planning Engineering | | 0 |
| Total State Funds Requested (must equal total from question #6) | | 1,584,000 |

14. Program Performance

a. What specific purpose or goal will be achieved by the funds requested?

Continued operational funding for 12 short term residential beds to provide community based care for adults with serious mental health and/or co-occurring issues who are awaiting placement, diversion, or discharge from state hospital placement and/or inpatient hospitalization.

b. What activities and services will be provided to meet the intended purpose of these funds?



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Provision of a secure, intensive behavioral health residential program structured as a therapeutic community 24 hrs. a day, 7 days per week. Without this community placement option, adults experiencing acute/sub-acute crisis would require admission/re-admission to psychiatric hospitalization. Services are provided for approximately 90 days and licensed by the AHCA.

c. What direct services will be provided to citizens by the appropriation project?

Qualified professionals provide medical and behavioral assessments, comprehensive service planning, psychosocial rehabilitation, counseling, psychiatric services, activities of daily living, care coordination for benefits/legal,forensic/employment/ancillary needs, case management, substance use services, and discharge planning.

d. Who is the target population served by this project? How many individuals are expected to be served?

Elderly persons, persons with poor mental and physical health, the homeless and unemployed, as well as current or former incarcerated persons. We expect upwards of 100 individuals to be served.

e. What is the expected benefit or outcome of this project? What is the methodology by which this outcome will be measured?

Program provides safe, therapeutic placement for individuals who may be at risk of homelessness and/or criminal activity. Readmission rates to state hospital or inpatient psychiatric placement will be reduced. The methodology that we will be using to measure the success of this program is to compare pre and post metrics for homelessness, criminal involvement, and jail booking data.

f. What are the suggested penalties that the contracting agency may consider in addition to its standard penalties for failing to meet deliverables or performance measures provided for the contract?

Non compliant deliverables and/or performance measures will be addressed through the managing entity, Central Florida Behavioral Health Network (CFBHN), with detailed corrective action plans.

15. Requester Contact Information

a. First Name **Last Name**

b. Organization

c. E-mail Address

d. Phone Number **Ext.**

16. Recipient Contact Information

a. Organization

b. Municipality and County

c. Organization Type

- For Profit Entity
- Non Profit 501(c)(3)
- Non Profit 501(c)(4)
- Local Entity
- University or College
- Other (please specify)



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d. First Name Last Name
e. E-mail Address
f. Phone Number

17. Lobbyist Contact Information

a. Name
b. Firm Name
c. E-mail Address
d. Phone Number