Quarterly RSS Inventory Reporting Submissions

SCOPE: Data is gathered by each Provider providing peer support services to Adult SMI and GMH/SA populations. The report is to be submitted on the 5th of each quarter and submitted to Mercy RBHA via the SFTP. The information in the reporting must be completed in a timely manner and provide accurate information. The information requested should not be changed, so changing, deleting, or adding columns should be avoided. Should the 5th of the month land on a weekend or holiday, the submission is expected on the first business day after the 5th.

Specific Data Requested RSS Inventory Tab:

1) **Column A**: Name of the provider agency employing the RSS. DO NOT merge cells
2) **Column B**: Name of the site. Give Street address/location at which RSS is employed. DO NOT merge cells
3) **Column C**: Last Name
4) **Column D**: First Name
5) **Column E**: Training program through which the individual was certified (i.e. issuer of the certificate) even if prior to 10/01/2012.
6) **Column F**: MM/DD/YYYY
7) **Column G**: Date of recertification, if applicable. MM/DD/YYYY (All RSS certified prior to 10/01/2012 were required to take a recertification exam. The test is no longer available.) Otherwise put N/A Original date of employment at current agency MM/DD/YYYY
8) **Column H:** Original date of employment at current agency MM/DD/YYYY
9) **Column I:** Initial start date as peer support MM/DD/YYYY
10) **Column J:** Only enter if termination from an agency occurs during reporting periods MM/DD/YYYY
11) **Column K:** Indicate if RSS/PSS is a dedicated PSS role. Y or N.
12) **Column L:** Enter as a percentage (e.g. 75%) of Full-time employment

Specific Data Requested Peer Support Utilization Tab:

1) **Column A:** Name of the provider agency site. **DO NOT** merge cells
2) **Column B**: Location name and Street address for Provider agency site. **DO NOT** merge cells
3) **Column C**: Total number of enrolled adults served at provider agency site receiving services and supports. (Total population)
4) **Column D**: Total number of unique members receiving Peer Support Services (self-help peer support code)
5) **Column E**: Total number of T19 unique members receiving peer support services at the site - had a peer support code in the reporting period
6) **Column F:** Number of NT19 unique members receiving peer support services at the site - had a peer support code in the reporting period
7) **Column G**: Total number of units H0038 billed in the reporting period
8) **Column H:** Total number of units H0038 HQ billed in the reporting period
9) **Column I**: Total number of units H2016 billed in the reporting period
10) **Column J**: Please indicate SMI (Serious Mentally Ill) population being served by placing "x" in box
11) **Column K:** Please indicate GMH (General Mental Health) population being served by placing "x" in box
12) **Column L**: Please indicate Substance Use or "SA" population being served by placing "x" in box
13) **Column M:** Please indciate Children's population being served by placing "x" in box

Specific Data Requested PFRO Referral Tracking *(PFRO Only)* :

1) **Column A:** Name of the peer and/or Family Run organization to which the referral was made **(your agency should be listed here)**
2) **Column B:** Name of the agency from which the referral originated **(This would typically be the provider agency)**
3) **Column C:** Total number of referrals made between the two organizations listed
4) **Column D:** Total number of completed referrals **(had all required information)** from agency in Column B to Agency in Column A
5) **Column E:** Total number of referrals for Title 19 Members
6) **Column F:** Total number of referrals for NTXIX members
7) **Column G:** Number of referrals for Adult Members
8) **Column H:** Number of referrals for Child Members
9) **Column I:** Number of referrals utilizing the Peer Support/self-help codes (H0038, H0038-HQ and H2016)
10) **Column J:** Total number of referrals for the Family Support code (S5110)

Specific Data Requested Credentialed Parent and Family Support Inventory Tab:

1) **Column A**: Name of the provider agency employing the Parent Family Support Partner. DO NOT merge cells
2) **Column B**: Name of the site. Give Street address/location at which the Parent Family Support Partner is employed. DO NOT merge cells
3) **Column C:** Last Name
4) **Column D:** First Name
5) **Column E:** Training program through which the individual was certified (i.e. issuer of the certificate).
6) **Column F:** MM/DD/YYYY
8) **Column G:** Original date of employment at current agency MM/DD/YYYY
10) **Column H:** Only enter if termination from an agency occurs during reporting periods MM/DD/YYYY
11) **Column I:** Indicate if PFSP is a dedicated PFSP role. Y or N.
12) **Column J:** Enter Y or N for 32 hr week or more Full-time employment

Specific Data Requested Children Family Support Utilization Tab:

1) **Column A:** Name of the provider agency site. **DO NOT** merge cells
2) **Column B**: Location name and Street address for Provider agency site. **DO NOT** merge cells
3) **Column C**: Total number of all enrolled children served at provider agency site with an open episode of care
4) **Column D**: Total number of children with Title 19 status who receive family support services at this site
5) **Column E:** Total number of children with CMDP status who receive family support services at this site
6) **Column F:** Total number of children with Title 21 status who receive family support services at this site
7) **Column G**: Total number of units S5110 billed in the reporting period
8) **Column H**: Total number of units S5110 GT billed in the reporting period
9) **Column I**: Total number of units S5110 HQ billed in the reporting period
10) **Column J**: Total number of units S5110 CG billed in the reporting period
11) **Column K**: Total number of units S5110 CG GT billed in the reporting period
12) **Column L**: Total number of units S5110 CG HQ billed in the reporting period
13) **Column M:** Please indicate Title 19 population being served by placing "x" in box
14) **Column N:** Please indicate CMDP population being served by placing "x" in box
15) **Column O**: Please indicate Title 21 population being served by placing "x" in box

Specific Data Requested Adult Family Support Utilization Tab:

1) **Column A:** Name of the provider agency site. **DO NOT** merge cells
2) **Column B**: Location name and Street address for Provider agency site. **DO NOT** merge cells
3) **Column C**: Total number of enrolled adults served at provider agency site with an open episode of care
4) Column D: Total number of unique members with Title 19 status who receive family support services at this site
5) **Column E:** Total number of unique members without Title 19 status who receive family support services at this site
6) **Column F:** Total number of units S5110 billed at the site during reporting period
7) **Column G**: Total number of units S5110 GT billed in the reporting period
8) **Column H**: Total number of units S5110 HQ billed in the reporting period
10) **Column I**: Total number of units S5110 CG billed in the reporting period
11) **Column J**: Total number of units S5110 CG GT billed in the reporting period
12) **Column K**: Total number of units S5110 CG HQ billed in the reporting period
13) **Column L**: Please indicate SMI (Serious Mentally Ill) population being served by placing "x" in box
14) **Column M**: Please indicate GMH (General Mental Health) population being served by placing "x" in box
15) **Column N**: Please indicate Substance Use or "SA" population being served by placing "x" in box

Other Important Information about the quarterly reporting submission

• All reports are to be submitted timely, the report must be complete and accurate by the 5th of the month in the quarter it is due. **Providers with late and/or inaccurate reports may result in financial sanctions or other contractual solutions until performance standards are met.**
• In order to get credit for handing in the report in on time, the report needs to be sent to the following naming convention through the **SFTP ONLY**. * *IF the naming convention* *DOES NOT* *match the naming convention below, Mercy RBHA* *WILL NOT* *receive your submission.*

Naming Convention
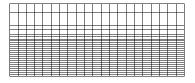## OIFA_OIFA-02_YYYYMM_ProviderName

Contact for Report
Colleen McGregor - McgregorC@MercyCareAZ.org

RSS INVENTORY

PROVIDER	SITE	LAST NAME	FIRST NAME	PEER SUPPORT EMPLOYMENT TRAINING	DATE CREDENTIALED	DATE RECREDENTIALED	DATE OF HIRE	DATE EMPLOYED AS PEER SUPPORT	END DATE	Dedicated Peer Support?	FTE			
The agency employing the RSS	Name and street address at which RSS is employed and providing services. If the RSS works at multiple sites, please only enter the primary site they work			Agency/training program through which they were credentialed (i.e. Name of the issuing agency/program on the certificate)	Enter as: MMDDYY (Column set to date)	All RSS credentialed prior to 10/01/2012 were required to take a recertification exam. As of 2/27/2015 the test is no longer available. If applicable enter as: MMDDYY. Otherwise leave blank. (Column set to date)	Original date of employment at current agency. Enter as: MMDDYY (Column set to date)	Initial start date as RSS. Enter as: MMDDYY (Column set to date)	Discontinuation of employment occurring during the reporting period listed in Column S. Enter as: MMDDYY (Column set to date)	Is this person's primary job duties peer support: Y or N?	32+ hour/week Y or N?			

PEER/FAMILY SUPPORT REFERRAL TRACKING

REFERRING AGENCY	AGENCY	REFERRALS	COMPLETED REFERRALS	TXIX REFERRALS	NTXIX REFERRALS	ADULT REFERRALS	CHILD REFERRALS	PEER SUPPORT	FAMILY SUPPORT	
Name of the agency *from which the referral for services originated* .	Name of the organization *to which the referral was made* .	Total # of referrals from agency in Column A to agency in Column B during reporting period	# of referral packets from agency in Column A to Agency in Column B with all necessary information	# of referrals for Title 19 Members	# of referrals for Non-Title 19 Members	# of referrals for Adult Members	# of referrals for Child Members	# of referrals for codes: H0038; H0038 GT; H0038-HQ; H2016	# of referrals for code S5110; S5110 CG; S5110 GT; S5110 HQ; S5110 CG HQ; S5110 CG GT	

PEER/FAMILY SUPPORT REFERRAL TRACKING

PROVIDER	SITE	LAST NAME	FIRST NAME	PARENT/FAMILY SUPPORT TRAINING PROGRAM	DATE CREDENTIALED	DATE EMPLOYED WITH PROVIDER	END DATE	Dedicated Parent/Family Support Provider?	FTE			
The agency employing the Credentialed Parent/Family Support Provider (PFSP)	Name and street address at which PFSP is employed and providing services. If the PFSP works at multiple sites, please only enter the primary site they work			Agency/training program through which they were credentialed (i.e. Name of the issuing agency/program on the certificate) EX: Mikid/CIC. If credentialed via "Test In" program, indicate "Test In" below.	Enter as: MMDDYY (Column set to date)	Initial start date - Enter as: MMDDYY (Column set to date)	Discontinuation of employment occurring during the reporting period. Enter as: MMDDYY (Column set to date)	Is this person's primary job duties parent/family support provider: Y or N?	32+ hour/week Y or N?			

Children Receiving Family Support

PROVIDER	SITE	SERVICE POPULATION	TXIX RECEIVING FAMILY SUPPORT	CMDP RECEIVING FAMILY SUPPORT	TXXI RECEIVING FAMILY SUPPORT	S5110 ENCOUNTERS	S5110 GT ENCOUNTERS	S5110 HQ ENCOUNTERS	S5110 CG ENCOUNTERS (Credentialed)	S5110 CG GT ENCOUNTERS (Credentialed)	S5110 CG HQ ENCOUNTERS (Credentialed)	TXIX	CMDP	TXXI
Name of the agency. Enter only once per agency.	Location name and address.	Total of all enrolled children served at the site with an open episode of Care	# of Children with Title 19 status who receive family support services at this site.	# of Children with CMDP status who receive family support services at this site.	# of Children with Title 21 status who receive family support services at this site.	Total # of units S5110 billed at the site during reporting period.	Total # of units S5110 GT billed at the site during reporting period.	Total # of units S5110 HQ billed at the site during reporting period.	Total # of units S5110 CG billed at the site during reporting period.	Total # of units S5110 CG GT billed at the site during reporting period.	Total # of units S5110 CG HQ billed at the site during reporting period.	Please indicate the populations served by placing an "x" in the cell.	Please indicate the populations served by placing an "x" in the cell.	Please indicate the populations served by placing an "x" in the cell.

PROVIDER	SITE	SERVICE POPULATION	TXIX RECEIVING FAMILY SUPPORT	NTXIX RECEIVING FAMILY SUPPORT	S5110 ENCOUNTERS	S5110 GT ENCOUNTERS	S5110 HQ ENCOUNTERS	S5110 CG ENCOUNTERS (Credentialed)	S5110 CG GT ENCOUNTERS (Credentialed)	S5110 CG HQ ENCOUNTERS (Credentialed)	SMI	GMH	SA	
Name of the agency. Enter only once per agency.	Location name and address.	Total of all enrolled members served at the site with an open episode of Care	# of unique Members with Title 19 status who receive family support services at this site.	# of unique Members without Title 19 status who receive family support services at this site.	Total # of units S5110 billed at the site during reporting period.	Total # of units S5110 GT billed at the site during reporting period.	Total # of units S5110 HQ billed at the site during reporting period.	Total # of units S5110 CG billed at the site during reporting period.	Total # of units S5110 CG GT billed at the site during reporting period.	Total # of units S5110 CG HQ billed at the site during reporting period.	Please indicate the population served by placing an "x" in the cell.	Please indicate the population served by placing an "x" in the cell.	Please indicate the population served by placing an "x" in the cell.	