Guidance 36
Intermediate Level FACT (FACT-IL) Team Model

Contract Reference: A.1.1.2, C.1.2.6.22.1

I. Level Of Care Description

Intermediate Level FACT (FACT-IL) is a service delivery model that provides community-based behavioral health treatment and support to adults diagnosed with serious mental illness (SMI). FACT-IL services are a multidisciplinary approach to mental health intervention to help participants achieve and maintain rehabilitation, resiliency, and recovery goals. It combines clinical case management with medical services, wellness management, and recovery support. By offering both clinical case management and recovery assistance, FACT-IL ensures continuity of care and ease of access to services until participants are ready for a full transition to community-based care.

As an adaptation of Florida Assertive Community Treatment (FACT) team services, FACT-IL is an evidence-informed model derived from the evidence-based Assertive Community Treatment (ACT) model and designed to provide a lower level of service intensity. It may serve as a step-down program for individuals who meet the Department's high-utilization criteria and require a structured array of services to prevent recurring admissions to acute care or residential treatment. FACT-IL may also support individuals who no longer need full FACT Team services but continue to need assistance transitioning to community-based care.

II. Eligibility

Intermediate Level FACT serves individuals 18 years of age and older diagnosed with a serious mental illness, as referenced in *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)* or latest edition.

The individual must also meet at least one of the following criteria:

- Requires ongoing, community-based psychiatric outreach and support to maintain stability and prevent significant negative outcomes such as death, victimization, hospitalization, homelessness, or violence that could compromise recovery.
- Is discharging from FACT Team services and would benefit from a strategic, gradual transition to community-based care to reduce the risk of psychiatric decompensation.

- Is determined to be the most appropriate candidate for FACT-IL compared to other available interventions or programs within the Managing Entity's service array.

Target Population

Subject to available capacity, the FACT-IL Team must prioritize the enrollment of individuals transitioning from a FACT team or being directly discharged from a state mental health treatment facility (SMHTF) or behavioral health teaching hospital (BHTH). The FACT-IL Team shall manage admissions to ensure that available service capacity is prioritized for these individuals whenever eligible referrals are received.

III. Service Description

Intermediate Level FACT is delivered by community behavioral health providers who collaborate with participants to explore their culture, beliefs, and values, and identify strengths and needs. Through that process, individualized treatment and recovery goals are developed and adjusted as necessary. The treatment and recovery process may include clinical care, medication management, faith-based approaches, peer support, family involvement, self-care, or other supportive strategies. Recovery is seen as ongoing growth and improvement health and wellness, including the ability to manage setbacks. Since setbacks are a natural part of life, resilience becomes a central component of the recovery process.

FACT-IL provides treatment and support to participants where they live or in an office setting, whichever is determined to be clinically appropriate. An after-hours on-call system must be provided for crisis intervention and support as needed.

Program Goals

The goals of the FACT-IL program are to:

- Reduce the frequency of crisis episodes.
- Promote independent functioning.
- Increase participants' time living successfully in the community.
- Enhance community involvement through increased time at work, in school, or social activities.
- Support personal satisfaction and autonomy.
- Improve overall quality of life for program participants.

FACT-IL is a clinical case management model with medical services, wellness management, and recovery support. The service array may include:

Psychiatric Services (via Psychiatric Advanced Practice Registered Nurse or Psychiatrist)

- Primary psychiatric care, if appropriate, or coordination with other psychiatric providers
- Psychiatric mental status assessment
- Medication and symptom management
- Brief supportive therapy

- Coordination with other providers for both physical and psychiatric care needs
- Service participants are seen on a regular schedule, preferably at least every three months
- Consultation and support of the Team Coordinator

Nursing (via Licensed Practical Nurse or Registered Nurse)

- Medication coordination and delivery
- Provision of injectable antipsychotic medications
- Consultation and support of the clinical case management team

Clinical Case Management (via Team Coordinator, Behavioral Health Clinician, and Case Specialists)

- Aftercare/Follow-up
- Assessment
- Case Management, including community-based service linkage and monitoring
- Information and Referral Services
- In-Home and On-Site Services Overlay
- Intervention Services, including supportive therapy
- Outpatient – Individual and Group
- Recovery Support – Individual and Group
- Engagement of natural supports
- Supported Employment
- Supported Housing/Living, including tenancy supports
- Person-centered planning and crisis planning
- Family psychoeducation
- Advocacy and benefits management
- Wellness management and recovery, which includes “manualized” curricula, such as Illness Management and Recovery (IMR); Wellness Management and Recovery (WMR); Wellness Recovery Action Plans (WRAP); Psychiatric Advance Directives (PADs)

Staffing Requirements

FACT-IL staffing combines practitioners with diverse educational backgrounds, training, and experience. This range of skills and expertise allows the team to provide comprehensive, individualized care.

Services must be are available Monday through Friday from 8:00 a.m. – 5:00 p.m., with an after-hours on-call system in place to provide crisis intervention and support as needed.

The minimum staffing patterns are:

# of Participants	Minimum Direct Service[1] FTE	Psychiatric Service Hours per Week	Minimum Total FTE
60	5	18.00	6

Within the guidelines of the prescribed staff-to-participant ratios presented in the staffing chart above, teams may exercise a degree of flexibility in team composition. However, FACT-IL services must minimally include:

- One full-time Licensed Team Coordinator
- One part-time[1] Psychiatric Advanced Practice Registered Nurse (APRN) or Psychiatrist
- One full-time Licensed Practical Nurse (LPN) or Registered Nurse (RN)
- One full-time Behavioral Health Clinician
- Two full-time Case Specialists
- One full-time[1] Administrative Assistant

Staff Roles and Credentials

The provider must maintain a current organizational chart indicating required staff and displaying organizational relationships and responsibilities, lines of administrative oversight, and clinical supervision.

Licensed Team Coordinator

The Team Coordinator must be a full-time employee with full clinical, administrative, and supervisory responsibility for the team, with no duties to other programs during the 40-hour workweek. The Team Coordinator must possess a Florida license in one of the following professions:

- Licensed Clinical Social Worker, Marriage and Family Therapist, or Mental Health Counselor licensed in accordance with Chapter 491, Florida Statutes
- Psychiatrist licensed in accordance with Chapter 458, Florida Statutes
- Psychologist licensed in accordance with Chapter 490, Florida Statutes

The Team Coordinator is a practicing clinician who provides services and clinical supervision at least 50 percent of the time. They are responsible for the team's administrative, clinical, and quality oversight. Preferably, the Team Coordinator is certified as a clinical supervisor. The Team Coordinator receives consultation from the psychiatric staff and administrative supervision from the Chief Executive Officer or their designee.

Psychiatric Advanced Practice Registered Nurse (APRN) or Psychiatrist

[1] Direct services staff does not include the psychiatric care provider or administrative staff.

The psychiatric APRN or psychiatrist provides clinical consultation to the entire team as well as psychopharmacological consultations for all participants, as needed. They monitor non-psychiatric medical conditions and medications, provide brief therapy, and provide diagnostic and medication education, with treatment decisions guided by a shared decision-making approach. When participants are hospitalized, the psychiatric provider communicates directly with the inpatient care team to ensure continuity of care. A minimum of 0.30 hours of psychiatric services must be available for each participant per week (e.g., 18 hours for 60 participants) and each participant must be seen by the psychiatric APRN or psychiatrist at least once every three months.

Psychiatrists must be certified by the American Board of Psychiatry and Neurology (ABPN), or eligible for board certification, and licensed in accordance with Chapter 458, F.S. If a Psychiatric APRN is employed, they must be licensed in accordance with Chapter 464, F.S., with access to a board certified, or board eligible, psychiatrist for weekly consultation.

Licensed Practical Nurse or Registered Nurse

The nursing staff performs the following critical roles:

- Manage the medication system,
- Administer and document medication treatment,
- Screen and monitor participants for medical problems/side effects,
- Communicate and coordinate services with other medical providers,
- Promote health, prevention, and education including assessing risky behaviors and supporting behavior change related to physical health,
- Educate team members on monitoring psychiatric symptoms and medication side effects, and
- With participant consent, develop strategies to support adherence to prescribed medications, such as behavioral tailoring and individualized reminders).

Behavioral Health Clinician

The Behavioral Health Clinician must hold a master's degree from an accredited university or college with a major in psychology, social work, counseling, or other behavioral science.

The Behavioral Health Clinician provides evidence-based therapeutic services and supports participants in achieving their behavioral health goals. The Behavioral Health Clinician may also integrate treatment for co-occurring mental illness and substance use disorders for participants with a history of substance abuse. This may include:

- Conducting assessments that consider the relationship between substance use and mental health.
- Monitoring participants' readiness for change and stages of treatment.
- Using outreach and motivational interviewing techniques.
- Applying cognitive-behavioral approaches and relapse prevention strategies.

- Delivering treatment aligned with the participant's stage of change readiness.

Additionally, the Behavioral Health Clinician provides consultation and training to other team members on integrated assessment and treatment skills for co-occurring disorders, including crisis intervention and individual and group therapy sessions.

Case Specialists

This position requires a minimum of a bachelor's degree in behavioral science, with a preference for individuals who are also credentialed as Certified Recovery Peer Specialists. Case Specialists provide rehabilitation and support services under clinical supervision and are essential members of the treatment team. Their responsibilities may include social and communication skills training, as well as training to enhance a participant's independent living. Key functions include ongoing assessments, problem-solving, assistance with activities of daily living, and coaching. Caseloads are determined by the Team Coordinator based on the needs of participants, but should not exceed 20 individuals per Case Specialist.

Administrative Assistant

An Administrative Assistant is responsible for organizing, coordinating, and monitoring the non-clinical operations. Key functions include providing direct support to staff, monitoring and coordinating daily team schedules and assisting staff in both office and field settings. Additionally, the Administrative Assistant serves as a liaison between participants and staff, responding to the needs of office walk-ins, phone calls from participants, and natural supports.

Service Requirements

- Services must be provided to participants and/or their family members, including natural support persons.
- At least 60 percent of all interventions must be delivered in natural settings and outside of the provider's office(s).
- Visits must take place at times and locations that reasonably accommodate the participant's and family's needs, including community locations and other natural settings.
- Visits must be scheduled at times that do not interfere with work, education, and other community activities.
- Documentation must demonstrate that more than one member of the team is actively engaged in providing direct service to each participant.

Services and Supports

The guiding principles of FACT-IL services include participant choice, cultural competence, person-centered planning, protection of rights of individuals served, stakeholder inclusion, and participant voice. In alignment with

these principles, the FACT-IL Team is inclusive of the following covered services and activities as defined in Chapter 65E-14.021, Florida Administrative Code[2]:

- Aftercare
- Assessment
- Care Coordination
- Case Management
- Crisis Stabilization
- Crisis Support/Emergency
- Day Care
- Day Treatment
- Incidentals Expenses
- In-Home and On-site
- Intensive Case Management
- Intervention – Individual and Group
- Medical Services
- Outpatient – Individual, Family, and Group
- Outreach
- Recovery Support – Individual and Group
- Supported Employment
- Supportive Housing/Living

The FACT-IL Team shall also provide or implement the following, as detailed below:

- Active Engagement

  Because FACT-IL services are voluntary, FACT-IL Teams should utilize engagement strategies, such as motivational interviewing to foster ongoing participation and strengthen relationships with participants. The FACT-IL Team should also monitor for indicators that a participant may require more assertive engagement. Such indicators may include missing appointments; limited rapport or lack of trust in the therapeutic relationship; inpatient admission; increased or frequent crisis episodes; homelessness or risk of homelessness; loss of natural supports; high-risk behaviors; or substance use that interferes with the participant's ability to engage in treatment.

  Treatment planning and subsequent therapeutic interventions must reflect appropriate, adequate, and timely implementation of services in response to the participant's changing needs.

- Administrative Tasks

  The FACT-IL Team performs administrative tasks, which include the following:

[2] Florida Department of State - Florida Administrative Code & Florida Administrative Register www.flrules.org/ (accessed February 2026)

- Establishment and maintenance of written policies and procedures for:
  - Personnel
  - Program organization
  - Admission and discharge criteria and procedures
  - Assessments and recovery planning
  - Provision of services
  - Medical records management
  - Quality assurance/quality improvement
  - Risk management
  - Rights of persons served
- Accurate record-keeping that reflects specific services offered to and provided for each participant, with records available for review by the Managing Entity and Department staff.
- Coordination of services with other entities to ensure the participant's needs are addressed.
- Staff training and supervision to ensure staff are aware of their obligations as an employee.
- A disaster support plan that addresses contingencies for staff, provision of needed services and medication, and post-disaster activities to support participants.

- Comprehensive Assessment

  The Team Leader assigns the individual's treatment team, including the Psychiatrist or Psychiatric APRN and primary case manager on the day of admission. The team is responsible for preparing a written Comprehensive Assessment within 60 days of the participant's admission to the program. The Comprehensive Assessment must meet the following requirements:
  - Each assessment area is completed by a team member with skill and knowledge in the area being assessed and is based upon all available information.
  - At a minimum, the Comprehensive Assessment includes:
    - Psychiatric history and diagnosis,
    - Mental status,
    - Strengths, abilities, and preferences,
    - Physical health,
    - History and current use of drugs or alcohol,
    - Education and employment history and current status,
    - Social development and functioning,
    - Activities of daily living,
    - Family and social relationships and support, and
    - Care recommendations.
  - The Comprehensive Assessment must be reviewed and signed by the Team Leader, Psychiatrist, Psychiatric APRN, or another qualified professional on the team. This includes a signed and dated

statement confirming that the assessment is complete, clinically appropriate, and that the assessment findings and care recommendations support the individual's diagnosis and needs.

- To supplement the Comprehensive Assessment, the team completes a psychiatric/social functioning history timeline no later than 120 days after the first day of admission.
- The team updates assessments at least annually and uses the updated assessments to update the Recovery Plan. All necessary areas essential for planning must be included in the updated assessment.

- Comprehensive Recovery Plan

  The team develops a Comprehensive Recovery Plan as an extension of the initial plan within 90 days of admission, following completion of all required assessments. The Comprehensive Recovery Plan must adhere to the following guidelines:

  - Planning is person-centered and actively involves the participant, guardian (if applicable),and any family members and significant others the participant wishes to include.
  - The plan is reviewed and updated at least every six (6) months during planned meetings, or sooner if clinically indicated, by the treatment team in collaboration with the participant.
  - The plan is reviewed and signed by the Team Leader, Psychiatrist or Psychiatric APRN, or another qualified professional on the team. This includes a signed and dated statement confirming that the services are medically necessary and appropriate for the individual's diagnosis and treatment needs.
  - The plan is based on assessment findings and:
    - Identifies the participant's strengths, resources, needs and limitations;
    - Establishes short- and long-term goals, including timelines;
    - Reflects the participant's preferences for services;
    - Outlines measurable treatment objectives as well as the services and activities required to achieve them; and
    - Addresses relevant life domains, such as symptom management, education, transportation, housing, activities of daily living, employment, daily structure, and family and social relationships, when identified as needs through assessment and agreed upon as goals by the individual.

- Daily Living Activities (DLA-20): Adult Mental Health

  The DLA-20 must be completed within the first 30 days of intake to establish a functional baseline. After the baseline is established, it should be readministered at regular intervals to monitor changes in functional capacity over time. At a minimum, the DLA-20 must be readministered every six (6) months; however, it may be completed more frequently based on provider preference or programmatic guidance. In addition, the DLA-20 must be administered at key transition points, including:

  - at discharge, except in cases of unplanned discharge;
  - when there is a change in level of care; and
  - following a significant life event.

  If a client's mental health, cognitive functioning, or level of independence demonstrates a noticeable improvement or decline, the DLA-20 may be readministered to document the change. Administration of the DLA-20 without direct contact with the client is considered invalid. Direct contact includes in-person, telehealth/video, or telephone interaction. In cases of unplanned discharge, the score from the most recent DLA-20 administration should be used as the discharge score.

  The Functional Assessment Rating Scale (FARS) may be used in addition to the required DLA-20 to provide supplemental information on an individual's level of functioning. Use of the FARS is optional and only intended to enhance clinical insight, treatment planning, and monitoring of functional progress.

- Initial Assessment and Recovery Plan
  The Team Leader, in coordination with the Psychiatrist or Psychiatric APRN, performs an initial assessment and develops an initial plan of care on the day of the participant's admission to the program. The participant, along with designated team members, will be actively involved in the development of the plan. This process is intended to ensure that immediate needs for medication, treatment, and basic support are addressed without delay. At a minimum, the initial assessment must include the following components:
    - A brief mental status examination
    - Assessment of symptoms
    - An initial psychosocial history
    - An initial health/medical assessment
    - Review of previous clinical information obtained at the time of admission
    - Preliminary identification of the participant's housing, financial, and employment status
    - Preliminary review of the participant's strengths, challenges, and preferences

Expected Outcomes

With the provision of FACT-IL services, participants are expected to demonstrate continued stabilization within the community, such as minimal or no use of psychiatric inpatient services, along with progress in life areas identified in the treatment plan. Examples of expected outcomes include:

- Maintenance of current areas of functioning and wellness, as desired and valued by the participant.
- Increased use of wellness self-management and recovery tools, including greater independence in medication management.
- Vocational and/or educational gains.
- Increased length of stay in independent, community residence.
- Improved functioning in activities of daily living, such as managing finances and transportation.
- Greater use of natural supports and development of meaningful personal relationships.
- Improved physical health.

Staff Communication and Planning

Consistent with the FACT model, the team must conduct daily organizational staff meetings at regularly scheduled times as established by the Team Coordinator. During these daily meetings, the team completes the following tasks:

- Conduct a brief, clinically relevant review of all participants at least weekly.
- Document any contacts within the past 24 hours (i.e., phone calls, home visits, transportation , etc.).
- Maintain a schedule for each participant including all treatment and service contacts to be carried out to reach the goals and objectives in the participant's recovery plan.
- Maintain a central file of all participant schedules.

- Develop a daily staff schedule consisting of a written timetable for all treatment and service contacts, which is divided and shared among staff working that day, based on:
    - each participant's schedule;
    - emerging needs;
    - the need for proactive contacts to prevent future crises; and
    - revisions to recovery plans, as needed, including the addition of service contacts to the daily staff assignment schedule in accordance with updated recovery plans.

Waiting List

Waiting list records are created when an individual has been determined eligible for FACT-IL services but capacity has been reached and services are not immediately available. An individuals' consent to participate in FACT-IL services must be obtained before they can be added to the waiting list.

Discharge Planning and Transitions

Discharge planning should begin immediately upon intake and the expectations and course of treatment should be discussed with the participant during the admission process. Long-term achievement of goals and markers for discharge should be discussed at each treatment plan update and participants should be consistently assessed for discharge readiness throughout engagement with services, including barriers to discharge, progress of discharge planning, and any changes to discharge plans.

Transfer Determination to a Higher Level of Care

Throughout FACT-IL services provision, despite the best clinical and medical efforts, a higher level of care may be needed. In this instance, participants may require admission to FACT services and thereby increase the intensity of services, as well as the full breadth of services.

This determination must be judged by the psychiatric APRN or psychiatrist on staff to be medically necessary, given an acute exacerbation of illness or significant reduction in functional status that is not adequately addressed within 4 weeks and for which FACT is medically necessary to address. In such cases, the goal will be for FACT to stabilize the participant and return to FACT-IL services, once determined medically appropriate.

Discharge Categories

Discharges shall be based on the following categories:

- **Successfully Completed Treatment/Services**: The participant demonstrates an ability to perform successfully in major role areas (i.e., work, social, and self-care) over time without requiring assistance from the program and no longer requires this level of care (i.e., successful completion).
- **Did Not Complete Treatment - Voluntary**: The participant lost contact, eloped, requested discharge, or chooses not to participate in services despite repeated efforts to develop a recovery plan acceptable to the participant.

- **Did Not Complete Treatment - Involuntary**: The participant has been admitted to inpatient or short-term residential treatment, for a continuous period of 45 calendar days, with no anticipated charge date.
    - The Intermediate Level FACT Team must communicate with the inpatient or short-term residential treatment provider to determine the anticipated length of stay and likely discharge setting. This information may be used to determine whether continued Intermediate Level FACT Team services are appropriate or whether prioritizing individuals on the waiting list would be more beneficial.
- **Incarcerated**: The participant has been in jail for a term exceeding 90 days. Otherwise, the participant remains enrolled with the Intermediate Level FACT Team.
    - The Intermediate Level FACT Team must communicate with the jail to determine release. This information may be used to determine whether continued services are appropriate or whether prioritizing individuals on the waiting list would be more beneficial.
- **Death**: The participant dies while receiving services.
- **Transferred to a State Mental Health Treatment Facility or Behavioral Health Teaching Hospital**: The participant has been admitted to a state mental health treatment facility or behavioral health teaching hospital.
- **Client Moved Out of Service Area**: The participant moves out of the service area.
- **Did Not Complete Treatment - Transferred to Another Provider**: The participant was admitted to a FACT Team or chose comparable community-based outpatient services with another provider.

Discharge Documentation

The following information must be included in the participant's medical record at the time of discharge:

- The reason(s) for discharge.
- The participant's status and condition at discharge.
- A final evaluation summarizing the participant's progress toward identified goals and outcomes.
- A discharge plan, developed in collaboration with the participant and their support system, outlining an ongoing mental health crisis plan.
- A summary of referrals made during the course of services.
- Documentation confirming that the participant was informed they may return to FACT-IL services, should they choose to do so and space is available.

IV. Outcome Measures

The Managing Entity must include the following outcome measures in each subcontract:

- Percent of adults with a serious mental illness who live in a stable housing environment equal to or greater than 90 percent (or the most current General Appropriations Act working papers transmitted to the Department of Children and Families).
- Percent of adults with a serious mental illness who are competitively employed equal to or greater than 24 percent (or the most current General Appropriations Act working papers transmitted to the Department of Children and Families).

- Average annual days worked, for pay, for adults diagnosed with a serious mental illness that is equal to or greater than 40 days (or the most current General Appropriations Act working papers transmitted to the Department of Children and Families).
- While enrolled, *fewer than 15 percent of individuals served* will be admitted to a Baker Act Receiving Facility.
- Upon successful completion, *95 percent of individuals served* will be living in a stable housing environment.
    - Individual provider performance between 90 percent and 95 percent will be considered below target but not be subject to financial consequences.
- Upon successful completion, *90 percent of individuals served* will maintain or improve their level of functioning, as measured by the Daily Living Activities (DLA-20): Adult Mental Health Assessment.

The Managing Entity must include the following process measures in each subcontract:

- *90 percent of all initial assessments* will be completed on the day of enrollment with written documentation of the service occurrence in the clinical record.
- *90 percent of all Comprehensive Assessments* will be completed within 60 days of enrollment with written documentation of the service occurrence in the clinical record.
- *90 percent of all Comprehensive Recovery Plans* will be completed within 90 days of enrollment with written documentation of the service occurrence in the clinical record.
- *90 percent of all psychiatric/social functioning history timelines* will be completed within 120 days of enrollment with written documentation of the service occurrence in the clinical record.

Beginning in Fiscal Year 2026–27, the Department and Managing Entities shall collect and analyze baseline data for the following potential performance measures. During the baseline data collection period, these measures will be used only for monitoring and evaluation. They will not be used to evaluate provider performance or to impose corrective action, financial penalties, or other adverse contractual consequences. The Department and the Managing Entities will evaluate the effectiveness and reasonableness of adopting additional measures for future program implementation. The measure will be adopted July 1, 2028, unless objections are raised.

On an annual basis, *75 percent of all individuals served* will maintain or demonstrate improvement in their functioning, as measured by the Daily Living Activities (DLA-20) Functional Assessment.

- Maintenance or improvement in functioning is determined by comparing the average DLA-20 score from the initial assessment score to the most recent recorded score.
- The numerator is the number of individuals served during the reporting period whose overall functioning score is equal to or greater than their initial score.
- The denominator is the number of individuals served during the reporting period who have more than one recorded DLA-20 score.

Upon successful completion, *at least 55 percent of individuals served* will demonstrate a 20% or greater improvement in their average (i.e., mean) DLA-20 assessment score from admission to discharge.

- Percentage of change is determined by subtracting the admission score from the discharge score, dividing by the admission score, and multiplying by 100.
- The numerator is the number of individuals who successfully complete treatment and demonstrate a 20% or greater improvement in their average DLA-20 assessment score from admission to discharge.
- The denominator is total number of individuals who successfully complete treatment during the reporting period and have both an admission and discharge DLA-20 assessment score.

V. Reporting Requirements

The Department may request ad hoc data from the Managing Entities as needed.

Template 39: Intermediate Level FACT Quarterly Report

This quarterly report displays aggregate census information, waiting list data, and other essential metrics necessary for the Department to assess program outputs and outcomes.

Vacant Position Report

This monthly report identifies the required FACT-IL Team composition (as indicated in section III) and indicates whether each position was filled or vacant for the reporting month. The report also reflects the ratio of participants to direct service staff members as of the last day of the reporting month.

Appendix A – Intermediate Level FACT Return on Investment Quarterly Report

This quarterly report is designed to measure and quantify the return on investment of services in both financial and human terms. Managing Entities are required to complete and submit the report each quarter. To obtain access to the ROI Quarterly Report in Smartsheet, Managing Entities must designate at least one point of contact who will be responsible for data submission.

VI. Incidental Expenses

Incidental expenses pursuant to chapter 65E-14.021, Florida Administrative Code, are allowable under this program Network Service Providers must follow state purchasing guidelines and any established process for review and approval and must consult the Managing Entity regarding allowable purchases.

Before utilizing Incidentals, the Family Well-being Treatment Teams must explore all other resources with the family, including eligibility for food, cash, and medical assistance through the Department of Children and Families Automated Community Connection to Economic Self Sufficiency (ACCESS) program. More information on ACCESS can be found at http://www.myflorida.com/accessflorida/.

APPENDIX A – INTERMEDIATE LEVEL FACT RETURN ON INVESTMENT QUARTERLY REPORT

The Return on Investment (ROI) Quarterly Report analyzes the fiscal impact of the Intermediate Level FACT model and demonstrates how the state's investment in the program generates measurable benefits. The report compares program expenditures with quantifiable cost savings and reduced utilization of other state-funded services. In addition to financial metrics, it captures human outcomes, including improvements in participant health, functioning, and other social indicators resulting from program participation.

Managing Entities are required to complete this report on a quarterly basis. To obtain access to the ROI Quarterly Report in Smartsheet, please designate at least one point of contact who will be responsible for data submission and provide the individual's name and email address.

Managing Entities must submit points of contact to: HQW.SAMH.ManagingEntitiesInquiries@myflfamilies.com

Reports are due on October 20, January 20, April 20, and August 15.