

## Receiving Facilities

### Designation & General Applicability

#### **Q. How is “premises” defined as to Baker Act or EMTALA?**

The Baker Act has the following definition that is the legal basis for the department’s requirement that everything on the premises of a receiving facility must be included in the designation.

394.67 Definitions.—

(19) "Premises" means those buildings, beds, and facilities located at the main address of the licensee and all other buildings, beds, and facilities for the provision of acute or residential care which are located in such reasonable proximity to the main address of the licensee as to appear to the public to be under the dominion and control of the licensee.

#### **Q. I have been reviewing both law and rule for any discussion about a "Baker Act Coordinator" either being required, or suggested. I understand the many functions this facilitates. Can you help?**

There is no statutory or regulatory requirement for a "Baker Act Coordinator" at hospitals or other receiving facilities. Every Baker Act receiving facility should have such a function assigned even if the size of the facility wouldn't justify this position as full-time.

In those cases, it might be a major duty assigned to a staff member. While not a scientific observation, the Coordinators who seem to be most successful are **not** licensed clinicians. The most successful seem to be administrative staff that are really smart, very focused on details, and can get along with a range of other people like physicians, family members, court personnel, etc. Often retired law enforcement officers do a great job as well certain MH Techs..

In any case, this isn't a responsibility that can be learned OJT without a mentor who knows the job very well. If not done right from day one, the facility will quickly be in a mess with the public defenders, state attorneys, and the court.

#### **Q. What rights and responsibilities do receiving facilities have?**

All receiving facilities, public or private, are permitted to hold a person on an involuntary basis, assuming that all aspects of law or administrative code required/prohibited of personnel and facilities are in full compliance. Requirements of public and private receiving facilities are basically the same. A facility that has chosen not to seek designation must be sure to transfer any person with a serious mental illness to a receiving facility at any time the person cannot provide well-reasoned, willful and knowing decisions about their mental health care since such persons are not eligible for voluntary care.

#### **Q. We are looking at the possibility of opening a psychiatric unit at another of our hospitals in the areas. However, we don’t want to be a “receiving facility.” Would**

**this unit have to accept patients in accordance to the Baker Act rules? If not, would you advise that we follow similar guidelines for our unit that is a receiving facility. This all speculation and we are not sure that an additional unit is going to open. I am so used to the receiving facility procedures, I would just want to be cautious with a psychiatric unit.**

Every licensed hospital would have to accept any person brought on voluntary or involuntary status because of the federal EMTALA law. However, you couldn't retain any person longer than 12 hours following medical clearance unless a physician had certified the person was competent to make well-reasoned, willful and knowing decisions about his/her mental health and medical conditions. One would question why they were in a inpatient psychiatric unit if they were this stable. If you are designated, you would have the legal standing to hold a person with an acute mental illness against his/her will or without express and informed consent longer than the 12 hours following medical clearance. Otherwise it could be considered false imprisonment.

In any case, chapter 395, FS requires that any hospital, regardless of whether it is designated, is required to uphold all right of patients held as voluntary or involuntary under the Baker Act in its facilities as a condition of licensure. These references are as follows:

395.003(5)(a) governing licensure of all hospitals states "Adherence to patient rights, standards of care, and examination and placement procedures provided under part I of chapter 394 shall be a condition of licensure for hospitals providing voluntary or involuntary medical or psychiatric observation, evaluation, diagnosis, or treatment".

(5)(b)"Any hospital that provides psychiatric treatment to persons under 18 years of age who have emotional disturbances shall comply with the procedures pertaining to the rights of patients prescribed in part I of chapter 394".

395.1041(6) RIGHTS OF PERSONS BEING TREATED.--A hospital providing emergency services and care to a person who is being involuntarily examined under the provisions of s. 394.463 shall adhere to the rights of patients specified in part I of chapter 394 and the involuntary examination procedures provided in s. 394.463, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under part I of chapter 394 and regardless of whether the person is admitted to the hospital.

395.1055(5) governing rules and enforcement states "The agency shall enforce the provisions of part I of chapter 394, and rules adopted thereunder, with respect to the rights, standards of care, and examination and placement procedures applicable to patients voluntarily or involuntarily admitted to hospitals providing psychiatric observation, evaluation, diagnosis, or treatment".

395.1065(4) governing criminal and administrative penalties states "In seeking to impose penalties against a facility as defined in s. 394.455 for a violation of part I of chapter 394, the agency is authorized to rely on the investigation and findings by the Department of Health in lieu of conducting its own investigation". *[Facility is defined as (10) "Facility" means **any hospital**, community facility, public or private facility, or receiving or treatment facility providing for the evaluation,*

*diagnosis, care, treatment, training, or hospitalization of persons who appear to have a mental illness or have been diagnosed as having a mental illness. "Facility" does not include any program or entity licensed pursuant to chapter 400 or chapter 429.]*

395.3025 Patient and personnel records; copies; examination.--

(1) Any licensed facility shall, upon written request, and only after discharge of the patient...

(2) This section does not apply to records maintained at any licensed facility the primary function of which is to provide psychiatric care to its patients, or to records of treatment for any mental or emotional condition at any other licensed facility which are governed by the provisions of s. 394.4615.

(3) This section does not apply to records of substance abuse impaired persons, which are governed by s. 397.501.

**Q. Our hospital requested to give up its designation as a receiving facility. Must every patient who is treated for mental health issues at any hospital in Florida fit into the category for Voluntary Admission or Involuntary Admissions as described in Chapter 394? Or, do the rules for Voluntary Admissions and Involuntary Admissions found in Chapter 394 only apply to receiving facilities?**

There are only voluntary or involuntary status – nothing else or in between. They apply whether a person is at a receiving facility or in another hospital – if truly voluntary, they can choose to be at a non-receiving facility, but if refusing or unable to consistently provide well-reasoned, willful and knowing decision making, must be transferred to a designated receiving facility. Chapter 395, FS, requires that all rights guaranteed to persons under voluntary or involuntary (there isn't any other status) must have their rights protected in all licensed hospitals regardless of designation (see above question and answer for details)

**Q. I'm an attorney representing a hospital that isn't designated as a receiving facility. The hospital admits patient Mr. B. After admission to the hospital it is determined that Mr. B meets the criteria for a BA-52. We initiates the BA-52 and then attempt to transfer Mr. B to a receiving facility. Mr. B is unfunded and none of the local receiving facilities have availability -- some of the local facilities state that they only have a limited number of unfunded beds and that they will not accept unfunded patient transfers unless they have an unfunded bed available. The 72 hour window is closing and no receiving facility will accept Mr. B. Mr. B's physicians believe that he meets the criteria for a BA-32 and they are willing to attest to that fact, but we've has been told that it cannot initiate a BA-32, because only administrators of receiving facilities can initiate a BA-32. What should we do?**

The bottom line is that your hospital should re-apply for designation so it can legally accept and hold persons. Your only other options are to discharge an obviously ill person or go to court and ask for judicial intervention. The first of these is an enormous risk to the person and to your hospital – never a good idea. Your hospital has no standing to petition the court under the Baker Act since it isn't a designated receiving facility and the court wouldn't have any jurisdiction to order admission, placement, or

treatment for a person in a facility not legally eligible to hold such a patient. The hospital can't function as a receiving facility without being designated as one.

**Q. When we become a hospital, do we need to be designated as a treatment facility? I understand that under the law there is a separate section for Veterans. What happens when there is a petition for placement after the 72 hour exam period expires? Would the hospital be able to keep the patient for the extended time? Please explain the impact of our designation as a "treatment facility" once our VA hospital is complete.**

DCF is not designating any VA hospitals any more, presuming that s. 394.4672 suffices as follows:

**394.4672 Procedure for placement of veteran with federal agency.**

(1)Whenever it is determined by the court that a person meets the criteria for involuntary placement and it appears that such person is eligible for care or treatment by the United States Department of Veterans Affairs or other agency of the United States Government, the court, upon receipt of a certificate from the United States Department of Veterans Affairs or such other agency showing that facilities are available and that the person is eligible for care or treatment therein, may place that person with the United States Department of Veterans Affairs or other federal agency. The person whose placement is sought shall be personally served with notice of the pending placement proceeding in the manner as provided in this part, and nothing in this section shall affect his or her right to appear and be heard in the proceeding. Upon placement, the person shall be subject to the rules and regulations of the United States Department of Veterans Affairs or other federal agency.

(2)The judgment or order of placement by a court of competent jurisdiction of another state or of the District of Columbia, placing a person with the United States Department of Veterans Affairs or other federal agency for care or treatment, shall have the same force and effect in this state as in the jurisdiction of the court entering the judgment or making the order; and the courts of the placing state or of the District of Columbia shall be deemed to have retained jurisdiction of the person so placed. Consent is hereby given to the application of the law of the placing state or district with respect to the authority of the chief officer of any facility of the United States Department of Veterans Affairs or other federal agency operated in this state to retain custody or to transfer, parole, or discharge the person.

(3)Upon receipt of a certificate of the United States Department of Veterans Affairs or such other federal agency that facilities are available for the care or treatment of mentally ill persons and that the person is eligible for care or treatment, the administrator of the receiving or treatment facility may cause the transfer of that person to the United States Department of Veterans Affairs or other federal agency. Upon effecting such transfer, the committing court shall be notified by the transferring agency. No person shall be transferred to the United States Department of Veterans Affairs or other federal agency if he or she is confined pursuant to the conviction of any felony or misdemeanor or if he or she has been acquitted of the charge solely on the ground of insanity, unless prior to transfer the court placing such person enters an order for the transfer after

appropriate motion and hearing and without objection by the United States Department of Veterans Affairs.

(4) Any person transferred as provided in this section shall be deemed to be placed with the United States Department of Veterans Affairs or other federal agency pursuant to the original placement.

With regard to holding a person after the 72-hour examination period has expired, there shouldn't be any problem if the petition was timely filed with the Clerk of Court before the 72 hour period expires and a hearing is scheduled by the court within 5 court working days.

**Q. Does a psychiatric unit have to be designated? Why would a psych unit not wish to be designated as a receiving facility?**

It's possible for a hospital to have a psychiatric unit without being designated. It can be a locked unit because persons served have a right to "request" release and to be released within 24 hours of the request unless a petition is filed with the court for involuntary placement within two court working days of the request for release or refusal of treatment.

However, law enforcement officers couldn't bring persons on involuntary status only to an undesignated facility – only to designated receiving facilities. An undesignated hospital can only admit or retain persons who not only want to be in the unit, but who are competent to provide express and informed consent to treatment (able to make well-reasoned, willful, and knowing mental health and medical decisions). Otherwise the person must be transferred to a designated receiving facility.

Hospitals that aren't designated have serious problems in not being able to legally retain persons, yet can't always successfully transfer them to receiving facilities within the 12 hour period permitted by law. This could result in false imprisonment complaints.

Questions are raised about the several hospitals in the state that have declined designation, including justifying how a person can be so stable as to be making well-reasoned decisions and yet be so acutely ill as to require an acute care locked inpatient setting. Insurers question whether negative charting is taking place in such situations to justify payments that might not be otherwise warranted.

Even in some designated receiving facilities, persons are routinely transferred from involuntary to voluntary status because physicians don't want to be bothered with the inconvenience of testifying at hearings. The landmark U.S. Supreme Court case on this subject was based in Florida that prohibited persons from being held on voluntary status if they weren't competent to consent to the admission and to treatment.

Regardless of whether a hospital has a psychiatric unit or if it is designated, it must document that it has upheld all rights of persons under the Baker Act

For the reasons cited above, there really are no benefit for a hospital with psychiatric capability from being designated. This is especially true in areas where a Transportation Exception Plan has been approved by your BCC and the DCF Secretary by which certain populations can be diverted away from a hospital and other populations can

bypass nearer receiving facilities and be brought directly to you. Designation by DCF provides a facility the authority to hold persons against their will or without their consent, while ensuring due process.

The only reason for declining designation may be to avoid scrutiny by DCF and a mistaken belief that they would no longer be responsible to protect the rights of persons held for psychiatric exam and treatment -- not good reasons. All licensed hospitals must still accept all persons brought to them under federal and state laws, regardless of whether they are designated.

**Q. is there an AG opinion, DCF legal opinion, or case law supporting the idea that hospitals can have locked psychiatric unit without being designated?**

There isn't any law, appellate decision or legal opinion on the issue. There is just chapter 395 governing hospital licensure, that requires all hospitals to comply with the Baker Act if holding persons on voluntary or involuntary status, detailed in replies to other FAW's.

The above references require hospitals to extend to any person held voluntarily or involuntarily the rights that would apply in a receiving facility to such persons. There isn't any prohibition against a non-designated hospital from holding persons for examination or treatment of mental illness as long as the person is willing to be there and is certified by a physician as competent to provide express and informed consent, e.g. well-reasoned, willful and knowing decision making about his/her medical or mental health treatment.

Since a designated receiving facility can and usually does have persons on voluntary status in locked units, the following provisions apply in a receiving facility as well as to a non-receiving facility:

**394.4625 Voluntary admissions.**

(2)DISCHARGE OF VOLUNTARY PATIENTS.—

**(a)A facility shall discharge a voluntary patient:**

1. Who has sufficiently improved so that retention in the facility is no longer desirable. A patient may also be discharged to the care of a community facility.

**2. Who revokes consent to admission or requests discharge.** A voluntary patient or a relative, friend, or attorney of the patient may request discharge either orally or in writing at any time following admission to the facility. The patient must be discharged within 24 hours of the request, unless the request is rescinded or the patient is transferred to involuntary status pursuant to this section. The 24-hour time period may be extended by a treatment facility when necessary for adequate discharge planning, but shall not exceed 3 days exclusive of weekends and holidays. If the patient, or another on the patient's behalf, makes an oral request for discharge to a staff member, such request shall be immediately entered in the patient's clinical record. If the request for discharge is made by a person other than the patient, the discharge may be conditioned upon the express and informed consent of the patient.

(b) A voluntary patient who has been admitted to a facility and who refuses to consent to or revokes consent to treatment shall be discharged within 24 hours after such refusal or revocation, unless transferred to involuntary status pursuant

to this section or unless the refusal or revocation is freely and voluntarily rescinded by the patient.

(3)NOTICE OF RIGHT TO DISCHARGE.—At the time of admission and at least every 6 months thereafter, a voluntary patient shall be notified in writing of his or her right to apply for a discharge.

(5)TRANSFER TO INVOLUNTARY STATUS.—When a voluntary patient, or an authorized person on the patient's behalf, makes a request for discharge, the request for discharge, unless freely and voluntarily rescinded, must be communicated to a physician, clinical psychologist, or psychiatrist as quickly as possible, but not later than 12 hours after the request is made. **If the patient meets the criteria for involuntary placement, the administrator of the facility must file with the court a petition for involuntary placement, within 2 court working days after the request for discharge is made. If the petition is not filed within 2 court working days, the patient shall be discharged.** Pending the filing of the petition, the patient may be held and emergency treatment rendered in the least restrictive manner, upon the written order of a physician, if it is determined that such treatment is necessary for the safety of the patient or others.

Since a non-designated hospital has no standing to file a petition for involuntary placement, the person held longer than 24 hours after a request for release or revokes consent to treatment must be transferred to a designated receiving facility.

A DCF attorney has advised that non-designated hospitals do not have authority to hold individuals against their will, even for the 24-hour period after request of discharge. In the absence of any other legal opinion that is binding on the Department, DCF must defer to the interpretation of Department counsel in providing technical assistance.

**Q. Is it ever ok for a facility to transfer a patient to another facility if they feel the individual is too violent and another facility may be more equipped to handle them?**

A designated receiving facility must be capable of safely managing the conditions of persons who are "dangerous to self or others". If it can't do this, it shouldn't be designated. This is based on adequacy of staff (number and competence) as well as the sufficiency of the facility to contain a person on voluntary and involuntary status.

The only exception to this is when a person has been arrested for a felony and the receiving facility determines and documents that it is unable to provide adequate security. However, a public receiving facility remains responsible for providing the examination and treatment to the person where he or she is held.

**Q. Is there anything in rule or statute requiring facilities to report elopements to DCF or AHCA?**

There isn't any such requirement in current Baker Act law or rules. However, "adverse" incidents have to be reported to DCF via contract provisions by public receiving facilities.

The proposed Baker Act legislation included a new section on reporting certain events, one of which was the following:

The unauthorized departure or absence of an individual from a facility in which he or she has been held for involuntary examination or involuntary placement.

Since this didn't pass last year and isn't under consideration this year, no change is expected. However, hospitals licensed under chapter 395, FS (instead of CSU's licensed under 394) are subject to have requirements governing adverse incidents in Chapter 395.0197, FS, governing hospital internal risk management programs. It doesn't appear that any of the "adverse incidents" includes elopement from the facility.

**Q. Do mental health professionals have any specified rights under the Baker Act?**

The Baker Act has the following provision:

**394.460 Rights of professionals.**--No professional referred to in this part shall be required to accept patients for treatment of mental, emotional, or behavioral disorders. Such participation shall be voluntary.

Just because a professional employed at or under contract with or with privileges at a hospital or other receiving facility refuses to provide a service doesn't mean the facility doesn't remain responsible for carrying out its duties. It must find another professional to perform the duty.

**Q. We have always considered that the Baker Act facility was the entire CSU unit, including the admit area and the actual locked unit. This is separated from the outpatient unit. If we have a person in OP for an appointment who requires a Baker Act, either the person walks to the Unit Admit area or we call the police for assistance. We do not call our unit staff to come over to OP and forcibly carry the person to the inpatient area. However, if the person is first seen in the Unit Admit area and the person is Baker Acted, we do not allow the person to leave. Are these procedures correct?**

DCF has always taken the position that everything that is on the premises of the address shown on the designation letter is considered the receiving facility. This means that you wouldn't be required to call law enforcement to "take the person into custody and deliver to the nearest receiving facility" as would be required by law if the outpatient section wasn't on the premises. However, if at any time you needed to call law enforcement for the safety of the person or staff, you could certainly do so.

**Q. I work in the psychiatric unit of a general hospital. The psychiatric unit is physically separate from the medical unit. Is the entire hospital (medical and the free standing psychiatric unit) considered the Baker Act receiving facility or is the psychiatric unit alone considered the receiving facility?**

Everything at the premises -- the address listed on your facility's letter of designation from DCF -- is incorporated in the designation. If the Medical Center is located at the

same address, it is also part of the receiving facility. Even if the medical center was separate from the receiving facility, it is required by virtue of its license to uphold the rights of all persons held under the Baker Act, as described in other FAQ's.

**Q. Can our receiving facility retain its designation and only accept patients during day/evening hours (not nights)?**

No. There are two references in the Florida Administrative Code that require a designated receiving facility to be open 24/7 as a condition of designation, as follows:

65E-5.351 Minimum Standards for Designated Receiving Facilities.

(1) Any facility designated as a receiving facility failing to comply with this chapter may have such designation suspended or withdrawn.

(2) Each receiving facility shall have policies and procedures that prescribe, monitor and enforce all requirements specified in Chapter 65E-5, F.A.C.

(3) Each receiving facility shall assure that its reception, screening, and inpatient services are fully operational 24-hours-per- day, 7-days-per-week.

65E-5.180 Right to Quality Treatment.

(5) Mental health services provided shall comply with the following standards:

(a) In designated receiving facilities, the on-site provision of emergency psychiatric reception and treatment services shall be available 24-hours-a-day, seven-days-a-week, without regard to the person's financial situation.

**Q. Our hospital was recently sold. What do we need to do to retain our receiving facility status?**

You need to submit an application for re-designation as a receiving facility due to the hospital's change of ownership, as follows:

65E-5.350 Eligibility Criteria and Procedures for Designation of Baker Act Receiving Facilities.

(7) Re-Applications for Renewal of Designation.

(c) A re-application must be submitted by a facility upon a change of controlling ownership of the facility or of the contractual management entity for the psychiatric service. Failure to submit notification to the department of changes of controlling ownership or a change in the management entity within 30 days after the change will terminate the facility's designation 60 days after the effective date of the action changing the control of ownership or management.

Your administrator should be working with DCF to accomplish this re-application within the time period permitted by law.

**Q. A local hospital based receiving facility just closed its psychiatric unit and gave up its designation. If individuals who meet criteria for involuntary or voluntary examination arrive at that hospital with or without injuries or in need of medical examination, must they be accepted by the hospital?**

Yes. A hospital is obligated by the federal EMTALA law to accept any person coming to its emergency department for the purpose of conducting a medical screening examination to determine if the person has an emergency medical condition. The federal government (CMS) defines an emergency medical condition to include psychiatric emergencies and substance abuse emergencies. If such an EMC exists, Jackson North would be required to transfer a person with such a psychiatric emergency to a Baker Act receiving facility within 12 hours after medical stabilization. It is responsible for the screening examination, stabilization of the person, provision of medical records, obtaining prior approval of any transfer from the destination facility, and arranging for safe/appropriate transportation.

Even though it has given up its designation and closed its psychiatric unit, the hospital is still required to uphold all rights of persons it holds under the voluntary or involuntary provisions of the Baker Act. Chapter 395, FS that governs hospital licensure has the following provisions:

395.003(5)(a) governing licensure of all hospitals states “Adherence to patient rights, standards of care, and examination and placement procedures provided under part I of chapter 394 shall be a condition of licensure for hospitals providing voluntary or involuntary medical or psychiatric observation, evaluation, diagnosis, or treatment”.

(5)(b) “Any hospital that provides psychiatric treatment to persons under 18 years of age who have emotional disturbances shall comply with the procedures pertaining to the rights of patients prescribed in part I of chapter 394”.

395.1041(6) RIGHTS OF PERSONS BEING TREATED.--A hospital providing emergency services and care to a person who is being involuntarily examined under the provisions of s. 394.463 shall adhere to the rights of patients specified in part I of chapter 394 and the involuntary examination procedures provided in s. 394.463, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under part I of chapter 394 and regardless of whether the person is admitted to the hospital.

395.1055(5) governing rules and enforcement states “The agency shall enforce the provisions of part I of chapter 394, and rules adopted thereunder, with respect to the rights, standards of care, and examination and placement procedures applicable to patients voluntarily or involuntarily admitted to hospitals providing psychiatric observation, evaluation, diagnosis, or treatment”.

395.1065(6) governing criminal and administrative penalties states “In seeking to impose penalties against a facility as defined in s. 394.455 for a violation of part I of chapter 394, the agency is authorized to rely on the investigation and findings by the Department of Health in lieu of conducting its own investigation”.

395.3025 Patient and personnel records; copies; examination.--

(1) Any licensed facility shall, upon written request, and only after discharge of the patient...

(2) This section does not apply to records maintained at any licensed facility the primary function of which is to provide psychiatric care to its patients, or to

records of treatment for any mental or emotional condition at any other licensed facility which are governed by the provisions of s. 394.4615.

(3) This section does not apply to records of substance abuse impaired persons, which are governed by s. 397.501.

**Q. We are considering the closure of our Child and Adolescent unit. If we were to move forward with this would we still be required to receive ages 0-13 when placed on a Baker Act. Is there a statute to this effect and if so what is it? Concerning the possibility of the Transportation Exception Plan, what are the steps involved/time frames to get this? Is there criteria that must be met in order to qualify for this? Do you know of facilities that have a Transportation Exception Plan in effect, and if so, how does it work for them?**

Enclosed information below that describes the statutory and code requirements related to Transportation Exception Plans.

**394.462 Transportation.--**

(1) Transportation to a Receiving Facility.--

(a) **Each county shall designate a single law enforcement agency within the county, or portions thereof, to take a person into custody upon the entry of an ex parte order or the execution of a certificate for involuntary examination by an authorized professional and to transport that person to the nearest receiving facility for examination. The designated law enforcement agency may decline to transport the person to a receiving facility only if: (a number of exceptions are listed in the law)**

**(3) EXCEPTIONS.--An exception to the requirements of this section may be granted by the secretary of the department** for the purposes of improving service coordination or better meeting the special needs of individuals. A proposal for an exception must be submitted by the district administrator after being approved by the governing boards of any affected counties, prior to submission to the secretary.

(a) A proposal for an exception must identify the specific provision from which an exception is requested; describe how the proposal will be implemented by participating law enforcement agencies and transportation authorities; and provide a plan for the coordination of services such as case management.

(b) The exception may be granted only for:

1. An arrangement centralizing and improving the provision of services within a district, which may include an exception to the requirement for transportation to the nearest receiving facility;
2. An arrangement by which a facility may provide, in addition to required psychiatric services, an environment and services which are uniquely tailored to the needs of an identified group of persons with special needs, such as persons with hearing impairments or visual impairments, or elderly persons with physical frailties; or
3. A specialized transportation system that provides an efficient and humane method of transporting patients to receiving facilities, among receiving facilities, and to treatment facilities.

(c) Any exception approved pursuant to this subsection shall be reviewed and approved every 5 years by the secretary.

### **65E-5.2601 Transportation Exception Plan.**

- (1) In determining whether to approve a proposal for an exception or exceptions to the transportation requirements of Section 394.462(3), F.S., the following shall be considered by the department:
  - (a) The specific provision from which an exception is requested;
  - (b) Evidence presented by the department's district or region of community need and support for the request;
  - (c) Whether the proposal is presented in a format that is clear, simple, and can be readily implemented by all parties and the public;
  - (d) How the proposed plan will improve services to the public and persons needing Baker Act services; and
  - (e) Whether the geographic boundaries identified in the proposal are distinct and unambiguous.
- (2) The proposal must include provisions which address:
  - (a) Accountability for delays or confusion when transportation fails to respond appropriately;
  - (b) How disputes which may arise over implementation of the plan will be resolved;
  - (c) Identification of the public official whose position is responsible for the continuing oversight and monitoring of the service in compliance with the terms of the approved proposal;
  - (d) The plan for periodically monitoring compliance with the proposal, public satisfaction with the service provided, and assurance of rights of each person served by the facility;
  - (e) The method complaints and grievances are to be received and resolved; and
  - (f) Community support and involvement including a description of the participation of designated public and private receiving facilities, law enforcement, transportation officials, consumers, families, and advocacy groups.
- (3) The approval by the governing boards of any affected counties, shall be certified in writing by the district or region's mental health and substance abuse program supervisor, prior to the plan's submission to the Secretary of the Department.

Under the federal EMTALA law, your hospital is required to accept all persons and to perform a medical screening examination, regardless of age or type of condition. This applies to those on voluntary or involuntary status. An emergency psychiatric condition is considered by the federal government to be an emergency medical condition even if no other medical condition exists. If you had no beds for psychiatrically impaired minors, your hospital would be responsible for seeking out a specialty hospital or receiving facility and obtaining prior approval before transferring the child once stabilized for transfer. You would be responsible for arranging safe and appropriate transport for the child to the destination facility.

EMTALA, the Emergency Medical Treatment and Active Labor Act, is the patient "antidumping" provision of Section 1867 of the Social Security Act. Corresponding state statutes are included in Chapter 395.1041 governing Access to Emergency Care. Chapter 395 is Florida's hospital licensing statute. It is more stringent than the federal EMTALA law in places.

With regard to your questions about hospitals' obligations under the Baker Act, chapter 395 addresses this in several cites.

395.003(5)(a) governing licensure of all hospitals states “Adherence to patient rights, standards of care, and examination and placement procedures provided under part I of chapter 394 shall be a condition of licensure for hospitals providing voluntary or involuntary medical or psychiatric observation, evaluation, diagnosis, or treatment”.

(5)(b)”Any hospital that provides psychiatric treatment to persons under 18 years of age who have emotional disturbances shall comply with the procedures pertaining to the rights of patients prescribed in part I of chapter 394”.

395.1041(6) RIGHTS OF PERSONS BEING TREATED.--A hospital providing emergency services and care to a person who is being involuntarily examined under the provisions of s. 394.463 shall adhere to the rights of patients specified in part I of chapter 394 and the involuntary examination procedures provided in s. 394.463, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under part I of chapter 394 and regardless of whether the person is admitted to the hospital.

395.1055(5) governing rules and enforcement states “The agency shall enforce the provisions of part I of chapter 394, and rules adopted thereunder, with respect to the rights, standards of care, and examination and placement procedures applicable to patients voluntarily or involuntarily admitted to hospitals providing psychiatric observation, evaluation, diagnosis, or treatment”.

395.1065(6) governing criminal and administrative penalties states “In seeking to impose penalties against a facility as defined in s. 394.455 for a violation of part I of chapter 394, the agency is authorized to rely on the investigation and findings by the Department of Health in lieu of conducting its own investigation”.

It appears from your message that your hospital may intend to retain its adult psychiatric unit and its designation as a receiving facility? If so, even under the state’s Baker Act it would required to accept any person brought by law enforcement for involuntary examination. A Transportation Exception Plan could be submitted to your Board of County Commissioners and to the DCF Secretary for approval to have minors of the age you specify diverted away from your hospital unless they have significant medical issues.

**Q. I had a question related to the process of relinquishing our Baker Act receiving facility designation. We are exploring all options of our providing mental health services due to declining reimbursements and increased managed care utilization. What it the formal process of notification to start this procedure? Further, if the designation is relinquished, and a patient is brought here to the medical center for medical clearance, who’s responsibility is it then to arrange for transfer to a designated receiving facility? The CSU would still be a receiving facility here in our town. Should patients be sent there after medical clearance?**

It isn’t clear from your question as to whether you were considering the closure of your behavioral health unit or just giving up the designation so this response will give some information regarding both.

Closure of a unit won't prevent people with severe psychiatric conditions from being brought to your hospital if they are believed to have medical conditions. EMTALA requires the hospital accept any person brought onto the premises, conduct the medical screening, and if found to have an emergency medical condition (including psychiatric and substance abuse emergencies absent any other medical condition) to stabilize the condition and meet all other requirements for an appropriate transfer before sending the person out for specialized care. One of the requirements is finding a designated receiving facility willing to accept the person within 12 hours after medical stabilization. This is a huge problem because other facilities are often full and often can't accept transfers. This would leave the patient in your hospital ER for extended periods of time with no legal authority to hold or medically treat.

This will be a special problem because there are many medical conditions that the CSU will be unable to accept as it is not licensed as a hospital and it isn't licensed to provide medical services. In those situations, your ED would have to seek out a general hospital that is designated as a receiving facility that also has the capability and capacity to manage the person's condition.

The responsibility for arranging safe and appropriate transportation of persons with emergency conditions from your ED (including psychiatric and substance abuse emergencies) remains that of the sending hospital. This is one of a number of requirements under the federal EMTALA law.

A facility can't keep a psychiatric unit open unless it is designated as a receiving facility because insurance companies won't typically pay for a patient on voluntary status -- defined in the law as one who is able to make well reasoned, willful and knowing decisions about his/her own medical and mental health conditions and is willing to stay. If a person doesn't meet these criteria, he/she must be converted to involuntary status and transferred to a designated receiving facility.

There may be few advantages for a hospital such as yours to give up its designation and close its unit. Perhaps the only advantage is it wouldn't have to accept transfers of psychiatric patients from other hospitals.

I see from your website that you serve a multi-county area and have a mission of providing a full range of quality health care services to everyone in the community. Serving the acute mental health needs of your residents is a critical need that can't be met by a CSU.

**Q. Can a Baker Act receiving facility accept only geriatric patients? Can a facility accept only 40-50 year olds? My understanding is that a transportation exception under 394 would be necessary for a certain population within a defined area to always be transported to a particular facility. However, this would not exclude other persons that law enforcement may bring to the nearest receiving facility. What do you say?**

You are correct. A Baker Act receiving facility is required by law to "accept" any person brought by law enforcement for involuntary examination. Once accepted, the facility can attempt to transfer a person who doesn't meet the facility's criteria to another receiving facility that does.

**394.462(1)(j) The nearest receiving facility must accept persons brought by law enforcement officers for involuntary examination.**

The Florida Administrative Code addresses this issue as well:

**65E-5.350 Eligibility Criteria and Procedures for Designation of Baker Act Receiving Facilities.**

(1) General Provisions. Pursuant to Sections 394.455(26) and 394.461, F.S., only facilities designated by the department are permitted to involuntarily hold and treat persons for a mental illness, except as required by 42 USC 1395 (EMTALA) for all hospitals providing emergency services for access, assessment, stabilization and transfer.

(3) Two types of licensed civil facilities are authorized to provide acute psychiatric treatment and are eligible to apply for designation as receiving facilities. **Since designation to receive persons under Chapter 394, Part I, F.S., does not distinguish between the capacity to serve adults and minors, all designated facilities are required to provide emergency services, consistent with their facility's licensure to persons regardless of age, except as provided for under subsection (4) of this rule.**

(4) Specific Circumstances for Designation. Pursuant to the exceptions authorized under Section 394.462(3), F.S., for transportation purposes, and at the discretion of the department's district or regional office with the approval of the mental health and substance abuse program supervisor, **a facility designation may be modified or restricted to specify services for just adults or for just children, consistent with its license and subject to inclusion and subsequent approval by required parties as part of an approved transportation exemption plan.**

(5) Application and Supporting Documentation for Designation. In order to apply for designation as a receiving facility, an applicant must complete and submit mandatory form CF-MH 3125, Feb. 05, "Application for Designation as a Receiving Facility," which is hereby incorporated by reference and may be obtained in accordance with Rule 65E-5.120, F.A.C., of this rule chapter. Required application information includes:

(d) Description of proposed psychiatric services including any distinct programs to be provided to each of the following consumer age groups, and the projected numbers of persons to be served in each following group:

1. Minors below 10 years of age;
2. Minors between the ages of 10 to 17 years;
3. Adults;
4. Persons 60 or more years of age; and
5. Other specific populations.

(f) Documentation of community need for maintaining or expanding the present level of designated facilities' services to meet the existing need, and why the applicant is best suited to meet this need.

1. The information **may address the public's need for specific services for minors, aged, blind or hearing-impaired persons.** Evidence of such need may include: Certificate of Need data and other information published by the Agency for Health Care Administration, the organization's or community's utilization of available or licensed bed capacity, geographical accessibility information, input from local governmental agencies, or information on the specific needs of

persons if the particular specialty services offered are accredited or certified by a nationally recognized body for that specific population or service.

If the receiving facility is a licensed hospital, it must accept any person coming to the facility on voluntary or involuntary status and provide a medical screening within the capability of the hospital to determine if the person has an emergency medical condition (EMC). Federal CMS defines an EMC to include psychiatric and substance abuse emergencies. If a psychiatric emergency exists, all aspects of the federal EMTALA law applies.

**Q. I work for the Sheriff's Office as the mental health coordinator. A few days ago, one of the Officers took a resident to a hospital to get a medical clearance and to Baker Act her to their mental health unit. This patient was over 55, but the staff at the Hospital stated they are not a Baker Act receiving facility. Everything I have read says that this hospital is a receiving center for patients 55 and over.**

This hospital is indeed designated as a Baker Act receiving facility. A Transportation Exception Plan had once been approved by your Board of County Commissioners and the Secretary of DCF permitting your law enforcement officers to bypass the nearest receiving facility to take persons under the age of 55 to the public receiving facility in a nearby county. Further, this hospital is subject to the state's hospital licensing law and to the federal EMTALA law. It must accept any person brought to it for a medical screening and can then initiate an appropriate transfer of persons with emergency medical conditions (including psychiatric and substance abuse emergencies) for whom it doesn't have the capability or capacity to serve.

**Q. Can we go on "divert status" when we are at capacity and have individuals waiting in our lobby for evaluation? I don't feel it's safe to continue to accept patients. We can't go over our licensed capacity, beyond what is allowed for by statute. What are our remedies?**

You cannot go on "divert status" with law enforcement. Receiving facilities must manage the back door instead of the front door in those circumstances. They can refuse voluntary admissions and they can refuse transfers of persons from other facilities at these times. However, when at capacity, they may need to:

1. Expedite stabilization of persons and arrange for their earlier discharge with sufficient aftercare to ensure safety.
2. Transfer those persons with sources of public or private insurance to private receiving facilities to make room for persons with no source of payment.
3. Go over licensed capacity temporarily while #1 and #2 are being addressed.

A number of persons waiting may not even be eligible for admission because they don't meet criteria. When demand increases to the level you described, triaging may assist in identifying those persons who can be released prior to admission.

## **Public Receiving Facilities and Crisis Stabilization Units**

**Q. Can you direct me to the area in 65E-5, FAC that speaks to the CMHC's responsibility for coordination of care?**

It's found in (5) of the Minimum Standards for Receiving Facilities, not Continuity of Care:

**65E-5.351 Minimum Standards for Designated Receiving Facilities.**

(1) Any facility designated as a receiving facility failing to comply with this chapter may have such designation suspended or withdrawn.

(2) Each receiving facility shall have policies and procedures that prescribe, monitor and enforce all requirements specified in Chapter 65E-5, F.A.C.

(3) Each receiving facility shall assure that its reception, screening, and inpatient services are fully operational 24-hours-per-day, 7-days-per-week.

(4) Each receiving facility shall have a compliance program that monitors facility and professional compliance with Chapter 394, Part I, F.S., and this chapter. Every such program shall specifically monitor the adequacy of and the timeframes involved in the facility procedures utilized to expedite obtaining informed consent for treatment. This program may be integrated with other activities.

(5) A public receiving facility that is affiliated with a publicly funded community mental health center shall ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness.

**Q. In a recent meeting with our public provider, they stated that their interpretation of FS 394 with respect to designation of private receiving facilities requires these facilities to provide indigent care. My response was that private facilities are required to perform an evaluation \ assessment. DCF funds a public system to serve the indigent. Of course, as a practical matter, private facilities do provide uncompensated care – but this is not a requirement for designation. Is this correct?**

The private receiving facilities are generally in chapter 395 hospitals. Thus they are governed by the federal EMTALA law (and chapter 395.1041,FS) and are obligated to accept all persons (voluntary and involuntary) for a "medical screening evaluation". If the person is determined to have an emergency psychiatric condition, this is an emergency medical condition under federal law and any subsequent pre-admission transfer would be governed by EMTALA. While a person governed by EMTALA cannot be transferred without their consent from a facility with the capability and capacity to meet the persons psychiatric needs solely because of inability to pay, such a transfer can be very legitimate if the person or their legal representative request such a transfer because of type of insurance or lack of insurance.

Once admitted to a hospital or found not to have an emergency condition, EMTALA no longer applies. At that point, the transfer provisions of the Baker Act apply:

**394.4685 Transfer of patients among facilities.--**

(3) Transfer From Private To Public Facilities.--

(a) A patient or the patient's guardian or guardian advocate may request the transfer of the patient from a private to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility.

(b) A private facility may request the transfer of a patient from the facility to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility. The cost of such transfer shall be the responsibility of the transferring facility.

(c) A public facility must respond to a request for the transfer of a patient within 2 working days after receipt of the request.

Designation by state DCF as a private receiving facility under 394, FS (also public facilities) would require the facility to accept any person brought by law enforcement for involuntary examination. Once accepted, the Mandatory Initial Involuntary Examination would have to be conducted / documented without unnecessary delay.

**65E-5.2801 Minimum Standards for Involuntary Examination Pursuant to Section 394.463, F.S.**

The involuntary examination is also known as the initial mandatory involuntary examination.

(1) Whenever an involuntary examination is initiated by a circuit court, a law enforcement officer, or a mental health professional as provided in Section 394.463(2), F.S., an examination by a physician or clinical psychologist must be conducted and documented in the person's clinical record. The examination, conducted at a facility licensed under Chapter 394 or 395, F.S., must contain:

- (a) A thorough review of any observations of the person's recent behavior;
- (b) A review of mandatory form CF-MH 3100, "Transportation to Receiving Facility," as referenced in subsection 65E- 5.260(2), F.A.C., and recommended form CF-MH 3001, "Ex Parte Order for Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., or other form provided by the court, or mandatory form CF-MH 3052a, "Report of Law Enforcement Officer Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C., or mandatory form CF-MH 3052b, "Certificate of Professional Initiating Involuntary Examination," as referenced in subsection 65E-5.260(1), F.A.C.

(c) A brief psychiatric history; and

(d) A face-to-face examination of the person in a timely manner to determine if the person meets criteria for release.

(2) If the physician or clinical psychologist conducting the initial mandatory involuntary examination determines that the person does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement, the person can be offered voluntary placement, if the person meets criteria for voluntary admission, or released directly from the hospital providing emergency medical services. Such determination must be documented in the person's clinical record.

Some private hospitals have a certain amount of charity/uncompensated care required as a condition of their Certificate of Need. This CON requirement is a continuing one even after licensure. Some of these hospitals also receive significant amounts of Public Medical Assistance Trust Funds dollars to offset the cost of caring for medical and/or psychiatric patients who are unable to pay for their own care.

Finally, the Baker Act makes no distinction between the obligations of public and private receiving facilities other than when an individual has felony charges and the public receiving facility is unable to provide for adequate security. However, in such cases, the public receiving facility remains responsible for providing mental health examination and treatment to the person where he or she is held. The statutory provisions of the Baker

Act place no requirement on private receiving facilities to serve indigent persons. Chapter 65E-5, FAC places requirements on public receiving facilities in exchange for their receipt of public funding. In fact, one of the requirements of a public receiving facility is:

**65E-5.351 Minimum Standards for Designated Receiving Facilities.**

(5) A public receiving facility that is affiliated with a publicly funded community mental health center shall ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness.

As you can see, the public receiving facility is ultimately responsible for securing access to and coordination of care for persons with acute mental illnesses.

**Q. Is there a requirement to have a licensed mental health professional on-site at our CSU 24/7 for evaluations?**

No, you are not required to have such a person on-site, but you must have a psychiatrist or other physician on-call 24/7. These requirements are incorporated the screening provisions with the references from the rules governing CSU's (65E-12) as well from 65E-5 below.

**65E-12.103, FAC Definitions.**

(8) "Emergency Screening" is the process whereby a person receives a preliminary determination as to type, extent and immediacy of the treatment needs.

**65E-12.107, FAC Minimum Standards for Crisis Stabilization Units (CSUs).**

In addition to sections 65E-12.104, 65E-12.105, and 65E-12.106, F.A.C., above, these standards apply to CSU programs.

**(1) Emergency Screening.** All persons who apply for admission pursuant to section 394.4625, F.S., or for whom involuntary examination is initiated pursuant to section 394.463, F.S., shall be assessed by the CSU or by the emergency services unit of the public receiving facility. Each receiving facility shall provide emergency screening services on a 24-hours-a-day, 7-days-a-week basis and shall have policies and procedures for identifying individuals at high risk. No person can be detained for more than 12 hours without being admitted or released. Everyone for whom involuntary examination is initiated pursuant to section 394.463, F.S., shall receive a face-to-face examination by a physician or clinical psychologist prior to release. The examination shall include a psychiatric evaluation, including a mental status examination, or a psychological status report.

(a) Unit policies and procedures shall be written concerning the detainment of persons who are awaiting an involuntary examination and disposition. These procedures shall address protection from harm, and the prevention of departure from the unit prior to the examination.

(b) Referral. Individuals referred, or to be referred, to a receiving facility under chapter 394, part I, F.S., who also require treatment for an acute physical condition shall be delivered and, if appropriate, admitted to an emergency medical or inpatient service for health care until medically cleared and stabilized

to meet the CSU's medical criteria as prescribed in its policies and procedures. Medical clearance shall be documented in the clinical record.

**(2) Admission.**

(a) All persons admitted to a CSU shall be admitted pursuant to chapter 394, part I, F.S., and chapter 65E-5, F.A.C. Each CSU shall provide admission services on a 24-hour-a-day, 7-days-a-week basis.

**(b) Initial Assessment.**

1. Upon admission to the CSU, an emotional and behavioral assessment as specified in (d) below shall be made based on facility program policy and procedures. This assessment shall be made by a mental health professional, registered nurse, or **other unit staff under the supervision of a mental health professional**. The consultation of a physician, psychiatrist, or clinical psychologist shall be available to the CSU staff for purposes of assisting in this assessment. Examination and disposition of a person who has been admitted involuntarily shall be **in accordance with the provisions of section 394.463, F.S.**

2. All persons admitted to a CSU shall be provided a nursing assessment, begun at time of admission and completed within 24 hours, by a registered nurse as part of the assessment process.

(c) Physical Examination. All persons admitted to a CSU shall be provided a physical examination within 24 hours of admission, based on program policies and procedures. The physical examination shall include a complete medical history and documentation of significant medical problems. It shall contain specific descriptive terms and not the phrase, "within normal limits." General findings shall be written in the clinical records within 24 hours.

(d) Emotional and Behavioral Assessment. For everyone admitted to a CSU an emotional and behavioral assessment shall be completed within 72 hours and entered into the clinical record. The assessment shall be made by a mental health professional **or other unit staff under the supervision of a mental health professional**

**65E-5.400, FAC Baker Act Funded Services Standards.**

**(5) Emergency Reception and Screening.**

(a) Providers authorized by the department shall have a policy and procedure manual for the specific service being provided. The administration of the provider organization shall ensure the completeness and accuracy of the manual and that organizational operations are in accordance with the manual. The manual must be approved by the respective departmental district or regional office for completeness and consistency in implementing this chapter and Chapter 394, Part I, F.S. The manual shall be consistent with the provisions of Chapter 394, Part I, F.S., and with Chapter 65E-5, F.A.C., and must include the following:

1. Procedures for responding to requests for services that specify a prompt screening to determine the person's immediacy of need, and for prioritizing access to services with limited availability. Staff skills shall be specific to the unique needs of the persons to be served;
2. A description of the services offered, recipient eligibility criteria, how eligible recipient facilities or individuals are informed of service availability, service locations, costs, criteria for response, hours of operation, staffing with staff qualifications and supervision, and organizational line of authority to the operating entity;

3. Procedures to be utilized to implement and document staff training in accord with Rule 65E-5.330, F.A.C., staff proficiency or competency including the performance of any subcontractors employed to provide services, and how training will be used to effect remediable identified deficiencies;
  4. Procedures for a complaint and grievance system that provide a prompt response to the individuals served, and mechanisms to monitor and evaluate service quality, and the outcomes attained by individuals served. Facility personnel shall provide each person served with a listing of his or her rights and a telephone number to which complaints may be directed;
  5. Procedures to determine if the individual has a case manager from a mental health center or clinic, as well as notification and coordination of activities with the case manager;
  6. Procedures to maintain a clinical record for each individual served and its safeguarding in accordance with Section 394.4615, F.S.; and
  7. Procedures to inform the public of the availability of services.
- (b) Procedures must assure that a psychiatrist or a physician shall be available on-call for consultation at all times and hours during which emergency reception and screening services are operated.**

You must have a psychiatrist or psychologist perform the Mandatory Initial Involuntary Examination as required “without unnecessary delay” (hopefully within 24 hours) and authorize release of the person if found to not meet the requirements for involuntary placement. However, if additional observation is required for someone who appears to meet the involuntary placement criteria, you generally have up to 72 hours before release authorized by a psychiatrist or psychologist or filing of the placement petition with the court.

**Q. Are all public receiving facilities not-for-profit? Our private psychiatric hospital is up for designation next year and would like to contract with DCF for Baker Act services and funding. Is a different type of license required?**

No, some for-profit organizations are designated as public receiving facilities. Each of these hospitals provides a service that DCF determined was needed that wasn't available from the not-for-profit CSU providers.

No different license is required -- just for DCF to contract with the hospital and change the type of designation from private to public. The only problem with this plan is that any funding for your hospital could have to be removed from current providers unless a new source of legislatively appropriated Baker Act funds has been identified..

**Q. How does a receiving facility receive public funding and what are the differences between a public and private receiving facility?**

A facility is designated as a "public" receiving facility when it enters into a contract with DCF for Baker Act services. The Department isn't obliged to contract with any facility and is limited to the availability of legislatively appropriated funds. The requirements of a private receiving facility are the same as a public, except for a provision in the Transportation section of the law that refers to persons with felony charges. There are also differences in the "Transfer" section.

**Q. When an indigent client sits in a non-designated hospital emergency room over the 12 hour limit, does the statute or rule preclude that facility from billing DCF for ongoing care?**

Such care is not eligible for payment -- it is governed under the following section of the Florida Administrative Code:

65E-5.400 Baker Act Funded Services Standards.

(1) Applicability. Designation as a public receiving facility is required for any facility licensed under the authority of Chapter 395 or 394, F.S., to be eligible for payment from Baker Act appropriations. Designation does not in and of itself represent any agreement to pay for any services rendered pursuant to Chapter 394, Part I, F.S., or this chapter. Public receiving facilities, under contract with the department, serve as a local focal point for district or region public information dissemination and educational activities with other local Baker Act involved entities and public agencies.

(2) Baker Act Funding.

(a) Only public receiving facilities, pursuant to Section 394.455(25), F.S., and only the costs of eligible Baker Act services provided to diagnostically and financially eligible persons may be paid with Baker Act appropriations

**Q. Our community has a crisis due to shortage of publicly funded Baker Act beds. Can our CSU expand to meet this need?:**

Not necessarily. Chapter 394.875, FS that governs crisis stabilization units, limits the size of such adult units to a maximum of 30 beds and children's units to a maximum of 20 beds.. There may also be insufficient funds available to expand. Further, crisis stabilization units are prohibited by law from exceeding their licensed capacity by more than 10 percent, nor may they exceed their licensed capacity for more than 3 consecutive working days or for more than 7 days in 1 month.

**Q. Where is the section that refers to a CSU's inability to go over census more than 3 days in a row and only seven times a month?**

The provision you ask about is in 394, Part IV:

394.875 Crisis stabilization units, residential treatment facilities, and residential treatment centers for children and adolescents; authorized services; license required.—

(9) Notwithstanding the provisions of subsection (6), crisis stabilization units may not exceed their licensed capacity by more than 10 percent, nor may they exceed their licensed capacity for more than 3 consecutive working days or for more than 7 days in 1 month.

Rules limiting to 20% of funded days used for non-financially eligible persons is included in the following (none of these can be Medicaid funded):

65E-5.400 Baker Act Funded Services Standards.

(1) (c) Persons receiving Baker Act funded services must meet financial eligibility criteria as established by the federal poverty guidelines. Public receiving facilities may provide Baker Act funded services to acutely ill persons who are financially ineligible if the total number of days of service paid for with Baker Act funds for financially ineligible persons does not exceed 20 percent of the total number of days paid for with Baker Act funds.

**Q. If DCF is funding several beds at a designated private receiving facility, does the receipt of such funding require re-designation as a public receiving facility?**

Yes, the hospital will have to be designated as public receiving facilities as quickly as possible to hopefully avoid any audit liability issues. The following regulatory provisions apply:

65E-5.400 Baker Act Funded Services Standards.

(1) Applicability. Designation as a public receiving facility is required for any facility licensed under the authority of Chapter 395 or 394, F.S., to be eligible for payment from Baker Act appropriations. Designation does not in and of itself represent any agreement to pay for any services rendered pursuant to Chapter 394, Part I, F.S., or this chapter. Public receiving facilities, under contract with the department, serve as a local focal point for district or region public information dissemination and educational activities with other local Baker Act involved entities and public agencies.

(2) Baker Act Funding.

(a) Only public receiving facilities, pursuant to Section 394.455(25), F.S., and only the costs of eligible Baker Act services provided to diagnostically and financially eligible persons may be paid with Baker Act appropriations.

65E-5.350 Eligibility Criteria and Procedures for Designation of Baker Act Receiving Facilities.

(1) General Provisions. Pursuant to Sections 394.455(26) and 394.461, F.S., only facilities designated by the department are permitted to involuntarily hold and treat persons for a mental illness, except as required by 42 USC 1395 for all hospitals providing emergency services for access, assessment, stabilization and transfer.

(2) Designation as a private receiving or treatment facility shall not entitle the facility to receive any funding appropriated for the Baker Act. Such funding is based solely on a contract between the department and the facility, specifically for this purpose.

(3) (a) Hospitals licensed under the authority of Chapter 395, F.S., to provide psychiatric care may be designated as either public or private receiving facilities.

(b) Facilities licensed under the provisions of Chapter 394, Part IV, F.S., shall only be designated as public receiving facilities and may include only crisis stabilization units (CSU) and children's crisis stabilization units (CCSU). Short-term residential treatment facilities (SRT) are not free-standing emergency care units and may only be designated collectively with a CSU or CCSU as part of a public receiving facility.

**Q. Our county matches DCF Baker Act funding on a 3:1 basis. Is there a mandate in the Florida Statute on Baker Act that counties must fund or provide a local match for Baker Act beds, or is this a voluntary process?**

Chapter 394, Part IV governs the financial aspects of funding, as follows:

**394.76 Financing of district programs and services.**--If the local match funding level is not provided in the General Appropriations Act or the substantive bill implementing the General Appropriations Act, such funding level shall be provided as follows:

(3) The state share of financial participation shall be determined by the following formula:

(b) ...All other contracted community alcohol and mental health services and programs, except as identified in s. 394.457(3), shall require local participation on a 75-to-25 state-to-local ratio.

(9)(a) State funds for community alcohol and mental health services shall be matched by local matching funds as provided in paragraph (3)(b). The governing bodies within a district or sub-district shall be required to participate in the funding of alcohol and mental health services under the jurisdiction of such governing bodies. The amount of the participation shall be at least that amount which, when added to other available local matching funds, is necessary to match state funds.

DCF/HQ answered a series of questions about matching requirements, as follows:

1. Must the match be given on an agency-specific basis or can a county allocation for a single agency, if large enough, meet the county's obligation? Local match is agency-specific. Chapter 394.76 (3)(b), F.S. specifies that local participation shall be on a 75 to 25 state to local ratio for eligible costs. Consequently, if a provider, under contract with ADM, incurs eligible state costs local government must match up to 25 percent.

2. The definition of "local matching funds" seems to imply a cash match. Can in-kind match be considered? Like providing a building or lease-hold improvements.

Chapter 65E-14.005, Matching, states that matching requirements may be satisfied by any or all of the following:

a) Allowable costs supported by non-State or Federal grants incurred by the contractor during the effective date of the contract:

(b) The value of third-party in-kind contributions applicable to the matching requirement period;

(c) When a contractor does not receive sufficient tax support from a public agency or where that support does not meet the 25 percent match requirement, volunteer services may be counted as local match up to and including 10 percent of the total budget; and,

(d) General revenue sharing funds under 31 U.S.C. 1221 are not considered a federal grant; therefore, allowable costs supported by these funds may count towards satisfying a matching requirement.

(e) Fees and program income may be used towards satisfying matching requirements. Fees include 1st and 3rd party fees, donations, and contributions.

3. Does the match need to buy a certain number of units of services?  
No. Match is based on allowable expenditures only per Chapter 394.76(3)(a), FS.

4. If a county wished to tie its funds (other than Baker Act) to purchase specific cost center units for specifically referred county clients, could these funds be considered "local match funds"?  
Absolutely!!!

Finally, the Florida Supreme Court also ruled on 3/12/81 {Andrew Sandegren v. State of Florida/Sarasota County Public Hospital Board Case # 58,868). The Supreme Court found that local governing bodies do not have the right to refuse to fund mental health programs as required by chapter 394. The judgment of a local governing body as to the necessity for such programs is not material when the legislature has declared that those programs are necessary and that a share of the cost should be locally funded... The legislature declared a necessity for mental health services and its intent that local governments participate in the financial responsibility for such services. The funding of local programs, therefore, has been made a ministerial, rather than a discretionary, act and is enforceable through mandamus. Mandamus will lie to compel performance of a clear legal duty... In our opinion, Sarasota County has a clear legal duty to fulfill the obligation imposed by this statute.

**Q. A CSU appears to be just an independent facility which just happens to have as one of its contracts, a contract with DCF to serve indigent patients. CSU's also has many commercial insurance contracts and other types of contracts as well. If the Baker Act law specifies that a BA facility is responsible for the transportation of a patient from that facility to another, then why is it that CSU's end up getting the facility accepting it's transfer to pick up the tab for the transportation and not being required to pay for it themselves? Many people think CSU's are State-run facilities when actually they are independent with a Board of Trustees just like everyone else. People also think that CSU's only take indigent people and therefore should not have to pay for transportation when often CSU's have as many contracts as other types of facilities. Is this correct?**

CSU's are established by state law, as follows:

394.875 Crisis stabilization units, residential treatment facilities, and residential treatment centers for children and adolescents; authorized services; license required.--

(1)(a) The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs. Crisis stabilization units may screen, assess, and admit for stabilization persons who present themselves to the unit and persons who are brought to the unit under s. 394.463. Clients may be provided 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services. Crisis stabilization units shall provide services regardless of the client's ability to pay and shall be limited in size to a maximum of 30 beds.

(5) The agency may not issue a license to a crisis stabilization unit unless the unit receives state mental health funds and is affiliated with a designated public receiving facility.

(9) Notwithstanding the provisions of subsection (6), crisis stabilization units may not exceed their licensed capacity by more than 10 percent, nor may they exceed their licensed capacity for more than 3 consecutive working days or for more than 7 days in 1 month.

The Florida Administrative Code places a level of responsibility on these public receiving facilities to assist in coordinating care for persons with acute mental illnesses. This would include assisting other hospitals to find available and appropriate beds, even if the CSU was unable to provide such a bed due to lack of capacity or capability.

**65E-5.351 Minimum Standards for Designated Receiving Facilities.**

(5) A public receiving facility that is affiliated with a publicly funded community mental health center shall ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness.

**65E-5.400 Baker Act Funded Services Standards.**

(1) Applicability. Designation as a public receiving facility is required for any facility licensed under the authority of Chapter 395 or 394, F.S., to be eligible for payment from Baker Act appropriations. Designation does not in and of itself represent any agreement to pay for any services rendered pursuant to Chapter 394, Part I, F.S., or this chapter. Public receiving facilities, under contract with the department, serve as a local focal point for district or region public information dissemination and educational activities with other local Baker Act involved entities and public agencies.

(2) Baker Act Funding.

(a) Only public receiving facilities, pursuant to Section 394.455(25), F.S., and only the costs of eligible Baker Act services provided to diagnostically and financially eligible persons may be paid with Baker Act appropriations.

(b) Baker Act services shall first be provided to acutely ill persons who are most in need of mental health services and are least able to pay.

(c) Persons receiving Baker Act funded services must meet financial eligibility criteria as established by the federal poverty guidelines. Public receiving facilities may provide Baker Act funded services to acutely ill persons who are financially ineligible if the total number of days of service paid for with Baker Act funds for financially ineligible persons does not exceed 20 percent of the total number of days paid for with Baker Act funds.

Since DCF doesn't have sufficient legislative appropriations to buy all of a public receiving facility's beds, the CSU must "sell" any available beds not paid with public dollars to private payers. If they didn't do this, the CSU couldn't meet its expenses and would close.

**Q. I have a question regarding the admission process related to the BA Statutes. Is there a provision that requires a CSU to conduct assessments prior to a physician's admission order *in a site other than the actual CSU*? Currently, we utilize a completely separate space to do all BA and voluntary assessments before an order for admission is given. We are looking at a safer more efficient way of "holding" clients during the assessment process. In years past, our agency did**

**the assessment right on the CSU. Is there a legal reason to separate clients during this "holding period"?**

A receiving facility, CSU or hospital, must be able to receive persons on a 24/7 basis to conduct assessments and, when appropriate, to admit persons for continuing examination.

**65E-12.107 Minimum Standards for Crisis Stabilization Units (CSUs).**

In addition to sections 65E-12.104, 65E-12.105, and 65E-12.106, F.A.C., above, these standards apply to CSU programs.

(1) Emergency Screening. All persons who apply for admission pursuant to section 394.4625, F.S., or for whom involuntary examination is initiated pursuant to section 394.463, F.S., shall be assessed **by the CSU or by the emergency services unit of the public receiving facility**. Each receiving facility shall provide emergency screening services on a 24-hours-a-day, 7-days-a-week basis and shall have policies and procedures for identifying individuals at high risk. No person can be detained for more than 12 hours without being admitted or released. Everyone for whom involuntary examination is initiated pursuant to section 394.463, F.S., shall receive a face-to-face examination by a physician or clinical psychologist prior to release. The examination shall include a psychiatric evaluation, including a mental status examination, or a psychological status report.

(a) Unit policies and procedures shall be written concerning the detainment of persons who are awaiting an involuntary examination and disposition. These procedures shall address protection from harm, and the prevention of departure from the unit prior to the examination.

The above provision of the Florida Administrative Code governing CSU's requires that this assessment take place at the CSU or by the emergency services unit of the public receiving facility. This seems to suggest that the ES staff of the receiving facility could potentially conduct the assessment at an off-site location. However, it is unknown if other public receiving facilities conducts these assessments off-site. The general practice is to conduct the assessments at a locked admitting area of the CSU, separate from the area where individuals reside who have already been admitted. There is no prohibition against having the assessment done on the CSU itself as long as the staff required for the CSU aren't diverted to handle ES or pre-admit duties.

### **Involuntary Status**

**Q. Does a psychiatric patient who is held on voluntary status need to be transferred to involuntary inpatient status and to a designated receiving facility due to a change in competency, need for ETO orders, or a request to be released that cannot be supported by the attending psychiatrist?**

Since your hospital has opted not to seek designation as a receiving facility, it isn't authorized to admit or hold any person who doesn't meet criteria to be on voluntary status. This means that if persons object to admission or even if not objecting, are unable to make well-reasoned, willful and knowing decisions about their own treatment, they must be transferred to a designated receiving facility. A person with either a court appointed guardian or one with a health care surrogate or proxy making health care

decisions would be ineligible for voluntary status. It is possible that a one-time ETO might be provided to a person on voluntary status -- if successful, no petition for involuntary placement would be required, assuming the person was certified by his/her attending physician as competent to consent or refuse consent to treatment.

However, even hospitals that aren't designated as receiving facilities are responsible for ensuring that all rights of persons held under the Baker Act must be observed, as follows:

395.003(5)(a) governing licensure of all hospitals states "Adherence to patient rights, standards of care, and examination and placement procedures provided under part I of chapter 394 shall be a condition of licensure for hospitals providing voluntary or involuntary medical or psychiatric observation, evaluation, diagnosis, or treatment".

(5)(b)"Any hospital that provides psychiatric treatment to persons under 18 years of age who have emotional disturbances shall comply with the procedures pertaining to the rights of patients prescribed in part I of chapter 394".

395.1041(6) Rights Of Persons Being Treated.--A hospital providing emergency services and care to a person who is being involuntarily examined under the provisions of s. 394.463 shall adhere to the rights of patients specified in part I of chapter 394 and the involuntary examination procedures provided in s. 394.463, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under part I of chapter 394 and regardless of whether the person is admitted to the hospital.

395.1055(5) governing rules and enforcement states "The agency shall enforce the provisions of part I of chapter 394, and rules adopted thereunder, with respect to the rights, standards of care, and examination and placement procedures applicable to patients voluntarily or involuntarily admitted to hospitals providing psychiatric observation, evaluation, diagnosis, or treatment".

395.1065(6) governing criminal and administrative penalties states "In seeking to impose penalties against a facility as defined in s. 394.455 for a violation of part I of chapter 394, the agency is authorized to rely on the investigation and findings by the Department of Health in lieu of conducting its own investigation".

395.3025 Patient and personnel records; copies; examination.--

(1) Any licensed facility shall, upon written request, and only after discharge of the patient...

(2) This section does not apply to records maintained at any licensed facility the primary function of which is to provide psychiatric care to its patients, or to records of treatment for any mental or emotional condition at any other licensed facility which are governed by the provisions of s. 394.4615.

(3) This section does not apply to records of substance abuse impaired persons, which are governed by s. 397.501.

Further, since the hospital is subject to EMTALA, it must accept any person of any age who is presented at the ED and must provide a medical screening to determine if he/she has an emergency medical condition (EMC). CMS defines an EMC to include a

psychiatric emergency or substance abuse emergency, even absent any other medical condition. While you have established the unit to serve a geriatric population, you would be required to admit persons not meeting these criteria if you aren't able to arrange an appropriate transfer to a designated receiving facility.

While the Baker Act prohibits your holding a person who isn't competent to provide consent, the federal EMTALA law requires you to either admit or transfer a person with an emergency medical condition. When the EMTALA law and state Baker Act laws are in conflict, you must abide by EMTALA. Once the person has been admitted, EMTALA no longer applies (although federal Conditions of Participation and emergency care provisions of chapter 395.1041, FS do apply) and you must then comply with the Baker Act.

It is difficult to comprehend how a hospital can attest to patients being able to make well-reasoned, willful, and knowing decisions about their treatment and still be able to justify to insurance companies as to the acuity necessary to justify continued inpatient care.

Since negative charting for the purpose of obtaining insurance payments would be inappropriate, one would assume that the insurers aren't aware of Florida law.

### Inducements

**Q. I was just asked by a hospital that is working toward becoming a designated receiving facility, if it is legally allowed to contact medical hospital to ask to become their 'preferred' choice when placing Baker Act patients. This facility stated they are not interested in doing this and are only interested in knowing if this is legal.**

Regarding your question, as long as no "inducement" is offered to the sending hospital, I'm not aware of anything illegal about the activity. Inducements could include any direct or indirect financial consideration for such referrals -- this clearly is a violation of federal and state laws.

However, if one can assume this provider is not interested in all referrals -- just insured ones, this could be a significant problem. While probably not illegal, it would be totally improper if this is the case. It is unlikely that the public receiving facility serving the area can handle all referrals of indigent persons on a timely basis and such other facility would be expected to take these as well. In fact, as a hospital, it will be required to accept any referrals of persons in psychiatric emergencies for which it has capability and capacity -- otherwise it could be guilty of "reverse dumping" under the federal EMTALA law.

### State Hospital Transfers

**Q. I coordinate admissions to a state civil hospital. Recently, referrals of individuals that are in hospitals and jails have been received. It is my understanding that a person must be in a receiving facility in order to be Baker Acted to a state institution. Please clarify for me under what circumstances can a person be Baker Acted to a state institution other than via a receiving facility.**

Only an administrator of a designated receiving facility or designated treatment facility has the legal standing to file a petition for involuntary inpatient placement under the Baker Act. Not only does there need to be a hearing conducted in compliance with s.394.467(6), but a "Transfer Evaluation" conducted by the local CMHC designated by DCF to first document that the admission criteria for the state hospital are met and that no less restrictive alternative is available and appropriate.

It is possible that a person on misdemeanor charges who has a serious mental illness could be held in a jail and two psychiatrists from a receiving facility examine the person in the jail, the receiving facility administrator files the petition, the court conducts the hearing at the jail, and the person waits in the jail until transfer to a treatment facility (state hospital) takes place. This procedure is possible in the case of a person whose behavior can't be managed in a receiving facility. This same procedure has taken place when a person needed to be held in a general hospital for medical treatment not available at a receiving facility while the Baker Act legal proceedings were carried out by a receiving facility and the court. The Baker Act, in s. 394.4599(2)(c)4, FS, requires that "the written notice of filing of the petition for involuntary placement must contain a notice that the patient, the patient's guardian or representative, or the administrator may apply for a change of venue for the convenience of the parties or witnesses or because of the condition of the patient." The hearing can be conducted wherever the court decides -- that could potentially be at a jail or general hospital instead of a courthouse or designated receiving/treatment facility.

## **Payment for Care**

### **Q. What legal references exist about who pays for the examination and treatment of persons under the Baker Act?**

The Florida Attorney General issued an Opinion on payment of involuntary examinations under the Baker Act. There are also references to fee collections in the law and rule.

#### **394.459(2), FS RIGHT TO TREATMENT.--**

(a) A person shall not be denied treatment for mental illness and services shall not be delayed at a receiving or treatment facility because of inability to pay. However, every reasonable effort to collect appropriate reimbursement for the cost of providing mental health services to persons able to pay for services, including insurance or third-party payments, shall be made by facilities providing services pursuant to this part.

#### **394.674, FS Eligibility for publicly funded substance abuse and mental health services; fee collection requirements.--**

(2) Crisis services, as defined in s. 394.67, must, within the limitations of available state and local matching resources, be available to each person who is eligible for services under subsection (1), regardless of the person's ability to pay for such services. A person who is experiencing a mental health crisis and who does not meet the criteria for involuntary examination under s. 394.463(1), or a person who is experiencing a substance abuse crisis and who does not meet the involuntary admission criteria in s. 397.675, must contribute to the cost of his or her care and treatment pursuant to the sliding fee scale developed under

subsection (4), unless charging a fee is contraindicated because of the crisis situation.

(3) Mental health services, substance abuse services, and crisis services, as defined in s. 394.67, must, within the limitations of available state and local matching resources, be available to each person who is eligible for services under subsection (1). Such person must contribute to the cost of his or her care and treatment pursuant to the sliding fee scale developed under subsection (4).

(4) The department shall adopt rules to implement client eligibility, client enrollment, and fee collection requirements for publicly funded substance abuse and mental health services.

**65E-5.400, FAC Baker Act Funded Services Standards.**

(1) Applicability. Designation as a public receiving facility is required for any facility licensed under the authority of Chapter 395 or 394, F.S., to be eligible for payment from Baker Act appropriations. Designation does not in and of itself represent any agreement to pay for any services rendered pursuant to Chapter 394, Part I, F.S., or this chapter. Public receiving facilities, under contract with the department, serve as a local focal point for district or region public information dissemination and educational activities with other local Baker Act involved entities and public agencies.

(2) Baker Act Funding.

(a) Only public receiving facilities, pursuant to Section 394.455(25), F.S., and only the costs of eligible Baker Act services provided to diagnostically and financially eligible persons may be paid with Baker Act appropriations.

(b) Baker Act services shall first be provided to acutely ill persons who are most in need of mental health services and are least able to pay.

(c) Persons receiving Baker Act funded services must meet financial eligibility criteria as established by the federal poverty guidelines. Public receiving facilities may provide Baker Act funded services to acutely ill persons who are financially ineligible if the total number of days of service paid for with Baker Act funds for financially ineligible persons does not exceed 20 percent of the total number of days paid for with Baker Act funds.

(d) An individual's diagnostic and financial eligibility shall be documented on mandatory form CF-MH 3084, Feb. 05, "Baker Act Service Eligibility," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter.

(3) This section applies to all Baker Act funded providers. All services including hospital inpatient facilities, crisis stabilization units, short-term residential treatment programs, and children's crisis stabilization units providing services purchased by the department under this chapter shall be consistent with licensure requirements and must comply with written facility policies and procedures.

**Q. Our Board of County Commission has questioned their obligation to match Baker Act monies. We have always understood there is a an obligation to provide a 25% match for Baker Act funding - but I can't find that in the regulation. Can you tell if there is a requirement for the County to match Baker Act funding and if yes, where it?**

The Baker Act doesn't deal with funding -- this is covered in Chapter 394, Part IV, FS and in chapter 65e-14, FAC, as well as in a Florida Supreme Court case. When I return, I can send you those provisions that may assist. However, these provisions require that the county provide that amount which when added to other available match is needed to reach the 25% level.

**Q. Our County Purchasing Department is searching for information on designated Baker Act facilities throughout the state of Florida and, I was hoping you would be able to answer a few questions for me, or direct me to someone who can.**

**Our public Baker Act receiving facility in our county s been designated for over 20 years, per the DCF state contract. Is there a designated BA receiving facility located in each county in Florida, and are these facilities chosen by DCF as part of the state contract or do these facilities have to bid on the state contract to provide BA services? If there is more than one qualified BA receiving facility in each county, do these counties bid out their amount of contract services (25%). If there is a county with more than one BA facility, and they do bid out services for the local match, could you give me their contact information?**

A listing of all designated receiving facilities (Public and Private) is posted on the DCF website and is included in an appendix to the state's Baker Act Handbook. Public and Private Receiving Facilities are licensed by the Agency for Health Care Administration (some are hospitals and others are non-hospital CSU's) and both are designated by DCF. The only difference between a public and private receiving facility is that a public receiving facility is under contract with DCF and receives state appropriated funding for Baker Act services.

There are multiple receiving facilities (public and/or private) in some of the more populous counties; some more rural counties have no designated receiving facility. In the latter situations, law enforcement is required to transport persons under involuntary status to the nearest receiving facility, which may be several counties away.

While the Baker Act authorizes Counties to require DCF to bid out Baker Act related services, no such bidding has occurred.

**394.457 Operation and administration.--**

(3) POWER TO CONTRACT.--The department may contract to provide, and be provided with, services and facilities in order to carry out its responsibilities under this part with the following agencies: public and private hospitals; receiving and treatment facilities; clinics; laboratories; departments, divisions, and other units of state government; the state colleges and universities; the community colleges; private colleges and universities; counties, municipalities, and any other governmental unit, including facilities of the United States Government; and any other public or private entity which provides or needs facilities or services. Baker Act funds for community inpatient, crisis stabilization, short-term residential treatment, and screening services must be allocated to each county pursuant to the department's funding allocation methodology. Notwithstanding the provisions of s. 287.057(5)(f), contracts for community-based Baker Act services for inpatient, crisis stabilization, short-term residential treatment, and screening provided under this part, other than those with other units of government, to be provided for the department must be awarded using competitive sealed bids when the county commission of the

county receiving the services makes a request to the department's district office by January 15 of the contracting year. The district shall not enter into a competitively bid contract under this provision if such action will result in increases of state or local expenditures for Baker Act services within the district. Contracts for these Baker Act services using competitive sealed bids will be effective for 3 years. The department shall adopt rules establishing minimum standards for such contracted services and facilities and shall make periodic audits and inspections to assure that the contracted services are provided and meet the standards of the department.

If your county chooses to have the Baker Act services put out to bid, it would have to inform DCF before January 15<sup>th</sup>. Otherwise, it would have to wait until following fiscal year to do so. This doesn't mean the County couldn't exercise some substantial influence on its public receiving facility(s) prior to that time to resolve any problems.