

ABC Annual FY09

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**ABC Annual Report FY09  
For ABC 404 Base and Treatment Funds  
For state fiscal year ending June 30, 2009  
Due: August 14th, 2009**

Include only ABC 404 Base and Treatment information in this report.

Please do not include any of the following in this report: 404 RFP for Early Childhood Mental Health Treatment (to 13 Boards in FY09), 404 Early Childhood Mental Health Professionals (Consultation), 404 Behavioral Health/ Juvenile Justice funds, 404 Intensive Home Based Treatment grants from ODMH to 15 Boards for 1/1/08 – 6/30/09, or FAST information. For descriptions of these funding categories, see the ODMH SFY 2009 Community Allocation Guidelines.

An \* indicates a question for which a response is required.

After you exit the survey or click on the "Done" button you will not be able to return to the survey. Therefore, be sure to have your answers ready to complete the survey in a single session.

**\* 1. County Name (pick one). Please remember that a separate report is required for each county within a multi-county board area:**



**\* 2. Name of organization submitting report**

**\* 3. Name of individual submitting report**

**\* 4. Email address:**

**\* 5. Phone number:**

**\* 6. Amount of ABC 404 Base and Treatment funds spent in this county in FY09:**

**7. Describe your county’s model for planning, decision making and distribution of ABC 404 Base and Treatment funds. Include in this description how you collaborate with your local Family and Children First Council and other community organizations, as applicable:**

**8. Describe any noteworthy achievements accomplished with ABC 404 Base and Treatment funds in your county this year:**

**\* 9. Were ABC 404 Base or Treatment funds used to pay Medicaid match?**

- No
- Yes

If Yes, how much?

**\* 10. Were ABC/404 Base or Treatment funds used during FY09 to provide any of the following?**

	Yes	No
A. Early Childhood Mental Health Treatment (which means one or more of the following: Play Therapy, Dina Small Group Therapy, Filial Therapy, Trauma-Focused Cognitive-Behavioral Therapy, Parent-Child Interaction Therapy, or Therapeutic Preschool)	<input type="radio"/>	<input type="radio"/>
B. Intensive Home-Based Treatment	<input type="radio"/>	<input type="radio"/>
C. Multi-Systemic Therapy	<input type="radio"/>	<input type="radio"/>
D. Functional Family Therapy	<input type="radio"/>	<input type="radio"/>
E. Mental Health Services Provided in Schools	<input type="radio"/>	<input type="radio"/>
F. Partial Hospitalization	<input type="radio"/>	<input type="radio"/>
	..	..

G. Other (please specify below)

**11. Specify "Other" from above.**

After you exit the survey or click on the "Done" button you will not be able to return to the survey. Therefore, be sure to have your answers ready to complete the survey in a single session.

If you would like a copy of this report for your records, please print before you click on the "Done" button.

By clicking on the "Done" button, you are submitting the report.

Thank you!

Done