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Table 1 - State Priorities

Number	Title	Description
1	Adults - Assurance of an effective array of clinical and support services	Assurance of an effective array of clinical and support services for persons enrolled in Medicaid and services which are essential for ongoing clinical care and support of individuals with serious mental illnesses who are not enrolled in Medicaid during this period of fiscal constraint.
2	Adults - Promote Provision of Evidence Based Practices	Promote Evidence Based Practices for individuals for whom DMH purchases services within the context of service benefit packages established by DMH for the Medicaid and non-Medicaid populations in need of mental health services.
3	Adults and Children/Adolescents- Bi-directional Integration of Primary Health Care and Behavioral Health Care	Bi-directional Integration of Primary Health Care and Behavioral Health Care
4	Adults - Advancement of the recovery vision	Advancement of the recovery vision including Wellness Recovery Action Planning, expansion of the scope and quality of consumer and family participation, and promotion of the utilization of the Certified Recovery Support Specialist (CRSS) credential.
5	Adults - Address the mental health needs of individuals who are homeless, and individuals who live in rural areas, and those who are elderly	Maintain and improve the provision of mental health services to persons who are homeless (including ex-offenders and veterans), to persons who reside in rural areas, and to elderly persons. (Criterion 4)
6	Adults and Children/Adolescents - Advancement of the use of data to support decision-making.	Advancement of the use of data to support decision-making.
7	Adults - Maintain a comprehensive system to serve the forensic needs of court –involved consumers	Maintain a comprehensive system to serve the forensic needs of court –involved consumers whose access to inpatient and outpatient services is ordered by the Court.
8	Adults/Child and Adolescent - Planning, within budgetary constraints, to address the needs of uninsured and underinsured consumers	Planning, within budgetary constraints, to address the needs of uninsured and underinsured adult and child and adolescent consumers who may remain unable to access services through the venue of ACA Health Care Reform by 2014.
9	Child and Adolescent - Assurance of an effective array of clinical and support services for children and adolescents	Assurance of an effective array of clinical and support services for children and adolescents enrolled in Medicaid and the provision of services which are essential for ongoing clinical care and support of those with serious emotional disturbances who are not enrolled in Medicaid during this period of fiscal constraint.
10	Child and Adolescent - Advancement of family -driven care	Advancement of family-driven care through parent education, parent-to parent supports, and promotion of the Certified Family Partnership Professional credential. Continued expansion of the scope and quality of parent and youth involvement. (Criterion I)
11	Child and Adolescent - Enhancement of collaborative efforts with state and local partners to address the mental health needs of youth	Enhancement of collaborative efforts with state and local partners to address the mental health needs of youth in the juvenile justice system, students in public schools, and the implementation of early interventions for families of young children.
12	Child and Adolesent - Promotion of Evidence-Informed Practices	Promotion of Evidence-Informed Practices and continue to expand the use of evidence informed practices in treatment programs throughout the State.
13	Child and Adolescent - Encourage and facilitate the use of the Public Health Model	Encourage and facilitate the use of the Public Health Model in the delivery of Mental Health services.
14	Child and Adolescent - Advancement and expansion of the use of video-conferencing and Tele-psychiatry	Advancement and expansion of the use of video-conferencing and Tele-psychiatry in clinical work in rural areas and partnering with universities and other stakeholders in planning initiatives to better align service delivery for children and adolescents in rural areas.
15	Address the Mental Health needs of children/adolescents who are homeless and those who reside in rural areas.	Plan the delivery of mental health services for children/adolescents with SED and their families who are homeless and for those who reside in rural areas utilizing interactive communication technology and academic/community partnerships to improve service alignments

Footnotes:

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Table 2 - Priority Area by Goal, Strategy, and Performance Indicator

Save Cancel

Start Year:

End Year:

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator	Achieved
Adults - Assurance of an effective array of clinical and support services	Continue to assure that a comprehensive array of community -based services are available to adults in need of mental health services (Criterion I).	Ensure that the following services are available: Mental health assessment, Treatment plan development, review and modification; Assertive community treatment, case management, community support (individual, group and residential), crisis intervention, mental health intensive outpatient, psychosocial rehabilitation, psychotropic medication administration, monitoring and training; short-term diagnostic and mental health services, therapy/counseling, assertive community treatment and Oral interpretation and sign language. · Work with system partners to provide supportive services including Educational Services, Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA), Substance Abuse Services (through DASA), Services for Co Occurring Mental Health Disorder and Substance Abuse, Medical and Dental Services (through HFS for individuals who are Medicaid eligible), and Community Integrated Living Arrangements.	Number of adults who are (a) Medicaid eligible or (b) non-Medicaid eligible who receive mental health services	DMH funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting. Registration data is submitted directly to the DMH information system which is operated by the DMH's Administrative Services Organization (ASO). Claims data, which is submitted to the state Medicaid agency Healthcare and Family Services (HFS), is returned to the ASO after processing where it is stored with registration information in the DMH data warehouse. This information is used as a basis for developing reports and for analytic purposes, and is the basis for reporting the data used to populate the majority of the URS tables. Data will be collected by fiscal year to compare change across years.	Yes

Adults - Promote Provision of Evidence Based Practices	Promote Evidence Based Practices for individuals for whom DMH purchases services within the context of service benefit packages established by DMH for the Medicaid and non-Medicaid populations in need of mental health services.	During FY2012 and FY2013, maintain the implementation of Evidence Based Supportive Employment.	Number of consumers receiving supported employment in FY2012 and FY2013. (National Outcome Measure)	Data for this indicator are generated through a special web-based database created specifically for the DMH SE initiative. Fidelity and outcomes data are submitted to the DMH SE coordinator. As always, DMH has developed specifications for reporting that DMH funded providers must use when submitting data. DMH only reports data for teams that have been found to exhibit fidelity to the evidenced based practice model.	Yes
Adults - Promote Provision of Evidence Based Practices	Promote Evidence Based Practices for individuals for whom DMH purchases services within the context of service benefit packages established by DMH for the Medicaid and non-Medicaid populations in need of mental health services.	FY2012-FY2013, continue provision of Assertive Community Treatment that meets national fidelity model requirements.	Number of persons with SMI receiving Assertive Community Treatment in FY 2012 and FY 2013 (National Outcome Measure)	DMH funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting. Registration data is submitted directly to the DMH information system which is operated by the DMH's Administrative Services Organization (ASO). Claims data, which is submitted to the state Medicaid agency Healthcare and Family Services (HFS), is returned to the ASO after processing where it is stored with registration information in the DMH data warehouse. This information is used as a basis for developing reports and for analytic purposes, and is the basis for reporting the data used to populate the majority of the URS tables. Data will be collected by fiscal year to compare change across years.	Yes
Adults - Promote Provision of Evidence Based Practices	Promote the provision of evidence based practices	By the end of FY 2013, through the provision of rental subsidies, continue implementation of a statewide permanent supportive housing initiative which targets an additional 300 consumers acquiring decent, safe, and affordable housing and support services in a manner consistent with the national standards for this evidence based practice.	Number of consumers who acquire appropriate permanent supportive housing in FY 2012 and 2013. (National Outcome Measure)	Individuals receiving permanent supported housing were not previously required to be registered for mental health treatment services. Therefore, it was necessary to create a special databaseto track access to and receipt of permanent supportive housing. The data for this indicator will be generated from permanent supportive housing applications which are stored in the special database, as well as a special PSH outcomes database	Yes
Adults and Children/Adolescents - Bi-directional Integration of Primary Health Care and Behavioral Health Care	Work with system partners to identify next steps in planning for bi-directional integration of primary health and behavioral health care	1. Review evaluations of bi-directional healthcare summit held in June 2011. 2. Meet with system partners to continue planning efforts for bi-directional integration of primary health and behavioral health care	Follow-up meeting with system partners to continue planning efforts.	Minutes of meetings held with system partners.	Yes
	Establish a comprehensive system of care				

Adults - Advancement of the recovery vision	based upon principles of Recovery/Resilience in which consumers are knowledgeable and empowered to participate and provide direction at all levels of the system	Educate consumers of mental health services in leadership, personal responsibility and self-advocacy, through participation in regional Recovery Conferences.	Number of regional Recovery Conferences held each year.	Document each regional recovery conference event. Aggregate data across regions by year to enable comparisons across years.	Yes
Adults - Advancement of the recovery vision	Establish a comprehensive system of care based upon principles of Recovery/Resilience in which consumers are knowledgeable and empowered to participate and provide direction at all levels of the system	Enhance the recovery orientation of mental health services through continuing education of certified WRAP Facilitators.	Number of regional WRAP continuing education/refresher trainings conducted each year	Each training event will be documented when held. Data will be aggregated by fiscal year for comparison across years.	Yes
Adults - Advancement of the recovery vision	Establish a comprehensive system of care based upon principles of Recovery/Resilience in which consumers are knowledgeable and empowered to participate and provide direction at all levels of the system	Conduct a series of statewide teleconferences designed to disseminate important information to consumers across the State.	Number of statewide teleconferences held each year	Document each teleconference event and aggregate by year for comparison across years.	Yes
Adults - Advancement of the recovery vision	Establish a comprehensive system of care based upon principles of Recovery/Resilience in which consumers are knowledgeable and empowered to participate and provide direction at all levels of the system	Support the role of Certified Recovery Support Specialists and their deployment statewide by hosting webinars for providers to help increase agencies' understanding of the role, value, function, and advantages of hiring CRSS professionals and by providing competency training events for individuals interested in obtaining the CRSS credential.	Number of training events held each year to increase stakeholder understanding of the CRSS credential and to increase competency in CRSS domains.	Document each training event and aggregate by year for comparison across years.	Yes
Adults and Children/Adolescents - Advancement of the use of data to support decision-making.	Use Quantitative data to assess access to care and perception of treatment outcomes to provide data for decision support. (Criterion 2)	Assess access to care by tracking the number of individuals who received treatment partitioned by race, gender and age.	Number of adults and number of children/adolescents receiving services from DMH-funded community-based providers.	DMH funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting. Registration data is submitted directly to the DMH information system which is operated by the DMH's Administrative Services Organization (ASO). Claims data, which is submitted to the state Medicaid agency Healthcare and Family Services (HFS), is returned to the ASO after processing where it is stored with registration information in the DMH data warehouse. This information is used as a basis for developing reports and for analytic purposes,	Yes

				and is the basis for reporting the data used to populate the majority of the URS tables. Data will be collected by fiscal year to compare change across years	
Adults and Children/Adolescents - Advancement of the use of data to support decision-making.	Use Quantitative data to assess access to care and perception of treatment outcomes to provide data for decision support. (Criterion 2)	Conduct a consumer survey to assess perception of care to determine the extent to which consumers and caregivers report positive outcomes that are attributable to treatment received.	Percentage of : a) adult consumers and b) caregivers of youth reporting positively about outcomes.	The DMH will utilize the MHSIP Adult Consumer Perception of Care Survey and the Youth Services Survey for Families to collect this data. This year, a random stratified sample of adults receiving treatment in June 2011 is being selected for the survey. This sample will be disseminated via mail in October 2011 with a goal of all data collected by early November. Similarly a random stratified sample of caregivers of children and adolescents receiving services in June 2011 is also being selected to receive the survey. This method will be used for the surveys for FY2012 and FY2013. The indicator values will be compared with data collected in succeeding years.	Yes
Adults - Maintain a comprehensive system to serve the forensic needs of court –involved consumers	Maintain a system of care to address the mental health needs of consumers with criminal justice involvement.	Maintain and monitor linkage to community services for individuals with serious mental illness released from Illinois jails	Percentage of eligible individuals released from Jail who are linked with community-based services.	A daily cross match of individuals receiving mental health services with individuals in jails in selected jurisdictions is used to identify individuals participating in the jail data linkage project. Data will be collected to track the number of individuals who are linked with community based mental health service providers.Data will be aggregated across the year for comparison with data from succeeding years.	Yes
Adults/Child and Adolescent - Planning, within budgetary constraints, to address the needs of uninsured and underinsured consumers	Identify resources to Purchase Mental Health Services for Uninsured and Underinsured Consumers	Use financial resources from the state general revenue fund, Federal Fund Participation (FFP) and grants as a basis to fund the purchase of mental health services. Enhance human resources of public through continued support of public/academic linkages, mental health and law enforcement training and training and coordination of providers of emergency and disaster services.	No indicators for this goal	No indicators are identified for this goal.	Yes
		Ensure that the following services are available: These services include: Mental health assessment, Treatment plan development, review and modification; Screening.Assessment, and Support Services (SASS), case management, community support (individual, group and residential), crisis intervention, mental health intensive outpatient, psychotropic medication administration,		DMH funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting.	

Child and Adolescent - Assurance of an effective array of clinical and support services for children and adolescents	Continue to assure that a comprehensive array of community-based services are available to children and adolescents in need of mental health services (Criterion I).	monitoring and training, therapy/counseling,short-term diagnostic and mental health services, Individual Care Grant For Children with Mental Illnesses, Oral interpretation and sign language. Work with system partners to provide supportive services including Educational Services, Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA), Substance Abuse Services (through DASA), Services for Co Occurring Mental Health Disorder and Substance Abuse, Medical and Dental Services (through HFS for youth who are Medicaid eligible), screening, assessment and support services (SASS), and Wraparound Services.	Number of youth who are a) Medicaid or b)non-Medicaid eligible who receive mental health services	Registration data is submitted directly to the DMH information system which is operated by the DMH's Administrative Services Organization (ASO). Claims data, which is submitted to the state Medicaid agency Healthcare and Family Services (HFS), is returned to the ASO after processing where it is stored with registration information in the DMH data warehouse. This information is used as a basis for developing reports and for analytic purposes, and is the basis for reporting the data used to populate the majority of the URS tables. Data will be collected by fiscal year to compare change across years.	Yes
Child and Adolescent - Advancement of family-driven care	Establish a system of care that is family driven and emphasizes services that are evidence-based.	Facilitate parent-to-parent support through the use of Family Resource Developers in system of care grants.	Number of Family Resource Developers hired in System of Care grant-funded programs.	The number of parents hired as system family resource developers for system of care grants will be aggregated across the year for comparison with data collected for subsequent years.	Yes
Child and Adolescent - Advancement of family-driven care	Establish a system of care that is family driven and emphasizes services that are evidence-based.	In FY2012 and FY2013 advance Family Driven Care in Illinois by certification of parent providers as Family Partner Professionals	The number of individuals who are credentialed as CFPPs by the end of each fiscal year	The number of parents certified as Family Partner Professionals will be aggregated across the year for comparison with data collected for subsequent years.	Yes
Child and Adolescent - Enhancement of collaborative efforts with state and local partners to address the mental health needs of youth	Integrate services for children and adolescents across service systems and across the developmental stages from early childhood through young adulthood. (Criterion 3-Juvenile Justice)	In 2012/FY2013, increase the number of youth receiving services through the Mental Health Juvenile Justice Initiative (MHJJ)	Number of youth served by the MHJJ program statewide	Aggregate the number of youth receiving services from the mental health juvenile justice program across the year that will be compared with data from subsequent years.	Yes
Child and Adolescent - Enhancement of collaborative efforts with state and local partners to address the mental health needs of youth	Integrate services for children and adolescents across service systems and the developmental stages from early childhood through young adulthood. (Criterion 3-Schools)	Provide technical assistance and implementation support to educators, parents, organizations and other state agencies on the coordination of the Illinois Interconnected Systems Model of School Based Mental Health.	Number of Technical Assistance events in each fiscal year	Aggregate data on the number of technical assistance events held across the fiscal years for comparison with subsequent years.	Yes
Child and Adolesent - Promotion of Evidence-Informed Practices	Continue to advance the implementation of evidence-informed practices in the child and adolescent service system through FY2013	Implement video based training methodologies and develop additional evidence-based content in an effort to increase and improve statewide EIP training.	The number of training events (including video-based)held to advance evidence-informed practices.	Each training event will be documented and the data aggregated across the year for comparison with subsequent years of data.	Yes
		In FY2012 and FY2013, fully establish and			

Child and Adolescent - Encourage and facilitate the use of the Public Health Model	Establish and nurture local systems of care, embedded in a public health model, consistent with core values and principles of CASSP and Family Driven Care to implement a prevention and early intervention initiative known as “Reaching Out to Help”.	implement the Reaching Out to Help initiative which is a 3-tiered public health model. Tier 1 consists of universal health promotion/prevention activities which target an entire population to promote and enhance emotional wellness by increasing developmentally appropriate mental health skills. Tier 2 is early intervention targeting children at greater risk of developing risky behaviors and mental health concerns. Tier 3 are treatment activities targeting children identified as having significant mental health concerns that require referral and linkage to clinical mental health treatment. Develop a baseline for measurement of outcomes and the implementation of local systems of care for the Reaching Out to Help Initiative.	The number of children and adolescents participating in Tier 1, Tier 2 and Tier 3 in FY 2012 and 2013.	Aggregate the number of children/adolescents participating in Tiers 1, 2 and 3 of the "Reaching Out to Help" Initiative across the year for comparison with subsequent years of data.	Yes
Child and Adolescent - Advancement and expansion of the use of video-conferencing and Tele-psychiatry	Advance and expand the use of video-conferencing and Tele-psychiatry in clinical work and partner with universities and other stakeholders to plan initiatives to better align service delivery for children and adolescents in rural areas	Through FY2013, continue to implement Tele-psychiatry services in seven rural sites in Illinois and, contingent upon funding opportunities, plan for further expansion of the program.	Number of youth living in rural areas receiving services through tele-psychiatry.	Aggregate data on the number of individuals receiving data across the year for comparison with subsequent years of data.	Yes
Address the Mental Health needs of children/adolescents who are homeless and those who reside in rural areas.	Maintain and increase provision of mental health services to families and children who are homeless and to those who reside in rural areas. (Criterion 4)	Track the number of youth with serious emotional disturbances who are homeless and receiving mental health services.	Number of individuals under age 18 who are homeless and who are receiving services. (NOM-Increased stability in housing)	DMH funded providers by contract must submit demographic, clinical information and claims data for all individuals receiving services funded using DMH dollars. The DMH provides data specifications to assure consistency of reporting. Registration data is submitted directly to the DMH information system which is operated by the DMH’s Administrative Services Organization (ASO). Claims data, which is submitted to the state Medicaid agency Healthcare and Family Services (HFS), is returned to the ASO after processing where it is stored with registration information in the DMH data warehouse. This information is used as a basis for developing reports and for analytic purposes, and is the basis for reporting the data.	Yes

Footnotes:

III: State Agency Expenditure Reports

Table 4 (URS Table 7) - Profile of Mental Health Service Expenditures and Sources of Funding

Start Year:

End Year:

Activity	A. SA Block Grant	B. MH Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention and Treatment	$	$	$	$	$	$	$
2. Primary Prevention	$	$	$	$	$	$	$
3. Tuberculosis Services	$	$	$	$	$	$	$
4. HIV Early Intervention Services	$	$	$	$	$	$	$
5. State Hospital	$	$	$	$	$	$	$
6. Other 24 Hour Care	$	$	$	$	$	$	$
7. Ambulatory/Community Non-24 Hour Care	$	$	$	$	$	$	$
8. Administration (Excluding Program and Provider Level)	$	$	$	$	$	$	$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	$	$	$	$	$	$	$
10. Subtotal (Rows 5, 6, 7, and 8)	$	$	$	$	$	$	$
11. Total	$	$	$	$	$	$	$

Please indicate the expenditures are actual or estimated.

Actual Estimated

Please identify which of the information in Table 4a is estimated rather than actual:

Identify the date by when all estimates can be replaced with actual expenditures:

Footnotes:

III: State Agency Expenditure Reports

Table 5 - MHBG Expenditures By Service

Expenditure Period Start Date: Expenditure Period End Date:

Service	Unduplicated Individuals	Units	Expenditures
Prevention (Including Promotion)			$0.00
Screening, Brief Intervention and Referral to Treatment	0	0	$0.00
Brief Motivational Interviews	0	0	$0.00
Screening and Brief Intervention for Tobacco Cessation	0	0	$0.00
Parent Training	0	0	$0.00
Facilitated Referrals	0	0	$0.00
Relapse Prevention/Wellness Recovery Support	0	0	$0.00
Warm Line	0	0	$0.00
Engagement Services			$0.00
Assessment	0	0	$0.00
Specialized Evaluations (Psychological and Neurological)	0	0	$0.00
Service Planning (including crisis planning)	0	0	$0.00
Consumer/Family Education	0	0	$0.00
Outreach	0	0	$0.00
Outpatient Services			$0.00
Individual evidenced based therapies	0	0	$0.00
Group therapy	0	0	$0.00
Family therapy	0	0	$0.00
Multi-family therapy	0	0	$0.00
Consultation to Caregivers	0	0	$0.00
Medication Services			$0.00
Medication management	0	0	$0.00

Pharmacotherapy (including MAT)	0	0	$0.00
Laboratory services	0	0	$0.00
Community Support (Rehabilitative)			$0.00
Parent/Caregiver Support	0	0	$0.00
Skill building (social, daily living, cognitive)	0	0	$0.00
Case management	0	0	$0.00
Continuing Care	0	0	$0.00
Behavior management	0	0	$0.00
Supported employment	0	0	$0.00
Permanent supported housing	0	0	$0.00
Recovery housing	0	0	$0.00
Therapeutic mentoring	0	0	$0.00
Traditional healing services	0	0	$0.00
Recovery Supports			$0.00
Peer Support	0	0	$0.00
Recovery Support Coaching	0	0	$0.00
Recovery Support Center Services	0	0	$0.00
Supports for Self Directed Care	0	0	$0.00
Other Supports (Habilitative)			$0.00
Personal care	0	0	$0.00
Homemaker	0	0	$0.00
Respite	0	0	$0.00
Supported Education	0	0	$0.00
Transportation	0	0	$0.00
Assisted living services	0	0	$0.00
Recreational services	0	0	$0.00

Trained behavioral health interpreters	0	0	$0.00
Interactive communication technology devices	0	0	$0.00
Intensive Support Services			$0.00
Substance abuse intensive outpatient (IOP)	0	0	$0.00
Partial hospital	0	0	$0.00
Assertive Community Treatment	0	0	$0.00
Intensive home based services	0	0	$0.00
Multi-systemic therapy	0	0	$0.00
Intensive Case Management	0	0	$0.00
Out-of-Home Residential Services			$0.00
Crisis residential/stabilization	0	0	$0.00
Adult Substance Abuse Residential	0	0	$0.00
Adult Mental Health Residential	0	0	$0.00
Youth Substance Abuse Residential Services	0	0	$0.00
Children's Residential Mental Health Services	0	0	$0.00
Therapeutic foster care	0	0	$0.00
Acute Intensive Services			$0.00
Mobile crisis	0	0	$0.00
Peer based crisis services	0	0	$0.00
Urgent care	0	0	$0.00
23 hr. observation bed	0	0	$0.00
Medically Monitored Intensive Inpatient	0	0	$0.00
24/7 crisis hotline services	0	0	$0.00
Other			$15036301.00
Psychiatric Services	0	0	$14867239.00
Jail Data Link Project	0	0	$169062.00

Footnotes:

III: State Agency Expenditure Reports

Table 6 - Primary Prevention Expenditures Checklist

Start Year:

End Year:

Strategy	IOM Target	MHBG Block Grant	Other Federal	State	Local	Other
Information Dissemination	Universal	$0	$0	$0	$0	$0
Information Dissemination	Selective	$0	$0	$0	$0	$0
Information Dissemination	Indicated	$0	$	$	$	$
Information Dissemination	Unspecified	$0	$	$	$	$
Information Dissemination	Total	$0	$0	$0	$0	$0
Education	Universal	$0	$	$	$	$
Education	Selective	$0	$	$	$	$
Education	Indicated	$0	$	$	$	$
Education	Unspecified	$0	$	$	$	$
Education	Total	$0	$	$	$	$
Alternatives	Universal	$0	$	$	$	$
Alternatives	Selective	$0	$	$	$	$
Alternatives	Indicated	$0	$	$	$	$
Alternatives	Unspecified	$0	$	$	$	$
Alternatives	Total	$0	$	$	$	$
Problem Identification and Referral	Universal	$0	$	$	$	$
Problem Identification and Referral	Selective	$0	$	$	$	$
Problem Identification and Referral	Indicated	$0	$	$	$	$
Problem Identification and Referral	Unspecified	$0	$	$	$	$
Problem Identification and Referral	Total	$0	$	$	$	$

Community-Based Process	Universal	$0	$	$	$	$
Community-Based Process	Selective	$0	$	$	$	$
Community-Based Process	Indicated	$0	$	$	$	$
Community-Based Process	Unspecified	$0	$	$	$	$
Community-Based Process	Total	$0	$	$	$	$
Environmental	Universal	$0	$	$	$	$
Environmental	Selective	$0	$	$	$	$
Environmental	Indicated	$0	$	$	$	$
Environmental	Unspecified	$0	$	$	$	$
Environmental	Total	$0	$	$	$	$
Section 1926 Tobacco	Universal	$	$	$	$	$
Section 1926 Tobacco	Selective	$	$	$	$	$
Section 1926 Tobacco	Indicated	$	$	$	$	$
Section 1926 Tobacco	Unspecified	$	$	$	$	$
Section 1926 Tobacco	Total	$	$	$	$	$
Other	Universal	$0	$	$	$	$
Other	Selective	$0	$	$	$	$
Other	Indicated	$0	$	$	$	$
Other	Unspecified	$0	$	$	$	$
Other	Total	$0	$	$	$	$

Footnotes:

III: State Agency Expenditure Reports

Table 9 - Maintenance of Effort for State Expenditures on Mental Health Services

Total Expenditures for SMHA		
Period (A)	Expenditures (B)	$\frac{B1(2010) + B2(2011)}{2}$ (C)
SFY 2010 (1)	$413,282,718	
SFY 2011 (2)	$333,054,677	$373,168,698
SFY 2012 (3)	$313,189,383	

Are the expenditure amounts reported in Column B "actual" expenditures for the State fiscal years involved?

SFY 2010	Yes	X	No	
SFY 2011	Yes	X	No	
SFY 2012	Yes	X	No	

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA: _____

Footnotes:

III: State Agency Expenditure Reports

Table 10 - Report on Set-aside for Children's Mental Health Services

State Expenditures for Mental Health Services		
Actual SFY 2008	Actual SFY 2011	Estimated/Actual SFY 2012
$89838188.00	$69941482.00	$65769770.00

States are required to not spend less than the amount expended in Actual SFY 2008. This is a change from the previous year, when the baseline for the state expenditures was 1994.

Footnotes:

Dollars allocated are substantially less for FY12 due to budget cuts, however DMH has maintained the percentage of funds allocated for childrens' services. The Illinois DMH intends to submit a request for a waiver to SAMHSA.