City of Providence
STATE OF RHODE ISLAND

RESOLUTION OF THE CITY COUNCIL

No. 357
Approved July 23, 2024

RESOLVED, That the Members of the Providence City Council hereby Authorize Approval of the following Contract Award by the Board of Contract and Supply in accordance with Section 21-26 (b)(4) of the Code of Ordinances.

The Providence Center (Police Department)	$93,170.77

IN CITY COUNCIL
JUL 18 2024
READ AND PASSED
RACHEL M. MILLER, PRESIDENT
CLERK

I HEREBY APPROVE.
Mayor
Date: 7/24/24

OFFICE OF THE INTERNAL AUDITOR
City of Providence

May 30, 2024

Ms. Tina Mastroianni
City Clerk's Office
City of Providence
25 Dorrance Street
Providence, RI 02903

Dear Tina:

I am writing to request that the following requested contract award be submitted to the City Council and the Finance Committee for approval:

- **Department of Information Technology**
  - Requesting approval to extend the contract with **Jimmy Chiu** for Lawson system Support for a total amount not to exceed **$30,000.00** in accordance with the Code of Ordinances, Section 21-26 (b) (2).
  - Requesting approval to pay **Ungerboeck Systems International, LLC** for "annual hosting and support of the VenueOps platform" in the amount of **$24,840.00** in accordance with the Code of Ordinances, Section 21-26 (b) (2)

- **Department of Parks**
  - Award to **John Rocchio Corporation** for Site Improvements to India Point Park in the amount of **$2,210,600.00** in accordance with the Code of Ordinances, Section 21-26 (b) (1).

- **Department of Public Property**
  - Award to **Bentley Builders** for "Design Build (D/B) Services for Major Construction Renovation Projects (Phase (IV), Fox Point Neighborhood" in the amount of **$30,000,000.00** in accordance with the Code of Ordinances, Section 21-26 (b) (1). **(Vartan Gregorian ES)**
  - Award to **Maron Construction** for "Design Build (D/B) Services for Major Renovation Projects, High School Facility" in the amount of **$30,000,000.00** in accordance with the Code of Ordinances, Section 21-26 (b) (1). **(Hope HS)**
  - Award to **Maron Construction** for "Design Build (D/B) Services for Minor Renovations Project, Middle School Facility" in the amount of **$15,000,000.00** in accordance with the Code of Ordinances, Section 21-26 (b) (1). **(DelSesto MS)**

- Award to **O&G Industries** for "Design Build (D/B) Services for New Construction Project (Phase 4), New Pre K-8 Facility, Elmhurst Neighborhood" in the amount of **$78,000,000.00** in accordance with the Code of Ordinances, Section 21-26 (b) (1). **(Robert F. Kennedy ES)**
- Award to **Dimeo Construction/JCJ Architecture** for "Design Build (D/B) Services for Major Construction and/or Additions Projects (Phase 4), Elmhurst Neighborhood in the amount of **$85,000,000.00** in accordance with the Code of Ordinances, Section 21-26 (b) (1). **(Nathanael Greene MS)**
- Award to **Gilbane Construction** for "Design Build (D/B) Services for Major Construction and/or Additions Projects (Phase IV), South Providence Neighborhood in the amount of **$95,000,000.00** in accordance with the Code of Ordinances, Section 21-26 (b) (1). **(Roger Williams MS)**
- Award to **Bentley Builders** for for "Design Build (D/B) Services for Minor Renovations Projects (Phase IV), Elementary School Facility in the amount of **$15,000,000.00** in accordance with the Code of Ordinances, Section 21-26 (b) (1). **(Anthony Carnevale ES)**
- Award to **Ahlborg Construction** for "Design Build (D/B) Services for New Construction Project (Phase 4), New Pre K-8 Facility, Mt Hope Neighborhood in the amount of **$48,500,000.00** in accordance with the Code of Ordinances, Section 21-26 (b) (1). **(Martin Luther King ES)**
- Requesting a change order with **Construction Junction** for the "Dexter St Garage Bathroom" in the amount of **$35,870.00** in accordance with the Code of Ordinance, Section 21-26 (b) (4).
- Requesting approval to pay **Federal Hill Commerce Association** in the amount of **$1,000,000.00** for a Capital Improvement Grant in accordance with the Code of Ordinances, Section 21-26 (b) (1) and (2).
- Requesting approval to pay **Woonasquatucket River Watershed Council** in the amount of **$350,000.00** for a Capital Improvement Grant in accordance with the Code of Ordinances, Section 21-26 (b) (2).

- **Water Supply Board**
  - Award to **Boyle and Fogarty Construction Co, Inc** for "Accelerated Lead Service Line Replacement Program contract 1.3" in the amount of **$19,668,680.00** in accordance with the Code of Ordinances, Section 21-26 (b) (1).

- **Department of Art, Culture and Tourism**
  - Requesting approval to amend the award for **Landmark Public Art Design Services** in the amount of **$960,011.00** in accordance with Code of Ordinances, Section 21-26 (b) (4).

- **Department of Human Resources**
  - Requesting approval to enter into a contract with **Blue Cross & Blue Shield of Rhode Island** for Medical Stop Loss Insurance in the amount of **$787,297.32** in accordance with the Code of Ordinances, Section 21-26 (b) (2).

- **Police Department**
  - Approval to purchase Armor Equipment from Arms Unlimited in the amount not to exceed **$23,415.00** in accordance with the Code of Ordinances, Section 21-26 (b) (2).

- Requesting a change order with **The Providence Center** in the amount of **$93,170.77** in accordance with the Code of Ordinance, Section 21-26 (b) (4)

Sincerely,

Gina M. Costa
Internal Auditor

Cc: John Arzoomanian, Department of Public Property
Alejandro Tirado, Director of Purchasing
Shomari Husband City Treasurer
Jim Silveria, Chief Information Officer
Wendy Nilsson, Superintendent of Parks
Ricky Caruolo, General Manager, Providence Water
Joe Wilson Jr, Art, Culture & tourism
Paul A. N. Winspeare, Chief of Human Resources Officer
Oscar L. Perez, Chief of Police

BRETT P. SMILEY
Mayor

OSCAR L. PEREZ
Chief of Police

Department of Public Safety, Police Department
"Building Pride in Providence"

May 9, 2024

The Honorable Brett P. Smiley
Chairman, Board of Contract and Supply
City Hall
25 Dorrance Street
Providence, RI 02903

RE: **Requesting Approval of a Change Order for a Contract with The Providence Center**

ID: 45361

Original ID: 42810 (10/23/2023)

Minority Participation: *0 % MBE, 0 %WBE*

Account Code: 250-302-53500/250-1128-23 - $295,176
Account Code: 101-302-53227 - $93,170.77

Dear Mayor Smiley,

The Providence Police Department respectfully requests approval of a change order for a contract with The Providence Center in the amount of $93,170.77 to provide a for Behavioral Health Co-Responder Clinician as approved in the FY22 BJA Connect and Protect Law Enforcement Behavioral Health Response Program for the period October 1, 2022, through September 30, 2025, in an amount not to exceed $388,346.77.

Original Contract Amount:	$ 295,176.00
Change Order #1	$ 93,170.77
Final Contract Amount	$ 388,346.77

The original request only reflected the amount for The Providence Center; the City's match portion of $93,170.77 as required within the grant was omitted. The Providence Center clinician shall conduct mobile crisis assessments in the community and work under the operational direction of the Providence Police Department.

The Providence Center
528 North Main Street
Providence, RI 02904

Respectfully Submitted,

Oscar L. Perez
Chief of Police

Financial Approval:

Enc:

BRETT P. SMILEY
Mayor

OSCAR L. PEREZ
Chief of Police

Department of Public Safety, Police Department
"Building Pride in Providence"

October 5, 2023

The Honorable Brett P. Smiley
Chairman, Board of Contract and Supply
City Hall
25 Dorrance Street
Providence, RI 02903

RE: **Approval to Enter into a Contract with The Providence Center for Behavioral Health Co-Respondent Clinician**

ID: 42810

Account Code: 250-302-53500/250-1128-23

Minority Participation: *0 % MBE, 0 %WBE*

Amount: $295,176

Dear Mayor Smiley,

The Providence Police Department respectfully requests approval to enter into a contract with The Providence Center to provide a for Behavioral Health Co-Responder Clinician as approved in the FY22 BJA Connect and Protect Law Enforcement Behavioral Health Response Program, in an amount not to exceed $295,176, for the period October 1, 2022, through September 30, 2025.

As stated within the contents of the grant proposal, this vendor would be providing these services if the grant was awarded. The Providence Center has an existing partnership with the Police Department and this grant is contingent on having them listed as subgrantee. The clinician shall conduct mobile crisis assessments in the community and work under the operational direction of the Providence Police Department.

The Providence Center
528 North Main Street
Providence, RI 02904

Respectfully Submitted,

(For) Oscar L. Perez
Chief of Police

Financial Approval:

Enc:

City of Providence

Rhode Island

Department of City Clerk

MEMORANDUM

DATE: October 23, 2023

TO: Purchasing Director

SUBJECT: **APPROVAL TO ENTER INTO CONTRACT, WITH THE PROVIDENCE CENTER, TO PROVIDE FOR A BEHAVIORAL HEALTH CO-RESPONDER CLINICIAN AS APPROVED IN THE FY22 BJA CONNECT AND PROTECT LAW ENFORCEMENT BEHAVIORAL HEALTH RESPONSE PROGRAM, FOR THE PERIOD OF OCTOBER 1, 2022, THROUGH SEPTEMBER 30, 2025 – PROVIDENCE POLICE DEPARTMENT**

DISPOSITION: VOTED: The Purchasing Director hereby authorizes Approval to Enter into Contract, with The Providence Center, to provide for a Behavioral Health Co-Responder Clinician as approved in the FY22 BJA Connect and Protect Law Enforcement Behavioral Health Response Program, for the period of October 1, 2022, through September 30, 2025, for a total contract amount not to exceed Two Hundred Ninety Five Thousand One Hundred Seventy Six Dollars ($295,176.00), all in accordance with the request of Colonel Oscar Perez, Chief of Police, in communication dated October 5, 2023.

cc: Pur.Dir.
Contr
PPD.
File

CB

Jina L. Mastroianni
City Clerk

Memorandum of Agreement

BETWEEN Providence Police Department

325 Washington St
Providence, RI 02903

AND CONTRACTOR The Providence Center, Inc.
528 North Main Street Providence,
RI 02904

This Memorandum of Agreement ("Agreement") sets forth work to be undertaken in accordance with the following scope of work and in accordance with the attached budget.

PROJECT TITLE: FY22 BJA 22 CONNECT AND PROTECT: LAW ENFORCEMENT BEHAVIORAL HEALTH RESPONSE PROGRAM

AGREEMENT NOT TO EXCEED: $295,176

General Terms and Conditions

1. PARTIES TO THE AGREEMENT

This Agreement is made between the Providence Police Department and The Providence Center, Inc. ("TPC"), a Rhode Island-based non-profit organization.

2. PERIOD OF PERFORMANCE

The period of performance covered by this agreement is October 1, 2022 to September 30, 2025.

3. MODIFICATION OF AGREEMENT

This Agreement may be modified, amended, or extended only by mutual written consent.

4. TERMINATION OF AGREEMENT

This Agreement may be terminated by either the Providence Police Department or TPC by giving a thirty (30) day written notice to the other party. Upon such notice, the parties shall not make any new financial commitments related to the project and, to the extent possible, shall cancel any outstanding commitments that relate to this Agreement. The parties shall not be responsible for any financial obligation incurred beyond the performance period end date above.

5. SCOPE OF WORK

During the term of this Agreement, TPC shall provide the services described in the Scope of Work attached as Exhibit A. The Providence Police Department and TPC shall not modify, alter, delete or substitute any element in the Scope of Work as set forth in Exhibit A without mutual written consent.

6. PAYMENT

In consideration of work and services performed by TPC in accordance with this Agreement, TPC will submit a quarterly report and invoice to the Providence Police Department. Any question or dispute regarding the report or invoice shall be submitted in writing to the signatories listed below and shall be resolved in writing

EXHIBIT A – Providence Police Navigator/Clinician Scope of Work

TPC will provide the following staff and services to the Providence Police Department.

- TPC will provide one full-time (37.5 hours/week) Behavioral Health Crisis Co-Responder Clinician (the "Clinician") to work under the operational direction of the Providence Police Department. The Clinician shall conduct mobile crisis assessments in the community during peak hours after normal business hours and weekends. The staffing pattern may be flexible and utilize existing staff as appropriate. The Clinician will be available from 11:00 am to 7:00 pm to supplement TPC's existing mobile crisis capacity. Calls for crisis assessment services will be routed through TPC's emergency answering service which provides coverage after-hours, on weekends, and on holidays. Providence Police Department Dispatch will have the Clinician's on duty cell phone to contact him/her directly. Providence Police Department will also respond to crisis situations to ensure the safety of the Clinician, the individual in crisis and others involved.
- TPC will also employ a Behavioral Health Crisis Co-Responder Manager at 10% to supervise the Clinician with the remaining 90% share being in-kind.
- The Providence Center will allocate 10% of clinical supervision to this project that will provide clinical supervision and case consultation to the Clinician and the Behavioral Health Crisis Co-Responder Manager.
- TPC shall provide the Police Supervisors and Behavioral Clinicians with computers and other devices that are, at its discretion, necessary to perform the tasks of this Agreement in the community.
- The Clinician may also participate in trainings of Providence Police Department officers and staff or staff of other community agencies. Such trainings might include but are not limited to effective use of verbal de-escalation techniques, Naloxone training, awareness, and access for community resources, etc.
- The Clinician will document all clinical services and outreach to individuals in TPC's electronic health record. Clinical services provided by the Clinicians will follow protocols developed for TPC electronic health records. Community meetings and trainings provided by the Clinician will be documented outside the electronic health record.
- The Clinician shall track program data to include the number of crises responded to with outcomes of those responses, the number of trainings provided, and personnel provided to, etc. The Clinician will work to identify and track other outcomes measures which capture efficacy of the program without compromising consumer's rights to privacy and protected health information. The Clinician will provide quarterly reports to a designated representative of the Providence Police Department.
- The Clinician shall participate in community integration meetings and partnership activities at the direction of Providence Police Department Command staff.
- TPC and the Providence Police Department recognize and agree that the amount to be invoiced under this Agreement does not equal the full costs to TPC of the services provided under this Agreement. The full costs of the services provided under this Agreement, include the salary, fringe benefits, and payroll taxes for the Clinician, local travel for the Clinician, the costs of clinical supervision and program coordination, training and professional development, and indirect costs that include TPC-wide functions such as payroll processing, legal, auditing, professional and general liability insurance, and administrative functions such as information technology, performance improvement, compliance, human resources, finance, billing, marketing, and health information services.
- Amounts invoiced to the Providence Police Department shall be invoiced quarterly based on the grant awarded amount of $295,176 for project period listed above.

12. EQUAL OPPORTUNITY AND CIVIL RIGHTS

TPC agrees that it will not discriminate against any employee or applicant for employment because of race, color, religion, handicap, age, sex or national origin. TPC will take affirmative action to ensure that applicants are employed, and employees treated during employment without regard to their race, color, religion, handicap, age, sex or national origin. TPC agrees to comply with all provisions of Executive Order No. 112246, as amended, 1965; Titles VI and VII of the Civil Rights Act of 1964; and the rules, regulations, and relevant orders of the Secretary of Labor; and all other relevant federal laws.

13. SUBCONTRACTS

It is understood that TPC shall not subcontract any of the work under this Agreement without the prior written approval of the Providence Police Department.

14. COUNTERPARTS

This Agreement may be executed in any number of counterparts, each of which shall be an original, but all of which together shall constitute one and the same instrument, and any of the parties or signatories may execute this Agreement by signing each counterpart. A copy or facsimile of a signature shall be binding upon the signatory as if it were an original signature.

AGREED BY:

Providence Police Department

Signature:

Name: Oscar L. Perez

Title: Chief of Police

Date: 10/4/2023

The Providence Center

Signature

Name: Stephen E. Burke

Title: V.P. Finance

Date: 10/4/2023

Approved as to form and correctness:

10/4/2023

Jeff Dana, City Solicitor
City of Providence

before payment of any invoice. Absent disputes, the Providence Police Department agrees to pay TPC the amount invoiced within 60 days. The parties acknowledge and agree that the compensation set forth in this Agreement was not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties. No part of this Agreement is intended to be, nor shall it be construed to be, an inducement or payment for referral of any patient.

7. ACCOUNTS, AUDITS, RECORDS

TPC shall maintain books, records, documents and other evidence and accounting procedures and practices sufficient to and to reflect properly all direct and indirect costs of whatever nature it claims to have been incurred for the performance of this Agreement. TPC shall preserve and make available its records until the expiration of three (3) years after the end of the project end period.

8. RECORDS, HEALTH INFORMATION COMPLIANCE

All documents, books and records pertaining to the provision of clinical services pursuant to this Agreement shall belong to and remain the property of TPC. Each party shall protect the privacy, integrity, security, confidentiality, and availability of (i) the protected health information (as that term is defined under the Standards for Privacy of Individually Identifiable Health Information at C.F.R. §160.103) disclosed to, used by, or exchanged by the parties by implementing appropriate privacy and security policies, procedures, and practices, and physical and technological safeguards and security mechanisms, all as required by, and set forth more specifically in, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Regulation and the HIPAA Security Regulation, as each may be amended from time to time and (ii) any information protected by Part 2 (i.e. 42 USC § 290dd-2, 42 CFR Part 2) and its implementing regulations and other applicable laws and regulations. All non-clinical documents, books, and records prepared by the Clinician in connection with the services under this Agreement shall belong to and remain the property of the Providence Police Department.

9. INDEMNIFICATION

Each party shall be responsible for its negligent acts or omissions and the negligent acts or omissions of its employees, officers, or directors, to the extent allowed by law, and agree to hold the other harmless from claims arising from the party's own fault or negligence.

10. INSURANCE VERIFICATION

The Providence Center shall maintain in full force and effect at its sole cost and expense throughout the term of this Agreement, the following types of coverage Insurance coverage, including without limitation,: (a) commercial general liability insurance with limits no less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the aggregate; (b) professional liability insurance of at least One Million Dollars ($1,000,000); (c) workers' compensation insurance in compliance with all applicable federal and state laws; and (d) automobile liability insurance covering owned, non-owned and hired vehicles with combined limits for bodily injury and property damage of at least One Million Dollars ($1,000,000) per accident. A party shall provide proof of insurance upon request of the other party. The Parties recognize and agree that the City of Providence and the Providence Center are both self-insured entities.

11. INDEPENDENT CONTRACTOR

The parties acknowledge that TPC is an independent contractor and that any staff person assigned to this project is not an employee of the City of Providence.

A. PROBLEM STATEMENT

A.1. Significance. Nationally, mental health situations account for approximately 10% of all police encounters[1-4]. While about 4% of all U.S. adults suffer from a serious mental illness, they may account for 25-50% of instances of use of lethal force by law enforcement (LE)[5]; their risk of being killed in a police encounter is 16 times greater than the general population[6]. From an economic perspective the healthcare system is overwhelmed - a 2020 study found that the top-decile of commercially insured patients drove 70% of all health care spending; of that top 10%, 57% had a mental health or substance abuse diagnosis and contributed 44% of all health care spending[7], and the effect is likely as or more pronounced for those covered by Medicaid (our primary demographic). Perhaps the most significant statistic, for our context, is that 45% of individuals with mental illness are not receiving appropriate care[8]. These individuals - those with an undiagnosed or untreated mental health condition who encounter police - are the ones we intend to target, and help.

Not only has Rhode Island, and Providence (PVD) specifically, mirrored these national indicators, in many ways the situation here is more worrisome. Mental Health America recently rated Rhode Island 48th (50 = worst) for prevalence (21%) of mental illness (national average = 18%) of mental illness.[9] Further, RI ranked higher than the national average on the following SAMHSA measures: (1) Percentage of illicit drug use among adolescents; (2) Percentage of binge alcohol use among individuals aged 12-20; (3) Adolescents who perceive no great risk from smoking marijuana once a month; (4) Percentage of alcohol dependence or abuse; (5) Percentage of illicit drug dependence or abuse; (6) Annual average of heavy alcohol use among adults 21 and older.[10] In this context, it is not surprising that a high proportion of law enforcement encounters in Providence involve people with mental health issues.

The proposed project directly addresses the intent of JMHCP to "support cross-system

collaboration to improve public safety responses and outcomes for individuals with mental illnesses (MI) .... who come into contact with the justice system," while addressing Objective 2, "Increase community capacity for mental health advocacy and wraparound services evidenced to support people with severe mental illness that are involved in the criminal justice system. " Significantly, our project focuses on early intervention and diversion.

A.2. Scope of *known* problem. We understand the mental health crisis in Providence - and its implications to law enforcement policies and practices - because for over a decade we have led the effort to improve systems and approaches. Since 2010 TPC has worked in partnership with the Providence Police Department (PPD), aided with prior DOJ grant funds. Together, we have designed and successfully implemented a "co-response" model (police officer teamed with a qualified mental health professional (QMHP)). Through this effort, in 2020, TPC clinicians had over 1,200 "contacts" as a result of emergency calls to the police (either through the statewide 911 system or directly to the PPD), which represented an estimated 15% of all PPD dispatches, involving an individual experiencing a substance use or other behavioral health (BH) episode. As key partners with the responding officers on these calls, our clinicians conduct BH assessments, while on-scene, and prescribe/ deliver appropriate treatment. Our effectiveness can be surmised by one important statistic: 95% of all police encounters that have included a TPC clinician have resulted in diversion of those individuals *from arrest* to treatment.

A.3. Scope of the *unknown* problem and need for further improvement. DOJ funding would allow us to not only enhance this vital co-response model, but to more than double the number of people served each year. This, we project, will be possible for two key reasons: (1) We will be discontinuing our focus on "high-utilizers" (the focus of the last DOJ grant awarded to PPD - final report to DOJ is pending), which we and the PPD have found to be a suboptimal use of resources. Briefly, the "highest utilizer" model did not 'intercept' people early enough in

the course of their illness - their conditions were too progressed to make significant impact by the time we intervened. Despite the intensity of outreach conducted by our team, and an enormous commitment of clinician-time, a relatively small number of high utilizers engaged in services. (2) Inefficiencies which are currently embedded in the model - related to dispatcher and officer training, and management of data - will be improved, enabling the same staffing configuration to achieve greater impact. It is our 12 years of experience in partnering with the PPD that has made the need for reform regarding point #2 evident; it is this same experience that will make the needed changes *possible* - because of the strong foundation of trust we have built together.

One of the major challenges we face as a team - PPD and TPC - is that we do not truly know the scope of the problem (i.e. the number of mental health incident (MHI) calls fielded by PPD dispatch). Consider: (1) It is sometimes challenging for dispatchers to know at the onset whether a call is a MHI, especially if that call is transferred from the statewide 911 system (which, many times, only indicates the "nature" of the call - police, fire, EMS). A better system to identify and code MHI calls would result in a clinician reaching the scene more quickly. Often, the need for a clinician is not recognized until the first officer is on-scene. (2) In the case implied in #1 (MHI identified only when an officer is on-scene), officers infrequently *re-code* the call in their report to reflect this status. Why is this significant? First, the lack of PPD data makes it more difficult for TPC to efficiently follow-up with the individual in the coming days, *especially* if the call is one which TPC did not have the staffing to respond to initially (i.e. 3rd shift). Second, without proper coding we do not truly understand the scope of the problem in our community, which hampers future response/ planning. (3) Many officers have not received structured training that would help them to quickly and accurately recognize a case of suspected mental illness, which means they may not properly code the call, or call for QMHP assistance

DOJ funding will be critical in helping us to provide a greater number of services and referrals, and to improve key systems - data collection, and training of dispatchers and officers. Further, this funding will help us to plan the transition from our current co-response model to the "clinician-only" or "direct-response" model (or "hybrid" model, which is more likely) which the Providence City Council (PCC) has voted to pursue. There has been intense dialog in our community over the past year, and a strong will to plan/ make this transition, as a means of addressing inequities and racial bias in our criminal justice system; in fact the Council has contracted with TPC to plan a "reimagined" public safety model for managing MHIs outside the purview of the police department.

A.4. Preliminary efforts to address these needs. Since 2010, TPC has "embedded" clinicians in the PPD; Providence was an early adopter of this approach - one of the first urban areas in the country to do so. Through the establishment and use of "co-response teams" which include a law enforcement (LE) officer and QMHP, we started our work by focusing on the general population of people encountering LE who were experiencing MH-related episodes. Later (beginning in 2018) we refocused our efforts on "high utilizers" - those individuals who are more likely to encounter police who also have a mental health issue (additional details: A.5).

Over the past 12 years Providence police have made contact with thousands of people (through an estimated 20,000 MHI calls-for-service) suffering from some form of mental illness or behavioral disorder; of those 20,000 an estimated 3,000 included a co-response with a TPC clinician. Of the 95% that were diverted from the criminal justice system, in part from the work of our QMHPs, approximately 40% were already TPC patients, and another 10% became new TPC patients. The remaining ~ 50% were referred to other agencies, lost to follow-up or refused care. Based solely on prison-costs, the project has saved millions of dollars, as a result of fewer arrests and incarcerations. Just as important, but not as easily measured - countless injuries and

traumatic experiences were avoided as a result of the de-escalation actions taken by our skilled clinicians, and their well-trained officers/ partners. We have learned as much through the collaborative, community-based process of developing this program, as we have from the execution and delivery of services thereof. Since the onset of our journey - over a decade ago - we have actively sought engagement from stakeholders including local cultural organizations, the Providence City Council/ elected officials, community health centers, civil rights organizations, emergency medical service (EMS) organizations and, of course, law enforcement. This *approach*, we believe, is the primary reason for our success.

A.5. Need for assistance/ overview of proposed plan. The goal of this project is to expand and improve TPC's co-responder model, until which time the community can develop a strategy to field both co-responder *and* direct-response models. The distinction between these two models is important, and a vital context in our community. In the past year there has been an intense grassroots push in Providence for police accountability, as well as realization that many calls into police dispatch do not require a law enforcement response. This dynamic has created both opportunities and challenges/ barriers for our work, which rests at the intersection of policing and mental health. The Providence City Council, in the past 12 months and as mentioned in A.3 above, has expressed growing interest in establishing a system of responding to MH-related incidents *outside of the purview of police*, and has in fact begun planning for such an initiative with our help. While we agree with this vision in principle, in practice "we" are not yet "there." Policies, systems (dispatch, monitoring, accountability, staffing, data collection/ analysis, etc.) are not yet in place to enable the *direct response* model. With time (perhaps 2-3 years) we believe a hybrid (co-response and direct response both operating within the City, under the control of different authorities) model can become a reality. During this gap period, we urgently need resources to improve and expand the effective co-responder model which we

developed 12 years ago. We now have resources to send a QMHP to only 15% of MHI calls.

As noted above, between 2018-2021 our agency partnered with the PPD on a DOJ-funded project to address "high utilizers" (frequent contact with the criminal justice system) with MH issues. During this period, we also maintained our co-responder model in partnership with the PPD, which has been funded with non-DOJ grant funds. As noted above, through a joint review, the PPD and TPC have determined that continuing to focus on the high-utilizer subpopulation is not a good use of limited resources. In this context, we are proposing to use DOJ funds to allow TPC "ride-along" clinicians to continue providing *crisis response* to support individuals in behavioral health crises, in collaboration with police officers, ideally *before* individuals become *high* utilizers of the criminal justice system. The TPC/ PPD co-response team will also provide follow-up "wellness checks" to those who previously encountered LE, and will continue to provide BH training to officers and department staff. This modified approach (drop focus on high utilizers, proactive wellness checks, continued officer training by embedded clinicians to *more* officers), combined with a PVD City Council match (see below) will enable an expansion of ~ 150% over the current level (1,200 to 3,000 contacts) in Year 1.

The PPD's 3-year DOJ grant ended on January 31, 2021 and we (TPC) received funding from the Rhode Island Foundation to continue the program (modified from "high utilizer" to "crisis response" for reasons noted above), but only through June 30, 2021. As a further demonstration of community buy-in for this collaborative effort, **the Providence City Council (on June 27, 2021) approved 12-months of continuation-funding for 2 existing clinicians;** the net result - combined with DOJ funding, if approved - will be that we can more than double the provision of services compared to our 2020/ 2021 effort. An additional three years of **DOJ funding will be used to hire a Clinical Supervisor and a Behavioral Health Crisis Clinician and Manager** , allowing a modified-version (crisis response vs. high-utilizer) of the previously-

funded DOJ project program. We will (in the planning phase, ~ 3 months) develop new data collection/ reporting systems, solicit additional community input to help us recalibrate the program and hire/ train the new clinicians, and during Phase 2 (~ 33 months) implement the improved and expanded program. Note: we are considering our co-response work over the next three years as a single project.

With these funds, we estimate that our team will engage with a minimum of 2,100 individuals with mental illness, diverting 95% or more away from the penal system. We will also train at least 250 police officers and support staff in evidence-based, trauma-informed strategies to more effectively engage with people experiencing mental health episodes. Further, and significantly, this project will serve as a bridge between the co-response and the direct-response (no LE officer) models. This will help to build consensus, and partnerships, among relevant stakeholders, smoothing the transition to this new model, which we anticipate will come to fruition within three years. Thus, our work may one day serve as a blueprint that can help other communities to respond to individuals with acute BH needs, while working through an anti-racist, anti-stigma lens.

B. PROJECT DESIGN AND IMPLEMENTATION

B.1.a. Deliverables - *Planning Phase.* We are proposing a ~3-month planning phase. Undertaking a relatively short planning process will allow us to expand direct services more quickly and is adequate since we are enhancing and expanding an *existing* co-response program. During the first quarter of the project we will engage the following stakeholders through a combination of virtual and in-person group meetings, one-on-one consultations and feedback on planning documents: PPD, Providence City Council, local civil rights and advocacy organizations, and City residents. Resulting deliverables will include: (1) **Written "Planning and Implementation Guide"** - a consensus (among all consulted-stakeholders) document that

reflects the joint goals and vision of our collaborative. The primary focus of this document will be (ii) transitioning from the high-utilization model which we were funded to implement between 2018-2021, to a crisis co-response model; (ii) a more systemized, comprehensive and descriptive approach to dispatching and coding/ recording MHI-related data to; (iii) Establishing roles and responsibilities particularly in regard to dispatch, coding and recording of relevant and appropriate (HIPAA) data. **(2) Improved data management system** - our current system is deficient; it captures too few metrics and is cumbersome for police officers. Since HIPPA rules prevent our clinicians from updating the police database we will work collaboratively with the PPD to better train dispatchers and create new codes (as appropriate) so richer metrics will be captured in the future. Currently, our clinicians must record important information in their own primitive spreadsheets, without potential for efficient future analysis. Dispatchers do not document: when a TPC clinician responds to a call, or; when a police officer responds to the same location/ individual (along with the clinician) on multiple occasions, or; whether the clinician potentially helped to avoid future calls for that individual. This situation is an impediment to improving our program and is an issue which will be addressed as an important element of our Planning Phase. These are data which are within the capacity of our partnership to capture, and which we intend to capture.

B.1.b. Deliverables - ***Implementation Phase.*** Our team, at minimum, will achieve the following results over the 33-month implementation period: (1) One of four full-time TPC clinicians will respond (along with a PPD officer) to ~ 53% of all calls (in Year 1) which require a mental health response (based on ***new*** dispatcher coding [planning phase]), increasing from an estimated 15% response rate over the last three years ("estimated" based on internal TPC data, because PPD does not currently record when a clinician is dispatched with officer). Based on historical data, this will equate to ~ 2,100 *full crisis assessments* over 3 years (or approximately

8,400 contacts [a single call often involves multiple "contacts"])). (2) Nearly 2,000 individuals (~ 95%) will be diverted from potential arrest to mental health treatment and/ or other appropriate resources. (3) 150 PPD officers and 5 dispatchers will receive training to more proficiently respond to MH calls, resulting in fewer instances which an officer must go "hands-on" when engaging with a resident. (4) A new dispatch/ data-coding system and protocol will be established to account for new metrics (previously mentioned), including: calls with TPC-clinician responding; repeat MH calls to the same location/ individual; MH-outcome (diversion, arrest, type of diversion).

B.2. Implementation strategy. The planning phase will leverage a 12-year foundation of data, relationships and positive outcomes for members of our community; nearly all elements of our proposed program model have been extensively applied and executed. Recognizing these conditions, we will be starting this DOJ-funded 3-year project from a position of strength and confidence. We will, however, still pursue an inclusive and structured process with our partners to ensure that: our expansion targets the right individuals/ calls, our new approach to managing data and follow-up with our clients is practical and provides actionable insights to our clinicians and managers, and work is compatible with and is supportive of a "hybrid" model (co-response and clinician-only response) that seems all but inevitable in Providence. The planning process will be led by a Clinical Supervisor in partnership with the PPD counterpart: the Major for the Community Policing Division.

The implementation phase will be structured similarly to our past crisis response work, with four main components: (1) Mental health response - two TPC clinicians (a credentialed QMHP - i.e. LCSW, LMHC, or RN) will be assigned to the first two shifts, and will always be paired with a police officer who has been trained by TPC or another qualified agency in evidence-based practices utilized in the law enforcement including Mental Health First Aid

(MHFA, and Crisis Intervention Training (CIT)). PPD dispatchers will be trained by TPC (with annual in-service training) and will be made familiar with appropriate situations which require dispatch of the co-response team. In these calls the clinician takes the lead, de-escalating, assessing the situation/ individual and recommending appropriate diversion measures (such as: immediate transport to a MH facility, referral to a MH provider within a specified time period). (2) Follow-up clinical care - subsequent to the encounter, usually within the following week, a TPC-based staff will follow-up with the individual or family involved in the original call for service to be sure a connection to resources were made and help to avoid further crises. TPC staff may also conduct follow up visits for persons who have police contact due to BH concerns and a co-response was not possible at the initial time of the call. (3) Officer, cadet and dispatcher training - will take place through (i) short vignettes during morning roll-call, (ii) 1-on-1 while officers are paired with TPC clinicians, and (iii) quarterly 2-hour trainings on key elements of the CIT curriculum including Etiology (various diagnosis via anti-stigma lens), verbal de-escalation, recognition of MHIs, resource availability and connection, context: traumatized communities have greater incidences of MHIs. In addition, training will be provided to new cadets in the annual police academy (to mirror topics covered above, along with MHFA). Finally, training for dispatchers will include development of and training on a decision-making tool or matrix; this would be a new way for dispatchers to engage with callers, ask questions about the nature of the call and make decisions about more appropriate response to dispatch. (4) Enhanced data management - as a new element, we will be restructuring the way that clinicians, dispatchers and officers record encounters.

B.3. Timeline/ project plan. Below is a general timeline of major project tasks/ deliverables, for the first 12 months of the project. Years 2 and 3 (with the exception of strategic planning phase) largely mirror Y1. Additional details entered through JustGrants, as required.

Table 1. Timeline/ project plan for Year 1

Month	Major Tasks	Details/ deliverables for Year 1 (Y2, Y3 = similar)
1-3	Strategic planning	• Conduct 1-1 and group meetings w/ stakeholders • Generate consensus on implementation plan • Create sub-plan/ timeline for d-base modifications • Produce written strategic plan to guide project • Create/ revise policies/ procedural manual • Train key personnel (officers, clinicians, dispatch)
4-12	Implementation of co-response services	• Clinician "ride-alongs" begin by month 4 • Dispatchers begin using new protocols • 2 clinicians/ shift respond to total of 50 calls/ mo. • 80 individuals referred to MH services/ month (in- and out-patient) • 20 individuals enroll as TPC patients in BH services/ month • 150 Police Officers trained portions of the CIT curriculum • Maintain diversion rate (i.e. non-arrest) of 95%
8	Implementation of new data system	TPC and PPD reps will meet regularly to map-out the integration (where possible) of data systems, to enable more efficient coding, management of and access to data. By month 8 system will be activated
1-12	Qtly reviews/ reporting	TPC will review program data, and will interview clinicians, on a quarterly basis for quality improvement purposes; reports will be submitted to DOJ as required
12	Formative evaluation	During month 12, PPD and TPC will convene to review the year's data and plan improvements

B.4. Priority areas. Below we summarize the ways which the project explicitly addresses the *Program-specific Priority Areas.* Also, descriptions of our strategies to address each of these priority areas are embedded throughout this narrative.

Priority Area (annotated)	How Project Address Priority Area
Promote effective strategies by law enforcement to identify and reduce the risk of harm to individuals with MI or CMISA and to public safety	• Training officers and dispatchers to; better recognize symptoms of behavioral health issues, understand etiology of behavioral health issues in effort to reduce stigma. • Teaching officers and dispatchers (through direct, 1-on-1 work with a TPC clinician) person-centered, empathetic approach to encourage respectful, humane interactions. • Promoting use of verbal de-escalation techniques among officers. • Clinicians provide community-based assessments to determine whether or not a person with BH concerns is able to remain safe in the community or if they require hospitalization. Avoiding unnecessary hospitalization is a trauma-informed best practice.
Promote effective strategies to expand the use of mental health courts and related services	TPC routinely interfaces with the RI Dept of BHDDH, and the RI MH Court, for the management of persons court-ordered to outpatient treatment. Clinicians also, at times, advocate for hospitals to seek court ordered care in the event a person is known to have repeated contacts with LE due to medication/ treatment non-adherence.
Use validated assessment tools to identify and prioritize individuals with a moderate or high risk of recidivism and a need for treatment	We utilize the evidence-based Columbia Suicide Severity Rating Scale. This is the only researched, standardized tool we use. We also utilize other assessment tools aimed at determining risk vs. factors indicating safety as it related to RI mental health law 40.1. TPC uses the CASE approach in interviewing people about risk, to assess suicide ideation.
Demonstrate and ensure that funds are used for public health and public safety; demonstrate active participation of co-applicants in administering the project	Services will be aimed at public health and safety in that activities will be generated from the PPD and the dispatch system. Though TPC is the largest community MH agency in the city, services provided through this program are not restricted to people already actively in treatment with the agency. The MOU between the PPD and TPC provides evidence of the commitment of both agencies in this initiative (though TPC is the sole "applicant" as submitting a "co" application was not an option). Funds will not be used for the treatment of incarcerated populations.

B.5. Use of DOJ grant support will supplement not supplant existing funding. As mentioned, and demonstrated through the presentation of data, our past efforts have made a positive impact on the City of Providence and its residents. Perhaps the best validation of this statement is that RI's largest foundation (a 6-month grant) as well as the Providence City Council (12-months of funding via the *American Rescue* funds) have stepped-in to ensure that the gains made by this successful program will continue. As a result, DOJ funding will be matched nearly dollar for dollar in Year 1 (committed), allowing us to double the program's impact. We are hopeful for the same result in Years 2 and 3 (too early to commit to future match from the City of PVD, since the City's 2023 budgeting process has not yet been finalized). Since, even with the combination of DOJ and City of PVD resources we will - at best - have the capacity to respond to 60% of MHI calls, DOJ funding will by no means be redundant.

C. CAPABILITIES AND COMPETENCIES

C.1. The Providence Center - background, capabilities, and experience. Founded in 1969, the mission of The Providence Center is to help people affected by mental health, BH, and substance use problems by providing treatment and supportive services within a community setting. As the largest community-based behavioral healthcare organization in the state, TPC provides the most comprehensive continuum of community-based services in Rhode Island, with over 60 programs and wraparound services, including outpatient treatment, crisis stabilization, integrated primary care, housing assistance, recovery support services, and wellness activities. TPC employs a staff of 750 and is committed to (and invests in) their ongoing professional development. The organization's annual budget is $58 million. Annually, TPC manages ~ $9 million in federal, state, and local grant funds. In addition, TPC enjoys extensive partnerships with a wide range of community groups, delivering BH services, on-site, in community health centers across RI, as well as the PVD Fire Dept and Dept of Corrections. TPC has been an

affiliate of the Care New England healthcare system since 2014 but is governed by its own Board of Trustees. TPC is accredited by the Commission on Accreditation of Rehabilitation Facilities and is licensed by the Dept. of BH, Developmental Disabilities and Hospitals.

C.2. Key personnel and partners - experience and capacity. This proposed project will be staffed by senior TPC managers, and clinicians with deep expertise in working with community groups, providing evidence-based clinical services, and training behavioral health and law enforcement personnel. Similarly, our partners in the PPD bring to the table broad experience and competencies in public safety/ law enforcement; and, because we will be working with many of the same officers/ supervisors, they also have experience with MHI calls. The **Project Director** of this joint effort will be Jacqueline Mancini-Geer, TPC Director of Acute Care. Mancini-Geer has managed TPC's police partnerships for the past 3 years. She also, as part of her responsibilities at TPC, oversees the agency's 24-hour emergency services program, Crisis Stabilization Unit, and the Home Base team which provides services to individuals who are chronically homeless. Mancini-Geer is a Licensed Mental Health Counselor, QMHP, a Certified Community Support Professional, and a member of the Rhode Island Disaster Behavioral Health Response Team. She will also be responsible for developing a systems-strategy for utilizing LE data for client follow-up, as appropriate and allowed within HIPAA regulations. She will work collaboratively with her counterpart at the PPD (the Major assigned to the Community Policing Division) to establish new systems policies/ protocols for collecting and analyzing program-related data. Two existing, and 2 new, full-time **Ride-Along Clinicians** will be assigned to this project in Year 1, to be supported with grant funds for clinical work. Rachel Armada, LICSW QMHP (3 yrs with TPC, 1yr with police) and Lauren Cann, MA QMHP new hire in co-responder role. In Year 1 one additional QMHP will be hired with DOJ funds (by Month 4). One source of match-funding (City of PVD) is guaranteed through June 30, 2022 after

which time the department is seeking renewal. All clinicians are/ will be titled Community Diversion Clinicians. The **PPD Major for the Division of Community Policing** will be responsible for overseeing training of officers and dispatchers, ensuring that new project-related PPD policies get implemented, and liaising with TPC.

C.3. Management and staffing structure. This project will be managed in accordance with TPC's existing policies and procedures which currently govern this program. The PD will maintain overall responsibility and will directly supervise clinical work. She will also liaise with the PPD, the City Council and other stakeholders. Clinicians will deliver direct services and will record program data on a daily basis. An annual review of data and formative evaluation will take place during a ~ 1/2-day retreat. The PD will meet with each clinician for bi-weekly clinical supervision, and attend monthly collaboration meetings with PPD, for program oversight and optimization. Clinical supervision will ensure a best practice trauma-informed, culturally competent approach is followed, and timely collection and reporting of data.

D. PLAN FOR COLLECTING THE DATA REQUIRED FOR THIS SOLICITATION

D.1, D.2. Plan for collecting performance measures. TPC already has a system in place for collecting performance measures, which is two-fold: (1) TPC clinicians, currently, use a spreadsheet to self-report metrics on all encounters including: evaluation performed, consultation, follow up, and outcome of interaction (resources provided, hospitalized, arrested). The clinicians also search the police database on a weekly basis for calls coded by dispatch as "MHI." If clinicians were not already aware of the interaction the person had with police, they attempt to engage with the person for follow up support; at that point, the clinician records the interaction or attempted outreach in their spreadsheet. The *Epic electronic medical record system* is used for all clinical documentation. Clinicians never track their activity in the police system. This data-recording protocol will continue.

The PPD's database (AGIS), has limited codes available, thus limiting the detail with which we can record our client engagements; this system does not record whether a clinician responds to a scene with an officer, or any other related data. We view this as a deficiency that inhibits our ability to fully understand the scope of the problem, and the effects of our efforts, and will thus be addressed, as mentioned in sections B.1.a and B.2. One of the objectives of this project is to improve and extend our data collection capabilities, as explicitly stated in our MOU with the PPD.

D.3, D.4. Use of data for quality improvement, and reporting. We will continue to review all available data (recorded by both our clinicians and our law enforcement partner) and reports on a monthly basis. We take this data into consideration when evaluating our work, and to help us improve. We look for trends (i.e. response times, type and numbers of referrals, # of clients arrested/ referred, etc.) as potential indicators of our performance - responsiveness (too slow?), whether appropriate referral was issued (retrospective review of cases and actions), etc. Our clinicians and their co-responding officers, as well as PDD dispatchers record data, daily. Oversight of data collection, and reporting, is the responsibility of the Project Director. As TPC has diligently done for the past three years in their partnership role with the PPD, reporting will continue DOJ as requested.

Solicitation Title:	BJA FY 22 Connect and Protec	Solicitation Category:	N/A
Project Title:	Providence Law Enforcement Behavioral Health Response Program	Federal Award Amount	$295,176.00
		Program Office:	BJA
Project Period:	10/1/22 - 9/30/25	UEI:	MDUUL23X2CK3
		TIN:	056000329
Managing Office:	OJP		
DOJ Grant Manager:	Mark Slater		
Grant Award Administrator:	Adam Richards		
FAW Case ID	FAW-172944		

1.Federal Agency and Organizational Element to Which Report is Submitted: U.S. Department of Justice

Federal Agency and Organizational Element to Which Report is Submitted

2.Federal Grant Or Other identifying number: 15PBJA-22-GG-02987-MENT

This is the grant number assigned to the award for this program.

3. Recipient Organization (Name and complete address including Zip code)

This is the organization name and complete address of the recipient organization.

Recipient Organization Name: PROVIDENCE POLICE DEPARTMENT

Street 1: 325 WASHINGTON ST

Street 2:

City: PROVIDENCE **County:** ——

State:	RI	**Province:**	—
Country:	USA	**ZIP / Postal Code:**	02903

4a. UEI

This is the recipient organization's Unique Entity Identifier (UEI) or Central Contract Registry UEI.

MDUUL23X2CK3

4b. EIN

This is the Employer Identification Number (EIN) of the recipient organization.

056000329

5. Recipient Account Number

Enter the account number or any other identifying number assigned by the recipient to the award. This number is for the recipient's use only and is not required.

—

6. Report Type

A final report shall be submitted within 120 days after the grant period end date.

Quarterly

7. Basis Of Accounting

Specify whether a cash or accrual basis was used for recording transactions related to the award and for preparing this report. Accrual basis of accounting refers to the accounting method in which expenses are recorded when incurred. For cash basis accounting, expenses are recorded when they are paid.

Cash

8. Project/Grant Period

Enter the project/grant period (start and end date). This should encompass the beginning date of the original award and the latest ending date under the award number

From	To
10/01/2022	09/30/2025

9. Reporting Period

Enter the start and end date of the reporting period. Federal Financial Reports will be submitted on a

From	To
01/01/2024	03/31/2024

quarterly basis. A final FFR shall be submitted at the completion of the award agreement. The following reporting periods shall be used for quarterly reports: • October 1 – December 31 (due by January 30) • January 1 – March 31 (due by April 30) • April 1 – June 30 (due by July 30) • July 1 – September 30 (due by October 30) Quarterly reports shall be submitted no later than 30 days after the end of each reporting period. Final reports shall be submitted no later than 120 days after the project or grant period end date.

10.Transactions:

	Cumulative
Federal Cash:	
10a.Cash Receipts Do not enter any information in this field. COPS, OJP, and OVW do not require a Grantee to report this information.	——
10b. Cash Disbursements Do not enter any information in this field. COPS, OJP, and OVW do not require a Grantee to report this information.	——
10c. Cash on Hand (line a minus b) Do not enter any information in this field. COPS, OJP, and OVW do not require a Grantee to report this information.	——
Federal Expenditures and Unobligated Balance:	
10d. Total Federal funds authorized The total Federal funds authorized as of the reporting period end date.	$295,176.00
10e. Federal share of expenditures Enter the cumulative amount of federal fund expenditures. **Cumulative means from award inception through the end of this reporting period.**	$0.00
10f.Federal Share of Unliquidated Obligations	$0.00

Enter the amount for the federal share of unliquidated obligations. On a cash basis, unliquidated obligations are obligations incurred, but not yet paid. They include direct and indirect expenses incurred but not yet paid or charged to the award, including amounts due to subrecipients or contractors. On an accrual basis, the obligations are incurred, but the expenditures have not yet been recorded. On the final report, for either cash or accrual basis, this Line should be zero (0). **Do not include any amount in Line 10f that have been reported in Line 10E. Include the unliquidated obligations that will be expensed by the end of the next quarter. Do not include any amount in Line 10f for a future commitment of funds (such as a long-term contract) for which an obligation or expense will not be incurred by the end of the next quarter.**

10g. Total Federal share (sum of lines e and f) $0.00

The sum of Lines 10e and 10f.

10h. Unobligated balance of Federal Funds (line d minus g) $295,176.00

The amount of Line 10d minus Line 10g.

Recipient Share:

10i. Total recipient share required $93,170.77

Enter the total required recipient share for grant period specified in Line 8. The required recipient share should include all matching and cost sharing provided by recipients and third-party providers to meet the level required by the program. This amount should not include cost sharing and match amounts in excess of the amount required by the program (for example, cost overruns for which the recipient incurs additional expenses and, therefore, contributes a greater level of cost sharing or match than the level required by the program).

10j. Recipient share of expenditures $0.00

Enter the cumulative recipient share of actual cash disbursements or outlays (less any rebates, refunds, or other credits) including payments to subrecipients and contractors. This amount may include the value of allowable third party in-kind contributions and recipient share of program income used to finance the non-Federal share of the project or program. Note: On the final report this line should be equal to or greater than the amount of Line 10i. **Cumulative means from award inception through the end of this reporting period.**

10k. Remaining recipient share to be provided (line i minus j) $93,170.77

The amount of Line 10i minus 10j.

Program Income:

10l. Total Federal program income earned ——

Enter the amount of federal program income earned. Do not report any program income here that is being allocated as part of the recipient's cost sharing amount included in Line10j. If this is a final report, this field is required and may not be left blank, but a zero (0) may be entered. **Cumulative means from award inception through the end of this reporting period.**

10m. Program Income expended in accordance with the deduction alternative ——

Enter the cumulative amount of program income that was used to reduce the Federal share of the total project costs. **Cumulative means from award inception through the end of this reporting period.**

10n. Program Income expended in accordance with the addition alternative ——

Enter the cumulative amount of program income that was added to funds committed to the total project costs and expended to further eligible project or program activities. **Cumulative means from award inception through the end of this reporting period.**

10o. Unexpended program income (line l minus line m and line n) $0.00

The amount of Line 10l from 10m and 10n.

11. Indirect Expense:

11a.Select either Not Applicable or the appropriate indirect cost rate(s).

11b.Enter the indirect cost rate(s) in effect during the reporting period

11c.Enter the beginning and ending effective dates for the rate(s).

11d.Enter the amount of the base against which the rate(s) was applied

11e.The amount of indirect costs charged during the time period specified. (11b x 11d)

11f.Enter the Federal share of the amount in 11e, using a dollar amount, not a percentage.

11a.Type of Rate(s)	11b.Rate	11c.Period From	11c.Period To	11d.Base

No items

11g.Totals Ba

Federal Share Total

$0.00

12.Additional Information

Enter any remarks, explanations or additional information required. Supporting documents may be added by clicking the

Remarks

Uploaded Documents

File Name
No items

Upload Supporting Documents

13.Certification

By submitting this report, I certify to the best of my knowledge and belief that the report is true, complete, and accurate, a receipts are for the purposes and objectives set forth in the terms and conditions of the Federal award. I am aware that a the omission of any material fact, may subject me to criminal, civil, or administrative penalties for fraud, false statements Section 1001 and Title 31, Sections 3729-3730 and 3801-3812).

Prefix: ——

First Name: Elaine **Middle Name:** **Last I**

Suffix: **Title:** ——

Full Name: Elaine Richards

Email Address: erichards@providenceri.gov

Telephone: 4012436222

Date: 08-Apr-2024