2024/2025 PBCME Opiate OD Deaths

- **PBC Medical Examiner (2024)- January 1 – December 31, 2024 – <u>No Pending Cases</u>**
  - Total drug overdose cases **343**
  - Total opioid OD deaths **244** (71% of total OD cases)
  - Total Fentanyl & Fentanyl analog cause or presence **222** (91%)

- **PBC Medical Examiner (2025) - January 1 – December 31, 2025 – <u>No Pending Cases</u>**
  - Total drug overdose cases **262**
  - Total opioid OD deaths **166** (63% of total OD cases)
  - Total fentanyl & fentanyl analog cause or presence **148** (89%)
  - **Decline in Opioid OD deaths - 2024/2025 (<32%)**

Xylazine: "tranq" non-opioid animal tranquilizer – **2024-27/ 2025- 8 (< 71%)**

New Fentanyl analogues:

- Fleurofentanyl – similar potency to Fentanyl – **2024-60/ 2025-14 (< 77%)**
- Carfentanil – 2024- 3/ 2025- 2
- Ketamine – 2024- 0/2025- 1

2025/2026 PBCME Opiate OD Deaths -SNAPSHOT-

- **PBC Medical Examiner (2025)- January 1 – March 31 (2025)– No Pending Cases**
  - Total drug overdose cases **69**
  - Total opioid OD deaths **41** (72% of total OD cases)
  - Total Fentanyl & Fentanyl analog cause or presence **39** (90%)

- **PBC Medical Examiner (2026) - January 1 – March 31, 2026 – <u>10 Pending Cases</u>**
  - Total drug overdose cases **46**
  - Total opioid OD deaths **19** (41% of total OD cases)
  - Total fentanyl & fentanyl analog cause or presence **16** (84%)
  - **Decline in Opioid OD deaths - 2025/2026 (<54%)**

Xylazine: "tranq" non-opioid animal tranquilizer – **2025-2/ 2026- 0**

New Fentanyl analogues:

- Fleurofentanyl – similar potency to Fentanyl – **2025-6/ 2026-0**
- Carfentanil – 2025- 1/ 2026- 0
- Ketamine – 2025- 0/2026- 0

PBCFR TRANSPORTS 2017-2025
January 1 – December 31

YEAR	#CALLS	# PATIENTS	%CHANGE/CALLS
2017	2675	2785	
2018	1509	1541	< 44 %
2019	1483	1510	< 2 %
2020	1771	1806	> 16 %
2021	1702	1743	< 4 %
2022	1446	1471	< 15 %
2023	1272	1298	< 12 %
2024	1231	1266	< 3 %
2025	745	753	< 39 %

12 Month Net change 2017-2025 – 72 % reduction in # transport Calls

FINAL 2017 12 MONTHS

Palm Beach County Fire Rescue
Primary or Secondary Impression = Opioid

1/1/2017 to 12/31/2017

9/25/2018

2017

January	# of Calls:	162	# of Patients:	165
February	# of Calls:	135	# of Patients:	138
March	# of Calls:	329	# of Patients:	343
April	# of Calls:	238	# of Patients:	251
May	# of Calls:	414	# of Patients:	429
June	# of Calls:	340	# of Patients:	373
July	# of Calls:	180	# of Patients:	183
August	# of Calls:	209	# of Patients:	215
September	# of Calls:	176	# of Patients:	180
October	# of Calls:	185	# of Patients:	195
November	# of Calls:	135	# of Patients:	136
December	# of Calls:	172	# of Patients:	177
GRAND TOTALS	# of Calls:	**2,675**	# of Patients:	**2,785**

FINAL 12 MONTHS 2018

Palm Beach County Fire Rescue
Primary or Secondary Impression = Opioid

1/1/2018 to 12/31/2018

1/10/2019

2018

January	# of Calls:	144	# of Patients:	148
February	# of Calls:	128	# of Patients:	130
March	# of Calls:	116	# of Patients:	120
April	# of Calls:	129	# of Patients:	133
May	# of Calls:	124	# of Patients:	126
June	# of Calls:	180	# of Patients:	182
July	# of Calls:	149	# of Patients:	151
August	# of Calls:	124	# of Patients:	129
September	# of Calls:	113	# of Patients:	114
October	# of Calls:	127	# of Patients:	129
November	# of Calls:	99	# of Patients:	99
December	# of Calls:	76	# of Patients:	80
GRAND TOTALS	# of Calls:	**1,509**	# of Patients:	**1,541**

FINAL 12 MONTHS 2019

Palm Beach County Fire Rescue
Primary or Secondary Impression = Opioid

1/1/2019 to 12/31/2019

1/10/2020

2019

January	# of Calls:	100	# of Patients:	102
February	# of Calls:	105	# of Patients:	107
March	# of Calls:	97	# of Patients:	100
April	# of Calls:	103	# of Patients:	104
May	# of Calls:	137	# of Patients:	139
June	# of Calls:	113	# of Patients:	115
July	# of Calls:	127	# of Patients:	132
August	# of Calls:	127	# of Patients:	128
September	# of Calls:	125	# of Patients:	128
October	# of Calls:	156	# of Patients:	159
November	# of Calls:	131	# of Patients:	133
December	# of Calls:	162	# of Patients:	163
GRAND TOTALS	# of Calls:	**1,483**	# of Patients:	**1,510**

Palm Beach County Fire Rescue
Primary or Secondary Impression = Opioid
1/1/2020 to 12/31/2020

1/5/2021

2020

January	# of Calls:	183	# of Patients:	187
February	# of Calls:	147	# of Patients:	149
March	# of Calls:	147	# of Patients:	148
April	# of Calls:	143	# of Patients:	148
May	# of Calls:	151	# of Patients:	154
June	# of Calls:	148	# of Patients:	153
July	# of Calls:	144	# of Patients:	147
August	# of Calls:	141	# of Patients:	143
September	# of Calls:	183	# of Patients:	190
October	# of Calls:	147	# of Patients:	150
November	# of Calls:	119	# of Patients:	119
December	# of Calls:	118	# of Patients:	118
GRAND TOTALS	# of Calls:	**1,771**	# of Patients:	**1,806**

Palm Beach County Fire Rescue
Primary or Secondary Impression = Opioid
1/1/2021 to 12/31/2021

1/3/2022

2021

January	# of Calls:	127	# of Patients:	129
February	# of Calls:	119	# of Patients:	121
March	# of Calls:	151	# of Patients:	156
April	# of Calls:	143	# of Patients:	144
May	# of Calls:	153	# of Patients:	159
June	# of Calls:	128	# of Patients:	130
July	# of Calls:	120	# of Patients:	122
August	# of Calls:	146	# of Patients:	150
September	# of Calls:	151	# of Patients:	154
October	# of Calls:	177	# of Patients:	185
November	# of Calls:	133	# of Patients:	134
December	# of Calls:	154	# of Patients:	159
GRAND TOTALS	# of Calls:	**1,702**	# of Patients:	**1,743**

Palm Beach County Fire Rescue
Primary or Secondary Impression = Opioid
1/1/2022 to 12/31/2022

1/3/2023

2022

January	# of Calls:	140	# of Patients:	144
February	# of Calls:	148	# of Patients:	150
March	# of Calls:	126	# of Patients:	130
April	# of Calls:	102	# of Patients:	103
May	# of Calls:	123	# of Patients:	127
June	# of Calls:	101	# of Patients:	104
July	# of Calls:	135	# of Patients:	137
August	# of Calls:	137	# of Patients:	140
September	# of Calls:	118	# of Patients:	118
October	# of Calls:	119	# of Patients:	119
November	# of Calls:	96	# of Patients:	96
December	# of Calls:	101	# of Patients:	103
GRAND TOTALS	# of Calls:	**1,446**	# of Patients:	**1,471**

Palm Beach County Fire Rescue
Primary or Secondary Impression = Suspected Opioid

10/4/2024

FISCAL YEAR **2024**

2024

January	# of Calls:	88	# of Patients:	93
February	# of Calls:	96	# of Patients:	97
March	# of Calls:	90	# of Patients:	90
April	# of Calls:	94	# of Patients:	98
May	# of Calls:	85	# of Patients:	87
June	# of Calls:	92	# of Patients:	98
July	# of Calls:	80	# of Patients:	82
August	# of Calls:	54	# of Patients:	54
September	# of Calls:	59	# of Patients:	59
October		186		195
November		135		136
December		172		177
		1231		1266

Palm Beach County Fire Rescue
Primary or Secondary Impression = Suspected Opioid
1/1/2025 to 12/31/2025

1/2/2026

FISCAL YEAR **2025**

2025

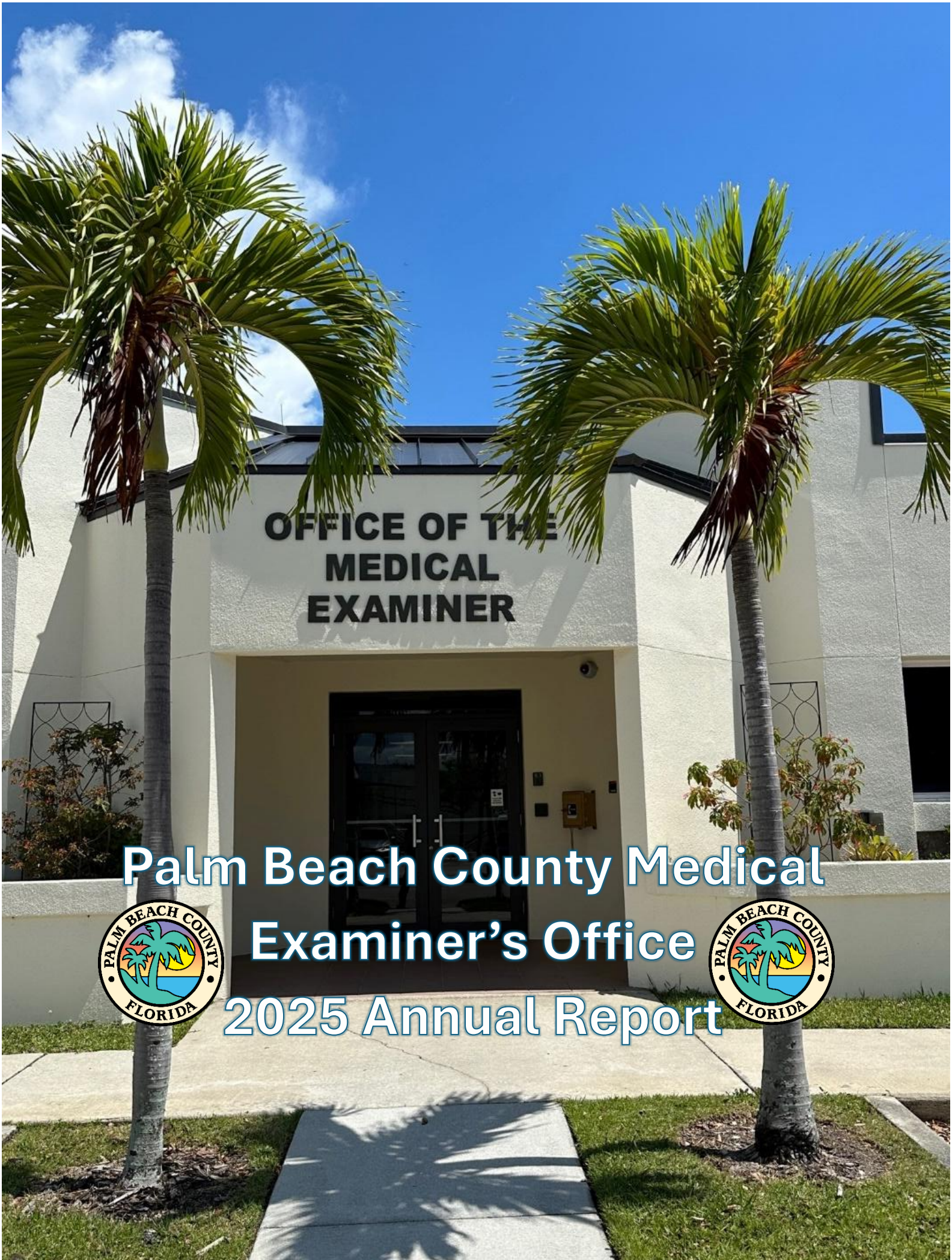
January	# of Calls:	43	# of Patients	43
February	# of Calls:	52	# of Patients	52
March	# of Calls:	77	# of Patients	77
April	# of Calls:	71	# of Patients	72
May	# of Calls:	82	# of Patients	82
June	# of Calls:	63	# of Patients	64
July	# of Calls:	54	# of Patients	55
August	# of Calls:	71	# of Patients	73
September	# of Calls:	66	# of Patients	67

FISCAL YEAR **2026**

2025

October	# of Calls:	64	# of Patients	66
November	# of Calls:	47	# of Patients	47
December	# of Calls:	55	# of Patients	55

GRAND TOTALS	# of Calls:	**745**	# of Patients	**753**



Palm Beach County Medical Examiner's Office

2025 Annual Report

Table of Contents

Introduction

The Palm Beach County Medical Examiner's Office (PBCMEO) is located at 3126 Gun Club Road in West Palm Beach. This facility includes medical examination areas, evidence and specimen storage areas, a tissue procurement area, X-ray facilities, and administrative areas and offices. Medicolegal death investigations are carried out 24 hours a day, every day of the year, including Federal Holidays. During weekdays, the PBCMEO is open to the public during normal business hours.

According to the Florida Legislature Office of Economic and Demographic Research[1], Palm Beach County is Florida's fourth most populous county, with 6.7% of Florida's population. In addition to its year-round and seasonal residents, Palm Beach County has several million visitors per year. If any person, resident or visitor, dies within Palm Beach County, and the circumstances of the death fulfill the criteria defined by Florida Statute 406.11[2], they will be referred to the Palm Beach County Medical Examiner's Office for investigation.

The Palm Beach County Medical Examiner's Office, District 15 of the Florida Medical Examiner system, is responsible for determining the cause and manner of death of people who die in Palm Beach County and fulfill the criteria of Florida Statute 406.11[2]. The Medical Examiner shall "make or have performed such examinations, investigations, and autopsies as he or she shall deem necessary or shall be requested by the state attorney" based on the following criteria of Florida Statute 406.11:

(a) When any person dies in the state:

1. Of criminal violence.
2. By accident.
3. By suicide.
4. Suddenly, when in apparent good health.
5. Unattended by a practicing physician or other recognized practitioner.
6. In any prison or penal institution.
7. In police custody.
8. In any suspicious or unusual circumstance.
9. By criminal abortion.
10. By poison.
11. By disease constituting a threat to public health.
12. By disease, injury, or toxic agent resulting from employment.

(b) When a dead body is brought into the state without proper medical certification.

(c) When a body is to be cremated, dissected, or buried at sea.

In 2025, 3,515 deaths were reported to the PBCMEO. This included 1,512 cases investigated and determined to not fulfill the criteria of F.S. 406.11. These are called non-Medical Examiner (non-ME) cases. The PBCMEO reviewed the death certificates of 9,228 decedents who were to be cremated, dissected, or buried at sea to determine if any fulfilled the criteria of F.S. 406.11 and thus become a

[1] https://edr.state.fl.us/content/area-profiles/county/palmbeach.pdf

[2] http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0406/Sections/0406.11.html

Medical Examiner (ME) case. Of those 9,228 cremation reviews, 94 (1.0%) became ME cases because they fulfilled the criteria of F.S. 406.11. The 2025 annual report concentrates on the 2,003 Medical Examiner (ME) cases for the year 2025.

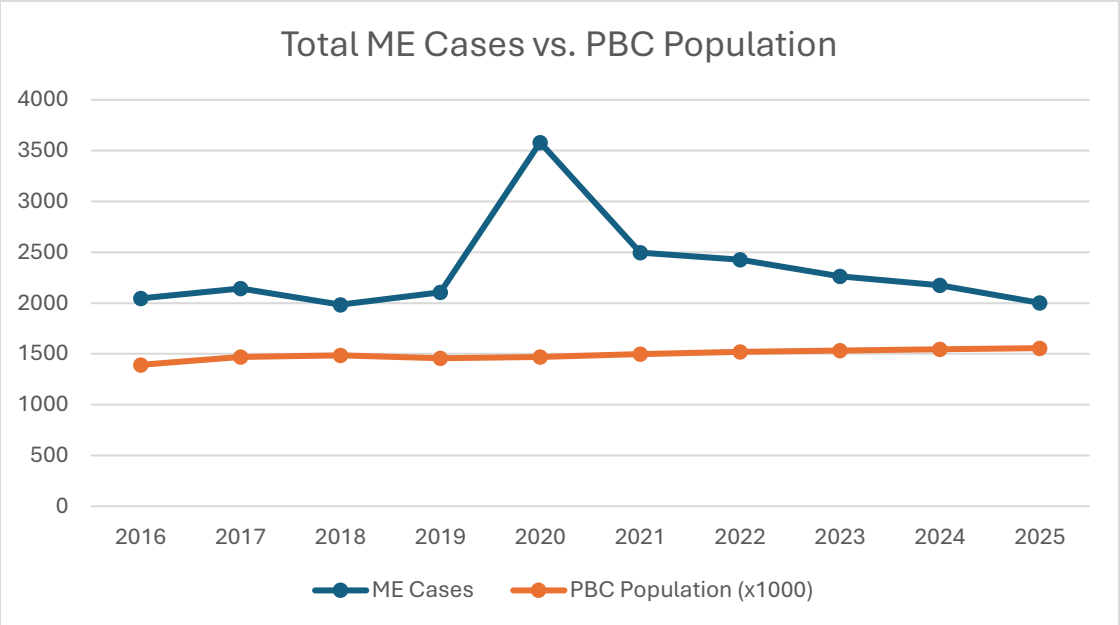
County Demographics

According to the Florida Legislature Office of Economic and Demographic Research, the population of Palm Beach County in 2025 was estimated to be 1,556,161 (The US Census Bureau[3] estimate for 2024 was 1,575,725). Based on data from the Florida Legislature Office of Economic and Demographic Research, this is an approximately 4.3% increase over the 2020 census. The U.S. Census Bureau statistics for 2025 indicates that 51.1% of the population was female, 4.9% of the population was under 5 years of age, and 25.4% was over 65 years old. Non-Hispanic white was the most common race (50.4%), followed by Hispanic/Latino (25.6%), Black/African American (20.4%), and Asian (3.3%). Foreign-born persons made up 27.7% of the population. Of those individuals under age 65 years, 15.5% had no health insurance. The median household income (in 2024 dollars) was $83,581 with 11.7% of the population living in poverty. According to Florida's Council on Homelessness, in 2025 1,520 people were homeless in Palm Beach County on a given night[4].

Workload

Graph 1: Total ME Cases vs. PBC Population

Graph 1 shows the total number of ME cases from 2016 to 2025 compared to the population of Palm Beach County over the same time period.



[3] https://www.census.gov/quickfacts/fact/table/palmbeachcountyflorida,FL/

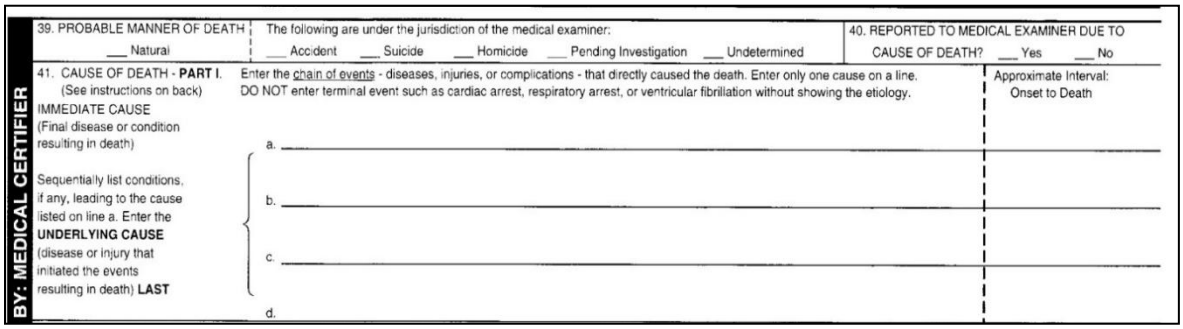
[4] https://www.myflfamilies.com/sites/default/files/2025-07/Florida%20Council%20on%20Homelessness%20Annual%20Report%202025.pdf

The dramatic increase between 2019 and 2020 is due to an increase in drug fatalities and the COVID-19 pandemic. Total deaths that meet Medical Examiner criteria have decreased steadily since 2021, despite the population increase in Palm Beach County during this period of time.

Manner of Death

For death certification, each death must be assigned an appropriate manner of death (Figure 1). The assignment of a manner of death is for public health purposes, although other entities (state attorney, insurance companies, etc.) may use this determination for their own purposes. The manners of death are natural, accident, suicide, homicide, and undetermined. A natural death is one that is entirely caused by a disease without contribution by any injury. Accidental deaths are those where an injury or poisoning causes death, and there is little or no evidence that the injury or poisoning occurred with the intent to harm or cause death. Suicides result from an injury or poisoning as a result of an intentional, self-inflicted act committed to do self-harm or cause the death of one's self. Homicides are deaths that result from a volitional act committed by another person with the intention to cause fear, harm, or death.[5] If the manner of death cannot be determined because there is more than one reasonable choice or there is a high degree of uncertainty, then it is undetermined.

Figure 1: Florida Death Certificate with Manner and Cause of Death Sections



BY: MEDICAL CERTIFIER

39. PROBABLE MANNER OF DEATH
___ Natural

The following are under the jurisdiction of the medical examiner:
___ Accident ___ Suicide ___ Homicide ___ Pending Investigation ___ Undetermined

40. REPORTED TO MEDICAL EXAMINER DUE TO CAUSE OF DEATH? ___ Yes ___ No

41. CAUSE OF DEATH - **PART I.** (See instructions on back)
IMMEDIATE CAUSE (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to the cause listed on line a. Enter the **UNDERLYING CAUSE** (disease or injury that initiated the events resulting in death) **LAST**

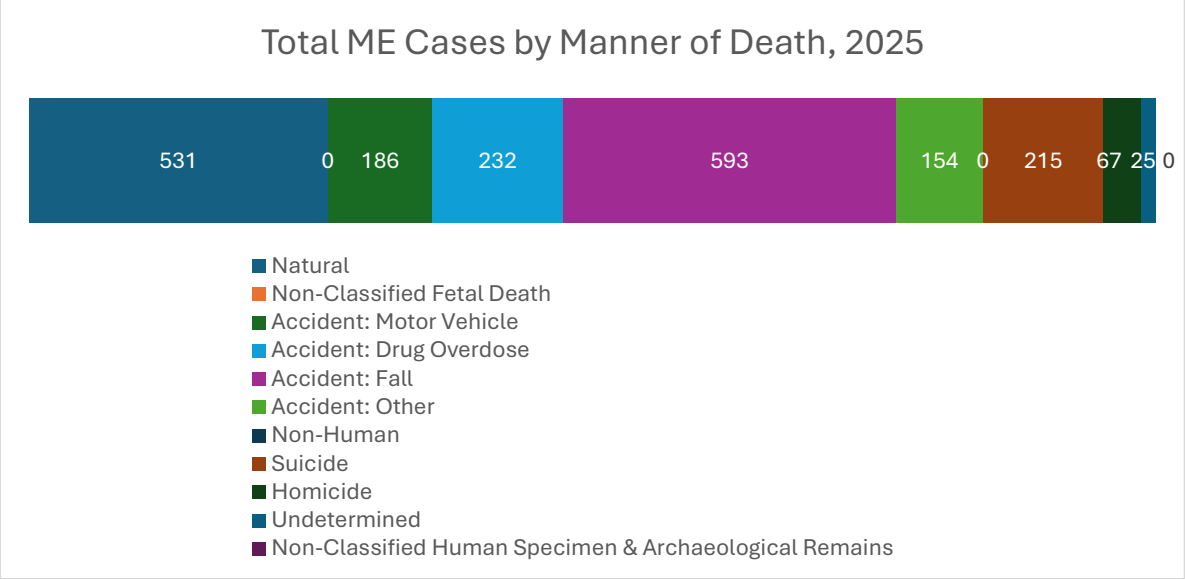
Enter the chain of events - diseases, injuries, or complications - that directly caused the death. Enter only one cause on a line. DO NOT enter terminal event such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology.

Approximate Interval: Onset to Death

a.
b.
c.
d.

[5] Hanzlick, R., Hunsaker III, J. C., & Davis, G. J. (2002). (Publication). A Guide for Manner of Death Classification (1st ed.). National Association of Medical Examiners.

Graph 2: Total ME Cases by the Manner of Death



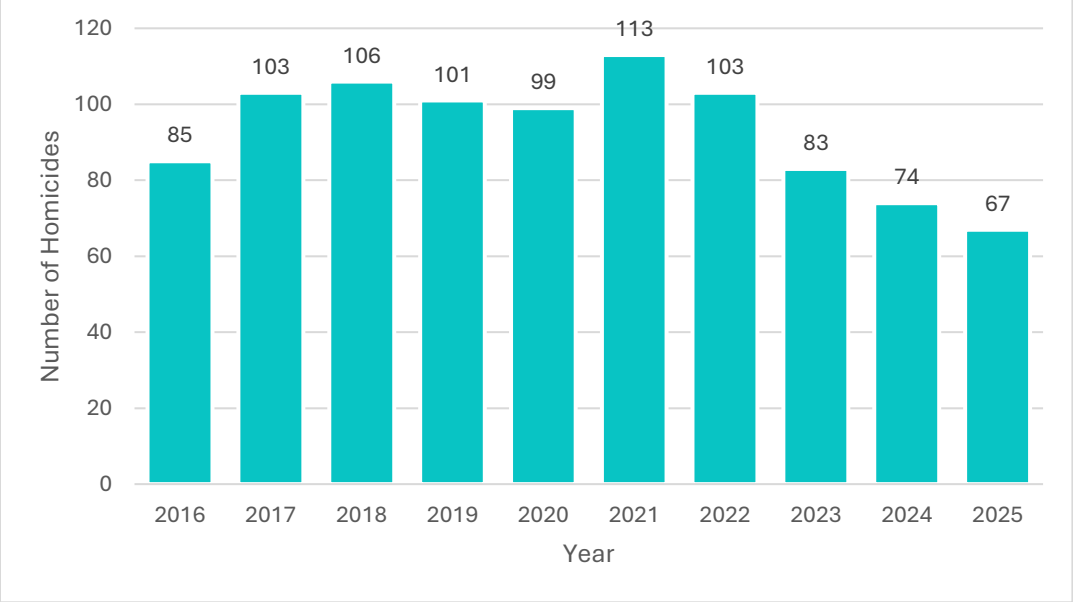
Graph 2 shows the proportions of death categorized by the manner of death in 2025. We further break down the accidental deaths into those involving motor vehicles, drug overdoses, falls, and other types of accidents such as drownings. Finally, we also include non-classified fetal deaths, non-human remains, and archaeological specimens that were examined in 2025.

In 2025, the majority (58.1%) of ME cases were accidents, and the majority of the accidents were fall-related (50.86%). This an increase from year 2024, when the plurality of accidents were fall-related (43.8%). The majority of fatal falls resulted in head injury or femur (hip) fractures, and occurred in elderly individuals. Fatal drug overdoses constituted 19.9% of all accidents, and motor vehicle fatalities another 16% of all accidents.

Homicides

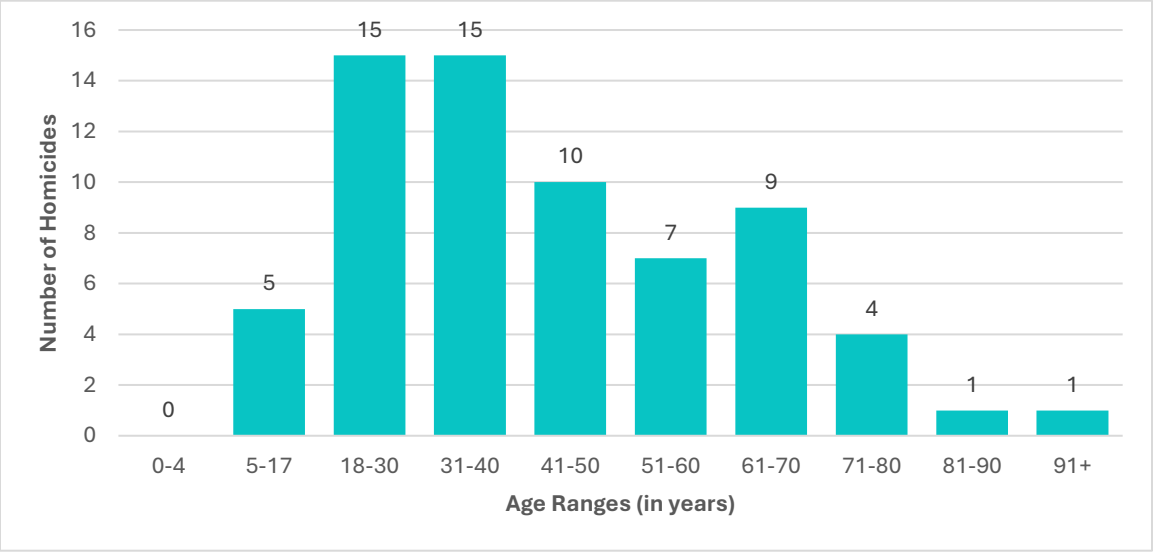
For death certification, homicide is defined as death at the hands of another person. Homicide determination is not a legal decision. The state attorney and investigative law enforcement agency will determine if and what criminal charges would be brought forth, not the Medical Examiner.

Graph 3: Annual Homicide Totals for 2016-2025



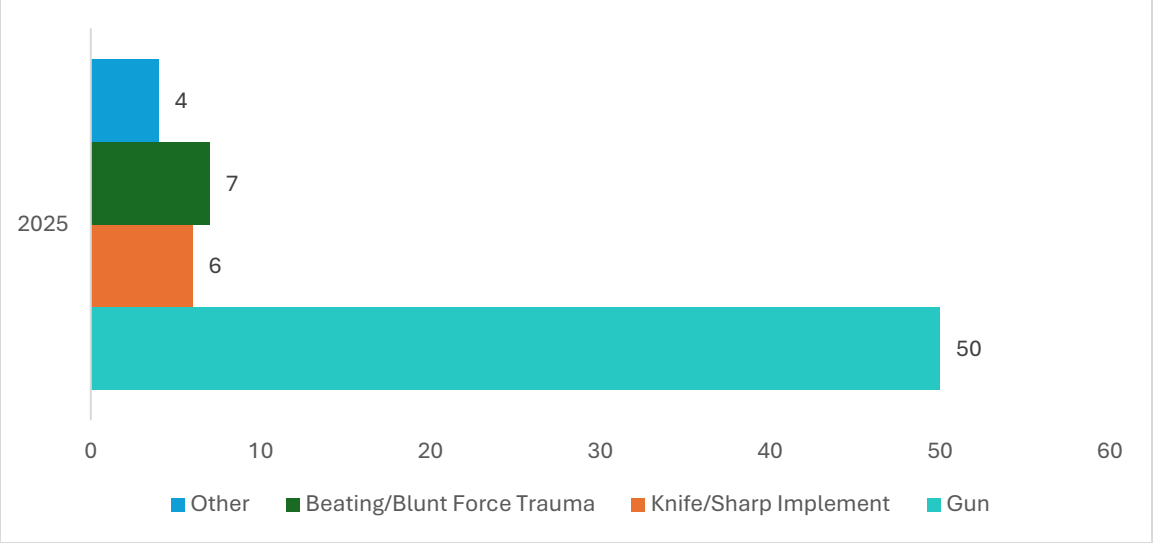
The average annual number of homicides for the last ten years is 93. In 2025, there were 26 fewer homicides than the annual average. The male:female ratio for homicide victims in 2025 was 3.5:1. Most 2025 homicide victims were Black/African American (35), followed by White (18) and Hispanic/Latino (12). The average age of homicide victims was 42 years, and the age distribution of homicide victims is seen in Graph 4.

Graph 4: Age Distribution of Homicide Victims in 2025



The most common means or instrument of death in the 2025 homicides was the gun, as seen in Graph 5. Other methodologies employed included blunt force injuries, sharp force injuries, strangulation, and methamphetamine intoxication.

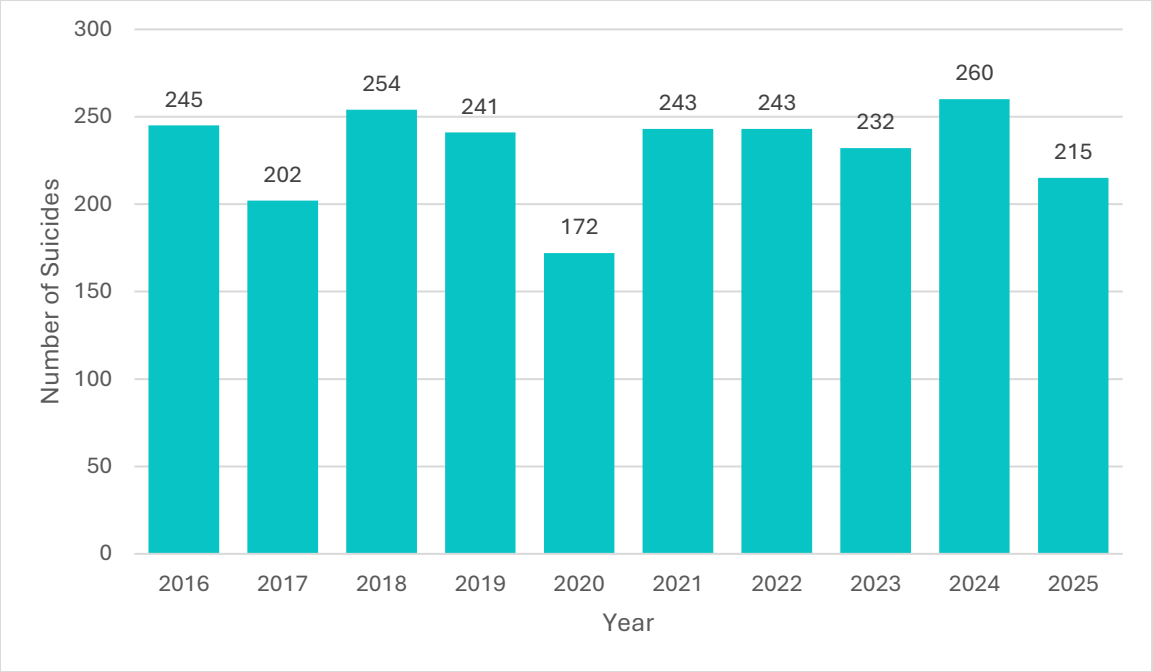
Graph 5: Types of Homicides in 2025



Suicides

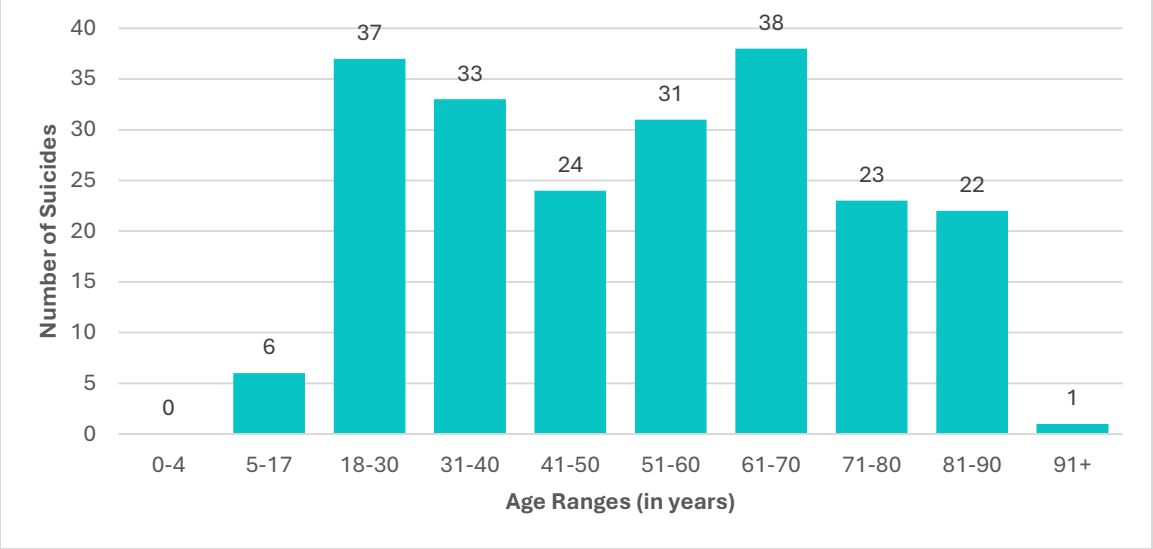
For death certification, suicide is defined as death at one's own hands.

Graph 6: Annual Suicide Totals for 2016-2025



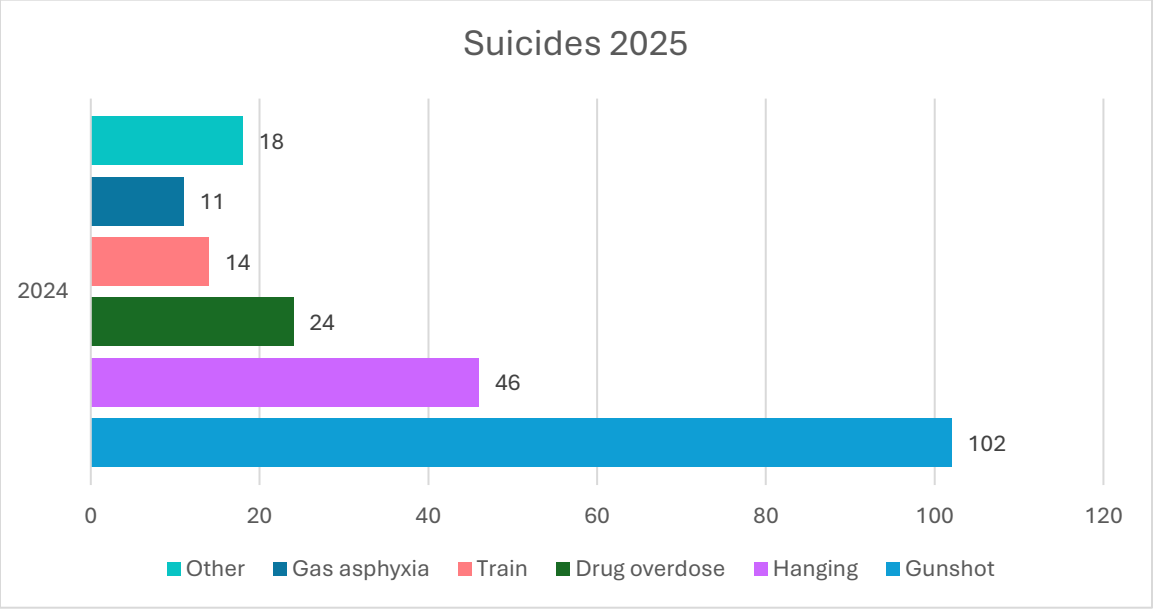
The average annual number of suicides for the last ten years is 231. In 2025, there were 16 fewer suicides than the annual average. The male:female ratio for suicide victims in 2025 was 4.2:1. Most 2025 suicide victims were White (163), Hispanic/Latino (27), followed by Black/African American (19), Other Race or Ethnicity (4), and Asian (2). The average age of a suicide victim was 51.9 years. The age distribution of suicide victims is seen in Graph 7.

Graph 7: Age Distribution of Suicide Victims in 2025



The most common means or instrument of death in the 2025 suicides was the gun, as seen in Graph 8. Gas asphyxia included four deaths from helium gas, three from carbon monoxide poisoning, three from nitrogen gas, and one from argon gas. The other types of suicide included jumping from height (6), drowning (4), sharp-force injuries (2), ingestion of chemical solvent (2), strangulation (1), pedestrian struck by vehicle (1), blast injuries (1), and asphyxia by plastic bag (1).

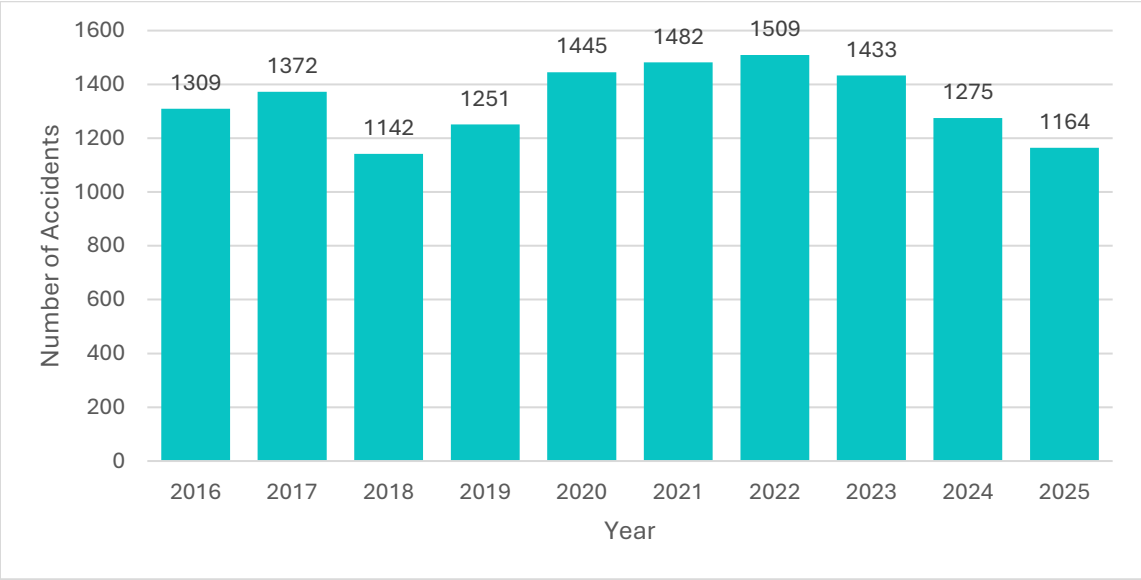
Graph 8: Types of Suicides in 2025



Accidents

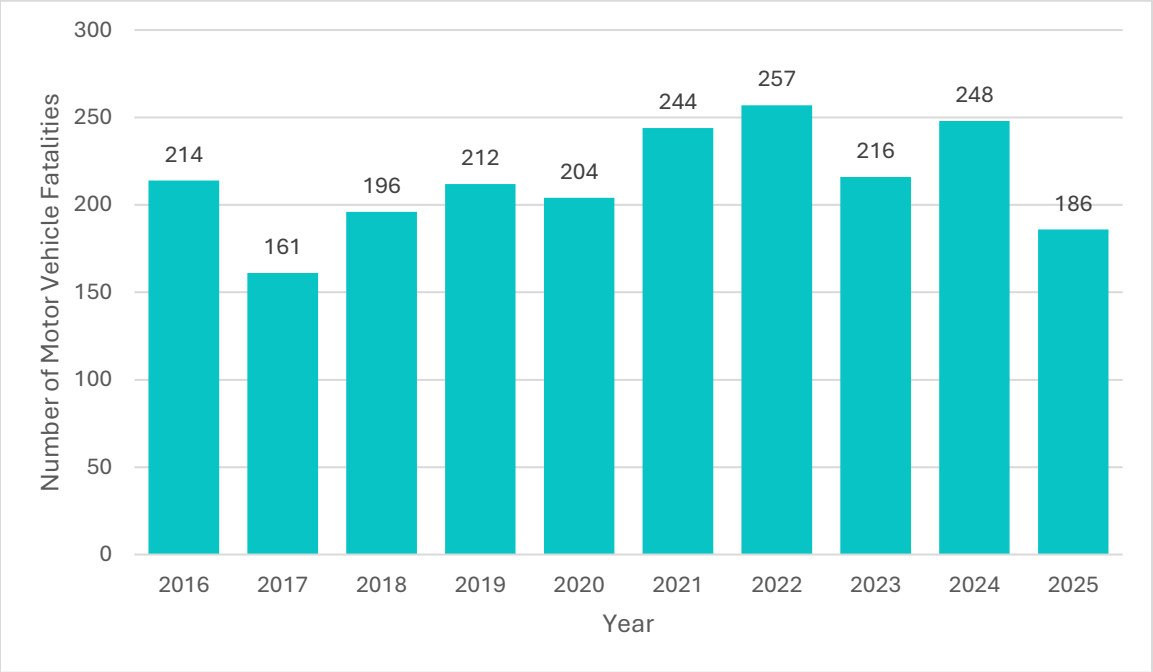
Accidents are deaths that result from an unintentional injury. In this report, we further break down the accidents into four large subgroups: deaths from motor vehicle collisions, drug overdoses, falls, and other accidental deaths. These subgroups are examined in greater detail later. In Graph 9, the marked increase in accidental deaths through 2022 is due to the rise in drug, predominantly opioid, fatalities. The decrease in accidental deaths since 2022 coincides with an overall decrease in deaths in Palm Beach County during that time.

Graph 9: Annual Accident Totals for 2016-2025



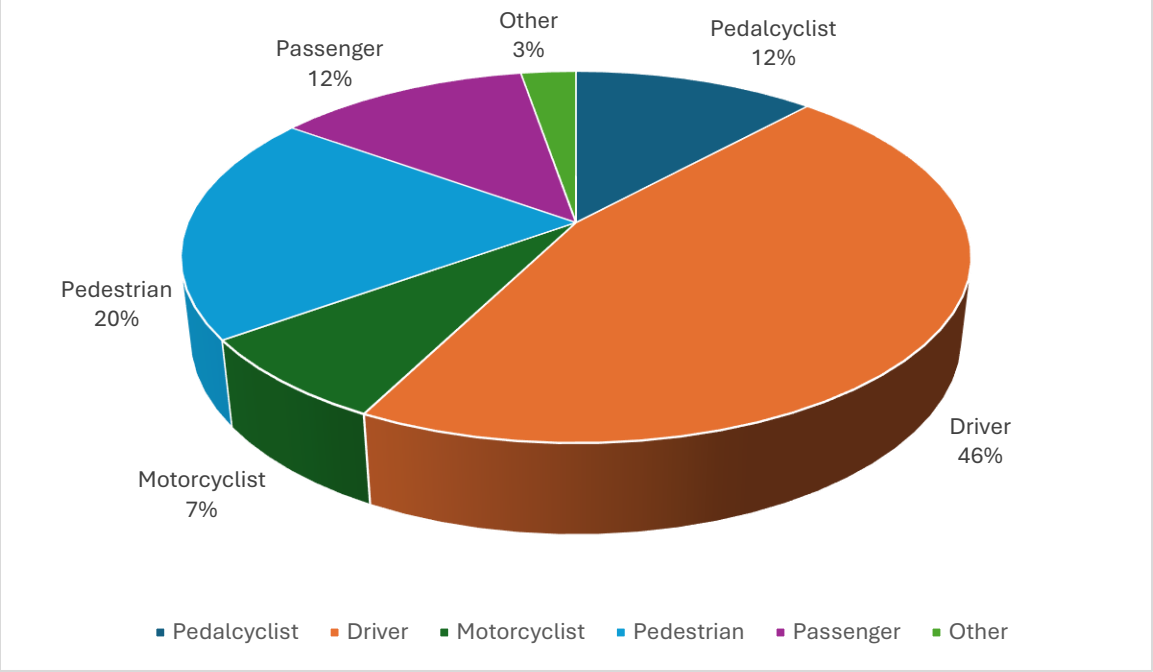
Accidents: Motor Vehicle Fatalities

Graph 10: Annual Accidental Motor Vehicle Fatality Totals for 2016-2025

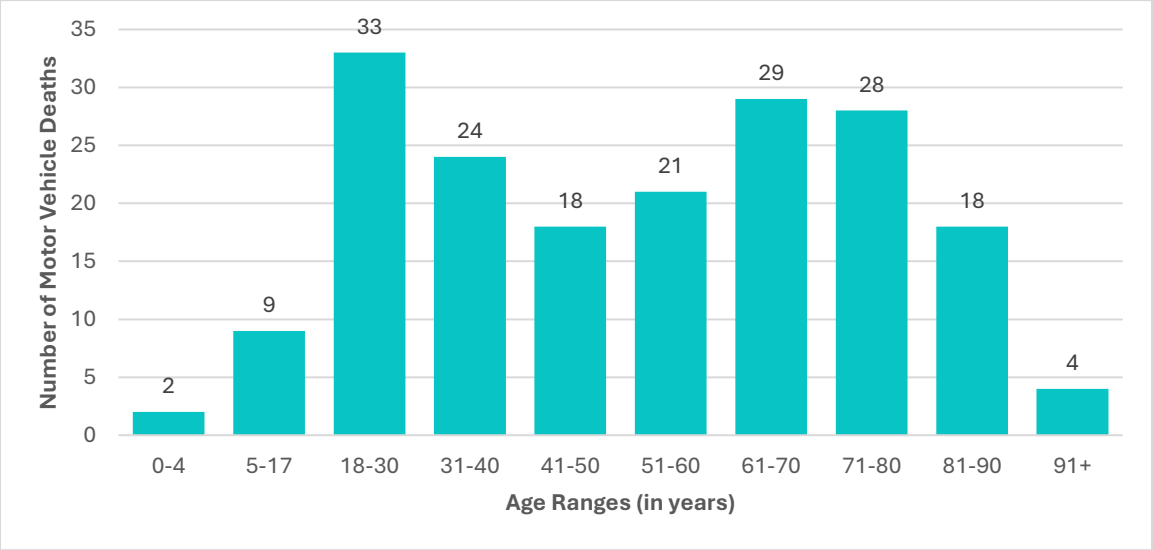


There were 186 accidental motor vehicle fatalities in Palm Beach County in 2025. Graph 10 shows the annual number of motor vehicle deaths from 2016 to 2025. In 2025, 18.8% of those killed in accidental motor vehicle collisions were driving a car. Other vehicles driven by decedents included motorcycles (15.6%), SUVs (7.53%), trucks (5.38%), planes (0.54%), e-bikes (2.15%), jet skis (0.54%), and scooters (2.15%). An additional one individual (0.54%) was driving an unknown vehicle type when they were killed. The remaining victims' percentages are seen in Graph 11. In 2025, men were 2.5 times more likely to accidentally die in a motor vehicle collision than women. White individuals were 3.2 times more likely to accidentally die in a motor vehicle crash than those of Black/African American descent, and 2.5 times more likely to accidentally die in a motor vehicle crash than those of Hispanic/Latino descent. The average age of the victims was 53 years old. The age distribution of decedents by decades is seen in Graph 12.

Graph 11: Victims of 2025 Motor Vehicle Fatalities



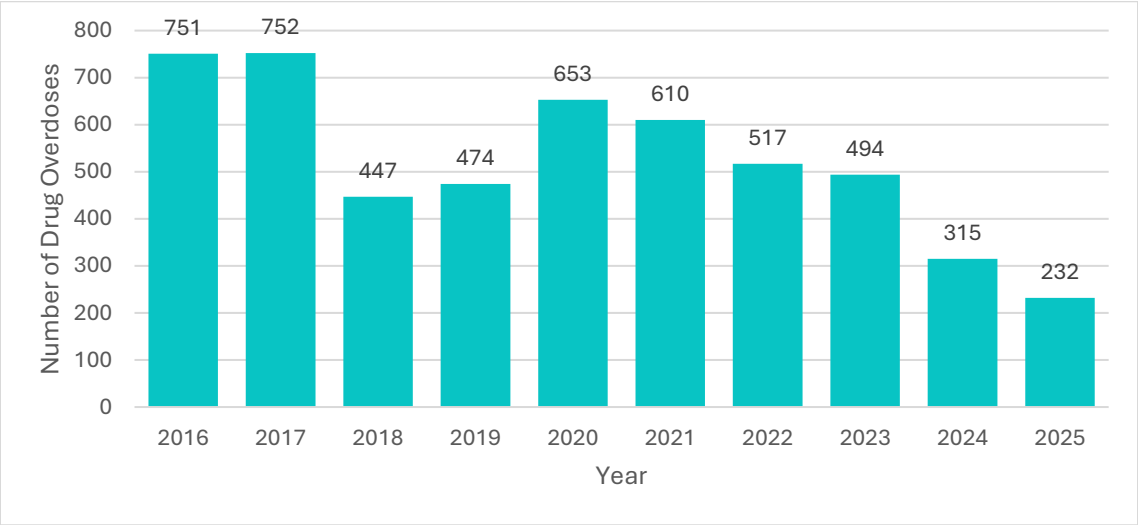
Graph 12: Age Distribution of Motor Vehicle Fatalities in 2025



Accidents: Drug Overdoses

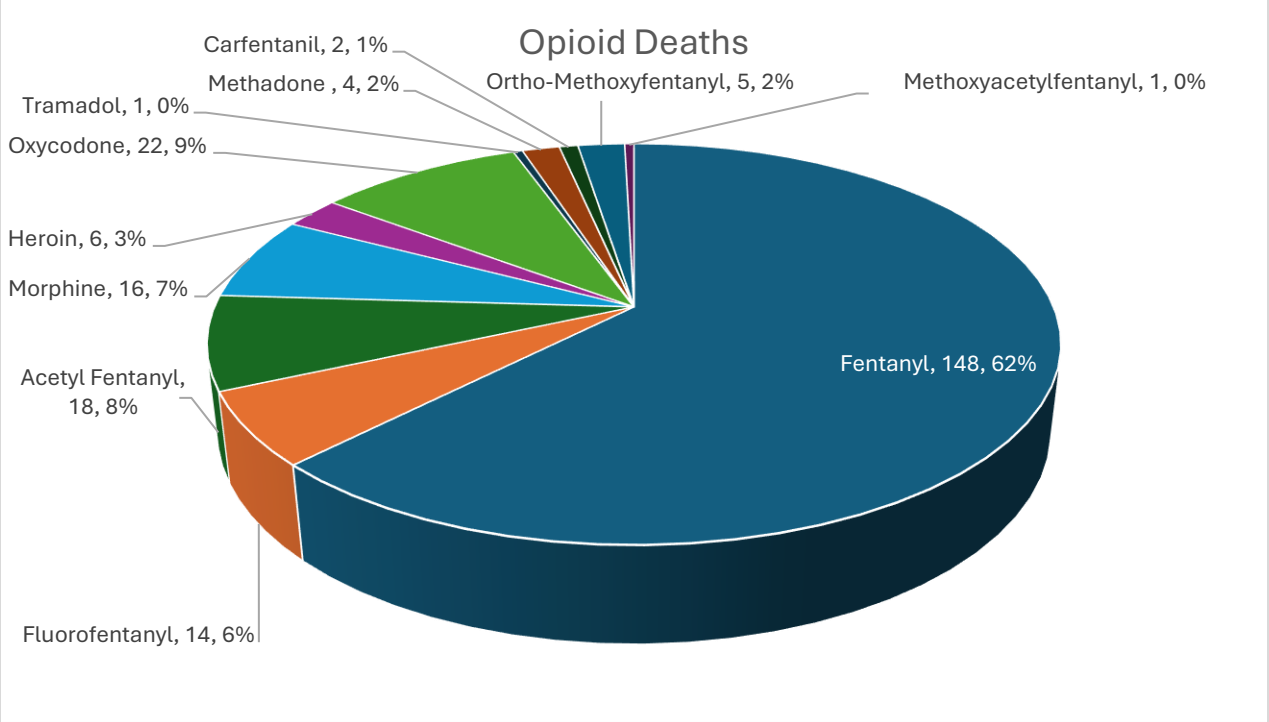
If a drug or drugs accidentally caused or contributed to the death of a person, then this was counted as an accidental drug death. Alcohol is considered a drug, along with illicit drugs (e.g., heroin, cocaine), prescription medications, and non-prescription medications. Opioids are a subset of both illicit drugs (e.g., heroin) and prescription medications (e.g., oxycodone). Suicidal drug overdoses, and drug overdoses in which the manner of death was undetermined, are not included in these graphs.

Graph 13: Annual Accidental Drug Overdose Totals for 2016-2025



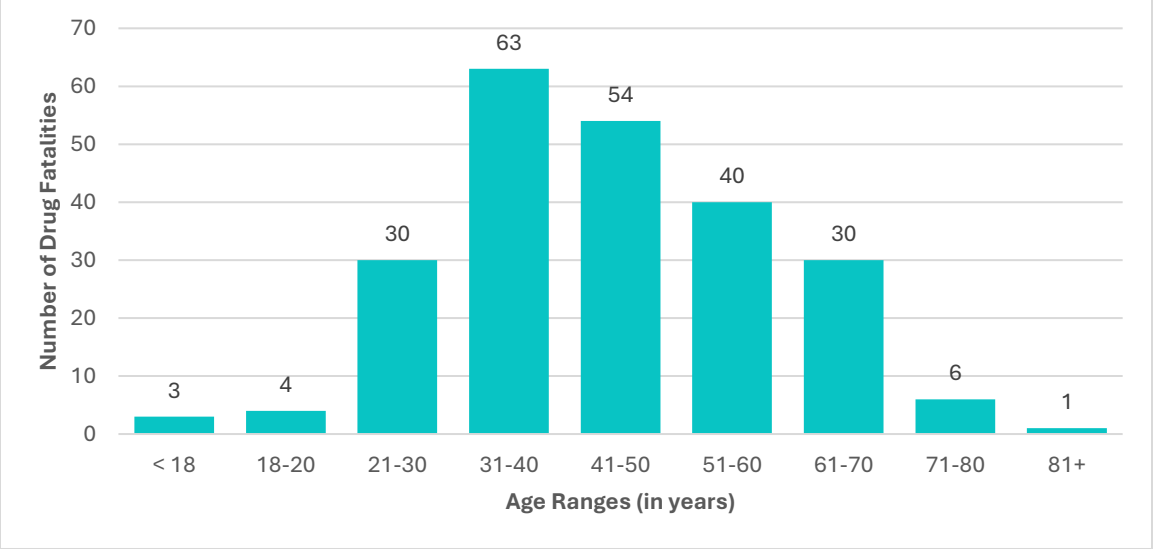
In 2025 there were 232 accidental drug fatalities, 166 (71.6%) of which involved one or more opioid drugs. The relative percentage of opioid drugs causing or contributing to the 232 drug fatalities in 2025 is seen in Graph 14.

Graph 14: Opioid Drugs in Accidental Drug Deaths, 2025



Fentanyl and its analogs (including acetyl fentanyl and fluorofentanyl) far exceeded the other opiates (such as heroin and oxycodone) in 2025. Most opioid deaths had multiple opioids contributing to the death; 27 opioid deaths were caused by illicit fentanyl alone. In 2025, the average age of accidental drug fatality victims was 43 years old. The age distribution of those dying from an accidental drug overdose is seen in Graph 15. The victims were predominantly men (1.8:1). White individuals were 8.2 times more likely to die of an accidental drug overdose than those of Black/African American ancestry or those of Hispanic/Latino ancestry.

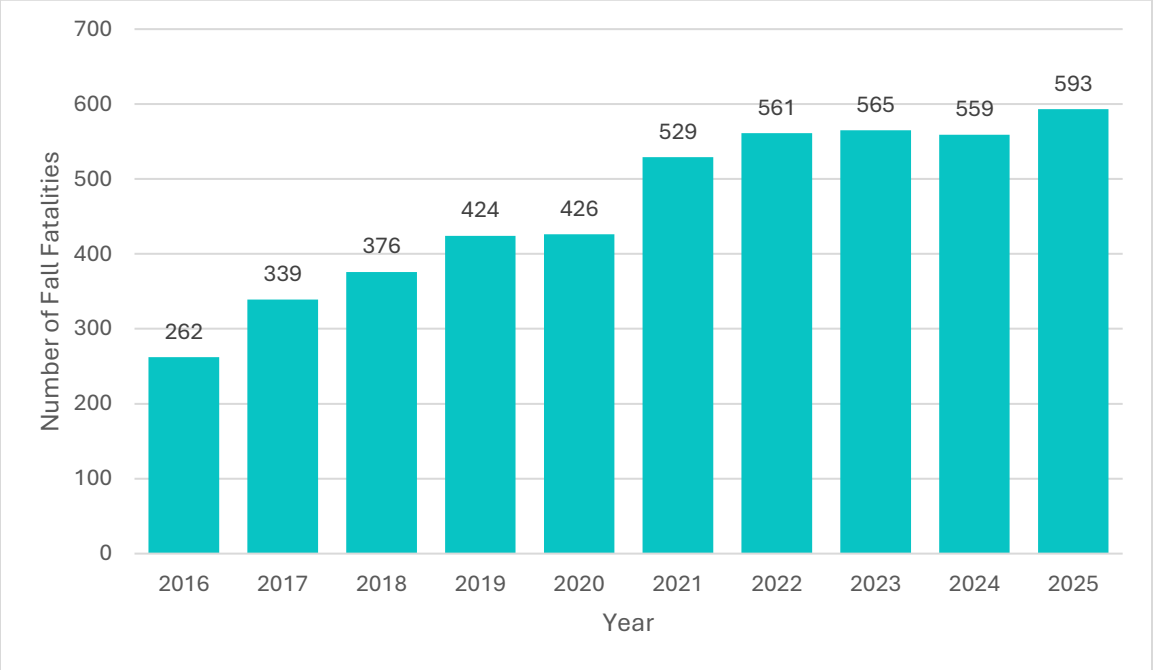
Graph 15: Age Distribution of Accidental Drug Overdose Fatalities in 2025



Accidents: Falls

Fatal falls have risen in recent years, as seen in Graph 16. The vast majority of these deaths occur in unstable elders who fall from a standing position. Women often have osteoporosis and are more likely to fracture their hip. Men with heart disease who were treated with anticoagulants were more likely to strike their head leading to fatal brain hemorrhage.

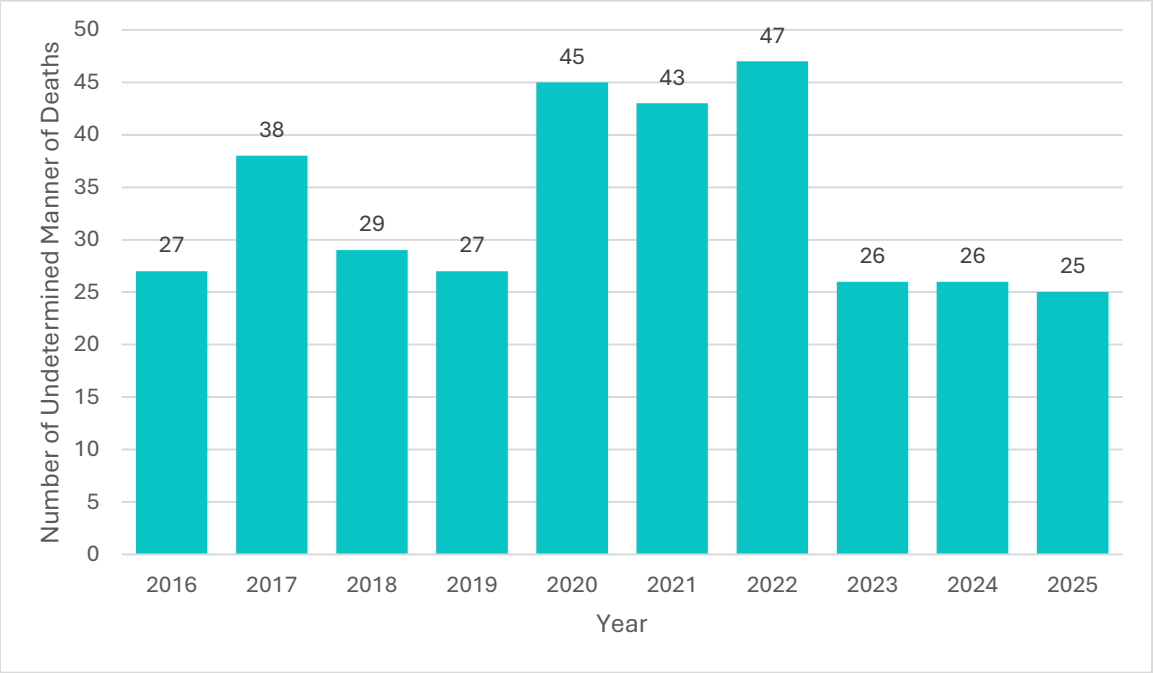
Graph 16: Annual Fatalities Caused by Falls Totals for 2016-2025



Deaths with an Undetermined Manner of Death

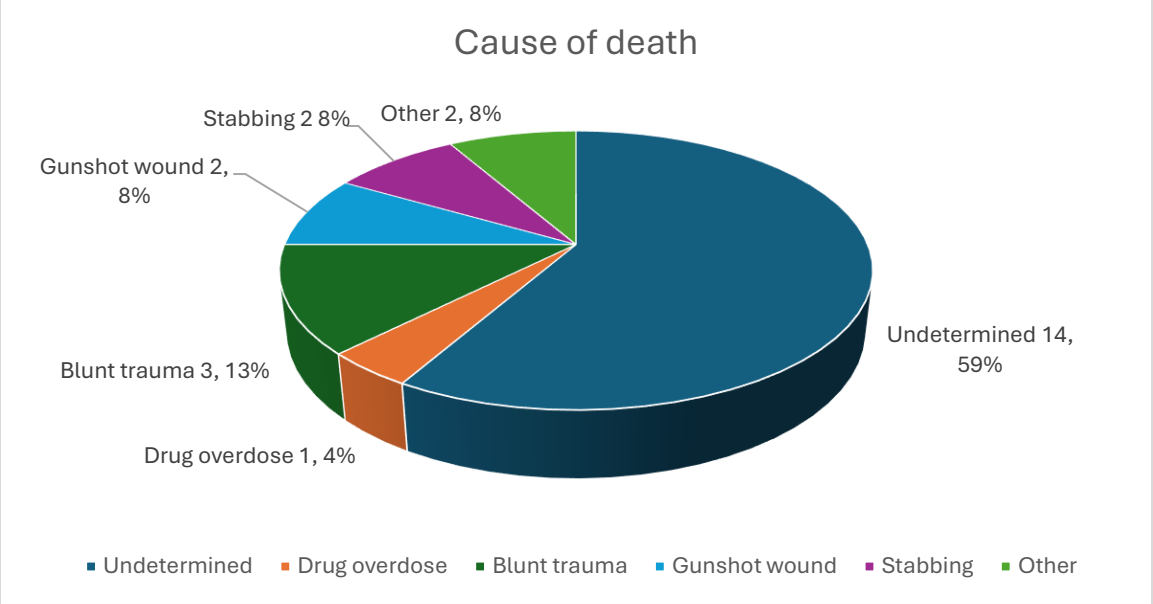
The manner of death is how the death came about, and is for death certification and public health purposes. The manners of death are natural, accident, suicide, homicide, and undetermined. If the manner of death cannot be determined because there is not enough information, or there is more than one reasonable choice, then it is undetermined. The annual number of deaths with an undetermined manner from 2016 to 2025 is seen in Graph 17.

Graph 17: Annual Undetermined Death Totals for 2016-2025



In 2025, there were 24 deaths in which the manner of death could not be determined. Cases where the manner of death was listed as undetermined may always be amended if additional information or circumstances become known. The causes of death in these cases are seen in Graph 18.

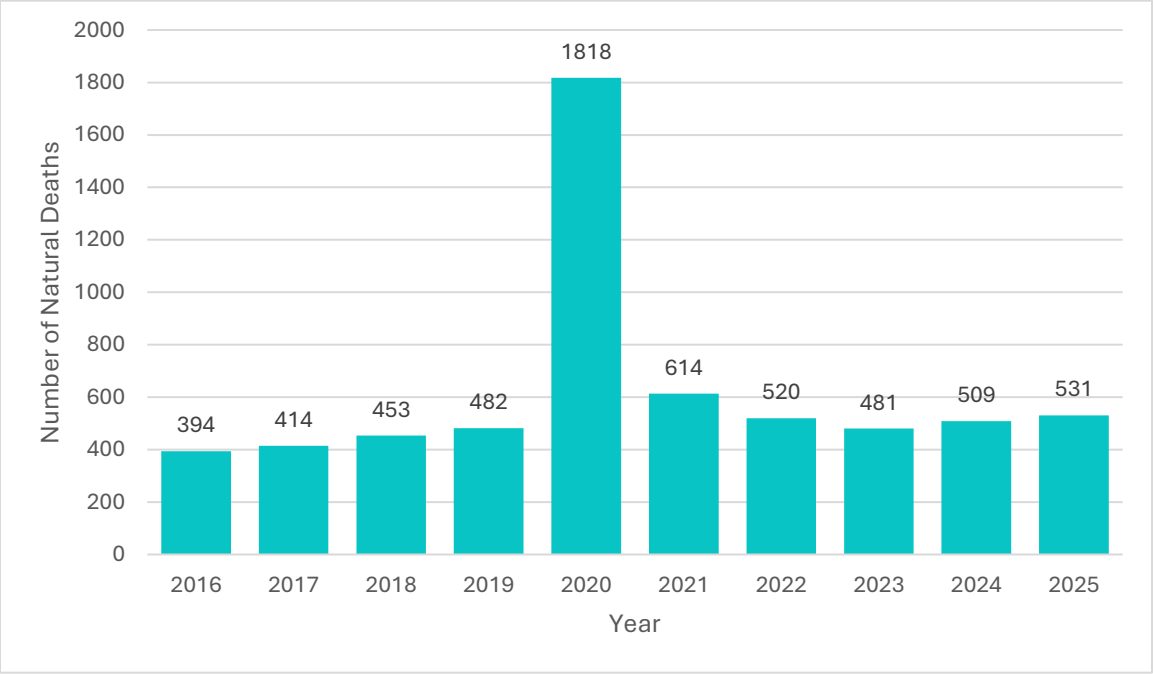
Graph 18: Causes of Death in 2025 Undetermined Manner of Death Cases



Natural Deaths

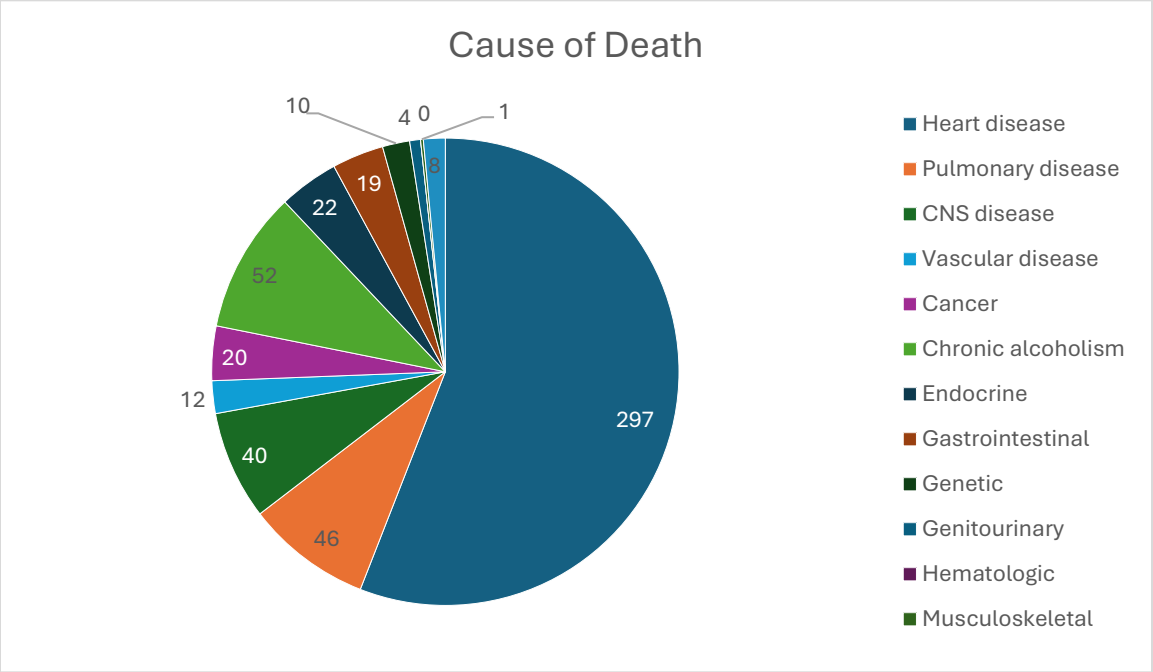
A natural death is one that is entirely caused by a disease without contribution by any injury. The annual number of natural deaths from 2016 to 2025 is seen in Graph 19.

Graph 19: Annual Natural Death Totals for 2016-2025



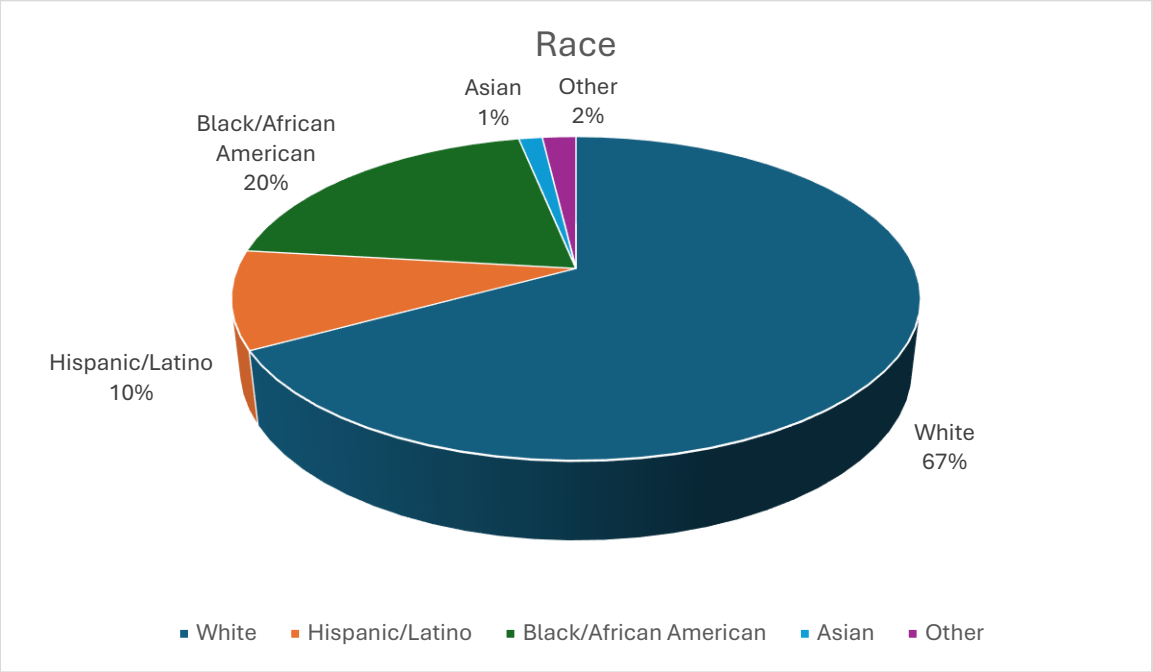
In 2025, the majority of natural deaths investigated by the Medical Examiner were due to heart disease, which is most likely to kill suddenly without any previous signs or symptoms. Graph 20 shows the diseases that caused natural deaths and examined by the Medical Examiner in 2025.

Graph 20. Causes of Natural Death Examined by the Medical Examiner in 2025



Of those who died of heart disease in 2025, 91% died of hypertension and/or atherosclerotic coronary artery disease. In 2025, the average age of those who died of natural disease, and fell under Medical Examiner jurisdiction, was 62 years with a range of 1 month to 104 years. Men outnumbered women 1.8:1. Graph 21 shows the relative proportions of people who died of natural disease by their race.

Graph 21: Race of Decedents Who Died of Natural Disease and Examined by the Medical Examiner in 2025



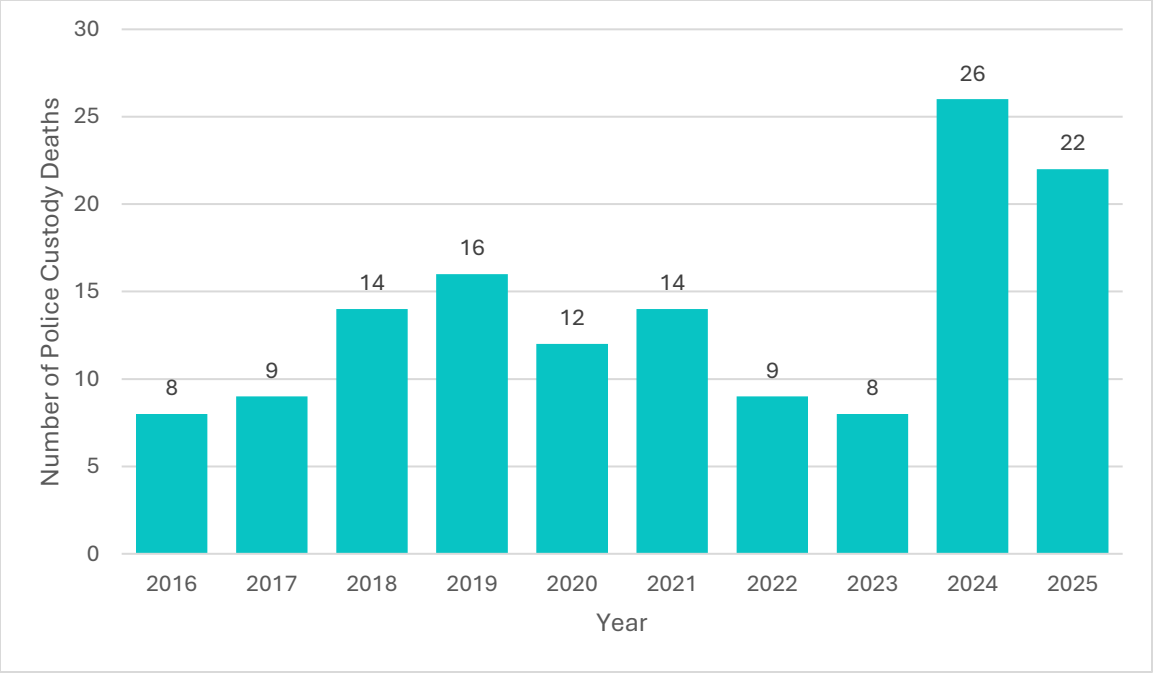
Deaths in Police Custody*

Deaths in police custody are of two broad categories: law enforcement-involved, and penal institution, as defined by the Florida Medical Examiner Commission. Law enforcement-involved deaths include, but are not limited to, individuals who die while in police pursuit, during or after arrest, while under house arrest, and those who are killed by law enforcement officials while in the line of duty. In 2025, twenty-four men and two women died in police custody. Their ages ranged from 20 to 78 years old.

The breakdown of those who died while in police custody is as follows. Nine people died of natural causes while incarcerated, three people were shot by police officers, three people overdosed while wearing ankle monitors, one person shot themself in police custody (in the process of arrest), one person died in a motor vehicle collision while under police pursuit, one person overdosed while incarcerated, one person died in a motor vehicle collision while wearing an ankle monitor, one person was a pedestrian struck by a police vehicle, one person died of previously sustained blunt force injuries while incarcerated, and one person suffered blast injuries while under police pursuit.

*The increase in deaths in police custody starting in 2024 stems from re-categorization within the Medical Examiner Database tracking system, and includes individuals who would not have been previously accounted for in earlier years.

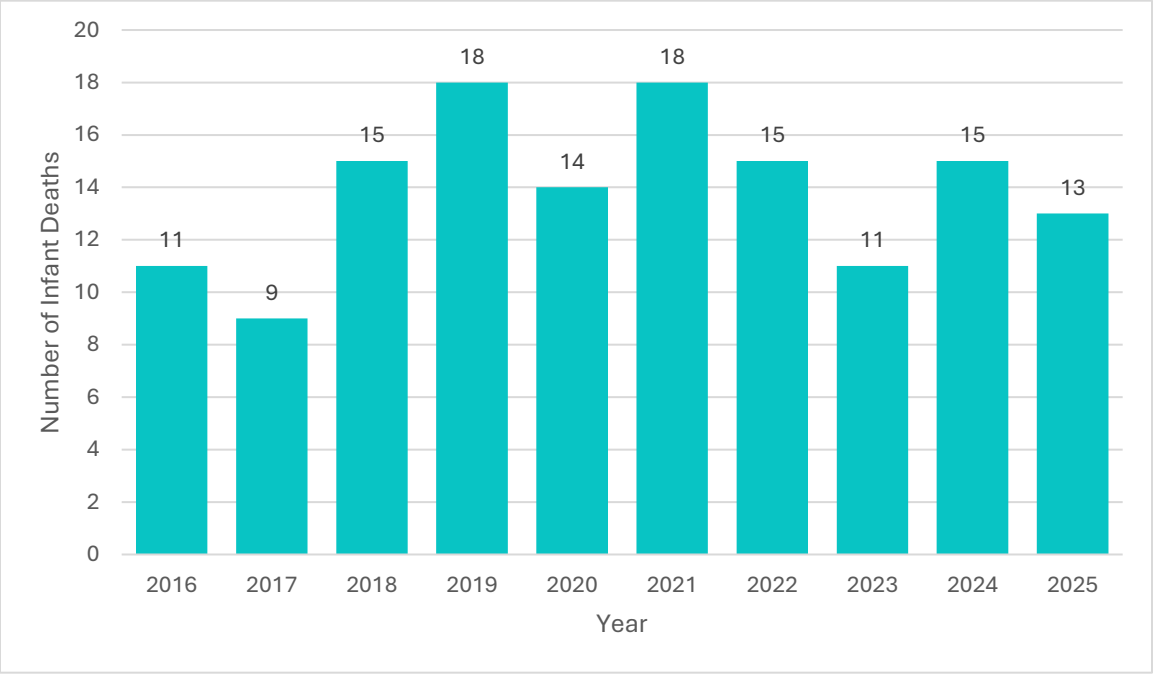
Graph 22: Annual Police Custody Deaths Totals for 2016-2025



Infant Deaths

An infant is a child under the age of one year. Graph 23 shows the number of infant deaths from 2016 to 2025.

Graph 23: Annual Infant Deaths Totals for 2016-2025

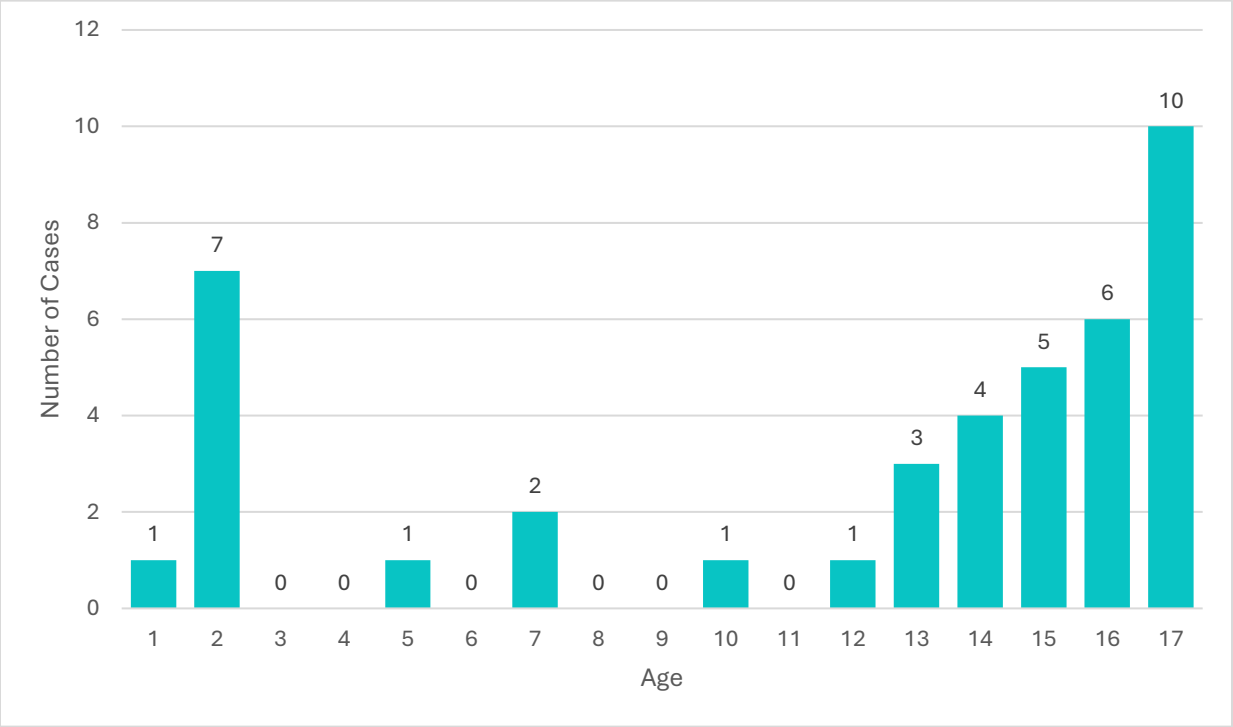


In 2025, thirteen infant deaths were investigated by the Palm Beach County Medical Examiner's Office. Ten infants were male, and three were female. Five infants were Black/African American, five infants were Hispanic/Latino, and three infants were White. The age range was 3 weeks to 8 months, and the average age was 2.7 months. Six deaths were asphyxia-related. One death was due to pneumonia, one death was related to viral infections, one death was classified as Sudden Unexplained Infant Death, one death was related to blunt force injuries, one death was related to congenital malformations, and two deaths were classified as undetermined. Seven deaths were related to an unsafe sleeping environment. No non-classified fetal deaths were investigated by the Palm Beach County Medical Examiner's Office in 2025.

Child Deaths

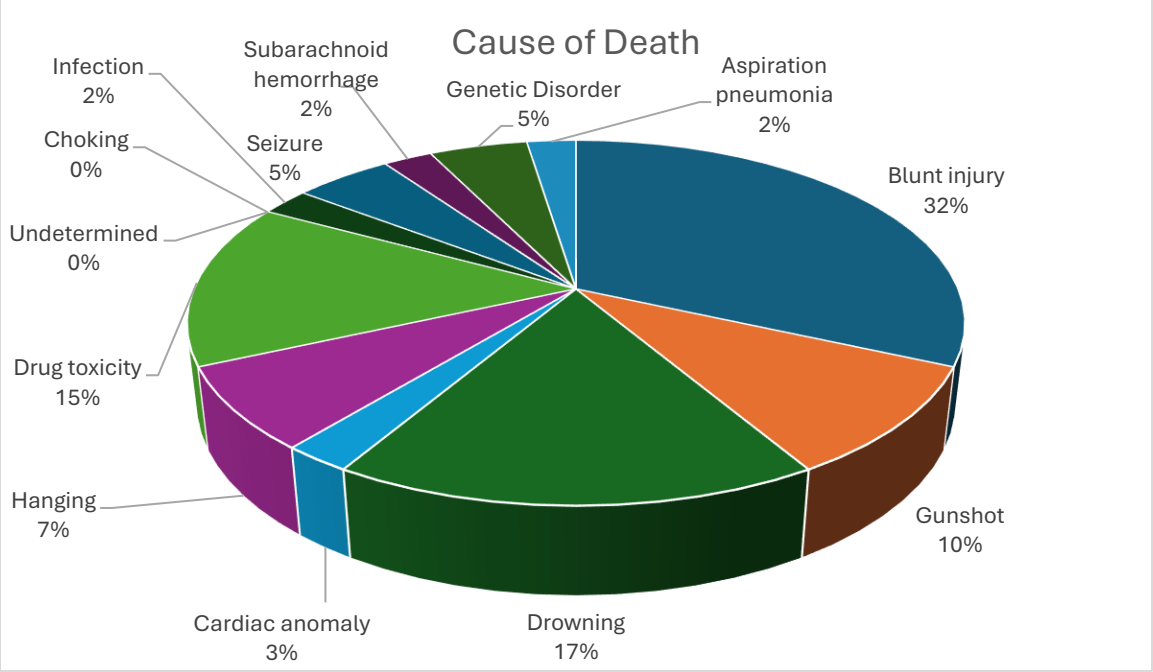
For our purposes, a child is greater than 1 year old, but less than 18 years of age. By this definition, 41 child deaths were investigated by the Palm Beach County Medical Examiner's Office in 2025. The average age was 12 years and the age distribution of child deaths in 2025 is seen in Graph 24. The ratio of males to females was 1.4:1. Sixteen of the children were White, fourteen were Black/African American, and eleven were Hispanic/Latino.

Graph 24: Age Distribution in Children Who Died in 2025

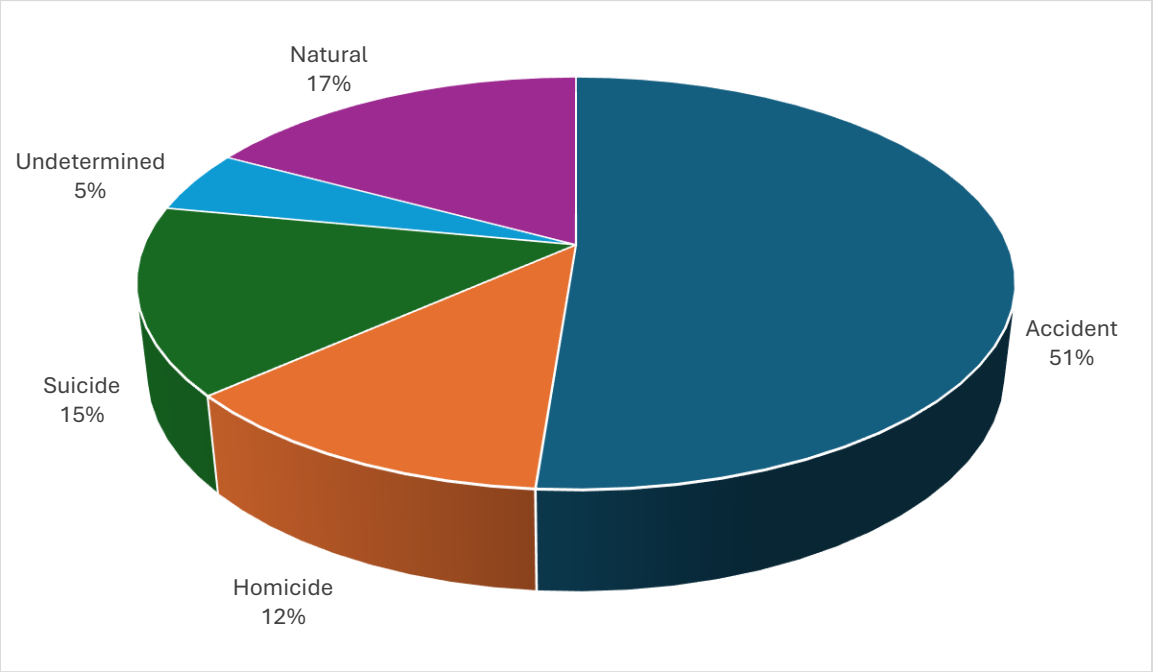


The distribution of cases by cause and manner of death are seen in Graphs 25 and 26.

Graph 25: Cause of Death in Child Deaths in 2025



Graph 26: Manner of Death in Child Deaths in 2025



Frequently Asked Questions (FAQ)

District 15: Palm Beach County Medical Examiner's Office website

http://discover.pbcgov.org/medicalexaminer/Pages/default.aspx

Email: D15ME@pbc.gov

Florida Statute 406

http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0406/0406PARTIContentsIndex.html

FAC 11-G

https://www.flrules.org/gateway/RuleNo.asp?ID=11G-2.006

Practice Guidelines for Florida ME

https://www.fdle.state.fl.us/MEC/Publications-and-Forms/Documents/2010-Guidelines-Adopted.aspx

Florida Association of Medical Examiners

http://www.thefameonline.com

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FARR FLORIDA ASSOCIATION OF RECOVERY RESIDENCES

State Attorney Addiction Recovery Task Force- April 2026

STATEWIDE PROGRAMS CERTIFIED - 276

April 14, 2026:

Units: 1,917		
Beds: 9,556		
Levels I, II & III:	**Units: 973**	**Beds: 5,483**
Level IV:	**Units: 944**	**Beds: 4,073**

- **Broward County has 27.8% of the units and 25.2% of the beds.**
- **Palm Beach County has 40.2% of the units and 36.7% of the beds.**

PALM BEACH COUNTY NUMBERS

- **101 Certified Providers**
- 770 Units, 3,509 Beds (Men: 1,740, Women: 593, Both: 1,155, LGBTQ+: 21)

Level I: 0 Programs, 0 Units, 0 Beds
Level II: 58 Programs, 300 Units, 1,538 Beds
Level III: 3 Programs, 29 Units, 78 Beds
Level IV: 49 Programs, 441 Units, 1,893 Beds

FLORIDA COUNTIES

County	Units	Beds
Alachua	3	15
Brevard	16	177
Broward	534	2,412
Clay	1	8
Collier	18	109
Duval	43	241
Escambia	10	44
Flagler	10	84
Highlands	2	8
Hillsborough	102	554
Indian River	27	170
Lee	43	306
Manatee	27	117
Martin	29	195
Miami-Dade	30	239
Orange	32	283
Okaloosa	0	0
Palm Beach	770	3,509
Pasco	50	259
Pinellas	96	329
Polk	1	5
Santa Rosa	4	52
Sarasota	19	68
Seminole	2	14
St. John's	3	21
St. Lucie	41	278
Volusia	14	103

RUNNING TOTALS

STATE CAPACITY TREND

FARR

Month	Year	Beds
July	2017	3,280
January	2018	4,153
January	2019	5,786
January	2020	5,781
January	2021	6,715
January	2022	6,872
January	2023	8,122
January	2024	9,203
January	2025	9,440
February	2025	9,486
March	2025	9,511
April	2025	9,760
May	2025	9,836
June	2025	9,842
July	2025	9,741
August	2025	9,722
September	2025	9,775
December	2025	9,831
January	2026	9,590
February	2026	9,606
March	2026	9,518
April	2026	9,556

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Revolutionizing Mental Health Care

April 8, 2026

Dr. Courtney Phillips

Current Program Update

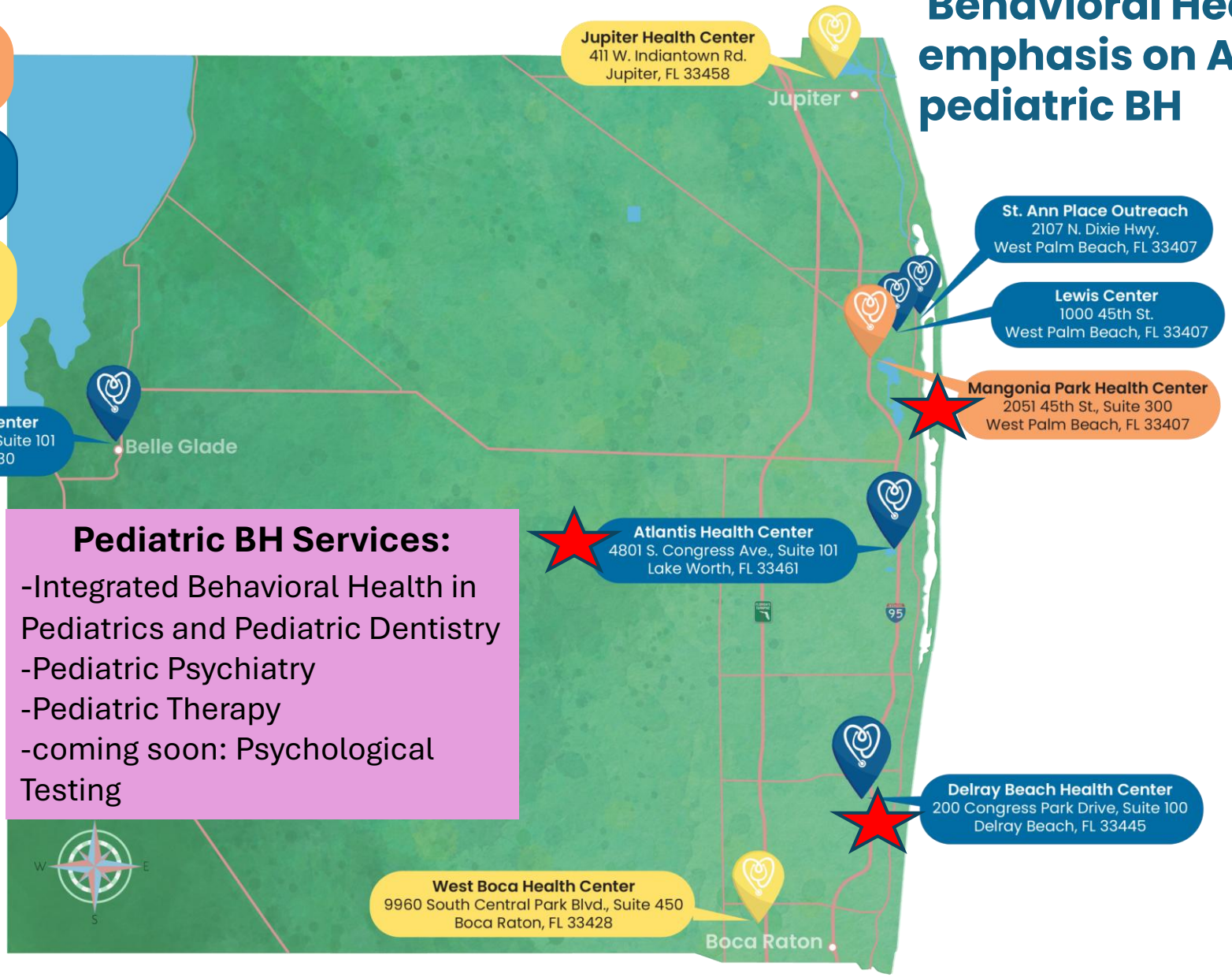
Health Care District
OF PALM BEACH COUNTY

Behavioral Health Locations with emphasis on Atlantis CHC for pediatric BH

OPEN DAILY 7AM-7PM

WALK-INS & APPOINTMENTS

TELEHEALTH OPTIONS



Pediatric BH Services:

-Integrated Behavioral Health in Pediatrics and Pediatric Dentistry
-Pediatric Psychiatry
-Pediatric Therapy
-coming soon: Psychological Testing

Access Points

CLINICAL TEAMS

- **7 Psychiatric Providers** (3 MD/DO and 4 PMHNP/PA-c) to see adults and children
- **16 mental health professionals** (13 Licensed social workers or mental health counselors, 3 registered interns)
- **5 Peer support specialists**
- **5 care coordinators**

ADULT AND PEDIATRIC PSYCHIATRIC CARE

Appointments and Walk-ins available daily, 7 a.m. to 7 p.m., including weekends

Call: 561-642-1000

Get Help Now

Health Care District

COMMUNITY HEALTH CENTER

Addict Sci Clin Pract. 2025 Dec 6;21(1):4. doi: 10.1186/s13722-025-00625-3.

Tracking functional recovery in a community-based substance use disorder program: a five-year descriptive evaluation using the brief addiction monitor

Courtney Phillips [1], Maria C Mejia [2], Darian Peters [2], Jacob Kalathoor [2], Lea Sacca [2], Belma Andric [3]

Affiliations + expand

PMID: 41353433 PMCID: PMC12805790 DOI: 10.1186/s13722-025-00625-3

Abstract

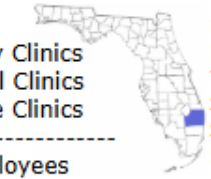
Objectives: Accessible, evidence-based treatment for substance use disorders (SUDs) remain a public health challenge due to complex clinical and social needs and barriers to long-term engagement. This study describes a five-year evaluation of a low-barrier, outpatient SUD treatment program implemented by the Health Care District of Palm Beach County, Florida, focusing on trends in functional recovery using the Brief Addiction Monitor (BAM) functional assessment.

Methods: Between February 2018 to March 2023, participants with substance use disorders received care through a Federally Qualified Healthcare Center (FQHC) based integrated model offering medication for opioid use disorder, other Medication assisted treatment, behavioral health services, medical , psychiatric, peer services, and care coordination. The BAM was administered at baseline and approximately every three months to assess substance use, risk, and protective factors. Data were analyzed per assessment to reflect variability in patient engagement and follow-up.

Health Care District OF PALM BEACH COUNTY

UDS REPORT SUMMARY 2025

SERVING PALM BEACH COUNTY, FL

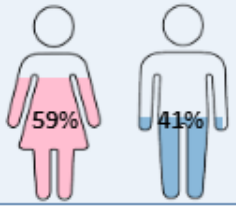


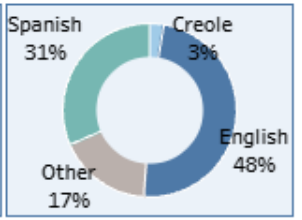
9 Primary Clinics
4 Dental Clinics
3 Mobile Clinics

274 Employees

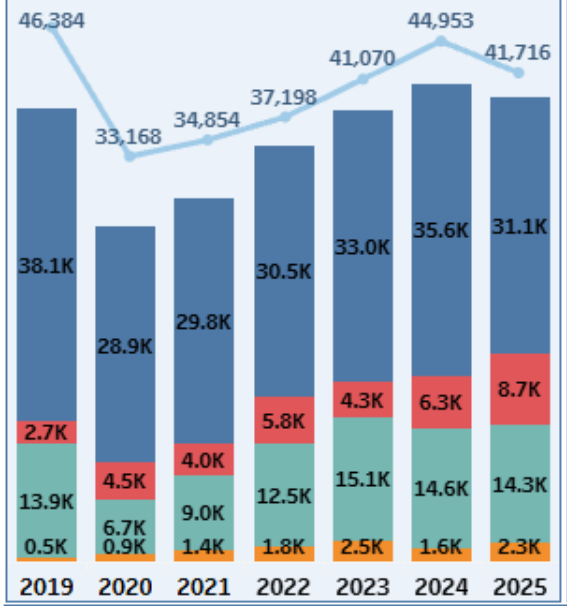
17 MD/DO
14 APRNs/PAs
7 Dentists; 7 Hygienists
2 Psychiatrists
22 LCSW/LMHC/Psy.D
15 FM Residents

Unique Patients	Visits	Homeless	Migrant	Below FPL	Virtual
42K	173K	22%	5%	73%	3%

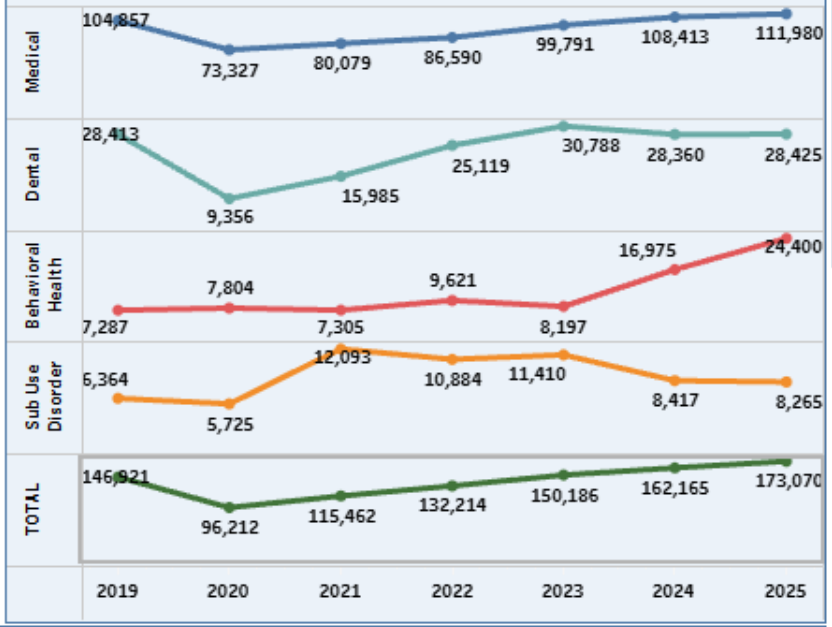




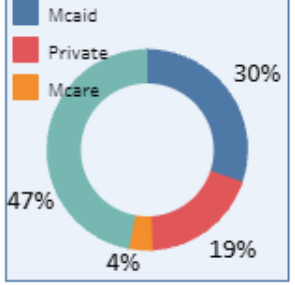
UNIQUE PATIENTS



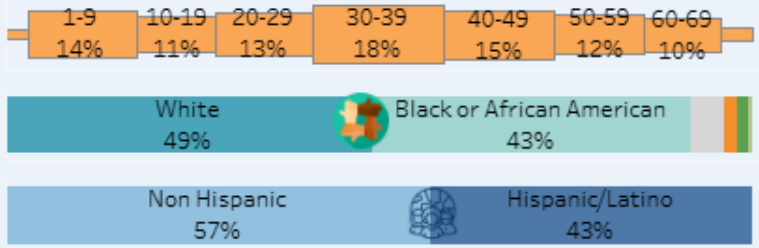
TOTAL PATIENT VISITS PER SERVICE TYPE



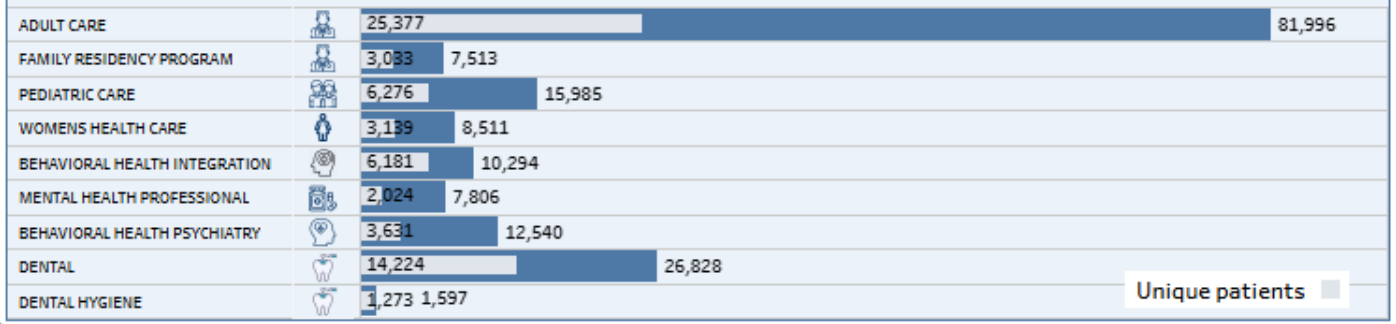
INSURANCE



AGE DISTRIBUTION



VISITS BY TYPE OF SERVICE



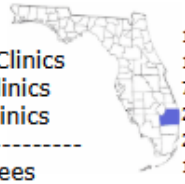
QUALITY MEASURES PERFORMANCE

		Pt Universe	
Heart Health	Coronary Artery Disease (CA..	5,283	87% ◆ 81%
	Hypertension	6,562	73% ◆ 80%
	Ischemic Vascular Disease (I..	997	83% ◆ 86%
	Tobacco use Screening and C..	20,330	94% ◆ 93%
Diabetes	Adult Weight Screening and ..	23,620	84% ◆ 90%
	Diabetes: (HbA1c > 9%)	4,289	26% ◆ 33%
Cancer Prevention	Breast Cancer Screening	4,128	59% ◆ 60%
	Cervical Cancer Screening	11,264	65% ◆ 65%
	Colorectal Cancer Screening	10,129	47% ◆ 82%
Childhood Measures	Childhood Immunization	506	54% ◆ 60%
	Dental Sealants	580	98% ◆ 75%
	Weight Screening and Couns..	5,075	85% ◆ 90%
Behavioral Health	Depression Remission	515	48% ◆ 14%
	Patients Screened for Depre..	24,456	92% ◆ 83%
HIV Prevention	HIV Screening	22,412	69% ◆ 32%

Health Care District
OF PALM BEACH COUNTY

UDS REPORT SUMMARY 2025

SERVING PALM BEACH COUNTY, FL

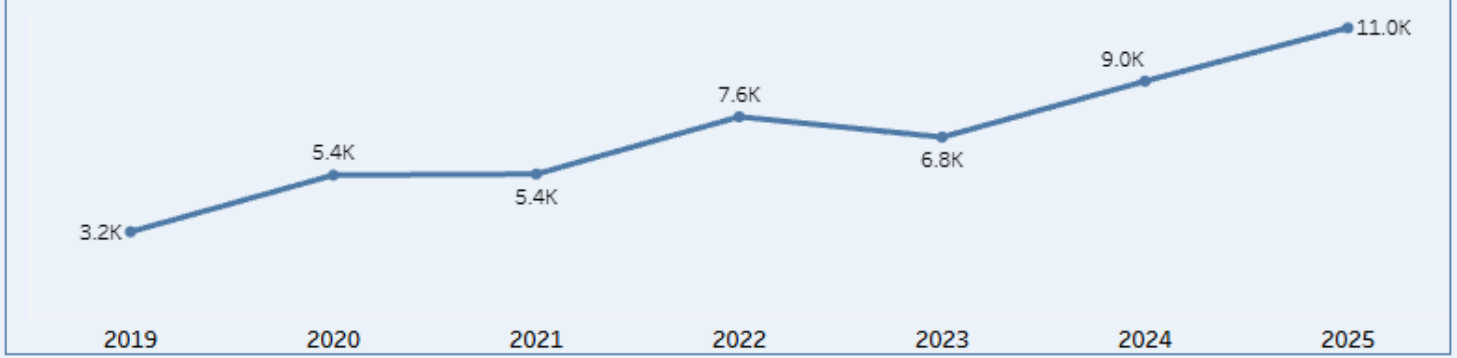


10 Primary Clinics
4 Dental Clinics
3 Mobile Clinics
---
274 Employees

17 MD/DO
14 APRNs/PAs
7 Dentists; 7 Hygienists
2 Psychiatrists
22 LCSW/LMHC/Psy.D
15 FM Residents

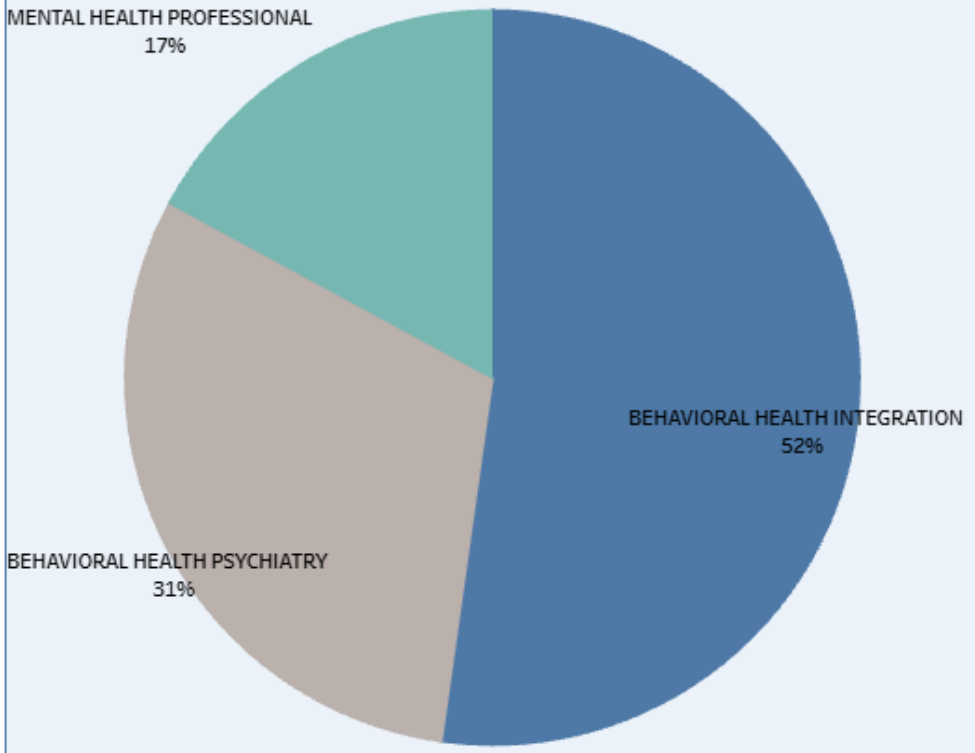
HCD Mental Health Services 5 Years Trend

Unique Patients



Visits

HCD Mental Health Unique Patients per Service Type 2025



Health Care District
COMMUNITY HEALTH CENTERS

Clinic Visit types, Trends & Different Service Utilization 1/1/2025 to 3/31/2026

Filters

ATLANTIS BELLEGLADE BOCA CPS DELRAY LAKE WORTH LANTANA LEWIS MANGONIA MOBILE ST ANN WEST PALM

Unique Patients	Patient Visits
9,943	39,198

Visit Type

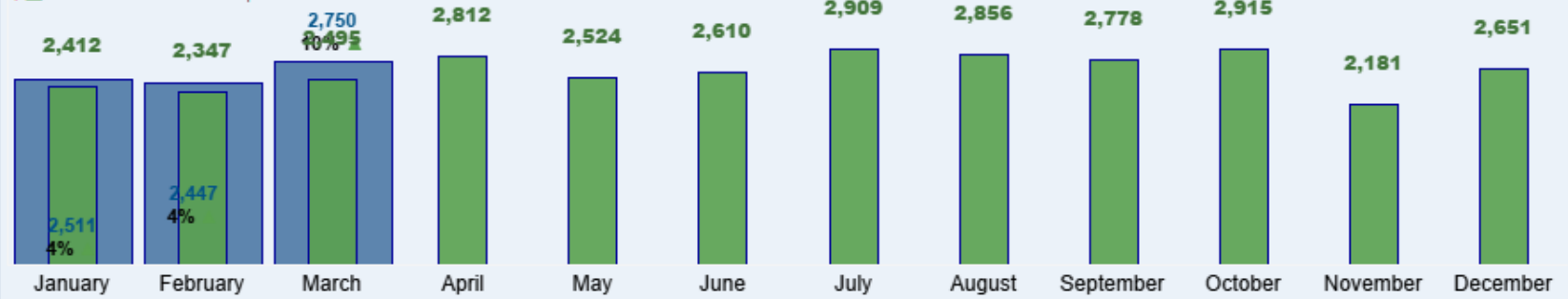
	Office Visit	Telemedicine	Nurse Only
Patients	9,162	2,785	23
Visits	33,465	5,711	23

Monthly Volume YoY

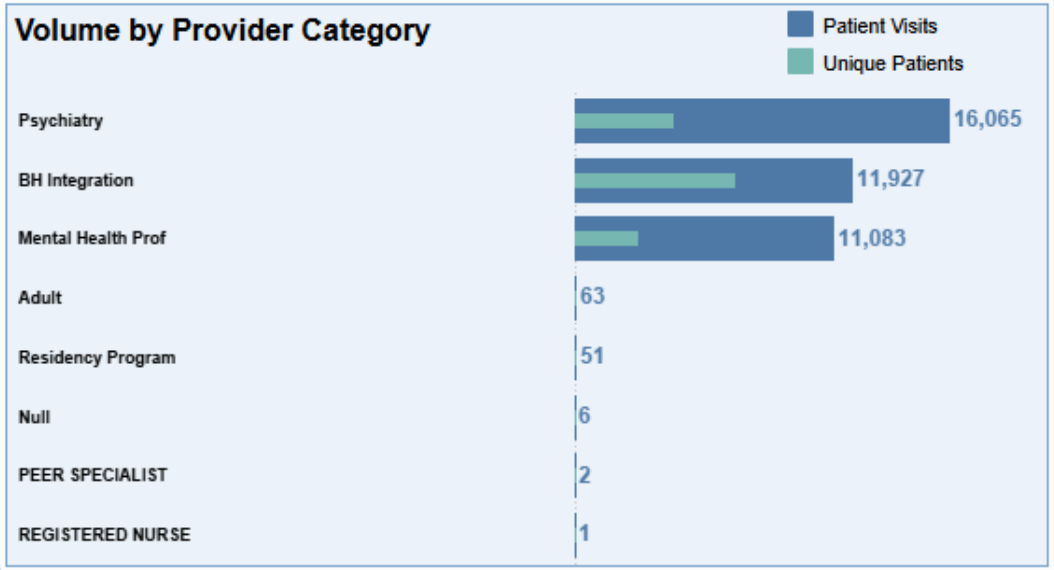
2025 2026

Monthly Volume

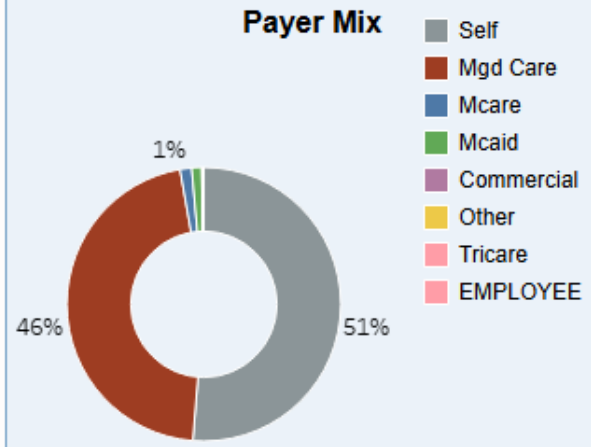
Previous Years Compare



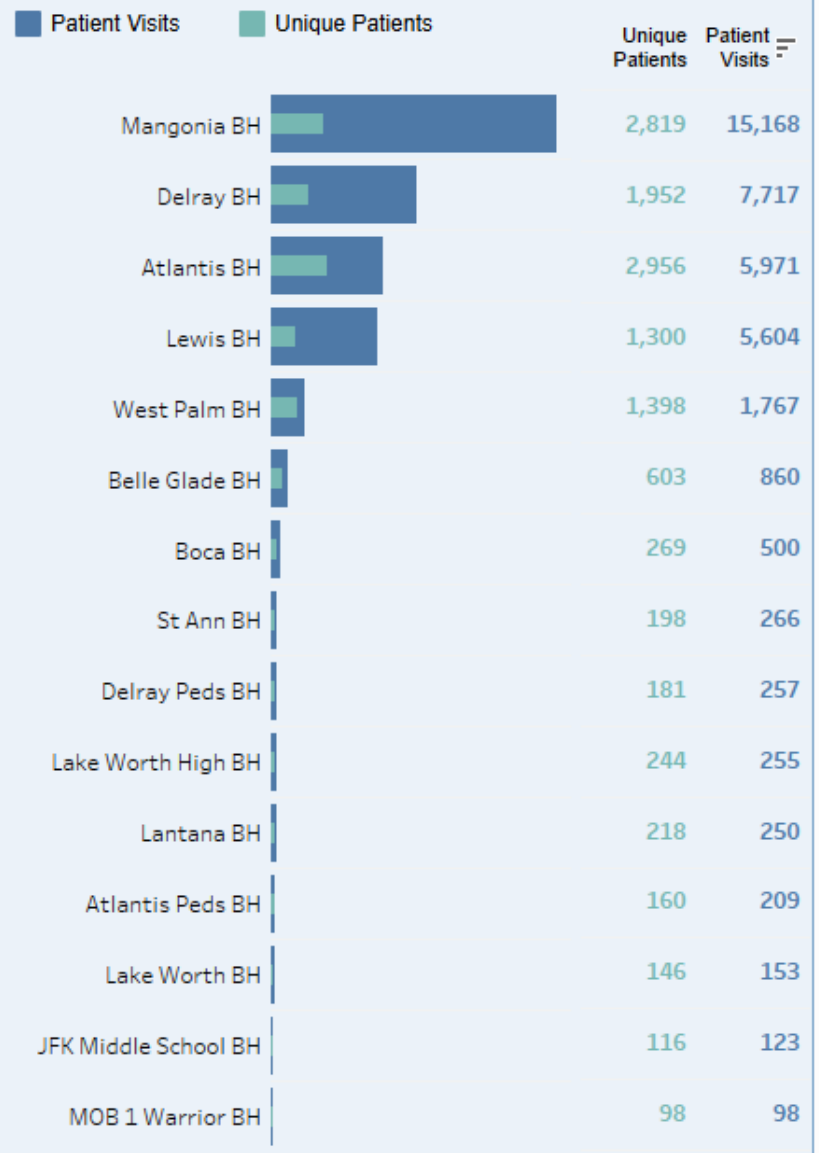
Volume by Provider Category



Payer Mix



Volume by Clinic



Health Care District
COMMUNITY HEALTH CENTERS

Clinic Visit types, Trends & Different Service Utilization 1/1/2025 to 3/31/2026

Filters

ATLANTIS BELLEGLADE BOCA CPS DELRAY LAKE WORTH LANTANA LEWIS MANGONIA MOBILE ST ANN WEST PALM

Unique Patients	Patient Visits
1,859	4,307

Visit Type

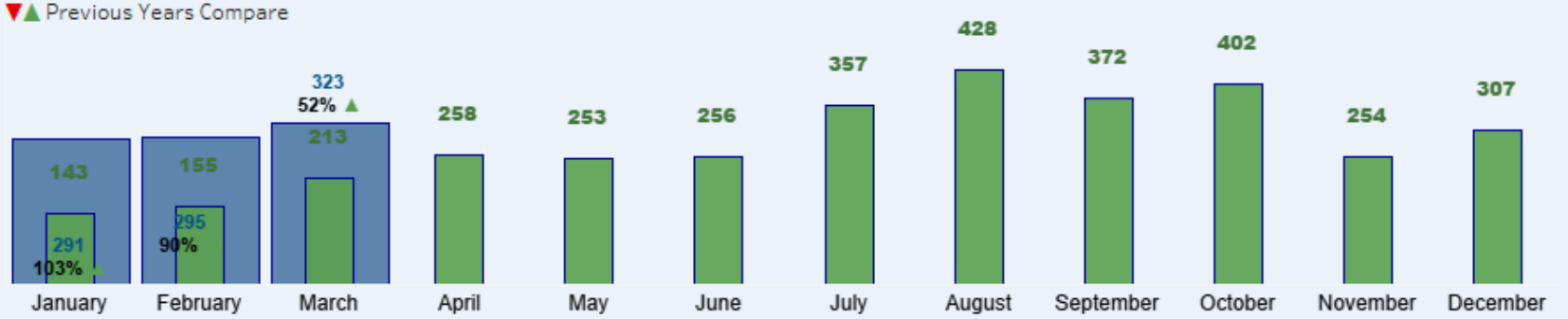
	Office Visit	Telemedicine
Patients	1,809	325
Visits	3,442	865

Monthly Volume YoY

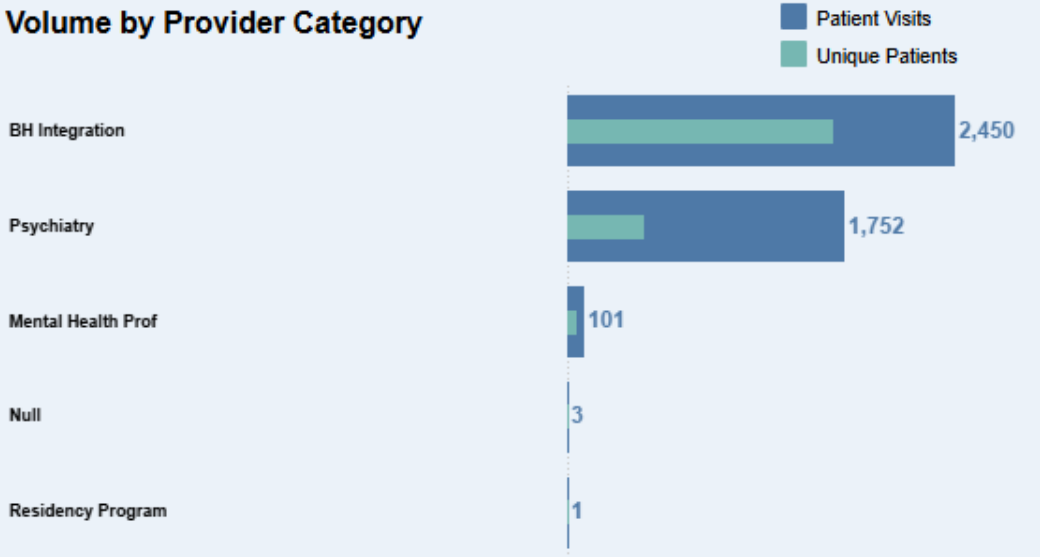
2025 2026

Monthly Volume

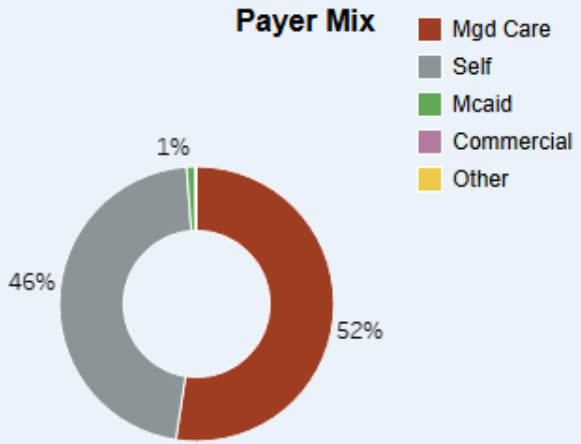
Previous Years Compare



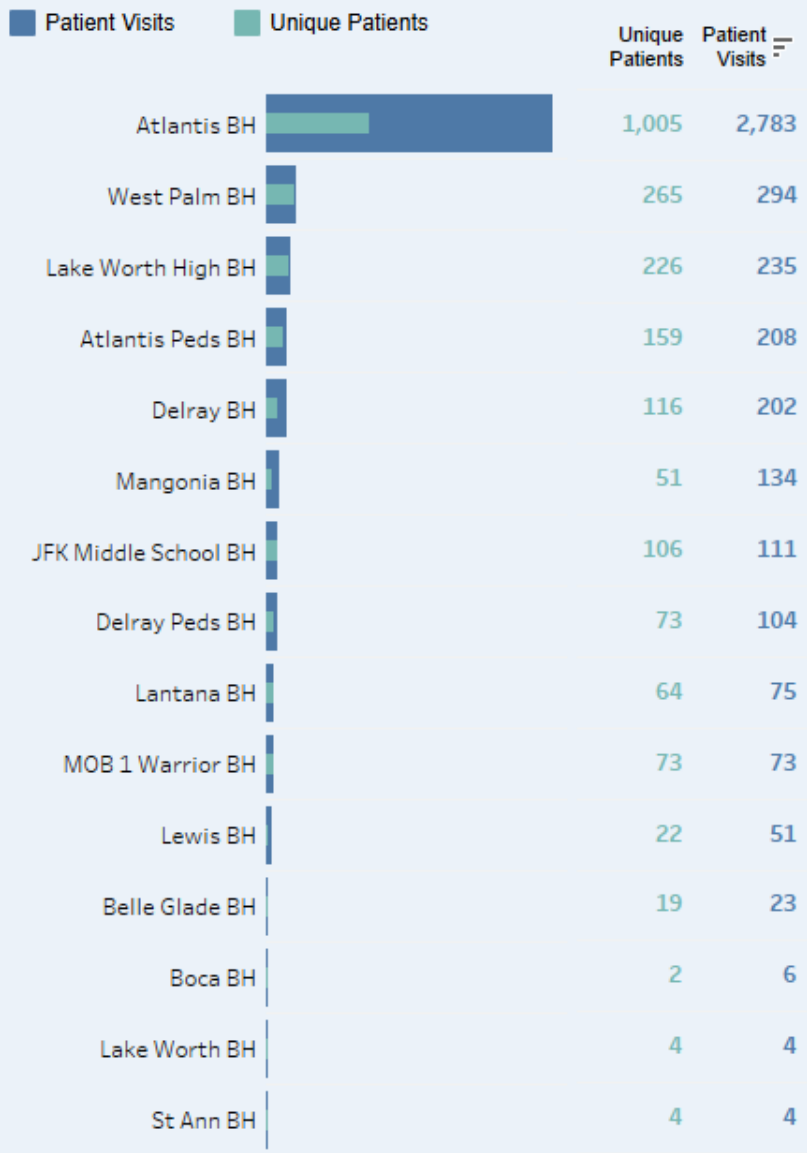
Volume by Provider Category



Payer Mix

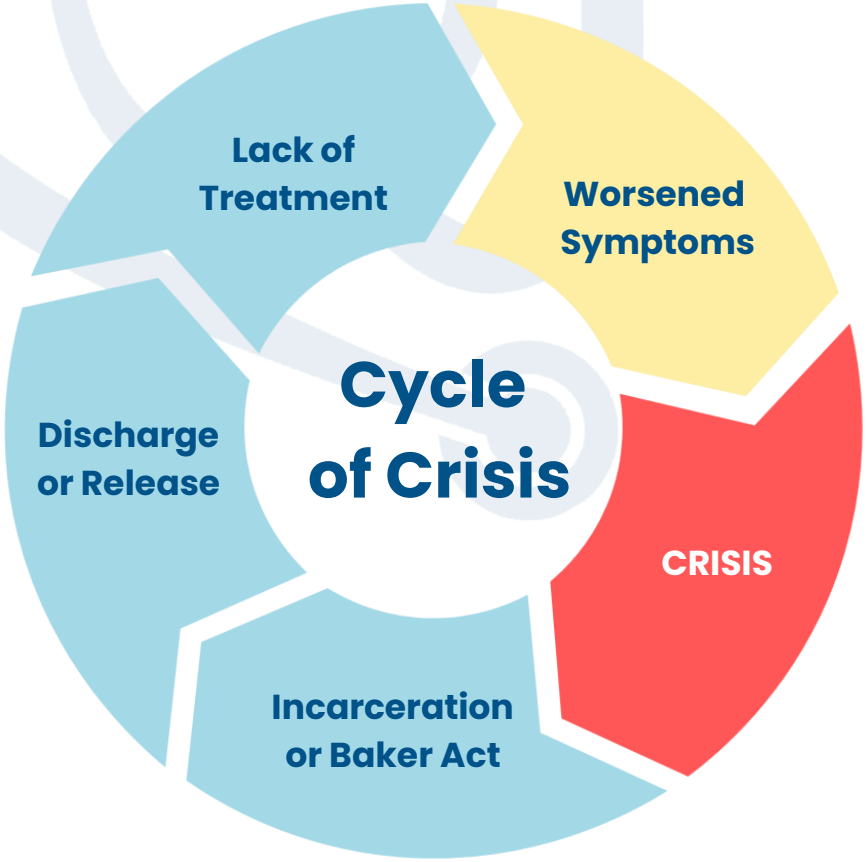


Volume by Clinic



The Problem in Palm Beach County

Together, the District and State have disrupted the revolving door of overdose.
It's time we do the same thing to the revolving door of mental health.



Behavioral Health: Palm Beach County, 2024[2]	
Healthcare Pressure – Mental Disorders	**Count**
Ed Visits for Mental Disorders (18+)	13,068
Hospitalizations for Mental Disorders (18+)	10,956
Pediatric ED Visits for Mental Disorder	969
Pediatric Hospitalizations for Mental Disorders	1,792
Total	**26,785**

An Alternative to Baker Acts.

Baker Act Data, Palm Beach County
July 1, 2024 - June 30, 2025
(Provisional)(3)

Involuntary Baker Act via Justice System:

7800

Palm Beach County Residents with 3 or more Baker Acts:

408

Health Care District OF PALM BEACH COUNTY

Current programs informing future strategy

- Law enforcement
- CJC
  - Drug court (already working with them)
  - Exploring T1 and T2 court collaboration
  - Have re entry programs onsite at the jail and pre release coming to Mangonia clinic
  - Applied for BJA-MH federal grant (pending)
- Culture Development
- Integration across silos (CJC, LE, School District, County, Homeless, SEFBHEN)
- People, Place, and purpose
  - Unite US
  - Homeless case conference
  - Street initiative
  - Peer and care coordination growth
- Increasing pediatric access in lower levels of care
  - NBH/HCD pediatric beds (500,000 from HCD given to NBH for 12 and under capital beds) (4.5 million will be given by HCD to NBH after opening for first year of operational budget of 12 and under beds)
- Increasing adult access in lower levels of care

How do providers meet this moment?

By leveraging a connected system of tools that seamlessly plugs into existing systems and workflows.

Self Sufficiency Score

Closed-Loop Referrals

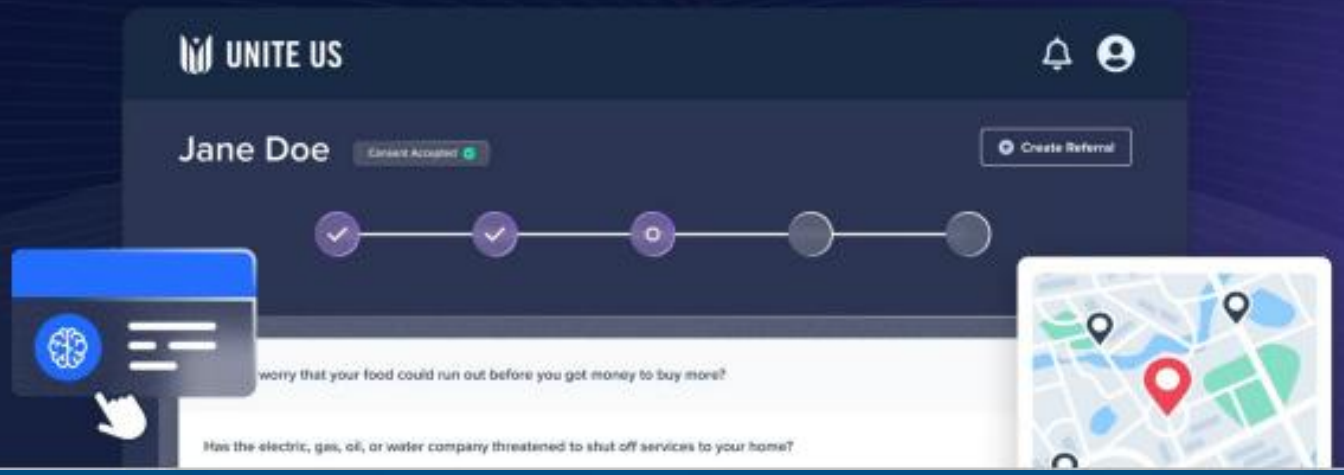
Self Service Tools

Secure Longitudinal Client Record

Accountable Networks

Outcomes Data Exchange

Screening Ingestion via API



UNITE US

Proprietary and Confidential

Breaking Down Silos in Mental Health

Physical Health Emergency

Behavioral Health Emergency

OPERATION C.O.A.S.T.

Crisis Outreach and Support Team

Roll Call Briefing & Overview

Police Pilot "Somewhere to Go"

C.O.A.S.T Somewhere to Go Program

8/1/2024 - 4/16/2026

Health Care District COMMUNITY HEALTH CENTERS

OPERATION C.O.A.S.T. Crisis Outreach and Support Team

Unique Patients
236

Visits
263

Existing HCD Patients
43 (18%)

Origin of Referral

WPB Police	59% (155)
PBSO Officer	14% (36)
Not Recorded	8% (22)
Riviera Beach Police Depar..	5% (12)
South County MRT	3% (9)

Volume by Officer

Total Unique Officers: 85

53 39 23 11 7 6 6 6 3 3 3 3 3 3 3 3 3 3 2

R O U N W Q AB 2350 222

Dispatch Call Type

Mental Health or Me..	106 (38%)
Trespassing	38 (14%)
Loiterer	37 (13%)
Other	34 (12%)
Drugs	25 (9%)
Drunk	12 (4%)
Suspicious person	9 (3%)
Disturbance	8 (3%)
Unwelcome Guest	5 (2%)
Vagrant	3 (1%)

34% 66%

Homeless
139 (52%)

Street	96
Shelter	21
Unknown	8
Other	5
Doubling..	4
Perman..	4
Transitio..	1

Age

18-45 57% | 45-65 33% | 65+ 8%

Race

White 106 45% | Black 78 33%

Ethnicity

Not Hispanic or Latino 167 71%

Was Seen by Psychiatrist
126 (52%)

Came Back to see a Psychiatrist
30 DAYS: 19 | >30 DAYS: 34

Upcoming Apps
12

Was Seen by BH provider
98 (40%)

Came Back to see BH provider
30 DAYS: 19 | >30 DAYS: 34

Missed Apps
174

Was Seen by PCP
36 (15%)

Came Back for Primary Care
30 DAYS: 30 | >30 DAYS: 42

Pt has not returned
pts. seen >6 weeks ago
141

Unique Officers over time

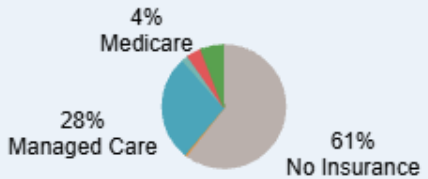
8 9 8 4 8 | 3 8 6 11 14 8 7 12 6 2 6 3 | 3 9 13 6

Sep Nov Feb Apr Jun Aug Oct Dec Feb Apr

Recommended Disposition

N/A
Patient did not follow Recommended Disposition
Patient followed Recommended Disposition

Staying in outpatient clinic appropr..	131 (74%)	28 (16%)	177
Baker Act	32 (89%)		36
No Disposition Entered			30
Other			8
Transfer to medical hospital			3



Monthly Volume

Patiant was seen
Patient Refused Services

Aug 20 17 3 | Sep 18 16 | Oct 14 13 | Nov 7 7 | Dec 12 12 | Jan 5 5 | Feb 14 14 | Mar 8 8 | Apr 24 23 | May 22 22 | Jun 13 13 | Jul 11 10 | Aug 16 16 | Sep 14 14 | Oct 3 3 | Nov 8 8 | Dec 5 5 | Jan 6 6 | Feb 10 9 | Mar 23 23 | Apr 10 10

Actual Disposition Not followed

Patient left without being seen after triage, Refusing Services	9 (82%)
Not Recorded	1 (9%)
Baker Act	1 (9%)

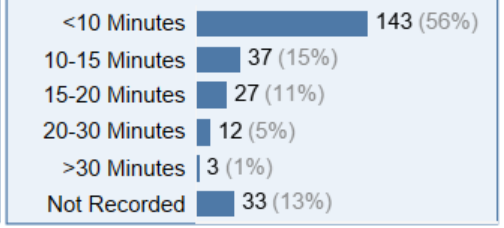
Health Care District
COMMUNITY HEALTH CENTERS

C.O.A.S.T Somewhere to Go Program

8/1/2024 - 4/7/2026

Unique Patients	Visits	Existing HCD Patients	Was Seen by Psychiatrist	BHT Documentation	Initial Safety Triage	Secondary Triage
228	255	39 (17%)	123 (52%)	89% 227/255	84% 214/255	164% 54/33

Arrival to Triage completion

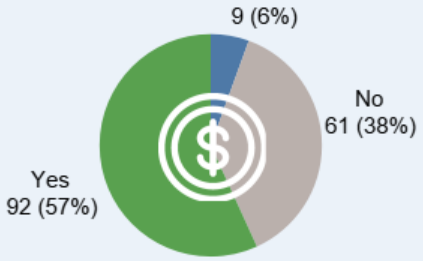


Screening Results on Initial Triage

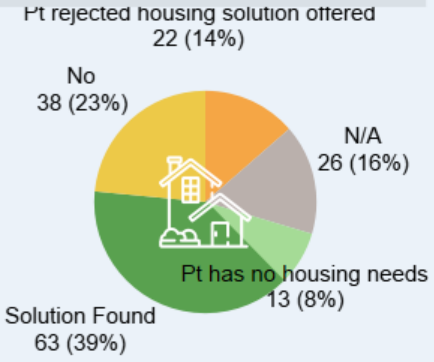
Screened Positive for Suicide (C-SSRS)	C-SSRS Risk Score	Screened Positive for Violence (Broset)	Screened Positive for Homicide Risk (Vrisk 10)	Screened Positive for Hallucination	Screened Positive for Confusion
35/193 (18%)	High Risk 27 (11%); Moderate Risk 8 (3%); Not performed 62 (24%)	3/193 (2%)	20/127 (16%)	12/93 (13%)	44/212 (21%)

Care Coordination Done: 162 (69%)

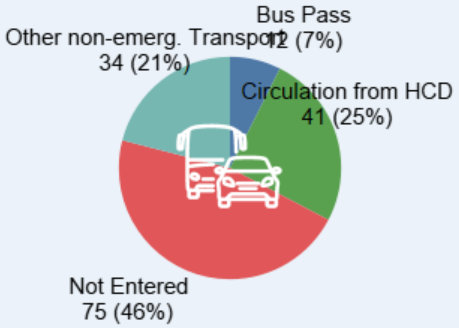
Insurance needs or Disability Addressed



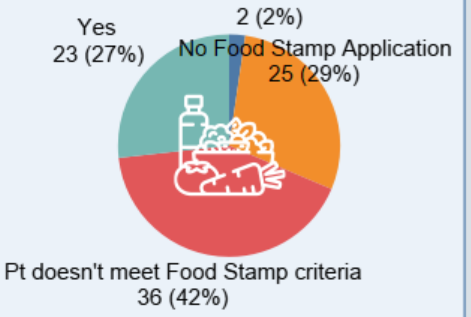
73% Housing Addressed



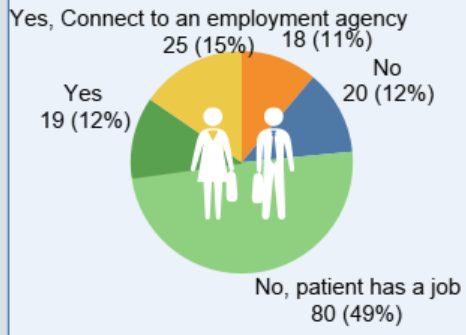
53% Transp. Addressed



53% Food Addressed



Employment Addressed

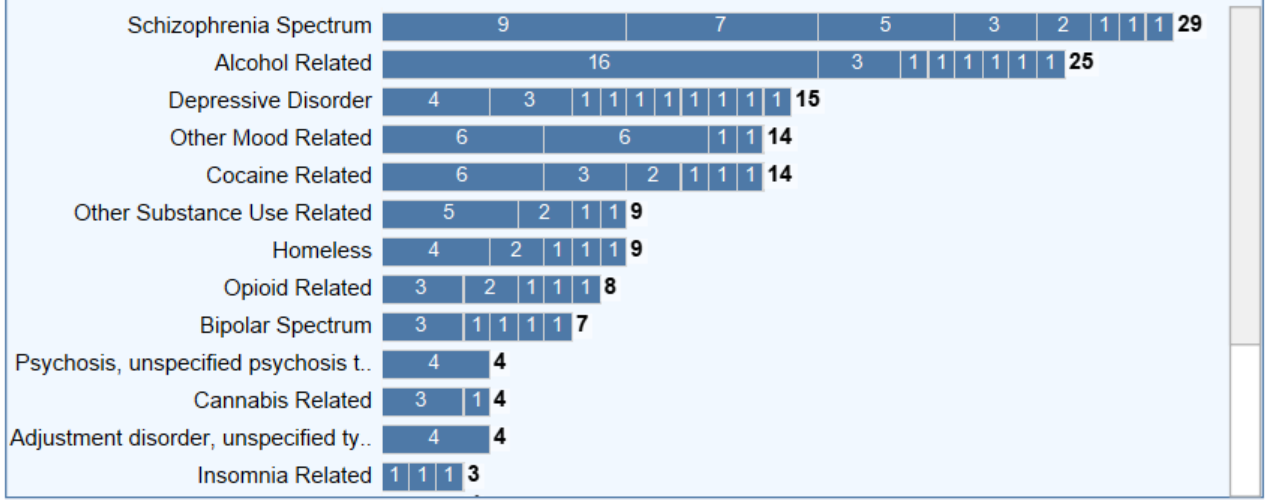


Health Care District
COMMUNITY HEALTH CENTERS

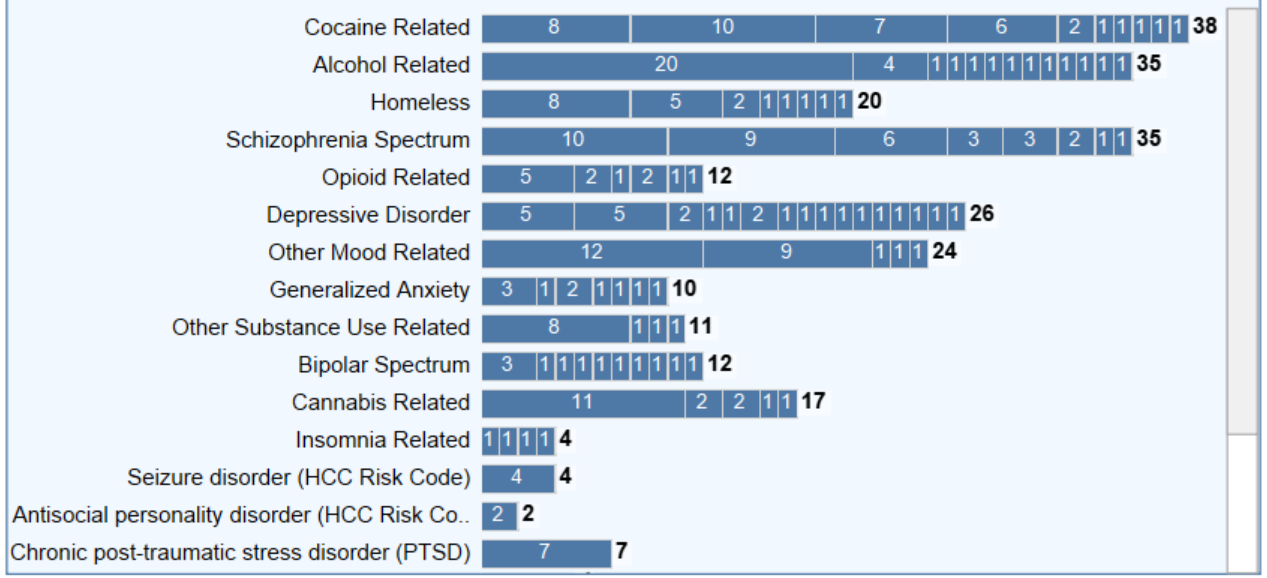
C.O.A.S.T Somewhere to Go Program

8/1/2024 - 4/7/2026

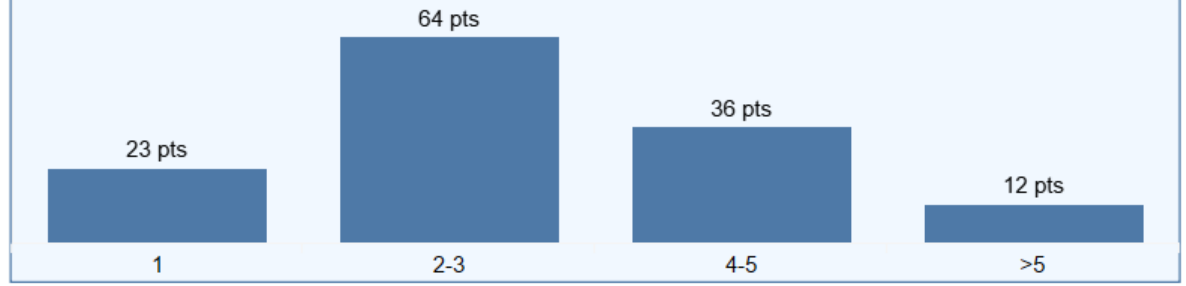
Top 20 Primary Visit Diagnosis



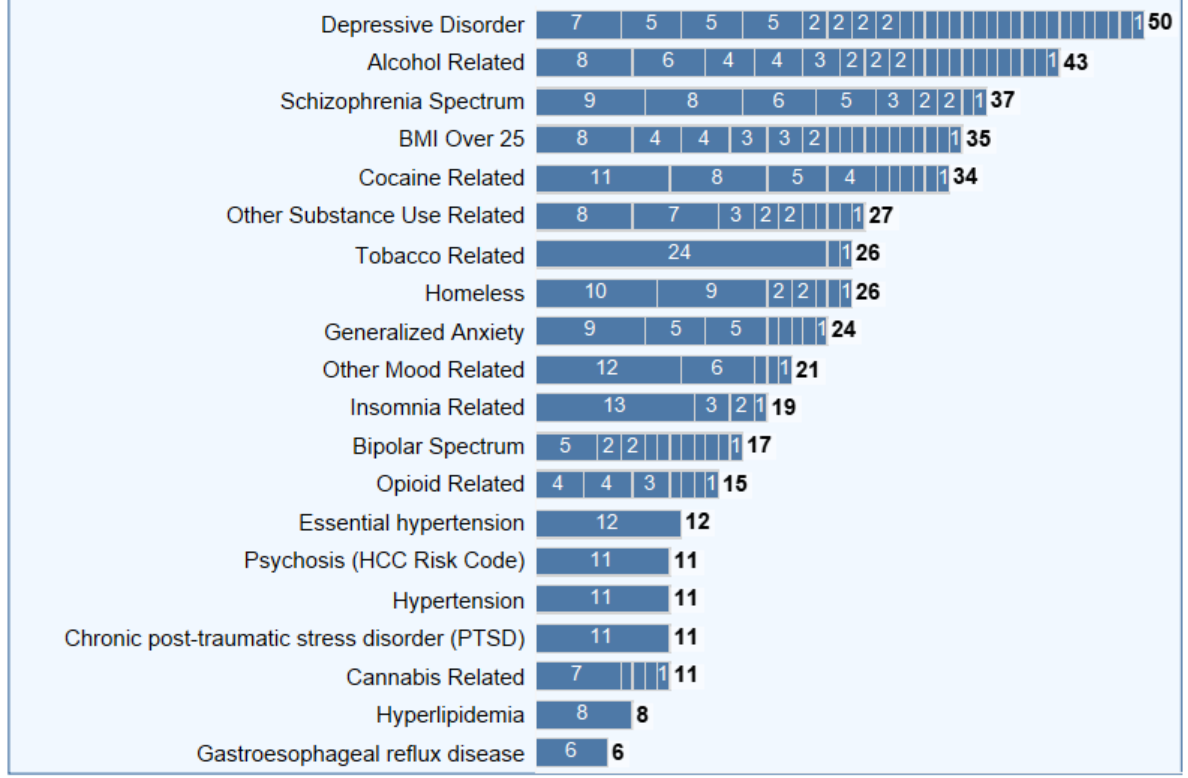
Top 20 All Visit Diagnosis



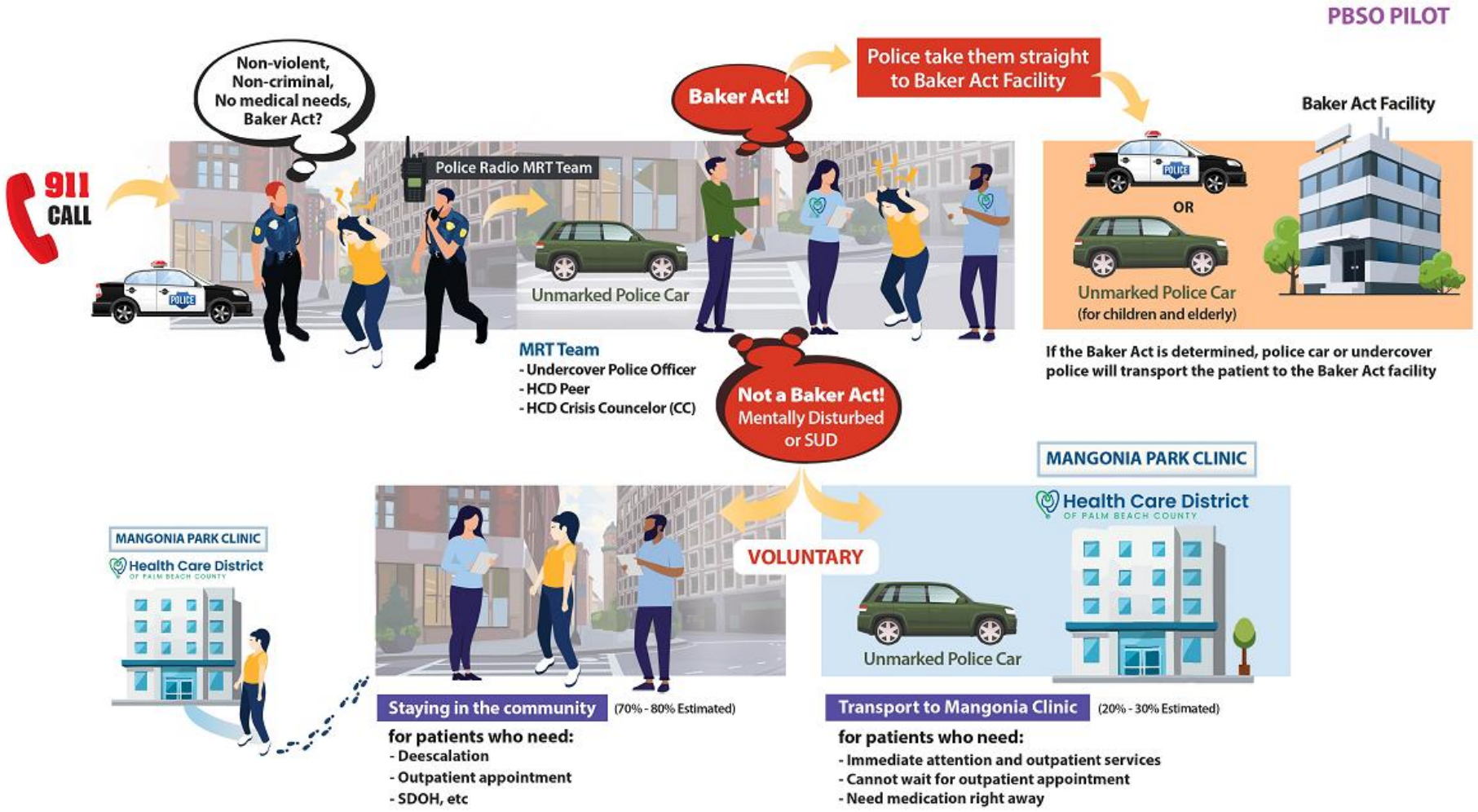
Number of Diagnosis per Patient



Top 20 Problems



PBSO CRT – “Someone to Respond”



***4 Regions Covered**
Tuesday-Friday : 8am-6pm

OPERATION C.O.A.S.T.
Crisis Outreach and Support Team

Health Care District
OF PALM BEACH COUNTY

PBSO and HCD Crisis Response Team (CRT) Program

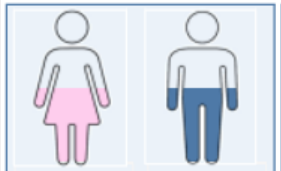
"Someone to Respond" Mental Health Crisis Co-Responding Unit Data

6/1/2024 - 4/7/2026

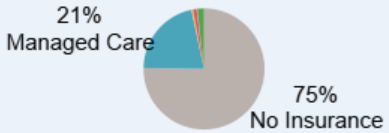
Health Care District of Palm Beach County

Operation C.O.A.S.T.

Number of Visits	Unique Patients	Duplicated Patients	Existing HCD Patients	Homeless	Arrests	Pt. Agreed to Disposition	Unit RealTime Response *(In progress)*	% Follow Up at HCD after Sched.
560	514	46	62 (12%)	54 (10%)	1	67%	56%	56%



Payer

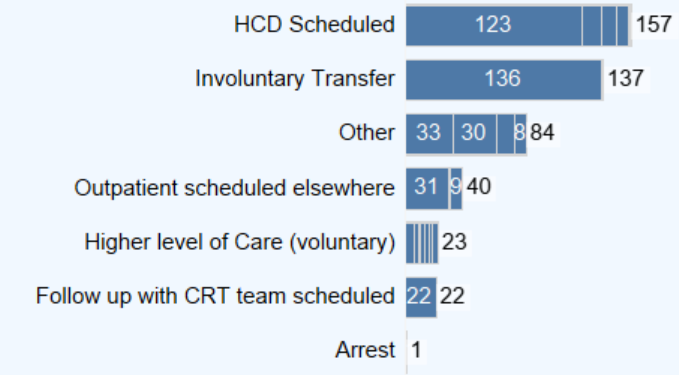


Age

Race

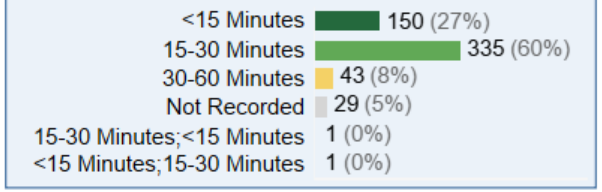
Ethnicity

Recommended Disposition

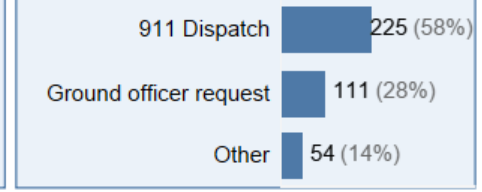


Came Back to see an HCD provider

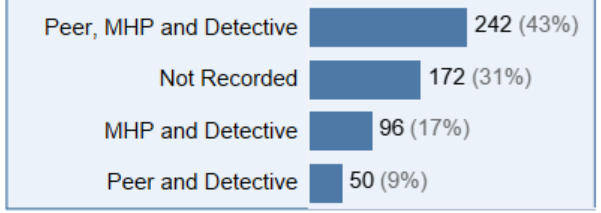
Unit Response Time to Scene



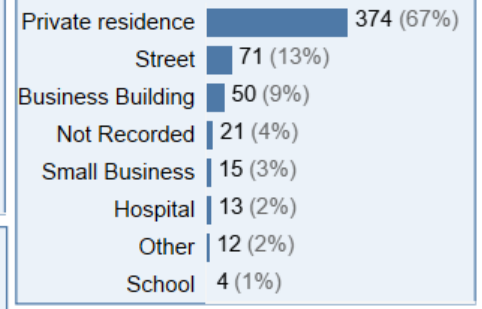
Call Origin (1/26/25)



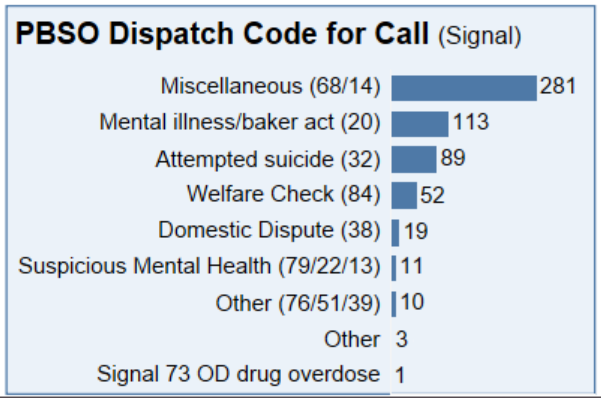
CRT Members on Scene (1/26/25)



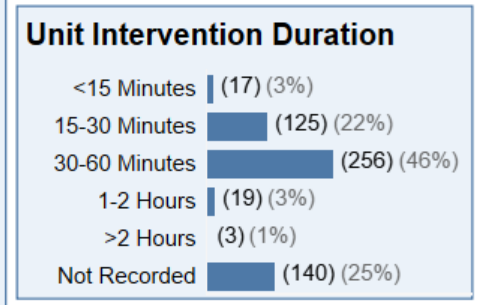
Unit Intervention Location



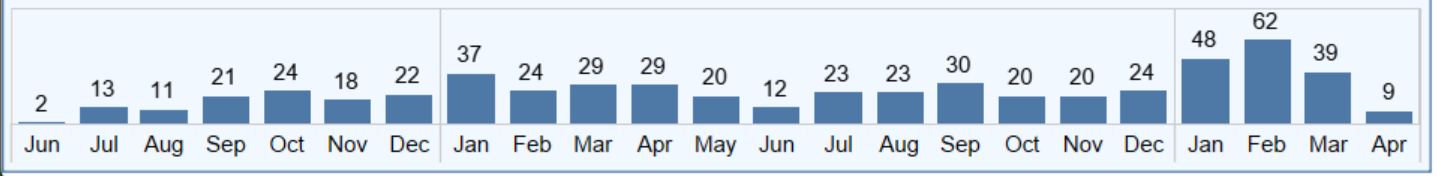
PBSO Dispatch Code for Call (Signal)



Unit Intervention Duration



Monthly Volume *(Unit operates 4 days per week 8:00AM - 6:00PM)*



Health Care District
OF PALM BEACH COUNTY
WE CARE FOR ALL

Two Waters Mental Health Center: The Structure

From Dirt to Difference: The Journey Begins!

Project Timeline

2025

- Land purchased
- Architects and Design Contractors Onboarded

2026

- *Planning and Design*

2027

- Construction Starts
- Groundbreaking

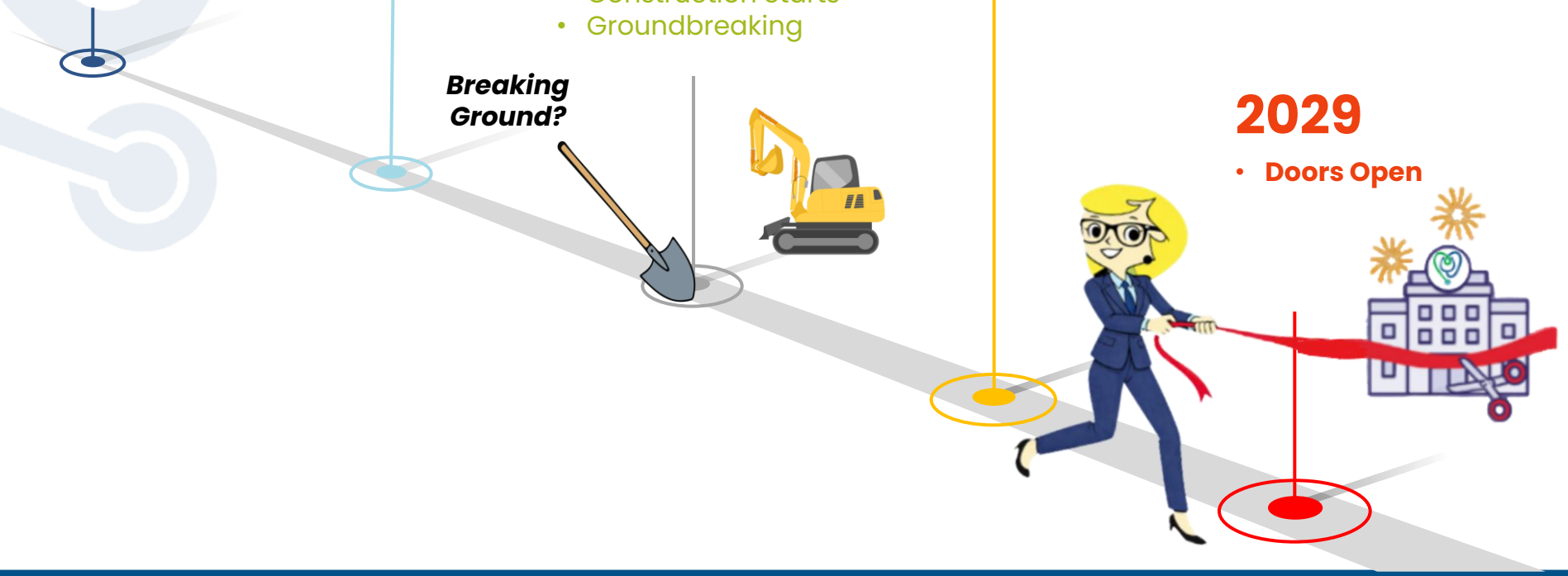
Breaking Ground?

2028

- Construction Finalizes
- Operational Development

2029

- **Doors Open**



Floor Plan (Draft)

Estimated 71,000 ft²
Courtyards Access from Clinical Spaces

Neighborhoods
Centralized Lobby & Registration
FQHC (Outpatient)
Pharmacy
Discharge Lounge
Administration Suite
Chairs Area
Inpatient Area

Sally Port Access 24/7
Covered Controlled Access Vestibule
Safe and Private Handoff from Police/EMS
Secured Dual-Door Reduces Elopement Risk
Law Enforcement Lounge
Outside Storage and Delousing

Chairs Observation Area
24/7 Staffing

48 Total Chairs
Adult = 32 (2 Pods of 16)
Youth = 16 (2 Pods of 8)
(One Pod of 8 is Flex)

Beds Inpatient Area
24/7 Staffing

32 Total Beds
Adult = 16 (2 Pods of 8)
Youth = 16 (2 Pods of 8)
(One pod of 8 is Flex)

Facility Details
Intuitive Wayfinding
Clear Sight Lines
Social Spaces, courtyard access, staff efficiencies
Family Zones, Lounge
Adult vs. Youth vs. Circulation

Adult Circulation (Draft)

Estimated 71,000 ft²
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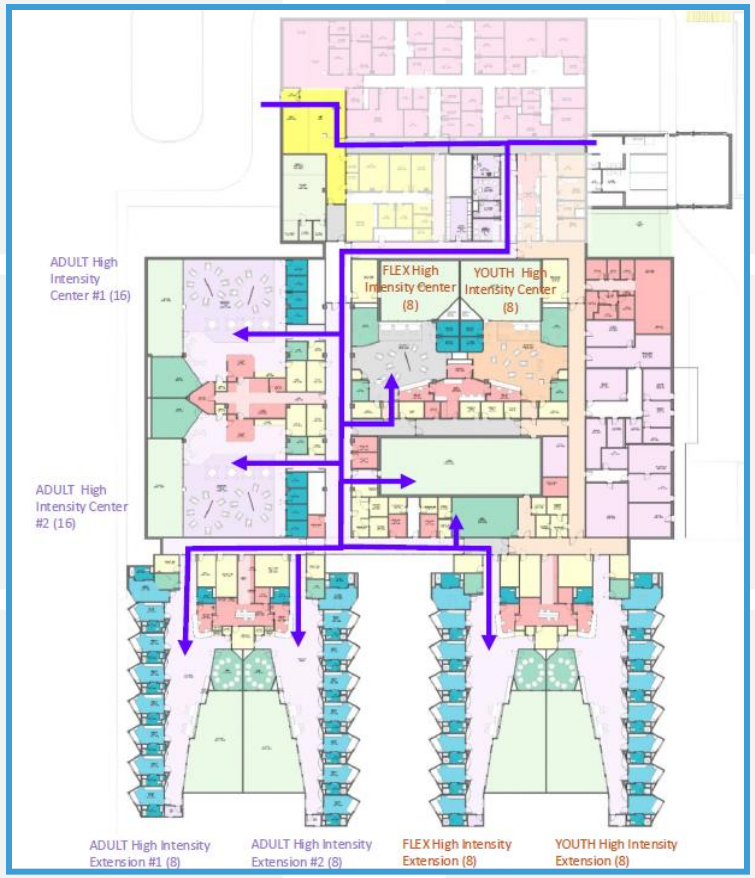

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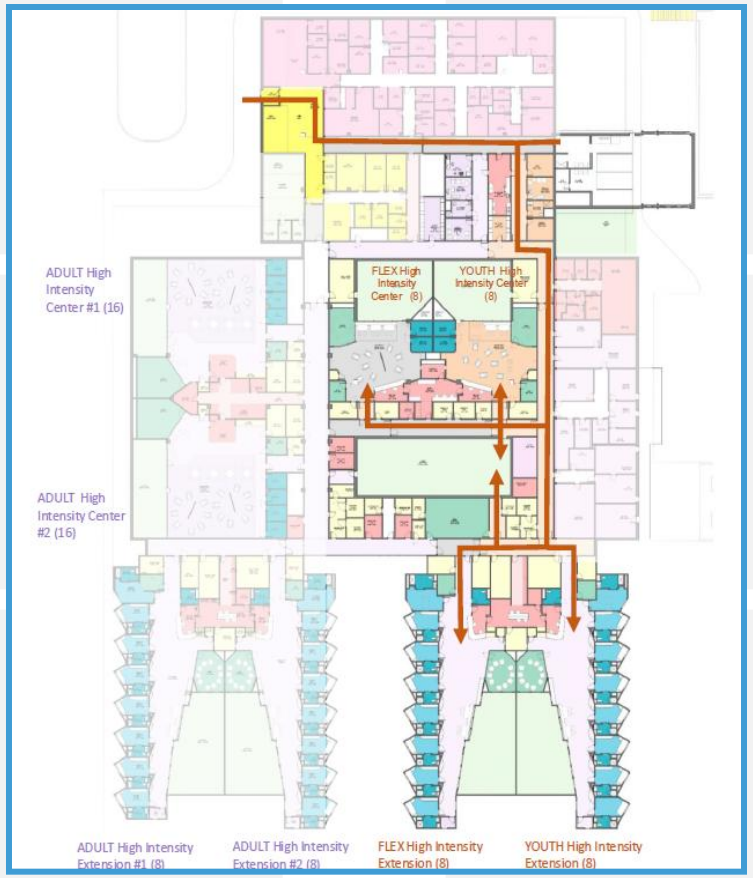

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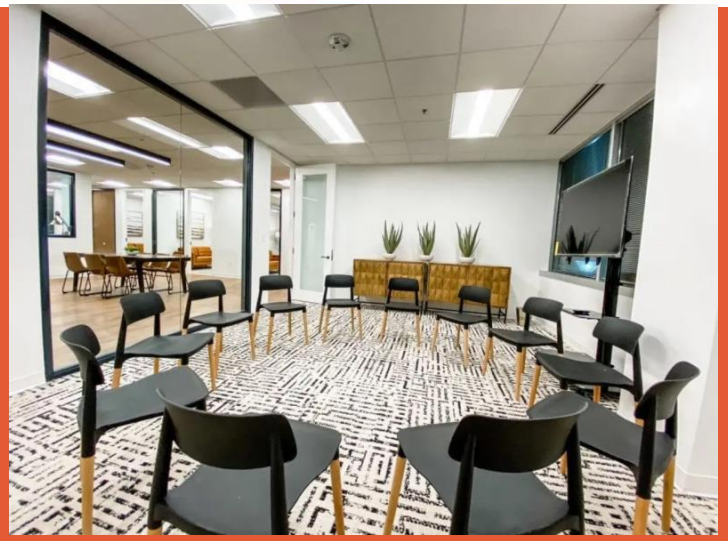
Facility Details
Intuitive Wayfinding
Clear Sight Lines
Social Spaces, courtyard access, staff efficiencies
Family Zones, Lounge
Adult vs. Youth vs. Circulation

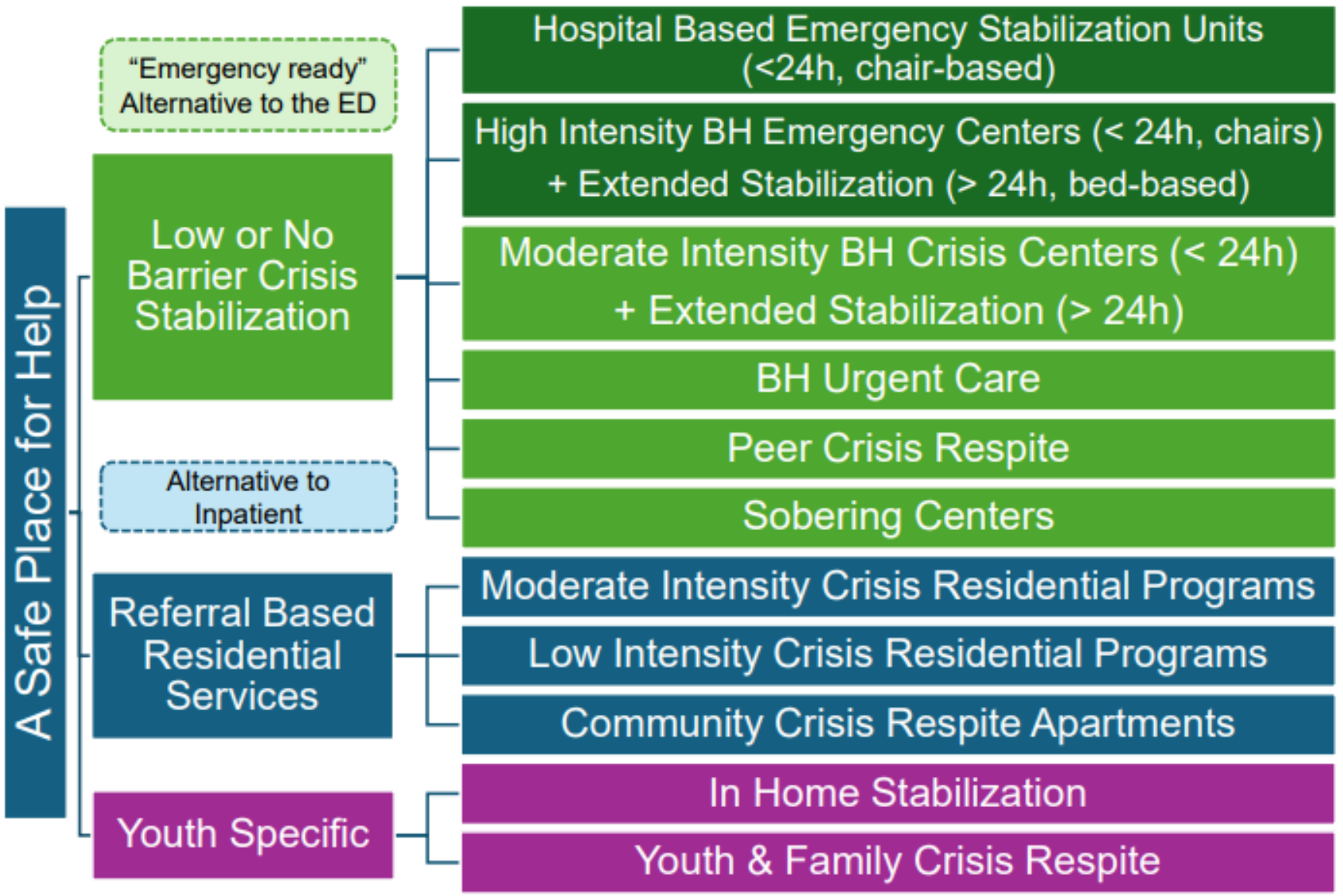
Imagery: Modern, Comfortable, Warm



Health Care District
OF PALM BEACH COUNTY
WE CARE FOR ALL

Two Waters Mental Health Center: The Inner workings

SAMHSA Definitions: A Safe Place for Help



Emergency Ready / Low/No Barrier

- **High-Intensity/Emergency**
  - All levels of acuity
  - Emergency meds
  - S/R as last resort
  - LE drop off
  - 24/7 capacity
- **Moderate Intensity/Crisis**
  - Not equipped to serve everyone
  - Voluntary only
  - Potentially limited hours
  - Pharmacy services may not be on site
- **Length of Stay**
  - < 24h, chairs
  - Extended: >24h, beds

Progress towards facility classification

Type	# states	# programs
Hospital-Based Emergency Stabilization Units	8	40
High Intensity Emergency Centers	10	119
High Intensity Extended Stabilization	11	228
Medium Intensity BH Crisis Centers	19	119
Medium Intensity Extended Stabilization (voluntary only)	8	71

	Either MH or SUD	MH only	MH and co-occurring SUD	ID/DD	SUD Only
All facilities	28	4	9	11	0
Some facilities	9	8	6	7	2
No facilities	4	11	9	8	19

Adapted from: https://nri-inc.org/profiles

Table 2: Characteristics of Crisis Stabilization Services, 2024

	Number of States	
	All in State	Some
Crisis Stabilization Facilities Accept Walk-in Clients		
Accept walk-in clients	32	9
Have dedicated drop off entrance for LE/EMS	19	13
Legal Status of Clients Served		
Voluntary only	18	10
Involuntary only	0	1
Both voluntary and involuntary	8	11
Crisis Stabilization Involuntary Patient Treatment Area		
Shared space	11	6
Separate space for involuntary	5	2
Crisis stabilization facilities have locked units	10	9
Medical Staff		
Crisis stabilization has on-site medical staff	23	12
Crisis stabilization has on-call medical staff	18	11
Other (RN on site or agreement with local hospital)	1	3
Workforce		
Use Peer Specialists	19	15
Use Licensed Behavioral Health Workers	33	5
Use Discharge Planners	27	7
On-Site Pharmacy		
Crisis stabilization facilities have on-site pharmacy	6	12
Access to Medications through Pyxis type device	9	12
Partner with off-site pharmacy	9	16
Crisis Stabilization Programs do not provide medications	3	6

High Intensity BH Emergency Center (23-hour obs)

Emergency BH treatment in a safe & therapeutic environment

The open design facilitates:

- **Safety**: Continuous observation
- **Therapeutic milieu**: Open area for therapeutic interactions with others
- **Flexibility**: Can accommodate surges in volume

Treatment starts with the assumption that the crisis can be resolved via:

- **Interdisciplinary Teamwork**
  - 24/7 psychiatric provider coverage (MD, NP, PAs)
  - Peers, nurses, techs, case managers
- **Early Intervention**
  - Door to doc time <90 min
  - Meds, detox/MAT
  - Peer support & groups
- **Proactive discharge planning**
  - Coordination with clinics, community resources & family supports

"Least Restrictive Care" means most people are

- discharged to community-based care
- converted to voluntary status

Quick & Easy Access for 1st Responders (police, EMS, mobile crisis)

so that the crisis facility is the preferred alternative to jail or the emergency room

Officers don't like:
- Waiting
- Being turned away
- Taking their guns off
- Parading people through the front lobby

Dedicated 1st responder entrance with secure sally port & workspace

Crisis Response Center - Tucson AZ

- Be easier to use than jail.
- Drop off time less than 10 min
- No prior ED "medical clearance"
- Never turn police away.
- Take everyone:
  - No such thing as "too agitated" or violent
  - Can be highly intoxicated
  - Involuntary or voluntary
  - Without using security guards

CIT Recommendations for Emergency Mental Health Receiving Facilities

1. Single Source of Entry
2. On Demand Access 24/7
3. **No Clinical Barriers to Care**
4. **Minimal Police Turnaround Time**
5. Wide Range of Disposition Options
6. Community Collaboration

Crisis Center Core CULTURE & Approach

SAFETY≠ CONTROL

True safety comes from **connection, options, and dignity**, not coercion.

Non-Coercive, humane, autonomy-driven crisis services

VOLUNTARY SUPPORT FIRST

Start with voluntary engagement; escalate only when necessary.

Minimal reliance on force.

Feeling Heard = ↑ Agency ↓ Danger

RETURN CONTROL QUICKLY

Minimize restrictions and restore autonomy as soon as possible.

Least restrictive, least coercive, most effective

CORE PHILOSOPHY:

Crisis Care works best when it treats suicidality and extreme states as human problems of pain and disconnection – met with relationship, choice, practical support, and dignified protection – rather than as threats to be controlled.

People recover – even from profound distress.

Services should be built on an expectation of recovery, not chronic risk management.

HOPE IS CLINICAL

Consistent, caring contact saves lives and fosters trust.

Empathy, genuineness, and unconditional positive regard create conditions for change.

RELATIONSHIP IS INTERVENTION

You can't therapy someone out of homelessness, fear, or isolation—meeting real needs is essential.

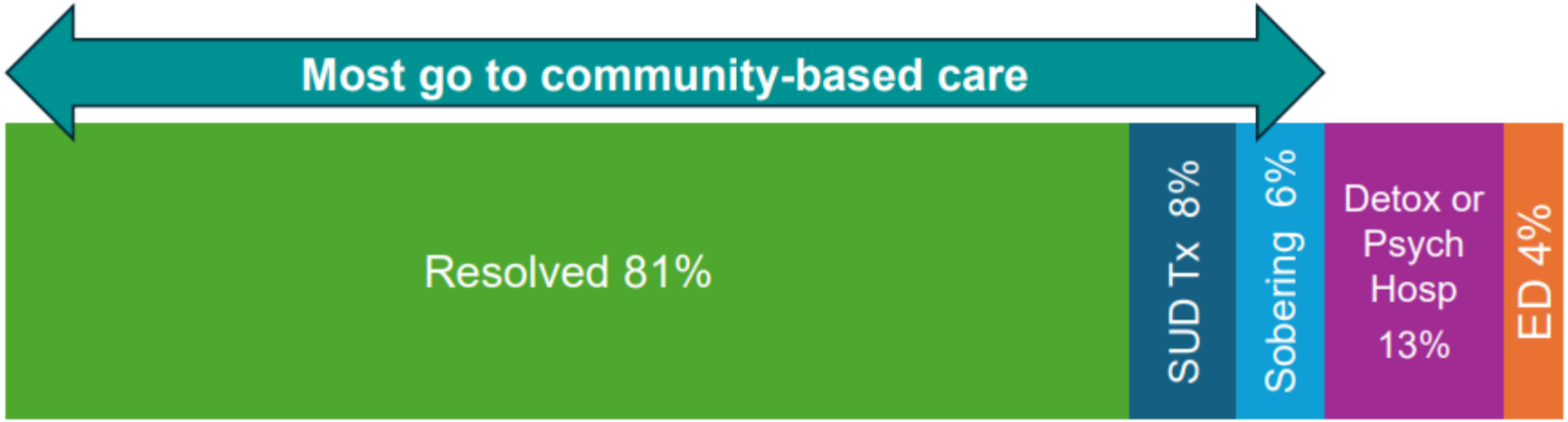
Safety, housing, belonging, esteem, purpose, rather than containment as the end goal.

PRACTICAL + EMOTIONAL SUPPORT TOGETHER

How People Should Feel When They Arrive

- Heard & Respected
- Supported & Empowered
- Connected, Not Controlled
- Hopeful About the Future

Crisis Facility Dispositions:



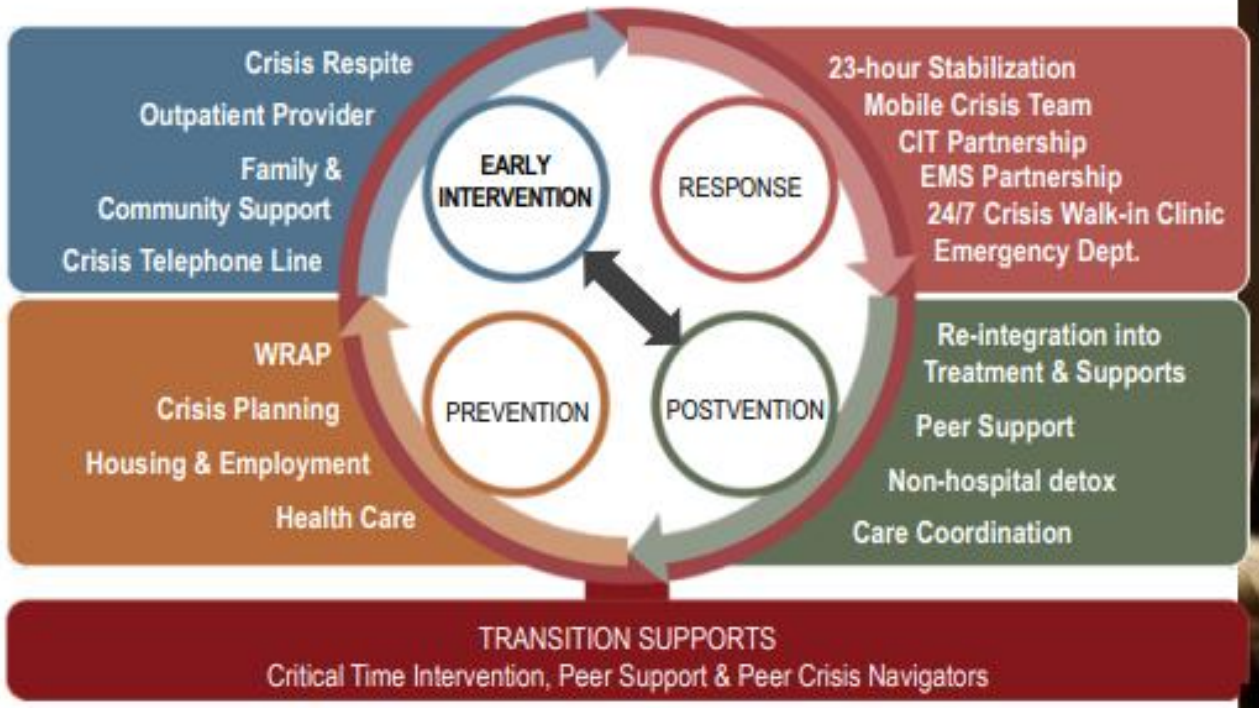
- Progress towards standardized outcomes
- Adapted from NRI profiles data
- 4-19 states reporting

63%
Left with an outpatient BH appt

Adapted from: https://nri-inc.org/profiles

Systems Thinking

A crisis system is
more than a collection of services.



Adapted from: Richard McKeon (Chief, Suicide Prevention Branch, SAMHSA). Supercharge Crisis Services, National Council for Behavioral Health Annual Conference, 2015.

Questions?

Health Care District
OF PALM BEACH COUNTY

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2026 NOTICE OF FUNDING OPPORTUNITY (NOFO) INFORMATION GUIDANCE
For
Opioid Settlement Funds (OSF)
Pilot Tiny Homes Recovery Transitional Housing

April 15, 2026 - June 30, 2027

Released: March 10, 2026, at 5:00 PM
Due date: March 17, 2026, at 12:00 PM (Noon) EST

Palm Beach County Board of County Commissioners (BCC)
Community Services Department (CSD)
810 Datura Street, Suite 200 West Palm Beach, Florida 33401
(561) 355-4700

Table of Contents

SECTION I: GENERAL INFORMATION

READ CAREFULLY AND COMPLY WITH ALL REQUIREMENTS

IN ACCORDANCE WITH THE PROVISIONS OF THE ADA, THIS NOFO AND DOCUMENTS LISTED CAN BE REQUESTED IN AN ALTERNATE FORMAT. AUXILIARY AIDS OR SERVICES WILL BE PROVIDED UPON REQUEST WITH AT LEAST THREE (3) DAYS NOTICE. PLEASE CONTACT COMMUNITY SERVICES DEPARTMENT (CSD) AT **(561) 355-4230 OR CSD-FAARFP@PBC.GOV.**

INTRODUCTION

The BCC, through the CSD invites eligible entities to submit proposals for Opioid Settlement Funds (OSF) for the development of tiny homes to be used for recovery transitional housing for eligible clients.

Proposed substance use, behavioral health and/or co-occurring disorder programs and services shall be provided within the Palm Beach County Resilience & Recovery Ecosystem of Behavioral Health and Substance Use Disorder Care (Ecosystem) (**Attachment 1**). The Ecosystem emphasizes resilience and social determinants of health with the aim toward building resilient and recovery-ready individuals and communities, as well as providing a clear system of care pathway that is person-centered and recovery-oriented. One that is also focused on individuals, improved long-term recovery outcomes and increased resiliency rather than solely on acute- and crisis-centric care.

Therefore, the purpose of this NOFO is to identify and select a minimum of one service provider to purchase and operate a Pilot Tiny Home Recovery Transitional Housing program consisting of a minimum of five (5) units for residents of Palm Beach County who are individual adults 18 and over and are recovering from substance use disorder. The Tiny Home Recovery Transitional Housing unit must accommodate a minimum of two (2) participants.

There will be a minimum of five (5) units onsite at any given time. The number one objective while participating in this project is to transition people into more permanent housing as quickly as possible, thereby opening space to help others off the street.

BACKGROUND

Opioid Settlement Funds

On March 22, 2022, the BCC approved participation in the Florida Opioid Agreement and Statewide Response Agreement and authorized the Mayor to execute the Subdivision Settlement and Participation Form.

As required by the Florida Allocation and Statewide Response Agreement, the County worked with the Palm Beach County League of Cities to secure inter-local agreements with municipalities located within Palm Beach County that represent more than 50% of municipalities' total population. Palm Beach County submitted its Florida Opioid Agreement and Statewide Response Agreement Qualified County Qualification Form to the State of Florida on April 12, 2022 FL_Opioids_Allocation_SW_Resp_Agreement.pdf. In the qualification form, Palm Beach County certified the following:

- The County has a population of at least 300,000 and an opioid taskforce or other similar board,

commission, council, or entity, including some existing sub-unit of the County's government responsible for substance abuse prevention, treatment, or recovery of which it is a member, or it operates in connection with its municipalities or others on a local regional basis.

- The County has an abatement plan that has been adopted or utilized to respond to the opioid epidemic.
- The County was, as of December 31, 2021, either providing or is contracting with others to provide substance use, prevention, recovery, and treatment services to its citizens.
- The County has entered into an inter-local agreement with at least 50% of the municipalities (by population) located within the County.

~~BHSUCOD~~

On November 15, 2022, the BCC approved the establishment of the Advisory Committee on Behavioral Health, Substance Use and Co-Occurring Disorders (BHSUCOD) and declared the BCC's expressed approval of a person-centered, recovery-oriented system of care. (Resolution R2022-1340) Resolution R2022-1340 PDF and the BHSUCOD 2022 Master Plan.. The BHSUCOD is charged with enhancing the County's capacity and effectiveness in formulating behavioral health and substance use disorder policies as well as offering recommendations regarding the County's provision of services to its citizens. It is also responsible for making recommendations on responding to the opioid epidemic, as provided in section 17.42 of the Florida Statutes (2022), entitled "Opioid Settlement Clearing Trust Fund" and complies with the Florida Plan requirement to have an opioid taskforce or other similar board. On November 15, 2022, the BCC approved the BHSUCOD 2022 Master Plan.

In March 2024, the BHSUCOD released a draft update to the 2022 BHSUCOD Plan. The BHSUCOD received regular community input and established a two-week period to receive public comment on the Behavioral Health and Substance Use Disorder Plan 2024 (2024 Plan). Following this public comment period, a thematic analysis was conducted and incorporated into the final 2024 Plan that the BHSUCOD approved in May 2024. The BCC reviewed the 2024 Plan in May 2024, wherein it also received public comment. On October 22, 2024, the BCC unanimously approved the final version of the 2024 Plan, which incorporated public comments, and the opioid settlement fund expense plan as presented to the BCC. Furthermore, it also adopted the BHSUCOD's recommendation that opioid settlement funds should be spent as follows: 90 percent (90%) on social determinants of health prioritizing housing, recovery supports, care coordination, and environmental strategies to include youth, families, and community education; and 10 percent (10%) on deep-end and crisis care. In doing so, the BCC recognized that prior focuses on acute crisis care have not provided long-term results in the absence of addressing basic needs and other supportive services.

See 2024 Plan at:
The Behavioral Health and Substance Use Master Plan 2024

NOFO Funding:

The total available for this NOFO is approximately $500,000 for the anticipated period of April 15, 2026, through June 30, 2027.

FUNDING AWARDED VIA THIS NOFO WILL BE PROVIDED FOR THE PURCHASE OF TINY HOMES ONLY. ONGOING OPERATIONAL COSTS WILL BE THE RESPONSIBILITY OF THE AGENCY AND/OR ITS COLLABORATING PARTNERS.

ELIGIBILITY

Qualified entities submitting applications for OSF Tiny Home Recovery Transitional Housing Units funding shall meet all statutory and regulatory requirements.

Applicants must be nonprofit treatment providers. For-profit entities and/or governmental entities are not eligible to apply for or to be subrecipients of OSF funds. All subrecipients must at a minimum, meet the eligibility standards described below:

To meet Threshold Review to be scored, a Nonprofit Applicant must:

- Hold current and valid 501(c)(3) status as determined by the Internal Revenue Service.
- Be chartered or registered with the Florida Department of State.
- Be incorporated for at least one agency fiscal year.
- Have provided the proposed services for at least six (6) months.
- Demonstrate accountability through the submission of acceptable financial audits performed by an independent auditor.
- Is not debarred
- Capacity to operate the project on a cost-reimbursement basis
- If awarded funding, Applicant must create a Vendor Registration Account OR activate an existing Vendor Registration Account through Palm Beach County Purchasing Department's Vendor Self Service (VSS) system, which can be accessed at: https://pbcvssp.co.palm-beach.fl.us/webapp/vssp/AltSelfService.
- Maintain contractual liability insurance substantially similar to the terms listed in **Attachment 12: INSURANCE**, if awarded funding.
- APPLICANT MUST HAVE LAND IDENTIFIED FOR TINY HOMES (as exemplified by Site Control, Local zoning and/or building code compliance).

While not a requirement, Applicants are strongly encouraged to hold accreditation from Nonprofits First or demonstrate that they are exempt due to having an alternative professional accreditation or Certification (i.e., Joint Commission Accreditation, CARF Certification, etc.). If you are currently unable to obtain accreditation, membership is strongly encouraged.

A. BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDERS PROGRAM OVERVIEW:

The County's collective and collaborative efforts have been directed at planning, developing and executing a comprehensive person-centered, recovery-oriented ecosystem of care. The County measures its initiatives primarily through a resilience and recovery capital framework because of its ability to capture resilience, health, well-being, social determinants of health and risk factors. Details on each of the levels can be found in **(Attachment 1)**

Social Determinants of Health

Critical to the BCC's goal of establishing a person-centered, recovery-oriented ecosystem of care is placing focus on social determinants of health (SDoH). CSD has engaged Florida Atlantic University's (FAU's) Center for Integrated Recovery and Wellness Studies to continue its research related to resilience and recovery capital and its relationship to SDoH in order to strengthen individual and community health, wellness and recovery from substance use disorder and mental illness.

The U.S. Centers for Disease Control and Prevention (CDC), Office of Disease Prevention and Health Promotion define SDoH as the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDoH are grouped into five domains: economic stability, education access and quality, health care access

and quality, neighborhood and built environment, and social and community context.

Substance Abuse Mental Health Services Administration (SAMHSA) recognizes the importance of addressing SDoH as key levers to achieving improved outcomes for people with behavioral health conditions. The White House Domestic Policy Council (DPC) in its 2023 *Playbook to Address Social Determinants of Health* emphasizes the fact that improving health and well-being across America requires addressing the social circumstances and related environmental hazards and exposures that impact health outcomes.

An inability to meet these social needs puts individuals at higher risk for exacerbating health conditions such as heart disease, stroke, depression, cancer, and diabetes according to the DPC. Compounding the problem, unmet social needs can cause major disparities in health outcomes that may be predetermined by geography, race, ethnicity, age, income, disability status, and several other factors.

As the Palm Beach County RCI data discussed above demonstrate, the primary factors contributing to low RCI scores are based on SDoH factors (personal financial wellbeing, employment, knowledge and skills, basic needs, transportation and social access to healthcare).

B. SERVICE CATEGORY

The BCC through the CSD invites eligible entities to submit proposals for the Opioid Settlement Funds Service Category for the Purchase of Tiny Homes Recovery Transitional Housing, as defined in this NOFO, for period from April 15, 2026 –June 30, 2027.

The sole service category that is the focus for this NOFO is **Pilot Tiny Homes Recovery Transitional Housing to Support People in Treatment and Recovery.**

Opioid Settlement Funded Pilot Tiny Home Recovery Transitional Housing Program

Program Guidelines

I. Program Purpose and Authority

The County, through its CSD, administers Opioid Settlement Funds (OSF) in accordance with the Florida Opioid Allocation and Statewide Response Agreement and the Behavioral Health and Substance Use Disorder Plan (Plan 2024).

The purpose of the Opioid Settlement Funded Tiny Home Transitional Housing Program ("Program") is to address housing instability as a critical social determinant of health for individuals impacted by substance use disorders by supporting the acquisition and operation of transitional tiny home housing paired with treatment and recovery-oriented supportive services.

This Program is implemented as a pilot initiative and is designed to complement Countywide housing strategies for individuals experiencing behavioral health and substance use disorders in need of transitional housing.

II. Allowable Use of Opioid Settlement Funds

Consistent with the Florida Opioid Allocation and Statewide Response Agreement, Opioid Settlement Funds under this Program may be used for:

- The acquisition of prefabricated tiny home units intended for use as transitional housing.
- Program models that integrate housing with treatment, case management, and recovery supports.

Opioid Settlement Funds may not be used for ongoing operating subsidies unrelated to the approved scope, or for purposes inconsistent with State or County opioid settlement requirements.

III. Program Model

The Program supports a community-based transitional housing model with the following core elements:

- Prefabricated tiny homes unit must accommodate a minimum of two (2) participants;
- Owned and operated by a nonprofit provider;
- Recovery-Oriented System of Care Principles that are Person-Centered;
- Time-limited transitional housing, with a maximum length of stay of up to twenty-four (24) months per participant;
- Wraparound treatment and supportive services delivered on-site or through coordinated partnerships; and
- Integration of social determinants of health, including housing instability, for populations impacted by opioid use disorder and co-occurring behavioral health conditions.

a. Eligibility and Programmatic Guidelines for Agencies Seeking Funding for Tiny Homes

Proposals for Tiny Homes must demonstrate the capacity to comply with the following programmatic guidelines:

- **Alignment of Recovery-Oriented System of Care** (ROSC)
  The ROSC guidelines and elements must be integrated into the Agency's program where the Tiny Homes are located for participants.
- **Integration of Care**
  Medication-Assisted Treatment (MAT) must not be prohibited, and it must follow FDA-approved medications, such as methadone, buprenorphine, and naltrexone—along with evidence-based counseling and therapy, as appropriate.
- **Beyond Detoxification**
  Outpatient Treatment approaches must extend beyond the management of acute withdrawal symptoms and explicitly address underlying neurobiological changes associated with substance use disorders in order to promote and support sustained, long-term recovery.
- **Addressing Psychosocial Needs**
  Effective Treatment programs must address co-occurring psychosocial needs, including but not limited to mental health services, vocational training, legal assistance, and stable housing supports.
- **Individualized Recovery Planning**
  Outpatient Treatment and Recovery services must be individualized and responsive to each participant's unique clinical needs, personal circumstances, and stage of recovery. A uniform or "one-size-fits-all" approach is not acceptable.

- **Shared Decision-Making**
  Programs must incorporate shared decision-making practices, ensuring that participants and providers collaborate.

b. Services and Support Components

Funded programs must provide, at a minimum, the following core services and support components. Services may be delivered directly or through formal partnerships and must be appropriately coordinated to ensure continuity of care:

1. **Recovery Support Services**
   Peer-to-peer support and other non-clinical supports that promote sustained recovery.
2. **Clinical Treatment Services**
   Evidence-based substance use disorder treatment services, including outpatient, intensive outpatient, and residential levels of care integrated with mental health and primary care services as appropriate.
3. **Case Management and Care Coordination**
   Comprehensive case management services, including linkage to needed services, care coordination across providers, and ongoing monitoring and follow-up.
4. **Prevention and Education**
   Community-based prevention, wellness education, and harm reduction initiatives designed to reduce risk and promote health and safety for participants.
5. **Family and Community Services**
   Services that support family engagement, advocacy, and meaningful involvement of families and community supports in treatment and recovery planning.
6. **Vocational and Social Support Services**
   Employment readiness and placement services, educational support, and transportation assistance to promote economic stability and social reintegration.
7. **Recovery Community Engagement**
   Incorporating Recovery "Community" Engagement activities with participants on a weekly/monthly basis to promote community with other residents in recovery. This may include but not be limited to engagement with the nearest Recovery Community Organization/Recovery Community Centers (i.e., Rebel Recovery, the HUBs), planning recovery-friendly activities, gatherings, socials, etc.

FUNDING AWARDED VIA THIS NOFO WILL BE PROVIDED FOR THE PURCHASE OF TINY HOMES ONLY. ONGOING OPERATIONAL/WRAPAROUND/SUPPORTIVE SERVICES COSTS WILL BE THE RESPONSIBILITY OF THE AGENCY

OSF Funding Requirements

Individuals served through OSF funding must be residents of Palm Beach County with a Substance Use/Co-Occurring Disorder and all activities must take place within Palm Beach County.

Proposals for OSF funding are to establish new programs or expand and/or enhance the availability of services and supports. Opioid Settlement Funds shall be supplemental to and shall not take the place of any other funds, including, but not limited to, funding from other grants that have lapsed or shrunk, whether it is a county, state or federal grant. OSF funding is to be utilized as funding of last resort, meaning that other existing funding, such as insurance to pay for services, shall be exhausted before OSF funding is used. Funding shall be used exclusively to fund the programs or projects that align with the goals of the 2024 Plan and are a Core Strategy and/or an Approved Use under the State Opioid Settlement Agreement.
Proposals submitted for the OSF Funding shall:

- Demonstrate alignment with Palm Beach County's Resilience and Recovery Ecosystem of Behavioral Health and Substance Use Disorder Care. (**See Attachment 1)**
- Demonstrate alignment with the 2024 Plan. The Behavioral Health and Substance Use Master Plan 2024
- Identify the Core Strategies and/or Approved Uses that the proposal meets and identify how funding will be allocated for each strategy or approved use.
- Agree to utilize evidence-based or evidence-informed practices with fidelity.
- Agree to measure individual and/or community resilience through regular administration of the Resiliency/Recovery Capital Index Survey.
- Agree to participate in research related to initiatives.
- Comply with the OSF Programmatic Requirements.
- Integrate via collaborative agreements for the provision of ongoing supportive services to participants residing in the OSF Tiny Homes Recovery Transitional Housing units.
- Operate the OSF Tiny Homes Recovery Transitional Housing program for a minimum of ten (10) years.
- Comply with State and County reporting requirements for OSF funds. (**See Attachment 2)**
- Comply with 2 Code of Federal Regulations (CFR) Part 200, which provides uniform administrative requirements, cost principles and audit requirements applicable to this funding source. https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200.

C. FUNDING AVAILABILITY

All proposals must be category-specific (Tiny Homes Recovery Transitional Housing).

The BCC determines available funding for each of the fiscal years covered by this NOFO. The total funding available for the 2026-2027 State Fiscal Year (FY) is $500,000. A maximum of $100,000 will be awarded per tiny home unit.

A Tiny Homes Recovery Transitional Housing Unit is defined as: prefabricated tiny home is a dwelling unit 400 square feet or less (excluding lofts) that is constructed off-site in a factory setting, transported to a final building site, and installed on a foundation. The must meet all applicable local, building, zoning, permitting, compliant with Americans with Disability (ADA) and other applicable federal, state, and local government rules/regulations.

Further, the BCC see public safety as critical components of successful human services programs. As such, while we will not prescribe policies, we expect the following to be fully adopted and/or adhered to by the successful applicant and/or its collaborating partners:

- Maintain on-site security 24 hours per day, 365 days per year.
- Establish, maintain, and enforce a set of client rules and expectations, as well as accountability procedures.
- Report all incidents of criminal activity, by residents or guests, to appropriate enforcement agency.
- Always meet all fire code requirements to ensure ingress and egress are available.
- Build and maintain relationships with appropriate public safety personnel which may include: First Responders and other critical partners.
- Lighting features must remain in working condition and be maintained.
- Notify CSD immediately in cases of natural disaster, criminal activity, or significant first responder response as soon as possible and no longer than 12 hours after incident.
- Not to allow overnight guests of residents and create reasonable limitations for number and length of visit per resident.
    - Important to note that external service providers/service partners are not considered guests of

residents and should not be limited in length or frequency of visit.

REQUIRED OUTCOME:

Pilot Tiny Homes Recovery Transitional Housing Category

Programs in the Pilot Tiny Homes Recovery Transitional Housing Category shall address the following outcome

Outcome: Purchase and install a minimum of five (5) Tiny Homes Recovery Transitional Housing Units

ADDITIONAL REQUIREMENTS FOR PROPOSALS

Applicant Agencies will be required to register with the State to gain access to the Florida Opioid Implementation and Financial Reporting System (FOIFRS). To obtain access to FOIFRS, an access request email should be sent to: HQW.SAMH.Opioid.Data.Access.Support@myflfamilies.com

See SECTION VII – DEFINITIONS for definitions of populations and key principles.

SECTION II: PROPOSAL SUBMISSION

Applicants shall submit project applications, along with required supporting materials, through the CSD NOFO submission website, located at:

https://pbcc.samis.io/go/nofo/

All documents must be submitted by the deadline date and time, per application instructions.

Late applications will not be accepted or reviewed.

Applicants must submit at least one (1) online application package to be considered for funding.

PUBLISH/RELEASE DATE

March 10, 2026, at 5:00 PM EST

DEADLINE DATE

The deadline to submit written questions to CSD-FAARFP@PBC.GOV is 12:00 PM (Noon), March 13, 2026, which is one (1) business day before the submission deadline.

Proposals submitted through the online application website must be completed and received by **12:00 PM (Noon) EST** on **March 17, 2026**. Proposals submitted after 12:00 PM. to the website will not be accepted or reviewed.

This NOFO is issued, as well as any addenda, for the BCC by CSD.

CONTACT PERSONS FOR OSF PILOT TINY HOMES RECOVERY TRANSITIONAL HOUSING NOFO:

The contact person is CSD-FAARFP@PBC.GOV.

SCHEDULE OF EVENTS/TIMELINE

FY 2026 NOFO for OSF PILOT TINY HOMES RECOVERY TRANSITIONAL HOUSING TIMELINE

DATE	ITEM	RESPONSIBLE
March 10, 2026	2026-2027 NOFO for OSF PILOT TINY HOMES RECOVERY TRANSITIONAL HOUSING is posted for release on March 10, 2026, in Advantage	CSD
March 10, 2026	FY 2026 NOFO for OSF PILOT TINY HOMES RECOVERY TRANSITIONAL HOUSING is posted on the AA NOFO Website: https://discover.pbcgov.org/communityservices/financiallyassisted/Pages/RFP.aspx	CSD
March 10, 2026	OSF PILOT TINY HOMES RECOVERY TRANSITIONAL HOUSING NOFO Release Day - Available for Public at 5:00 PM EST	CSD
March 16, 2026	Final day to submit written questions 12:00 PM (Noon) EST	Applicants
March 17, 2026	**OSF PILOT TINY HOMES TRANSITIONAL HOUSING NOFO PROPOSAL SUBMISSION DEADLINE – 12:00 (Noon) PM EST**	**Applicants**
March 17, 2026	Cone of Silence Begins for OSF PILOT TINY HOMES RECOVERY TRANSITIONAL HOUSING NOFO	CSD, Applicants, Reviewers, BCC
March 26, 2026	OSF PILOT TINY HOMES RECOVERY TRANSITIONAL HOUSING Review Panel meets to review and score proposals	CSD and Reviewers
March 26, 2026	Staff reconciles review panel scoring, and funding availability to develop recommended allocations	CSD
March 26, 2026	Staff posts scoring results on the Webpage	CSD
April 7, 2026	Final date to file a Funding Grievance	Applicants
April 15, 2026	Estimated date that the OSF PILOT TINY HOMES RECOVERY TRANSITIONAL HOUSING Contracts will be Approved	CSD
April 15, 2026	Estimated date that the Cone of Silence Ends for FY 2026 OSF PILOT TINY HOMES RECOVERY TRANSITIONAL HOUSING NOFO	CSD, Applicants, Reviewers, BCC

EXPENSE OF PROJECT APPLICATION

All expenses incurred with the preparation and submission of proposals to the County, or any work performed in connection therewith, shall be borne by applicants. No payment will be made for proposals received or for any other effort required of or made by applicants prior to commencement of work as defined by an agreement approved by the BCC.

PROJECT APPLICATIONS OPEN TO THE PUBLIC

Applicants are hereby notified that all information submitted as part of, or in support of, OSF applications will be available for public inspection in compliance with the Florida Public Records Act.

CONE OF SILENCE

This NOFO includes a Cone of Silence. The Cone of Silence will apply from the date the NOFO is due back to the department, which is **March 17, 2026**, until the final OSF contract agreements (approximately April 15, 2026) are approved by the BCC.

All parties interested in submitting a proposal are hereby advised of the following:

Lobbying - Cone of Silence

Applicants are advised that the "Palm Beach County Lobbyist Registration Ordinance" (Ordinance) is in effect. A copy of the Ordinance can be accessed at:

http://discover.pbcgov.org/legislativeaffairs/Pages/Lobbying_Regulations.aspx

Applicants shall read and familiarize themselves with all of the provisions of said Ordinance, but for convenience, the provisions relating to the Cone of Silence have been summarized here**.**

"Cone of Silence" means a prohibition on any non-written communication regarding this NOFO between any Applicant/Respondent or Applicant's/Respondent's representative and any County Commissioner or Commissioner's staff, any member of a local governing body or the member's staff, a mayor or chief executive officer that is not a member of a local governing body or the mayor or chief executive officer's staff, or any employee authorized to act on behalf of the commission or local governing body to award a contract.

An Applicant's representative shall include but not be limited to the Applicant's employee, partner, officer, director or consultant, lobbyist, or any, actual or potential subcontractor or consultant of the Applicant.

The Cone of Silence is in effect as of the submittal deadline. The provisions of this Ordinance shall not apply to oral communications at any public proceeding, including technical assistance conferences, and contract negotiations during any public meeting. The Cone of Silence shall not apply to contract negotiations between any employee and the intended awardee and any dispute resolution process following the filing of a protest. The Cone of Silence shall terminate at the time that the BCC awards or approves a contract, when all proposals are rejected, or when an action is otherwise taken that ends the solicitation process.

SECTION III: SCOPE OF SERVICES

ANTICIPATED TERMS OF SERVICE

OSF Funding Term:	April 15, 2026 – June 30, 2027
OSF Start Date:	April 15, 2026
OSF End Date:	June 30, 2027

All contracts are contingent upon annual appropriations and approval by the BCC.

TERMS AND CONDITIONS

1. **Proposal Guarantee**
   Proposer guarantees their commitment, compliance and adherence to all requirements of the NOFO by submission of their proposal.

2. **Modified Proposals**
   Proposer may save any unfinished on-line proposal and continue to modify the proposal until the proposal is submitted. Once submitted, the proposal can no longer be modified.

3. **Late Proposals, Late Modified Proposals**
   Proposals and/or modifications to proposals submitted after the deadline are late and will not be considered.

4. **Palm Beach County Office of the Inspector General Audit Requirements**
   Palm Beach County has established the Office of the Inspector General in Palm Beach County under Article XII, Section 2-422, as may be amended, to provide independent oversight of County and Municipal operations (Article XII, Section 2-423). It also has the authority to detect and prevent fraud, waste, mismanagement, misconduct, and other abuses by elected and appointed officials and employees, agencies and instrumentalities, contractors, their subcontractors and lower tier subcontractors, and other parties doing business with the county or a municipality and/or receiving county or municipal funds. Its aim is to promote economy, efficiency and effectiveness in government and conduct audits and investigations of, require production of documents from, and receive full and unrestricted access to the records.

   The Inspector General has the power to subpoena witnesses, administer oaths and inspect the activities of the agency, its officers, agents, employees, and lobbyists in order to ensure compliance with contract requirements and detect corruption and fraud. Failure to cooperate with the Inspector General or interference or impeding any investigation shall be in violation of Palm Beach County Code 2-421 through 2-440, and punished pursuant to section 125.69, Florida Statutes, in the same manner as a second-degree misdemeanor.

5. **Commencement of Work**
   The County's obligation will commence when the contract is approved by the BCC or their designee and upon written notice to the proposer. The County may set a different starting date for the contract. The County will not be responsible for any work done by the proposer, even work done in good faith, if it occurs prior to the contract start date set by the County.

6. **Non-Discrimination**
   The County is committed to assuring equal opportunity in the award of contracts and complies with all laws prohibiting discrimination. Pursuant to Palm Beach County Resolution R2025-0748, as may be amended, the proposer warrants and represents that throughout the term of any awarded agreement, including any renewals thereof, if applicable, all of its employees are treated equally during employment without regard to race, color, religion, disability, sex, age, national origin, ancestry, marital status, familial status, sexual orientation, or genetic information. Failure to meet this requirement shall be considered default of the agreement.

7. **OSF funding requires compliance with 2 CFR Part 200, State and County requirements.**

8. **Required Threshold Elements for Proposals to be accepted and scored**

All proposals must:

- Demonstrate alignment with Palm Beach County's Resilience and Recovery Ecosystem of Behavioral Health and Substance Use Disorder Care. (**See Attachment 1)**
- Demonstrate alignment with the 2024 Plan. The Behavioral Health and Substance Use Master Plan 2024
- Identify the Core Strategies and/or Approved Uses that the proposal meets and identify how funding will be allocated for each strategy or approved use.
- Agree to utilize evidence-based or evidence-informed practices with fidelity.
- Evidence of site control for the entire project site(s) in the form of a fully executed contract for purchase of the property(ies), option to purchase, long-term lease, lease option, recorded deed, or recorded certificate of title.
- Identify the current zoning and land use for the project site and identify all applicable development review processes including but not limited to: re-zoning, zoning variances, future land use changes, comprehensive plan amendments, platting, site plan approval, and building permitting. Provide estimated dates/timeframes for all submittals, reviews, hearings, and approvals, and indicate the status of project applications in all such applicable development review processes.
- A detailed development pro forma that identifies all development sources and uses of funding, and that identifies all proposed sources of County funding/subsidy. Include documentation supporting all proposed construction costs in the form of either an estimate of probable cost prepared by a tiny home manufacturer.
- Documentation evidencing availability of all sources of funding required for the non-County balance of the project development budget. Acceptable documentation includes documentation from the funding source(s) providing a firm or a conditional commitment to fund and identifying all terms and conditions.
- Applicant and/or Collaborating Partners agree to participate in research related to initiatives.
- Comply with the OSF Programmatic Requirements.
- Comply with State and County reporting requirements for OSF funds. (**See Attachment 2)**
- Comply with 2 Code of Federal Regulations (CFR) Part 200, which provides uniform administrative requirements, cost principles and audit requirements applicable to this funding source. 2 CFR Part 200 (up to date as of 1-22-2025).

9. Scoring: Maximum score is 100 points

Qualified entities are invited to submit applications to provide services to Palm Beach County residents. The Review Panel will score all proposals based on how clear the proposal is, how comprehensively it addresses the subcategory, including what was noted in terms of what the County is looking to fund, and overall, how responsive it is to the requirements that have been outlined in this NOFO. Although scoring is done individually by each panelist, part of the scoring process includes discussing amongst the panelists, each proposal's strengths, missed opportunities and overall quality.

The scoring sections are:

- Program Narrative and Implementation: maximum score 50 points
- Organizational Capacity: maximum score 25 points
- Budget: maximum score 25 points

Total Maximum Score: 100 points

The SCORE awarded to a proposal is reflective of how competitive the proposal is. (**See Attachment 4**)

10. Government and Corporate Activism

In accordance with section 287.05701, Florida Statutes, Palm Beach County and CSD, including all members of any Review Panel team, will not (1) give preference to a proposer based on the proposer's social, political, or ideological interest and (2) request any information or documentation relating to a proposer's social, political, or ideological interests.

11. Reservation of Rights – Additional Terms and Conditions

The County reserves the right, at the time of award and contract negotiation, to impose additional terms, conditions, performance requirements, reporting requirements, restrictive covenants, reverter provisions, compliance conditions, or other contractual provisions as deemed necessary to protect the County's interests and ensure compliance with State and County requirements.

Submission of a proposal constitutes acceptance of the County's right to include such additional terms in the final agreement.

12. Experiencing Unforeseen Technical Issues:

An applicant that experiences unforeseen technical issues beyond its control with the WebAuthor/SAMIS system, which prevents it from submitting its application by the deadline, must contact the CSDFAARFP@PBC.GOV to report the technical issue, Monday through Friday between the hours of 9:00 a.m. and 5:00 p.m., Eastern Time (ET) within 24 hours after the application deadline to request approval to submit its application after the deadline. The applicant's email must describe the technical difficulties, and must include a timeline of the applicant's submission efforts. Note: CSD does not automatically approve requests to submit a late application even in the event of technological difficulties. After CSD reviews the applicant's request, and verifies the reported technical issues, CSD will inform the applicant whether the request to submit a late application has been approved or denied. If CSD determines that the late application submission was due to the applicant's failure to follow all required procedures, CSD will deny the applicant's request to submit its application.

The following conditions generally are insufficient to justify late submissions:

- Failure to follow each instruction in the CSD NOFO.
- Failure to complete all required questions within the application.
- Technical issues with the applicant's computer or information technology environment, such as issues with firewalls or browser incompatibility.

SECTION IV: CONTENTS OF PROPOSAL AND INSTRUCTIONS

The NOFO Guidance as well as additional resources and information are available at:

http://discover.pbcgov.org/communityservices/financiallyassisted/Pages/RFP.aspx

http://discover.pbcgov.org/BusinessOpportunities/Pages/default.aspx

Paper copies are available upon request.

The 2026-2027 OSF PILOT TINY HOMES RECOVERY TRANSITIONAL HOUSING NOFO Application and NOFO Guidance is for reference purposes only. Proposals must be submitted through the CSD NOFO Application Submission website.

All agencies applying for OSF funds must complete and submit all items listed below.

The deadline for application package submission is **March 17, 2026, at 12:00 PM (Noon) EST**. To be considered for funding, Application Packages must be timely submitted on the CSD NOFO Application Submission Website: https://pbcc.samis.io/go/nofo/

Applications may be revised prior to final submission; however, once a proposal is submitted, it cannot be changed.

If it is not submitted, it cannot be considered.

Applications must be:

- Written in plain language in a narrative that fully addresses all questions in the 2026-2027 OSF PILOT TINY HOMES RECOVERY TRANSITIONAL HOUSING NOFO
- Aligned with this NOFO Guidance Document.
- Understandable to people unfamiliar with the agency, your programs or areas of expertise.
- Specifically addresses the funding priorities set out in this NOFO.

Please refer to this 2026 - 2027 OSF PILOT TINY HOMES RECOVERY TRANSITIONAL HOUSING NOFO Guidance for further description or definitions.

OSF Review Panel meetings, during which the Panel will review and score all applications, are open to the public and scheduled as follows:

End times for the Review Panel meetings will be dependent on the number of applications received. Please check the CSD website for any changes to the meeting location. Please note that although a Webex link is provided, reviewers are expected to be physically present at 810 Datura Street, in either the Basement Conference Room or the Second Floor Human Services Conference Room. Members of the public are encouraged to attend in person as well. There will be no time set aside for Public Comment at the proposal review sessions; however, members of the public are welcome to hear the review teams discuss the proposals.

OSF Review Panel Scoring Public Meetings

March 26, 2026, at 10:00 AM.
CSD's Basement Conference Room and Virtual

View the FAA Website for the Virtual Meeting link: https://discover.pbcgov.org/communityservices/financiallyassisted/pages/rfp.aspx

Members of the public who plan to attend the meeting in person are asked to please notify CSD as soon as possible at CSD-FAARFP@PBC.GOV.

Communication Media Technology (CMT) may be accessed at the following location: 810 Datura Street, West Palm Beach, FL 33401, Basement Conference Room.

People wishing to attend in person may do so at 810 Datura Street, West Palm Beach FL 33401, Basement Conference Room.

Anyone interested in additional information may contact CSD by mail at 810 Datura Street, West Palm Beach, FL 33401 (ATTN: OSF NOFO), or by email at CSD-FAARFP@PBC.GOV.

Also, those wishing to make public comments may contact CSD by sending your comments via traditional mail to CSD at 810 Datura Street, West Palm Beach, FL 33401 (ATTN: OSF NOFO), or email at CSD-FAARFP@PBC.GOV.

Public participation is solicited without regard to race, color, national origin, age, sex, religion, disability or family status.

In accordance with the Americans with Disabilities Act (ADA), persons with disabilities requiring accommodations in order to participate in this public meeting can contact CSD-FAARFP@PBC.GOV or call (561) 355-4230 no later than three (3) business days prior to such meeting.

Individuals who require special accommodations under the ADA or persons who require translation services for a meeting (free of charge), please call (561) 355-4230 or email CSD-FAARFP@PBC.GOV at least five business days in advance. Hearing impaired individuals are requested to telephone the Florida Relay System at #711.

2026 – 2027 OSF PILOT TINY HOMES RECOVERY TRANSITIONAL HOUSING NOFO APPLICATION COMPONENTS

****START A NEW APPLICATION – DO NOT USE AN OLD ONE****

Proposal

Federal ID Agency Name
Doing Business As (DBA)
Please indicate name(s) by which agency is known or does business.
Address City State
Zip Code NOFO/RFP
Additional Editors Program Name

OSF Application Required 2026 - 2027 OSF PILOT TINY HOMES RECOVERY TRANSITIONAL HOUSING NOFO Cover Sheet

Click to download the REQUIRED 2026 – 2027 OSF PILOT TINY HOMES RECOVERY TRANSITIONAL HOUSING NOFO **Cover Sheet Template.** See **Attachment 5**.
Please upload once you have completed the form.

Please upload your document in the same format as the template: **.doc** OR **.docx** OR **.pdf**
Please name your document as such: ***(Agency Name or Initials)*****CoversheetFY26**

NOFO Information Document
Click to download the **2026 – 2027 OSF PILOT TINY HOMES RECOVERY TRANSITIONAL HOUSING NOFO Guidance** document for reference throughout the application.

General Contact Information

CEO/Executive Director Name and Title CEO/Executive Director Email
Agency Contract Person Name and Title Agency Contract Person Phone
Agency Contract Person Email

Total Funding Amount Requested
Please enter total funding amount that you are requesting.

Total Number of Tiny Home Recovery Transitional Housing Units
Please enter total number of Tiny Homes Recovery Transitional Housing Units expected to purchase with the funding requested.

Internal Control Questionnaire
Click to download the REQUIRED **Internal Control Questionnaire**. Please upload once you have completed the form. (**See Attachment 6**)

Please upload your document in the same format as the template: **.doc** OR **.docx**
Please name your document as such: ***(Agency Name or Initials)*****InternalControl**

Policies and Procedures
Please upload your agency's policies and procedures.

Please upload your document in the same format as the template: **.doc** OR **.docx**
Please name your document as such: ***(Agency Name or Initials)*****Policies**

2026 - 2027 OSF PILOT TINY HOMES RECOVERY TRANSITIONAL HOUSING NOFO

1. Category
Tiny Homes Recovery Transitional Housing Units

2. Focus Population(s) to be served by the purchase of Tiny Homes for Recovery Transitional Housing units
Focus population is adults ages 18 and over who are in recovery and who are experiencing housing instability.
Select All that Apply:

3. Use of Funding
Is this funding being used for the following?
a. Match Funding to state or federal funding
b. Other Funding Source (Explain) **(1,000 Characters)**

4. OSF State Core Strategies/Approved Uses
Indicate which core strategy your proposal is aligned with using the document.
(**Attachment 7**)

Download the REQUIRED Opioid Settlement Funding Agreement Information Template. (**See Attachment 7**).
Please upload once you have completed the form.
Please upload your document in the same format as the template: **.doc** OR **.docx**
Please name your document as such: (Agency Name or Initials)**CoreStrategiesFY26**

Program Implementation and Design (50 Points)

Overarching Principles
Please respond to the following questions. Consider the overarching principles and the category descriptions, including what the County is seeking, that were in this NOFO Guidance Document and the area of focus the

proposal seeks to address.

5. Geographic Location (3,000 Characters)
Will your program focus on specific geographic locations within Palm Beach County? If so, specify location (i.e., town, zip codes (if known), community, neighborhood). Briefly describe why this location is your focus for the proposal.

Program Narrative

6. Description of the Proposed Program (10,000 Characters)
Describe the proposed program and your history of providing the proposed services (including collaborating partner's history of providing the proposed services as applicable).

Collaborations and Partnerships

7. Collaborations and Partnerships (6,000 Characters)
If your proposal involves collaborating or partnering with other organizations to implement the proposed project, please identify the organizations with which Applicant's organization will collaborate or partner (i.e. Fiscal Agent). Attach a current copy of the Agreement or MOU/MOA.

Describe roles and responsibilities of the collaboration or partnership to implement the proposed project if funded.

Please upload your document in the same format as the template: **.pdf**
Please name your document as such: ***(Agency Name or Initials)*****COLLABORATION** or ***(Agency Name or Initials)*****PARTNERSHIP** or ***(Agency Name or Initials)*****MOU/MOA**, as applicable.

8. Program Barriers (6,000 Characters)
Describe any barriers you anticipate in implementing your proposal. Describe your plan to address these barriers or other anticipated challenges. State if no barriers or challenges are anticipated.

Organizational Capacity (25 Points)

9. Applicants' Experience Providing the Proposed Program and Key Personnel (10,000 Characters)
Describe your experience developing/implementing shelter, transitional, recovery, or other recovery related housing programs. Describe the roles and responsibilities of key program personnel. Include whether these personnel are on staff or will need to be hired for these key positions. Additionally, if applicable, identify and describe the roles and responsibilities your project partners play.

10. Population Expertise (4,000 Characters)
Explain why your organization and your project partners, if applicable, are the appropriate entities to address the needs for the population you propose to serve.

11. Monitoring (5,000 Characters)
Discuss any findings from prior program monitoring. Identify any findings that were made, program response to findings, and how they were addressed.

12. Nonprofit First Certification (Not Required and Not Scored)
Is Agency accredited by Nonprofits First or another Accreditation body?
Select: Yes or No

13. Accreditation and Certification (Not Required and Not Scored)

Please upload your Nonprofit First Accreditation Certificate or other Accreditation from an established accreditation entity.

a. Please upload your document in the same format as the template: .**pdf**
b. Please name your document as such: ***(Agency Name or Initials)*** **Certifications**

14. Describe your Project's Site Control/Plan (5,000) characters)
In the form of a fully executed contract for purchase of the property(ies), or option to purchase, long-term lease, lease option, recorded deed, or recorded certificate of title.

Upload your Project's Site Control/Plan documentation:

a) Please submit Project's Site Plan in one of the following formats: **PDF,** OR **Word**
b) Please name your Project's Site Plan as such: ***(Agency Name or Initials) Site Plan_*****2026-2027**

15. Describe your Project's Compliance with applicable Zoning and Land use regulations, South Florida Building Code, ADA, Development Review Process and Timeline. (10.000 characters).
Include the current zoning and land use for the project site and identify all applicable development review processes including but not limited to: re-zoning, zoning variances, future land use changes, comprehensive plan amendments, platting, site plan approval, and building permitting. Provide estimated dates/timeframes for all submittals, reviews, hearings, and approvals, and indicate the status of project applications in all such applicable development review processes.

Upload your Project Zoning/Land Use regulations
a) Please submit Project's Zoning compliance documentation in one of the following formats: **PDF,** OR **Word**
b) Please name your Project's Zoning compliance documentation as such: ***(Agency Name or Initials) Zoning Compliance_*****2026-2027**

Sustainability

16. Program Sustainability (5,000 Characters)
Describe how your organization will continue to address this need or solve this problem when the OSF funding period ends.

Budget (25 Points)

17. FY 2026 Proposed Program Budget

a. Complete proposed program budget using the template provided in the online application. Review the "sample" and "guidelines" tabs provided before completing the template. Ensure the requested fund justifications are complete.
b. Ensure OSF administration expenses are limited to 5%. The Budget Justification must be thoroughly completed. (Please describe in the narrative section, in detail, each of the line items requested in the budget. Employee positions should include brief descriptions of their duties in the program. If an employee's salary or a portion thereof is being charged to the budget for your proposal, include the time-keeping mechanisms that will be utilized to ensure that OSF funds are exclusively being utilized to support the proposal. If you are charging an indirect/administrative cost rate, then you must remove any other line items related to indirect/administrative expenses.

c. Complete and upload the detailed Pro Forma identifies all development sources and uses of funding, and that identifies all proposed sources of County funding/subsidy. Include documentation supporting all proposed construction costs in the form of either an estimate of probable cost prepared by a licensed architect or by written price estimates from at least two (2) tiny home manufacturers.

Click to download the REQUIRED **2026 - 2027 Budget Worksheet Template**. (**See Attachment 8**) Please upload once you have completed the form.

a) Please submit budget in one of the following formats: **.xls** OR **.xlsx**
b) Please name your budget as such: ***(Agency Name or Initials)*** **Budget_2026-2027**
c) Please submit project pro forma in one of the following formats: **.xsls, PDF,** OR **Word**
d) Please name your pro forma as such: ***(Agency Name or Initials) Pro Forma*****_2026-2027**

18. Total Agency Budget
The Total Agency Budget must be attached to the proposal. The Budget forms that are part of the proposal do not need to be utilized for this budget as it can be in any form, but it should include all agency funding sources as well as expenditures by program.

a. Please submit Total Agency Budget in one of the following formats: **.pdf** OR **.xls** OR **.xlsx**
b. Please name your Total Agency Budget as such: ***(Agency Name or Initials)*** **TAB_2026-2027**

19. Audit Report (Fiscal)
Submit most recent audit report. If there were findings, describe corrective actions and whether such corrective actions successfully resolved the findings.

a. Please submit Audit Report in the following format: **.pdf**
b. Please name your Audit Report as such: ***(Agency Name or Initials)*** **Audit_FY*****(Year of most recent audit)*****.pdf**

20. Audit Report Corrective Actions Explanation (5000 Characters)
Please provide any Audit Report Corrective Actions Explanation, if applicable.

21. Year End Financials
Submit Year-End Financial Statements. If not submitted explain why.

a. Please submit Year-End Financial Statements in the following format: **.pdf**
b. Please name your Year-End Financial Statements as such: ***(Agency Name or Initials)*** **YEFS_FY20____**

22. IRS Form 990
Submit IRS Form 990. If not submitted explain why.

a. Please submit IRS Form 990 in the following format: **.pdf**
b. Please name your IRS Form 990 as such: ***(Agency Name or Initials)*** **IRS990_FY24**

23. YEFA/IRS 990 Explanation (1,000 Characters)
Please provide any Year End Financials/IRS Form 990 explanation, if applicable.

24. Unit Cost (4,000 Characters)
Submit proposed Unit Cost service description and unit cost of service rate. (Is this an industry standard? If so, please state source)

Ensure both the unit cost service description and cost rate are clear and accurately calculated. Formulas used to arrive at the cost rate must be included.

If using Actual Cost reimbursement, provide a description of how you will document the expenses.

25. OSF Funding
Is OSF funding being used to replace another funding source?
Select: Yes or No

If yes, please explain and identify the other funding source that OSF is replacing.

Scope of Work (No Points)

This section will be used to develop your contract agreement if your program is funded. These items will be monitored by contract monitors.

26. Scope of Work (SOW) Template

Click to download the REQUIRED **2026 - 2027 Scope of Work Template**. (**See Attachment 9)**
Please upload once you have completely filled it out.

- **a.** Please submit SOW in one of the following formats: **.doc** OR **.docx (Please do not submit as a pdf).**
- **b.** Please name your SOW as such: ***(Agency Name or Initials)*** **SOW2026-2027**

27. Unit of Service Rate and Definition (USRD) Template
Click to download the REQUIRED **2026-2027** Unit of Service Rate and Definition **Template**. (**See Attachment 13)**

Please upload once you have completely filled it out.

- **a.** Please submit Unit of Services Rate and Definition the following formats: .doc OR .docx (**DO NOT** submit in PDF format)
- **b.** Please name your Unit of Services Rate such: (Agency Name or Initials)Unit Rate FY26

SECTION V: APPLICATION REVIEW PROCESS

The application review process is welcoming to persons with disabilities, persons who have experienced Behavioral Health, Substance Use or Co-Occurring disorders, and persons with limited English proficiency. If you need any accommodations, please contact CSD-FAARFP@PBC.GOV.

- CSD shall recruit OSF Review Panel members.
- Review Panel members shall be trained, as appropriate, and receive submitted applications.
- Applications for OSF funding shall be reviewed, discussed, and scored by the Review Panel.
- Funding recommendations will be posted to the CSD website once all proposals are scored.
- Applicant(s) have seven (7) business days following the posting of funding recommendations to file a grievance notice.

- Funding recommendations are submitted to the BCC for final approval.
- Contract agreements, based on the funding recommendations, are submitted to the BCC for final approval.

SECTION VI: GRIEVANCE NOTICE FORM

2026-2027 OSF Pilot Tiny Homes Recovery Transitional Housing NOFO
Grievance Notice Form
Palm Beach County Community Services Department

Grievances may be filed by an entity submitting a NOFO (Proposer) that is aggrieved in connection with deviations from the established PROCESS for reviewing proposals and making recommended awards. The amount of recommended awards may not be grieved through this procedure.

If you wish to file a grievance with the Palm Beach County Community Services Department, this Grievance Notice Form must be completed, submitted, and received by the Director of the Community Services Department within seven (7) business days of posted funding recommendations. You will receive a written response within fifteen (15) business days of the receipt of this form by the Director of the Community Services Department. There is no administrative fee associated with filing this grievance.

When completed, submit this Grievance Notice Form via mail or email to:

Dr. James Green, Director Community Services Department
810 Datura Street, First Floor, West Palm Beach, Florida 33401
JGreen1@pbc.gov

Entity Filing Grievance: _____

Which process was allegedly deviated from? _____

Describe in detail the alleged deviation; include how you were directly affected and what remedy you seek (add additional pages as needed):

_____

_____

_____

What remedy does the applicant seek?

_____

_____

_____

_____	_____
Authorized Agency Representative Name and Title	Agency Filing Grievance
_____	_____
Authorized Agency Representative Signature	Date

SECTION VII: DEFINITIONS

Adults – Individual(s) 18 years of age and over.

Care Coordination - Care coordination involves deliberately organizing individual care activities and sharing information among all of the service providers concerned with an individual's care to achieve safer and more effective care. This means that the individual's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the individual.[1]

Ensure services are delivered using trauma-informed, recovery-oriented, and culturally responsive practices.

No Wrong Door – "No Wrong Door" in the context of substance use, behavioral health and co-occurring disorders systems refers to a service delivery approach where individuals seeking help can access appropriate services regardless of where they enter the system. The system is designed to be person-centered, focusing on the needs of the individual rather than the capabilities or constraints of a service provider. It aims to reduce barriers to services by ensuring that the burden of navigating complex systems does not fall on the individual seeking help. Also, it aligns with broader public health strategies that advocate for comprehensive, integrated care models.

Prefabricated Tiny Home – A prefabricated (prefab) tiny home is a compact, factory-built dwelling—typically under 400 square feet—constructed off-site in sections or as a complete unit, then transported and installed on a foundation or trailer. These homes emphasize efficiency, sustainability, and faster, more affordable construction compared to traditional site-built home. The Tiny Home Recovery Transitional Housing unit must accommodate a minimum of two (2) participants.

Pro-Forma - is a forward-looking financial model that estimates a project's costs, revenues, and profitability, typically used in real estate and development to evaluate feasibility. It serves as a "what-if" analysis tool, forecasting net operating income (NOI), cash flow, and return on investment (ROI) based on assumptions like occupancy, rental rates, and expenses.

Supportive & Treatment Services - Provide or coordinate the delivery of wraparound services, including but not limited to:

- Behavioral health and substance use disorder treatment
- Case management and care coordination
- Primary care coordination
- Benefits enrollment (e.g., Medicaid, SSI/SSDI, SNAP)
- Employment and workforce linkage
- Life skills development and tenancy readiness
- Permanent housing navigation and placement.

SITE Plan – A site plan (or plot plan) is a detailed, top-down, scaled drawing showing a property's boundaries, existing structures, and proposed improvements. It serves as a comprehensive map for construction, landscaping, and permitting, detailing features like buildings, driveways, utilities, and setbacks. It is crucial for planning and municipal approval.

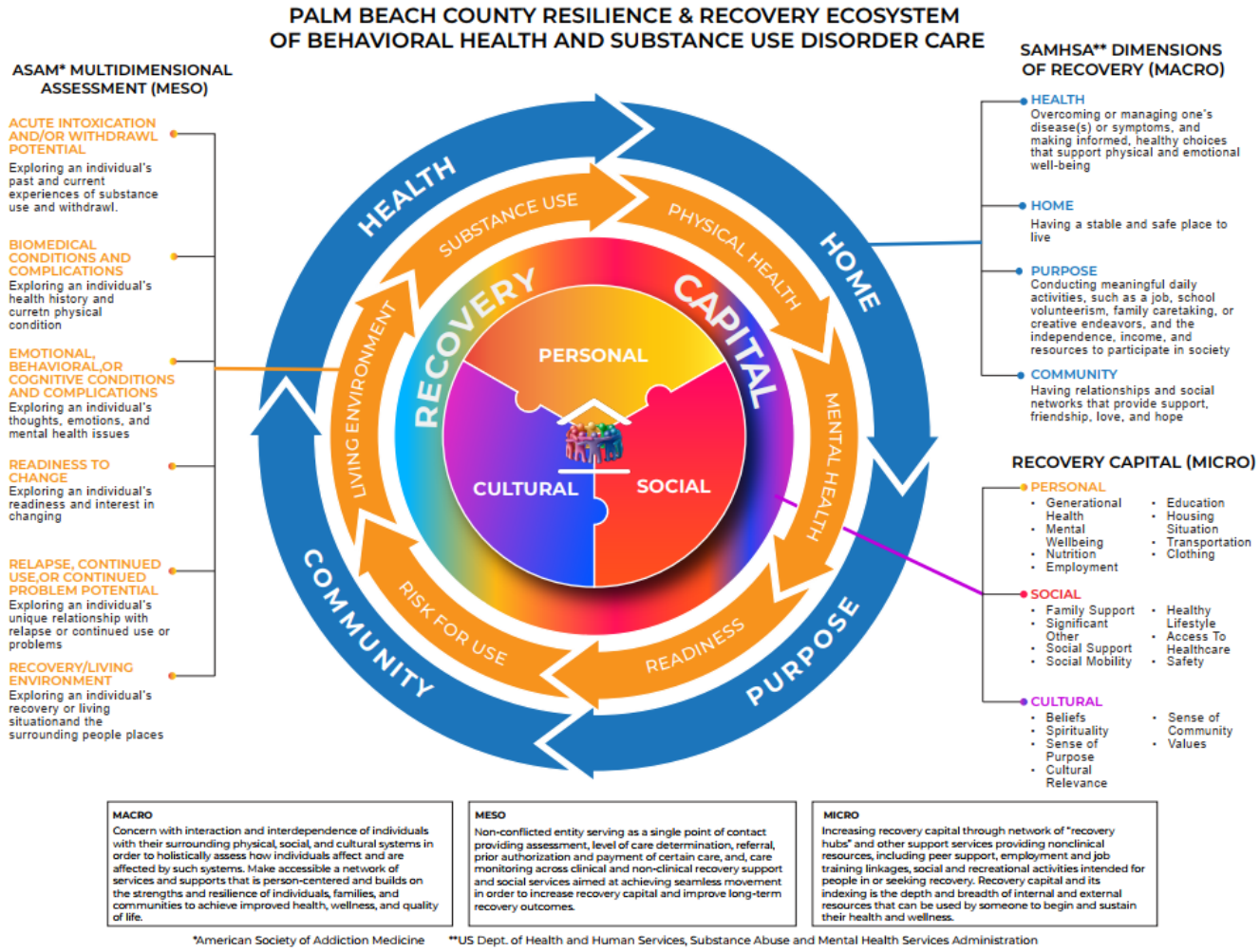
Trauma Informed Care (TIC) Model – An approach that recognizes the widespread impact of trauma and

[1] Internet Citation: Care Coordination. Content last reviewed November 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/ncepcr/care/coordination.html

understands potential paths for recovery, recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system, responds by fully integrating knowledge about trauma into policies, procedures, and practices and seeks to actively resist re-traumatization. TIC models generally include a focus on the following: Safety; Trustworthiness and Transparency; Peer Support; Collaboration and Mutuality; Empowerment; Voice and Choice; and Cultural, Historical, and Gender Issues.

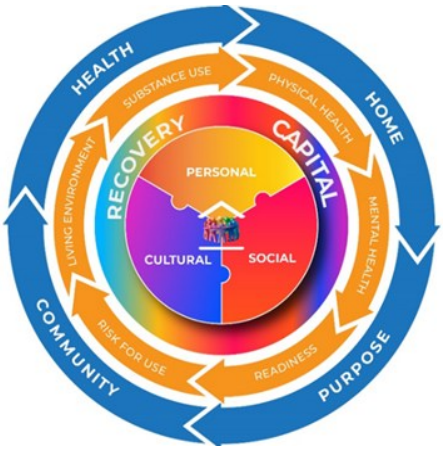
Warm Hand-off – A warm hand-off is more than the provision of information or referrals – it is compassionate and non-coercive accompaniment to an appropriate care provider. It is a form of referral to treatment or other services. A transfer of care through face-to-face, phone or video interaction in the presence of the person being helped.

ATTACHMENT 1: PALM BEACH COUNTY RESILIENCE & RECOVERY ECOSYSTEM



The ecosystem, at the Macro level, is concerned with interaction and interdependence of individuals with their surrounding physical, social, and cultural systems to holistically assess how individuals affect and are affected by such systems. It makes accessible a network of services and supports that are person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve improved health, wellness, and quality of life. (**See Attachment 1** https://discover.pbcgov.org/communityservices/financiallyassisted/Pages/RFP.aspx)

Resilience and Recovery Ecosystem of Behavioral Health and Substance Use Disorder Care



The Meso level provides a non-conflicted entity serving as a single point of contact providing assessment, level of care determination, referral, prior authorization and payment of certain care, and care monitoring across clinical and non-clinical recovery support and social services aimed at achieving seamless movement in order to increase recovery capital and improve long-term recovery outcomes.

The Micro level aims to increase an individual's resilience and recovery capital through a network of "Recovery Hubs" and other support services providing nonclinical resources, including peer support, employment and job training linkages, social and recreational activities intended for people in or seeking recovery.

SAMHSA indicates resilience is a key component to a system of care. In an extensive literature review published in *Child and Adolescent Psychiatry*, resilience is defined as "a multi-systemic dynamic process of successful adaption or recovery in the context of risk or a threat." One of the conclusions from this study is that resilience is unanimously negatively associated with depression, anxiety and trauma symptoms in youth, and is therefore meaningful for screening purposes in at-risk populations/situations.

As such, higher levels of resilience offer better mental health and health outcomes. This is true, not only in adolescents' and children's populations, but in the adult population as well. Thus, foundationally, increasing resilience across populations is a major aim.

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ATTACHMENT 2: STATE AND COUNTY OSF REPORTING AND RETENTION REQUIREMENTS

- State and local governments shall follow their existing reporting and records retention requirements along with considering any additional recommendations from the Opioid Abatement Taskforce or Council.
- State and Local Governments shall ensure that any provider or sub-recipient of Opioid Funds at a minimum does the following:
    - Any provider shall establish and maintain books, records and documents (including electronic storage media) sufficient to reflect all income and expenditures of Opioid Funds.
    - Any provider shall retain and maintain all client records, financial records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to the use of the Opioid Funds during the term of its receipt of Opioid Funds and retained for a period of six (6) years after it ceases to receive Opioid Funds or longer when required by law. In the event an audit is required by the State or Local Government, records shall be retained for a minimum period of six (6) years after the audit report is issued or until resolution of any audit findings or litigation based on the terms of any award or contract.
    - At all reasonable times for as long as records are maintained, persons duly authorized by State or Local Government auditors shall be allowed full access to and the right to examine any of the contracts and related records and documents, regardless of the form in which kept.
    - A financial and compliance audit shall be performed annually and provided to the State (refer to: F.S. 215.97 Florida Single Audit Act).
    - All providers shall comply and cooperate immediately with any inspection reviews, investigations, or audits deemed necessary by The Office of the Inspector General (section 20.055, F.S.) or the State.
    - No record may be withheld nor may any provider attempt to limit the scope of any of the foregoing inspections, reviews, copying, transfers or audits based on any claim that any record is exempt from public inspection or is confidential, proprietary or trade secret in nature; provided, however, that this provision does not limit any exemption to public inspection or copying to any such record.

Additionally, Opioid Settlement specific reporting and accountability.

- Reporting on expenditures for the previous fiscal year are to be reported to the Department of Children and Families (DCF) by no later than August 31st.
- Reporting to DCF is due by July 1st of each year on how Opioid Funds will be expended in the upcoming fiscal year.

  The State Taskforce or Council will set other data sets that need to be reported to DCF to demonstrate effectiveness of expenditures on Approved Purposes.
- DCF has established a statewide Opioid Implementation and Financial Reporting System ("Florida Opioid Implementation and Financial Reporting System" (FOIFRS) to which providers may request access for the purpose of submitting implementation plans and financial reports.

For additional information, please see: https://www.dropbox.com/scl/fi/63tkre5ewz4t6eedkuocl/FL-Opioids-Allocation-SW-Resp-Agreement-with-

Exhibits.pdf?rlkey=u15tc1iddeczhlfdxaq1j2kjg&e=1&st=8qwdchlx&dl=0

Access to the Opioid Data Management System.

Please find the link below to the Smartsheet request access form. Additionally, there are few important points to keep in mind:

- **DCF-SAMH Office of Opioid Recovery User Access Request Form** [app.smartsheet.com]
- Each person needing access should complete the Smartsheet form.
- First-time requestors should select **"Add New User"** in the Action Requested box dropdown.
- Ensure that the checkbox for **"Check here when you are ready to proceed with the rest of the form"** is selected, as it will reveal the remaining questions.
- The CF112 **Confidentiality Nondisclosure Agreement link is provided within the form.** If you've completed this agreement and the DCF Security Awareness Certificate within the past 365 days, you may attach the same documentation.
- If you need to complete the DCF Security Awareness training video, our team will set you up in the My FL Learn training portal, and you will receive a separate email with setup instructions.

Please allow at least 72 business hours to receive your invitation to activate your account. We recommend bookmarking the link for easy access later. Should you have any questions or require further assistance, please feel free to reach out.

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Attachment 3 OSF Standard Template (Placeholder)

ATTACHMENT 4: NOFO SCORING GUIDE

FY 2026 OSF NOFO

Program Implementation and Design Questions (50 Points)				
	Criteria	**0-16 points**	**17-35 points**	**36-50 points**
5. Geographic location	Clarity (location(s) and rational for selecting the location(s))	The geographic location(s) is vague, missing details, or unclear why the location(s) were chosen	The geographic location(s) is mostly clear, covers the main locations, but lacks detail	The geographic location(s) is detailed, clear, and fully explains all key rational for selecting the location(s)
6. Description of the proposed program	Clarity, completeness, relevance	The proposal is vague, missing key components, or unclear	The proposal is mostly clear, covers the main components, but lacks detail	The proposal is detailed, clear, and fully explains all key components of the program
7. Collaborations/Partnerships	Clarity of partners, roles, and responsibilities; documentation completeness	Partners unclear, roles poorly defined, and no MOA/MOU or MOU/MOA are not connected to the proposal to make an impact. It does not clearly state the joint planning and mentoring throughout the process of preparation and through implementation. The MOU/MOA does not provide a clear role and responsibility delineation and does not provide appropriate financial remuneration to the smaller non-profit, grass-roots organization. /MOA attached or	Partners identified with partial role clarification and MOU or MOA is somewhat connected to the proposal to make an impact. It somewhat clearly states the joint planning and mentoring throughout the process of preparation and through implementation. The MOU/MOA provides a clear role and responsibility delineation and somewhat provides appropriate financial remuneration to the smaller non-profit, grass-roots organization.	Partners clearly identified, roles/responsibilities well-defined. MOU or MOA is directly connected to the proposal to make an impact and starts at the beginning of the proposal's planning and development process. It also includes joint planning and mentoring throughout the process of preparation and through implementation. The MOUMOA provides clear role and responsibility delineation and provides appropriate financial remuneration to the smaller non-profit, grass-roots organization.
8. Program Barriers	Realism, completeness, and clarity of mitigation	Barriers unaddressed or a mitigation plan missing	Some barriers were identified with the partial mitigation plan.	Barriers were clearly identified, and mitigation

	strategies		The plan seems reasonable, with strategies not clearly developed, and the feasibility is questionable.	strategies are well-developed, realistic, and feasible.

Organizational Capacity (25 Points)				
	Criteria	**0-8points**	**9-17 points**	**18-25 points**
9. Project Experience Description and Key Personnel	Clarity, completeness, identification of staffing needs, and inclusion of partners	Roles unclear or missing, staffing needs not addressed	Roles are mostly described, with partial clarity on staffing and partners	Roles are clearly described, staffing needs are addressed, partner roles are included, and well-defined
10. Population Expertise	Relevance, expertise, capacity to serve population	Organization/partners not clearly qualified or appropriate	Organization/partners partially appropriate, limited explanation	Organization/partners clearly appropriate, demonstrated expertise and capacity to serve population
11. Monitoring	Identification of findings, responses, and resolution	Findings not described or not addressed	Findings are partially described with a limited response	Findings clearly identified, responses well-articulated, and resolution demonstrated
14. Project Site Plan Description	Detailed and comprehensive description of the site plan including layout, structures, infrastructure, parking, utilities, accessibility, and overall project design demonstrating strong feasibility.	Vague or incomplete site plan description; key project elements unclear.	Basic site plan description provided but lacking important details about layout or infrastructure.	Clear description of site plan with most major elements identified; minor details may be missing.
14. Property Control Documentation	Fully executed and valid documentation demonstrating site control (recorded deed, purchase contract, option agreement, or long-term lease).	Partial documentation provided; site control uncertain.	Documentation provided but not fully executed or lacking clarity regarding control of the property.	Documentation provided demonstrating site control with minor details missing.
15. Zoning and Land Use	Clearly identifies zoning and	Minimal information	Zoning or land use referenced but	Identifies zoning and land

Compliance	future land use designation and thoroughly explains how the project complies with applicable regulations.	regarding zoning or land use compliance.	explanation of compliance is limited.	use designation with clear explanation of compliance.
15. Development Review Process and Timeline	Identifies all required development review processes (e.g., rezoning, variances, site plan approval, permitting) and provides realistic timelines and application status.	Limited understanding of required approvals; timelines missing.	Some processes identified but timeline or application status unclear.	Most review processes identified with general timeline information.
16. Program sustainability	Clarity, feasibility, long-term planning	Sustainability plan unclear or missing	Sustainability plan partially described	Clear, feasible, and detailed plan for sustaining the program beyond funding period
Budget (25 Points)				
	Criteria	**0-5 Points**	**6-10 Points**	**11-15 Points**
17. 2026 – 2027 Proposed Program Budget	Completeness, accuracy, justification, adherence to OSF guidelines	Budget incomplete, unclear, or non-compliant	Budget mostly complete, partial justification, minor guideline issues	Budget complete, accurate, fully justified, and fully compliant with OSF guidelines
18. Total Agency Budget	Completeness and inclusion of all funding sources	Budget missing or incomplete	Budget mostly complete, minor omissions	Comprehensive budget including all agency funding sources and expenditures
19. Audit Report (Fiscal)	Submission, clarity, explanation of findings	Audit not submitted or findings unexplained	Audit submitted with partial explanation of findings	Audit submitted, findings addressed, corrective actions clearly explained
20. Audit Report Corrective Actions Explanation	Completeness, clarity, effectiveness	Explanation missing or unclear	Partial explanation provided	Clear, thorough explanation of corrective actions and effectiveness
21. Year-End Financials	Submission, format, explanation	Not submitted or unclear	Submitted with partial explanation	Submitted in the correct format with clear explanation
22. IRS Form 990	Submission and explanation	Not submitted or unclear	Submitted with partial explanation	Submitted with clear explanation if applicable

23. YEFA/IRS 990 Explanation	Clarity and relevance	Missing or unclear	Partially explained	Clear and complete explanation provided
24. Unit Cost	Accuracy, clarity, industry standard, methodology	Unclear, inaccurate, or missing methodology	Partially clear and justified	Accurate, clearly calculated, methodology explained, industry standards cited if applicable
25. OSF Funding	Explanation, clarity	Not explained or unclear	Partially explained	Clear, complete explanation if OSF funding replaces another source
26. Scope of Work	Not Scored	N/A	N/A	N/A
27. Unit of Service Rate and Definition	Not Scored	N/A	N/A	N/A

ATTACHMENT 5: REQUIRED COVER SHEET

REQUIRED COVER SHEET

PALM BEACH COUNTY DEPARTMENT OF COMMUNITY SERVICES OPIOID SETTLEMENT FUNDS 2026-2027

PLEASE RESPOND TO *ALL* QUESTIONS LISTED BELOW:

(NOTE: This form is formatted using MS Word, Times New Roman, and 10pt font)

QUESTIONS:	AGENCY RESPONSES:
NAME OF AGENCY:	
SERVICE CATEGORY (identify the service category for which the proposal is being submitted):	
PROGRAM TITLE:	
PRIORITY POPULATION (include the unduplicated number to be served annually)**:**	
GEOGRAPHIC AREA TO BE SERVED:	
COMMISSION DISTRICT(S) TO BE SERVED:	
PROGRAM STATUS (expanded or new program):	
PROGRAM START DATE (if new program):	
TOTAL PROGRAM BUDGET:	$
AMOUNT OF FUNDING REQUEST (how much you are requesting in the proposal):	$
UNIT COST SERVICE DESCRIPTION:	
UNIT COST OF SERVICE:	
IDENTIFY IF AGENCY IS CURRENTLY ACCREDITED BY NONPROFITS FIRST: (Yes or No)	
OVERVIEW (3 sentence overview of the program – this must be short and concise and will be used to communicate the purpose of programs and services to the Board of County Commissioners and various publications):	

SPECIAL NOTICE:

Contracted agencies must comply with the current Health Insurance Portability and Accountability Act (HIPAA). If your agency does not provide services that fall under HIPAA Privacy Rules, please state that in the above overview.

ATTACHMENT 6: INTERNAL CONTROL QUESTIONNAIRE

GENERAL			
The following questions relate to the internal accounting controls of the overall organization.	**Yes**	**No**	**N/A**
1. Are the duties for key employees of the organization defined?			
2. Is there an organization chart that sets forth the actual lines of responsibility?			
3. Are written procedures maintained covering the recording of transactions?			
a. Covering an accounting manual?			
b. Covering a chart of accounts?			
4. Do the procedures, chart of accounts, etc., provide for identifying receipts and expenditures of program funds separately for each grant?			
5. Does the accounting system provide for accumulating and recording expenditures by grant and cost category shown in the approved budget?			
6. Does the organization maintain a policy manual covering the following:			
a. Approval authority for financial transactions?			
b. Guidelines for controlling expenditures, such as purchasing requirements and travel authorizations?			
7. Are there procedures governing the maintenance of accounting records?			
a. Are subsidiary records for accounts payable, accounts receivable, etc., balanced with control accounts on a monthly basis?			
b. Are journal entries approved, explained and supported?			
c. Do accrual accounts provide adequate control over income and expense?			
d. Are accounting records and valuables secured in limited access areas?			
8. Are duties separated so that no one individual has complete authority over an entire financial transaction?			
9. Does the organization use an operating budget to control funds by activity?			
10. Are there controls to prevent expenditure of funds in excess of approved, budgeted amounts? For example, are purchase requisitions reviewed against remaining amount in budget category?			
11. Has any aspect of the organization's activities been audited within the past 2 years by another governmental agency or independent public accountant?			
12. Has the organization obtained fidelity bond coverage for responsible officials?			
13. Has the organization obtained fidelity bond coverage in the amounts required by statutes or organization policy?			
14. Are grant financial reports prepared for required accounting periods within the time imposed by the grantors?			
15. Does the organization have an indirect cost allocation plan or a negotiated indirect cost rate?			

CASH RECEIPTS	YES	NO	N/A
1. Does the organization have subgrant agreements which provide for advance payments and/or reimbursement of cost?			
2. If advance payments have been made to the organization:			
a. Are funds maintained in a bank with sufficient federal deposit insurance?			
b. Is there an understanding of the terms of the advance (i.e. to be used before costs can be submitted for reimbursement)?			

PURCHASING, RECEIVING, AND ACCOUNTS PAYABLE	YES	NO	N/A
The following conditions are indicative of satisfactory control over purchasing, receiving, and accounts payable.			
1. Prenumbered purchase orders are used for all items of cost and expense.			
2. There are procedures to ensure procurement at competitive prices.			
3. Receiving reports are used to control the receipt of merchandise.			
4. There is effective review by a responsible official following prescribed procedures for program coding, pricing, and extending vendors' invoices.			
5. Invoices are matched with purchase orders and receiving reports.			
6. Costs are reviewed for charges to direct and indirect cost centers in accordance with applicable grant agreements and applicable Federal Management circulars pertaining to cost principles.			
7. When accrual accounting is required, the organization has adequate controls such as checklists for statement closing procedures to ensure that open invoices and un-invoiced amounts for goods and services received are properly accrued or recorded in the books or controlled through worksheet entries.			
8. There is adequate segregation of duties in that different individuals are responsible for (a) purchase (b) receipt of merchandise or services, and (c) voucher approval.			

PURCHASING	YES	NO	N/A
1. Is the purchasing function separate from accounting and receiving?			
2. Does the organization obtain competitive bids for items, such as rental or service agreements, over specified amounts?			
3. Is the purchasing agent required to obtain additional approval on purchase orders above a stated amount?			
4. Are there procedures to obtain the best possible price for items not subject to competitive bidding requirements, such as approved vendor lists and supply item catalogs?			
5. Are purchase orders required for purchasing all equipment and services?			
6. Are purchase orders controlled and accounted for by prenumbering and keeping a logbook?			
7. Are the organization's normal policies, such as competitive bid requirements, the same as grant agreements and related regulations?			
8. Is the purchasing department required to maintain control over items or dollar amounts requiring the ADECA to give advance approval?			

9. Under the terms of 2 CFR 200, certain costs and expenditures incurred by units of State and local governments are allowable only upon specific prior approval of the grantor Federal agency. The grantee organization should have established policies and procedures governing the prior approval of expenditures in the following categories.			
a. Automatic data processing costs.			
b. Building space rental costs.			
c. Costs related to the maintenance and operation of the organization's facilities.			
d. Costs related to the rearrangement and alteration of the organization's facilities.			
e. Allowances for depreciation and use of publicly owned buildings.			
f. The cost of space procured under a rental purchase or a lease-with-option-to-purchase agreement.			
g. Capital expenditures.			
h. Insurance and indemnification expenses.			
i. The cost of management studies.			
j. Preagreement costs.			
k. Professional services costs.			
l. Proposal costs.			
10. Under the terms of 2 CFR 200 certain costs incurred by units of State and local governments are not allowable as charges to Federal grants. The grantee organization should have established policies and procedures to preclude charging Federal grant programs with the following types of costs.			
a. Bad debt expenses.			
b. Contingencies.			
c. Contribution and donation expenditures			
d. Entertainment expenses.			
e. Fines and penalties.			
f. Interest and other financial costs.			
g. Legislative expenses.			
h. Charges representing the nonrecovery of costs under grant agreements.			

RECEIVING	**YES**	**NO**	**N/A**
1. Does the organization have a receiving function to handle receipt of all materials and equipment?			
2. Are supplies and equipment inspected and counted before acceptance for use?			
3. Are quantities and descriptions of supplies and equipment checked by the receiving department against a copy of the purchase order or some other form of notification?			
4. Is a logbook or permanent copy of the receiving ticket kept in the receiving department?			
ACCOUNTS PAYABLE	**YES**	**NO**	**N/A**
1. Is control established over incoming vendor invoices?			
2. Are receiving reports matched to the vendor invoices and purchase orders, and are all of these documents kept in accessible files?			

3. Are charges for services required to be supported by evidence of performance by individuals other than the ones who incurred the obligations?			
4. Are extensions on invoices and applicable freight charges checked by accounts payable personnel?			
5. Is the program to be charged entered on the invoice and checked against the purchase order and approved budget?			
6. Is there an auditor of disbursements who reviews each voucher to see that proper procedures have been followed?			
7. Are checks adequately cross referenced to vouchers?			
8. Are there individuals responsible for accounts payable other than those responsible for cash receipts?			
9. Are accrual accounts kept for items which are not invoiced or paid on a regular basis?			
10. Are unpaid vouchers totaled and compared with the general ledger on a monthly basis?			

CASH DISBURSEMENTS	**YES**	**NO**	**N/A**
The following conditions are indicative of satisfactory controls over cash disbursements: i. Duties are adequately separated; different persons prepare checks, sign checks, reconcile bank accounts, and have access to cash receipts. ii. All disbursements are properly supported by evidence of receipt and approval of the related goods and services. iii. Blank checks are <u>not</u> signed. iv. Unissued checks are kept in a secure area. v. Bank accounts are reconciled monthly. vi. Bank accounts and check signers are authorized by the board of directors or trustees. vii. Petty cash vouchers are required for each fund disbursement. viii. The petty cash fund is kept on an imprest basis.			
1. Are checks controlled and accounted for with safeguards over unused, returned, and voided checks?			
2. Is the drawing of checks to cash or bearer prohibited?			
3. Do supporting documents, such as invoices, purchase orders, and receiving reports, accompany checks for the check signers' review?			
4. Are vouchers and supporting documents appropriately cancelled (stamped or perforated) to prevent duplicate payments?			
5. If check signing plates are used, are they adequately controlled (i.e., maintained by a responsible official who reviews and accounts for prepared checks)?			
6. Are two signatures required on all checks or on checks over stated amounts?			
7. Are check signers responsible officials or employees of the organization?			
8. Is the person who prepares the check or initiates the voucher other than the person who mails the check?			
9. Are bank accounts reconciled monthly and are differences resolved?			
10. Concerning petty cash disbursements:			

a. Is petty cash reimbursed by check and are disbursements reviewed at that time?			
b. Is there a maximum amount, reasonable in the circumstances, for payments made in cash?			
c. Are petty cash vouchers written in ink to prevent alteration?			
d. Are petty cash vouchers canceled upon reimbursement of the fund to prevent their reuse?			

PAYROLL	**YES**	**NO**	**N/A**
The following conditions are indicative of satisfactory controls of payroll: i. Written authorizations are on file for all employees covering rates of pay, withholdings and deductions. ii. The organization has written personnel policies covering job descriptions, hiring procedures, promotions, and dismissals. iii. Distribution of payroll charges is based on documentation prepared outside the payroll department. iv. Payroll charges are reviewed against program budgets and deviations are reported to management for follow-up action. v. Adequate timekeeping procedures, including the use of time clock or attendance sheets and supervisory review and approval, are employed for controlling paid time. vi. Payroll checks are prepared and distributed by individuals independent of each other. vii. Other key payroll and personnel duties such as timekeeping, salary authorization and personnel administration are adequately separated.			
1. Are payroll and personnel policies governing compensation in accordance with the requirements of grant agreements?			
2. Are there procedures to ensure that employees are paid in accordance with approved wage and salary rates?			
3. Is the distribution of payroll charges checked by a second person and are aggregate amounts compared to the approved budget?			
4. Are wages paid at or above the Federal minimum wage?			
5. Are procedures adequate for controlling: (a) Overtime wages, (b) Overtime work authorization, and (c) Supervisory approval of overtime?			
6. Are payroll checks distributed by persons not responsible for preparing the checks?			

PROPERTY AND EQUIPMENT	**YES**	**NO**	**N/A**
The following conditions are indicative of satisfactory control over property and equipment: i. There is an effective system of authorization and approval of capital equipment expenditures. ii. Accounting practices for recording capital assets are reduced to writing. iii. Detailed records of individual capital assets are kept and periodically balanced with the general ledger accounts. iv. There are effective procedures for authorizing and accounting for disposals. v. Property and equipment is stored in a secure place.			

1. Are executive authorizations and approvals required for originating expenditures for capital items?			
2. Are expenditures for capital items reviewed for board approval before funds are committed?			
3. Does the organization have established policies covering capitalization and depreciation?			
4. Does the organization charge depreciation or use allowances on property and equipment against any grant programs that it administers?			
5. Is historical cost the basis for computing depreciation or use allowances?			
6. Are the organization's depreciation policies or methods of computing use allowances in accordance with the standards outlined in Federal circulars or agency regulations?			
7. Are there detailed records showing the asset values of individual units of property and equipment?			
8. Are detailed property records periodically balanced to the general ledger?			
9. Are detailed property records periodically checked by physical inventory?			
10. Are differences between book records and physical counts reconciled and are the records adjusted to reflect shortages?			
11. Are there procedures governing the use of property and equipment?			

INDIRECT COSTS	**YES**	**NO**	**N/A**
1. Does the organization have an indirect cost allocation plan or a negotiated indirect cost rate?			
2. Is the plan prepared in accordance with the provisions of 2 CFR 200?			
3. Has audit cognizance for the plan been established and are the rates accepted by all participating Federal and State agencies?			
4. Does the organization have procedures which provide assurance that consistent treatment is applied in the distribution of charges as direct or indirect costs to all grants?			

ATTACHMENT 7: CORE STRATEGIES AND APPROVED USES CROSSWALK

Please complete this form as completely as possible, including the allocation of funds for each strategy and/or approve use; outcomes and whether the focus is on SDoH or Acute Crisis/Residential.

Schedule A Core Strategies	Description
A. Naloxone or other FDA-approved drug to reverse opioid overdoses	1. Expand training for first responders, schools, community support groups and families; and 2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.
B. Medication-Assisted Treatment (MAT) Distribution and other opioid-related treatment	1. Increase distribution of MAT to non-Medicaid eligible or uninsured individuals; 2. Provide education to school-based and youth-focused programs that discourage or prevent misuse; 3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and 4. Treatment and Recovery Support Services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication with other support services.
C. Pregnant & Postpartum Women	1. Expand Screening, Brief Intervention, and Referral to Treatment ("SBIRT") services to non Medicaid eligible or uninsured pregnant women; 2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder ("OUD") and other Substance Use Disorder ("SUD")/Mental Health disorders for uninsured individuals for up to 12 months postpartum; and 3. Provide comprehensive wrap-around services to individuals with Opioid Use Disorder (OUD) including housing, transportation, job placement/training, and childcare
D. Expanding Treatment for Neonatal abstinence Syndrome	1. Expand comprehensive evidence-based and recovery support for NAS babies; 2. Expand services for better continuum of care with infant-need dyad; and 3. Expand long-term treatment and services for medical monitoring of NAS babies and their families.
E. Expansion of Warm Hand-off Programs and Recovery Services	1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments; 2. Expand warm hand-off services to transition to recovery services; 3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions. ; 4. Provide comprehensive wrap-around services to individuals in recovery including housing, transportation, job placement/training, and childcare; and 5. Hire additional social workers or other behavioral health workers to facilitate expansions above.
F. Treatment for Incarcerated Population	1. Provide evidence-based treatment and recovery support including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system; and 2. Increase funding for jails to provide treatment to inmates with OUD.

G. Prevention Programs	1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco); 2. Funding for evidence-based prevention programs in schools.; 3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing); 4. Funding for community drug disposal programs; and 5. Funding and training for first responders to participate in pre-arrest diversion programs, post overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.
H. Expanding Syringe Services Programs	1. Provide comprehensive syringe services programs with more wrap-around services including linkage to OUD treatment, access to sterile syringes, and linkage to care and treatment of infectious diseases.
I. Evidence-based data collection and research analyzing the effectiveness of the abatement strategies in the State	No further description provided
Schedule B Approved Uses	
A. Treat Opioid Use Disorder	Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following: 1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment (MAT) approved by the U.S. Food and Drug Administration. 2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine (ASAM) continuum of care for OUD and any co-occurring SUD/MH conditions 3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services. 4. Improve oversight of Opioid Treatment Programs (OTPs) to assure evidence-based or evidence informed practices such as adequate methadone dosing and low threshold approaches to treatment. 5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose. 6. Treatment of trauma for individuals with OUD (e.g., violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (e.g., surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma. 7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions. 8. Training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including tele mentoring to assist community-based providers in rural or underserved areas. 9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions. 10. Fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

	11. Scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD or mental health conditions, including but not limited to training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas. 12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 (DATA 2000) to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver. 13. Dissemination of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service-Opioids web-based training curriculum and motivational interviewing. 14. Development and dissemination of new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication-Assisted Treatment.
B. Support People in Treatment and Recovery	Support people in treatment for or recovery from OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following: 1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare. 2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services. 3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions. 4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved medication with other support services. 5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions. 6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions. 7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions. 8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions. 9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of

	high-quality programs to help those in recovery. 10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family. 11. Training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma. 12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment. 13. Create or support culturally appropriate services and programs for persons with OUD and any co occurring SUD/MH conditions, including new Americans. 14. Create and/or support recovery high schools. 15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.
C. Connect people Who Need Help to the Help they Need (Connections to Care)	Provide connections to care for people who have – or at risk of developing – OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following: 1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment. 2. Fund Screening, Brief Intervention and Referral to Treatment (SBIRT) programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid. 3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common. 4. Purchase automated versions of SBIRT and support ongoing costs of the technology. 5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments. 6. Training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services. 7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically-appropriate follow-up care through a bridge clinic or similar approach. 8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose. 9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid related adverse event. 10. Provide funding for peer support specialists or recovery coaches in

	emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose. 11. Expand warm hand-off services to transition to recovery services. 12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people. 13. Develop and support best practices on addressing OUD in the workplace. 14. Support assistance programs for health care providers with OUD. 15. Engage non-profits and the faith community as a system to support outreach for treatment. 16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.
D. Address the Needs of Criminal-Justice Involved Persons	Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following: 1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as: a. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative (PAARI); b. Active outreach strategies such as the Drug Abuse Response Team (DART) model; c. “Naloxone Plus” strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services; d. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (LEAD) model; e. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or f. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise

E. Address the Needs of Pregnant or Parenting Women and their families, including babies with neonatal abstinence syndrome	Address the needs of pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with neonatal abstinence syndrome (NAS), through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following: 1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women – or women who could become pregnant – who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome. 2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum. 3. Training for obstetricians or other healthcare personnel that work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions. 4. Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; expand long-term treatment and services for medical monitoring of NAS babies and their families. 5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with Neonatal Abstinence Syndrome get referred to appropriate services and receive a plan of safe care. 6. Child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions. 7. Enhanced family supports and child care services for parents with OUD and any co-occurring SUD/MH conditions. 8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events. 9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including but not limited to parent skills training. 10. Support for Children's Services – Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

F. Prevent Over-Prescribing and Ensure Appropriate Prescribing and Dispensing of Opioids	Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following: 1. Fund medical provider education and outreach regarding best prescribing practices for opioids consistent with Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing). 2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids. 3. Continuing Medical Education (CME) on appropriate prescribing of opioids. 4. Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain. 5. Support enhancements or improvements to Prescription Drug Monitoring Programs (PDMPs), including but not limited to improvements that: a. Increase the number of prescribers using PDMPs; b. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or c. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules. 6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules. 7. Increase electronic prescribing to prevent diversion or forgery. 8. Educate Dispensers on appropriate opioid dispensing.

G. Prevent Misuse of Opioids	Support efforts to discourage or prevent misuse of opioids through evidence-based or evidence informed programs or strategies that may include, but are not limited to, the following: 1. Fund media campaigns to prevent opioid misuse. 2. Corrective advertising or affirmative public education campaigns based on evidence. 3. Public education relating to drug disposal. 4. Drug take-back disposal or destruction programs. 5. Fund community anti-drug coalitions that engage in drug prevention efforts. 6. Support community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction – including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). 7. Engage non-profits and faith-based communities as systems to support prevention. 8. Fund evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others. 9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids. 10. Create of support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions. 11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills. 12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or other drug misuse.

H. Prevent Overdose Deaths and Other Harms (Harm reduction)	Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence based or evidence-informed programs or strategies that may include, but are not limited to, the following: 1. Increase availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, individuals at high risk of overdose, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public. 2. Public health entities provide free naloxone to anyone in the community 3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public. 4. Enable school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support. 5. Expand, improve, or develop data tracking software and applications for overdoses/naloxone revivals. 6. Public education relating to emergency responses to overdoses. 7. Public education relating to immunity and Good Samaritan laws. 8. Educate first responders regarding the existence and operation of immunity and Good Samaritan laws. 9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs. 10. Expand access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use. 11. Support mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions. 12. Provide training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions. 13. Support screening for fentanyl in routine clinical toxicology testing.

I. First Responders	In addition to items in sections C, D, and H relating to first responders, support the following: 1. Educate law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs. 2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.
J. Leadership, Planning and Coordination	Support efforts to provide leadership, planning, coordination, facilitation, training and technical assistance to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following: 1. Statewide, regional, local, or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment intervention services; to support training and technical assistance; or to support other strategies to abate the opioid epidemic described in this opioid abatement strategy list. 2. A dashboard to share reports, recommendations, or plans to spend opioid settlement funds; to show how opioid settlement funds have been spent; to report program or strategy outcomes; or to track, share, or visualize key opioid-related or health-related indicators and supports as identified through collaborative statewide, regional, local, or community processes. 3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list. 4. Provide resources to staff government oversight and management of opioid abatement programs.
K. Training	In addition to the training referred to throughout this document, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following: 1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis. 2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (e.g., health care, primary care, pharmacies, PDMPs, etc.).

L. Research	Support opioid abatement research that may include, but is not limited to, the following: 1. Monitoring, surveillance, data collection, and evaluation of programs and strategies described in this opioid abatement strategy list. 2. Research non-opioid treatment of chronic pain. 3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders. 4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips. 5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids. 6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (e.g. Hawaii HOPE and Dakota 24/7). 7. Epidemiological surveillance of OUD-related behaviors in critical populations including individuals entering the criminal justice system, including but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring (ADAM) system. 8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids. 9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.

ATTACHMENT 8: BUDGET WORKSHEET

Example of Blank template

FY 2026 PROGRAM BUDGET WORKSHEET

PBCCSD Funded Budget Items			Proposed Program Name		Palm Beach County		PBC Program		PBC Program		PBC Program		Total Program Funding
Program Period: FY 2026					Proposed		Confirmed		Pending		Pending		Pending
TOTAL PROGRAM FUNDING AMOUNT =					$ -		$ -		$ -		$ -		$ -
Program Expenses	Schedule A Core Strategies	Schedule B Approved Uses	Narrative		Total		Total		Total		Total		Total
Personnel					$ -		$ -		$ -		$ -		$ -
Program Manager													-
Program Assistant													-
Fringe Benefits - Program													-
Community Educator													-
													-
Building /Occupancy					$ -		$ -		$ -		$ -		$ -
Rent/Lease													-
Building Maintenance													-
Insurance													-
													-
Utilities					$ -		$ -		$ -		$ -		$ -
Electric													-
Water													-
Telephone													-
													-
Project Supplies/Equipment					$ -		$ -		$ -		$ -		$ -
Office Supplies													-
Postage/Shipping													-
Printing													-
Materials/Program Supplies													-
Equipment Rental													-
													-
Professional Fees					$ -		$ -		$ -		$ -		$ -
Conference Registration Fees													-
Training													-
Travel/Mileage													-
													-
TOTAL PROGRAM EXPENSES =					$ -		$ -		$ -		$ -		$ -
Administrative Expenses			Narrative										
Personnel					$ -		$ -		$ -		$ -		$ -
Executive Position #1													-
													-
Consulting Fees					$ -		$ -		$ -		$ -		$ -
XYZ Consultants													-
TOTAL ADMINISTRATIVE EXPENSES =					$ -		$ -		$ -		$ -		$ -
Administrative % of PBC Award					#DIV/0!								

Example of Completed Budget Submission

FY 2026 PROGRAM BUDGET WORKSHEET

PBCCSD Funded Budget Items			Proposed Program Name		Palm Beach County Program	PBC Program Funder #2	PBC Program Funder #3	PBC Program Funder #4	Total Program Funding (All Sources)
Program Period: FY 2026					Proposed	Confirmed	Pending	Pending	Pending
			TOTAL PROGRAM FUNDING AMOUNT =		$ 120,195.00	$ 45,000.00	$ 19,000.00	$ 7,500.00	$ 191,695.00
Program Expenses	Schedule A Core Strategies	Schedule B Approved Uses	Narrative		Amount	Amount	Amount	Amount	Amount
Personnel					$ 72,445.00	$ 45,000.00	$ 17,500.00	$ 7,500.00	$ 142,445.00
Program Manager	E. Expansion of Warm Hand-off Programs and Recovery Services	C. Connect people Who Need Help to the Help they Need (Connections to Care)	Program manager position for community support service. Salary expense is 100% funded by PBC FAA award and includes fringe benefits.		$ 25,000.00	$ 30,000.00			$ 55,000.00
Program Assistant	E. Expansion of Warm Hand-off Programs and Recovery Services	C. Connect people Who Need Help to the Help they Need (Connections to Care)	Program Assistant role is to support the program manager and community educator with daily tasks. This salary expense is 50% funded by PBC FAA award. Total salary expense is $15,000. , with 50% allocated to PBC ($7,500). (Salary expense does not include fringe benefits)		$ 7,500.00	$ 15,000.00	$ 7,500.00	$ 7,500.00	$ 37,500.00
Fringe Benefits - Program Assistant	E. Expansion of Warm Hand-off Programs and Recovery Services	B. Support People in Treatment and Recovery	Fringe benefits expense for Program Assistant. Fringe benefits for this position total ($1,800), with 50% allocated to Palm Beach County FAA in the amount of $900		$ 900.00				$ 900.00
Community Educator	E. Expansion of Warm Hand-off Programs and Recovery Services	B. Support People in Treatment and Recovery	Community Educator position is the primary interface with local schools, charities and support groups. Total Salary (including fringe benefits) billed to Palm Beach County FAA = $39,045		$ 39,045.00		$ 10,000.00		$ 49,045.00
Building /Occupancy					$ 27,050.00	$ -	$ -	$ -	$ 27,050.00
Programmatic Rent/Lease	D. Expanding Treatment for Neonatal abstinence Syndrome		Note: Rent for areas that house admin staff should be listed seperately under admin seciton* Rent expense for Lake Worth facility. Total rental expense for FY16 = $35,000. Allocation to Palm Beach County FAA award= $20,000. Remaining $15,000 will be paid by other		$ 20,000.00				$ 20,000.00
Building Maintenance			Maintenance expense for building XYZ		$ 3,800.00				$ 3,800.00
Insurance			Commercial, General, Liability Insurance		$ 3,250.00				$ 3,250.00
Utilities					$ 2,400.00	$ -	$ 1,500.00	$ -	$ 3,900.00
Electric			Electric Utility Services expense for location X		$ 1,200.00		$ 1,000.00		$ 2,200.00
Water			Water Utility service for location X		$ 850.00		$ 500.00		$ 1,350.00
Telephone			Telephone expense for landline at location X		$ 350.00				$ 350.00

FY 2026 PROGRAM BUDGET WORKSHEET

PBCCSD Funded Budget Items			Proposed Program Name	Palm Beach County Program	PBC Program Funder #2	PBC Program Funder #3	PBC Program Funder #4	Total Program Funding (All Sources)
Program Period: FY 2026				Proposed	Confirmed	Pending	Pending	Pending
			TOTAL PROGRAM FUNDING AMOUNT =	$ 120,195.00	$ 45,000.00	$ 19,000.00	$ 7,500.00	$ 191,695.00
Program Expenses	**Schedule A Core Strategies**	**Schedule B Approved Uses**	**Narrative**	**Amount**	**Amount**	**Amount**	**Amount**	**Amount**
Project Supplies/Equipment				$ 4,900.00	$ -	$ -	$ -	$ 4,900.00
Office Supplies			Office supplies for program staff	$ 500.00				$ 500.00
Postage/Shipping			Postage expense for client related mailing	$ 750.00				$ 750.00
Printing			Printing expense for program brochures	$ 650.00				$ 650.00
Materials/Program Supplies			Program related supplies used to support client base	$ -				$ -
Equipment Rental			Monthly Equipment rental fee for use of X = $500 ($6000 per year). Palm Beach County to cover 50% of this expense ($3000).	$ 3,000.00				$ 3,000.00
Professional Fees				$ 2,950.00	$ -	$ -	$ -	$ 2,950.00
Conference Registration Fees			Professional development program fee	$ 350.00				$ 350.00
Training			Staff training expense for program/medical/intervention training for client	$ 1,500.00				$ 1,500.00
Travel/Mileage			Program staff mileage reimbursement for client and training related meetings	$ 1,100.00				$ 1,100.00
			TOTAL PROGRAM EXPENSES =	$ 109,745.00	$ 45,000.00	$ 19,000.00	$ 7,500.00	$ 181,245.00
Administrative Expenses			**Narrative**					
Personnel				$ 7,500.00	$ -	$ -	$ -	$ 7,500.00
Executive Position #1 (JL)			A 5% allocation of the Executive Director salary expense (including fringe benefits) will be billed to Palm Beach County FAA. Executive Director total salary expense = $85,000. 5% allocation to Palm beach County FAA = %	$ 7,500.00				$ 7,500.00
Consulting Fees				$ 2,950.00	$ -	$ -	$ -	$ 2,950.00
XYZ Consultants			Accounting and audit expenses for FAA program. Annual Accounting fee = $950, Annual Audit fee = $2,000. Total expense = $2,950	$ 2,950.00				$ 2,950.00
			TOTAL ADMINISTRATIVE EXPENSES =	$ 10,450.00	$ -	$ -	$ -	$ 10,450.00
Administrative % of PBC Award				9.52%				

ATTACHMENT 9: SCOPE OF WORK

2026 – 2027 SCOPE OF WORK AND SERVICES

Agency Name:
Program Name:
Location:
Funding Priority:

Scope of Work

A. **Program Description:**

B. **Priority/Focus Population**: Will be defined as …

   i. **Eligibility Criteria**: Adult residents of Palm Beach County ages 18 and over with a substance use or co-occurring disorder.

   ii. **Documentation of Eligibility:** All Individuals will be screened for eligibility. Supporting documentation of eligibility will be retained in each Participant's file.

C. **Individuals Served:** A minimum of # unduplicated Individuals.

D. **Service Delivery:**

   i. AGENCY shall

ATTACHMENT 10 – UNIT RATE

2026 – 2027 OSF AGENCIES
UNITS OF SERVICE RATE AND DEFINITION

Agency Name:
Subcategory: **Tiny Homes Recovery Transitional Housing**
Program Name:

Service	Unit Cost / Actual Cost	Total Contract Amount
Prefabricated Tiny Homes:		
Admin Costs (capped at 5%)		
Total Contract Amount		

Actual Cost/Unit Cost expenses shall mean expenses authorized by the COUNTY pursuant to this Agreement, and reasonably incurred by AGENCY directly in connection with AGENCY'S performance of its duties and Scope of Work pursuant to this Agreement. AGENCY will sustain the program for the full Agreement period regardless of the rate of expenditure of above funds.

For actual cost reimbursement items, backup documentation must be submitted along with the invoice and signed cover letter that may include but is not limited to the following: program general ledger, copies of paid receipts, copies of checks, invoices, or any other applicable documents acceptable to the Palm Beach County Department of Community Services. Additional items may be requested as part of the invoice submission, or via desk and/or on-site monitoring on a periodic basis.

ATTACHMENT 11 - INSURANCE REQUIREMENTS

Prior to execution of the agreement by the COUNTY, the AGENCY must obtain all insurance required under this article and have such insurance approved by the COUNTY's Risk Management Department.

A. AGENCY shall, at its sole expense, agree to maintain in full force and effect at all times during the term of the agreement, insurance coverage and limits (including endorsements), as described herein. AGENCY shall agree to provide the COUNTY with at least ten (10) day prior notice of any cancellation, non-renewal or material change to the insurance coverages. The requirements contained herein, as well as COUNTY's review or acceptance of insurance maintained by AGENCY are not intended to and shall not in any manner limit or qualify the liabilities and obligations assumed by AGENCY under the Agreement. Where permitted by the policy, coverage shall apply on a primary and non-contributory basis.

B. **Commercial General Liability** AGENCY shall maintain Commercial General Liability at a limit of liability not less than **$500,000** Each Occurrence. Coverage shall not contain any endorsement excluding Contractual Liability or Cross Liability unless granted in writing by COUNTY's Risk Management Department.

B. **Business Automobile Liability** AGENCY shall maintain Business Automobile Liability at a limit of liability not less than **$500,000** Each Accident for all owned, non-owned and hired automobiles. In the event AGENCY does not own any automobiles, the Business Auto Liability requirement shall be amended allowing AGENCY to agree to maintain only Hired & Non-Owned Auto Liability. This amended requirement may be satisfied by way of endorsement to the Commercial General Liability, or separate Business Auto coverage form.

C. **Workers' Compensation Insurance & Employers Liability** AGENCY shall maintain Workers' Compensation & Employers Liability in accordance with Florida Statute Chapter 440.

D. **Professional Liability** AGENCY shall maintain Professional Liability or equivalent Errors & Omissions Liability at a limit of liability not less than **$1,000,000** Each Claim. When a self-insured retention (SIR) or deductible exceeds **$10,000**, COUNTY reserves the right, but not the obligation, to review and request a copy of AGENCY's most recent annual report or audited financial statement. For policies written on a "Claims-Made" basis, AGENCY shall maintain a Retroactive Date prior to or equal to the effective date of the agreement. The Certificate of Insurance providing evidence of the purchase of this coverage shall clearly indicate whether coverage is provided on an "occurrence" or "claims - made" form. If coverage is provided on a "claims - made" form the Certificate of Insurance must also clearly indicate the "retroactive date" of coverage. In the event the policy is canceled, non- renewed, switched to an Occurrence Form, retroactive date advanced, or any other event triggering the right to purchase a Supplement Extended Reporting Period (SERP) during the life of the agreement, AGENCY shall purchase a SERP with a minimum reporting period not less than three (3) years.

E. **Additional Insured** AGENCY shall endorse the COUNTY as an Additional Insured with a CG 2026 Additional Insured - Designated Person or Organization endorsement, or its equivalent, to the Commercial General Liability. The Additional Insured endorsement shall read "Palm Beach County Board of County Commissioners, a Political Subdivision of the State of Florida, its Officers, Employees and Agents."

F. **Waiver of Subrogation** AGENCY hereby waives any and all rights of Subrogation against the COUNTY, its officers, employees and agents for each required policy. When required by the insurer, or should a policy condition not permit an insured to enter into a pre-loss contract to waive subrogation without an endorsement to the policy, then AGENCY shall agree to notify the insurer and request the policy be endorsed with a Waiver of Transfer of rights of Recovery Against Others, or its equivalent. This Waiver of Subrogation requirement shall not apply to any policy, which specifically prohibits such an endorsement, or which voids coverage should AGENCY enter into such a contract on a pre- loss basis.

G. **Certificate(s) of Insurance** No later than the execution of the agreement, AGENCY shall deliver to the COUNTY's representative as identified in Article 24, a Certificate(s) of Insurance evidencing that all types and amounts of insurance coverages required by the agreement have been obtained and are in full force and effect. The Certificate of Insurance shall be issued to

Palm Beach County Board of
Commissioners c/o Community Services
Department
810 West Datura Street
West Palm Beach, FL
33401
ATTN: Office of Behavioral Health and Substance Use Disorders

H. **Umbrella or Excess Liability** If necessary, AGENCY may satisfy the minimum limits required above for Commercial General Liability, Business Auto Liability, and Employer's Liability coverage under Umbrella or Excess Liability. The Umbrella or Excess Liability shall have an Aggregate limit not less than the highest "Each Occurrence" limit for either Commercial General Liability, Business Auto Liability, or Employer's Liability. The COUNTY shall be specifically endorsed as an "Additional Insured" on the Umbrella or Excess Liability, unless the Certificate of Insurance notes the Umbrella or Excess Liability provides coverage on a "Follow-Form" basis.

Right to Review COUNTY, by and through its Risk Management Department, in cooperation with the contracting/monitoring department, reserves the right to review, modify, reject or accept any required policies of insurance, including limits, coverage, or endorsements, herein from time to time throughout the term of the agreement. COUNTY reserves the right, but not the obligation, to review and reject any insurer providing coverage because of its poor financial condition or failure to operate legally.

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Oxford House™

FLORIDA STATE OXFORD HOUSES

Total Houses	**299**
Total Beds	**2616**
Men Houses	**181**
Men Beds	**1574**
Women Houses	**50**
Women Beds	**420**
Women with Children Houses	**60**
Women with Children Beds	**551**
Men with Children Houses	**8**
Men with Children Beds	**71**

For an up-to-date listing of all Oxford Houses in Florida please go to:

oxfordvacancies.com

Searches can be done by State & County
Clicking on the house name will pull up google maps to show the home location.

Oxford House continues to expand its life-saving network of recovery homes throughout Florida, bringing hope and stable recovery support to more individuals than ever before.
In early April, the Oxford House Florida State Association successfully hosted its annual statewide convention. Attendees participated in informative trainings on the Oxford House model and meaningful discussions focused on building stronger community, personal recovery and achieving personal/professional goals.
This June, Oxford House in Florida is excited to present 10 special premieres of its powerful new documentary, Welcome Home: An Oxford House Story. These screenings will offer audiences an inspiring look into the transformative power of peer-supported recovery.

The documentary premieres will be held in the following cities:

Wednesday, June 3 — Panama City
Thursday, June 4 — Gainesville
Thursday, June 4 — Jacksonville
Thursday, June 4 — Tallahassee
Wednesday, June 10 — Fort Myers
Thursday, June 11 — Daytona
Thursday, June 11 — West Palm Beach
WPB Rinker Playhouse • 7:00 PM – 9:00 PM
701 Okeechobee Blvd, West Palm Beach, FL 33401
Wednesday, June 17 — Orlando
Thursday, June 18 — Pensacola
Thursday, June 18 — Tampa

Mark your calendars and please join us as we spotlight the power of self-help, accountability, and support in long-term recovery!

Michael McKeogh
Regional Manager
601-402-6864
michael.mckeogh@oxfordhouse.org

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A bill to be entitled

An act relating to community residences for people with disabilities and for recovery communities; amending s. 419.001, F.S.; defining terms; deleting definitions related to community residential living arrangements; creating s. 419.003, F.S.; providing the purpose and duties of a community residence; requiring that the residents of a community residence receive care by supportive staff as may be necessary; authorizing residents to be self-governed or supervised by a certain sponsoring entity; providing that a community residence is not subject to ch. 419, F.S., under certain circumstances; providing that a community residence that constitutes a family may not be used in the calculation of certain spacing distances; requiring that a community residence be licensed or certified, or operate pursuant to a charter from an entity recognized or sanctioned by the Congress of the United States; authorizing a local government to revoke or nullify the siting approval of a community residence under certain circumstances; prohibiting a sponsoring entity whose license, certification, or charter, or application for such license, certification, or charter, has been revoked or denied from operating a community residence; providing for the nullification of zoning approval under certain circumstances; authorizing the sponsoring entity of a community residence to appeal the revocation or denial of its license or

certification; requiring that zoning approval granted to a sponsoring entity be stayed pending the outcome of such appeal; requiring a sponsoring entity of a community residence to notify the designated local government official of the revocation or denial of its license, certification, or charter within a specified timeframe; requiring the sponsoring entity to cease operations within a specified timeframe after receiving notice of the denial or revocation of its license, certification, or charter; requiring the sponsoring entity to arrange for relocation of residents; requiring that enforcement of the denial or revocation of a license, certificate, or charter be stayed pending the outcome of an appeal; providing an exception; providing distance requirements for the siting of a community residence; providing that a community residence constitutes a residential use allowed in certain areas if it complies with specified requirements; providing that a community residence is considered a residential use of a property for purposes of local government land use and zoning codes; providing non-applicability; authorizing a local government to adopt less restrictive zoning for the siting of a community residence; authorizing a local government to require a sponsoring entity for a community residence to cease operations immediately under certain circumstances; requiring a local government to require a sponsoring entity of a community residence to cease operations immediately

under certain circumstances; creating s. 419.005, F.S.; providing that a family community residence or transitional community residence constitutes a residential use allowed in specified zoning districts if certain requirements are met; providing that a family community residence or transitional community residence does not constitute a residential use allowed under certain circumstances; creating s. 419.007, F.S.; authorizing a sponsoring entity for a community residence, family community residence, or transitional community residence to apply for a reasonable accommodation if specified requirements are met; requiring a local government to authorize a reasonable accommodation for a proposed community residence, family community residence, or transitional community residence for which the state does not offer a license, certification, or charter if specified requirements are met; requiring a local government to authorize a reasonable accommodation for a community residence, family community residence, or transitional community residence that is intended to house more than 12 unrelated people if specified requirements are met; creating s. 419.009, F.S.; requiring that a recovery community be licensed or certified by a licensing or certifying entity; authorizing a local government to revoke siting approval for a recovery community under certain circumstances; prohibiting a sponsoring entity for a recovery community from operating under certain circumstances; prohibiting a

sponsoring entity for a recovery community whose license or certification has been denied or revoked from operating in this state; providing for the nullification of certain zoning approval; requiring that zoning approval be stayed pending a sponsoring entity's appeal of the revocation or denial of its licensure or certification; requiring a sponsoring entity to notify the designated local government official or other applicable entity within a specified timeframe that its license or certification has been revoked or denied; requiring a sponsoring entity whose license or certification has been revoked or denied to cease operations within a specified timeframe; requiring the sponsoring entity to make arrangements for the relocation of residents; requiring that enforcement of a denial or revocation of a license or certification be stayed pending the outcome of an appeal; providing an exception; providing that a recovery community constitutes a residential use allowed in certain zoning districts if certain conditions are met; providing specifications for the measurement of distance requirements; providing non-applicability; authorizing a local government to adopt less restrictive zoning for siting recovery communities; authorizing a local government to require a sponsoring entity for a recovery community to cease operations immediately under certain circumstances; requiring a local government to require a sponsoring entity of a recovery community to cease operations

immediately under certain circumstances; creating s. 419.013, F.S.; requiring that a recovery community in specified locations be allowed a reasonable accommodation if certain requirements are met; creating s. 419.015, F.S.; requiring a local government to respond in writing within a specified timeframe to requests regarding whether a proposed community residence or recovery residence is within a certain spacing distance from certain other residences; requiring that such response include certain information; requiring a local government to provide the sponsoring entity of a community residence or recovery residence with certain information; amending ss. 393.501, 400.464, 400.9972, 429.11, 429.67, and 1003.57, F.S.; conforming provisions to changes made by the act; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 419.001, Florida Statutes, is amended to read:

419.001 Community Residences and Recovery Communities ~~Site selection of community residential homes~~.~~—~~For the purposes of this chapter, the term:

(1) ~~For the purposes of this section, the term:~~

~~(a)~~ "Community residence" means a residential living arrangement, with the exceptions established in s.419.002(1), (2), and (3), for unrelated individuals with disabilities living as a single functional family in a dwelling unit, town home,

duplex, or triplex who need the mutual support furnished by other residents of the dwelling as well as the support services, if any, provided by any staff of the community residence. Residents may be self–governing or supervised by a sponsoring entity or its staff, which provide habilitative or rehabilitative services related to the residents' disabilities. A community residence emulates a biological family to foster normalization of its residents, integrate them into the surrounding community, and use neighbors as role models for those residents capable of going into the community and interacting with neighbors. Supportive inter–relationships between residents are an essential component. Its primary purpose is to provide shelter; foster and facilitate life skills; and meet the physical, emotional, and social needs of the residents in a mutually supportive family–like environment. Community residences include, but are not limited to, those residences licensed by the Florida Agency for Persons with Disabilities, the Florida Department of Elder Affairs, the Florida Agency for Health Care Administration, and the Florida Department of Children and Families, and Recovery Residences certified by the state's designated credentialing entity established under s. 397.487, and recovery residences democratically operated by their residents pursuant to a charter from an entity recognized or sanctioned by Congress. A community residence shall be considered a residential use of property for purposes of all local government land-use and zoning codes.

(2) "Congregate living facility" means a group living arrangement that provides long-term care, accommodations, food service, and one or more personal care services to people

without disabilities or to people with disabilities who pose a direct threat to the health or safety of others, and not related to the owner or administrator by blood or marriage. A congregate living facility may be a group living arrangement too large to emulate a family; a group living arrangement in which normalization and community integration and the use of neighbors without the condition of the residents of the congregate living facility as role models are not integral elements; an intermediate care or assisted living facility that does not emulate a family; a group living arrangement that is an alternative to incarceration for people who pose a direct threat to the health or safety of others; a group living arrangement for people undergoing treatment in a program at the same site; or a facility for the treatment of substance use disorder where treatment is the primary purpose and use, whether it provides only services or includes a residential component on site. A congregate living facility is not a community residence or a recovery community.

(a) Congregate living facilities include, but are not limited to:

1. An intermediate care or assisted living facility that does not operate as the functional equivalent of a family.

2. A group living arrangement that is an alternative to incarceration for people who pose a direct threat to the health or safety of others.

3. A facility for the treatment of substance use disorders where treatment is the primary purpose and use of the facility.

(b) A congregate living facility is not a community residence or a recovery community.

(3) “Disability” means a physical or mental impairment that substantially limits any of an individual’s major life activities, impairs an individual’s ability to live independently, having a record of such an impairment, or being regarded as having such an impairment as defined in the Federal Fair Housing Act and Americans With Disabilities Act. People with disabilities include, but are not limited to:

(a) An elderly person with disabilities as defined in s. 429.65(9),

(b) A person with physical disabilities as defined in s. 760.22(3),

(c) A person with development disabilities as defined in s. 393.063 (11),

(d) A person with mental illness as defined in s. 394.455 (29), and

(e) A person in recovery from substance abuse, as defined in s. 397.311(48).

The term “disability” does not include individuals with substance use disorder who are currently using illegal substances or currently using legal substances to which they are addicted, or to individuals who constitute a direct threat to the health and safety of others.

(4) “Family community residence” means a community residence that provides a long term living arrangement of at least 6 months and does not limit how long a resident may live there. Typical uses may include, but are not limited to, the following:

(a) A community residential home for people with

disabilities who do not pose a threat to the health and safety of other persons or whose residency would result in substantial physical damage to the property of others.

(b) Group homes for people with disabilities that emulate a family, including, but not limited to, people with mental illness, substance use disorder, or physical disabilities.

(c) An assisted living facility for the elderly or other people with disabilities licensed under s. 429.07.

(d) An adult family–care home licensed under Florida s. 429.67.

(e) A community residential home licensed by the Department of Elderly Affairs, the Agency for Persons with Disabilities, the Department of Children and Families or the Agency for Health Care Administration which provides a living environment for residents who operate as the functional equivalent of a family.

(f) An intermediate care facility for people with developmental disabilities licensed under s.400. 962 that emulates a family.

(g) Housing licensed under ch.394.

(h) Recovery residences certified under s. 397.487, certified recovery residences, as defined in s. 397.311(5), where residency is typically at least 6 months.

(i) Recovery residences democratically operated by their residents pursuant to a charter from an entity recognized or sanctioned by Congress.

(5)~~(b)~~ "Licensing or certifying entity" ~~or "licensing entities"~~ means the Department of Elderly Affairs, the Agency for Persons with Disabilities, ~~the Department of Juvenile~~

~~Justice,~~ the Department of Children and Families, the Florida Association of Recovery Residences or other certifying or licensing entity as determined by the Department of Children and Families pursuant to s. 397.487, or the Agency for Health Care Administration~~, all of which are authorized to license a community residential home to serve residents~~.

(6)~~(c)~~ "Local government" means a county as set forth in chapter 125 or a municipality incorporated under ~~the provisions of~~ chapter 165.

(7)~~(d)~~ "Long term" means a continuous period of 6 or more months ~~"Planned residential community" means a local government-approved, planned unit development that is under unified control, is planned and developed as a whole, has a minimum gross lot area of 8 acres, and has amenities that are designed to serve residents with a developmental disability as defined in s. 393.063 but that shall also provide housing options for other individuals. The community shall provide choices with regard to housing arrangements, support providers, and activities. The residents' freedom of movement within and outside the community may not be restricted. For the purposes of this paragraph, local government approval must be based on criteria that include, but are not limited to, compliance with appropriate land use, zoning, and building codes. A planned residential community may contain two or more community residential homes that are contiguous to one another. A planned residential community may not be located within a 10-mile radius of any other planned residential community~~.

(8) "Reasonable accommodation" means providing one or more individuals with a disability and providers of housing for one

or more individuals with a disability the opportunity to receive modification or waiver of certain requirements to land use, zoning, property maintenance code and building code regulations to give such individual or individuals with a disability an equal opportunity to use and enjoy a dwelling, within the meaning of 42 U.S.C §3604(f).

(9) "Recovery community" means multiple dwelling units, including adjacent multifamily structures, duplexes, triplexes, and quadraplexes; attached single-family dwellings; a series of adjacent single-family detached dwellings; or a group of such adjacent dwellings which are not held out to the general public for rent or occupancy and which provide a mutually supportive, drug-free and alcohol-free living arrangement for people in recovery from substance use disorder who do not operate as the functional equivalent of a single family and are under the auspices of a single sponsoring entity or group of related sponsoring entities.

(a) Recovery communities include land uses for which the sponsoring entity is eligible to apply for certification pursuant to s. 397.487.

(b) The term does not include other group living arrangements for people who are not disabled or any community residence, congregate living facility, institutional or medical use facility, shelter, lodging or boarding house, extended stay hotel, nursing home, vacation rental, or other living arrangement for similar use.

(10) "Recovery residence" has the same meaning as in s. 397.311.

(11)~~(e)~~ "Resident" means any of the following: a frail

elder as defined in s. 429.65; a person who has a disability as defined in s. 760.22 ~~s. 760.22(3)(a)~~; a person who has a developmental disability as defined in s. 393.063; a nondangerous person who has a mental illness as defined in s. 394.455; a person in recovery from a substance use disorder; or live-in staff ~~or a child who is found to be dependent as defined in s. 39.01, or a child in need of services as defined in s. 984.03~~.

(12)~~(f)~~ "Sponsoring entity ~~agency~~" means an agency or unit of government, a for-profit ~~profit~~ or nonprofit agency, or any other person or organization that ~~which~~ intends to establish or operate a community residence, recovery community, or congregate living facility ~~residential home~~.

(13) "Transitional community residence" means a community residence that provides a temporary living arrangement of less than 6 months for unrelated people with disabilities. Transitional community residences include, but are not limited to:

(a) A group home for individuals with a disability which operates as the functional equivalent of a family.

(b) A community residence for people with disabilities who do not pose a direct threat to the health and safety of other persons or whose residency would not result in substantial physical damage to the property of others.

(c) Housing connected to outpatient treatment licensed under chapter 394.

(d) A living arrangement licensed by the Department of Elderly Affairs, the Agency for Persons with Disabilities, the Department of Children and Families, or the Agency for Health

Care Administration which provides a living environment for 7 to 14 unrelated residents who operate as the functional equivalent of a family.

(e) A certified recovery residence as defined in s. 397.311, at which residency is typically less than 6 months.

(f) A separate residential community housing component, pursuant to s. 397.311(9), of a day or night treatment facility with a community housing license

~~(2) Homes of six or fewer residents which otherwise meet the definition of a community residential home shall be deemed a single-family unit and a noncommercial, residential use for the purpose of local laws and ordinances. Homes of six or fewer residents which otherwise meet the definition of a community residential home shall be allowed in single-family or multifamily zoning without approval by the local government, provided that such homes are not located within a radius of 1,000 feet of another existing such home with six or fewer residents or within a radius of 1,200 feet of another existing community residential home. Such homes with six or fewer residents are not required to comply with the notification provisions of this section; provided that, before licensure, the sponsoring agency provides the local government with the most recently published data compiled from the licensing entities that identifies all community residential homes within the jurisdictional limits of the local government in which the proposed site is to be located in order to show that there is not a home of six or fewer residents which otherwise meets the definition of a community residential home within a radius of 1,000 feet and not a community residential home within a radius~~

~~of 1,200 feet of the proposed home. At the time of home occupancy, the sponsoring agency must notify the local government that the home is licensed by the licensing entity. For purposes of local land use and zoning determinations, this subsection does not affect the legal nonconforming use status of any community residential home lawfully permitted and operating as of July 1, 2016.~~

~~(3)(a) When a site for a community residential home has been selected by a sponsoring agency in an area zoned for multifamily, the agency shall notify the chief executive officer of the local government in writing and include in such notice the specific address of the site, the residential licensing category, the number of residents, and the community support requirements of the program. Such notice shall also contain a statement from the licensing entity indicating the licensing status of the proposed community residential home and specifying how the home meets applicable licensing criteria for the safe care and supervision of the clients in the home. The sponsoring agency shall also provide to the local government the most recently published data compiled from the licensing entities that identifies all community residential homes within the jurisdictional limits of the local government in which the proposed site is to be located. The local government shall review the notification of the sponsoring agency in accordance with the zoning ordinance of the jurisdiction.~~

~~(b) Pursuant to such review, the local government may:~~

~~1. Determine that the siting of the community residential home is in accordance with local zoning and approve the siting. If the siting is approved, the sponsoring agency may establish~~

~~the home at the site selected.~~

~~2. Fail to respond within 60 days. If the local government fails to respond within such time, the sponsoring agency may establish the home at the site selected.~~

~~3. Deny the siting of the home.~~

~~(c) The local government shall not deny the siting of a community residential home unless the local government establishes that the siting of the home at the site selected:~~

~~1. Does not otherwise conform to existing zoning regulations applicable to other multifamily uses in the area.~~

~~2. Does not meet applicable licensing criteria established and determined by the licensing entity, including requirements that the home be located to assure the safe care and supervision of all clients in the home.~~

~~3. Would result in such a concentration of community residential homes in the area in proximity to the site selected, or would result in a combination of such homes with other residences in the community, such that the nature and character of the area would be substantially altered. A home that is located within a radius of 1,200 feet of another existing community residential home in a multifamily zone shall be an overconcentration of such homes that substantially alters the nature and character of the area. A home that is located within a radius of 500 feet of an area of single-family zoning substantially alters the nature and character of the area.~~

~~(4) Community residential homes, including homes of six or fewer residents which would otherwise meet the definition of a community residential home, which are located within a planned residential community are not subject to the proximity~~

~~requirements of this section and may be contiguous to each other. A planned residential community must comply with the applicable local government's land development code and other local ordinances. A local government may not impose proximity limitations between homes within a planned residential community if such limitations are based solely on the types of residents anticipated to be living in the community.~~

~~(5) All distance requirements in this section shall be measured from the nearest point of the existing home or area of single-family zoning to the nearest point of the proposed home.~~

~~(6) If agreed to by both the local government and the sponsoring agency, a conflict may be resolved through informal mediation. The local government shall arrange for the services of an independent mediator. Mediation shall be concluded within 45 days of a request therefor. The resolution of any issue through the mediation process shall not alter any person's right to a judicial determination of any issue if that person is entitled to such a determination under statutory or common law.~~

~~(7) The licensing entity shall not issue a license to a sponsoring agency for operation of a community residential home if the sponsoring agency does not notify the local government of its intention to establish a program, as required by subsection (3). A license issued without compliance with the provisions of this section shall be considered null and void, and continued operation of the home may be enjoined.~~

~~(8) A dwelling unit housing a community residential home established pursuant to this section shall be subject to the same local laws and ordinances applicable to other noncommercial, residential family units in the area in which it~~

~~is established.~~

~~(9) Nothing in this section shall be deemed to affect the authority of any community residential home lawfully established prior to October 1, 1989, to continue to operate.~~

~~(10) Nothing in this section shall permit persons to occupy a community residential home who would constitute a direct threat to the health and safety of other persons or whose residency would result in substantial physical damage to the property of others.~~

~~(11) The siting of community residential homes in areas zoned for single family shall be governed by local zoning ordinances. Nothing in this section prohibits a local government from authorizing the development of community residential homes in areas zoned for single family.~~

~~(12) Nothing in this section requires any local government to adopt a new ordinance if it has in place an ordinance governing the placement of community residential homes that meet the criteria of this section. State law on community residential homes controls over local ordinances, but nothing in this section prohibits a local government from adopting more liberal standards for siting such homes~~.

Section 2. Section 419.002, Florida Statutes, is created to read:

419.002 Community residences.—

(1) PURPOSE AND DUTIES.—

(a) A community residence shall do all of the following:

1. Provide safe and accommodating shelter for persons with disabilities.

2. Emulate a family unit by providing the opportunity for

residents to form supportive relationships that nurture their physical, emotional, and social needs within a family–like relational structure.

3. Foster the normalization of residents, assist their integration into the surrounding community, and, when residents are capable, utilize neighbors without disabilities as role models.

4. Provide a safe and nurturing space for residents to gain and practice life skills.

(b) The residents of a community residence must receive care by supportive staff as may be necessary to meet their physical, emotional, and social needs.

(c) Residents may be self–governing or may be supervised by a sponsoring entity that provides habilitative or rehabilitative services related to the residents' disabilities.

(2) COMMUNITY RESIDENCES EXEMPTED FROM THIS CHAPTER.—

(a) A community residence constitutes a family for purposes of zoning and is not subject to this chapter when:

1. The number of occupants of a community residence, including live–in staff, does not exceed the maximum number of unrelated individuals, as determined by the definition of family, family unit, household, or a similar term in the appropriate local government land use code, ordinance, or regulation;

2. A local government's land use code, ordinance, or regulation does not stipulate a specific number of unrelated people that constitutes a family, family unit, household, or similar term; or

3. A local government's land use code, ordinance, or

regulation does not define family, family unit, household, or a similar term.

(b) No community residence that is exempted from this chapter pursuant to subsection 419.002(2)(a)1. shall be included when determining spacing distance requirements.

(3) LICENSURE AND OPERATIONS.—

(a) A community residence must be licensed or certified when the State of Florida offers licensing or certification, or must operate pursuant to a charter from an entity recognized or sanctioned by the Congress of the United States.

(b) A local government may revoke or nullify siting approval of a community residence if:

1. The sponsoring entity fails to provide the local government with evidence of permanent licensure or certification; or

2. The community residence is not operated pursuant to a charter from an entity recognized or sanctioned by Congress.

(c) A sponsoring entity of a community residence whose license, certification, or charter, or application for such license, certification, or charter, has been revoked or denied by a licensing or certifying entity may not operate in this state. Any zoning approval granted to such sponsoring entity becomes null and void upon the revocation or denial of its license, certification, or charter. The sponsoring entity of a community residence may appeal the revocation or denial of its license, certification, or charter. Any zoning approval granted to a sponsoring entity must be stayed pending the outcome of such appeal.

(d) The sponsoring entity of a community residence shall

notify the designated local government official within 5 calendar days after receiving notice that its license, certification, or charter has been revoked or denied. The sponsoring entity shall cease operations within 60 calendar days after the date on which the sponsoring entity receives notice of the denial or revocation, except that the local government may require operations to cease when continued operation poses a threat to the health and safety of the residents or the community residence. In such event, the sponsoring entity shall coordinate the reunion of the residents with their families or arrange for the relocation of the residents to a safe and secure living environment. Enforcement of a revocation or denial must be stayed pending the outcome of an appeal unless a local government requires the sponsoring entity to cease operations.

(4) SITING.—

(a) Spacing distances under this section must be measured from the nearest lot line of the existing community residence, recovery community, or congregate living facility closest to the proposed community residence or recovery community to the nearest lot line of the proposed community residence or recovery community. No community residence that is exempted from this chapter pursuant to subsection 419.002(2)(a) shall be included when determining spacing distance requirements. Each street and alley within the specified spacing distance requirement counts as 1 parcel lot.

Section 3. Section 419.003, Florida Statutes, is created to read:

419.003 Community residences; permitted use.—

(1) A family community residence constitutes a residential

use allowed as of right in all zoning districts where residences are allowed as of right, provided that it complies with subsections 419.003(3), 419.003(4), and 419.003 (5).

(2) A transitional community residence constitutes a residential use allowed as of right in all zoning districts where multifamily dwellings, duplexes, triplexes, or other forms of multi–family structures are allowed as of right, provided that it complies with subsections 419.003(3) and 419.003(4).

(3) Family and transitional community residences referenced in subsections 419.003(1) and 419.003(2) of this section shall be allowed as of right as permitted uses only when in compliance with the following requirements:

(a) The proposed community residence will be located at least 660 feet or 7 consecutive parcel lots, including each street and alley as one parcel lot, whichever is a greater distance, from the closest existing community residence, recovery community, or congregate living facility; and

(b) The proposed community residence has been issued and maintains:

(i) The license, certification or charter required to operate the proposed family community residence; or

(ii) A provisional or conditional license, certification or charter during an application process as determined by the designated licensing, certifying or chartering entity.

(c) No more than 12 individuals occupy the proposed community residence subject to the local government’s standard housing, building, or property maintenance code’s provisions related to overcrowding.

(4) A community residence is considered a residential use

of property for purposes of local government land use and zoning codes when in compliance with this chapter.

(5) EXCEPTIONS.—

(a) For purposes of local land use and zoning determinations, this section does not affect:

1. The legal nonconforming use status of any community residence lawfully permitted and operating before January 1, 2027.

2. The authority of any community residence lawfully established before January 1, 2027, to continue to operate.

(b) This section does not require a local government to amend its land use code if it has adopted zoning provisions governing the placement of community residences that meet the criteria of s. 419.003 and s. 419.004.

(c) This section does not prohibit a local government from adopting less restrictive zoning for siting community residences.

(d) No spacing distance may be greater than those specified in this chapter. A local government may adopt spacing distances less than those specified in this chapter or no spacing distance.

(6) ENFORCEMENT.—

(a) A local government may require a sponsoring entity for a community residence to cease operations immediately if continued operation poses an immediate and significant threat to the health and safety of the residents or the surrounding community.

Section 4. Section 419.004, Florida Statutes, is created to read:

419.004 Community residences; reasonable accommodation.

(1) A proposed community residence that does not comply with standards required in s. 419.003(3)(a) shall be allowed as a reasonable accommodation from the respective local government when the applicant has demonstrated that:

(a) The proposed community residence will not interfere with the normalization and community integration, and, where practical, the use of neighbors without disabilities as role models, of the residents of the closest existing community residence or recovery community and that the closest community residence, recovery community, or congregate living facility will not interfere with the normalization and community integration of the residents of the proposed community residence. Primary factors when determining compliance with this provision include:

(i) The linear distance along the pedestrian right of way between the two uses.

(ii) The likelihood of residents of each site interacting with residents of the other site.

(iii) Whether the residents of both sites have different disabilities or no disability, and

(iv) The proposed community residence in combination with any existing community residences, recovery communities, and/or congregate living facilities will not alter the residential character of the surrounding neighborhood by creating an institutional atmosphere or by creating or intensifying an institutional atmosphere or de facto social service district by clustering community residences, recovery communities, or

congregate living facilities on a block face or concentrating them in a neighborhood.

(2) When the State of Florida does not offer a license or certification for the type of community residence proposed and the population it would house, or the community residence proposed is not eligible for a recovery residence democratically operated by its residents from an entity recognized or sanctioned by the Congress of the United States, as required in s. 419.003(4), the local government must authorize a reasonable accommodation for the proposed community residence when the applicant has demonstrated that:

(a) The proposed community residence will be operated in a manner effectively similar to that of a licensed, certified, or chartered community residence; and

(b) Staff who reside or work in the community residence are adequately trained in accordance with standards typically required by licensing or state certification for a community residence; and

(c) The community residence emulates a family unit and operates to achieve normalization, community integration, and, when the residents are capable, the use of neighbors without disabilities as role models; and

(d) The rules and practices governing the operation of the community residence operate to protect the residents from abuse, exploitation, fraud, theft, neglect, insufficient support, use of illegal drugs or alcohol, and misuse of prescription medications.

(3) When a proposed community residence would house more than 12 unrelated people as required in s. 419.003(4), the local

government must authorize a reasonable accommodation for the proposed community residence when the applicant has demonstrated that:

(a) The proposed number of residents greater than 12 is necessary to ensure the therapeutic or financial viability of the proposed community residence;

(b) The primary function of the proposed community residence is residential where any medical treatment is merely incidental to the residential use of the property;

(c) The proposed community residence will emulate a family unit rather than as a boarding or rooming house; nursing home; short term rental; continuing care facility; motel; hotel; treatment center; rehabilitation center; institutional use facility; assisted living facility or community residential home that does not comport with the definition of community residence in this chapter; or other nonresidential use; and

(d) The requested number of residents in the proposed community residence will not interfere with the normalization and community integration of the occupants of the closest existing community residence or recovery community or, when the residents are capable, the use of neighbors without disabilities as role models.

(4) A transitional community residence must be allowed to obtain a reasonable accommodation to be sited in a single–family zone where single-family detached dwellings are the only dwellings allowed as permitted uses provided that the applicant demonstrates that:

(a) The proposed transitional community residence complies with s. 419.003(3) and, when applicable s. 419.004(1), s.

419.004(2), and s. 419.004(3), and

(b) The proposed transitional community residence is found to be compatible with the residential uses allowed as of right in the zoning district.

Section 5. Section 419.005, Florida Statutes, is created to read:

419.005 Recovery community as a permitted use.—

(1) LICENSURE AND OPERATIONS.—

(a) A recovery community must be licensed or certified by a licensing or certifying entity. A local government may revoke siting approval of a recovery community if the sponsoring entity fails to provide evidence of permanent licensure or certification.

(b) A sponsoring entity for a recovery community whose license or certification has been denied or revoked may not operate in this state. Any zoning approval granted to such sponsoring entity becomes null and void upon the denial or revocation of such license or certification. If a sponsoring entity appeals a revocation or denial of licensure or certification, any zoning approval granted to such sponsoring entity must be stayed pending the outcome of the appeal.

(d) The sponsoring entity must notify the designated local government official or other applicable entity that its license or certification has been revoked or denied within 5 calendar days after receiving notice of such revocation or denial. The sponsoring entity must cease operations within 60 calendar days after such notice, except that the local government may require operations to cease when continued operation poses a threat to the health and safety of the residents or the recovery

community. The sponsoring entity must coordinate the reunion of the residents with their families or arrange for the relocation of the residents to a safe and secure living environment. Enforcement of the revocation or denial of a license or certification must be stayed pending the outcome of an appeal unless a local government requires the sponsoring entity to cease operations.

(2) SITING AND ZONING.—

(a) A recovery community constitutes a residential use allowed in all zoning districts where townhouses, duplexes, triplexes, or other forms of multifamily structures are allowed as permitted uses, provided that the sponsoring entity has received certification from the designated certifying entity as established by s. 397.487 and meets the following requirements:

1. A proposed recovery community housing up to 16 occupants is located at least 660 feet or 7 consecutive parcel lots, whichever is the greater distance, with each street and alley counting as 1 parcel lot, from the closest recovery community, community residence, or congregate living facility;

2. A proposed recovery community housing 17 to 30 occupants is located at least 900 feet or 9 consecutive parcel lots, consecutive parcel lots, whichever is the greater distance, with each street and alley counting as 1 parcel lot, from the closest recovery community, community residence, or congregate living facility;

3. A proposed recovery community housing 31 to 50 occupants is located at least 1,300 feet or 13 consecutive parcel lots, whichever is the greater distance, with each street and alley counting as 1 parcel lot, from the closest recovery community,

community residence, or congregate living facility;

4. A proposed recovery community housing 51 to 100 occupants is located at least 1,400 feet or 14 consecutive parcel lots, whichever is the greater distance, with each street and alley counting as 1 parcel lot, from the closest recovery community, community residence, or congregate living facility; or

5. A proposed recovery community housing more than 100 occupants is located at least 1,500 feet or 15 consecutive parcel lots, whichever is the greater distance, with each street and alley counting as 1 parcel lot, from the closest recovery community, community residence, or congregate living facility.

(3) EXCEPTIONS.—

(a) For purposes of local land use and zoning determinations, this section does not affect:

1. The legal nonconforming use status of any recovery community lawfully permitted and operating before January 1, 2027.

2. The authority of any recovery community lawfully established before January 1, 2027, to continue to operate.

(b) This section does not require a local government to amend its land use code if it has adopted zoning provisions governing the placement of recovery communities that meet the criteria of s. 419.005 and s. 419.006.

(c) This section does not prohibit a local government from adopting less restrictive zoning for siting recovery communities.

(d) No spacing distance may be greater than those specified in this chapter. A local government may adopt spacing

distances less than those specified in this chapter or no spacing distance.

(4) ENFORCEMENT.—

(a) A local government may require a sponsoring entity of a recovery community to cease operations immediately if continued operation poses an immediate and significant threat to the health and safety of the residents or the surrounding community.

(b) This section does not permit persons to occupy a recovery community who would constitute a direct threat to the health and safety of other persons or whose residency would result in substantial physical damage to the property of others.

Section 6. Section 419.006, Florida Statutes, is created to read:

419.006 Recovery communities as reasonable accommodation.—

(1) A recovery community proposed to be located within the distance requirements specified in s. 419.006(2)(a) from the closest existing community residence, recovery community, or congregate living facility must be allowed a reasonable accommodation if the sponsoring entity demonstrates that:

(a) The proposed recovery community will not interfere with the normalization and community integration of the residents of the closest existing community residence or recovery community and that the closest existing community residence, recovery community or congregate living facility will not interfere with the normalization community integration, or, when the residents are capable, the use of neighbors without disabilities as role models. Primary factors when determining compliance with this provision include:

1. The linear distance along the pedestrian right-of-way between the two residences.

2. The likelihood of residents of one site interacting with residents of the other site.

3. Whether the residents of both sites have different disabilities or no disability.

(b) The proposed recovery community in combination with any existing community residences, recovery communities, or congregate living facilities will not alter the residential character of the surrounding neighborhood by creating an institutional atmosphere or by creating or intensifying an institutional atmosphere or de facto social service district by clustering recovery communities, community residences, or congregate living facilities on a block face or concentrating them in a neighborhood.

Section 7. Section 419.007, Florida Statutes, is created to read:

419.007 Community residences and recovery communities; applicable spacing distance; assistance.—

(1) A local government shall respond in writing within 10 business days to a request from a housing provider as to whether a proposed site for a community residence or recovery community is within the applicable spacing distance established by this chapter from the closest existing community residence or recovery community. The response shall include the calculated distance relied upon to deny an otherwise permitted use.

(2) If the proposed community residence or recovery community is within the applicable spacing distance specified in s. 419.003(3)(a) and s. 419.005(2)(a), the local government

must, upon request by the sponsoring entity, provide, at no charge and in writing within 20 business days after receiving the request, all of the following information:

(a) The address of the existing community residence, recovery community, or congregate living facility within the applicable spacing distance from the proposed community residence or recovery community.

(b) The exact linear distance along the pedestrian pathway of the proposed community residence or recovery community from the closest existing community residence, recovery community, or congregate living facility.

(c) The addresses and general nature of the residents' disabilities in all existing community residences and recovery communities as well as the nature of the population served at any congregate living facilities within a one-half mile radius of the proposed community residence or recovery community.

Section 8. Subsection (2) of section 393.501, Florida Statutes, is amended to read:

393.501 Rulemaking.—

(2) Such rules must address the number of facilities on a single lot or on adjacent lots, except that there is no restriction on the number of facilities designated as community residences as defined in s. 419.001 ~~residential homes located within a planned residential community as those terms are defined in s. 419.001(1)~~.

Section 9. Paragraph (k) of subsection (6) of section 400.464, Florida Statutes, is amended to read:

400.464 Home health agencies to be licensed; expiration of license; exemptions; unlawful acts; penalties.—

(6) The following are exempt from licensure as a home health agency under this part:

(k) The delivery of community residential services for which the community residence ~~residential home~~ is licensed under chapter 419, to serve the residents in its facility.

Section 10. Paragraph (c) of subsection (3) of section 400.9972, Florida Statutes, is amended to read:

400.9972 License required; fee; application.—

(3) An applicant for licensure must provide:

(c) Proof of compliance with local zoning requirements, including compliance with the requirements of chapter 419 if the proposed facility is a community residence ~~residential home~~.

Section 11. Subsection (3) of section 429.11, Florida Statutes, is amended to read:

429.11 Initial application for license.—

(3) If the applicant is a community residence ~~residential home~~, the applicant must provide proof that it has met the requirements specified in chapter 419.

Section 12. Subsection (5) of section 429.67, Florida Statutes, is amended to read:

429.67 Licensure.—

(5) Unless the adult family-care home is a community residence ~~residential home~~ subject to chapter 419, the applicant must provide documentation, signed by the appropriate governmental official, that the home has met local zoning requirements for the location for which the license is sought.

Section 13. Paragraph (e) of subsection (2) of section 1003.57, Florida Statutes, is amended to read:

1003.57 Exceptional students instruction.—

(2)

(e) This subsection applies to any nonresident student with a disability who resides in a residential facility and who receives instruction as an exceptional student with a disability in any type of residential facility in this state, including, but not limited to, a public school, a private school, a group home facility as defined in s. 393.063, an intensive residential treatment program for children and adolescents as defined in s. 395.002, a facility as defined in s. 394.455, an intermediate care facility for the developmentally disabled or ICF/DD as defined in s. 393.063 or s. 400.960, or a community residence ~~residential home~~ as defined in s. 419.001.

Section 14. This act shall take effect July 1, 2026.

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HEALTH

Historic decline in U.S. overdose deaths threatened by changing street drug supply

APRIL 14, 2026 · 1:03 PM ET

Brian Mann

A forensic chemist with the Drug Enforcement Administration holds vials of fentanyl pills at a DEA research laboratory in this file photo. Fentanyl deaths are plunging in the U.S, but the recovery is threatened by a new "synthetic soup" of toxic street drugs.

Mark Schiefelbein/AP/AP

Earlier this year, Naida Rutherford, the coroner in Richland County, South Carolina, was helping investigate what appeared to be a mysterious overdose. The case had many of the hallmarks of a typical fentanyl death.

"Every sort of physical manifestation, like the foam coming from the mouth and nose, as if they had an overdose," Rutherford said. "Their blood tested negative for any substance, which was very odd."

Her team was stumped, so Rutherford expanded the testing, looking for new compounds. "That's where we found the cychlorphine," she told NPR, referring to one of the incredibly potent synthetic opioids spreading fast in the U.S. street drug supply.

THE STORY BEHIND THE STORY

8 theories why fentanyl deaths are plummeting

"This is the first time we've seen it in South Carolina, which is very scary because none of us knew to test for it."

Experts say the U.S. addiction crisis is evolving fast, in ways that appear both hopeful and incredibly dangerous. The peril comes from a street drug supply that chemists now describe as a "synthetic soup."

Where once most drug users mostly consumed plant-based substances such as cocaine and heroin, drug gangs and cartels have shifted to producing and selling synthetic substances made from industrial chemicals.

Fentanyl and methamphetamines have been around for years. Now, illicit chemists are adulterating batches of street drugs with a fast-changing and often baffling mix of compounds, ranging from Novocaine to a stabilizer used in plastics manufacturing called BTPMS.

"Why those in particular are being put into the drug supply is a bit of a medical mystery at this point," said Nabarun Dasgupta, a researcher who studies street drugs and overdose patterns at the University of North Carolina.

"We're encountering something we've never seen before"

"Once a month or every other month, we're encountering something that we've never seen before, and we don't have indications of it being seen in the United States before," said Ed Sisco, a research chemist with a federal agency that tracks and tests street drugs called the National Institute of Standards and Technology.

The list of new chemical substances is dizzying. There are dangerously powerful sedatives like medetomidine, which can damage the human heart, and xylazine, sometimes known as tranq, which often causes devastating flesh lesions. Public health officials say new types of synthetic opioids, including cychlorphine and nitazenes, are often more potent than fentanyl.

According to Sisco, street drug users now have no way of knowing what they're putting in their bodies. "Substances that are in the supply are constantly changing and the other thing we see is the amount [and potency] of the substances is constantly changing," he said.

That variability makes it impossible for even experienced street drug users to protect themselves from toxic batches and potentially lethal doses. These unpredictable drug "cocktails" are also often resistant to standard medical treatments, like Narcan and naloxone, used to reverse opioid overdoses.

Medetomidine, in particular, is far more complicated to treat after an overdose or when a person goes into withdrawal from the drug, often requiring extensive and costly hospital care.

"The problem with medetomidine is that the withdrawal from it is life-threatening if you quit cold-turkey," said Dasgupta. "That is not the case with fentanyl or xylazine."

This month, the Centers for Disease Control and Prevention issued a health alert warning of the spread of medetomidine. State attorneys general in South Carolina and other states have warned of the spread of cychlorphine.

Drug deaths still dropping

The good news, researchers say, is that so far the spread of these industrial, toxic chemicals in the street drug supply hasn't derailed what amounts to a historic, sustained drop in the number of people dying from fatal overdoses.

As of October 2025, the most recent month where preliminary data is available from CDC, roughly 71,542 people had died in the U.S. over a 12-month period.

That's down dramatically from the 12-month peak of nearly 113,000 drug deaths recorded in August 2023.

"This is unprecedented and historic, for the longest consecutive months of decline," said Lori Ann Post, a researcher at Northwestern University whose new paper in the *American Journal of Public Health* tracks the steady improvement. "That is awesome."

Most researchers credit a mix of factors for the recovery, from less potent illicit fentanyl on the streets to better health and addiction care.

According to Post, deaths from opioids — including pain pills, heroin, fentanyl and other synthetic opioids — declined so rapidly in the U.S. that for the first time in decades overdoses from stimulants like cocaine and methamphetamines now kill more people than opioids.

"Opioids went way down. We have better interventions to treat opioid use disorder, we have reversal agents like Narcan [also known as naloxone] to undo an overdose," she said.

"This is what we've been waiting for, to turn the tide," said Dasgupta, at the University of North Carolina. He pointed to the stunning drop in mortality for young people across the U.S., citing a particularly hopeful development in the state of Maine.

"It's remarkable that no one in Maine under age 25 has died [from a drug overdose] in nearly 12 months. Zero is a meaningful number," Dasgupta said.

But every expert interviewed for this story said the situation in U.S. communities remains perilous as chemicals in the street drug supply become more potent and unpredictable.

Post and Dasgupta pointed to a crisis in Baltimore, Md., last summer when dozens of people were rushed to the hospital for overdoses after being exposed to a new variety of illicit benzodiazepines. Fortunately, in that case, everyone survived, but the potential for injury or death from drug poisoning remains high.

HEALTH

The pipeline of deadly fentanyl into the U.S. may be drying up, experts say

One mystery that street drug researchers are trying to unravel is why drug cartels and dealers would create an illegal marketplace so dangerous for customers, often selling batches of street drugs so heavily laced with chemicals that they make people sick rather than producing the euphoric high that buyers crave.

According to Dasgupta, gangs that are mixing synthetic street drugs are increasingly "turning to [chemicals] that aren't desirable."

He believes this spread of heavily adulterated fentanyl, and other drugs, could actually be contributing to the drop in overdose deaths as more people opt out of risky drug use.

"People who have been using for a long time are saying, that's enough, that's not what I signed up for," Dasgupta said.

overdose deaths fentanyl

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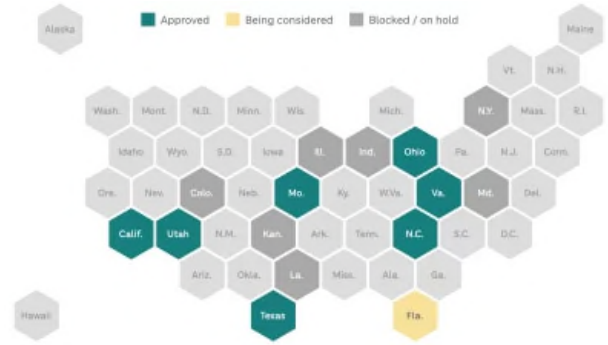

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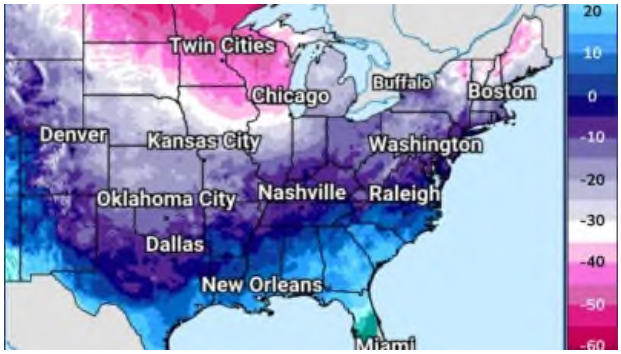

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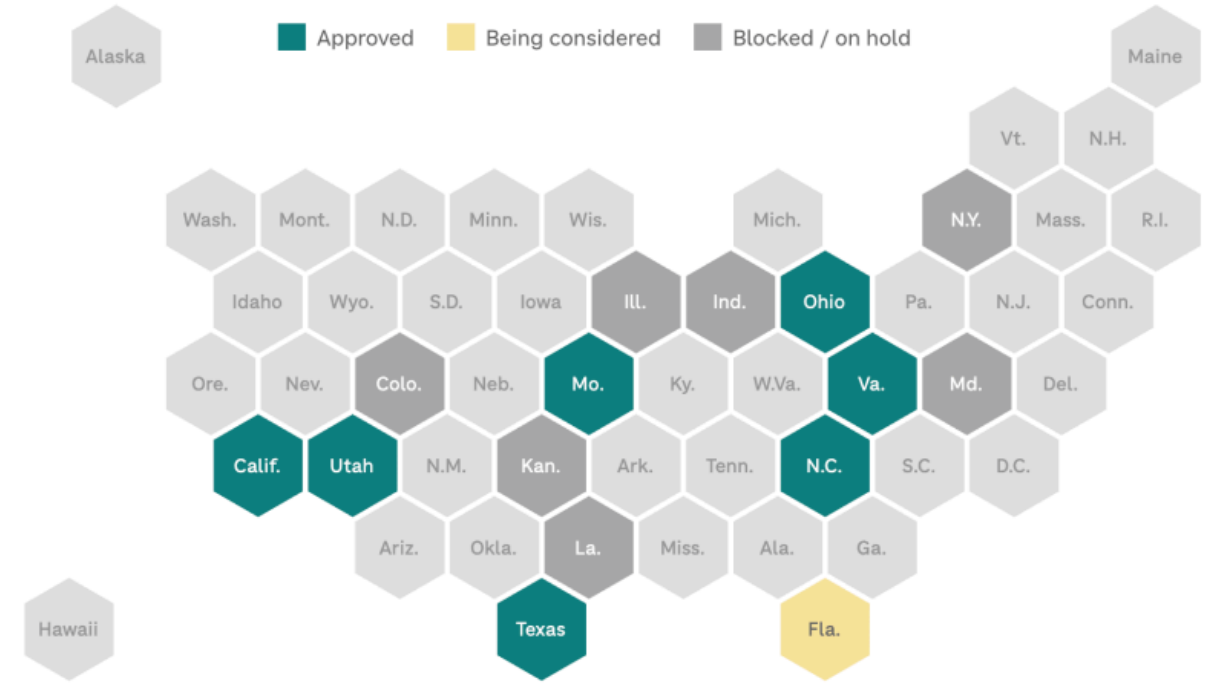

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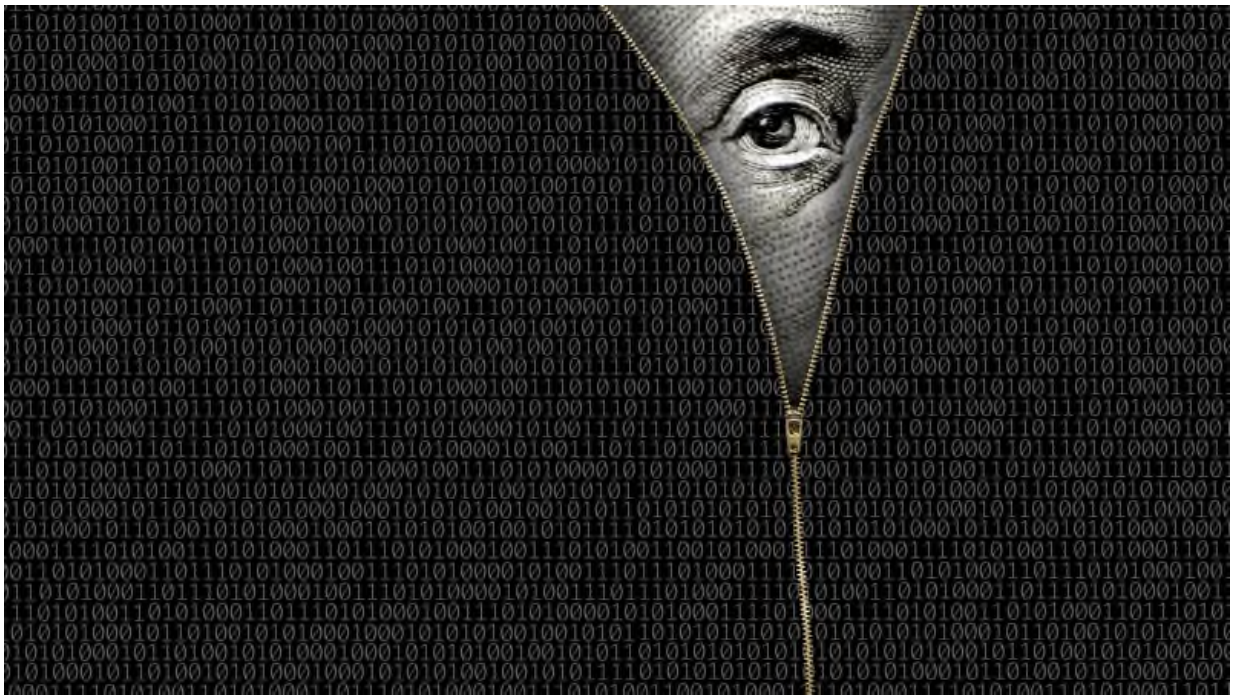

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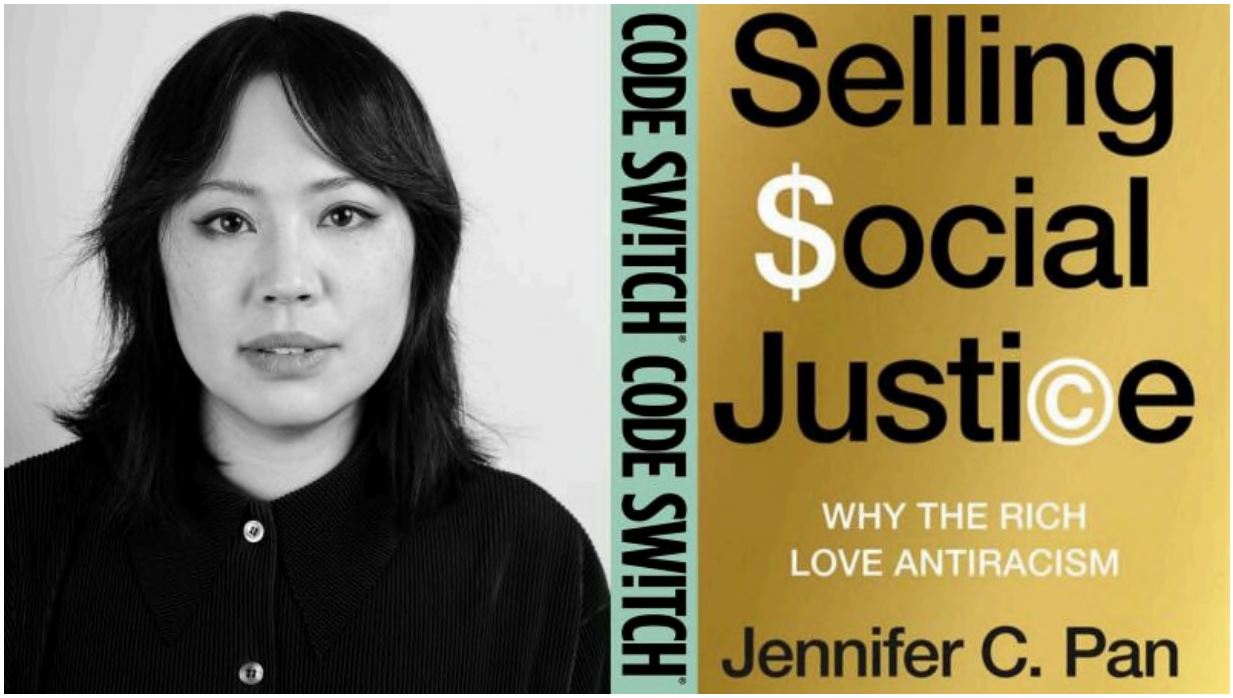

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Good afternoon,

The Florida Department of Children and Families has launched a new online database to make it easier to find and verify licensing information for Florida Substance Use Disorder (SUD) providers.

A link to the new SUD provider look-up app may be found on the Department's Licensing webpage Substance Use Disorder Licensing and Regulation | Florida DCF, replacing the current Licensed Provider Dashboard.

The New Tool Offers:

- **One simple search:** Look up a provider and see all their licensed services in one place.
- **Clear licensing details**: Improved provider visibility by grouping each provider's sites and components under a consolidated listing, allowing the user an at-a-glance view of the status of each license (probationary, regular, interim) and the ability to drill down into site-specific information including licensing applications, inspection reports, and administrative actions.
- **Mobile-friendly access:** A mobile-friendly tool that works on phones, tablets, and computers, with a layout that adjusts to your screen.
- **Interactive map:** Quickly find provider locations and confirm facility addresses.

Important note: This database is intended for licensing verification and transparency. It is not a quality rating and does not constitute an endorsement of any provider.

Please share this information with partners and stakeholders who refer, advocate, or support those seeking services. A contact form is provided on the Department's Licensing webpage Substance Use Disorder Licensing and Regulation | Florida DCF for questions or comments.

Thank you for your continued partnership in serving Floridians,

TOGETHER WE ARE ONE
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