Multi-System Youth Technical Assistance and Funding Application

PART A of the application must be completed by ALL applicants requesting technical assistance and funding.
PART B of this application must only be completed by applicants requesting funding.
Release of Information must be completed for ALL new applications.

FCFCs should email applications to MSY@medicaid.ohio.gov.
OhioRISE care coordinators should email applications to OHRMSYapplications@aetna.com.
All applications must be encrypted when emailed. FCFCs can also fax to 614-728-1521.

☐ Please check this box to mark the child/youth's needs as URGENT, i.e. without urgent consideration of this application, the child could be relinquished within a few days and/or face other significant challenges.
Please describe the urgency of the situation below.

Requesting Entity & OhioRISE Engagement:

☐ Family and Children First Council (FCFC) ☐ OhioRISE Care Coordinator

If the child/youth is enrolled in OhioRISE, please complete the following:

OhioRISE Care Coordination Engagement	OhioRISE Care Coordination Tier	Has a CANS been completed
☐ Yes ☐ No ☐ Declined	☐ 1 ☐ 2 ☐ 3	☐ Yes, Date:__/__/__ ☐ No

If not engaged in OhioRISE care coordination ('No' or 'Declined' above) detail the reason why.

PART A: To be completed by applicants requesting technical assistance and/or funding.

I. Requesting Applicant Information

Agency / Organization Name			Contact Person	
Street Address		County	Email	
City	State	Zip Code	Phone Number	Fax Number

II. Child/Youth Information

Name			Social Security Number	
Date of Birth	Age in Years & Months		Gender	Race/Ethnicity
Home Street Address	City	County	State	Zip Code
Phone Number	Guardian			
Primary Insurer *(if Medicaid include ID #)*	Secondary Insurer *(if applicable)*			
Current Placement	Child Eligible for IV-E ☐ Yes ☐ No		Previous Adoption ☐ Yes ☐ No	
Grade Level	School Placement ☐ ED ☐ LD ☐ OHI ☐ DH			

Reason for Referral Check all that apply*:*

☐ Assistance with facilitation and/or outreach with state and local partners and other interested parties ☐ Assistance with facilitation of managed care and other insurance involvement	☐ Child/youth at risk of custody relinquishment ☐ Child/youth at risk of out of state placement ☐ Custody already relinquished ☐ Request for clinical review

Indicate the child/youth' and family's involvement with local / state systems.

Local / State System Involvement	Name(s) and Contact Information
☐ County Child Welfare / Child Protection System	
☐ Local Health Dept. and/or Bureau of Medical Handicaps	
☐ School or Education Provider	
☐ County Board of Mental Health / Addiction Services	
☐ Opportunities for Ohioans with Disabilities/Employment	
☐ Other	
☐ Juvenile Justice. If FCFC please complete information below.	

	Current	Previous	Pending
Adjudicated delinquent (other than a violent offense)	☐	☐	☐
Adjudicated unruly	☐	☐	☐
Charged and/or adjudicated (felony/ misdemeanor offense of violence)	☐	☐	☐
Placed on Probation	☐	☐	☐
DYS committed	☐	☐	☐
DYS aftercare residential Tx	☐	☐	☐
Paroled	☐	☐	☐
Clinical recommendation for secure residential Tx for violent &/or aggressive behavior	☐	☐	☐

Local / State System Involvement	Name(s) and Contact Information
☐ County Board of Developmental Disabilities (CBDD). If YES… A. Eligible for CBDD services (non-waiver)? ☐ Yes ☐ No ☐ Not yet determined B. Eligible for a CBDD Medicaid Waiver? ☐ Enrolled on a CBDD Medicaid Waiver. If YES, which one? ☐ Self ☐ Individual Options ☐ Level 1 ☐ On a waiting list for a Waiver ☐ Denied a Waiver ***Please include all available CBDD documentation w/your application***	

Indicate the child/youth's current or past exposure to the following:

☐ Physical abuse	☐ Neglect	☐ In-utero drug or alcohol exposure
☐ Sexual abuse	☐ Mental / emotional trauma	☐ Domestic violence
☐ Emotional abuse	☐ Physical trauma	☐ Other (describe)

Indicate the child/youth's current or past experiences with the following:

☐ Mental health	☐ Physical delays	☐ Sensory delays (speech/hearing)
☐ Physical health	☐ Intellectual delays	☐ Other (describe)
☐ Substance use	☐ Social/emotional delays	

Indicate the child/youth's current or past behaviors and/or characteristics*:*

☐ Aggression: physical	☐ Fire setting/arson	☐ Sleep disturbance/disorder
☐ Aggression: verbal	☐ Homicidal ideation(s)	☐ Stealing/robbery/shoplifting
☐ Attention/hyperactivity	☐ Hallucination(s)/delusion(s)	☐ Suicidal ideation/attempt
☐ Authority challenges	☐ Peer relations challenges	☐ Tantrums/severe anger
☐ Bizarre behavior/language	☐ Running away	☐ Vandalism
☐ Breaking/entering	☐ Self-harm/mutilation	☐ Victim Domestic Violence/IVP
☐ Commit Domestic Violence/IPV	☐ Sex offender/predator/assault	☐ Withdrawal (social/emotional)
☐ Eating disorder(s)	☐ Sexual identity/orientation issues	☐ Witness to violence
☐ Encopresis/enuresis	☐ Sexualized behavior/advances	

Indicate the current and past types of services and resources in use for the child/youth and family.

	Current	Past 12 months	Past 24 months	N/A	Details about specific services/ resources INCLUDE NAMES OF SERVICE PROVIDERS
Family and Children First Care coordination / case management	☐	☐	☐	☐	
OhioRISE Care coordination	☐	☐	☐	☐	
Other Care coordination / Case management	☐	☐	☐	☐	
In-home services and supports *(ex. home visiting, IHBT)*	☐	☐	☐	☐	
Outpatient community-based behavioral health services *(ex. counseling, family therapy)*	☐	☐	☐	☐	
Inpatient psychiatric treatment	☐	☐	☐	☐	
Residential treatment	☐	☐	☐	☐	
Group home	☐	☐	☐	☐	
Therapeutic foster home	☐	☐	☐	☐	
Foster home	☐	☐	☐	☐	
Respite *(residential and/or foster)*	☐	☐	☐	☐	

	Current	Past 12 months	Past 24 months	N/A	Details about specific services/ resources <u>INCLUDE NAMES OF SERVICE PROVIDERS</u>
Crisis services	☐	☐	☐	☐	
Mentoring / peer services	☐	☐	☐	☐	
Skill Building services / supports	☐	☐	☐	☐	
Family therapy	☐	☐	☐	☐	
Intellectual and/or developmental disabilities services / supports	☐	☐	☐	☐	
Other *(specify)*	☐	☐	☐	☐	

Indicate which of the additional supporting documentation is included with the application

- ☐ FCFC Service Coordination Plan or OhioRISE Child and Family Centered Care Plan (CFCP)
- ☐ CANS / Level of Care Assessment
- ☐ Psychosocial, Psychological and/or neuropsychological assessment and/or discharge summary
- ☐ Mental Health or Substance Use Treatment Plan
- ☐ Developmental Disabilities Service Plan
- ☐ Individualized Education Plan (IEP/504 Plan)
- ☐ Transition / Discharge Plan
- ☐ Other supporting documentation (including medical documentation)

If you are submitting an OhioRISE Child and Family Centered Care Plan with this application move to Part B.

Describe the child/youth's involvement with the education system. Include details about education challenges (attendance, truancy, learning difficulties, school behavior problems) and indicate if the child is getting necessary supports.

List relevant diagnoses and current medications. Include behavioral health (emotional, psychological, substance use), medical, intellectual, developmental, and others, as applicable.

Describe current and past actions taken by local entities, including county/local agencies, OhioRISE, schools, providers, and others, to support the child/youth and family. If applicable, describe cross-system efforts taken to avoid an out-of-home placement. *Please describe in detail to prevent application processing delays.*

Describe the child/youth and family strengths.

Describe the child/youth and family dynamics, circumstances, and challenges that resulted in this request. ***Please include information about current and past parent/caregiver engagement.***

List any additional information that would be helpful. Please include safety concerns, if applicable.

PART B: To be completed by applicants requesting funding.
Applicants requesting funding must complete ALL of the following sections.

Background Information for Funding Request

Funding will be authorized / not authorized on a case-by-case basis. **Funding requests will be considered for authorization only if all five of the following eligibility criteria have been met.**

- ☐ 1. The child/youth has multi-system needs and is at risk for custody relinquishment, OR
  - ☐ the child/youth has already been relinquished.
- ☐ 2. The applicant has identified availability of local resources (including funding) and/or clinically indicated services to support the child/youth and family.
- ☐ 3. Multi-system local and/or regional agencies are working to coordinate care for the child/youth and family.
- ☐ 4. Financial resources have been reasonably exhausted, as detailed below
- ☐ 5. The child/youth will be placed in the least restrictive setting, and the setting will be documented as clinically appropriate to meet the treatment needs of the child/youth and family.

It is our intent to ensure local resources are reasonably exhausted before state-level funding is authorized. Check the boxes below to indicate specific financial resources, including local funding options, that have been explored and/or exhausted for this case to date.

Resource Explored?	Child / Family Eligible?	Reasonably exhausted?
☐ OhioRISE	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ OhioRISE Flex Funds	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ OhioRISE 1915 (c) Waiver	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Adoption Assistance	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Child Support	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Family Centered Services and Supports (FCSS)	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Home Energy Assistance Program (HEAP)	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Local Developmental Disabilities Board	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Local Mental Health / Addiction Board	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Medicaid / Medicaid Managed Care	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Metropolitan Housing Authority	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Post Adoption Special Services Subsidy (PASSS)	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Prevention, Retention, and Contingency (PRC)	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Private health insurance	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Social Security/Disability Insurance (SSI/SSDI)	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Social Security Survivor's Benefits	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ State Adoption Maintenance Subsidy (SAMS)	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Supplemental Nutrition Assistance Program (SNAP)	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Temporary Assistance for Needy Families / Cash Asst.	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure

If you indicate **yes** above, please provide detailed information about amounts and how funds have been used.

III. Funding Request

Check items 1-4 below to indicate the type(s) of funding being requested. Provide detailed information about how each type of requested funding will be used and the entities / providers that may use authorized funds to deliver services. **Please note: funding may not be authorized until provider(s) of services have been identified and the child/youth has been accepted for service provision by the provider(s).**

☐ **1. Care Coordination/Wraparound to prevent custody relinquishment or for a relinquished child/youth.**

Provider(s) of service(s):	Amount: $

☐ 30 days ☐ 60 days ☐ 90 days Start date: ____/____/____ End Date: ____/____/____

Detailed description of how funds will be used:

☐ **2. In-home and/or community supports to prevent custody relinquishment.**

Provider(s) of service(s):	Amount: $

☐ 30 days ☐ 60 days ☐ 90 days Start date: ____/____/____ End Date: ____/____/____

Detailed description of how funds will be used:

☐ **3. In-home and/or community supports for a relinquished child/youth transitioning to a community setting.**

Provider(s) of service(s):	Amount: $

☐ 30 days ☐ 60 days ☐ 90 days Start date: ____/____/____ End Date: ____/____/____

Detailed description of how funds will be used:

☐ **4. Residential treatment and/or room and board for treatment to prevent custody relinquishment.**

Residential treatment updates will be required every 30 days, regardless of authorized funding time period.

Provider(s) of service(s), including address:	Amount: $

☐ 30 days ☐ 60 days ☐ 90 days Start date: ____/____/____ End Date: ____/____/____

List the referral source for residential placement, attach level of care and referral documentation.	Detailed description of how funds will be used:

Estimated daily itemized costs associated with the residential funding request. Check and describe all that apply.

☐ Room & board: $ _____

☐ Behavioral health treatment: $ _____

☐ Other supportive services (i.e. 1:1 care): $ _____ Description: _____

If financial support for residential treatment is authorized, describe how the applicant and family will begin to work on discharge planning upon admission; if the child/youth is already residing in a residential treatment setting at the time of application, describe how discharge planning will begin or continue upon notification of authorization of funding.

By signing below, the applicant certifies that the information submitted with this application, including any attachments, is true and accurate to the best of their knowledge and belief. If funding is authorized to support residential treatment, the applicant commits to begin discharge planning upon admission; if the child/youth is already residing in residential treatment at the time of application, the applicant commits to begin this work upon notification of authorization of funding.

If funding is authorized, the applicant commits to provide timely updates regarding the use of funding for services and supports. If services and supports for the child/youth and family become disrupted, the applicant commits to provide an update within 72 hours.

By signing below, the parent/legal guardian commits to maintaining involvement in the child's plan of care for all placements and services, including learning skills and coping behaviors, as appropriate. If funding is authorized to support residential treatment, the parent/legal guardian commits to immediately begin working toward reintegrating the youth into the family setting, to begin or continue to fully participate in discharge planning, and to allow the child to return to their home when deemed clinically appropriate.

The Multi System Youth Custody Relinquishment Prevention program only available when funding is authorized by the Ohio General Assembly. Funding is provided through grants and funding is limited. The applicant acknowledges that the receipt of funding is not guaranteed and waives any right to funding beyond 30 days of initial authorization; funding can be rescinded at any time. Applications will be reviewed by a team of individuals from multiple state agencies and determinations will be made using objective criteria. Applicant also acknowledges the information above will be shared for purposes of determining grant eligibility consistent with the terms of the attached information release. Funding determinations are final and not subject to appeal.

_____ _____

Care Coordinator *(Signature)* Date

_____ _____

Parent/Legal Guardian *(Signature)* Date

LEGIBLE SIGNATURES ARE REQUIRED ABOVE.

Multi-System Youth Technical Assistance and Funding
RELEASE OF INFORMATION

Child/Youth Name	
Date of Birth	Social Security Number

I, _____, authorize the release of all information, including substance use disorder information if applicable, required for service coordination, funding reviews and program evaluation of the Multi-System Youth Program process to be exchanged between and among the following organizations, including all members of the Ohio Family and Children First Council Cabinet and/or his or her designee(s), and staff from the Office of the Ohio Governor:

All member agencies of the Ohio Family and Children First (OFCF) Governor's Children's Cabinet per section 121.37 of the Ohio Revised Code, including The Ohio Department of Medicaid and its contractors.

All of the following _____county and local organizations

- Board of Developmental Disabilities (DD)
- Juvenile Court
- Department of Job and Family Services
- Public Children's Services Agency
- Alcohol Drug and Mental Health (ADAMH) Board
- Family and Children First Council
- OhioRISE Care Management Entity

And all the following organizations (please name applicable organizations below):

Educational Service Center
Residential/In-Patient Facility
School District of Residence & Attendance
Behavioral Health Provider(s)
In-home service provider(s)
OhioRISE CME
Medicaid Managed Care Entity or Entities
Other
Any exceptions or exclusions for information released

Please Initial:

_____ I understand and acknowledge that this authorization extends to all or any parts of the record designated above, which may include treatment for mental illness, and/or alcohol/drug abuse/dependency, AIDS/HIV, and/or educational records. I understand that this information will be released only to the participating agency representatives and that any information released to such representatives may not be further disclosed or shared with any person(s)/organization(s) specifically listed on this form without my written, prior authorization, unless:

- Required to do so by federal and/or state law or regulation
- Unless an emergency exists
- Unless permitted by this or other policies of the _____ Family and Children First Council, or
- Unless the information has been sufficiently de-identified that the recipient would be unable to link the information to the client.

I understand that these records are protected by state and/or federal confidentiality regulations and cannot be disclosed without my written consent, unless provided for in the regulations.

This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

_____ I do not consent to the disclosure of any information *(will prevent proceeding the Multi-System Youth Program and Funding)*

1. This authorization will remain effective as long as the MSY program is active, unless an earlier date or condition/event is specified here _____. This consent is subject to revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it.

2. However, I understand that I *HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION, IN WRITING*, by sending/providing such written notification to ATTN: Multi-System Youth (MSY) Administrator; 50 West Town Street, Suite 400; Columbus, Ohio 43215.

3. I understand that I have the right to refuse to sign this authorization; however, should I refuse to sign the authorization, the child or youth listed above will not be eligible for financial assistance from the Multi- System Youth Program.

4. I have the right to inspect or copy the protected health information and protected educational information to be used of disclosed as permitted under law.

I have read or have had this document read to me and I understand its content.

_____

Signature of Parent or Guardian Date

_____

Relationship to Child or Youth

_____

Name of Child or Youth Date

_____

Signature of Child or Youth if information regarding SUD is involved Date

_____

Witness Date

****A copy of this signed authorization shall have the same force and effect as the original.**

***42 CFR part 2 prohibits unauthorized disclosure of these records.

LEGIBLE SIGNATURES ARE REQUIRED ABOVE.