



Multi-System Youth Case Update Form

PART A of the form must be completed by ALL who have received funding from the Program. PART B of this form must be completed by applicants requesting new or continued funding.

FCFCs should email updates to MSY@medicaid.ohio.gov

OhioRISE care coordinators should email updates to OHRMSYapplications@aetna.com

All updates must be encrypted when emailed.

FCFCs: If encrypted email is not an option, please fax the update to 614-728-1521.

Part A: Update form

Non-residential services expenditures: This update form must be completed at least every 90 days to provide updates on expenditures and case progress for non-residential services.

Residential services expenditures: This update form must be completed on a monthly basis (every 30 days) to provide updates on expenditures and case progress for residential services.

I. Updating Agency Information

Agency Name, Contact Person, Street Address, County, Email, City, State, Zip Code, Phone Number, Fax Number, Today's Date

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

**Describe changes in any of the following that occurred this reporting period.** If you indicate yes for any item listed below, please provide detailed information about the changes and how they may impact the youth's discharge plan. *Please describe in detail to prevent application processing delays.*

	<b>Changes?</b>	<b>Description of changes</b>
<b>Child/youth's custody</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	
<b>Child/youth's placement</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	
<b>Child/youth's providers</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	
<b>Care Coordination through FCFC or OhioRISE</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	Current tier of OhioRISE care coordination, if applicable
<b>CANS Completed</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	Most recent CANS completion date ___/___/_____
<b>Health Insurance Coverage</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	
<b>School/Education</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	
<b>Resources</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	
<b>Family circumstances that may impact custody status</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	
<b>Family circumstances that may impact discharge plan</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	
<b>Treatment / care plan</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	
<b>Transition / Discharge plan</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	

### III. Accounting & Insurance

Authorized funding amount for the reporting period	\$	Amount used during the reporting period	\$	Total authorized funds to date	\$
Does the child have third party (private) insurance?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, has third party (private) insurance been billed for the services provided?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please provide funding amounts paid by other insurance: _____					
If the child has third party (private) insurance that has not been billed, why is this the case?					

### IV. Treatment Updates

*This section **must** be completed for all children/youth who received MSY funds to support treatment, residential and community based.*

**Select one of the following options:**

- I have a monthly treatment summary from the provider that addresses all the questions below, and it is attached.
- I have a treatment summary from the community/in home provider that addresses all the questions below, and it is attached.
- I do not have a monthly treatment summary from the provider, and I will provide treatment updates through answers to the questions below.

**Provide a detailed description of treatment provided to date. Please include information regarding restraints, emergency response or law enforcement involvement, and/or safety concerns.**

**Did the child/youth actively participate in treatment and/or services during the reporting period? If so, to what extent? If not, how is their lack of participation being addressed?**

**Have any medications or significant interventions been changed during the reporting period? If so, how is the child/youth responding to the change(s)?**

**What progress has been made? If progress has not been made, please describe why this is the case.**

**Describe the current discharge or sustainability plan, including custody, living arrangements, services needed/established, follow-up, ongoing care coordination planning and other needed supports. If the child/youth is receiving residential treatment and discharge planning has not started, please justify why discharge planning is not occurring and include the date it will start.**

**Describe the current level of family engagement.**

**Describe how education has been provided in the residential or community setting. Please include information regarding communication with the child/youth's school district on returning to school and/or providing educational services during treatment.**

**To request new or continued funding, please continue to Part B below.**

## Part B: Additional MSY Funding Request

If new or continued funding is being requested, check items 1-4 below to indicate the type(s) of funding. 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 providers of services have been identified and the child/youth has been accepted for service provision by the providers.**

<input type="checkbox"/> <b>1. Care Coordination/Wraparound to prevent custody relinquishment or for a relinquished child/youth.</b>	
Provider(s) of service(s):	Amount: \$
<input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days      Start date: ___/___/___	End Date: ___/___/___
Detailed description of how funds will be used:	
<input type="checkbox"/> <b>2. In-home and/or community supports to prevent custody relinquishment.</b>	
Provider(s) of service(s):	Amount: \$
<input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days      Start date: ___/___/___	End Date: ___/___/___
Detailed description of how funds will be used:	
<input type="checkbox"/> <b>3. In-home and/or community supports for a relinquished child/youth transitioning to a community setting.</b>	
Provider(s) of service(s):	Amount: \$
<input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days      Start date: ___/___/___	End Date: ___/___/___
Detailed description of how funds will be used:	
<input type="checkbox"/> <b>4. Residential treatment and/or room and board for treatment to prevent custody relinquishment.</b> <i>Residential treatment updates will be required every 30 days, regardless of authorized funding time period.</i>	
Provider(s) of service(s), including address:	Amount: \$
<input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 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.	
<input type="checkbox"/> Room & board: \$ _____	
<input type="checkbox"/> Behavioral health treatment: \$ _____	
<input type="checkbox"/> Other supportive services (e.g., 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 is 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.

<b>Care Coordinator</b> <i>(Signature)</i>	Date
<b>Parent/Legal Guardian</b> <i>(Signature)</i>	Date

LEGIBLE SIGNATURES ARE REQUIRED ABOVE.