



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.

ATTACHMENT A must be completed for ALL new applications.

All applications must be encrypted when emailed to MSY@medicaid.ohio.gov.

If encrypted email is not an option, applications can be faxed 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.

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

I. Requesting Applicant Information

Agency 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	State	Zip Code
Phone Number		Guardian		
Primary Insurer (if Medicaid include ID #)		Secondary Insurer (if applicable)		
Current Placement		Child Eligible for IV-E <input type="checkbox"/> Yes <input type="checkbox"/> No		Previous Adoption <input type="checkbox"/> Yes <input type="checkbox"/> No
Grade Level	School Placement <input type="checkbox"/> ED <input type="checkbox"/> LD <input type="checkbox"/> OHI <input type="checkbox"/> DH		Education Scholarship <input type="checkbox"/> Autism <input type="checkbox"/> John Peterson	

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

Local / State System Involvement				Name(s) and Contact Information	
<input type="checkbox"/> County Child Welfare / Child Protection System					
<input type="checkbox"/> County Family and Children First Council					
<input type="checkbox"/> Local Health Dept. and/or Bureau of Medical Handicaps					
<input type="checkbox"/> School or Education Provider					
<input type="checkbox"/> County Board of Mental Health / Addiction Services					
<input type="checkbox"/> Juvenile Justice. IF YES, please check status below:					
	Current	Previous	Pending		
Adjudicated delinquent (other than a violent offense)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Adjudicated unruly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Charged and/or adjudicated (felony/ misdemeanor offense of violence)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Placed on Probation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
DYS committed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
DYS aftercare residential Tx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Paroled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Clinical recommendation for secure residential Tx for violent &/or aggressive behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> County Board of Developmental Disabilities (CBDD). If YES... A. Eligible for CBDD services (non-waiver)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not yet determined B. Eligible for a CBDD Medicaid Waiver? <input type="checkbox"/> Enrolled on a CBDD Medicaid Waiver. If YES, which one? <input type="checkbox"/> Self <input type="checkbox"/> Individual Options <input type="checkbox"/> Level 1 <input type="checkbox"/> On a waiting list for a Waiver <input type="checkbox"/> Denied a Waiver <i>Please include all available CBDD documentation w/your application</i>					
<input type="checkbox"/> Opportunities for Ohioans with Disabilities/Employment					
<input type="checkbox"/> Other					

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.

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

<input type="checkbox"/> Physical abuse	<input type="checkbox"/> Neglect	<input type="checkbox"/> In-utero drug or alcohol exposure
<input type="checkbox"/> Sexual abuse	<input type="checkbox"/> Mental / emotional trauma	<input type="checkbox"/> Domestic violence
<input type="checkbox"/> Emotional abuse	<input type="checkbox"/> Physical trauma	<input type="checkbox"/> Other (describe)

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

<input type="checkbox"/> Mental health	<input type="checkbox"/> Physical delays	<input type="checkbox"/> Sensory delays (speech/hearing)
<input type="checkbox"/> Physical health	<input type="checkbox"/> Intellectual delays	<input type="checkbox"/> Other (describe)
<input type="checkbox"/> Substance use	<input type="checkbox"/> Social/emotional delays	

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

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

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

Describe current and past actions taken by local entities, including county/local agencies, 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.*

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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	Details about specific services/resources, INCLUDING NAMES OF SERVICE PROVIDERS
Care coordination / case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
In-home services and supports (<i>ex. home visiting, transition services</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Outpatient community-based behavioral health services (<i>ex. counseling</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Inpatient psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Residential treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Group home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Therapeutic foster home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Foster home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Respite (<i>residential and/or foster</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crisis services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mentoring / peer services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skill Building services / supports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Family therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Intellectual and/or developmental disabilities services / supports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (<i>specify</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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.

Attach additional supporting documentation, including any of the following:

- ☐ County FCF Service Coordination Plan (**REQUIRED** if applicant is a County FCFC)
- ☐ 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)
- ☐ Other supporting documentation (including medical documentation)

III. Reason for Referral *Check all that apply*

- | | |
|---|--|
| <input type="checkbox"/> Assistance w/ facilitation of outreach to / engagement of state and local partners | <input type="checkbox"/> Child/youth at risk of custody relinquishment |
| <input type="checkbox"/> Assistance w/ facilitation of managed care and other insurance involvement | <input type="checkbox"/> Child/youth at risk of out of state placement |
| <input type="checkbox"/> Assistance w/ coordination among interested parties | <input type="checkbox"/> Custody already relinquished |
| | <input type="checkbox"/> Request for clinical review |

IV. Release of Information – ATTACHMENT A

- ☐ Check to indicate this application is being submitted with a release of information form.

Please continue to PART B below if requesting funding.

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

V. 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?
<input type="checkbox"/> Adoption Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
<input type="checkbox"/> Child Support	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
<input type="checkbox"/> Family Centered Services and Supports (FCSS)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
<input type="checkbox"/> Home Energy Assistance Program (HEAP)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
<input type="checkbox"/> Local Developmental Disabilities Board	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
<input type="checkbox"/> Local Mental Health / Addiction Board	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
<input type="checkbox"/> Medicaid / Medicaid Managed Care	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
<input type="checkbox"/> Metropolitan Housing Authority	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
<input type="checkbox"/> Post Adoption Special Services Subsidy (PASSS)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
<input type="checkbox"/> Prevention, Retention, and Contingency (PRC)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
<input type="checkbox"/> Private health insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
<input type="checkbox"/> Social Security/Disability Insurance (SSI/SSDI)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
<input type="checkbox"/> Social Security Survivor's Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
<input type="checkbox"/> State Adoption Maintenance Subsidy (SAMS)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
<input type="checkbox"/> Temporary Assistance for Needy Families / Cash Asst.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure

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

VI. 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 providers of services have been identified and the child/youth has been accepted for service provision by the providers.**

<input type="checkbox"/> 1. Care Coordination/Wraparound to prevent custody relinquishment or for a relinquished child/youth.			
Provider(s) of service(s):		<input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days	Amount: \$
Detailed description of how funds will be used:			
<input type="checkbox"/> 2. In-home and/or community supports to prevent custody relinquishment.			
Provider(s) of service(s):		<input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days	Amount: \$
Detailed description of how funds will be used:			
<input type="checkbox"/> 3. In-home and/or community supports for a relinquished child/youth transitioning to a community setting.			
Provider(s) of service(s):		<input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days	Amount: \$
Detailed description of how funds will be used:			
<input type="checkbox"/> 4. Residential treatment and/or room and board for treatment to prevent custody relinquishment. <i>If funding for residential treatment is authorized, updates will be required every 30 days, regardless of authorized funding time period.</i>			
Provider(s) of service(s), including address:		<input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days	Amount: \$
		Detailed description of how funds will be used:	
List the referral source for residential placement, and if available, attach level of care and referral documentation.			
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 (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 is a pilot program for State Fiscal Year 2020 and grant funding is limited. The applicant acknowledges that the receipt of funding is not guaranteed and waives any right to beyond 30 days of initial authorization or can be rescinded at any time. Applications will be reviewed in the order in which they are received, 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.

FCFC Director/Coordinator *(Signature)*

Date

Parent/Legal Guardian *(Signature)*

Date

LEGIBLE SIGNATURES ARE REQUIRED ABOVE.
STAMPS AND ELECTRONIC SIGNATURES ARE NOT ACCEPTABLE FOR THIS FORM.

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

**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.

All of the following _____ county 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

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)
Medicaid Managed Care Plan
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 until June 30th, 2022, 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 or 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.

STAMPS AND ELECTRONIC SIGNATURES ARE NOT ACCEPTABLE FOR THIS FORM.