Ohio Department of Medicaid

Multi-system Youth Initial Application Training

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Ohio Department of Medicaid
Office of Strategic Initiatives
May 1, 2024

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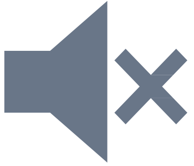
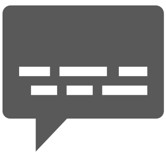
Housekeeping



All participants will be muted.

Today's presentation was included in the meeting appointment. It will also be sent out via email.

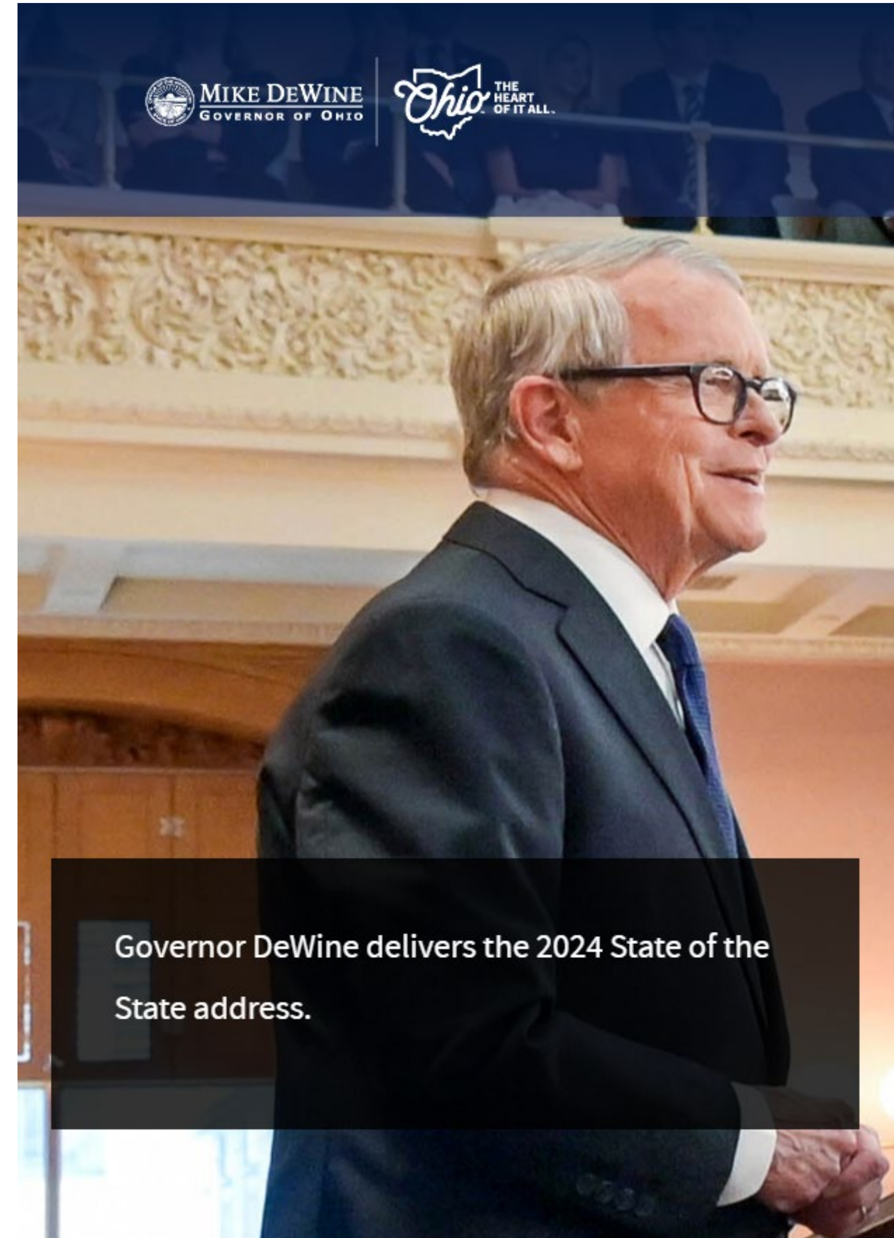


Submit your questions and comments via the Questions box. If there is time, will address questions at the end of or during the Office Hour Sessions that are being held later.

Make sure to also check the chat box for messages that may be sent to all attendees.

GOVERNOR DEWINE'S FOCUS ON CHILDREN

Since taking office in 2018, Governor DeWine has made billions of dollars of investments in Ohio's children. Every biennial budget proposed by the Governor has contained new and sustained funding for Children's Initiatives. Many of these investments include funding related to children's health, including funding for supporting youth with multi-system needs.



Governor DeWine delivers the 2024 State of the State address.

HISTORY OF THE MULTI-SYSTEM YOUTH PROGRAM IN OHIO

Kids enrolled in Medicaid often receive services from other state and local systems. Most children are adequately served by Medicaid and other state and local agencies, but a subset of kids cannot get the care they need. These children – the ones with the most complex multi-system needs – will greatly benefit from Medicaid's new model of care coordination and targeted service enhancements for kids.

In SFY20, the DeWine administration created the State Multi-System Youth Custody Relinquishment Prevention Program, with an initial appropriation of $6M for the state fiscal year.

The State MSY Program aims to prevent transfer of custody to the child protection system solely for the purpose of obtaining funding to access treatment when they have exhausted local resources.

HISTORY OF THE MULTI-SYSTEM YOUTH PROGRAM IN OHIO

UPDATES TO MULTI-SYSTEM YOUTH FUNDING ACCESSIBILITY

CLEAR DOCUMENTATION TO ACHIEVE SHARED GOALS

Based on stakeholder feedback, the State MSY Team made updates to the forms used to access and use the State MSY Program. These updates:

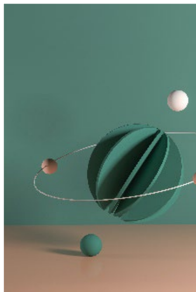
- Ensure the MSY program's goals and overarching principles are clear to requestors and legal guardians; and
- Ensure the MSY State Team is getting the right information up front to make funding determinations, rather than going back and forth via email with requestors.

INITIAL APPLICATION

MSY PROGRAM OVERVIEW

Children and youth served by the MSY program must either be at risk for custody relinquishment or have been recently relinquished for a short period of time (ex: 30 days) solely to access care.

Each child or youth served by the MSY program must be supported by one or more legal guardians who are willing to actively participate in the young person's care planning and treatment.



Children and youth served by the MSY program must have multi-system needs and be using creative multi-system supports.

All applicants must have a local/regional team working to coordinate and follow their care.

The MSY Program is intended to address acute needs and prevent immediate custody relinquishment.

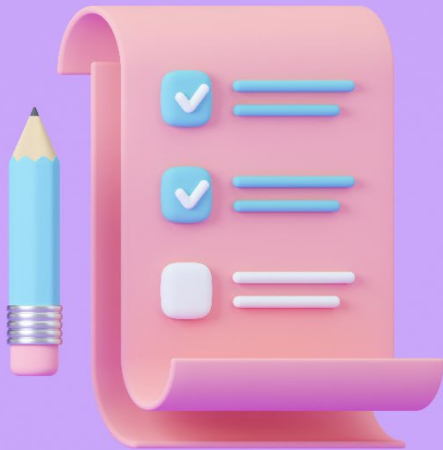
Care funded by the MSY Program must be clinically appropriate and provided in the least restrictive setting possible to support the child or youth's needs.

Applicants seeking funding for out-of-home care must document recent use of intensive levels of community-based care.

The MSY Program is intended to assist caregivers when local resources and other payment sources have been exhausted.

UPDATES TO MULTI-SYSTEM YOUTH FUNDING ACCESSIBILITY

STREAMLINING AND SIMPLIFYING COMMUNICATION



The State MSY Team is rolling-out the following new forms to Family and Children First Councils (FCFCs) and Care Management Entities (CMEs):

1) **Initial Application** form;
2) **Update Form & Application for Additional / Shifted Funds**

Today's training is focusing on the **Initial Application** form**.**

There are NO CHANGES to the Initial Application form submission process (CMEs submit to Aetna, FCFCs submit to ODM).

GENERAL MSY PROGRAM REMINDER

REMINDER – MSY Program Principle:

MSY funding is intended to meet acute short-term needs to prevent custody relinquishment.

The Program is not intended to provide long-term funding to support long-term needs. Instead, the MSY Program can help fill in gaps while longer-term funding and services are put into place by the child/youth's care team.

When longer-term funding is needed to support the child or youth's care, the requestor and legal guardian and the Team supporting the child/youth and caregiver(s) must work together to secure sustainable longer-term funding for care.

GENERAL MSY INITIAL APPLICATION FORM REMINDERS

- MSY is a **grant** and technical assistance program, and an application is required
  - The **entity leading** care coordination (CME or FCFC) is the entity responsible for completing MSY tasks
- Initial and additional funds are **not guaranteed**.
- Maximum duration of funding per request is **90 days**
- Do not leave fields **blank** – use “N/A” if field is not applicable
- Use of **yes/no** questions is intentional
- Provide details that **completely address the question** asked
- All areas/questions should be addressed. **Incomplete applications will not be processed and will be returned to the submitter for completion.**

URGENT APPLICATIONS/CURRENT HOSPITALIZATION

COMPLETE THIS SECTION TO FLAG AS URGENT IF AN ACTION WILL OCCUR WITHIN THE NEXT THREE BUSINESS DAYS

Multi-System Youth Custody Relinquishment Prevention Program Application

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.

All sections of the application must be completed. Incomplete applications will not be processed and will be returned to the submitter for completion.

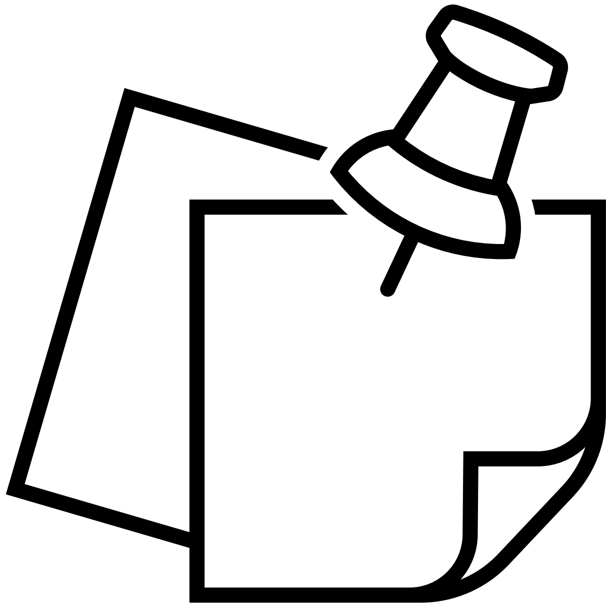
☐Check this box when the child/youth is at risk for custody relinquishment or other significant challenges within the next 3 business days. Provide a brief explanation of the circumstances and key dates.

Click or tap here to enter text.

☐Check this box if the youth is currently hospitalized.

Date of hospitalization: MM/DD/YY	Anticipated date of discharge: MM/DD/YY

URGENT APPLICATIONS/CURRENT HOSPITALIZATION NOTES



- An application is considered urgent when an action will occur **within 3 business days**
- An **explanation about risk of custody relinquishment/ emergency** must be included
  - Should be brief (bulleted points) and include key dates
  - If the anticipated date of discharge is unknown (for a youth that is currently hospitalized), please enter “unknown”
- Additional details can be provided throughout the application, as **the full application is required to be completed**

EIGHT SECTIONS NEEDED FOR SUCCESSFUL MSY APPLICATION FORM SUBMISSIONS

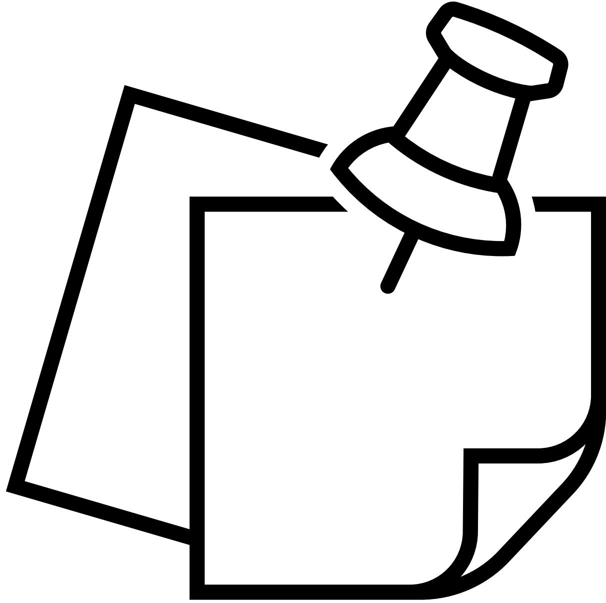
1. Child/Youth Caregiver Information
2. History of Services/Supports
3. Cross-System Involvement and Approaches
4. Request for State Assistance
5. Local Resource Attestation
6. Supporting Documentation
7. MSY Requestor/Legal Guardian Information
8. Release of Information

Section 1:
Child/Youth & Caregiver Information

SECTION 1: CHILD/YOUTH & CAREGIVER INFORMATION

- Requestor/Youth Information
- Caregivers/Living Arrangements
- Adoption Assistance/Custody
- OhioRISE Enrollment and Care Coordination
- Family Strengths and Challenges
- Assessments
- Clinical Indications

NOTES FOR COMPLETING SECTION 1: CHILD/YOUTH & CAREGIVER INFORMATION



- **Medicaid ID** is required, when the youth is enrolled
- Requests information to **address/support the need** for the application:
  - Living situation
  - Custody Information
  - OhioRISE Enrollment and Care Coordination
  - Strengths and Challenges
  - Assessments
  - Clinical Indications
- Expanded information/documentation about use of PASSS funding for adopted youth in receipt of adoption assistance

NOTES ABOUT CARE COORDINATION

- The entity leading care coordination is the entity responsible for completing MSY tasks.
- Care coordination is the family's voice and choice, however:
  - If youth is eligible for OhioRISE through the **OhioRISE waiver**, the OhioRISE CME must lead care coordination
  - If FCFC is leading care coordination, OhioRISE can still be involved as team member and vice-versa
- If parent/guardian declines OhioRISE care coordination and elects to have the FCFC lead care coordination, the family is only declining care coordination from OhioRISE, and the child/youth may be eligible to receive other OhioRISE services.

SAMPLE FROM SECTION 1: CAREGIVERS/LIVING ARRANGEMENTS (PAGES 2-3)

Caregivers, Living Arrangements, Adoption Assistance, Custody Relinquishment	
Caregiver Name	**Relationship**
Caregiver 1	
Caregiver 2	
Caregiver 3	Relationship
Where is the child/youth living now? Click or tap here to enter text.	
If the child/youth is not living at home now, when did they last live at home and what caused that to change? Click or tap here to enter text.	
Describe others living in the home now, or others who will be in the home when child/youth returns: Click or tap here to enter text.	
Describe any concerning family or relational dynamics between the child/youth and their caregivers: Click or tap here to enter text.	
If the child/youth lives at home, describe any barriers to the child/youth successfully remaining in the family home. If the child/youth is living out of the home, describe any barriers to them returning to a family home: Click or tap here to enter text.	
Outline supports the child/youth's caregivers and family need for the child/youth to successfully live at home: Click or tap here to enter text.	

Include **all adult caregivers** living in the home

REMINDER – MSY Program Principle:

Each child or youth served by the MSY program must be supported by one or more legal guardians who are willing to actively participate in the young person's care planning and treatment.
Guardians of children and youth who receive MSY Program funding for out-of-home care must be willing to have the young person return to the home as quickly as clinically appropriate.

SECTION 1: ADOPTION ASSISTANCE/PASSS/CUSTODY (PAGE 3)

If the child or youth was adopted, do the caregivers receive adoption assistance?

☐ Yes ☐ No ☐ Not adopted

IF YES	All families with an adopted child/youth must apply for PASSS or exhaust PASSS prior to requesting MSY Program funding. **A copy of the PASSS award letter or verification of PASSS application must be submitted with this application.** Information regarding PASSS: https://ohiokan.jfs.ohio.gov/passs/ Date of last application for PASSS funding: MM/DD/YY Status of last application: ☐ Pending ☐ Awarded ☐ Denied Current PASSS award: Amount: $Click or tap here to enter text. Dates: MM/DD/YY to MM/DD/YY Covered services: Click or tap here to enter text.

The **parent/legal guardian** is responsible for submitting the PASSS application each year

The PASSS funding application period begins on **July 1 each year**

Is the youth at risk of custody relinquishment? ☐ Yes ☐ No	IF YES: briefly describe the factors contributing to the risk of custody relinquishment: Click or tap here to enter text.
Has the youth recently been relinquished solely for the purposes of accessing treatment? ☐ Yes ☐ No	IF YES: describe the factors that led to relinquishment and indicate when custody will transition back to the family if funding is authorized: Click or tap here to e

If funding is supported by the state MSY team, **verification** of custody being returned is required before funding will be authorized/released

REMINDER – MSY Program Principle:

Children and youth served by the MSY program must either be at risk for custody relinquishment or have been recently relinquished for a short period of time (ex: 30 days) solely to access care. Funding will only be authorized for care provided on or after the date of application and for dates of service after custody return.

SAMPLE FROM SECTION 1: STRENGTHS AND CHALLENGES (PAGES 3-4)

Strengths	
Child/youth strengths	Click or tap here to enter text.
Caregiver strengths	Click or tap here to enter text.
Brief Overview of Behavioral, Physical Health, and Intellectual/Developmental Disabilities (I/DD) Challenges	
Behavioral health and/or I/DD diagnoses	Click or tap here to enter text.
Other relevant diagnoses	Click or tap here to enter text.
Physical health challenges	Click or tap here to enter text.
Trauma history	Click or tap here to enter text.
Safety considerations	Click or tap here to enter text.

Provide **detailed answers** and include resulting behaviors

If a challenge **does not apply** to a child/youth, mark “N/A

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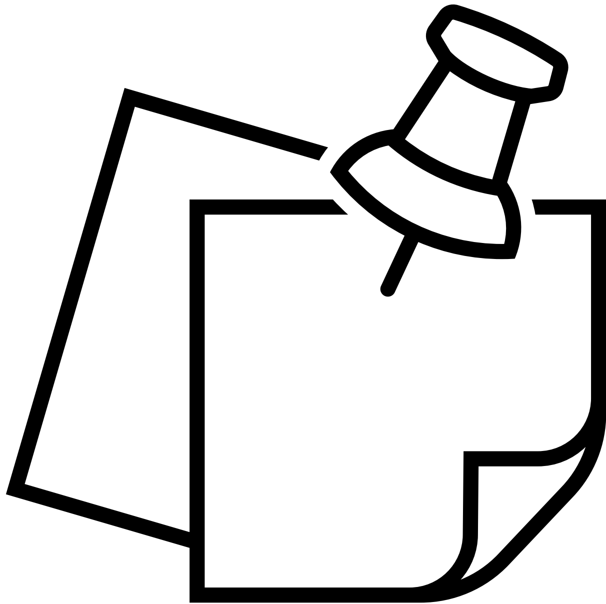
NOTES FOR COMPLETING SECTION 1: CHILD/YOUTH & CAREGIVER INFORMATION – ASSESSMENTS & CLINICAL INDICATIONS



REMINDER – MSY Program Principle:

Care funded by the MSY Program must be clinically appropriate and provided in the least restrictive setting possible to support the child or youth's needs.

- All applications for out-of-home care require a recent (within 30 days) CANS assessment recommending out-of-home care, or other clinical documentation (from an appropriately credentialed clinical) indicating the need for out-of-home care.
- Applications for out-of-home substance use disorder care require a recent (within 30 days) ASAM assessment recommending a residential level of care.

SECTION 1: ASSESSMENTS (PG 4)

Assessments

List all recent assessments being used to inform care coordination and treatment planning. Include copies of the assessments with your supporting documentation.

Please note:

1. A CANS assessment must be completed no more than 30 days prior to requesting funding for out-of-home care.
2. An ASAM assessment is recommended for all children/youth with substance use disorders (SUDs). An ASAM assessment must be completed no more than 30 days prior to requesting funding for out-of-home SUD care.

Assessment Type	Date Completed	Recommended level of care
Click or tap here to enter text.	MM/DD/YY	Click or tap here to enter text.
Click or tap here to enter text.	MM/DD/YY	Click or tap here to enter text.
Click or tap here to enter text.	MM/DD/YY	Click or tap here to enter text.
Click or tap here to enter text.	MM/DD/YY	Click or tap here to enter text.

Type "N/A" if the type of assessment **does not recommend** a level of care

SECTION 1: CLINICAL INDICATIONS (PG 4)

Clinical Indications
What levels and types of services and supports have recently been recommended by clinicians involved in the child/youth's care? Ex: intensive community-based mental health and/or I/DD services, short-term out-of-home stabilization care, residential treatment services to address XX diagnoses, etc.
Click or tap here to enter text.
Information about the recommending clinician(s):

Name	Credential(s)	Relationship to child/youth
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

Describe the **clinically recommended** services/supports

Valid credentials include: MD, DO, CNS, CNP, PA, Board Licensed Psychologist, LPCC, LPC, LISW, LSW, LIMFT, LMFT, LICDC, and LCDC

Court personnel supporting out of home treatment must have one of the credentials listed above, or another practitioner with appropriate credentials must be listed with their recommendations

Section 2:

History of Services/ Supports

SECTION 2: HISTORY OF SERVICES AND SUPPORTS

Counseling
- Individual
- Family

In Home/ Community
- IHBT/MST/FFT
- ABA
- IOP
- PHP
- MRSS

Respite

Psychiatry / Medication Therapy

Acute and Urgent Care
- Emergency Department Visits
- Inpatient Admissions

Services to address I/DD Needs

Congregate Out of Home Treatment
- Residential Facility
- Therapeutic Group Home

Treatment Home / Foster Home

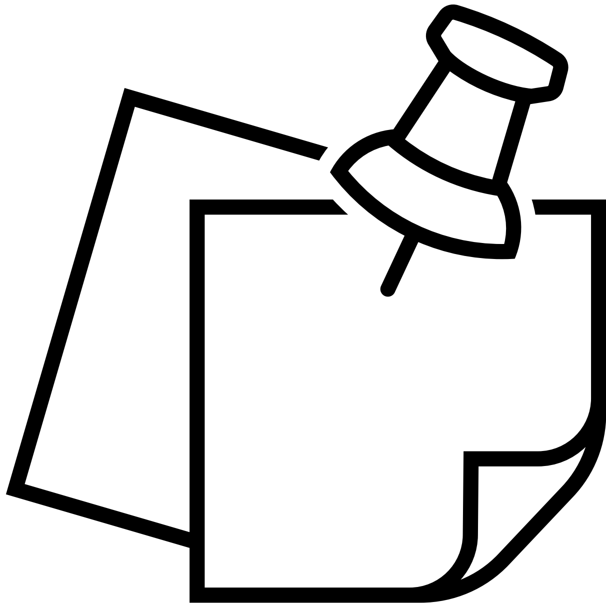
Describe **current** and **previous** services that have been used to support the child/youth's multi-system needs

REMINDER – MSY Program Principle:

Applicants seeking funding for out-of-home care must document recent use of intensive levels of community-based care.

The availability of intensive community care varies greatly across the state. In many cases, even when specific evidence-based and evidence-informed practices are not available, a mix of other outpatient services and supports – including natural supports – should be exhausted before using out-of-home care.

NOTES FOR COMPLETING SECTION 2: HISTORY OF SERVICES/SUPPORTS



Designed to capture if the youth has **ever received** any of the services/supports listed

- If **yes**, provide information about:
  - **When/where** service was provided
  - Youth/family **engagement**
  - **Response** to the service/support
- If they have **not** accessed the listed service/support, **explain** why not and **answer questions** specific to the service/support

SAMPLE FROM SECTION 2: INDIVIDUAL COUNSELING SUPPORTS (PAGE 3)

THIS GUIDANCE ALSO APPLIES TO FAMILY COUNSELING

SECTION 2: History of Services and Supports

Indicate **all** current and **previous** services that have been used to support the child/youth's multi-system needs.

<table>
<tr><th colspan="3">Individual Counseling</th></tr>
<tr><td colspan="3">Has youth ever had individual counseling? ☐ Yes ☐ No
IF NO: why? Click or tap here to enter text. If no counseling, explain why and move to next service/support</td></tr>
<tr><td colspan="3">Is youth currently linked with individual counseling? ☐ Yes ☐ No</td></tr>
<tr><td rowspan="4">IF YES</td><td>Agency: Click or tap here to enter text.</td><td>Name of provider: Click or tap here to enter text.</td></tr>
<tr><td>Approx. date service began: MM/DD/YY</td><td>Duration of service: Click or tap here to enter text.</td></tr>
<tr><td colspan="2">Youth engagement in service: ☐ Declined to participate ☐ Barriers to engagement ☐ Fully engaged
Describe engagement and barriers to engagement, if any: Click or tap here to enter text.</td></tr>
<tr><td colspan="2">Youth response to service: ☐ Condition improved ☐ Condition declined ☐ No change in condition</td></tr>
<tr><td>IF NO</td><td colspan="2">List all previous encounters including approximate dates of service, reason for discontinuation, youth engagement and response, caregiver engagement, and summary of clinical recommendations at discharge.
Click or tap here to enter text.</td></tr>
</table>

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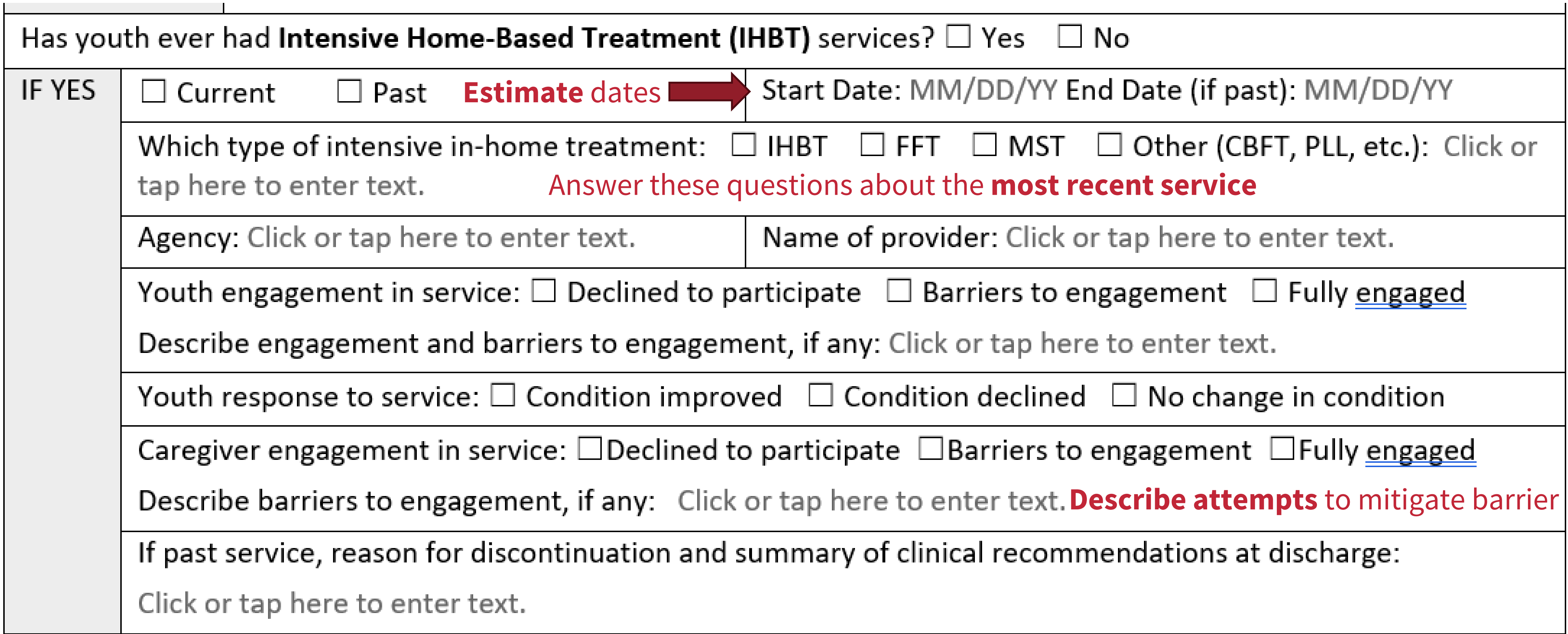
SAMPLE FROM SECTION 2: INTENSIVE IN-HOME/COMMUNITY SERVICES (PAGE 5)

Intensive In-Home and Community-Based Services Intensive in-home and community-based services include, but are not limited to: Intensive Home-Based Treatments (IHBT), Applied Behavior Analysis (ABA) Therapies, Intensive Outpatient Programs (IOP), Partial Hospitalization Programs, and Mobile Crisis Response	
Has youth ever had intensive levels of in-home and/or community-based services? ☐ Yes ☐ No	
IF NO, why?	☐ Not available in area ☐ Time constraints prevent child/youth/family's participation ☐ On waitlist ☐ Other (describe): Click or tap here to enter text.
IF NO, explain	How has the team supporting the child/youth creatively worked to create an intensive level of care and supports for the young person? Click or tap here to enter text.

Check all that apply and describe 'Other'

SAMPLE FROM SECTION 2: IN-HOME/COMMUNITY SUPPORTS - IHBT (PAGE 5)

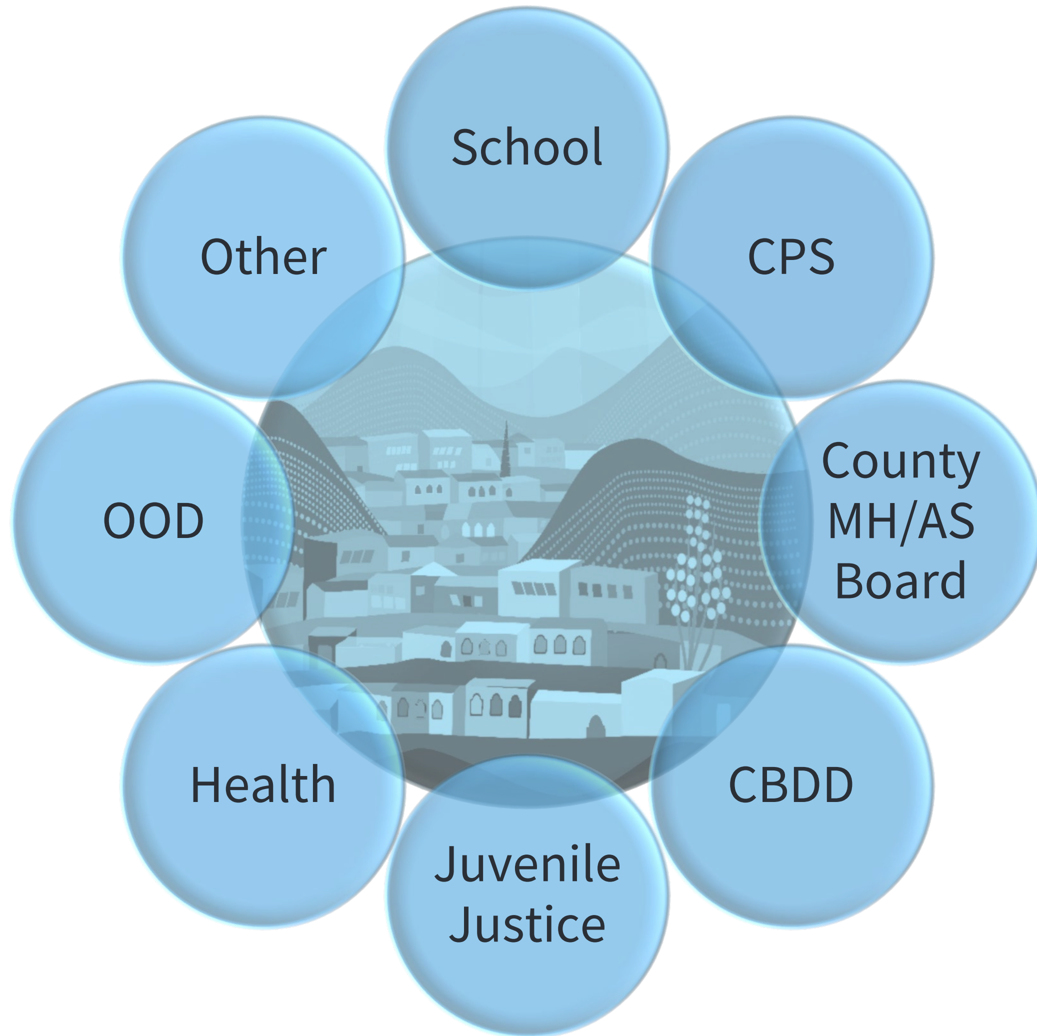
THIS GUIDANCE ALSO APPLIES TO ABA, IOP, PHP AND MRSS SUPPORTS



Has youth ever had **Intensive Home-Based Treatment (IHBT)** services? ☐ Yes ☐ No		
IF YES	☐ Current ☐ Past **Estimate** dates	Start Date: MM/DD/YY End Date (if past): MM/DD/YY
	Which type of intensive in-home treatment: ☐ IHBT ☐ FFT ☐ MST ☐ Other (CBFT, PLL, etc.): Click or tap here to enter text. Answer these questions about the **most recent service**	
	Agency: Click or tap here to enter text.	Name of provider: Click or tap here to enter text.
	Youth engagement in service: ☐ Declined to participate ☐ Barriers to engagement ☐ Fully engaged Describe engagement and barriers to engagement, if any: Click or tap here to enter text.	
	Youth response to service: ☐ Condition improved ☐ Condition declined ☐ No change in condition	
	Caregiver engagement in service: ☐Declined to participate ☐Barriers to engagement ☐Fully engaged Describe barriers to engagement, if any: Click or tap here to enter text. **Describe attempts** to mitigate barrier	
	If past service, reason for discontinuation and summary of clinical recommendations at discharge: Click or tap here to enter text.	

Section 3:
Cross-System Involvement & Approaches

SECTION 3: CROSS-SYSTEM INVOLVEMENT AND APPROACHES



REMINDER – MSY Program Principle:

Children and youth served by the MSY program must have multi-system needs and be using creative multi-system supports.

All applicants must have a local/regional **team** working to coordinate and follow their care. The team must be actively working to use creative solutions to serve the unique needs of the child/youth and their caregiver(s).

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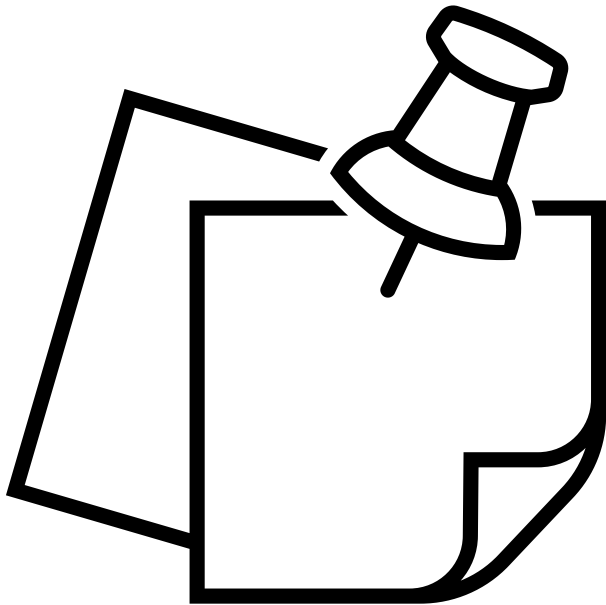
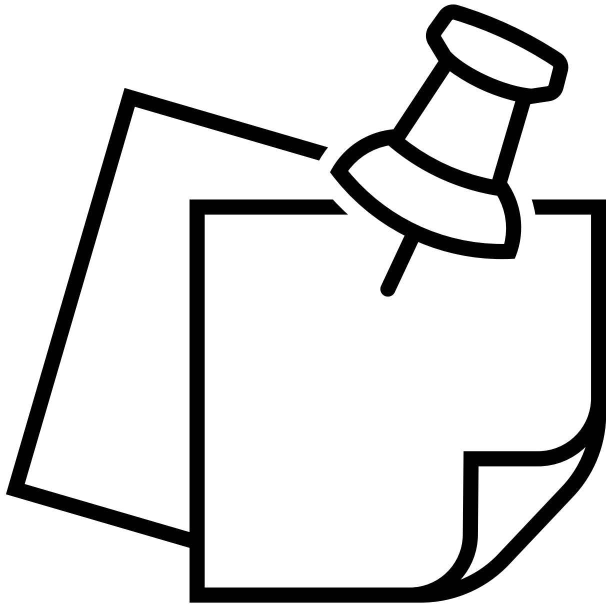
NOTES FOR COMPLETING SECTION 3: CROSS-SYSTEM INVOLVEMENT AND APPROACHES



- Which systems are actively involved in the youth's care team?
- Describe the involvement
  - **Education**
    - If recent change: reason for the change
    - Describe specially designed services
    - History of behaviors
    - Progress
  - **County Child Protection**
    - Is the youth in custody now or in the past?
    - What lead to the involvement with this system?
  - **County Board of Mental Health/Addiction Services**
  - **County Board of Developmental Disabilities**

NOTES FOR COMPLETING SECTION 3: CROSS-SYSTEM INVOLVEMENT AND APPROACHES



- **Juvenile Justice**
  - Actively participate
  - Court ordered services
    - If yes, is there a clinical recommendation?
  - Adjudicated delinquent
  - Currently in detention
- **Local Health Department/Bureau of Medical Handicaps**
- **Opportunities for Ohioans with Disabilities/Employment**
- **Other**

- Describe the **creative approaches** the team is currently using and has attempted to use to support the unique needs of the child/family and their caregivers

SAMPLE FROM SECTION 3: CREATIVE APPROACHES (PAGE 10)

Describe the creative approaches the team is currently using and has attempted to use to support the unique needs of the child/family and their caregivers.

Click or tap here to enter text.

- What available services and resources in your community did you pull together to create something different that best addressed the child/youth's needs?
- What connections did you create for the child/youth/family that made them feel welcomed within their own community (e.g., libraries, parks, clubs, etc.)

Section 4:
Request for State Assistance

SECTION 4: REQUEST FOR STATE ASSISTANCE

Technical Assistance Request

Care Coordination/ Wrap-around Request

In-Home Community Support Request

Out of Home Treatment Request

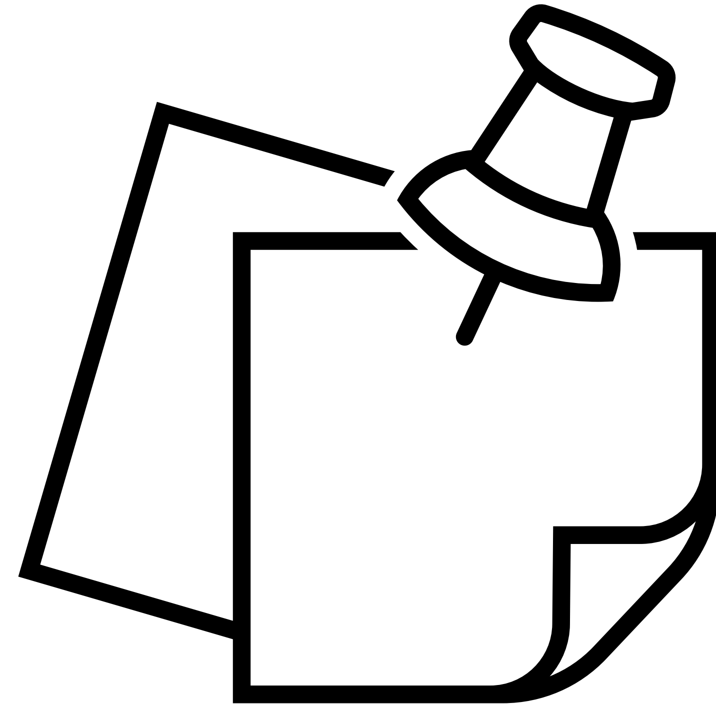
SECTION 4: REQUEST FOR STATE ASSISTANCE NOTES

Technical Assistance (TA) requests - describe barriers and expectations/goals that could be addressed through TA

Care Coordination/Wrap Around requests (FCFC only) - describe in detail how the funds will be used

In-Home/Community Support requests –

- Describe in detail **how** the funds will be used
- Document services are **not billable** to another funding source
- **Amount field** = total amount requested (rate x days)
  - If the **number of days** requested is not 30, 60 or 90 days, please select 'other' and indicate the number of days.
- Detailed description field should describe the expected # of hours, cost breakdown, service description and rate by provider



SAMPLE FROM SECTION 4: OUT-OF-HOME TREATMENT REQUESTS (PAGE 12)

☐ **4. Funding for out-of-home treatment to prevent custody relinquishment.** ***Cost and tentative discharge planning information must be provided below.***			
Provider(s) of service(s) and address: Provider info	Amount: $ 18,000.00	☐ 30 days ☐ 60 days ☒ 90 days	Start date: 5/1/24 End Date: 7/29/2024
Describe the treatment setting (e.g., QRTP, mental health or child protection group home, treatment home, I/DD waiver setting, etc.): Click or tap here to enter text.			

Total MSY funding being requested (daily amount x # days)

Is the child/youth already being served in this out-of-home treatment setting? ☐ Yes ☐ No	IF YES	What date did the youth start receiving out-of-home treatment from this provider? MM/DD/YY What funding sources have been used to support the out-of-home treatment to date? Click or tap here to enter text.

Describe, provide dates and when/why funding is ending

Does the CANS or another clinical assessment recommend out of home care?	☐ Yes ☐ No	IF NO	Please do not apply for MSY funding for out-of-home care
Does the child/youth's care coordination team believe the child will gain therapeutic benefit from out of home treatment?	☐ Yes ☐ No	IF NO	Why not? Click or tap here to enter text.
Does the child/youths OhioRISE Child and Family-Centered Care Plan or FCFC Plan of Care include a goal of out-of-home care?	☐ Yes ☐ No	IF NO	Why not? Click or tap here to enter text.

Estimated daily itemized costs and payor coverage associated with the out-of-home funding request. Check and describe all that apply.

Type of service	Daily Amount	OhioRISE Coverage	Medicaid MCO Coverage	Private Insurance Coverage
☒ Room & board	$ 200.00	N/A	N/A	☐ Yes ☒ No
☐ Treatment	$ Click or tap here to enter text.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ 1:1 Supports	$ Click or tap here to enter text.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Other supportive services (describe): Click or tap here to enter text.	$ Click or tap here to enter text.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

SAMPLE FROM SECTION 4: OUT-OF-HOME TREATMENT REQUESTS (PAGE 12)

Funding page example for a request that is not 30,60 or 90 days.

☒ 4. Funding for out-of-home treatment to prevent custody relinquishment. *Cost and tentative discharge planning information must be provided below.*

Provider(s) of service(s) and address: Provider info	Amount: $ 9,000.00	☐ 30 days ☐ 60 days ☐ 90 days ☒ Other 45 days	Start date: 5/1/24 End Date: 6/14/2024

Describe the treatment setting (e.g., QRTP, mental health or child protection group home, treatment home, I/DD waiver setting, etc.):

Total MSY funding being requested (daily amount x # days)

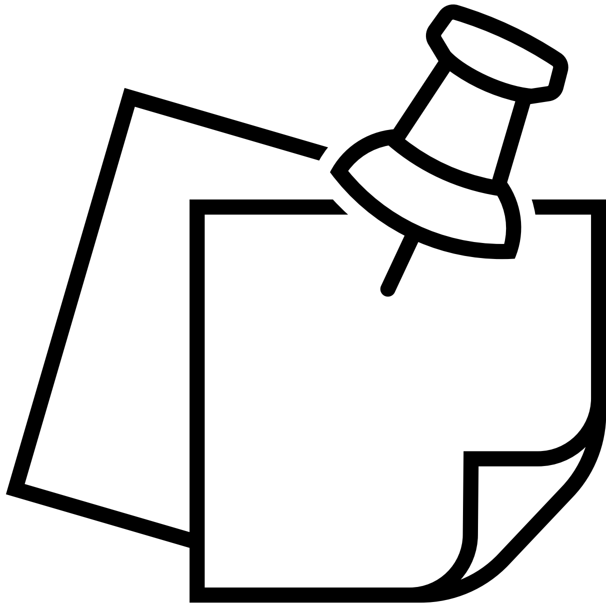
Is the child/youth already being served in this out-of-home treatment setting? ☐ Yes ☐ No	IF YES	What date did the youth start receiving out-of-home treatment from this provider? MM/DD/YY What funding sources have been used to support the out-of-home treatment to date? Click or tap here to enter text. Describe, provide dates and when/why funding is ending
Does the CANS or another clinical assessment recommend out of home care? ☐ Yes ☐ No	IF NO	Please do not apply for MSY funding for out-of-home care
Does the child/youth's care coordination team believe the child will gain therapeutic benefit from out of home treatment? ☐ Yes ☐ No	IF NO	Why not? Click or tap here to enter text.
Does the child/youths OhioRISE Child and Family-Centered Care Plan or FCFC Plan of Care include a goal of out-of-home care? ☐ Yes ☐ No	IF NO	Why not? Click or tap here to enter text.

Estimated daily itemized costs and payor coverage associated with the out-of-home funding request. Check and describe all that apply.

Type of service	Daily Amount	OhioRISE Coverage	Medicaid MCO Coverage	Private Insurance Coverage
☒ Room & board	$ 200.00	N/A	N/A	☐ Yes ☒ No
☐ Treatment	$ Click or tap here to enter text.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ 1:1 Supports	$ Click or tap here to enter text.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Other supportive services (describe): Click or tap here to enter text.	$ Click or tap here to enter text.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Ohio Department of Medicaid

NOTES FOR COMPLETING SECTION 4: OUT-OF-HOME TREATMENT REQUESTS



- **Amount** field = the total amount requested (daily amount X number of days)
  - Do not include services **covered by other funding sources** (e.g., treatment, 1:1, transportation, etc.) in the MSY funding amount
  - If services are only partially covered by OhioRISE, Medicaid Managed Care Organization or Private Insurance, please include those details in your email submission.
- If the **number of days** requested is not 30, 60 or 90 days, please select 'other' and indicate the number of days
- Describe the **funding sources** that have been used to support the out-of-home treatment to date.
- **Do not apply** for MSY funding without a clinical recommendation for out-of-home treatment. If the most recent CANS (within the past 30 days) does not support out-of-home treatment, a clinical recommendation from an appropriately licensed clinician must be submitted with the application. The clinical recommendation needs to be on organizational letterhead, dated (within past 90 days) and signed.
- Out-of-home treatment requests should **accurately reflect** provider information, costs and the timeframe being requested. Work with providers to ensure this information is accurate prior to submission.

SAMPLE FROM SECTION 4: TENTATIVE OUT-OF-HOME DISCHARGE PLAN (PAGES 12-13)

Out-of-home Care Tentative Discharge Plan	
Goals	How will state funds be used to advance treatment goals for the child/youth prior to discharge? Click or tap here to enter text.
Timing	Anticipated date of discharge from this out-of-home treatment setting: MM/DD/YY ☐ Unknown because child/youth is not yet in out of home care Factors that will be considered when determining discharge date: Click or tap here to enter text.
Teaming	Who is actively participating in the care coordination team responsible for discharge planning, making decisions about and/or coordinating treatment?

Mark "Unknown" **only** if no estimate and not yet in out-of-home treatment

Team member name	Contact information	Role in supporting the child/youth during the transition
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

Include **all active** members of the care coordination team

Living Arrangements	Where will the child/youth live in a family setting after discharging from out-of-home treatment funded by MSY?	Click or tap here to enter text.
	If there isn't a plan for where the child/youth will live in a family setting after discharge, what steps will be taken during the first month of out-of-home treatment to identify where the child/youth will live in a family setting after discharge?	Click or tap here to enter text.
	What will the caregivers do within the first month of out-of-home treatment to prepare for the child/youth's return?	Click or tap here to enter text.

Describe **all circumstances / barriers** involved in the youth returning home after treatment

SECTION 4: OUT-OF-HOME DISCHARGE PLAN CON'T (PAGE 13)

<table>
<tr><td rowspan="5">Treatment services needed to return to the community</td><td colspan="3">

Treatment Service	Provider	Funding Source
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

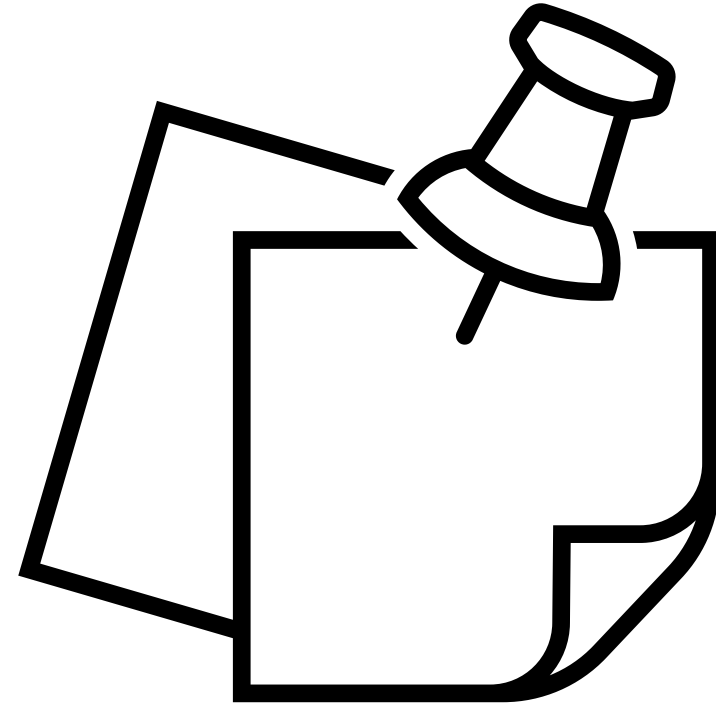
</td></tr>
<tr><td>If providers of the services indicated above are not available, what will the team do within the first month of out-of-home treatment to create access to similar services at an appropriate intensity?</td><td colspan="2">Click or tap here to enter text.</td></tr>
<tr><td>What steps will be taken to coordinate aftercare with these providers:</td><td colspan="2">Click or tap here to enter text.</td></tr>
<tr><td>Would the child/youth benefit from any of the above treatment services starting prior to the child/youth being discharged from the treatment facility? ☐Yes ☐No</td><td>IF YES</td><td>Please explain:
Click or tap here to enter text.</td></tr>
<tr><td></td><td colspan="2"></td></tr>
<tr><td rowspan="3">Supports needed to return to the community</td><td>What supports will the child/youth need after discharge from out-of-home treatment?</td><td colspan="2">Click or tap here to enter text.</td></tr>
<tr><td>What supports will the child/youth's caregivers need after discharge from out-of-home treatment?</td><td colspan="2">Click or tap here to enter text.</td></tr>
<tr><td>What funding sources will be used to pay for the supports identified above?</td><td colspan="2">Click or tap here to enter text.</td></tr>
</table>

Describe the **initial** discharge plan in detail in this section

Department of Medicaid

SECTION 4: DISCHARGE PLANNING NOTES

- **Discharge planning** is one of the key criteria for the MSY program.
- An active discharge plan is expected from the date of **admission**.
  - Describe the initial discharge plan, which will change and grow over time as needs are identified (addressed in **updates**).
- If there are additional treatment services/providers that do not fit here, additional documentation can be submitted with the application.

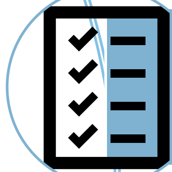


Sections 5-8:

Attestations, Documentation, and Release of Information

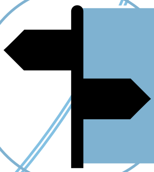
ATTESTATIONS, DOCUMENTATION, AND RELEASE OF INFORMATION

Local Resource Attestation



Supporting Documentation

MSY Requestor /Legal Guardian Attestation



Release of Information

NOTES FOR COMPLETING SECTION 5: LOCAL FUNDS USE ATTESTATION FOR FUNDING REQUESTS

Describe how local funds have been used and exhausted prior to applying for MSY funds. Include detailed information about funding sources, how and when funds have been used, and amounts. **MSY funding will not be authorized if local resources are not first used and exhausted.**

Click or tap here to enter text.

Check the boxes below to indicate each of the specific financial resources that have been explored and/or exhausted to support the child/youth and their caregiver(s) as they are facing the risk of custody relinquishment.

Resource Explored?	Child / Family Eligible?	Reasonably exhausted?
☐ Local Child Protection System Funding	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Local FCFC Funding, which may include: • FCFC Flexible pooled funding • MSY-PCSA funds • Family Centered Services and Supports (FCSS) • Local pooled funding	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Local Developmental Disabilities Board Funding	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Local Mental Health / Addiction Board Funding	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Post Adoption Special Services Subsidy (PASSS)	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Private health insurance	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Medicaid / Medicaid Managed Care	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ 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
☐ Prevention, Retention, and Contingency (PRC)	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Child Support	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ SSI/SSDI, SS Survivor's Benefits	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Other (describe)		

REMINDER – MSY Program Principle:

The MSY Program is intended to assist caregivers when local resources and other payment sources have been exhausted.

The MSY Program is the funder of last resort and can only be accessed when local funds, health insurance, post-adoption assistance funds, and other sources of funding are used first. MSY Program funding cannot be used to supplant other funds.

- Detailed information about other funding sources that have been used **first** must be provided.
- If a child/family is eligible for a resource, a response to the "Reasonably exhausted" question is required.
- **MSY funding will not be authorized if local resources are not used first and exhausted.**

Ohio Department of Medicaid

SECTION 6: IDENTIFY ATTACHED SUPPORTING DOCUMENTATION

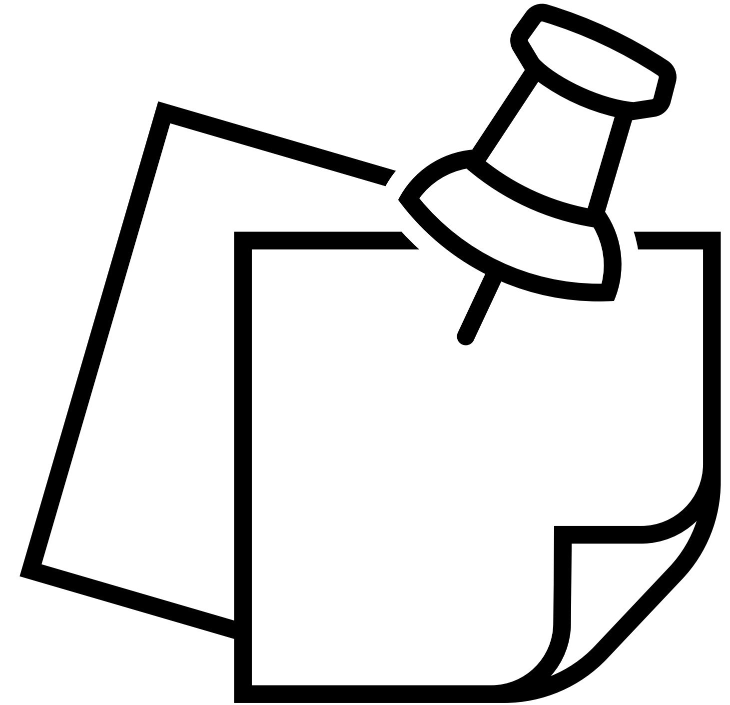
- FCFC Service Coordination Plan or OhioRISE Child and Family Centered Plan – required for all
- Assessments that inform care coordination and treatment planning – required for all out of home care
- PASSS Award Letter or Verification of PASSS application
- Hospital (inpatient and/or emergency room) discharge summary
- Mental Health or substance use treatment plan
- Educational records
- Developmental Disabilities Service Plan
- Other supporting documentation

NOTES FOR COMPLETING SECTION 7: REQUESTOR & LEGAL GUARDIAN ATTESTATION

- **Both** the requestor and the legal guardian must initial (may be typed or handwritten) that they have read, understand and attest to each of the terms
- Highlighting a few items from the form:
  - MSY program funding is intended to meet **acute short-term needs to prevent custody relinquishment**. When longer-term funding is needed to support the child or youth's care, the requestor and legal guardian commit to work together to secure sustainable longer-term funding for care.
  - Updates are due **at least every 90 days** and prior to requesting additional funds.
  - The requestor commits to notifying the appropriate parties (Aetna, ODM, etc.) and providing updates **within 14 days** of a disruption in MSY-funded services and supports.
- A few items require only legal guardian attestation
- Attestation must be signed by the FCFC Director/Coordinator or the OhioRISE CME Supervisor and the child/youth's legal guardian
  - Handwritten or electronic signatures/dates are accepted

NOTES FOR SECTION 8: RELEASE OF INFORMATION

- **All fields** on the ROI must be completed by the parent/legal guardian
- List the youth/family's **county of residence** in the county/local organizations section
- List all parties serving on the youth's **care team** on the organization section
- If the parent/legal guardian initials that they **do not consent** to the disclosure of any information, the application cannot be reviewed.
- **Electronic or handwritten** signature/dates will be accepted
- If the parent/guardian **specifies a period of time** for the release of information, the requestor needs to ensure this covers the time frame of the request (including checking when submitting updates and continued funding requests).



Next Steps

KEY DATES

NEW INITIAL APPLICATION FORM

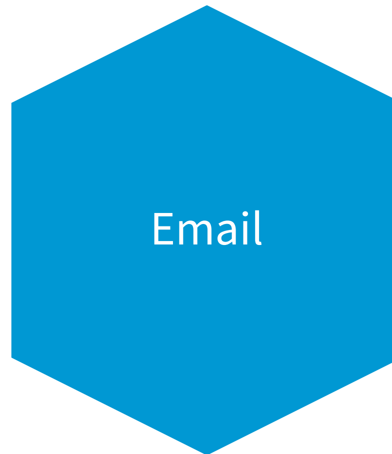
- **April 12**: Release of New MSY Initial Application Form and Training Dates to FCFCs/CMEs
- **May 1:** MSY Initial Application Training #1
- **May 6:** MSY Initial Application Training #2
- **Mid to Late May:** Office Hours on the New MSY Initial Application Form
- **May 24:** All applicants will begin using the New MSY Initial Application Form

KEY DATES

UPDATES AND APPLICATIONS FOR ADDITIONAL / SHIFTED FUNDS

- **May 2:** Release of New Continued Funding Request and Update form to FCFCs/CMEs
- **June 12:** MSY CFR/Update Form Training #1
- **June 18:** MSY CFR/Update Form Training #2
- **Late June:** Office Hours on the New Continued Funding Request and Update form
- **July 1:** All applicants will begin using the New Continued Funding Request and Update form

Ways to Engage with MSY



FCFC: MSY@medicaid.ohio.gov

OhioRISE: OHRMSYapplications@aetna.com

THANK YOU!