Multi-System Youth Technical Assistance and Funding Application

Please refer to the Guidance for Multi-System Youth Technical Assistance and Funding for additional information regarding this application and how it should be completed.

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.
ATTACHMENT B must be completed to provide updates on authorized funding.
ATTACHMENT C must be completed for all continued funding requests.

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

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	Gender	Race/Ethnicity	
Street Address	City	State	Zip Code
Phone Number		Guardian	
Primary Insurer *(if Medicaid include Medicaid Number)*		Secondary Insurer *(if applicable)*	
Is Child Eligible for IV-E? ☐ Yes ☐ No		Current Placement	

Local / State System Involvement	Other Contributing Factors
☐ Child Welfare/CPS	☐ Child Support
☐ Family and Children First	☐ Adjudication
☐ School	☐ Substance Use
☐ Juvenile Court, Other Youth Services	☐ Developmental Disability
☐ Developmental Disabilities	☐ Mental Illness Diagnosis
☐ Health	☐ Behavioral Concerns (Specify?)
☐ Mental Health / Addiction Services	☐ Other *(Specify)*
☐ Other *(Specify)*	

Services/Resources Utilized for Child/Youth and Family	**Current**	**Past 24 Months**	**Please Describe Specific Services/Resources in Detail. Please Include Providers and Relevant Outcomes**
Care Coordination and/or Case Management	☐	☐	
In-home Services and Supports *(ex. wraparound services, home visiting, transition services)*	☐	☐	
Community-Based Behavioral Health Services *(ex. out-patient services, group therapy)*	☐	☐	
Residential Treatment/group home	☐	☐	
Inpatient Psychiatric Treatment	☐	☐	
Therapeutic Foster Home	☐	☐	
Foster Home	☐	☐	
Respite *(indicate residential, foster or both)*	☐	☐	
Crisis Services	☐	☐	
Mentors	☐	☐	
Skill Building Services/Supports	☐	☐	
Family Therapy	☐	☐	
Other (Specify)	☐	☐	

Please describe the strengths of the child/youth and the family and any additional comments:

Any additional information that would be helpful *(Include any risk for out of home placement)*:

Please 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
- ☐ Treatment Plan
- ☐ Individualized Education Plan *(IEP/504 Plan)*
- ☐ Other supporting documentation

Previous Adoption ☐ Yes ☐ No	Grade Level	School Placement ☐ ED ☐ LD ☐ OHI ☐ DH
List behavioral health diagnosis/diagnoses *(if any)*		

III. Reason for Referral *Please check all that apply*

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

IV. Release of Information

☐ 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. "Funding will be authorized / not authorized on a case-by-case basis. Funding requests will be authorized only if all five of the following eligibility criteria have been met. Please note: only one of two the criteria for number one below must be met."

☐ 1. The child/youth has multi-system needs and is at risk for custody relinquishment or

☐ 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 *(at a minimum: Medicaid, private insurance, PASSS, and/or county funds);* and

☐ 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.

VI. Please detail the purpose of this funding request by providing the following information. In space provided, please provide detailed narrative information about how funds will be used and entities *(i.e. provider agencies, others)* that may receive this funding to deliver services.

Service	Estimated Time	Amount Requested
☐ 1. Care Coordination/Wraparound to prevent custody relinquishment or for a relinquished child/youth.	☐ 30 days ☐ 60 days ☐ 90 days	$
☐ 2. In-home and/or community supports to prevent custody relinquishment.	☐ 30 days ☐ 60 days ☐ 90 days	$
☐ 3. In-home and/or community supports for a relinquished child/youth transitioning into a community setting.	☐ 30 days ☐ 60 days ☐ 90 days	$
☐ 4. Residential treatment and/or room and board for treatment to prevent custody relinquishment.	☐ 30 days ☐ 60 days ☐ 90 days	$

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. The parent/legal guardian commits to maintaining involvement in the child's plan of care and to allowing the child, if placed out of the home, 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

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):

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 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

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

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

ATTACHMENT B:

To be completed at least every 90 days to provide updates on expenditures and case progress. This update must be completed on a *monthly basis* (every 30 days) when funding is being used for residential purposes.

All associated invoices/payments for this time period should be emailed to MSY@medicaid.ohio.gov with submission of this attachment.

<table>
<tr><td>Time period start</td><td colspan="2">Time period end</td></tr>
<tr><th>Service</th><th>Original Duration</th><th>Original Amount Received</th></tr>
<tr><td>☐ 1. Care Coordination/Wraparound to prevent custody relinquishment or for a relinquished child/youth.</td><td>☐ 30 days ☐ 60 days ☐ 90 days</td><td>$</td></tr>
<tr><td colspan="3">Please provide all relevant outcomes to date:</td></tr>
<tr><td>☐ 2. In-home and/or community supports to prevent custody relinquishment.</td><td>☐ 30 days ☐ 60 days ☐ 90 days</td><td>$</td></tr>
<tr><td colspan="3">Please provide all relevant outcomes to date:</td></tr>
<tr><td>☐ 3. In-home and/or community supports for are linquished child/youth transitioning into a community setting.</td><td>☐ 30 days ☐ 60 days ☐ 90 days</td><td>$</td></tr>
<tr><td colspan="3">Please provide all relevant outcomes to date:</td></tr>
<tr><td>☐ 4. Residential treatment and/or room and board for treatment to prevent custody relinquishment.</td><td>☐ 30 days ☐ 60 days ☐ 90 days</td><td>$</td></tr>
<tr><td colspan="3">Please provide all relevant outcomes to date:</td></tr>
</table>

ATTACHMENT C: To be completed for continued funding requests.

Please detail the purpose of this continued funding request by providing the following information. In space provided, please provide detailed narrative information about how funds will be used and entities (i.e. provider agencies, others) that may receive this funding to deliver services.

Service	Estimated Time	Amount Requested
☐ 1. Care Coordination/Wraparound to prevent custody relinquishment or for a relinquished child/youth.	☐ 30 days ☐ 60 days ☐ 90 days	$
☐ 2. In-home and/or community supports to prevent custody relinquishment.	☐ 30 days ☐ 60 days ☐ 90 days	$
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____ ________________________

FCFC Director/Coordinator *(Signature)* Date

____ ________________________

Parent/Legal Guardian *(Signature)* Date