The Children's Mental Health Care Coordination Program

Requirement: 65E-9.008(4), F.A.C. and 394.4781, F.S.

Frequency: Reports Due Monthly and Quarterly

Due Date: 10th of each month and quarterly

Description:

The Children's Mental Health Care Coordination Program is a network of community-based services and supports that is youth-guided and family-driven to produce individualized, evidence-based, culturally and linguistically competent outcomes that improve the lives of children and their families. Section 394.491, Florida Statute, outlines guiding principles for child and adolescent mental health treatment and support systems. Consistent with these principles, children and adolescents receive services within the least restrictive and most normal environment appropriate to meet their individual clinical and behavioral needs. In addition to offering traditional Case Management and therapies, LSFHS implements the Family Service Planning Team (FSPT) and Child and Family Staffing (CFS) program models to offer care coordination and non-traditional supports to children and families in need of more intensive mental health treatment. These services are offered by contracted Network Service Providers throughout the Region.

The FSPT process is designed to be a child-centered, family-focused and a community-based program that funds less traditional therapeutic services for children living in the community to divert them from residential placement. Through participation in the FSPT process, families are able to access services such as therapeutic camps, behavior analyst services, therapeutic friends or mentors, and specialized therapies that would not be covered under the child's insurance plan. The FSPT team is a multidisciplinary group of professionals that engages the child and parents or other caregivers to consider the strengths and needs of the child and family. These teams work together with the family to strategize ways for a youth to remain at home or to return home from a residential treatment setting as soon as possible.

The CFS process facilitates the placement of youth into residential treatment when a child is recommended for this level of care by a physician. The CFS team is comprised of all individuals involved with the child and family (i.e. AHCA, legal guardian, treating provider, Department of Juvenile Justice, school representative(s), family advocate, Managed Care Organizations or other persons invited by the youth and family). The CFS team provides information and support to facilitate the child's admission into residential treatment. The CFS team monitors the child's progress while in residential treatment and ensures recommended services are in place when a youth is discharged.

LSFHS has contracted with Network Service Providers in each Circuit to coordinate both of the processes described above. To ensure the implementation and administration of these programs, the Network Service Providers shall adhere to the staffing, service delivery and reporting requirements described in this Incorporated Document.

Eligibility:

In order to be eligible for FSPT services, the Network Service Provider shall ensure that the child meets the following eligibility criteria:

1. Are eligible for publicly funded substance abuse and mental health services pursuant to s. 394.674, F.S.; For Children's mental health services:
    a. Children who are at risk of an emotional disturbance;
    b. Children who have an emotional disturbance;
    c. Children who have a serious emotional disturbance; and
    d. Children diagnosed as having a co-occurring substance abuse and emotional disturbance or serious emotional disturbance;
2. Has an IQ of 70 or higher; individuals with an IQ below 70 will be considered on a case-by-case basis.
3. Does not meet criteria for Autism, Intellectual Disability, or Pervasive Developmental Delay as a primary diagnosis or area of concern;
4. Are not in foster care and does not have an open case with DCF/CBC oversight;
5. Are participating with a community mental health provider but the provider has determined that outpatient services covered by insurance are not effective in resolving the child's behaviors;
6. Are willing to participate in a family-driven process that ensures all least restrictive measures have been exhausted before pursuing residential treatment; and
7. Are willing to participate in non-traditional therapeutic services.

In order to be eligible for CFS services, the Network Service Provider shall ensure that the youth meet the following eligibility criteria:

1. Has documented exhaustion of all least restrictive community services;
2. Has been recommended for residential treatment by a physician;
3. Has been assessed and diagnosed as being emotionally disturbed by a psychiatrist or clinical psychologist who has specialty training and experience with children, per s. 394.4781, F.S., and who meet the following criteria, per Chapters 65E-9 and 65E-10, F.A.C.:
    a. Be under the age of 18;
    b. Currently assessed (within 90 days prior to placement) by a psychologist or a psychiatrist licensed to practice in the State of Florida, with experience or training in children's disorders; who attests, in writing, that:
        i. The child has an emotional disturbance as defined in Section 394.492(5), F.S., or a serious emotional disturbance as defined in Section 394.492(6), F.S.;
        ii. The emotional disturbance or serious emotional disturbance requires treatment in a residential treatment setting;
        iii. A less restrictive setting than residential treatment is not available or clinically recommended;

iv. The treatment provided in the residential treatment setting is reasonably likely to resolve the child's presenting problems as identified by the psychiatrist or psychologist; and

v. The nature, purpose, and expected length of treatment have been explained to the child and the child's parent or guardian.

Program Requirements:

FSPT Program Requirements

The Network Service Provider serves as a vehicle for youth and families to purchase non-traditional therapeutic services to prevent the need for residential placement. FSPT team providers shall:

1. Identify specific dates and times no more than twice a month per County to schedule FSPT staffings with youth and families. These dates and times should be at fixed intervals (i.e. second and fourth Wednesday of the month etc.) FSPT staffings are approximately 15 minutes for each youth and family;
2. Ensure youth and families referred to FSPT meet the eligibility criteria;
3. Notify the referral source within 48 hours of the receipt of the referral, advise the referral source of acceptance or denial due to FSPT eligibility criteria and the date and time of the next FSPT staffing;
4. Collect and file a completed referral packet for each youth which includes a completed FSPT application and exchange of information forms (See Appendix D), and any supportive documentation validating the need for non-traditional therapeutic services being requested;
5. Schedule FSPT meetings to staff cases referred to FSPT and submit the CFS/FSPT agenda to LSFHS at Childrensservices@lsfnet.org one week prior to the staffing date;
6. Coordinate FSPT staffings which includes ensuring that all parties involved with the child have been invited (i.e. legal guardians, school system representatives, insurance representatives, Department of Juvenile Justice representatives, agency providers, etc.);
7. Develop relationships and work collaboratively with agency providers which includes fostering communication between case managers, care coordinators and school personnel;
8. Facilitate the FSPT staffing with the goal of identifying non-traditional therapeutic services in accordance to youth and family preferences;
9. Assess appropriateness for youth and families to benefit from non-traditional therapeutic services during FSPT meetings.
10. Communicate the POS review and approval process to youth and families;
11. If it is determined that the youth would benefit from services within the community and the service is not covered by a Third Party Liability (TPL) or reimbursable by another payor source, the FSPT Chairperson from each circuit will complete and submit the POS request form (See Appendix E) for purchases in the amount of $1,000.00 or more to the Clinical Care Support Specialist at LSFHS for review and approval and will require dual signatures, (of both the clinical care support specialist and the Director of Program Operations) for authorization. The POS request form must be emailed to the LSFHS via encrypted email: childrensservices@lsfnet.org. For purchases less than $1,000.00, the FSPT Chairperson (or designee) must complete the POS

Request Form, but does not need to submit to LSFHS for review and approval. The completed POS Request Form must be placed in the consumer's chart.

12. The POS form must be completed in its entirety and provide a clinical justification for the requested POS service;
13. All POS purchases must be approved through the Network Service Provider's internal approval process, but only those purchases in excess of $1,000.00 will require prior approval from LSFHS.
    a. Any POS request in excess of $1,000 must be submitted to LSFHS for approval and will require dual signatures, (of both the clinical care support specialist and the Director of Program Operations or above) for authorization.
14. Services that may be requested include, but are not limited to: therapeutic friend/life coach, parent education, outpatient counseling, psychiatric services, behavioral analysts, psychological assessments (for mental health purposes only), psychosexual assessments, tutoring, therapeutic camps, respite and extracurricular activities;
15. LSFHS will monitor the email daily for any POS requests. LSFHS will review and either approve or deny the request. If the POS is denied LSFHS will complete the section with justification for the denial and forward the POS in an encrypted email and send back to the FSPT Chairperson requesting the services;
16. Reasons to deny a POS include, but are not limited to: incomplete FSPT application, incomplete POS request, TPL covers the service being requested, lack of therapeutic justification for how the service will benefit the client, a non-community child such as a foster care child or under DCF supervision with CBC oversight, a non-behavioral primary health diagnosis such as autism, pervasive developmental delay, non-emotional or non-behavioral based developmental disability or an IQ below 70 (consumers with an IQ less than 70 will be considered on a case by case basis);
17. It is the Network Service Provider's responsibility to ensure adequate resources to fund approved POS requests;
18. Original invoices are to be maintained in the Network Service Provider's records for audit purposes;
19. The Network Service Provider shall keep a current list of proposed vendors and rates for services to be utilized during the POS process that can be provided at any time upon request. The Network Service Provider will exhaust all other funding sources for treatment first before requesting funds from the Managing Entity;
20. The Network Service Provider shall staff youth and families receiving non-traditional services funded through the POS process bimonthly to assess progress and appropriateness of services and must be documented in the client chart;
21. The Network Service Provider shall complete the FSPT/CFS Staffing Form (See Appendix B) by indicating individuals that participated in the FSPT, staffing notes and recommended services. Any POS must be documented on this form and in the progress notes.
22. Progress notes should include clinical justification for POS purchase and renewal of service(s).

CFS Program Requirements

The Network Service Provider shall schedule and facilitate CFS as appropriate. The Network Service Provider shall:

1. Refer youth to CFS who have documented exhaustion of all least restrictive community services and have a recommendation for residential treatment by a physician;
2. Request and review clinical documentation from community service providers (i.e. psychological, psychiatric evaluations, treatment plans, treatment plan reviews, discharge summaries etc.). This is in an effort to ensure that the SIPP packet (See Appendix G) is complete utilizing the SIPP Packet Checklist (See Appendix F);
3. Has been assessed and diagnosed as being emotionally disturbed by a psychiatrist or clinical psychologist who has specialty training and experience with children, per s. 394.4781, F.S., and who meet the following criteria, per Chapters 65E-9 and 65E-10, F.A.C.:
    a. Be under the age of 18;
    b. Currently assessed (within 90 days prior to placement) by a psychologist or a psychiatrist licensed to practice in the State of Florida, with experience or training in children's disorders; who attests, in writing, that:
        i. The child has an emotional disturbance as defined in Section 394.492(5), F.S., or a serious emotional disturbance as defined in Section 394.492(6), F.S.;
        ii. The emotional disturbance or serious emotional disturbance requires treatment in a residential treatment setting;
        iii. A less restrictive setting than residential treatment is not available or clinically recommended;
        iv. The treatment provided in the residential treatment setting is reasonably likely to resolve the child's presenting problems as identified by the psychiatrist or psychologist; and
        v. The nature, purpose, and expected length of treatment have been explained to the child and the child's parent or guardian.
    c. Have been reviewed a minimum by the CFS team and been presented with all available options for treatment.
4. Schedule a CFS staffing, submit agenda at least one week prior to the scheduled CFS and submit clinical documentation (See Appendix A) to LSFHS at childrensservices@lsfnet.org prior to the staffing date;
5. Ensure a copy of the completed SIPP packet is forwarded to the appropriate AHCA or Managed Care Organization representative with notification of the scheduled staffing;
6. Coordinate CFS staffing which includes ensuring that all parties involved with the child have been invited (i.e. legal guardians, school system representatives, insurance representatives, Department of Juvenile Justice representatives, agency providers, etc.);
7. During the CFS staffing, the Network Service Provider shall inform the parent, guardian, or family member(s) of the availability of SIPP treatment programs, provide information regarding how to request a tour of the available facilities and the Managed Care Organization shall update the guardian of the medical necessity determination;

8. Complete the FSPT/CFS Staffing Form (Appendix B) by indicating individuals that participated in the CFS and staffing notes. FSPT/CFS Staffing Forms are to be maintained in the Network Service Provider's records for audit purposes;
9. Forward the completed SIPP packet to the identified SIPP provider for determination of appropriateness. Upon approval, the SIPP provider will contact the referring provider, the managing entity, Network Service Provider, or legal guardian to advise, schedule and coordinate the residential treatment admission;
10. In the event a legal guardian chooses to waive a CFS, the Network Service Provider shall submit the completed SIPP packet to LSFHS at Childrensservices@lsfnet.org along with the CFS waiver form (Appendix J.) This should be done prior to sending the packet to SIPP providers;
11. While youth is in residential placement, staff youth 11 or older at least every 90 days and youth 10 or under at least every 30 days;
12. Ensure case managers complete the CFS Review Report (See Appendix H) to be presented at the CFS staffing. This information should be kept in the consumer file; and
13. Ensure recommended services are in place when a youth is discharged from residential treatment.

Funding and Allocations

In order to appropriately serve children in accordance with the provisions contained herein, the following allocations must be made to the contract award for this program:

- Incidental Expenditures for Purchase of Services for Enrolled Clients: 35%
- Intervention Services for Specific, Identified Clients: 35%
- Information and Referral Services: 30%

Providers may elect to designate up to 10% of total contract award to Recovery Support services by reducing the allocation to Incidental Expenditures for Purchase of Services for Enrolled Clients with prior approval from LSF Health Systems.

Performance Measures

The Network Service Provider shall attain a minimum of 100 percent of the performance measures identified below.

1. 65% of youth and families participating in FSPT are diverted from CFS.
    a. The numerator is the total number of youth and families diverted from CFS.
    b. The denominator is the total number of youth and families participating in FSPT services.
    c. The percentage of youth and families diverted from CFS will be equal to or greater than 65%.

2. 100% of youth and families that request to have a CFS without participating in the FSPT process will be successfully diverted back to complete the FSPT process:
    a. The numerator is the total number of youth and families requesting a CFS without participating in the FSPT process that are diverted back to the FSPT process.
    b. The denominator is the total number of youth and families requesting a CFS without having participated in the FSPT process.
    c. The percentage of youth and families requesting a CFS without participating in the FSPT process successfully diverted back to the FSPT process will be equal to 100%.

Required Reports

The Network Service Provider shall submit the following reports:

1. **Appendix C - FSPT Monthly Tracking Report:** A report that includes the FSPT Service Log and details the outcomes for the month.
    a. Due Date: Monthly, by the 10th of each month
    b. Submit to Childrensservices@lsfnet.org
2. **Appendix I - The Children's Mental Health Care Coordination Program Quarterly Progress Report:** A report that details the outcomes for the quarter.
    a. Due Date: Quarterly, by the 10th of each month
    b. Submit to Childrensservices@lsfnet.org
3. **Appendix K** - **FSPT Monthly Purchase of Services**: A report detailing the purchases of services for the month.
    a. Due Date: Monthly, by the 10th of each month as invoice back-up data
    b. Submit to Network Manager and Childrensservices@lsfnet.org

APPENDIX A

FSPT/CFS AGENDA

Date: **Location:**

TIME	NAME	STATUS	SCHOOL/PLACEMENT	REVIEW/NEW	DOB	MH CASE MGT.	PARENT	OTHER
9:00								
9:15								
9:30								
10:00								
10:15								
10:30								
11:00								
11:15								
11:30								
12:00								
12:15								
12:30								

***If you are the Case Manager for a child on this agenda, it is your responsibility to notify the parent, school, and any other parties involved. Any problems or changes, please call _____**

APPENDIX B

Community Service Plan/Notes

FAMILY SERVICE PLANNING TEAM (FSPT)/CHILD AND FAMILY STAFFING (CFS) FORM

STATEMENT OF CONFIDENTIALITY

Date: _____

Client: _____ Client ID:_____

My signature below indicates that I understand and affirm that all information being release to me under Florida Statue 394.459 is confidential and will be used for the sole purpose of treatment, education and/or case management for the child identified.

NAME	RELATIONSHIP TO CHILD	PHONE #	SIGNATURE

Client: _____ Client ID: _____ Date of Service: _____

Mental Health Services/TCM/Therapy/Medication Management:
Substance Abuse:
Health:
Educational:
Family/Social Supports:
Activity:
Duration: **Staff Signature:**

APPENDIX C

FSPT Monthly Tracking Report

Month: _____

Circuit: _____

Please identify the number of Consumer staffed through the Family Services Planning Team this month:_____

Of those staffed, how many Purchase of Service (POS) requests were completed?_____

How many consumers were referred to other non-LSFHS funded community services or resources?_____

How many consumers were referred to CFS this month that were redirected to FSPT?_____

How many consumers have DJJ (Department of Juvenile Justice Involvement)? _____

How many consumers have Child Welfare involvement? (Please include all youth with open abuse investigations, CBC oversight, or open dependency cases, **not** those placed in foster care) _____

Please identify the number of consumers staffed through Child and Family Staffings this month. Please specify new referrals versus youth currently placed in SIPP:_____

Please identify below any consumers by name that were staffed through FSPT that will require a referral to CFS:

Submitted by: _____Agency:_____

APPENDIX D

Family Services Planning Team-FSPT Application

Date		Application Completed By		Child's Gender: ☐ Male ☐ Female			
Child's Name		DOB		Age		County	
Race	☐White ☐Black ☐American Indian ☐Alaskan Native ☐Asian ☐Native Hawaiian or Other Pacific Islander ☐Multi-Racial ☐Other						
Ethnicity	☐Puerto Rican ☐Mexican ☐Cuban ☐Other Hispanic ☐Haitian ☐Mexican American ☐Spanish/Latino ☐Other						
SS #		Insurance		Financial Information			
Parent/Guardian		Relationship to Client					
Address		City		Zip			
Phone – Home		Work		Cell			
Email Address		Emergency Contact		Phone			
Strengths							
Challenges							
Diagnosis							
Medications							
History of Abuse/Neglect	☐Yes ☐No	Comments:					
Current Agencies Involved	☐Child Welfare ☐Department of Juvenile Justice Involvement ☐Child Medical Services ☐Agency For Persons With Disability ☐Other_____						
Child was adopted through the state of Florida (not private)	☐Yes ☐No Comments:						
Mental Health Assessment(s) Completed	☐Yes ☐No (If yes, please include with application)						
Psychological Evaluation Completed	☐Yes ☐No (If yes, please include with application)						
Medication Evaluation Completed	☐Yes ☐No (If yes, please include with application)						
School							
Student ID		IQ		Grade			

Previous and Current Mental Health and Substance Abuse Treatment Providers		
Individual Therapy	Provider Name:	Dates:
Medication Management	Provider Name:	Dates:
Family Therapy	Provider Name:	Dates:
Baker Acts	Provider Name:	Dates:
Mentoring Services	Provider Name:	Dates:
Behavioral Therapy	Provider Name:	Dates:
Day Treatment	Provider Name:	Dates:
Substance Abuse Treatment	Provider Name:	Dates:
Reason for FSPT Referral:		

BEHAVIORAL CHECKLIST

Within last 6 months	More than 6 months ago		Within last 6 months	More than 6 months ago	
☐	☐	Victim of physical abuse	☐	☐	Noncompliant behavior
☐	☐	Victim of sexual abuse	☐	☐	Runaway
☐	☐	Perpetrator of sexual abuse	☐	☐	Damaged property
☐	☐	Socially inappropriate sexual behavior	☐	☐	Fire setting
☐	☐	Emotional abuse/neglect	☐	☐	Stole property
☐	☐	Verbally threatens suicide	☐	☐	Suicidal gesture
☐	☐	Avoids social contact	☐	☐	Actual suicidal attempt
☐	☐	Frequently anxious	☐	☐	Hurt someone
☐	☐	Frequent nightmares	☐	☐	Poor peer relationships
☐	☐	Threatened to hurt someone	☐	☐	Bizarre behaviors
☐	☐	Thought disorder/hallucinations	☐	☐	Chronic eating disorder
☐	☐	Cruelty to animals	☐	☐	Self-injurious behavior
☐	☐	Frequent bedwetting (in child over five)	☐	☐	Pregnancy
☐	☐	Used drugs or alcohol	☐	☐	Chronic eating disorder
☐	☐	School suspensions	☐	☐	Parental abandonment
☐	☐	Frequently unmanageable behavior	☐	☐	Truancy
☐	☐	Significant school behavior/problems			

Notes:_____
_____
_____
_____

INFORMATION RELEASE AUTHORIZATION
BY PARENT/LEGAL GUARDIAN

I hereby authorize the release of all available substance abuse, alcohol abuse, medical, social, psychological, psychiatric and/or educational information from the records of:

Child _____

Social Security number _____

to the Department of Children and Families, Family Service Planning Team (FSPT) and/or Child and Family Staffing Committee (CFS).

I authorize the Department of Children & Families/Substance Abuse and Mental Health Program Office, Lutheran Services of Florida Health Systems to release this information to providers of medical, mental health and substance abuse treatment, the FSPT, the FSPT Coordinator, the CFS and the CFS Coordinator.

I understand that all of the information transferred in these instances will be considered confidential and will be made available or used only for professional purposes for one (1) year. Therefore, I release all agencies involved from any legal liability that may arise from the transfers of information.

I certify that I am the parent or legal guardian of the above named child, or that I am a student of majority age, and have the authority to sign this release.

_____ _____

Signature Date

_____

PRINT Name

_____ _____

Witness Date

APPENDIX E
REQUEST FOR PURCHASE OF SERVICES

Client Data			
SSN:		County of Residence:	
Last Name:		Primary Insurance:	
First Name:		Legal Custodian's Name:	
Middle Initial:		Legal Custodian's Phone Number:	
Gender:	Male ☐ Female ☐	Legal Custodian's Address:	
Date of Birth:		Current Mental Health Provider:	
Other Services already in place? If yes, which ones? (e.g. outpatient counseling, med mgmt., etc.)			
Other funding streams already explored? If yes, which ones?			

Part I – Initial Screening – Clinical Eligibility		
The child meets the following criteria: **1**) A current mental health diagnosis. **2**) An IQ of 70 or higher. **3**) The child is a community child (not in foster care or have DCF/CBC oversight). **4**) The child does **not** meet criteria for Autism/Mental Retardation/Pervasive Developmental Delay. **5**) The child would benefit from services not covered by Third Party Liability or reimbursable by another payor source.	**Yes** ☐	**No** ☐

Part II – Service Requested	
Type of Service**:** ☐ Therapeutic Friend/Life Coach ☐ Parent Education ☐ Outpatient Counseling ☐ Psychiatric Services ☐ Behavior Analyst ☐ Psychosexual ☐ Tutoring ☐ Camp ☐ Gas Cards ☐ Respite ☐ Psychological (mental health purposes only) ☐ Sexual Victim's Counseling ☐ Extracurricular Activities ☐ Other:	**Clinical justification on how the requested service will benefit the client therapeutically:**
Estimated Cost of Service:	Vendor to Provide Service:
Frequency of Service**:**	Vendor Credentials**:**
Length of Service**:**	Vendor Telephone No.**:**
Duration of Service**:**	Vendor Address:

Requestor Data	
Form completed by**:**	Date:
FSPT Agency**:**	FSPT Chairperson Name**:**
FSPT Address**:**	FSPT Telephone No.**:**
FSPT Fax Number**:**	FSPT Email:

This section to be completed by LSF: **(Director signature required ONLY for those purchases in excess of $1000)**	
The requested services has been:	Approved: ☐ Denied ☐
Comments:	

Client Data			
SSN:		County of Residence:	
_____ Clinical Care Support Specialist		_____ Date	
_____ Director of Program Operations		_____ Date	

APPENDIX F
SIPP PACKET COMPONENT CHECKLIST

_____ Child and Family Staffing Summary

_____ Admissions Checklist

_____ Magellan Release Form

_____ LSF Paperwork

_____ SIPP recommendation by clinical psychologist/psychiatrist (within the last 3 months)

_____ Current FSPT Application (check that consent is within 1 year

_____ School Psychological (if available) most useful

_____ Passing FCAT scores

_____ Proof that youth has passing school grades (on grade level)

_____ IQ is required.

Clinical Records – purpose is to show that outside services have been exhausted

_____ Baker Act discharge reports

_____ Therapy notes/history of attending individual, family counseling

_____ Medication management reports (psychiatrist notes etc.)

_____ Family Preservation Team notes

_____ Behavioral Analyst notes

_____ ANY proof of therapy which has occurred

_____ CFAR(s)

School Records

_____ IEP (if ESE student)

_____ Report card

_____ School Social history (if available)

Medical

_____ Immunization records

_____Birth Certificate

_____ Medical Stability within 3 months

_____ Physical within three months

_____ Copy of Medicaid card

_____ Dental within the last year

APPENDIX G

SIPP PACKET DOCUMENTS

Family Commitment Involvement Form

A Residential Application has been submitted LSF Health Systems for _____for consideration for a mental health residential treatment. Please check each box to indicate your agreement with the following:

☐ I have been given information on Residential Treatment and the Child and Family Staffing (CFS) and understand the process. I may contact the Lutheran Services Florida Managing Entity 904-900-1075, for concerns and additional questions that may arise.

☐ I understand, if and when my child is found eligible for Residential Treatment, my child may not be placed until LSF Health Systems authorizes an appropriate level of treatment and funding is secured. While my child is awaiting treatment, I agree to continue working with the Community Mental Health and Substance Providers to ensure that my child remains as stable as possible until admission to the treatment facility.

☐ I have completed the financial information form and agree to financially participate in the support of residential treatment services to the extent of my ability. Services will not be denied based solely on the inability to pay for services.

☐ I am committed to actively participate in my child's treatment including family therapy weekly and to assist my child in achieving his/her treatment goals. I will participate in family therapy in person at least once a month while my child is receiving treatment at the Residential Treatment Facility. I will also participate in treatment planning and discharge planning, which includes follow up services (i.e. medication, mental health and social support services) as recommended. In addition, I will schedule an appointment with the Children's Targeted Case Manager for continued services to ensure that my child remains stable in the community.

☐ I may invite additional people to attend the Child and Family Staffing that have knowledge of my child, including my child. (My child can attend, but will be asked to participate after the clinical information has been presented).

This form is to be completed and submitted to the Children's Targeted Case Manager and LSF Health Systems or their designee with the Residential Application.

_____

Name (Please Print)

_____

Signature Date

Consent to Release Protected Health Information (PHI)

LSF Health Systems

[9428 Baymeadows Rd, Ste 320]

[Jacksonville, FL 32256]

Managing Entity for

Florida Medicaid Statewide Inpatient Psychiatric Programs

Protected Health Information (PHI) means information about your health. Federal and state laws protect the privacy of your PHI. The laws say we cannot give anyone your child's PHI unless you say it is OK. By signing this paper, you give us your OK. We will only give out the PHI that you say we can share. And, we will only give it to the people or agencies that you list. Do you have questions? We can help. Call LSF Health Systems at 904-900-1075.

Part 1 Who is the patient?

Last Name	First Name	Middle Initial

ID Number (SSN)	Date of Birth (MM/DD/YYYY)	Phone Number (with area code)

Address	City	State	Zip Code

Check One

☐ I am the patient OR

☐ I have the legal right to act for this person. (Check one below; if "other" fill in blank)

I'm his or her: ☐ Parent OR ☐ Guardian, OR ☐ Other _____

Part 2 Who can give out the PHI?

LSF Health Systems or the designated Network Service Provider may give out your child's PHI. LSF Health Systems provides oversight for Florida's Statewide Inpatient Psychiatric Programs (SIPP).

Part 3 Who can the PHI be given to?

Part 4 What PHI can we share?

LSF Health Systems or the designated Network Service Provider makes a reasonable effort to limit the use and disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use, request, or disclosure. We will only share the PHI that you OK. This OK includes facts about your child's treatment while receiving services in Florida's Statewide Inpatient Psychiatric Program (SIPP).

Part 5 When does my OK end?

Your OK will end when you tell us it does. Tell us when you want your OK to end:

☐ My OK ends on this date (It cannot be more than one year from your OK)

OR

☐ My OK ends when this happens: _____

(It can be something like "you can share my child's medical records this one time.") If you do not tell us when your OK ends then we will end your OK in one year from when you sign. After one year, we will need a new OK.

Giving your OK is up to you. You do not have to share your child's information.

- You do not have to OK this paper. You will still get benefits and treatment.
- You can take back your OK. You must tell us in writing. Mail it to [9428 Baymeadows Rd, Ste. 320]; [Jacksonville, Florida 32256].
- What if you take back your OK? This will not take back the PHI that we have already shared. But, we will not share any more of your child's PHI.
- If we share your child's PHI with the people or agencies that you named, they may share it with others. Not everyone has to follow privacy rules.
- You have a right to get a copy of this signed OK. If you need a copy, call LSF at [904-900-1075].
- If you do not understand, or have questions, we can help. Call LSF at [904-900-1075].

I give my OK to share the information listed in this paper.

_____ _____

Signature or Mark of Patient Date

Part 8 Signature of Authorized Representative (if any)

Authorized Representative means you have legal proof that you can act for this person. A representative signs for a person who cannot legally sign on his or her own. If the patient is less than 18 years old, a parent or guardian should sign for the minor.

_____ _____

Signature of Person signing on behalf of patient Date

Printed Name: _____
Address: _____
Phone: _____

You should get a copy of this signed paper. Remember, Protected Health Information (PHI) means any information about your health in the past, present, or future. It includes facts like your child's address and date of birth. A full definition of PHI is at 45 CFR §160.103.

NOTICE TO ANYONE OTHER THAN THE PATIENT

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR 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 the information to criminally investigate or prosecute any alcohol or drug abuse patient.

APPENDIX G

Residential Treatment Application

Part 1

Child & Family Staffing (CFS) Requested: _____ Today's Date: _____
Child & Family Staffing (CFS) Denied: _____Reason Denied: _____

Child & Family Staffing Date (s): _____Family Service Planning Team Date (s): _____

Requested Program (check one): Statewide Inpatient Psychiatric Program ☐ Residential Treatment Center ☐
Specialized Therapeutic Group Care ☐

PLEASE PRINT CLEARLY

CLIENT Name		**DOB**		**AGE**		**County**	
SS #		**Medicaid #**				**Private Insurance**	

PARENT/GUARDIAN						**RELATIONSHIP**	
Address				**City**		**Zip**	
Phone – Home		**Work**				**Cell**	
EMAIL ADDRESS				**Emergency Contact**		**Phone**	

FAMILY SERVICE COUNSELOR				**AGENCY**	
Phone – Office		**Cell**		**Fax**	
Supervisor Name			**Office Phone**		
EMAIL ADDRESS					
JUVENILE PROBATION OFFICER		**Office Phone**		**Cell**	
EMAIL ADDRESS					
TARGETED CASE MANAGER		**Office Phone**		**Cell**	
EMAIL ADDRESS					

OTHER PARTIES		**AGENCY**	
Office Phone			
Supervisor Name		**Office Phone**	
EMAIL ADDRESS			

FAMILY SERVICE PLANNING TEAM (FSPT) Documents Attached: _____

Brief History: _____

_____

_____

_____

_____

Part 2

DSM Diagnosis		
Axis Ia:	**Ib:**	**Ic:**
Axis II:		
Axis III:		
Axis IV:		
Axis V:		
Current GAF:	**Full Scale IQ:**	**ESE Placement:**

List Medications (response, side effects, allergies, etc)	
Current Medications: **1.** **2.** **3.** **4.** **5.**	**Past Medications:** **1.** **2.** **3.** **4.** **5.**
Allergies:	**Additional information about medications:**

Number of Baker Acts year & dates: **Where:_____Dates:_____** **_____Dates:_____** **_____Dates:_____** **_____Dates:_____** **_____Dates:_____**	**Number of screenings in the past year & dates:** ***Please attach the last two CFAR reports if available to this form***	**Delinquency program involvement:** **Yes ☐ No ☐** **Charges:_____** **_____** **_____** **Attach DJJ Face Sheet:____**

List Mental Health Treatment, Substance Abuse Treatment, and/or Behavioral Intervention received in the past, please include the dates of service if known:

BACKGROUND INFO/PREVIOUS TREATMENT:
Individual Therapy: Where_____
Dates:_____
Medication Mgmt: Where?_____
Dates:_____ _____ Family Therapy:
Where?_____ Dates:_____
Mentoring Services: Where?_____
Dates:_____ Behavior Therapy/Plans: Who?
_____ Dates:_____ Day
Treatment: Where?_____
Dates:_____ Substance Abuse Treatment:
Where?_____Dates:_____ Types of
Substance that client would
use:_____

What treatment has been successful:
_____
_____
_____
Barriers to treatment (i.e. transportation, no in-home services, compliance, etc…)
_____
_____
_____
Other Treatment
Information_____
_____
_____
_____
_____

Describe the Child's Emotional & Behavioral Patterns Where Appropriate

Self Destructive Acts:	**Impaired Self Control:**
Aggressive (including physical, verbal and destruction of property):	**Sexual Acting Out**:
Social and Emotional Maladjustment:	**Maladaptive Behaviors:**
Arson:	**Hallucinations or Delusions:**
Suicidal Attempts, Gestures, Plan or Intention:	**Disruptive Behaviors:**
Neglect of Self:	**Runaway:**

Withdrawal:	**Substance Abuse:**

Current Medical Needs (if any):

CHECKLIST

Use this three-step checklist to guide you in completing the residential treatment application. Once you have checked all the boxes and attached the necessary documents the application is complete. Please return the checklist with your application and supporting documentation.

The Substance Abuse and Mental Health Program Office (LSF Health Systems or designee) will review all applications for completeness within 72 hours of receipt (provided staff availability). Every family will be offered a Child and Family Staffing when Residential Treatment is being considered for their child. In some instances this staffing may be optional. It is the Program Offices goal to access residential treatment for eligible children in the most timely and efficient manner.

STEP 1

☐ **An assessment completed by a licensed psychologist or psychiatrist that must include:**

- The child has an emotional disturbance as defined in Section 394.492(5), F.S., or a serious emotional disturbance as defined in Section 394.492(6), F.S.;
- The emotional disturbance or serious emotional disturbance requires treatment in a residential treatment center; please specify Statewide Inpatient Psychiatric Program for Medicaid funded/eligible children or Residential Treatment Center for Non-Medicaid funded children or Specialized Therapeutic Group Care,
- All available treatment that is less restrictive than residential treatment has been considered or is unavailable;
- The treatment provided in the residential treatment center is reasonably likely to resolve the child's presenting problems as identified by the licensed psychologist or psychiatrist;
- The treatment facility is qualified by staff, program and equipment to give the care and treatment required by the child's condition, age, and cognitive ability;
- The child is under the age of 18; and
- The nature, purpose and expected length of the treatment has been explained to the child and the child's parent or guardian.

STEP 2

☐ **FSPT/CFS Packet and Initial CFS Report**

☐ **Clinical Records**

(Psychiatric and/or Psychological evaluations will be required)

☐ Psychiatric Evaluation with recommendation completed within the last year (must include information listed in **Step 1**)

- ☐ Psychological Evaluation (including FULL Scale IQ) with recommendation completed in the last year or
  - Most recent School Psychological Evaluation, if child is under ESE Classification
  - Other performance factors may help identify a child's intellectual capacity
- ☐ Psychosocial Evaluation, if applicable
- ☐ Previous Clinical Information (i.e., admission reports, evaluations, discharge summaries) from Baker Acts, Residential & Inpatient Admissions, Partial Hospitalizations, Outpatient Treatment, etc.
- ☐ Psychiatric Notes/Medication Log
- ☐ Baker Act Reports (Admission, Discharge, History and Physical)
- ☐ Previous Residential Information

- ☐ **Foster Care Only** for **SIPP** (*plus* above documents, if applicable):
  - Suitability Assessment
  - Comprehensive Assessment
  - Court Order for residential care
  - Court Order for medications

☐ **Medical & School Records**

- ☐ Birth Certificate
- ☐ Immunization Records
- ☐ Medical Stability or Medical Clearance - Physical within last 90 days
- ☐ IEP, if in Special Education (ESE Classification) or last Report Card, if Regular Education

_____

- ☐ Dental Records
- ☐ Court Ordered Custody/Adoption
- ☐ Financial Worksheet (*NON Medicaid Children & Medicaid Children recommended for RTC or STGH*)
- ☐ Family Involvement Commitment Letter and the Lutheran Services Consent Form

STEP 3

☐ **Complete Part 1, Part 2 and Gather & Include All the Clinical, Medical, Educational & Financial Information listed in the Checklist Section of this application.**

☐ **PACKET/DOCUMENTS CONFIDENTIAL SUBMISSION OPTIONS**

Deliver or mail two **(2)** copies of the completed packet to your local Family Service Planning Team Provider. You may also contact LSF Health Systems at childrensservices@lsfnet.org to determine who that provider is if you are unaware as to who that provider is.

Packet reviewed by: _____ **Forwarded to Provider:**

_____

Date: _____

DO NOT FORWARD PACKETS TO THE PROVIDER. THEY WILL *ONLY* ACCEPT PACKETS FROM THE SAMH MANAGING ENTITY CONTRACTED PROVIDER

⇒ If your child has been ACCEPTED, you will be NOTIFIED of the admission date or in some cases, that your child has been placed on the Northeast Region (Circuits 4,7, 3,8, and 5) waitlist for admission.

⇒ If your child has been DENIED by the SIPP or Magellan, you will be NOTIFIED and informed how to appeal the decision and/or the Grievance Procedures, which ever applies to your situation.

For questions, contact LSF Health Systems and ask for the Children's Mental Health Specialist at (904)900-1075.

LSF HEALTH SYSTEMS

Sliding Fee Scale Assessment For Placement In Residential Treatment Facilities

Florida Administrative Code 65E-14.018 requires all state contracted agencies "develop a sliding scale fee that applies to persons for services that are paid for by state, federal, or local matching funds who have an annual gross family income at or above 150 percent of the Federal Poverty Income Guidelines." Sliding fee scales are based on the current year Poverty Guidelines for the 48 Contiguous States and the District of Columbia or the latest version located here: https://aspe.hhs.gov/poverty-guidelines

Date: _____ Client's Name: _____DOB:_____

Client's SS#:_____ VO/CFS Approval Date: _____

Parent/Guardian Name: _____

Case Manager's Name: _____Case Management Agency: _____

Name of person completing this form: _____

Current Family Income: Please include all adult family members' income, consisting of part-time and/or full-time employment, unemployment compensation, SSI benefits, etc. Income from sources such as seasonal type work or other work of less than 12 months duration, commissions, overtime, bonuses and unemployment compensation shall be computed as the estimated annual amount of such income for the ensuing 12 months. Historical data based on the past 12 months may be used if a determination of expected income cannot logically be made.

Worksheet for each adult family member
(Use additional sheets if necessary)

A.	HOURLY WAGE	$	A.	HOURLY WAGE	$
B.	WEEKLY WAGE	$	B.	WEEKLY WAGE	$
C.	BI-WEEKLY	$	C.	BI-WEEKLY	$
D.	MONTHLY WAGE	$	D.	MONTHLY WAGE	$
E.	ANNUAL WAGE	$	E.	ANNUAL WAGE	$
F.	SSI BENEFITS	$	F.	SSI BENEFITS	$

G.	UNEMPLOYMENT	$	G.	UNEMPLOYMENT	$

Total Annual Family Income $_____

Number of Adult Persons in the Household_____.

Number of Children in the Household_____

Monthly Contribution: _____Guardian Signature: _____ Date: _____

Table 1

Federal Poverty Guideline	**Discount**	**Co-Pay Amount**	**Federal Poverty Guideline**	**Discount**	**Co-Pay Amount**
0%-150%	Co-pay	$ 2.00 per day	225%-240%	56%	$_____ per day
150%-165%	96%	$____ per day	240%-255%	39%	$_____ per day
165%-180%	94%	$____ per day	255%-270%	19%	$_____ per day
180%-195%	89%	$____ per day	270%-285%	10%	$_____ per day
195%-210%	81%	$____ per day	285%-300%	5%	$_____ per day
210%-225%	70%	$____ per day	300% and above	0%	$_____ per day
***The total negotiated charges to a client shall not exceed 5% gross household income**					

The 2020 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Table 2

Persons in Household	48 Contiguous States and D.C. Poverty Guidelines (Annual)							
	100%	133%	138%	150%	200%	250%	300%	400%
1	$12,760	$16,971	$17,609	$19,140	$25,520	$31,900	$38,280	$51,040
2	$17,240	$22,929	$23,791	$25,860	$34,480	$43,100	$51,720	$68,960
3	$21,720	$28,888	$29,974	$32,580	$43,440	$54,300	$65,160	$86,880
4	$26,200	$34,846	$36,156	$39,300	$52,400	$65,500	$78,600	$104,800
5	$30,680	$40,804	$42,338	$46,020	$61,360	$76,700	$92,040	$122,720
6	$35,160	$46,763	$48,521	$52,740	$70,320	$87,900	$105,480	$140,640
7	$39,640	$52,721	$54,703	$59,460	$79,280	$99,100	$118,920	$158,560
8	$44,120	$58,680	$60,886	$66,180	$88,240	$110,300	$132,360	$176,480
Add $4,480 for each person over 8								

Sample:

Step 1) Take the amount of the family's gross yearly earnings.

2) Use the number of persons in the family (household Ex: 1, 2, 3, 4 etc.), move to the right of Table 2 and get the poverty guideline amount.

3) Divide the gross income by the poverty guideline amount.

4) When you get the answer, move the decimal over two places. This will be a percentage

5) Look up the percentage from step 4, on table 1. Move to the right on table 1 to see the discounted amount. (ex: 0% thru 96%)

6) The discounted amount is adjusted off of the per day fee of residential treatment.

*Gross income: 40,000.00

*Persons in household: 3 look at Table 2 and find the number of persons in household. Scan to the right and find the amount in the poverty guidelines.

*Table 2, Poverty Guidelines amount. 21,720

*Divide the gross income by Table 2 40,000/21720 = 1.84

by the Poverty guidelines amount.

*Move decimal two places to the right. 184%

*Look up the % on Table1 (discount). 89%

The Residential Daily rate maybe. $417.00 daily rate (417.89=371.13)

*Apply the 89% discount. 417-371.13= $45.87 client share

The family co-pay amount is: $45.87 per day. Place this number in the monthly contribution space on page 1.

Please note: Prior to placement in a residential treatment you may be asked to show proof of earnings.

MEDICAL STABILITY STATEMENT FOR RESIDENTIAL TREATMENT SERVICES

Date: _____

PATIENT (PRINT): _____ COUNTY: _____
LAST FIRST

Date of Birth: __-____-____ Social Security #: _____-_____-_____

I, _____, have examined the above patient on _____ (Date) and have determined that he or she is currently in good physical health. At this time, this patient has no acute or chronic conditions that will require extensive medical treatment and the need for medical care other than routine.

Physician Signature _____ Date _____

ATTACH A COPY OF THE PHYSICAL EXAMINATION THAT HAS BEEN DONE WITHIN THE LAST 90 DAYS ……

INTERNAL USE ONLY **Residential Facility:** _____

The attending Psychiatrist reviewed the above statement and the supporting documents.

Physician Signature _____ Date _____

APPENDIX H

CFS Review Report

Today's Date				Report Completed By			
Date of Last CFS (either initial/review)				Previous CFS Recommendations/ Status			
Current Placement (include date of admission)							
Client Name		DOB		Age		County	
SS #		Medicaid #				Private Insurance	
Parent/Guardian				Relationship to Client			
Address		City				Zip	
Phone – Home		Work				Cell	
Email Address		Emergency Contact				Phone	
Family Service Counselor				Agency			
Phone – Office		Cell				Fax	
Email Address							
Juvenile Probation Officer							
Phone – Office		Cell				Fax	
Email Address							
Case Manager				Agency			
Phone-Office		Cell				Fax	
Email Address							
Other Provider:				Agency			
Phone-Office		Cell				Fax	
Presenting Issues							
Current DSM V Diagnosis							
Medication (response, side effects, change in medications)							
Discharge Plan				Anticipated Discharge Date			

Mental Health Treatment Goal Update (Complete the following or attach an updated treatment plan review)				
Status Rate Key:	1-Goal Reached	2-Progression	3-No Change	4-Regression
Goal 1				
Status Rate #		Comments:		
Goal 2				
Status Rate #		Comments:		
Goal 3				
Status Rate #		Comments:		
Brief Summary of Client's Progress in Treatment Since the Last CFS				

APPENDIX I

The Children's Mental Health Care Coordination Program **QUARTERLY PROGRESS REPORT**				
Provider Name				
Circuit				
Reporting Period	**From**		**To**	

Reporting Requirement	**Annual Target**	**This Quarter**	**Year to Date**
The percentage of youth/families in FSPT that are diverted from CFS.	65%		
The percentage of youth/families that request to have a CFS without participating in the FSPT process that are successfully diverted to complete the FSPT process.	100%		

ATTESTATION	
I hereby attest the information provided herein is accurate, reflects services provided in accordance with the terms and conditions of this contract, and is supported by client documentation records maintained by this agency.	
Authorized Name, Title, and Agency Name *(please print)*	

HEALTH SYSTEMS

APPENDIX J

Child Family Staffing Waiver

I, _____, (parent/legal guardian) of child _____, DOB_____, am requesting to waive the child and family staffing for my child. I understand that waiving the Child and Family Staffing means my child's case will not be reviewed by an interdisciplinary team of mental health professionals for the purpose of care coordination. I understand that waiving the Child and Family Staffing has no bearing on whether or not my insurance will cover my child's treatment.

I understand that this waiver is applicable only to inpatient residential treatment and those applicants for therapeutic group homes, *must* complete a child and family staffing prior to placement.

_____ _____
Signature of Parent/Legal Guardian Date:

_____ _____
Signature of FSPT/CFS Coordinator Date:

_____ _____
Signature of LSFHS Representative Date:

FSPT/CFS Process Flow Chart