Mental Health & Recovery Services Board of Allen, Auglaize and Hardin Counties FY2025 Standards Manual

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This Manual, which is attached to and made a part of the contract between the Mental Health and Recovery Services Board of Allen, Auglaize and Hardin Counties and each of its contract providers/ agencies ("Agreement") providing services that align with the behavioral health continuum of care (ORC 340.032) contains guidance and additional requirements for those agencies. Attached to the Standards Manual are Exhibits to help the agencies comply with Agreement reporting requirements. The Exhibits gather many documents/reports in one place for the convenience of the agencies.

CONTRACT ELIGIBILITY

The Board will consider contracting with agencies that meet ALL of the following criteria:

- Is registered with the Internal Revenue Services (IRS)
- Boards may only contract with residential facilitates that require licensure under ORC 5119.34 if the facility is so licensed and with community addiction and mental health service providers to provide certifiable services and supports that require certification under ORC 5119.36 if services and supports are so certified.
- Civil Rights Provisions-ORC 340.12 states that community addiction and mental health service providers under contract with a Board shall not discriminate in the provision of services or supports under its authority, in employment, or under a contract, on the basis of race, color, religion, ancestry, military status, sex, age, disability, or national origin. In addition, pursuant to ORC 5119.25, the Director of OhioMHAS may withhold state and federal funds from a Board that denies available services based on those same classes. Discrimination is prohibited and could result in cancellation of the contract.
- Certified by the Ohio Department of Mental Health and Addiction Services (OHMHAS) (Treatment, Prevention, Recovery Housing Provider only).
- Is accredited by CARF, COA, TJC (JCAHO), ORH or other National accrediting body recognized by OMHAS (Treatment Providers and Recovery Housing Providers Only)
- Has been certified to provide Medicaid funded services (Treatment Providers Only).
    - Services have been provided with no-disciplinary actions requiring suspension or other disciplinary action against said provision for the three prior years before application to the Board.
- Can produce unqualified financial audits for the three consecutive years prior to current application
    - Agencies that have had prior contracts with the Board will need to provide their financial audit annually and upon request.
- Any contracts and/or agreements authorized by this Board in the future shall have statement with regards to non-discrimination

Agencies that do not meet the criteria above, but have a working relationship with the Board, may be considered an Affiliate Agency. Affiliate Agencies may be listed on the Board website and may be included in some or all collaborative meetings, but do not have a formal contract with the Board. The Board, at its discretion, may engage in small single service contracts or Memorandums of Understanding with an Affiliate Agency.

In order for an agency to be considered for a Fee for Service contract with the Mental Health and Recovery Services Board of Allen, Auglaize and Hardin Counties ("Board"), the agency must be capable of billing insurance companies and Medicaid because the Mental Health and Recovery Services Board of Allen, Auglaize and Hardin Counties dollars are always to be the dollars of last resort. Without this capability the Mental Health and Recovery Services Board of Allen, Auglaize and Hardin Counties will not

consider entering into a Fee for Service contract with an agency. (See "Use of Board Funds" on page 19? of this manual)

In addition to the Mental Health and Recovery Services Board of Allen, Auglaize and Hardin Counties (Board) Standards outlined in this Manual, contracting agencies are required to be in compliance with the Administrative Rules of the Ohio Mental Health and Addiction Services (Ohio MHAS) governing community behavioral services, facilities and providers.

CHIEF CLINICAL OFFICER/MEDICAL DIRECTOR

The designated agency who contracts with the Board is to provide the Board with the name of the Chief Clinical Officer. The Chief Clinical Officer must be identified in a Memorandum of Understanding on the hiring agencies letterhead. The duties of the Chief Clinical Officer are identified in ORC 5122.27 (See **Exhibit 1** for more information on the role of the designated agency that will be included in that identified agency's contract).

SERVICE DEFINITIONS

Mental health and addiction services provided by the agency shall comply with OhioMHAS Service Definitions and requirements ORC 340.032.

DOCUMENTATION REQUIREMENTS

The following information is *to be used to assist Board-contracted providers in complying with applicable requirements and is not intended to constitute legal advice or guidance. Please consult your agency's legal counsel for further clarification of all state and federal laws, rules and regulations.*

Per OAC 5122-27-02, treatment records must be maintained for at least seven years after a client has been discharged from a program or services are no longer provided, and prevention records for at least three years. For all other records, if OhioMHAS rules do not address their retention and the agency's accreditation body does not have an applicable records retention standard, the agency shall develop its own policy for retaining each such type of record.

Documentation rules apply to, but are not limited to, individualized service plans, progress notes, billing records, and quality improvement/assurance reports. When the Board reviews agency documentation, the following rules will apply:

A. For all treatment services billed in whole or in part with public funds, the following documentation shall be included in the individual client record and/or billing card:

    1. Client Name

    2. Case Number and UCI

    3. Dates of Service, time of day of contact, and duration of contact

    4. Service Code Numbers (as per GOSH taxonomy)

    5. Signature and discipline of the agency staff member(s) responsible for developing the individualized service plan

    6. Location of service/service site (as per GOSH location codes)

7. Amount and source of third-party payments
8. Number of units provided
9. GOSH authorization /enrollment forms
10. Documented evidence of clinical supervision of staff developing the plan, as applicable
11. Any other documentation requirements contained in OAC 5122-27-02

B. Any documentation that requires a signature must include a date and credentials to be valid.

C. Signatures will not be accepted if they are on a blank document, a partially completed document, or a photocopied signature. OhioMHAS rule 5122-26-08.1 (Security of clinical records systems) allows the use of electronic client signatures. The code defines Electronic signatures as – a code consisting of a combination of letters, numbers, characters, or symbols that is adopted or executed by an individual as that individual's electronic signature; a computer-generated signature code created for an individual; or an electronic image of an individual's handwritten signature created by using a pen computer.

D. Mental Health Treatment Exceptions to Parental Consent: In accordance with section 5122.04 and 3719.012 of the Revised Code, upon the request of a minor fourteen years of age or older, a mental health professional may provide outpatient mental health services, EXCEPT FOR THE USE OF MEDICATION, without the consent or knowledge of the minor's parent or guardian. The minor's parent or guardian shall not be informed of the services without the minor's consent unless the mental health professional treating the minor determines that there is a compelling need for disclosure based on a substantial probability of harm to the minor or to other persons, and if the minor is notified of the mental health professional's intent to inform the minor's parent, or guardian. Services provided to a minor pursuant to this section shall be limited to not more than six sessions or thirty days whichever occurs sooner. After the sixth session or thirty days the mental health professional shall terminate the services or, with the consent of the minor, notify the parent, or guardian, to obtain consent to provide further outpatient services. OhioMHAS interpretation of this standard is it applies to each treatment episode that the adolescent has and is not to be interpreted as a "once in a "lifetime" practice. The minor's parent or guardian shall not be liable for the costs of services which are received by the minor without parental consent.

E. Alcohol/Drug Treatment Exceptions to Parental Consent: In accordance with 3719.012 of the Revised Code, a minor may give consent for the diagnosis or treatment by a physician licensed to practice in this state of any condition which it is reasonable to believe is caused by a drug of abuse, beer, or intoxicating liquor. The parent or legal guardian is not liable for the payment of any charges made for medical or surgical services rendered to the minor without parental consent.

F. Individualized Service Plans (ISP) and SUD Case Management Plans– An ISP must be completed, in accordance with the requirements of OAC 5122-27-03, for each service that requires an individual client record (ICR) to be maintained under OAC Chapter. A complete ISP must be completed within five sessions or one month of admission, whichever is longer, excluding crisis intervention mental health service provided in accordance with OAC. A SUD Case Management plan must also be developed for each client receiving addiction services treatment within seven (7) days of completion of the assessment or at the time of the first face-to-face contact following assessment, whichever is later. The agency may develop a separate ISP and SUD case management plans or integrate the ISP and case management plan of care into one plan. Each ISP must include the signature of the agency staff member responsible for developing the ISP, the date on which it was developed, and documented evidence of clinical supervision of staff developing the plan, as applicable. Evidence of clinical supervision may be by supervisor signature on the ISP, or other documentation by the supervisor in the ICR.

G. Ohio's Duty to Protect Statute (ORC 2305.51) states that mental health professionals and organizations have a duty to protect against violence communicated by a mental health client. (See **Exhibit 2** – Duty to Protect Documentation Form ORC 2305.51 states that:

1) A mental health professional or mental health organization may be found liable for damages or disciplinary action if the client or a knowledgeable person has communicated to the professional or organization an explicit threat of inflicting imminent and serious physical harm to, or causing the death of one or more clearly identifiable potential victims, the professional or organization has reason to believe that the client or patient has the intent and ability to carry out the threat, and the professional or organization fails to take one or more of the following actions in a timely manner:

   i. Exercise any authority the professional or organization possesses under Ohio law to hospitalize the client or patient on an emergency basis.

   ii. Exercise any authority the professional or organization possesses under Ohio law to have the client or patient involuntarily or voluntarily hospitalized.

   iii. Establish and undertake a documented treatment plan that is reasonably calculated, according to appropriate standards of professional practice, to eliminate the possibility that the client or patient will carry out the threat. Concurrent with establishing and undertaking the treatment plan, the mental health professional or organization must initiate arrangements for a second opinion "risk assessment through a management consultation" about the treatment plan. In the case of a mental health organization, the second opinion must be obtained from the organization's clinical director. In the case of a mental health professional who is not acting as part of a mental health organization, the second opinion may be obtained from any mental health professional that is licensed to engage in independent practice.

   iv. Communicate to a law enforcement agency with jurisdiction in the area where each potential victim resides, where a structure threatened by a mental health

client or patient is located, or where the mental health client or patient resides, and if feasible, communicate to each potential victim (or potential victim's parent or guardian if the potential victim is a minor or has been adjudicated incompetent) all of the following information: the nature of the threat, the identity of the mental health client or patient making the threat, and the identity of each potential victim of the threat.

2) If a mental health professional or mental health organization takes action under the statute, the law requires the professional or organization to consider each of the alternative actions set forth in the act and documents the reasons for choosing or rejecting each alternative. The professional or organization may give special consideration to those alternatives that, consistent with public safety, would least abridge the rights of the mental health client or patient under Ohio law. The professional or organization is not required to take an action that, in the exercise of reasonable professional judgment, would physically endanger the professional or organization, increase the danger to a potential victim, or increase the danger to the mental health client or patient.

3) The professional or organization is not liable in damages in a civil action and is not to be made subject to disciplinary action by any entity with licensing or other regulatory authority over the professional or organization, for disclosing any confidential information about a mental health client or patient that is disclosed for the purpose of taking any of the actions listed above.

HIPAA COMPLIANCE

Definitions

HIPAA - Health Insurance Portability and Accountability Act of 1996.

Protected Health Information (PHI) - individually identifiable health information that is transmitted by electronic media; maintained in any electronic media such as magnetic tape, disc, optical file; or transmitted or maintained in any other form or medium, i.e., paper, voice, fax, Internet, etc.

PHI generally includes such individually identifiable health information as name, address, phone number, fax number, date of birth, social security number, or other unique identifying number(s).

Minimum Necessary – the minimum amount of PHI necessary to achieve the purpose of the use or disclosure.

The parties shall comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Each party shall take necessary reasonable steps to comply with HIPAA requirements, including the following:

If one of the parties agrees to use or disclose PHI *on behalf of* the other party, both parties will enter into a business associate agreement prior to such use or disclosure. The elements of such agreements shall conform to HIPAA requirements.

The parties shall cooperate in determining how information will be transmitted to conform with requirements related to electronic data interchange (EDI). If necessary, the parties will enter into a Trading Partner Agreement, which defines the duties of the parties for EDI transmissions.

The parties shall cooperate in assessing joint security issues in order to allow the parties to conform to security requirements. If necessary, the parties will enter into appropriate agreements in accordance with HIPAA requirements, which will address joint security issues.

DISCLOSURES AND RELEASES OF INFORMATION

Upon request of the Board, the Provider shall distribute the Board's HIPAA privacy notice, at the time of enrollment, to clients who will receive services funded through the Board. A signed acknowledgement that the client has received the Board's Notice shall be retained in each client's file and made available to the Board upon request.

Any uses or disclosures of PHI will be made in accordance with the HIPAA regulations and when applicable, any stricter or more stringent requirements of other federal or state law will be adhered to, including but not limited to the federal regulations governing the confidentiality of drug and alcohol abuse treatment records.

Requests for, and disclosures of, PHI will comply with the minimum necessary standard as required by the HIPAA regulations.

Agencies shall ensure that clients sign all releases or authorizations for the disclosure of information, including information required to be disclosed under the Agreement with the Board which are necessary under, and conform to, the applicable requirements of state and federal law.

Release of mental health records/information and minors - HIPAA and Ohio law require that a parent/ guardian must sign the release of information unless the client/minor is receiving confidential mental health services pursuant to ORC 5122.04, in which case, only the client/minor must sign the release.

Release of SUD records/information and minors- 42 CFR Part 2 and Ohio law require that both the client/ minor receiving addiction treatment AND the parent/guardian sign the consent/authorization to release information. The client/minor must authorize the provider to contact the parent /guardian or find the minor lacks in capacity to make a rational choice in accordance with 42 C.F.R. part 2.14(c)(2). When a minor is receiving addiction services without parent/guardian consent pursuant to ORC 3719.012, only the client/minor must sign the consent.

ACCESS TO PROVIDER RECORDS

The Board, OhioMHAS, State Auditor, and any other party with proper legal authority shall have the right to inspect the Provider's program, personnel, accounting and clinical records while complying with HIPAA minimum necessary standards, as required to discharge their legal responsibilities.

The Contract Agency shall provide BOARD with information which is reasonably necessary to permit Board to: (i) Monitor and evaluate the Provider's compliance with the terms of the Agreement and (ii) Perform its duties under applicable requirements, including but not limited to, reporting and monitoring activities, oversight, system administration and program and service evaluation.

There may be times when the Board staff or a third party with whom the Board contracts requires access to client records. Specific clinical records must be made available to the Board staff (or an agent of the Board who has a signed business associate agreement with the MHRSB allowing for the review of patient information) for utilization and clinical review at no charge by the agency to the Board.

The Board Executive Director and/or their designee may obtain immediate access to information without prior notice, including access to staff, individual client records and client accounts, when such information is reasonably related to allegations of abuse or neglect of a client being investigated or to prevent imminent harm to clients.

The Board and agency shall maintain the client's right to confidentiality as required by law or as provided by Provider policies, to the extent that the latter does not conflict with legal requirements.

INCOME DETERMINATION

These income determination guidelines apply to all services under contract with the Board that are to be reimbursed in whole or in part with public funds (See also **Exhibit 3** – Subsidy Scale).

For GOSH, agencies have submitted a common fee schedule to the Board. Agencies cannot change the fee schedule without prior approval from the Board.

The agency is to verify income for all clients whose services are to be reimbursed by the Board. When a client reports no income, the agency must document this. This information must be completed on the enrollment form for GOSH, following enrollment instruction provided by GOSH, except for emergency situations. In addition, completion of **Exhibit 4: GOSH Enrollment Status Form** is required and must be uploaded into GOSH upon enrollment to initiate payment.

Re-determination of income is recommended to be done upon self-report of a change of income and, **at least once a year**. Any changes must be submitted to GOSH.

If a client cannot sign the GOSH release form because of their mental illness after every attempt is made by the agency to do so, approval for payment will be requested from the Executive Director of the Board in writing by completing **Exhibit 5: Request for Financial Assistance.** Reasons for not obtaining signature will be documented in the client's file.

Once approval for payment is received, the agency will submit those claims through GOSH. The Agency will be responsible for getting approval to the GOSH administrator for claims processing.

When a client is in crisis, the first priority is to resolve the crisis. If the crisis is resolved and the person is able to relate the required information, agencies may bill (Board/Medicaid) for crisis intervention services. If the client returns to the agency for services, a revised enrollment form must be submitted to the Board with all required fields completed.

GROSS INCOME

Household income includes related and/or financially responsible individuals.

Gross Income includes:

- Wages
- Social Security

- Funds collected from annuities and pensions
- Dividends
- Interest
- Veteran's Pension
- Alimony
- Net Income from a Business or Farm
- Unemployment Compensation
- Social Security Disability Income
- Supplemental Security Income
- Rental Income
- Fees from services or any other source of income which is taxable under present federal or state laws
- Worker's Permanent Compensation
- Gifts and Inheritances (in excess of $10,000 per year)
- Child Support

Gross Income excludes:

- Income earned by minors (under age 18)
- Food stamps
- Bank withdrawals
- Student benefits
- Rebates
- Grants
- Loans which require repayment
- Utility allowance
- Cash assistance from ODHS
- Worker's Temporary Compensation
- Training stipends
- Insurance proceeds
- Gifts & Inheritances (less than $10,000 per year)
- Veteran Benefits
- Military Allowance

NUMBER OF DEPENDENTS

Dependents shall be determined by the number of persons supported by the above (Gross Income). The number of dependents can be documented by a signed self-declaration.

SUBSIDY SCALE/SLIDING FEE SCHEDULE – (Exhibit 3)

Agencies must adopt the Board's subsidy/sliding fee schedule identifying client co-pay responsibility. GOSH will be used to capture the residents' sliding fee scales (referred to in GOSH business rules as co-insurance). When claims are processed through GOSH, the percentage share to be paid by the member will be deducted from the total billed amount and the net will be paid by the Board. It is the provider's responsibility to collect the balance from the client. All people enrolled should have a sliding fee schedule assigned with the appropriate rider codes assigned (data on family size and income). Not only is there the possibility of a client moving from Medicaid to non-Medicaid but Medicaid does not pay for all services – only Medicaid services. Therefore, by design a Medicaid client can receive non-

Medicaid services. The sliding fee can be applied to any non-Medicaid services, though in most cases none will apply since the person would be eligible for 100% reimbursement.

Board dollars can be applied to any individual with an income at or below 350% of poverty. Individuals above 350% of poverty are also eligible for Board subsidy based on the approved subsidy scale.

When a client has health insurance coverage (including Medicare), contract agencies must ensure that they bill the insurance company for the services prior to billing the Board. Failure to do so will result in payback to the Board for those services.

In the event a client is unable to meet expenses associated with their deductible, the agency may utilize a financial assistance waiver. Waivers must be documented on the Request for Financial Assistance form (**Exhibit 5**). It is required that individuals identified to be 100% indigent are required to complete a Medicaid application through the Boards contract with Elevate who assists clients with the Medicaid application process. It is strongly recommended that the agency work with the client to access resources from other social service agencies before submission of a financial assistance waiver. Individuals who are identified as 100% indigent will automatically qualify for board funding for up to 30 days, for continued board funding they will be required to demonstrate compliance with submission of Medicaid application and proof of denial.

If a contracted agency does not have the ability to process claims through GOSH, they will be asked by the Board to follow the process below:

NON-GOSH Enrollment/Residency Verification Process:

1. The following enrollment/residency verification items are needed for individuals served with board funds and appropriate forms will be provided:
    a. Back up to invoicing to verify residency, income, etc.
    b. Include Demographics
    c. Include sliding scale fee
    d. Include residency verification
    e. Include disclosure/consent

<u>WAIVER OF CONSUMER FEES</u>

The Board recognizes that standard means-tested approaches to payment for services are sometimes limited in their ability to capture the true picture of a client’s financial circumstances. There may be times that a client is simply unable to pay their prescribed share as determined by the Subsidy Scale, and these instances often require immediate remedy to engage or retain a client in critical services.

To that end, the Board has authorized the agencies to reduce or waive fees when circumstances truly warrant such consideration. The agency must balance the acuteness of need, the availability of client and other resources, and the clinical prognosis in order to make a defensible determination of hardship. In order to assess the number of clients granted financial assistance, any deviation from the Subsidy Scale must be documented on the Request for Financial Assistance form (**Exhibit 5**).

Financial Assistance waivers should be utilized only as a last resort and precedence should be given to those clients in populations identified as priority (SMD, SED, Severely Addicted).

PROGRAM AUDIT REQUIREMENTS

The Board may conduct billing and program audits periodically on a schedule to be determined by the Board in advance. The reviewer(s) will provide at least a 24-hour notice on when the audit will be performed. The agencies will either provide a list of active clients to the auditor or provide UCI's of clients receiving services Board-funded services to draw an adequate sample. Within the sample size, the auditor will select a representative sample of the types of clients served by the agency (substance abuse/mental health, adult/child, etc.). At times, the Board may conduct focused audits and identify specific client files to be pulled by the agency for review.

Agencies are considered to be in compliance with reporting requirements if reports are complete, accurate and received within specified timeframes.

The scope of the audit will include the items identified above. Additional items, specific to individual providers, may also be reviewed. Providers will individually be notified of these items for review. Following completion of the audit, the agency will be forwarded a written draft for review. Following this review any needed additions and/or corrections will be made.

Each section of the audit report will include the following categories: generalized observations; issues requiring management response; and findings. Any items listed in the categories of issues requiring management response and findings must be addressed in the agency response to the draft report. Failure to respond in writing will be considered non-compliance. Corrective action plans must include timelines and a description of the steps to be taken. It is expected that corrective action can be completed on all issues sometime over the subsequent quarter and timeframes must reflect this. When reviewing corrective action plans, the Board will work in good faith with the providers to determine what is within the control of the agency and what is not in their control.

A final report will be forwarded to the agency Executive Director and the Board Executive Director.

USE OF BOARD/WE CARE PEOPLE BRAND AND ACKNOWLEDGEMENT OF BOARD FUNDING

The Board encourages the use of the current board logo on all print materials that are collaboratively agreed upon by the agencies.

COMMUNITY AWARENESS OF SERVICES

The Board encourages community awareness of services offered by contracted providers. Contracted providers are to update their services offered with local 211 providers to ensure accurate information and referral dissemination. Updates should occur upon any change in services offered.

CONTINUOUS QUALITY ASSURANCE –BOARD PROCESSES

Agencies as identified in their contracts will participate in the Board's Comprehensive Quality Improvement Plan (APF submission) and the processes prescribed by the Board's strategic plan and Community Assessment and Plan (CAP) submitted to OhioMHAS. Agencies will participate in surveys of staff, consumers, and family members as conducted by the Board.

PERFORMANCE/QUALITY IMPROVEMENT PLAN

The agency shall implement a QI plan in accordance with applicable department standards and/or accreditation standards (OAC 5122-28-03). When these reports identify issues or offer recommendations, providers must document in their subsequent CQI report how these issues/ recommendations were dealt with via their CQI process.

CONTINUOUS QUALITY ASSURANCE REPORTING

Performance monitoring is an integral part of effective service delivery and is prescribed by standard to help agencies be successful with new, modified, and existing agency processes (5122-28-03(B2).

Agencies are required to document the processes used to ensure performance improvement and achievement of all certification standards (5122-25-03).

Agencies are to submit a quarterly quality assurance report to the Board to report Board identified outcomes of general services and Board funded programs. Outcome reports are due on the following schedule:

- Quarter 1 (July-September) due October 31
- Quarter 2 (October-December) due January 31
- Quarter 3 (January-March) due April 30
- Quarter 4 (April-June) due July 31

Agencies shall also provide the following information with their quarterly report:

1. Hours of Operation by location
2. Number of new Client's served each quarter.
3. Every indigent Client is referred to Elevate-include the number of clients served by payor.

CONTRACT AGENCY FINANCIAL RECORDS

All contract agencies shall maintain their financial records in accordance with Ohio Administrative Code 5122:1-5-01, Annual budget, financial reporting, independent financial audit requirements.

Contract agencies shall be able to document the actual cost for each service provided, utilizing an appropriate and acceptable method approved by the Board.

Agencies shall submit financial statements in accordance with the following Standard Financial Statement Reporting Package.

Financial statements must be prepared in accordance with Generally Accepted Accounting Principles (GAAP).

Financial statements must be prepared on an accrual basis.

If the agency operates in more than the Allen, Auglaize, Hardin Board areas, statements must include both AAH and the total agency if the contract is more than $250,000.

At a minimum, the Standard Financial Statement Reporting Package must include:

Balance Sheet
  As of current month ending
Profit and Loss (Statement of Financial Position)
  Current month actual column
  Year-to-date actual column
  Annual budget column
  By Cost Center (i.e. Services, Programs, Location, etc.) per contract
Cash Flow Statement
  As of the current month ending
Accounts Receivable (A/R) Aging Report
  Aged by 30, 60, 90, 180, 365 days or similar
  Must be by payer source (self-pay, insurance, Medicaid, non-Medicaid Board, Medicare, etc.)

If agencies are funded via Program Subsidy, then they must submit cost center information in their financial statement.

If an agency adds a new line item to the revenue or expense budget, they must report that prior to submitting the monthly budget report.

The Standard Financial Statement Reporting Package will be reviewed using the Financial Statement Review Form (**Exhibit 6**).

FISCAL DEFINITIONS AND REQUIREMENTS

ACCRUAL ACCOUNTING – Contract agencies shall submit their monthly financial statements and follow the accrual accounting method.

ALLOWABLE/UNALLOWABLE COSTS – Those costs which are permissible or not permissible for inclusion in the computation of rates and unit cost. Unallowable costs include but are not limited to: bad debt expense, medications received as “in kind” through patient assistance programs, etc., fines and penalties, interest, fundraising, and investment management costs, and other unallowable cost items as defined in the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (hereinafter referred to as “Uniform Guidance”). (See Summary of O.M.B. Circular A-122 here Circulars | OMB | The White House)

COST REIMBURSEMENT – The services paid under cost reimbursement are paid after the expense is incurred and paid by the provider unless other arrangements have been approved by Board Executive Director. All cost reimbursement programs must generate revenue, if possible, and it must be included in the program.

FEE FOR SERVICE – Payments for “services as billed” will be made each month as they are processed thru GOSH but the payments are not to exceed the maximum amount allocated to Fee for Service under the Contract. Billing must be submitted to GOSH for processing on or before the last business day of the second month (August 31) after the expiration of the Agreement.

Any staff time covered by grant funds may not bill any “fee for service” for services provided by such staff without preapproval by Board staff.

THIRD PARTY INSURANC*E* – All services must be processed through insurance prior to the Board assuming payment.

GRANT – Services paid on a grant basis are to be billed monthly, and may be billed in the month preceding the month being billed for (i.e. bill in June for July). Board has until the last day of the month to pay the invoice. Any unexpended grant money shall be returned to the Board. Grant billings are expected to be properly recorded using accrual accounting to ensure proper reporting of profit/loss monthly. If there is an inability to provide services that are grant funded, for greater than 30 days, it must be reported to MHRSB. Agencies are expected to provide grant funded services 365 days of the contract fiscal year unless otherwise authorized by the Executive Director of MHRSB.

If an agency is required to input an application/budget into GFMS for their funding, the drawdown must be completed and funds received by the Board prior to the Board paying the agency invoice. The agency will be responsible for completing outcome reports required in GFMS.

*Program Subsidy Grant*s - are designed to ensure that an agency does not lose money operating a program that the Board determines is essential to their contract. The Grant is calculated with a maximum 2.5% profit by the agency after administrative overhead (maximum 12% unless otherwise determined in the contract) and any related revenue to the program is applied to the program (an example of this would be that all crisis revenue generated by expenses within the crisis program would be posted to the crisis program when determining any loss in the program). Services paid for as a program subsidy are to be tracked by the contract agency in separate “cost centers” or “funds”. The following are the parameters of billing for Program Subsidy Grant payments:

1. A profit and loss statement of each program paid through the grant will be submitted to MHRSB on a monthly basis.
2. The maximum profit % in the program is set at 2.5%
3. Administrative overhead shall not exceed 12% of the program it is applied to, unless otherwise determined in the contract.

CONTRACT FINANCIAL REVISIONS

Providers wishing to amend Cost Reimbursements, Grants, Program Subsidies or Unit Rates may submit proposals for contract revisions at any time prior to April 1 of the current fiscal year contract. Providers must submit the following each time they are requesting contract revisions:

1. Revised Budget for the program or service being reconsidered
2. Revised APF reflecting the program changes for reconsideration
3. Revised Agency budget reflecting the overall contract impact

ADMINISTRATIVE OVERHEAD

Administrative overhead costs are those personnel and non-personnel costs that benefit the agency as a whole and cannot be allocated to a specific service or services. Examples: Executive Director, Fiscal Director, Maintenance, Depreciation etc.

The combined administrative overhead may not exceed 12% of the contract budget, unless otherwise determined in the contract.

APPLICATION FOR PROGRAM FUNDING (APF)

All APF's submitted by the provider become a part of the contract. Any changes must be re-negotiated. Applications for Program Funding are to be updated annually for board funded programs (See **Exhibit 6**). Any new programs that an agency would like the Board to consider funding must also complete an APF using the template provided (**Exhibit 7**).

ADDITION OF SERVICES

Provider must receive prior approval of the Board for any mental health and/or/drug services or programs not identified in the provider's APF that will be initiated using Board controlled Federal, State, or Local governmental funds, or block grants during the contract year.

Provider must receive prior approval from the Board before initiating any new service or program initiative in order to assure that it will not adversely impact its ability to fulfill its obligations under the Agreement.

CLIENT RIGHTS AND GRIEVANCE POLICY AND PROCEDURES

The agency shall have a policy regarding client rights and grievance procedures that is in compliance with the OhioMHAS Certification Rules. (OAC 5122-26-18).

Client grievances shall be reported quarterly as part of the quarterly Continuous Quality Assurance reports to the Board.

For forensic clients- If a conflict arises between the rights of a mental health client in a forensic status and the obligations of that client's conditional release, then the local forensic monitor shall attempt to resolve the issue using agency procedures or mediation. If this conflict persists, the forensic monitor has the discretion to take the issue directly to court for resolution. The issue will no longer be considered a grievance bound by the agency's process/procedures if the court has issued a ruling on the issue.

A violation of client rights and/or the client grievance process by the agency may subject the Board/ agency contract to termination as outlined within the Agreement.

The Board maintains a Complaint Policy and Procedure, which allows individuals and/or groups to file a complaint with the Board related to contract services. Contract agencies will be notified of any complaint(s) filed with the Board and whenever possible, the Board will redirect the individual and/or group of individuals to the appropriate contracting agency for resolution. Any contacts regarding client rights will be handled according to the client rights policy of the Board. This policy does not supersede any existing grievance policy and procedure.

AGENCY STAFF

Agency shall ensure that its staffing levels are sufficient, and that staff have the appropriate education, training and/or experience in order to adequately fulfill its contractual obligations under the Agreement,

including but not limited to clinical and financial staff. Provider shall ensure that services are being provided by appropriately licensed and/or certified individuals. If Board determines that as a result of inadequate staffing levels, qualifications and/or licenses/certifications, that the delivery of services under this Contract are or will be negatively impacted, or that the agency cannot or will not be able to fulfill its contractual obligations, Board may take any action it deems appropriate, including but not limited to, reporting such information to OhioMHAS, CARF or other accreditation/certification bodies, and/or the suspension of payments in accordance with the Reimbursement by Board section.

Due to behavioral health workforce shortages in our area, the Board has made available consultation services for contracted agencies to become eligible for various scholarship and loan repayment opportunities. The board expects agencies to comply with steps to making these opportunities available to local behavioral health professionals.

RESIDENCY

A client receiving services paid for with Board funds must be a resident of Allen, Auglaize, or Hardin County except as otherwise stated in this Manual. The case record shall document the residency of each client. For residency issues: 1) Residency issues related to OhioMHAS State Hospital Admissions are governed by the OhioMHAS Residency Determination and Dispute Process for Inpatient Services Guidelines and 2) All other residency issues are governed by the OhioMHAS Guidelines and Operating Principles for Residency Determinations among CMH/ADAS/ADAMHS Boards (**Exhibit 8**). That document and its attachments provide guidance on the following residency issues: Homelessness, out of state issues, legal and illegal immigrants, college students, children in foster care, and other categories.

The Board is notified of possible residency issues at the time of enrollment. It will be the Board's responsibility to notify agencies of a residency dispute so that agencies can assist with residency verification.

Residency Procedures:

1. GOSH- A client must be enrolled in GOSH prior to any claims being submitted for payment. Clients must sign the appropriate releases before they can be entered into GOSH.
2. A client may be enrolled with a Social Security number of 5's if not provided for the first 30 days. On or after the 31st day the service will be denied.
3. Clients who move outside of Allen, Auglaize, or Hardin County and services are being paid by the Board may receive services provided by a Board contract agency for up to thirty days to aid the client's transition to a new community. In such circumstances, the agency shall obtain Board approval and provide the client UCI number.
4. During the thirty-day period, the Board's contract agency shall: assist the client to enroll with the appropriate GOSH enrollment center, prepare for the release of client files, monitor that the client has access to an adequate supply of medications, and make the necessary contacts and visits with the appropriate mental health/substance abuse providers in the client's new community. An agency must complete the *Request for Financial Assistance* when it wishes to seek Board reimbursement for unusual cases (**Exhibit 5**).

PAYMENT OF BOARD FUNDS

1. Last Dollar Reimbursement - Board dollars will be considered "dollars of last resort". Therefore, the Board will only be responsible for portions of the contract amount rate for which an individual and/or a third party is not obligated to pay, including but not limited to Medicare and Medicaid
2. The Board shall not subsidize an agency for any discounted rate negotiated between that agency and a third-party payer (e.g., contract panel agreements, EAP discounted rates).
3. The agency shall be paid the allocated Board subsidy in payments determined by the Board/agency contract.
4. The agency shall maintain a billing system that meets GOSH & HIPAA requirements.
5. Agencies shall ensure that all clients eligible for Medicaid coverage apply for such coverage unless the client is medically unable to do so. Clients eligible for Medicaid coverage who do not apply for Medicaid coverage will not be eligible to receive any reimbursement for services provided under contract with the Board unless the individual is denied coverage or there is another valid and documented clinical reason for not applying as identified in **Exhibit 5** submission.
6. Miscellaneous reports required by OhioMHAS in relationship to special fund line items must be completed and returned to the Board in compliance with stated guidelines. Failure to complete such forms will result in withholding of funds until such reports are received in accordance with this section.
7. Medicaid and Medicare are reimbursed outside of the Board system. Agencies may not bill the difference between the amount received and the agency's rate through GOSH for Medicare and/or Medicaid claims submitted.
8. Payment under the Agreement may be suspended if any required reports or information, including but not limited to those listed in this section and in the Reporting Requirements section, is not submitted in an adequate and timely manner, or is not made to Board as required by the Agreement. Payment may also be suspended if the Board determines that agency has inadequate staffing levels, qualifications and/or licenses/certifications as described in the Agency Staff requirements. Payment shall not be withheld for any reason unless the Board has given the agency notice of the Board's intent to withhold funds and an explanation of the reason for that action not less than 10 working days prior to withholding payment. Payments shall only be suspended until the situation for which payment was withheld is corrected. Situations that remain uncorrected may be considered a material, uncured breach of the Agreement subject to the Agreement's termination provisions.

CONTRACT AGENCY BILLING

1. Fee for Service payments will be adjudicated through GOSH.
2. Housing Assistance Funds - Funds can only be spent on individuals who are SMD/SED or in recovery housing for substance dependency.
3. Adjustments to rates - The Board must approve any rate changes following submission and Board approval of Budget package. If the Board approves the requested changes, agencies must allow thirty (30) days for rate changes to be established in GOSH. Rates may only be adjusted following the completion of a revised budget submission. Agencies are to submit a revised budget if they anticipate significant changes in utilization and/or funding source.
4. Agencies are to adhere to all Medicaid billing procedures and requirements.

REPORTING REQUIREMENTS AND SCHEDULE

Major Unusual Incidents Reports	Agencies to report using WEIRS within 24 hours of discovery, exclusive of weekends & holidays
(1) Monthly Financial Statements	Monthly by the 21st
Provider's certificate of Insurance	At Renewal and within 30 days of receipt of any notice of non-renewal or cancellation
Quality Assurance Reports: Annual Summary of Client Grievances Quarterly Quality Assurance Outcome Reports Hours of Operation Self-Pay Collection New Clients enrolled into GOSH Clients served by Payor Clients served by Elevate Staffing Report prepared by County Client Statistical Report Access/waiting list by program as required by Ohio MHAS	Last business day of month following each quarter
Application for Program Funding (APF)-**Exhibit 7**	April 1st
Annual Agency audits	Nov. 30th
List of Agency Board members and officer's names and addresses	Provided with Budget and anytime altered
Calculation of Budgeted Unit Rates/Program Costs	Provided with Budget and anytime altered
Up to date inventory of equipment purchased with federal funds	July 1st
Provider Agency Closure	If applicable
Copy of Disparities Impact Statement Policy/Plan	Provided with Budget and anytime altered
Copy of OHMHAS Certification	Provided with Budget and anytime updated

(1) Monthly Financial Statements are to include Balance Sheet, Profit and Loss, Cash Flow/Cash on Hand Statement and the monthly A/R Aging summary by payer.

INCIDENT NOTIFICATION

Notification of Incident Reporting: OhioMHAS has defined an "Incident" as any event that poses a danger to the health and safety of clients, staff and/or visitors of the provider, and is not consistent with routine care of persons served or routine operation of the provider. An incident report shall be submitted in written form to the agency's executive director or designee within twenty-four (24) hours of discovery of a reportable incident. "Reportable Incident" means an incident that must be reported to OHIO MHAS

and to the Board. In addition, the Board is requesting an incident form be completed for all active client's overdose.

Reportable incidents shall be documented in the Web Enabled Incident Reporting System (WEIRS) within twenty-four (24) hours of their discovery, exclusive of weekends and holidays and ensure that the board of residence is selected on the form (Administrative Rule 5122-26-13).

DETERMINATION OF SPMI/SED

Severely Emotionally Disturbed: A designation for those individuals under 18 years of age who have serious emotional disturbances and are at the greatest risk for needing services.

SED designation will be determined by:

- Symptom severity including but not limited to psychosis, suicide attempts, and hospitalization
- Functional impairment that substantially interferes with major life activities
- Intensity of services required

Severe and Persistent Mental Illness: A designation for those adults with severe and persistent mental illnesses who are at the greatest risk for needing services.

- Symptom severity including but not limited to psychosis, suicide attempts, and hospitalization
- Functional impairment that substantially interferes with major life activities
- Intensity of services required

SATISFACTION SURVEY

Contract agencies will collect a sample of customer and referral satisfaction surveys as per OhioMHAS certification requirements. The agencies shall inform the Board as to how they will meet these requirements. Contract providers will also submit to Board the listing of the referring agencies developed by each provider participating in the referral source satisfaction survey process. Satisfaction Survey data is to be reported in the agency Continuous Quality Improvement report.

DISPARITIES IMPACT STATEMENT

The MHRSB is committed to ensuring that all members of our community are provided effective, equitable, understandable, and respectful quality care. The board's efforts to advance and sustain organizational governance and leadership that promotes health equity through contract requirements and continuous quality review is achieved through a variety of ways. In addition, the board has an Equal Opportunity plan which governs hiring practices.

The Board has an Affirmative Action Policy and Plan for both how it performs and operates and through Contract Standard Manuals request each agency to operate in accordance with an established Affirmative Action Policy and Plan.

Agencies who the board contracts with to provide services to our community members must have a hiring policy acknowledging they are an Equal Opportunity Employer and will hire individuals solely upon the basis of their qualifications for the job for which they have applied.

Agencies who the board contracts with to provide services to our community members must have and participate in Cultural Diversity training as part of their -on boarding and on-going professional development.

Agencies who the board contracts with to provide services to our community members must have a policy on how to obtain and use language assistance services for the individuals they serve. This is accomplished in a variety of ways.

This commitment is included in all written materials and social media outlets.

Agencies who the board contracts with to provide services to our community members must collect and submit demographic information. This information is included in both agency and board annual reports and disseminated to all community members. This information has been key in developing and implementing strategic services to increase the number of minority individuals served in our behavioral health system.

OUTCOMES
Agencies shall comply with the requirements of OAC 5122-28-04 and their national accreditation bodies for outcomes measurement and maintaining results-oriented data on their services.

AGENCY CLOSURE PLAN
Upon notification of a contract agency closure (within 1-2 business days), the Mental Health and Recovery Services Board of Allen, Auglaize and Hardin counties is to work with the CEO of the closing agency to follow guidelines outlined in OAC 5122-26-14 *Provider closing or acquisition*, if necessary the Board will assume operation of the facility under ORC 340.037 *Operation of facility to provide addiction or mental health services*. (See **Exhibit 9**)

COMMUNICATION
All official communication with the Board shall be directed to the Executive Director.

APPROVAL OF VARIATIONS
When approval needs to be given for any variations from the aforementioned standards, it shall be done at the sole discretion of the Board.

REVISIONS TO THE STANDARDS MANUAL
This Standards Manual may be subject to revision at the sole discretion of the Board, at any time. Any revisions will be sent to the contracting agencies and shall be incorporated by reference into the Standards Manual as of the effective date of the revision.

EXHIBIT 1

DESIGNATED AGENCY ROLES AND RESPONSIBILITIES

The BOARD having **designated agency** to perform functions under Chapter 5122, **DESIGNATED AGENCY** agrees to perform the functions described in Chapter 5122 of the Ohio Revised Code which may be designated to an agency, including, but not limited to the following:

1. Evaluation and approval of all adult voluntary admissions to public hospitals as required by section 5122.02(B).
2. Evaluation of all adult emergency admissions to hospitals as required by section 5122.05(A).
3. Evaluation of affidavits for adults referred by Probate Court as required by section 5122.13.
4. Treatment of all adult clients committed to the BOARD/ **DESIGNATED AGENCY** pursuant to section 5122.15.

I. EVALUATION AND APPROVAL OF VOLUNTARY ADMISSIONS

DESIGNATED AGENCY shall perform all evaluations of clients seeking admission as voluntary patients in public hospitals. Evaluations shall be completed within twelve hours of the time the client applies for admission as a voluntary patient.

DESIGNATED AGENCY shall report the results of evaluations of voluntary admissions to the BOARD, or its designee, each month. BOARD may choose to implement other reporting mechanism in lieu of **DESIGNATED AGENCY** reporting if it desires to do so. Cost of such alternate reporting mechanism shall be borne by BOARD.

III. EVALUATION OF EMERGENCY ADMISSIONS

DESIGNATED AGENCY shall evaluate all clients admitted under section 5122.10 (emergency admissions). **DESIGNATED AGENCY** shall determine whether the client’s condition meets the criteria for emergency admissions under section 5122.10. **DESIGNATED AGENCY** shall complete the evaluation of each emergency admission not later than 48 hours after the time of the admission.

DESIGNATED AGENCY shall report the results of evaluations of emergency admissions, including clinical conclusions and recommendations for least restrictive alternatives, to the Chief Clinical Officer of the facility receiving the emergency admission immediately upon completion of the evaluation. **DESIGNATED AGENCY** shall provide copies of reports of evaluations of emergency admissions to the BOARD, or its designee each month.

IV. EVALUATION OF AFFIDAVITS REFERRED BY PROBATE COURT

DESIGNATED AGENCY shall perform all evaluations of all affidavits referred by the Probate Court under section 5122.13. **DESIGNATED AGENCY** shall complete the evaluation of each referral not later than three days after the time of the referral (note that the time for completion of the investigation of the affidavit is not specified in statute) or within such time period as is required by Probate Court.

V. <u>JUDICIAL HEARINGS</u>

DESIGNATED AGENCY shall cooperate with the attorney for the BOARD in the preparation and presentation of the case for involuntary commitments under Chapter 5122. **DESIGNATED AGENCY** shall make documents and personnel available to the attorney as the attorney deems necessary to prepare the case on behalf of the BOARD, subject to whatever requirements of privilege and/or confidentiality that may apply under Federal law, State law, or BOARD policy.

VI. <u>ACCEPTANCE OF COURT COMMITMENTS</u>

DESIGNATED AGENCY shall accept all judicial commitments on behalf of BOARD made pursuant to 5122.15(C). **DESIGNATED AGENCY**, in conjunction and with approval of the BOARD, may provide/arrange for all available treatment, facilities, and services required by said clients under such a commitment order.

(a) NOTICE OF FINAL DISPOSITION
DESIGNATED AGENCY shall evaluate the client and recommend placement in the least restrictive setting which is available and consistent with treatment goals. **DESIGNATED AGENCY** shall notify the BOARD, counsel for the client, and the court of the final placement within three (3) working days after the placement is made.

(b) PERIODIC EVALUATIONS

DESIGNATED AGENCY shall evaluate all clients committed by the court in accordance with the requirements of Chapter 5122. **DESIGNATED AGENCY** shall recommend discharge of all persons found not to be mentally ill subject to hospitalization under court order as defined by 5122.01(A) and (B).

(c) APPLICATIONS FOR CONTINUED COMMITMENT

If the client's condition requires further commitment pursuant to court order, **DESIGNATED AGENCY** shall prepare all applications for continued commitment required under 5122.15(H) within the time limits set forth in the statute. A copy of such application shall be provided to counsel for the client and the BOARD.

(d) TRANSFERS

If **DESIGNATED AGENCY** determines that a client may be served in a less restrictive setting which is available within the area served by the BOARD, **DESIGNATED AGENCY** shall transfer the client to such setting. If **DESIGNATED AGENCY** determines that a client must be served in a more restrictive setting, **DESIGNATED AGENCY** shall carry out such transfer in accordance with procedures required under Chapter 5122. **DESIGNATED AGENCY** shall be responsible for arranging for transportation of clients who

are being transferred (or specify what other transportation arrangements have been made).

(e) AVAILABILITY OF RECORDS

If a client under an order of commitment by a court has been transferred from one provider to another, **DESIGNATED AGENCY** shall ensure that all records required to provide treatment or services to the client are transferred in a timely manner.

(f) NOTICES

DESIGNATED AGENCY shall be responsible for providing all notices and information required under this Agreement and Chapter 5122 for persons committed by court order.

VII. SUPERVISION AND CONTROL

DESIGNATED AGENCY shall have exclusive control of the development, implementation, and supervision of all programs and services described herein as well as final responsibility for the care and treatment of all clients being treated by **DESIGNATED AGENCY** under Chapter 5122. At all times during the duration of this Agreement, the BOARD and **DESIGNATED AGENCY** shall act as independent contractors in the performance of their respective obligations under this Agreement.

VIII. CONFIDENTIALITY OF CLIENT RECORDS

All parties shall ensure that confidentiality of client records is maintained. No record shall be released except as permitted by Chapter 5122 and applicable provisions of Federal and State law.

IX COMPLIANCE WITH CHAPTER 5122

DESIGNATED AGENCY shall comply with all requirements of Chapter 5122 in performing the duties delegated to it by BOARD.

X. CHIEF CLINICAL OFFICER / MEDICAL DIRECTOR

The **DESIGNATED AGENCY** local Chief Clinical Officer / Medical Director also serves as the Chief Clinical Officer / Medical Director for BOARD.

XI. TREATMENT FOR PERSONS IN FORENSIC STATUS

(a) As the Board's designated "Forensic Monitor" the Agency is responsible for the coordination of forensic cases, the monitoring of NGRI acquitees among hospitals and all community providers involved with the individual; the monitoring of NGRI acquitees on "conditional release"; and planning and coordinating community services for forensic individuals.

(b) The Staff Forensic Monitor shall be appointed by the Agency. This staff person shall be responsible for:

1. Acting as liaison between county, courts, law enforcement, hospital and treatment providers within or outside the county.
2. Receiving and reviewing reports on:
   a. Psychiatric condition
   b. Treatment
   c. Compliance with "conditional release" requirements
   d. Risk Assessment
3. Reporting to local courts and law enforcement.
4. Risk management following Agency policies and procedures and reporting violations.
5. Reporting violations to the appropriate authorities.
6. Resolving disputes that may arise
7. Monitoring compliance with State guidelines and developing reports as required.

(c) A “Community Risk Management Policy” shall be maintained by the Agency. Said policy shall relate to service provision and monitoring in accordance with State guidelines.

(d) Individuals in Forensic Status shall have access to all mental health and substance use disorder services funded through the Board, especially community psychiatric support, crisis intervention, medication/somatic, and housing when available.

(e) Training on forensic matters shall occur annually and be ongoing for the staff forensic monitor and for all other “key” Agency staff. Training shall include but not be limited to legal definitions, court processes, report writing, public safety issues, risk assessment and management, community supports, forensic monitoring, personality disorders, substance use disorders and violence prevention.

(f) The Agency agrees to follow the procedures as outlined in the 2012 Forensic Manual from Ohio Mental Health and Addiction Services (OMHAS).

Exhibit 2

Duty to Protect Documentation Form (OAC 5122-3-12)

Name of Patient ____________________Date of Birth ________Patient Number ___

On _______________________, an imminent threat to seriously physically harm another

(Date) identifiable person or structure was communicated to me by

Name of person) (Relationship to patient)

The nature of the threat was to

(Explicit threat) to the following person(s) or structure.

(Specific person or structure)

A. Based on my knowledge of the patient, it is my judgment that the patient

_________ **does not have** the intent or ability to carry out the threat because:

Note: If the patient does not have the ability or intent to carry out the threat, no further action is legally mandated. However, clinical steps should be considered.

OR

B. Based on my knowledge of the patient, it is my judgment that the patient

_________ **does have** the intent and ability to carry out the threat.

Since the patient is already hospitalized in accordance with Ohio Revised Code Section 2305.51, I have initiated the following option(s) and, after consideration, have chosen not to pursue other options at this time, based on the following reasons, in order to fulfill my duty to protect potential victims from threatened violence.

Exhibit 2

(IF SECTION B IS CHOSEN, BOTH SECTIONS BELOW MUST BE COMPLETED.)

1. Establish and undertake a documented treatment plan reasonably calculated to eliminate the threat, and concurrently initiate a risk assessment and management consultation with a consultant (licensed independent mental health professional appointed by the Chief Clinical Officer or designee).

___________ Chosen ___________ Not Chosen

Reason:

2. Warning to law enforcement and, if feasible, intended victim(s).

___________ Chosen ___________ Not Chosen

Reason:

STEPS TAKEN to implement the **option(s) I have chosen** are:

(include any persons to whom a warning is given, as well as the date, time and specifics; or specific changes in the treatment plan or the initiation of the required consultation and name of consultant).

Mental Health Professional (Print Name)

Mental Health Professional Signature, Credentials Date

Allen/Auglaize/Hardin Sliding Fee Setup FY 2025

Federal Poverty Guidelines FY 2024	
Single Person	$ 15,060
Each Additional Person	$ 5,380

Sliding Fee Scale Range	
Lower Bound	200%
Upper Bound	350%

These limits mean the following

At an income level below 20000%% of Federal Poverty Levels, the client would not pay any portion of their bill

From 20000%% to 35000%% of Federal Poverty Levels, the client would be expected to pay a portion of their bill

At 35000%% of Federal Poverty Levels, the client would be expected to pay their entire bill

FAMILY SIZE

Monthly Income Values (These are the income values GOSH is expecting)

Client %	Board %	Rider	1		2		3		4		5		6		7		8		9		10	
0	100	Z	$ -	$ 2,511	$ -	$ 3,407	$ -	$ 4,304	$ -	$ 5,201	$ -	$ 6,097	$ -	$ 6,994	$ -	$ 7,891	$ -	$ 8,787	$ -	$ 9,684	$ -	$ 10,581
10	90	B	$ 2,511	$ 2,887	$ 3,407	$ 3,918	$ 4,304	$ 4,949	$ 5,201	$ 5,981	$ 6,097	$ 7,011	$ 6,994	$ 8,043	$ 7,891	$ 9,074	$ 8,787	$ 10,105	$ 9,684	$ 11,136	$ 10,581	$ 12,168
25	75	E	$ 2,887	$ 3,263	$ 3,918	$ 4,429	$ 4,949	$ 5,594	$ 5,981	$ 6,761	$ 7,011	$ 7,925	$ 8,043	$ 9,092	$ 9,074	$ 10,257	$ 10,105	$ 11,423	$ 11,136	$ 12,588	$ 12,168	$ 13,755
40	60	H	$ 3,263	$ 3,639	$ 4,429	$ 4,940	$ 5,594	$ 6,239	$ 6,761	$ 7,541	$ 7,925	$ 8,839	$ 9,092	$ 10,141	$ 10,257	$ 11,440	$ 11,423	$ 12,741	$ 12,588	$ 14,040	$ 13,755	$ 15,342
60	40	L	$ 3,639	$ 4,015	$ 4,940	$ 5,451	$ 6,239	$ 6,884	$ 7,541	$ 8,321	$ 8,839	$ 9,753	$ 10,141	$ 11,190	$ 11,440	$ 12,623	$ 12,741	$ 14,059	$ 14,040	$ 15,492	$ 15,342	$ 16,929
80	20	P	$ 4,015	$ 4,391	$ 5,451	$ 5,962	$ 6,884	$ 7,529	$ 8,321	$ 9,101	$ 9,753	$ 10,667	$ 11,190	$ 12,239	$ 12,623	$ 13,806	$ 14,059	$ 15,377	$ 15,492	$ 16,944	$ 16,929	$ 18,516
100	0	T	$ 4,391	+	$ 5,962	+	$ 7,529	+	$ 9,101	+	$ 10,667	+	$ 12,239	+	$ 13,806	+	$ 15,377	+	$ 16,944	+	$ 18,516	+

FAMILY SIZE

Annual Income Values (These values are here for reference of an annualized income)

Client %	Board %	Rider	1		2		3		4		5		6		7		8		9		10	
0	100	Z	$ -	$ 30,120	$ -	$ 40,872	$ -	$ 51,636	$ -	$ 62,400	$ -	$ 73,152	$ -	$ 83,916	$ -	$ 94,680	$ -	$ 105,432	$ -	$ 116,196	$ -	$ 126,960
10	90	B	$ 30,132	$ 34,632	$ 40,884	$ 47,004	$ 51,648	$ 59,376	$ 62,412	$ 71,760	$ 73,164	$ 84,120	$ 83,928	$ 96,504	$ 94,692	$ 108,876	$ 105,444	$ 121,248	$ 116,208	$ 133,620	$ 126,972	$ 146,004
25	75	E	$ 34,644	$ 39,144	$ 47,016	$ 53,136	$ 59,388	$ 67,116	$ 71,772	$ 81,120	$ 84,132	$ 95,088	$ 96,516	$ 109,092	$ 108,888	$ 123,072	$ 121,260	$ 137,064	$ 133,632	$ 151,044	$ 146,016	$ 165,048
40	60	H	$ 39,156	$ 43,656	$ 53,148	$ 59,268	$ 67,128	$ 74,856	$ 81,132	$ 90,480	$ 95,100	$ 106,056	$ 109,104	$ 121,680	$ 123,084	$ 137,268	$ 137,076	$ 152,880	$ 151,056	$ 168,468	$ 165,060	$ 184,092
60	40	L	$ 43,668	$ 48,168	$ 59,280	$ 65,400	$ 74,868	$ 82,596	$ 90,492	$ 99,840	$ 106,068	$ 117,024	$ 121,692	$ 134,268	$ 137,280	$ 151,464	$ 152,892	$ 168,696	$ 168,480	$ 185,892	$ 184,104	$ 203,136
80	20	P	$ 48,180	$ 52,680	$ 65,412	$ 71,532	$ 82,608	$ 90,336	$ 99,852	$ 109,200	$ 117,036	$ 127,992	$ 134,280	$ 146,856	$ 151,476	$ 165,660	$ 168,708	$ 184,512	$ 185,904	$ 203,316	$ 203,148	$ 222,180
100	0	T	$ 52,692	+	$ 71,544	+	$ 90,348	+	$ 109,212	+	$ 128,004	+	$ 146,868	+	$ 165,672	+	$ 184,524	+	$ 203,328	+	$ 222,192	+

ServiceGroup	Category	ServiceCode
SLIDING FEE SERVICES	Original Setup	90792
SLIDING FEE SERVICES	Original Setup	H0001
SLIDING FEE SERVICES	Original Setup	H0004
SLIDING FEE SERVICES	Original Setup	H0005
SLIDING FEE SERVICES	Original Setup	H0014
SLIDING FEE SERVICES	Original Setup	H0015
SLIDING FEE SERVICES	Original Setup	H0020
SLIDING FEE SERVICES	Original Setup	M1550
SLIDING FEE SERVICES	Original Setup	M1620
SLIDING FEE SERVICES	Added 12/18/2017	90785
SLIDING FEE SERVICES	Added 12/18/2017	90785
SLIDING FEE SERVICES	Added 12/18/2017	90832
SLIDING FEE SERVICES	Added 12/18/2017	90833
SLIDING FEE SERVICES	Added 12/18/2017	90834
SLIDING FEE SERVICES	Added 12/18/2017	90836
SLIDING FEE SERVICES	Added 12/18/2017	90837
SLIDING FEE SERVICES	Added 12/18/2017	90838
SLIDING FEE SERVICES	Added 12/18/2017	90846
SLIDING FEE SERVICES	Added 12/18/2017	90847
SLIDING FEE SERVICES	Added 12/18/2017	90849
SLIDING FEE SERVICES	Added 12/18/2017	90853
SLIDING FEE SERVICES	Added 12/18/2017	93000
SLIDING FEE SERVICES	Added 12/18/2017	93005
SLIDING FEE SERVICES	Added 12/18/2017	93010
SLIDING FEE SERVICES	Added 12/18/2017	96372
SLIDING FEE SERVICES	Added 12/18/2017	99201
SLIDING FEE SERVICES	Added 12/18/2017	99202
SLIDING FEE SERVICES	Added 12/18/2017	99203
SLIDING FEE SERVICES	Added 12/18/2017	99204
SLIDING FEE SERVICES	Added 12/18/2017	99205
SLIDING FEE SERVICES	Added 12/18/2017	99211
SLIDING FEE SERVICES	Added 12/18/2017	99212
SLIDING FEE SERVICES	Added 12/18/2017	99213
SLIDING FEE SERVICES	Added 12/18/2017	99214
SLIDING FEE SERVICES	Added 12/18/2017	99215
SLIDING FEE SERVICES	Added 12/18/2017	99341
SLIDING FEE SERVICES	Added 12/18/2017	99342
SLIDING FEE SERVICES	Added 12/18/2017	99343
SLIDING FEE SERVICES	Added 12/18/2017	99344
SLIDING FEE SERVICES	Added 12/18/2017	99345
SLIDING FEE SERVICES	Added 12/18/2017	99347
SLIDING FEE SERVICES	Added 12/18/2017	99348
SLIDING FEE SERVICES	Added 12/18/2017	99349
SLIDING FEE SERVICES	Added 12/18/2017	99350
SLIDING FEE SERVICES	Added 12/18/2017	99354
SLIDING FEE SERVICES	Added 12/18/2017	99354
SLIDING FEE SERVICES	Added 12/18/2017	99355
SLIDING FEE SERVICES	Added 12/18/2017	99355
SLIDING FEE SERVICES	Added 12/18/2017	H0004

SLIDING FEE SERVICES	Added 12/18/2017	H0005
SLIDING FEE SERVICES	Added 12/18/2017	H0014
SLIDING FEE SERVICES	Added 12/18/2017	H0015
SLIDING FEE SERVICES	Added 02/13/2018	H2017
SLIDING FEE SERVICES	Added 02/13/2018	H2036
SLIDING FEE SERVICES	Not in current codeset, should be deleted from SFS	90801
SLIDING FEE SERVICES	Not in current codeset, should be deleted from SFS	90862
SLIDING FEE SERVICES	Not in current codeset, should be deleted from SFS	90863
SLIDING FEE SERVICES	Not in current codeset, should be deleted from SFS	A0780
SLIDING FEE SERVICES	Not in current codeset, should be deleted from SFS	H0003
SLIDING FEE SERVICES	Not in current codeset, should be deleted from SFS	H0007
SLIDING FEE SERVICES	Not in current codeset, should be deleted from SFS	H0016
SLIDING FEE SERVICES	Not in current codeset, should be deleted from SFS	H0031
SLIDING FEE SERVICES	Not in current codeset, should be deleted from SFS	M1551
SLIDING FEE SERVICES	Not in current codeset, should be deleted from SFS	M1621
SLIDING FEE SERVICES	Not in current codeset, should be deleted from SFS	M1622
SLIDING FEE SERVICES	Not in current codeset, should be deleted from SFS	S0201
SLIDING FEE SERVICES	Not in current codeset, should be deleted from SFS	T1006

Modifier	ServiceDescription	CodeSet	Keep
	Psychiatric Diagnostic Evalulation - includes medical	0	X
	Alcohol and/or drug assessment	0	X
	BH counseling and therapy, per 15 min	0	X
	Alcohol and/or drug services; group counseling	0	X
	Alcohol and/or drug services; ambulatory detoxific	0	X
	SUD Partial Hosp IOP	0	X
	Methadone Administration	0	
	Social and Recreational	0	
	Employment/Vocational	0	
	Interactive Complexity Add On	2	X
	Interactive Complexity Add On	2	X
	Psychotherapy, 30 minutes	2	X
	Psychotherapy Add On, 30 min w/ patient/family mbr	2	X
	Psychotherapy, 45 minutes	2	X
	Psychotherapy Add On, 45 min w/ patient/family mbr	2	X
	Psychotherapy, 60 minutes	2	X
	Psychotherapy Add On, 60 min w/ patient/family mbr	2	X
	Family psychotherapy (w/o patient present) 50 min	2	X
	Family psychotherapy with patient 50 min	2	X
	Multiple-family group psychotherapy	2	X
	Group psychotherapy(other than multiple-fam grp)	2	X
	Electrocardiogram, ECG with report & interpretation	2	
	Electrocardiogram, ECG; tracing only	2	
	Electrocardiogram, ECG interpretation and report only	2	
	Therapeutic, prophylactic, or diagnostic injection	2	X
	Office/OP visit for E&M of a new patient 10 min	2	X
	Office/OP visit for E&M of a new patient 20 min	2	X
	Office/OP visit for E&M of a new patient 30 min	2	X
	Office/OP visit for E&M of a new patient 45 min	2	X
	Office/OP visit for E&M of a new patient 60 min	2	X
	Office/OP visit for E&M established patient 5 min	2	X
	Office/OP visit for E&M established patient 10min	2	X
	Office/OP visit for E&M established patient 15 min	2	X
	Office/OP visit for E&M established patient 25 min	2	X
	Office/OP visit for E&M established patient 40 min	2	X
	Home visit for E&M of a new patient 20 min	2	
	Home visit for E&M of a new patient 30min	2	
	Home visit for E&M of a new patient 45 min	2	
	Home visit for E&M of a new patient 60 min	2	
	Home visit for E&M of a new patient 75 min	2	
	Home visit for E&M established patient 15 min	2	
	Home visit for E&M established patient 25 min	2	
	Home visit for E&M established patient 40 min	2	
	Home visit for E&M established patient 60 min	2	
	Prolonged Office/OP direct w/pat 1st hr Add-On	2	X
	Prolonged Office/OP direct w/pat 1st hr Add-On	2	X
	Additional 30 minutes for prolonged service Add On	2	X
	Additional 30 minutes for prolonged service Add On	2	X
	BH counseling and therapy, per 15 min	2	X

	Alcohol and/or drug services; group counseling	2	X
	Alcohol and/or drug services; ambulatory detoxific	2	X
	SUD Partial Hosp IOP	2	X
	Psychosocial rehabilitation service 15 min	2	X
TG	Alcohol and/or other drug treatment program, per diem.	2	X
	NULL	0	
	NULL	0	
	NULL	0	
	NULL	0	
	NULL	0	
	NULL	0	
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	NULL	0	
	NULL	0	

Discard
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Vlookup	P_Rider	P_FamilySize	P_MinSalary	P_MaxSalary
01B	B	1	2511.00	2886.99
01E	E	1	2887.00	3262.99
01H	H	1	3263.00	3638.99
01L	L	1	3639.00	4014.99
01P	P	1	4015.00	4390.99
01T	T	1	4391.00	999999.99
01Z	Z	1	0.00	2510.99
02B	B	2	3407.00	3917.99
02E	E	2	3918.00	4428.99
02H	H	2	4429.00	4939.99
02L	L	2	4940.00	5450.99
02P	P	2	5451.00	5961.99
02T	T	2	5962.00	999999.99
02Z	Z	2	0.00	3406.99
03B	B	3	4304.00	4948.99
03E	E	3	4949.00	5593.99
03H	H	3	5594.00	6238.99
03L	L	3	6239.00	6883.99
03P	P	3	6884.00	7528.99
03T	T	3	7529.00	999999.99
03Z	Z	3	0.00	4303.99
04B	B	4	5201.00	5980.99
04E	E	4	5981.00	6760.99
04H	H	4	6761.00	7540.99
04L	L	4	7541.00	8320.99
04P	P	4	8321.00	9100.99
04T	T	4	9101.00	999999.99
04Z	Z	4	0.00	5200.99
05B	B	5	6097.00	7010.99
05E	E	5	7011.00	7924.99
05H	H	5	7925.00	8838.99
05L	L	5	8839.00	9752.99
05P	P	5	9753.00	10666.99
05T	T	5	10667.00	999999.99
05Z	Z	5	0.00	6096.99
06B	B	6	6994.00	8042.99
06E	E	6	8043.00	9091.99
06H	H	6	9092.00	10140.99
06L	L	6	10141.00	11189.99
06P	P	6	11190.00	12238.99
06T	T	6	12239.00	999999.99
06Z	Z	6	0.00	6993.99
07B	B	7	7891.00	9073.99
07E	E	7	9074.00	10256.99
07H	H	7	10257.00	11439.99
07L	L	7	11440.00	12622.99
07P	P	7	12623.00	13805.99
07T	T	7	13806.00	999999.99
07Z	Z	7	0.00	7890.99

08B	B	8	8787.00	10104.99
08E	E	8	10105.00	11422.99
08H	H	8	11423.00	12740.99
08L	L	8	12741.00	14058.99
08P	P	8	14059.00	15376.99
08T	T	8	15377.00	999999.99
08Z	Z	8	0.00	8786.99
09B	B	9	9684.00	11135.99
09E	E	9	11136.00	12587.99
09H	H	9	12588.00	14039.99
09L	L	9	14040.00	15491.99
09P	P	9	15492.00	16943.99
09T	T	9	16944.00	999999.99
09Z	Z	9	0.00	9683.99
10B	B	10	10581.00	12167.99
10E	E	10	12168.00	13754.99
10H	H	10	13755.00	15341.99
10L	L	10	15342.00	16928.99
10P	P	10	16929.00	18515.99
10T	T	10	18516.00	999999.99
10Z	Z	10	0.00	10580.99

EXHIBIT 4

Mental Health & Recovery Services Board

ALLEN • AUGLAIZE • HARDIN

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GOSH ENROLLMENT STATUS FORM

Client Name____D.O.B.________________

GOSH Individual ID:____

To begin receiving payment for services delivered to individuals without insurance coverage, this form is to be completed and uploaded into the GOSH system.

Check the appropriate box regarding the Client's Medicaid Enrollment Status:

_____ Client is referred for enrollment with Elevate ***Attach Referral**

_____ Client has received a Medicaid Denial within 12 months ***Attach Evidence**

_____ Client was seen for a crisis assessment ***If seen for a crisis, you must select the "In crisis at enrollment" check box within GOSH.**

_____ Not applicable due to income above 138% poverty level

FOR GOSH ENROLLMENT ONLY (Individuals that you are not seeking board funding for):

_____ Client has ACTIVE Medicaid

_____ Client has other insurance coverage

Enrolling Agency Name

Agency Employee Signature Date

EXHIBIT 4

Mental Health & Recovery Services Board

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INSTRUCTIONS

When uploading this form, select the folder "Financial Documentation" and the Name "Insurance Information."

Enrollment Documents Authorizations Payer Spans Episodes Programs Surveys Outcomes Grants Insurer Claims Limits

Individual ID: 128510
- Claims Correction
- Financial Documentat...
- HIPAA Documentation
- Miscellaneous
- Residency Verficatio...
- Special Reimbursemen...

Document: Type: Status: New Id: Close

Storage:
File to upload: Choose File No file chosen Upload
Folder: Financial Documentation
Document:
Name: Insurance Information
Date: 07/03/2024 04:38 PM
Approved:
Created By:
Modified By:
Document ID:
Delete
Close
Link Document

Document Comments Add Comment

*If seen for a crisis, you must select the "In crisis at enrollment" check box within GOSH.

Member Enrollment Type: Full Status: New Create Master Delete Print Collapse Close

Client Name: MII: Select UCI: UPI:
Last: First: MI: DOB: Age: Gender:
Address: Address2:
City: State: OH Zip Code: County: Allen
Home Phone: Work Phone: Non-English Language:
Race: Ethnicity: Marital Status:
Medicaid No: SSN: Client Id: Start Date:
Enroll Plan: 3rd Party
Family Size: Mo. Income: Sliding Fee: % CoPay Amount: Rider: Insurance:
Affiliation Code(s): ...
☐ SMD/SED ☐ Disclosure Signed ☐ AOD release of info signed ☐ Consent for treatment signed ☐ In crisis at enrollment ☑ Check eligibility
Created By: Modified By:
Submit
Print Delete Create Master Enrollment ID: Individual ID: View Update History

Enrollment Comments

Exhibit 5

Mental Health and Recovery Services Board of Allen, Auglaize and Hardin Counties

Request for Financial Assistance Form

Generally, clients receiving services with MHRSB funds shall be a resident of Allen, Auglaize, or Hardin Counties. Residency issues will be governed by the OhioMHAS definitions as incorporated in the Guidelines and Operating Principles for Residency Determinations among CMH/ADAS/ADAMHS Boards.

However, MHRSB and the contract agency may determine that providing services to non-residents of Allen, Auglaize, or Hardin Counties is appropriate, or that there is sufficient hardship to adjust client fees for county residents.

Before seeking authorization from the MHRSB for services to non-county residents or filing for hardship status, the client must sign the appropriate releases and enroll in GOSH prior to any claims being submitted for payment.

Begin Date: ________________________ End Date: ____________________________
Maximum of 3 months

Choose Type: General Financial Assistance_________ No Social Security Number Override________

Patient or Applicant Name: ____Date of Birth: ________________________

Address: ____ City: ___________________________

Zip: ________ Home Phone Number: _____________________Cell Phone Number ________________

Gender: _____ Ethnicity: _____ GOSH Individual ID Number_____________________________

THE FOLLOWING QUESTIONS MUST BE COMPLETED FOR FINANCIAL ASSISTANCE CONSIDERATION

1. **Are you a resident of Allen, Auglaize, or Hardin Counties?** Yes ___ No ____
   a) If "NO", where is your residence? ____
2. **Have you applied for Medicaid or other county assistance**? Yes ____ No ______
   a) If "YES" what date did you turn in application? __________________________
   b) If "NO" are you diagnosed with a severe emotional disturbance or severe and persistent mental illness? _______________________________
3. **Do you have health insurance coverage?** Yes ____ No _____
   a) If "YES", (and the insurance has not been billed) Please send a copy of your insurance cards(s) with this application

Please check the situation that applies to the assistance being requested:

DA _____ Medication _____ High Deductible _____
Outpatient Treatment _____ Doctor _____
Expedited Admission to CSU _____ Out of Benefits ______ Hospital Discharge _____
Other _____ Housing _______________

Explain:
____
____

PLEASE LIST EVERYONE IN YOUR HOUSEHOLD BELOW, IF YOU NEED ADDITIONAL SPACE, PLEASE USE BACK OF THIS FORM.

NAME	RELATIONSHIP TO PATIENT	AGE	GROSS INCOME IN THE 3 MONTHS PRIOR TO DATE OF SERVICE	INCOME SOURCE EMPLOYER NAME (STATE IF COLLEGE STUDENT)	CLIENT SLIDING FEE

INCOME IS CONSIDERED TO BE GROSS INCOME BEFORE TAXES ARE TAKEN OUT AS DEFINED IN THE CONTRACT STANDARDS MANUAL PAGE 10.

IF YOU REPORTED ZERO TOTAL INCOME, HOW ARE YOU BEING SUPPORTED? ____

CERTIFICATION: BY SIGNING THIS DOCUMENT, I AFFIRM THE ANSWERS ON THIS APPLICATION ARE TRUE. SHOULD A SUBSEQUENT REVIEW OF AN INDIVIDUAL'S FINANCIAL ASSISTANCE APPLICATION REVEAL THAT INFORMATION PROVIDED BY THE INDIVIDUAL WAS EITHER INCORRECT OR FRAUDULENT, THE DECISION TO PROVIDE FINANCIAL ASSISTANCE MAYT BE REVERSED AND THE RESPONSIBLE PARTY WILL BE BILLED. I UNDERSTAND THAT THE INFORMATION WHICH I SUBMIT IS SUBJECT TO VERIFICATION BY MY PROVIDER, INCLUDING CREDIT REPORTING AGENCIES, AND SUBJECT OT REVIEW BY FEDERAL AND/OR STATE AGENCIES AND OTHERS AS REQUIRED.

PATIENT SIGNATURE: ____ DATE: ___________________

Signature of Agency Supervisor: ____

APPROVAL STATUS BY MENTAL HEALTH & RECOVERY SERVICES BOARD:

Request Approved   Request Denied

Signature of MHRSB Director or Designee ____

Date of Approval ____

Financial Statement Review Form

				From Client F/S	
(1)	Financial Statement Period		Current Assets	$ -	Yes
(2)	Date Statements Received from Provider		Current Liabilities	$ -	No
(3)	Net Income/(Loss) - Current Month		Year-to-Date Expenses	$ -	
(4)	Net Income/(Loss) - Year-to-Date		Year-to-date # of days	0	
(5)	Cash Balance (Amount of Cash available to cover operating expenses)		Average Daily Expenses		
(6)	Days Cash on Hand (Measures # of days of cashto cover operating expenses) Benchmark: 45				
(7)	Current Ratio -(Measures ability to meet short-term obligations); Benchmark 2.0				

		YES/NO
(8)	All Required Statements Provided?	
	Balance Sheet	
	Income Statement	
	Cash Flow Statement	
	A/R Aging Report	
(9)	Current Month, Year-to-date and Budget Columns Presented?	
(10)	Cash Balance on B/S agrees with Cash Flow Statement?	
(11)	A/R Balance agrees with A/R Aging report?	
(12)	Line of Credit Increase?	
(13)	Does Net Income on Income Statement agree with Balance Sheet?	
(14)	Does Prior month Statement's Y-T-D NI + Current Month NI = Current Y-T-D NI?	
(15)	Do Revenues appear to be in line with budgeted amounts?	
(16)	Do Expenses appear to be in line with budgeted amounts?	
(17)	Do any Revenues or Expenses appear to be out of the ordinary or inconsistent?	
(18)	Do any Cash Flow items appear to be out of the ordinary or inconsistent?	
(19)	A/R aging report appear to be aged Properly	
(20)	A/R aging report appear to have excess receivables over 180 days old?	

Review Notes:

Financial Statement Review Form

(1)	Financial Statement Period	
(2)	Date Statements Received from Provider	
(3)	Net Income/(Loss) - Current Month	
(4)	Net Income/(Loss) - Year-to-Date	
(5)	Cash Balance (Amount of Cash available to cover operating expenses)	
(6)	Days Cash on Hand (Measures # of days of cashto cover operating expenses)	
(7)	Current Ratio -(Measures ability to meet short-term obligations)	

		YES	**NO**
(8)	All Required Statements Provided?		
	Balance Sheet		
	Income Statement		
	Cash Flow Statement		
	A/R Aging Report		
(9)	Current Month, Year-to-date and Budget Columns Presented?		
(10)	Cash Balance on B/S agrees with Cash Flow Statement?		
(11)	A/R Balance agrees with A/R Aging report?		
(12)	Line of Credit Increase?		
(13)	Does Net Income on Income Statement agree with Balance Sheet?		
(14)	Does Prior month Statement's Y-T-D NI + Current Month NI = Current Y-T-D NI?		
(15)	Do Revenues appear to be in line with budgeted amounts?		
(16)	Do Expenses appear to be in line with budgeted amounts?		
(17)	Do any Revenues or Expenses appear to be out of the ordinary or inconsistent?		
(18)	Do any Cash Flow items appear to be out of the ordinary or inconsistent?		
(19)	A/R aging report appear to be aged Properly		
(20)	A/R aging report appear to have excess receivables over 180 days old?		

Review Notes:

Mental Health and Recovery Services Board
of Allen, Auglaize and Hardin Counties

Application for Program Funding

The Mental Health and Recovery Services Board Program Proposal Application for Funding is designed to assist agencies to fully document their programming. The information in this application will provide important descriptions of priority and specialized services and programs requesting funding from the Board. The application will serve as a guide to determine the need and appropriateness of programming, establish funding priorities, and document the impact and effectiveness of services provided.

Information contained in the applications will help ensure that the Board priorities and strategic goals are reflected in all funded services. These priorities are:

- Ensure the future financial viability of the services in the Allen, Auglaize and Hardin service delivery system.
- Ensure the quality and effectiveness and accessibility of services resulting in positive client outcomes.
- Retain professional staff with demonstrated competencies within the system.

The Board is committed to funding efficient and cost-effective programming that will move consumers towards recovery.

Please provide a 50-word summary of the program for which funds are requested (Agency to complete)

(Agency to complete)

<table>
<tr><td colspan="3">TOTAL COST OF PROGRAM</td><td colspan="3">$</td></tr>
<tr><td colspan="3">BOARD FUNDS REQUESTED FOR PROGRAM</td><td>$</td><td>% of Total Cost</td><td></td></tr>
<tr><td>Number to be served</td><td></td><td>Cost per participant</td><td colspan="3">$</td></tr>
</table>

Section 1. Program Requirements (Board to complete Section 1)

1.1 The following are requirements developed by the Board that are to be followed by the agency to maintain program funding.

-
-
-
-
-

1.2 What data will be collected on the program?

Section 2. Detailed Program Description (Agency to complete Section 2)

2.1 Please describe the proposed program/services in greater detail.

- **How will the program be implemented?**
- **Is this a new or continuing program? If continuing, how long has the program/service been provided?**
- **What are the staff credentials, # of FTE's, and training requirements?**
- **What services are included in the program (service description and new BH code)?** (i.e. assessment, individual counseling, pharmacological management, information dissemination, etc.)

2.2 How will the agency ensure access to the program? (i.e. marketing, advertising, meetings with referral sources, etc.)

2.3 How many people need this program and what do they look like? (i.e. age, gender, race, special needs, Board identified priority populations)

2.4 Does the program collaborate with any other agencies or organizations? Please list all that apply and the nature of the collaboration.

2.5 What are potential barriers to implementing the program effectively? How will the agency address these issues?

2.6 Where will the program be delivered? (county, school, agency, home)?

Guidelines and Operating Principles for Residency Determinations Among CMH/ADAS/ ADAMHS Boards

1. The purpose of these guidelines and operating principles is to clarify what is to take place, in terms of Board responsibilities and residency determinations, when clients seek services outside their service district of residence.
2. For the purposes of MACSIS, the county of assigned residency determines into which Board's service system (i.e. group and plan) an individual is to be enrolled. In special circumstances a client may live in a Board area which differs from that to which residency/enrollment has been legitimately and appropriately assigned.
3. A fundamental tenet that is to guide residency policy and its interpretation is that continuity-of-care is paramount and that responsibility to ensure this in instances of out-of-district placement or referral should rest ultimately with the "home" Board from which the client came. A Board should not be in a position to shift this responsibility by facilitating the relocation of clients to facilities or services which lie outside its service district. The "home" Board to which a client's residency is assigned should carry the following responsibilities (some of which may be delegated to another entity):
   a. Assuring reasonable client access to the services called for in the Board's approved Community Plan in a fair and equitable manner.
   b. Enrolling eligible persons in its benefit plans in accordance with the applicable business rules and providing for the provision and management of these benefits.
   c. Serving as the local authority for funding, contracting, coordinating, monitoring, and evaluating services. These responsibilities include clinical oversight and utilization review responsibilities as authorized by Chapters 340 and 5122 of the Revised Code.
   d. Providing the necessary financial resources (to the extent such resources are available to the Board).
4. Residency determinations are to be based upon the following:
   i. For mental health clients, the statutory provisions contained in ORC 5122.01(S), which read as follows:

      "Residence" means a person's physical presence in a county with intent to remain there, except that if a person (1) is receiving a mental health service at a facility that includes nighttime sleeping accommodations, residence means that county in which a person maintained his primary place of residence at the time he entered the facility, or (2) is committed pursuant to section 2945.38, 2945.39, 2945.40 2945.401 [2945.40.1], or 2945.402 [2945.40.2] of the Revised code, residence means the county where the criminal charges were filed.

   ii. For alcohol/drug clients, the definition of residency established by OhioMHAS, which reads as follows:

      "Residence means a person's physical presence in a county with intent to remain there, except that, if a person is receiving alcohol or other drug addiction services from a program that includes

nighttime sleeping accommodations, residence means that county in which the person maintained his/her primary place of residence at the time he/she entered the program."

5. All policies involving residency-related issues are to be consistent, whether mental health or alcohol/ drug issues are involved. There are not to be differing residency determinations/assignments depending upon the nature of the diagnosis, type of service, or sources of financial support. Accordingly, OhioMHAS shall adhere to a policy of reciprocity, wherein each shall defer to the other in the determination of when residency remains with a "home" Board because of a client's placement in a special residential program or facility or because of other unusual circumstances.
6. The provisions of ORC Section 5122.01(S) and the OhioMHAS definition of residency shall be construed to apply to all specialized residential programs or facilities in which clients are placed because of their need for treatment, supervision/support, or other specialized services, with this principle to be defined and operationalized as follows:
   a. A primary criterion for what constitutes a specialized residential program or facility shall be that it is subject to licensure (or some comparable certification).
   b. The type of facilities encompassed includes hospitals, nursing homes, OhioMHAS-licensed certified residential facilities, ODH-licensed Adult Care Facilities, mental retardation group homes, ICF/MR'S, rest homes, drug/alcohol residential programs, crisis shelters, foster-care homes, etc..
   c. The term "mental health services" is to be construed broadly to encompass all those items contained in OAC 5122-25-02(B) and ORC Section 340.09 and the term "alcohol or other drug addiction services" shall include all those alcohol/drug services identified in OAC 3793:2-1-08 through 17.
   d. The phrase "receiving (MH or AOD) services at a program/facility" is to be understood to mean "while on the rolls of the program/facility." It is not necessary either for the services to be provided "on the premises of the program/facility" or "by an employee of the program/facility." Likewise, it is not necessary for said services to be officially certified for the purposes of residency determination.
   e. There is to be no "statute of limitations" on designated residency remaining with the "home" Board for persons placed in specialized residential programs/facilities that lie outside its service district.
   f. Designated residency shall remain with the "home" Board regardless of whether it was directly involved in facilitating placement in an out-of-district specialized program/facility.
   g. Residency shall not remain with the "home" Board in those situations where a client is placed for an indefinite period in a facility for reasons having nothing to do with mental health or alcohol/ drug needs and then develops such problems subsequent to placement. However, no discharge directly from a state hospital to a facility shall cause a change in residency, regardless of the reasons for the discharge.
7. The interpretation of the provisions of ORC Section 5122.01(S) and the OhioMHAS definition of residency in regard to "intent to remain" shall be guided by the following:

a. "Intent to remain" is to be interpreted to mean a person's expressed or reasonably implied intent, together with actions which taken as a whole indicate a desire to remain permanently in the county. There can be no intent to remain when a person is visiting, transient or present in a county for only a time-limited specific purpose.

b. In addition to stated intent, which shall be given primacy, the following are other factors which may be considered in assessing whether a person's actions demonstrate intent to be a resident:

- mailing address
- voting
- car registration
- job or other vocational efforts
- payment of taxes
- location of family
- general conduct.

i. Where a client lacks the capacity to communicate clearly or is unwilling to state an intent (and there is no compelling evidence to think otherwise), it shall be assumed that the client intends to remain in the service district he/she is currently located.

ii. Boards and their agents are not to be involved in efforts to coerce or unduly influence client intent vis-a-vis residency.

8. Residency for children is to be determined by the residency of the parents (or guardian) and should change when the parents move (even when this occurs in the middle of a hospitalization or residential placement). When temporary or permanent legal custody of a child has been awarded to some other official entity (such as a CSB, ODYS, etc.), residency should remain with the "home" Board of the county where the court which ruled maintains jurisdiction.

a. This guideline is not intended to resolve boundary issues between the responsibilities of Boards versus those of CSB's, juvenile courts, DYS, etc.. Rather, it is intended to clarify that it is the responsibility of the "home" Board to work through such matters for its clients.

b. Persons with handicapping conditions who consequently may remain in the custody of a CSB, etc., through their 21st year shall be considered to be children for the purposes of these guidelines.

9. The interpretation of these residency provisions for children is to be guided by the provisions of ORC Sections 3313.64(A)(1 and 4), 3313.64 (C)(2), and 2151.35, which deal with the determination of local responsibility within the educational system.

10. For clients committed pursuant to ORC Sections 2945.38, 2945.39, 2945.40 2945.401 [2945.40.1], or 2945.402 [2945.40.2] of the Revised code, residency shall remain with the Board of the service district in which the charges were filed only for as long as the client remains in a forensic status. If and when the client's status reverts to a civil commitment, at that point the client's residency shall be changed to that to which it would be for non-forensic clients (i.e. the "home" Board from which the client originally came). For those clients who may be in a non-hospital setting when their

commitment status changes, residency should be determined by type of facility and/or intent, depending upon the circumstances. When residency shifts because of a change in forensic status, the Board from which residency is being shifted is to give timely notice to the new Board of residency.

11. Where special circumstances, such as result from unusual geographic boundaries, create situations where the applicability of the residency criteria in the law may be especially problematic, the Boards involved may negotiate a "Memorandum of Understanding" as to how various issues will be addressed, rather than repeatedly disputing individual cases.

12. A Board (directly or through its contract agencies) may receive requests for services from a client whose residency rests with the Board of another service district (with this encompassing clients involved in emergencies while away from home, clients wishing to travel to receive non-emergency services from a provider in another district, and clients placed in a specialized residential facility who seek additional services beyond that which the facility itself may provide). Such requests for services from non-residents should be dealt with as follows:

    a. Services other than emergency/crisis services and Medicaid-billable services should remain the sole responsibility of the "home" Board of residency, with this responsibility understood to encompass the items listed in section #2 of this document.

    b. The Chief Clinical Officer (or designee) of the "home" Board should be responsible for determining what services may be clinically necessary and appropriate for an individual seeking services outside of his/her "home" district. The "home" Board should bear ultimate responsibility for overseeing and supporting the provision of appropriate out-of-district services (to the extent they are approved as being consistent with the Board's Community Plan and sufficient financial resources are available).

    c. For non-Medicaid services, a Board may have "preferred providers" (i.e. its contract agencies) and expect residents seeking Board-subsidized services to use these organizations.

    d. Non-emergency services may be provided to out-of-district clients by either the "home" Board of residence or the Board from which the client is seeking services. However, no Board should be expected or assumed to provide ongoing, non-emergency services to out-of-district clients without its explicit consent and without a mutually agreeable reimbursement mechanism having been negotiated. All Boards should adopt official policies and procedures which layout how it will respond to requests of its residents who seek services outside the Board's service district.

    e. Anytime an SMD client is placed in an out-of-district residential facility with the involvement of the public community mental health system, the "home" Board should notify the Board where the facility is located and work out matters of service coordination and continuity-of-care.

    f. Contract agencies are free to serve whomever they wish with funds other than those provided pursuant to a contract with a Board.

13. A person incarcerated in an out-of district jail facility shall remain a resident of the district from which he/she came. However, to facilitate and support Board-sponsored programs for the provision of services to a local jail facility, by mutual agreement a temporary re-assignment of a jail inmate to

a plan of the local Board may be effected. Upon release from the jail facility, the plan assignment shall revert to the original Board of residence.

14. Residency disputes are to be addressed as follows:
    a. Ultimate responsibility for resolving residency disputes shall rest with OhioMHAS, whose decisions shall be binding.
    b. OhioMHAS shall officially adopt and distribute these "Guidelines and Operating Principles" (along with any subsequent modifications), with the explicit understanding that they are to be followed in the determination of residency.
    c. Boards are expected to work out routine questions of residency among themselves without resorting to an official dispute resolution process.
    d. As the initial step in the formal dispute resolution process, the Board which believes that an individual's residency has been inappropriately determined is to contact the Board it believes is the proper Board to which residency should be assigned. This is to be done in writing and, unless there are extenuating circumstances, is to take place within ten working days of the time a Board first becomes aware that a residency assignment may need to be questioned.
    e. After receipt of the written statement initiating the residency dispute process, the two Boards shall have five additional working days to agree upon the appropriate residency designation. If the matter remains unresolved, either Board may refer the matter to OhioMHAS for final resolution. This shall be done in writing and shall occur immediately upon expiration of the five working days during which the Boards are to attempt to resolve the matter between themselves. The Director of OhioMHAS (or his/her designee) shall make a final determination about residency within ten additional working days, during which time the Boards involved in the dispute and other relevant parties (including, where appropriate, the client) are to be contacted. A written determination, including the rationale for the decision, is to be provided to both Boards.
15. A public record (with client names deleted) of precedents for how residency disputes are resolved by OhioMHAS is to be maintained, so as to serve as a guide for dealing with subsequent disputes.
16. While residency questions are being resolved, essential client services are to be maintained, with the primary responsibility for this to rest with the Board from whose system an individual is receiving services. As part of the resolution of a residency dispute, it shall be determined which Board shall be responsible for the costs of treatment services provided during the period of the dispute. In cases where the appropriate state agency determines that a Board other than the Board which paid for the services is the appropriate Board of residence then the Board which paid for the cost of service will invoice the Board of residence. The Board of residence will be expected to pay the Board of service within a reasonable amount of time.
17. No Board is to alter an individual's residency/plan assignment within MACSIS without the explicit approval of the other affected Board or a formal OhioMHAS resolution of a residency dispute. (Normal practice should be for the receiving Board to effect a residency change in MACSIS.)
18. Nothing in this document should be interpreted as precluding two Boards from effecting a transfer of residency responsibilities when they mutually determine this to be in the best interest of a client.

a. These guidelines deal only with inter-Board residency issues and are not intended to address situations where individuals may be placed or seek services across state lines. It is felt that the issues involved are enough different to warrant separate consideration.

ENROLLMENT GUIDELINES FOR COLLEGE STUDENTS

INTRODUCTION

The purpose of these enrollment guidelines are to clarify payment responsibilities for students needing behavioral health services and engage all at-risk students (whether in-state, out-of-state, or international students) needing treatment beyond the scope of what the university/colleges provide.

ENROLLMENT

Payment in the MACSIS system begins with proper enrollment. If an in-state student has a valid Ohio Medicaid card and needs behavioral health services beyond the scope of what the university/college can provide, then it is the responsibility of the Home Board/agency (that Board in the county of the students legal residence) to enroll and assume responsibility for the payment of subsequent claims.
If the student is not eligible for Medicaid, the primary enrollment issue to address for any in-state or out-of-state college student is to determine the tax dependency status of the student. Agency staff must find out if the student is an IRS Tax Dependent. Verification of this would be a copy of the parents/guardians most recently filed federal tax forms. Absent this, agencies can request a signed declaration of dependency status from the parent/guardian.

IN STATE STUDENTS

If the student is a tax dependent, then the board area in which the parent(s)/guardian(s) reside is the child's county of residence (the Home board). Enrollment should be made with the Home Board where the parent(s)/guardian reside and the student is to be enrolled by the Home Board in one of that county's plan(s)/panel(s). Payment for services beyond either the scope of what the university/college can provide and or the Home Board's plan/panel is the responsibility of the parent/guardian. However, if this presents a hardship to an economically disadvantaged family and when such services are clinically indicated, MHRSB contract providers may apply for reimbursement by completing the *Request For Authorization to Provide Services to MACSIS Exceptions* form outlined in the Board's Standards Manual.

If the student is not an IRS dependent, and any of the following characteristics apply, the student shall be enrolled into MHRSB Services and the individual can be assessed against the agency's income determination guidelines and uniform sliding fee scale.

1. The student has established residency in Allen, Auglaize, or Hardin County
2. The student expresses an intent to remain (defined below)'
3. The student is emancipated, in graduate-level coursework, or has dependent children living in the County.

OUT OF STATE STUDENTS

If the student is from out of state and is tax dependent, payment for services are the responsibility of the parent/guardian. When they (or some other party) is responsible for the payment of the student's

services, then the student should not be enrolled into MACSIS. Only those clients whose services are paid in whole or part with public funds administered by the Board are to be enrolled.

However, if this presents a hardship to an economically disadvantaged family and when such services are clinically indicated, the MHRSB providers may implement the income determination guidelines and uniform sliding fee scale to assess if there are any first or third party payers.

If, after a determination of hardship or clinical necessity a student is enrolled, these students should be enrolled using the address of the parent(s)/guardian(s) and using "OUTSTATE" in the Sales Rep field.
If the student is not a tax dependent, the same three characteristics identified above for in-state students applies to out of state students to establish enrollment into MHRSB AAH services.

INTERNATIONAL STUDENTS

For international students, there is no IRS dependency category to guide enrollment and subsequent payment. The majority of International students will have an F-1 visa and are not required to have health insurance. Students with a J-1 visa are required to have health insurance. Is any of these international students has first or third party payers, they are responsible for the payment of the student's services, then the student should not be enrolled into MACSIS. Only those clients whose services are paid in whole or part with public funds administered by the Board are to be enrolled. However, if this presents a hardship to an economically disadvantaged family and when such services are clinically indicated, the MHRSB providers may implement the income determination guidelines and uniform sliding fee scale to assess if there are any first or third party payers.

If, after a determination of hardship or clinical necessity a student is enrolled for behavioral health services beyond the scope of what the University/college provide, these students should be enrolled in MHRSB services using the address of the parent(s)/guardian(s) and using "OUTSTATE" in the Sales Rep field. MHRSB providers shall assess payment responsibility through the uniform sliding fee schedule and implement the income determination guidelines to assess if there are any first or third party payers.

Agencies shall develop referral relationships with each of the area colleges/universities to address other services or special needs of the students (e.g., interpreter services).

INTENT TO REMAIN

Section 7 of the MACSIS residency guidelines defines intent to remain as:
The interpretation of the provisions of ORC Section 5122.01 (S) and the ODADAS definition of residency in regard to "intent to remain" shall be guided by the following:

1. "Intent to remain" is to be interpreted to mean a person's expressed or reasonably implied intent, together with actions which taken as a whole indicate a desire to remain permanently in the county. There can be no intent to remain when a person is visiting, transient or present in a county for only a time-limited specific purpose.

2. In addition to stated intent, which shall be given primacy, the following are other factors which may be considered in assessing whether a person's actions demonstrate intent to be a resident:
    - mailing address
    - voting
    - car registration
    - job or other vocational efforts
    - payment of taxes

- location of family
- general conduct.

3. Where a client lacks the capacity to communicate clearly or is unwilling to state an intent (and there is no compelling evidence to think otherwise), it shall be assumed that the client intends to remain in the service district he/she is currently located.
4. Boards and their agents are not to be involved in efforts to coerce or unduly influence client intent vis-a-vis residency.

Residency for children is to be determined by the residency of the parents (or guardian) and should change when the parents move (even when this occurs in the middle of a hospitalization or residential placement). When temporary or permanent legal custody of a child has been awarded to some other official entity (such as a CSB, ODYS, etc.), residency should remain with the home Board of the county where the ruling court maintains jurisdiction.

Homeless Client Guideline

These clients are to be enrolled in a plan/panel of the board in which they present for services (a type of rolling enrollment).

Example: The client was originally enrolled in a plan/panel of the Franklin County ADAMHS Board. This client subsequently presents in Montgomery county for services and claims to be homeless (please note that this client can claim an address of homeless or an address of a homeless shelter). The Montgomery County ADAMHS Board should assume responsibility for the client's services by transferring enrollment into one of their plan/panel combinations. If this client continues their journey and presents for services in Butler county two months later and again claims to be homeless, the Butler County Boards should assume responsibility for the client's services by transferring enrollment into one of their plan/panel combinations. Please note, it is intended for MACSIS to track this type of client to assist in identifying such populations and their need for continuity of care.

How to process enrollments/transfers in MACSIS:

A. Client not previous enrolled. Board are in which the client presents as homeless should enroll immediately for benefits. Note: A client in this situation should NEVER be terminated for benefits prior to another board assuming responsibility.

B. Client previously enrolled. If the client is already enrolled in another Board's plan/panel, then the Board in which client has presented for services and stated homelessness MUST immediately transfer the client into one of their plan/panel combinations. As previously noted above, a client in this situation should NEVER be terminated for benefits prior to another board assuming responsibility.

Migrant Worker Guideline

The following guideline is applicable to Legal Migrant Workers. (Illegal Migrant workers are still under discussion, however, it was noted that boards should be utilizing the "Out of County Service Matrix" when dealing with these clients.)

These clients are to be enrolled in a plan/panel of the board in which they present for services (a type of rolling enrollment).

Please reference the "Homeless Client Guideline" above.

Out-of-State Client Guideline

How to handle the enrollments within MACSIS:

A. If the client has a valid Ohio Medicaid card, then the Board in which the client has presented for service should enroll the client in one of their plan/panel combinations or if the client has previously been enrolled, immediately transfer the client to one of their plan/panel combinations.

B. If the client does NOT have a valid Ohio Medicaid card, then the Board could exercise their local option to enroll these clients for service. (Please reference the enrollment guideline for out of state college students.)

Agency Closure Plan

Upon notification of a contract agency closure (within 1-2 business days), the Mental Health and Recovery Services Board of Allen, Auglaize and Hardin counties is to work with the CEO of the closing agency to follow guidelines outlined in OAC 5122-26-14 *Provider closing or acquisition*, if necessary MHRSB will assume operation of the facility under ORC 340.037 *Operation of facility to provide addiction or mental health services* [Effective 7/1/2017]. Steps outlined below:

Step 1 – Communication

Once MHRSB is made aware of the closure they are to contact Board members by phone AND email with this prepared statement: "(Agency Name) has provided notice of its intent to close its doors and is no longer providing services. The Agency Closure Plan has been put in motion." As well as contact the following entities:

1. Contact County Commissioners and notify of situation.
2. Notify the Press and submit the press release
3. Notify key stakeholders by phone call, email, personal visits, and/or sending press release through an email blast.

If "no other qualified private or public facility, community addiction service provider, or community mental health services provider is immediately available and willing to operate such a facility or provide the service" the Executive Director will seek board approval to operate the facility for "not longer than one year" (in accordance with ORC 340.037).

Step 2-Work with Agency on Transition Plan

The Executive Director of MHRSB immediately (within one to two business days) to meet in person with the CEO of the agency to provide them with a copy of OAC 5122-26-14 *Provider Closing or Acquisition*.

1. Prior to the meeting the Executive Director to provide a copy of OAC 5122-26-14 to the CEO.
2. Establish the closing agency's plan to transfer clients that require ongoing services after the projected closing date.
3. MHRSB to generate a list of the closing agency's board of trustees and their address and telephone numbers from the Contract Standard's Manual.

Step 3-Client Records and Care

1. MHRSB staff to request a list of all Medicaid and non-Medicaid clients served at the agency within the past 90 days to determine current case load. Remove duplicates and generate a list that identifies clients served at the agency by diagnosis. MHRSB to prioritize SMD/ SPMI and SUD clients with need for case management services, supportive housing and medication management to facilitate a smooth transition to another agency.

2. MHRSB to assist the closing agency with compiling a complete list of agencies that would be available to accept clients transferring from the closing agency. The list generated included agency name, address, telephone number and fax number.
3. MHRSB to notify other contract agencies of the impending closure of a treatment agency and detailed the process for clients to obtain their medical records from the closing agency by providing a contact name, telephone number and a fax number.
4. MHRSB to assist in reaching out to contract provides to determine how many clients they could admit that would be transferred from the closing agency.

Step 4-IT and Financial Management

MHRSB CFO to manage IT and financial issues.

1. The CFO to research deed owner/liens on the property to be vacated by the agency closure and obtained copies of said documents.
2. The CFO to research other properties the agency slated to close rented and/or owned.
3. The CFO to update the MHRSB Executive Director on the financial and building status.

Step 5- Identify New Provider

Implement APF process to identify potential agencies to assume operation. When an agency is identified, notify the new agency provider that was chosen through the APF process that MHRSB would like to enter into a contract.

1. MHRSB funding to become available to assist with the temporary expansion of capacity through contract revisions, increase in Board operating and IT budgets.
2. MHRSB to contract with additional support staff if necessary.
3. MHRSB to schedule special meeting for budget approvals.