Mental Health & Recovery Services Board of Allen, Auglaize and Hardin Counties FY2019 Standards Manual

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This Manual, which is attached to and made a part of the contract between the Mental Health & Recovery Services Board of Allen, Auglaize and Hardin Counties and each of its major contract providers/agencies ("Agreement") 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 IRS and the State of Ohio as a Not-For-Profit Entity
- Certified by the Ohio Department of Mental Health and Addiction Services (OMHAS) (Treatment or Prevention Provider only).
- Is Accredited by CARF, COA, TJC (JCAHO) or other National accrediting body recognized by OMHAS (Treatment Providers Only)
- Has been certified to provide Medicaid funded services for a minimum of three years. (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 not need to provide this information with the application but must be able to produce the information upon request.
- Any contracts and/or agreements authorized by this Board in the future shall have statement with regards to non-discrimination

The Board may consider applications from entities that do not meet all of the criteria listed above, if a service is needed to meet the Continuum of Care for Allen, Auglaize, and Hardin Counties and cannot be provided by applicants that meet the criteria above.

Agencies that do not meet the criteria above, but have a working relationship with the Board, may be considered an Affiliate Agency. Affiliate Agencies are 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)

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.

SERVICE DEFINITIONS

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

See **Exhibit 1**: Special Treatment Rules and Definitions / Prevention Taxonomy and Definitions

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. Client record systems utilizing electronic signatures shall comply with section 3701.75 of the Revised Code. Incomplete documentation can be completed only if the "added" documentation is reflected as a late entry, dated on the date of the late entry, and initialed by appropriate staff.

D. There must be sufficient back-up documentation. For example, billing must be supported by documentation that indicates the client was seen on that date such as a progress note; dated client signatures related to clinical services must be verified by documentation that the client was seen on that date; quality improvement meetings need to be supported by meeting minutes, etc.

E. 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.

F. 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.

G. Individualized Treatment Plans (ITP) and AoD Case Management Plans– An ITP 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 ITP 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. An AoD 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 ITP and AoD case management plans or integrate the ITP and case management plan of care into one plan. Each ITP must include the signature of the agency staff member responsible for developing the ITP, 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 ITP, or other documentation by the supervisor in the ICR.

H. The ITP shall be periodically reviewed at the client's request; when clinically indicated; when there is a change in the level of care; or when a recommended service is added, terminated, denied, or no longer available to the client. Documentation of review of an AoD case management plan of care or integrated plan shall be at least every ninety days, or as clinically indicated, if sooner. Reviews of a case management plan of care shall be based upon a case management reassessment at least every ninety days. Documentation of the results of non-case management periodic review shall occur at least annually.

I. HIPAA and psychotherapy notes- Under HIPAA, Personal Health Information (PHI) pertaining to mental health clients may be used or disclosed for the purposes of treatment, payment, operations or for other purposes permitted by HIPAA (e.g. To Health Oversight Agencies, As Required by Law, etc.) without a written authorization from the client EXCEPT for psychotherapy notes. Psychotherapy notes are defined in the HIPAA regulations as "notes recorded (in any medium) by a health care provider who is a *mental health professional* documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are *separated from the rest of the individual's medical record.* HIPAA requires that an authorization must be obtained for any use or disclosure of psychotherapy notes except for a few limited situations and providers are permitted to give an unreviewable denial in response to an individual's request to access to psychotherapy notes pertaining to the individual. This 'Psychotherapy Notes' classification severely limits use and disclosure of the information. Therefore, the Board requires that contract agencies with staff keeping "psychotherapy notes" on clients being provided services under the Board contract shall make all notes part of the medical record, keeping them subject to the same use and disclosure requirements of all other PHI under HIPAA.

J. 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 11** – Duty to Protect Documentation Form). A *mental health professional* means an individual who is licensed, certified, or registered under the Revised Code, OR otherwise authorized in the State of Ohio, to provide mental health services for compensation, remuneration, or other personal gain (ORC 2305.51(A)(1)(d)). A *mental health organization* means an organization that engages one or more mental health professionals to provide mental health services to one or more mental health clients. A *mental health client* is an individual receiving mental health services from a mental health professional or organization. *Mental*

health services means a service provided to an individual or group of individuals involving the application of medical, psychiatric, psychological, professional counseling, social work, marriage and family therapy, or nursing principles or procedures to either of the following: (i) assessment, diagnosis, prevention, treatment, or amelioration of mental, emotional, psychiatric, psychological, or psychosocial disorders or diseases, as described in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association; OR (ii) assessment or improvement of mental, emotional, psychiatric, psychological, or psychosocial adjustment or functioning, regardless of whether there is a diagnosable, pre-existing disorder or disease. 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 protected health information *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 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 AOD 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 4 –** 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 except for emergency situations.

Re-determination of income must be done upon self-report of a change of income and, **at least once a year**. Any changes must be submitted to the Board via a notation on an enrollment form. A client going in to bankruptcy should be considered for a redetermination.

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 7: 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 Board will be responsible for getting approval to the Board 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 4)

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 hardship waiver. Waivers must be documented on the Request for Financial Assistance form (**Exhibit 7**). It is strongly recommended that the agency work with the client to access resources from other social service agencies before submission of a hardship waiver.

WAIVER OF CONSUMER FEES

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 hardship, any deviation from the Subsidy Scale must be documented on the Request for Financial Assistance form (**Exhibit 7**).

Hardship 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).

CLIENT ELIGIBILITY CHECKS

Contract Agencies agree to allow the Board to send information pertaining to their clients into MITS to check client eligibility for Medicaid and compare to information in GOSH (MHRSB billing system) to ensure the Board is not paying for services to clients that would be covered by Medicaid.

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.

Generally, agency compliance audits will follow the procedures outlined in **Exhibit 8** – Medical Necessity Review Forms. 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

All brochure, letterhead, print materials, advertising, and other communications (e.g. web sites, social networking sites) shall denote the role of the Board. The Board encourages agencies to use the We Care People logo on all print materials.

CONTINUOUS QUALITY IMPROVEMENT –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 Plan 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 IMPROVEMENT REPORTING

Performance improvement 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(A).

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

The agency shall develop a process for planning, doing, checking, and acting upon its performance. This process shall include at a minimum the utilization of the following four performance improvement methodologies:

1. Designing a performance improvement process (planning).
2. Monitoring performance through data collection (doing).
3. Analyzing current performance (checking).
4. Demonstrating that data collected and analyzed pursuant to this rule are used to improve performance, practices, and processes (acting).

To assist the agencies in standardizing reporting on Continuous Quality Improvement, the MHRSB is prescribing the following format for Quarterly Reports (**Exhibit 2**).

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
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.

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 **Exhibit 6**, Summary of O.M.B. Circular A-122)

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 the Board for GOSH processing on or before the last business day of the second month (August 31) after the expiration of the Agreement.

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

Any staff covered by a cost reimbursement may not bill any "fee for service" without preapproval by Board staff.

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

PERFORMANCE INCENTIVE – Payment for first month is an advance. Payments for subsequent months are based on achievement of approved performance standards based on negotiated terms of the contract.

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 are vacant grant funded positions, for greater than 30 days, they 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.

Program Subsidy Grants - 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 14%) 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 14% of the program it is applied to.

TITLE XX – Payment for services covered by Title XX federal funds will be made as services are billed. Agencies will provide the Board with the claim/client information necessary for the Board to determine those claims that are eligible.

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 14% of the contract budget.

APPLICATION FOR PROGRAM FUNDING (APF)

All APF's submitted by the provider become a part of the contract. Any changes must be re-negotiated.

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. (See **Exhibit 9**, OAC 5122-26-18).

Client grievances shall be reported quarterly as part of the quarterly Continuous Quality Improvement reports to the Board (see **Exhibit 2**).

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.

The agency shall have a specific policy regarding non-discrimination of persons who are HIV infected.

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.

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 5**). 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 Authorization to Provide Services to GOSH Exceptions* when it wishes to seek Board reimbursement for unusual cases (**Exhibit 7**).

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. The Board shall reimburse the cost of Consultation less any payments received for such services by the agency.
6. 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.
7. Miscellaneous reports (i.e. SAPT, etc) 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.
8. 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.
9. 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 MITS and Medicaid billing procedures and requirements.

REPORTING REQUIREMENTS AND SCHEDULE

Major Unusual Incidents Reports	Within 24 hours of discovery, exclusive of weekends & holidays
(1) Monthly Financial Statements	Monthly by the 21st
Provider's certificate of Insurance in accordance with requirements set forth in Section 16 of the Agreement	At Renewal and within 30 days of receipt of any notice of non-renewal or cancellation
Quality Assurance Reports: Annual Summary of Client Grievances APF Outcome Reports 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
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
Listing of Agency's actual employee salaries by title and position	Provided with budget
Up to date inventory of equipment purchased with federal funds	July 1st

(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) or on standardized forms/media (see **Exhibit 3**) and shall be forwarded to both OhioMHAS and to the board of residence within twenty-four (24) hours of their discovery, exclusive of weekends and holidays (Administrative Rule 5122-26-13).

It is a MHRSB policy that an agency who has a lease with the Board are required to complete the attached form in their lease if any minor incidents, accidents, or injuries are reported. **(Exhibit 12)**

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 Board staff (Associate Director or Executive Director) as needed and where appropriate.

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. SPMI designation will be determined by Board staff (Associate Director or Executive Director) as needed and where appropriate.

- 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 (see **Exhibit 2**).

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. The Board also requires data directed toward the National Outcomes Measures (NOMs) be included in the Program Feasibility Analysis (APF) Quarterly Reporting Process.

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.

Treatment Services	Special Rules
Outpatient Program (services include BH counseling AND therapy, assessment, diagnostic assessment)	Two providers can bill the same hour of service if two different services are being provided as long as the services are allowable, there is sufficient documentation, and the service is directly related to the ISP. The restriction is that you can not bill two services provided to the same person at the same time. **RE: ODADAS AoD assessments(3793:2-1-08(k))– a program may accept an assessment from a program certified by ODADAS OR an assessment containing comparable elements of an assessment required by the rule that has been completed with 90 days of the admission of the client. The SOQIC diagnostic assessment update would meet this criteria.** Assessment services may be provided at an alcohol and drug addiction program site certified by the Ohio Department of Alcohol and Drug Addiction services or in the natural environment of the client being served. In relationship to diagnostic assessment (non-physician) services, application of the sliding fee scale should be at zero, irrespective of client income. In this way, agencies can be reimbursed for crisis and diagnostic services via health insurance and board dollars with the exception of the annual client insurance deductible requirements.
Pharmacological Management Services (Medication Somatic)	Group med somatic (called pharmacological management on the taxonomy) is a valid service for both Medicaid and non-Medicaid services. The service is an hour unit and the length of service is divided by the number of participants to arrive at the number of units each client is to be billed. Service durations of less than 8 minutes per person are not billable.
Intensive Home Based Treatment (IHBT)	A comprehensive service that bundles mental health services into a single coordinated service which includes community psychiatric supportive treatment (CPST) service, mental health assessment service, crisis response, behavioral health counseling and therapy service, and social services which support the basic needs and functioning of the youth and family. IHBT incorporates components of resilience and system of care principles into all aspects of treatment.
Intensive Outpatient	Structured individual and group alcohol and drug addiction activities and services that are provided at a certified treatment program site for a minimum of eight hours per week with services provided at least three days per week. If an agency does not provide IOP services, then the clinically appropriate mix of individuals and group services should be offered to meet the level of care.
Group Counseling	ODADAS- The client to counselor ratio for group counseling shall not be greater than 12:1.
Employment/Vocational	The purpose and intent of employment/vocational service is to promote recovery and secure/maintain employment by providing training and skill development that is goal-oriented, ability-based, and incorporates individual choice.
Residential Community Residence	For adult residential services, documentation shall be kept in accordance with the policies and procedures of the Housing Program with which the Board contracts. (See further definitions below)
Case Management (ODADAS) (Non-Clinical)	Case Management services may be provided by any staff member approved by the Program Director. Most services provided by students are not eligible for reimbursement by Medicaid. The one exception is AOD Case Management.
Hotline (ODADAS)	A log should be kept on incoming calls or referrals; including date, unit of service and disposition. a program's twenty-four hour per day, seven days per week capability to respond to telephone calls often anonymous, made to a program for crisis assistance. The caller may or may not become a client of the program.
Crisis Intervention (ODADAS/ODMH)	Crisis staff shall be available on a twenty-four hour, seven days a week basis, including availability of a consult with a psychiatrist (OAC 5122-29-10, paragraph (B) (1). The agency shall arrange that access to a psychiatrist A crisis plan will be established that includes referral and linkages to appropriate services and coordination with other systems. The crisis plan should also address safety issues, follow-up instructions, alternative actions/steps to implement should the crisis recur, voluntary/involuntary procedures and the wishes/preferences of the individual and parent/guardian, as appropriate.

	In relationship to crisis intervention, application of the sliding fee scale should be at zero, irrespective of client income. In this way, agencies can be reimbursed for crisis and diagnostic services via health insurance and board dollars with the exception of the annual client insurance deductible requirements.
Hotline (ODADAS)	A program's twenty-four hour per day, seven days per week capability to respond to telephone calls often anonymous, made to a program for crisis assistance. The caller may or may not become a client of the program.
Training Service (non-prevention) (ODADAS)	Means developing alcohol and/or drug service skills of staff and personnel not employed by the agency (e.g. counselors'/clinicians' training on counseling techniques and approaches; sessions for clinicians on the effect of various types of drugs).
Consultation (ODADAS)	Assisting an individual in accessing alcohol and other drug services or other necessary services generally occurring prior to admission. Consultation is a cross-system or within-system collaboration on behalf of an individual to assist in assessment and triage decisions. This process may include family members or other significant persons. Within-system does not include consultation within a treatment agency. The Board shall reimburse the cost of Consultation less any payments received for such services by the Agency
Referral & Information (ODADAS)	Responding to inquiries from people, usually by telephone, about services provided by the program or services provided by other health care organizations and contacting another health care organization provider in order to obtain services for an individual. This service does not include "hotline services".
Intervention Service (ODADAS)	Those activities that seek to detect alcohol and/or other drug problems and addiction and to intervene in such a way as to arrest the progression of such problems. It includes early intervention services.
Outreach Service (ODADAS)	A planned approach to reach a target population within their environment. The purpose of this approach is to prevent and/or address issues and problems as they relate to the use/abuse of alcohol or drugs.

Service	Special Rules
Community Psychiatric Supportive Treatment / Individual CSP Service	No SMD/SED eligible client shall be denied CSP services or put on a waiting list. Case management/CSP services are to be provided to individuals who are addicted to a substance or SMD/SED (or SMD/SED eligible via the SSI/SSDI eligibility certification process) at no charge to the individual. Group CSP- Services are not for the exclusive purpose of social or recreational activity, but must evidence a clear therapeutic objective specifically identified in the client's ISP; and the group CSP activities are consistent with the treatment objectives stated in the ISP of each person served, and are reflected in the progress notes. The service must be documented in accordance with federal, state, and local regulations. CPST group services can be delivered off-site at a location other than that of the certified agency. However, the certified agency will need to alert the ODMH Office of Licensure and Certification as there are building health/safety issues that will need to be satisfied.
Group CSP Service	

Residential and Housing Service Categories (Productivity of Board owned housing is 80% occupancy)		
Service	Definition	Special Rules
Crisis Care	Provision of short-term care to stabilize person experiencing psychiatric emergency	Offered as an alternative to inpatient psychiatric unit. Staff 24 hours' day/7 days a week

Foster Care	Living situations in which the (child or adult) client resides with a non-related family or person in that person's home for purpose of receiving care, supervision or assistance	
Residential Care	Includes room and board, and personal care 24/7 if specified in license. Rules in program or service agreement attached to housing are applicable. Treatment services are billed separately. May or May not be licensed by the State. Usually agency operated and staffed; provides 24-hour supervision in active treatment oriented or structured environment. *Billing unit – Daily*	Adult Care Facilities Licensed as Type I, II or III Buckeye Boys Ranch-Comprehensive tx Residential care facility Residential support ½ way house Group home Supervised Group Living Lodges Boarding Home Rest Home
Respite Care	Short-term living environment, it may or may not be 24-hour care. Reasons for this type of care are more environmental in nature. May provide supervision, services and accommodations. Treatment services are billed separately. *Billing unit – Daily*	Placement during absence of another caretaker where client usually resides Respite Care
Temporary Housing	Non–hospital, time limited residential program with an expected length of occupancy and goals to transition to permanent housing. Includes room and board, with referral and access to treatment services that are billed separately. Ohio tenant landlord law does NOT cover agreement. *Billing unit – Daily*	Commonly referred to as time limited, short term living. Transitional Housing Programs Homeless county residence currently receiving services Persons waiting for housing
Community Residence	Person living in an apt where they entered into an agreement that is NOT covered by Ohio tenant landlord law. Rules in program or service agreement attached to housing. Refers to financial sponsorship and/or provision of some degree of on-site supervision for residents living in an apartment dwelling. Usually Board or agency owned. Treatment services are billed separately. *Billing unit – Daily or Monthly*	Service Enriched Housing Apartments with non-clinical staff attached SAMI housing- no alcohol on site Supervised Apartments
Subsidized Housing	Person living in an apt where they entered into a lease with accordance to Ohio tenant landlord law or a mortgage and, in instances where ODMH allocated funds have been used, an exit strategy for the subsidy has been developed. Treatment services are billed separately. *Billing unit – Daily or Monthly*	Home - Ownership HAP Housing as Housing Person living in rental unit subsidized by state or Board funds Type IV –not licensed

Service	Special Rules
Other Mental Health Services	"Other mental health services" means services other than those listed under divisions (A) to (Q) of section 340.09 of the Revised Code. Other mental health services may include representative payeeship, transportation and other supportive mental health services and may be offered by a variety of entities, including YMCAS, churches, children's cluster or family and children first. Category to be used for billing for contact with family/client prior to opening of case (i.e. referral to Family Council, Wrap Around, and Early Intervention in school settings).
Wrap Around	Submit MACSIS claims per incident use.
Prevention (MH)	"Prevention service" means actions oriented either toward reducing the incidence, prevalence, or severity of specific types of mental disabilities or emotional disturbances; or actions oriented toward population groups with multiple service needs and systems that have been identified through recognized needs assessment techniques. Included in this service are actions such as personal and social competency building, stress management, and systems change.

Ohio Department of Alcohol and Drug Addiction Services – Continuum of Care/Service Taxonomy- Prevention

DEFINITION – PREVENTION	PREVENTION STRATEGIES & DEFINITIONS	Direct Services Interventions that directly serve the customer and allow for two-way interaction at that instance.	Indirect Services Interventions that indirectly serve the customer and are typically one-way communication and do not allow for interaction.
Alcohol and other drug [AOD] prevention focuses on preventing the onset of AOD use, abuse and addiction. AOD prevention includes addressing problems associated with AOD use and abuse up to, but not including assessment and treatment for substance abuse and dependence. **AOD prevention is** a proactive multifaceted, multi - community sector process involving a continuum of *culturally appropriate* prevention services which empowers individuals, families and communities to meet the challenges of life events and transitions by creating and reinforcing conditions that impact physical, social, emotional, spiritual, and cognitive well-being and promote safe and healthy behaviors and lifestyles. **AOD prevention is** a planned sequence of activities that, through the practice and application of evidence based prevention principles, policies, practices, strategies and programs, is intended to inform, educate, develop skills, alter risk behaviors, affect environmental factors and/or provide referrals to other services. **Prevention Service Categories by Population Served:** • **Universal** Prevention Services: Services target everyone regardless of level of risk before there is an indication of an AOD problem;	**Information Dissemination** is an AOD prevention strategy that focuses on building awareness and knowledge of the nature and extent of alcohol and other drug use, abuse and addiction and the effects on individuals, families and communities, as well as the dissemination of information about prevention, treatment and recovery support services, programs and resources. This strategy is characterized by one-way communication from source to audience, with limited contact between the two.	☐ ***AOD Information Sharing:*** – Speaking Engagements- A wide range of prevention activities intended to impart information about AOD use/abuse issues to general and/or targeted audiences. This is typically a one-time presentation to a customer. – Staffed Information Booths- Generally, a school or community-focused gathering that offers the opportunity to disseminate materials and information on AOD prevention and health related issues. Ex: Health Fair – AOD Information/Resource lines- Specific/ designated Hotline intended to provide information about AOD use/abuse prevention and treatment resources and services only. (This does not include an agency's main phone line or general information and referral or crisis line)	☐ ***Material Distribution*** – Billboards – PSA's – Newsletters – Brochures – Other Publications – Resource Directories – Tool Kits – Clearinghouse – Press Release – TV/Radio Spot – Curricula Development
	Alternatives are AOD prevention strategies that focus on providing opportunities for positive behavior support as a means of reducing risk taking behavior, and reinforcing protective factors. Alternative programs include a wide range of social, recreational, cultural and community service/volunteer activities that appeal to youth and adults.	☐ ***Social and Recreational AOD Prevention Services*** Social, recreational and creative arts activities for youth and adults that are identified and promoted as AOD Free activities/events. – Youth-Led Prevention – Youth and Adult Leadership Activities – Youth group activities – Community Service/Service Learning Activities – Cultural Programs/Events. – Community Events. – Community Drop-In Center Activities	

Exhibit 1

DEFINITION – PREVENTION	PREVENTION STRATEGIES & DEFINITIONS	Direct Services Interventions that directly serve the customer and allow for two-way interaction at that instance	Indirect Services Interventions that indirectly serve the customer and are typically one-way communication and do not allow for interaction.
• Selected Prevention Services: Services target persons or groups that can be identified as "at risk" for developing an AOD problem; • Indicated Prevention Services: Services target individuals identified as experiencing problem behavior related to alcohol and other drug use to prevent the progression of the problem. These services do not include clinical assessment and/or treatment for substance abuse and dependence. *The term Alcohol and Other Drugs* [AOD] includes, but is not limited to the following drugs of abuse - alcohol, tobacco, illicit drugs, inhalants, prescription and over-the-counter medications. *Culturally appropriate* means the service delivery systems respond to the needs of the community being served as defined by the community and demonstrated through: • needs assessment activities • capacity development efforts • policy • strategy and prevention practice implementation • program implementation • evaluation • quality improvement and sustainability activities *Evidence Based Prevention Practice* means- • Prevention policies, strategies, programs and practices are consistent	**Education** is an AOD prevention strategy that focuses on the delivery of services to target audiences with the intent of affecting knowledge, attitude and/or behavior. Education involves two-way communication and is distinguished from information dissemination by the fact that interaction between educator/facilitator and participants is the basis of the activities. Activities affect critical life and social skills including decision making, refusal skills, critical analysis and systematic judgment abilities.	☐ *Facilitated Instruction* – Classroom, Small Group or One on One Instruction, – Parenting and Family Education/Skills Training – Peer Leader and Peer Educator Programs – Education Programs for Youth/Adult Groups – Educational Support Groups – Cultural Program – Trainings/Workshops/Conferences: Prevention training and education offered to external professionals, students, workforce and /or the general public. – Mentoring program: education, training or activity led by staff for Mentees, Mentors or both.	
	Community-Based Process is an AOD prevention strategy that focuses on enhancing the ability of the community to provide prevention services through organizing, training, planning, interagency collaboration, coalition building and/or networking.	☐ *Community Enhancement Services* – Community and Volunteer Training – Capacity Building Activities – Multi-Agency Coordination and Collaboration – Community Team Building – Coalition Building – Focus Groups	☐ *Assessing Community Need* – *Needs Assessment Surveys*

Exhibit 1

DEFINITION – PREVENTION	PREVENTION STRATEGIES & DEFINITIONS	Direct Services Interventions that directly serve the customer and allow for two-way interaction at that instance.	Indirect Services Interventions that indirectly serve the customer and are typically one-way communication and do not allow for interaction.
with prevention principles found through research to be fundamental in the delivery of prevention services. • Prevention policies, strategies, programs and practices have been identified through research to be effective. **Practice Based Evidence -** • The service delivery system utilizes evaluation of its policies, strategies, programs and practices to determine effectiveness. • The service delivery system utilizes evaluation results to make appropriate adjustments to service delivery policies, strategies, programs and practices to improve outcomes.	**Environmental** prevention is an AOD prevention strategy that represents a broad range of activities geared toward modifying systems in order to mainstream prevention through policy and law. The environmental strategy establishes or changes written and unwritten community standards, codes and attitudes, thereby influencing incidence and prevalence of alcohol and other drug use/abuse in the general population.	☐ ***Community Change: Mobilization, Capacity and/or Sustainability*** – Consultation to Communities- Intended to maximize the development of and/or local enforcement of procedures governing the availability and distribution and abuse of AOD. – Regulating Youth Access Activities- Activities intended to prevent the sale of tobacco products and alcohol to minors. (compliance checks) – Interventions Addressing Location, Restrictions on Access and Density of Retail Outlets- Programs that outline strategies to control the growth and location of alcohol outlets in a community by addressing the local zoning authorities and the liquor licensing authority. May include activities focused on closing problem alcohol and tobacco outlets and/or reforming sales practices. (meetings and testimonies) – Server/Seller Oriented Activities- Community action strategies that encourage local bars, restaurants and/or other alcohol providers to train alcohol servers in techniques that discourage intoxication and drinking and driving. (meetings and trainings) – Advocacy Activities- (face to face)	☐ ***Community Change:*** – Campaigns – PSA's – Billboards – Web campaigns – Articles – Social Norm Change – Establish and Review of School Policies. – The Review and Modification of Advertising Practices. – Product Pricing Strategies- – Establishing AOD-Free Policies-. – Change Program, Policy or Practice ie: Environmental Codes, Ordinances, Regulations and Legislation. – Environmental Scan

Exhibit 1

DEFINITION – PREVENTION	PREVENTION STRATEGIES & DEFINITIONS	Direct Services Interventions that directly serve the customer and allow for two-way interaction at that instance.	Indirect Services Interventions that indirectly serve the customer and are typically one-way communication and do not allow for interaction.
	Problem Identification and Referral is an AOD prevention strategy that refers to intervention oriented prevention services that primarily targets indicated populations to address the earliest indications of an AOD problem. Services by this strategy focus on preventing the progression of the problem. This strategy does not include clinical assessment and/or treatment for substance abuse and dependence. *Note: Screening means to gather information in order to make an informed decision in regards to the individual's appropriateness for PIR services, referral to other services and/or to refer the individual on for further assessment services.	☐ ***Intervention, Brief Screening and Referral Services*** – Drug-Free Workplace Programs/EAP Programs – Student Assistance Program Services. – Support Groups. – Consumer Advocacy and Linkage – Risk Reduction Activities	

Exhibit 1

Agency Continuous Quality Improvement Quarterly Report Template

1. Utilization

Graphs will reflect reporting quarter then year to date.

Total Served All Counties	Month	Month	Month
MH			
AOD			
CSP			
PMS			

Total Served Allen	Month	Month	Month
MH			
AOD			
CSP			
PMS			

Total Served Auglaize	Month	Month	Month
MH			
AOD			
CSP			
PMS			

Total Served Hardin	Month	Month	Month
MH			
AOD			
CSP			
PMS			

Total Assessments	Month	Month	Month
MH			
AOD			
Crisis			

Total Discharges	Month	Month	Month
MH			
AOD			
Crisis			

2. Program Reports - Note major highlights of programs including changes, utilization, etc.
   Specific information can be reported in the PFA Quarterly Report Summaries as determined by the Board.
3. Safety and Environment Committee Summary
4. Continuous Quality Improvement Committee Minutes and Summary Report
5. Client Grievances, Major Unusual Incidents, Incident Reports, Client Concerns
6. Program Feasibility Analysis Quarterly Report Summaries
7. Balanced Scorecard Report
8. Quarterly Staffing Report
9. Customer/Referral Source Satisfaction (Annual)

Ohio Department of Mental Health and Addiction Services
Class One: Residential Facility Notification of Incident
Licensure and Certification

Print Form

Provider Generated Incident No.:	Date Submitted to OMHAS:	Date of Discovery:	Date of Incident:	Time of Incident:

Provider/Facility Name: License Number:

Provider/Facility Address (street, city, state, zip):

Name of Facility Contact:	Phone Number:	Email Address:

Name of Person Completing Report, if different than Facility Contact:

Notifications Made:
- ☐ ADAMH/CMH Board (list names): _____
- ☐ Children Services Board
- ☐ Family/Guardian
- ☐ ODMH
- ☐ Other Protective Agency
- ☐ Other: _____

Type of Incident (check all that apply)

Abuse and Neglect by Staff (including allegations):
- ☐ Physical
- ☐ Sexual
- ☐ Neglect
- ☐ Defraud

Death of Resident:
- ☐ Suicide
- ☐ Accidental
- ☐ Homicide of Resident
- ☐ Natural

- ☐ Homicide by Resident
- ☐ Suicide Attempt

Seclusion or Restraint Death
- ☐ Death during seclusion or restraint
- ☐ Death within twenty-four hours of seclusion or restraint
- ☐ Death related to or the result of seclusion or restraint

- ☐ Involuntary Termination of Treatment by Facility without Appropriate Resident Involvement, i.e., without informing resident, providing a reason, and offering a referral

Medication: (resulting in permanent resident harm, hospitalization, or death)
- ☐ Error
- ☐ Adverse Drug Reaction

- ☐ Medical Events Impacting Facility Operations

Seclusion or Restraint Related Injury to Resident:
- ☐ Injury requiring first aid
- ☐ Injury requiring emergency/unplanned medical intervention
- ☐ Injury requiring hospitalization

Theft of Medication:
- ☐ Employee
- ☐ Resident
- ☐ Other/Unknown

Inappropriate Use of Seclusion or Restraint
- ☐ Seclusion
- ☐ Mechanical Restraint
- ☐ Physical Restraint, including Transitional Hold

- ☐ Sexual Assault by Non-Staff, Including Visitor, Resident, or Other (i.e., rape, sexual battery, etc.)

- ☐ Physical Assault Injury by Non-Staff, including Visitor, Resident, or Other when Emergency/Unplanned Medical Intervention or Hospitalization is required

- ☐ Self-Injurious Behavior when Emergency/Unplanned Medical Intervention or Hospitalization is required

Temporary Relocation of Some or All Residents to another unit, facility or location for a Minimum Period of One Night Due To:
- ☐ Fire
- ☐ Failure/Malfunction (Gas leak, power outage, equipment failure etc.)
- ☐ Disaster (Flood, tornado, explosion, excluding snow/ice)
- ☐ Other, (please specify) _____

Inappropriate Restraint Technique and Other Use of Force (Prohibited in OAC 5122-26-16(D)(2))
- ☐ Any technique that obstructs the airway or impairs breathing
- ☐ Any technique that restricts the residents ability to communicate
- ☐ Behavior management interventions that employ unpleasant or aversive stimuli
- ☐ Use of mechanical restraint on a resident under age 18
- ☐ A drug or medication that is used as a restraint and is not a standard treatment or dosage
- ☐ Any technique that obstructs vision
- ☐ The use of handcuffs or weapons including pepper spray, mace, nightstick, stun guns, taser

In regard to the selected incident, was seclusion or restraint (as defined in OAC 5122-26-16) used and/or involved? ☐ Yes ☐ No

If yes, select all that apply.
- ☐ Seclusion - ____ total minutes this episode
- ☐ Physical Restraint - ____ total minutes this episode
- ☐ Mechanical Restraint - ____ total minutes this episode
- ☐ Involuntary Emergency Medications

Use of seclusion or restraint without prior notification
- ☐ Seclusion
- ☐ Mechanic Restraint
- ☐ Physical Restraint including Transitional Hold

Ohio Department of Mental Health and Addiction Services
Class One: Residential Facility Notification of Incident
Licensure and Certification

Provider Generated Incident No.:	License Number:

Persons Involved In The Incident

Race/Ethnicity Codes
A = Asian B = Black/African American H = Hispanic I = Alaskan Native M = Bi/Multiracial N = Native Am./Am.Indian
P = Native Hawaiian/Other Pacific Islander W = White U = Unknown

Resident(s) Involved/HIPAA Identifer (Please No Resident Names)	Age	Gender: F = Female M = Male	Race (see codes above)	P = Perpetrator V = Victim

Other(s) Involved (Initials or Facility Identifer - No names please):	S = Staff V = Visitor O = Other	P = Perpetrator V = Victim

Additional Information (No Names Please):

Please submit form to OhioMHAS
614-485-9737 (Fax)
Community Client Safety Manager, 30 E Broad Street, 7th Floor, Columbus, OH 43215 (Mail)
IncidentReport@mha.ohio.gov (E-Mail)

This information is subject to a public record request

Definitions:
(1) "Emergency/Unplanned Medical Intervention" means treatment required to be performed by a licensed medical doctor, osteopath, podiatrist, dentist, physician's assistant, or certified nurse practitioner, but the treatment required is not serious enough to warrant or require hospitalization. It includes sutures, staples, immobilization devices and other treatments not listed under "First Aid", regardless of whether the treatment is provided in the agency, or at a doctor's office/clinic/hospital ER, etc. This does not include routine medical care of shots/immunizations, as well as diagnostic tests, such as laboratory work, x-rays, scans, etc., if no medical treatment is provided.
(2) "First Aid" means treatment for an injury such as cleaning of an abrasion/wound with or without the application of a Band-aid, application of a butterfly bandage/Steri-Strpis, application of an ice/heat pack for a bruise, application of a finger guard, non-rigid support such as a soft wrap or elastic bandage, drilling a nail or draining a blister, removal of a splinter, removal of a foreign body from the eye using only irrigation or swab, massage, drinking fluids for relief of heat stress, eye patch, and use of over-the-counter medications such as antibiotic creams, aspirin and acetaminophen. These treatments are considered first aid, even if applied by a physician. These treatments are not considered first aid if provided at the request of the client and/or to provide comfort without a corresponding injury.
(3) "Hospitalization" means inpatient treatment provided at a medical acute care hospital, regardless of the length of stay. Hospitalization does not include treatment when the individual is treated in and triaged through the emergency room with a discharge disposition to return to the community, or admission to psychiatric unit.
(4) "Injury" means an event requiring medical treatment that is not caused by a physical illness or medical emergency. It does not include scrapes, cuts or bruises which do not require medical treatment.
(5) "Sexual Conduct" means as defined by Section 2907.01 of the Ohio Revised Code, vaginal intercourse between a male and female; anal intercourse, fellatio, and cunnilingus between persons regardless of sex; and, without privilege to do so, the insertion, however slight, of any part of the body or any instrument, apparatus, or other object into the vaginal or anal opening of another. Penetration, however slight, is sufficient to complete vaginal or anal intercourse.
(6) "Sexual Contact" means as defined by Section 2907.01 of the Ohio Revised Code, any touching of an erogenous zone of another, including without limitation the thigh, genitals, buttock, pubic region, or, if the person is a female, a breast, for the purpose of sexually arousing or gratifying either person.

To review all definitions of reportable incidents:
http://codes.ohio.gov/oac/5122-30-03v1

Ohio Department of Mental Health and Addiction Services
Community Mental Health/Alcohol and Other Drug Provider Notification of Incident
Licensure and Certification

Provider Generated Incident No.:	Date Submitted to OhioMHAS:	Date of Discovery:	Date of Incident:	Time of Incident:

Provider Name: | Certification Number:

Provider Address (street, city, state, zip):

Name of Provider Contact: | Phone Number: | Email Address:

Name of Person Completing Report, if different than Provider Contact:

Notifications Made:
- ☐ ADAMH/CMH Board (list names): _____
- ☐ Children Services Board ☐ OhioMHAS ☐ Other: _____
- ☐ Family/Guardian ☐ Other Protective Agency

Type of Incident (check all that apply)

Abuse and Neglect by Staff (including allegations):
- ☐ Physical ☐ Sexual
- ☐ Neglect ☐ Defraud

Death of Client:
- ☐ Suicide
- ☐ Accidental and on grounds or during the provision of care or treatment
- ☐ Homicide by Client

Seclusion or Restraint Death
- ☐ Death during seclusion or restraint
- ☐ Death within twenty-four hours of seclusion or restraint
- ☐ Death related to or result of seclusion or restraint

☐ Involuntary Termination of Treatment by Provider without Appropriate Client Involvement, i.e., without informing client, providing a reason, and offering a referral

Medication (resulting in permanent client harm, hospitalization, or death)
- ☐ Error ☐ Adverse Drug Reaction

☐ Medical Events Impacting Agency Operations

Seclusion or Restraint Related Injury to Client
- ☐ Injury requiring first aid
- ☐ Injury requiring emergency/unplanned medical intervention
- ☐ Injury requiring hospitalization

☐ Employee Theft of Medication

☐ Use of Seclusion/Restraint by a Provider without Prior Notification that the Provider Permits the use of Seclusion or Restraint

Inappropriate Use of Seclusion or Restraint
- ☐ Seclusion ☐ Physical Restraint
- ☐ Mechanical Restraint ☐ Transitional Hold

☐ Sexual Assault by Non-Staff, Including Visitor, Client, or Other (rape, sexual battery, etc.)

☐ Physical Assault Injury by Non-Staff, including Visitor, Client, or Other when Emergency/Unplanned Medical Intervention or Hospitalization is required

Temporary Closure of One or More Provider Sites for more than seven consecutive calendar days:
- ☐ Fire
- ☐ Natural Disaster (Flood, explosion, excluding snow/ice)
- ☐ Failure/Malfunction (Gas leak, power outage, etc.)
- ☐ Other, (please specify) _____

Inappropriate Use of Restraint Technique or Other Use of Force (Prohibited in OAC 5122-26-16(D)(2))
- ☐ Behavior management interventions that employ unpleasant or aversive stimuli
- ☐ Any technique that restricts communication
- ☐ Any technique that obstructs vision
- ☐ Any technique that obstructs the airway or impairs breathing
- ☐ A drug or medication that is used as a restraint and is not a standard treatment or dosage
- ☐ The use of handcuffs or weapons
- ☐ Use of mechanical restraint on a client under age 18

In regard to the selected incident, was seclusion or restraint (as defined in OAC 5122-26-16) used and/or involved? ☐ Yes ☐ No
If yes, select all that apply.
- ☐ Seclusion - total min. this episode _____ minutes
- ☐ Physical Restraint - total min. this episode _____ minutes
- ☐ Mechanical Restraint - total min. this episode _____ minutes
- ☐ Involuntary Emergency Medications

Mental Health and Recovery Services ' l of Allen, Auglaize and Hardin Counties
Subsidy Scale

Sliding Fee Scale based on FPG
Updated: 7/1/2018

Co-Pay %		0%	U	10%	B	25%	E	40%	H	60%	L	80%	P	100%	T	Annual
								Monthly Incomes								
Family/ Household Size	100% Federal Poverty	From	Thru	From	Thru	From	Thru	From	Thru	From	Thru	From	Thru	From		
1	$ 1,005	0	$ 2,010	$ 2,010	$ 2,312	$ 2,312	$ 2,613	$ 2,613	$ 2,915	$ 2,915	$ 3,216	$ 3,216	$ 3,518	$ 3,519		$ 20,037
2	$ 1,354	0	$ 2,708	$ 2,708	$ 3,114	$ 3,114	$ 3,520	$ 3,520	$ 3,927	$ 3,927	$ 4,333	$ 4,333	$ 4,739	$ 4,740		$ 26,956
3	$ 1,702	0	$ 3,404	$ 3,404	$ 3,915	$ 3,915	$ 4,425	$ 4,425	$ 4,936	$ 4,936	$ 5,446	$ 5,446	$ 5,957	$ 5,958		$ 33,875
4	$ 2,050	0	$ 4,100	$ 4,100	$ 4,715	$ 4,715	$ 5,330	$ 5,330	$ 5,945	$ 5,945	$ 6,560	$ 6,560	$ 7,175	$ 7,176		$ 40,794
5	$ 2,399	0	$ 4,798	$ 4,798	$ 5,518	$ 5,518	$ 6,237	$ 6,237	$ 6,957	$ 6,957	$ 7,677	$ 7,677	$ 8,397	$ 8,398		$ 47,713
6	$ 2,747	0	$ 5,494	$ 5,494	$ 6,318	$ 6,318	$ 7,142	$ 7,142	$ 7,966	$ 7,966	$ 8,790	$ 8,790	$ 9,615	$ 9,616		$ 54,632
7	$ 3,095	0	$ 6,190	$ 6,190	$ 7,119	$ 7,119	$ 8,047	$ 8,047	$ 8,976	$ 8,976	$ 9,904	$ 9,904	$ 10,833	$ 10,834		$ 61,551
8	$ 3,444	0	$ 6,888	$ 6,888	$ 7,921	$ 7,921	$ 8,954	$ 8,954	$ 9,988	$ 9,988	$ 11,021	$ 11,021	$ 12,054	$ 12,055		$ 68,470
9	$ 3,792	0	$ 7,584	$ 7,584	$ 8,722	$ 8,722	$ 9,859	$ 9,859	$ 10,997	$ 10,997	$ 12,134	$ 12,134	$ 13,272	$ 13,273		$ 75,389
10	$ 4,140	0	$ 8,280	$ 8,280	$ 9,522	$ 9,522	$ 10,764	$ 10,764	$ 12,006	$ 12,006	$ 13,248	$ 13,248	$ 14,490	$ 14,491		$ 82,308
Calculations are based on these percents of the Federal Poverty Guidelines.		0 - 200%		201% - 230%		231% - 260%		261% - 290%		291% - 320%		321% - 350%		351% Above		

Co-Pay %		0%	U	10%	B	25%	E	40%	H	60%	L	80%	P	100%	T	
								Annual Income								
Family/ Household Size	100% Federal Poverty	From	Thru	From	Thru	From	Thru	From	Thru	From	Thru	From	Thru	From		
1	$ 12,060	0	$ 24,120	$ 24,121	$ 27,738	$ 27,739	$ 31,356	$ 31,357	$ 34,974	$ 34,975	$ 38,592	$ 38,593	$ 42,210	$ 42,211		
2	$ 16,248	0	$ 32,496	$ 32,497	$ 37,370	$ 37,371	$ 42,245	$ 42,246	$ 47,119	$ 47,120	$ 51,994	$ 51,995	$ 56,868	$ 56,869		
3	$ 20,424	0	$ 40,848	$ 40,849	$ 46,975	$ 46,976	$ 53,102	$ 53,103	$ 59,230	$ 59,231	$ 65,357	$ 65,358	$ 71,484	$ 71,485		
4	$ 24,600	0	$ 49,200	$ 49,201	$ 56,580	$ 56,581	$ 63,960	$ 63,961	$ 71,340	$ 71,341	$ 78,720	$ 78,721	$ 86,100	$ 86,101		
5	$ 28,788	0	$ 57,576	$ 57,577	$ 66,212	$ 66,213	$ 74,849	$ 74,850	$ 83,485	$ 83,486	$ 92,122	$ 92,123	$ 100,758	$ 100,759		
6	$ 32,964	0	$ 65,928	$ 65,929	$ 75,817	$ 75,818	$ 85,706	$ 85,707	$ 95,596	$ 95,597	$ 105,485	$ 105,486	$ 115,374	$ 115,375		
7	$ 37,140	0	$ 74,280	$ 74,281	$ 85,422	$ 85,423	$ 96,564	$ 96,565	$ 107,706	$ 107,707	$ 118,848	$ 118,849	$ 129,990	$ 129,991		
8	$ 41,328	0	$ 82,656	$ 82,657	$ 95,054	$ 95,055	$ 107,453	$ 107,454	$ 119,851	$ 119,852	$ 132,250	$ 132,251	$ 144,648	$ 144,649		
9	$ 45,504	0	$ 91,008	$ 91,009	$ 104,659	$ 104,660	$ 118,310	$ 118,311	$ 131,962	$ 131,963	$ 145,613	$ 145,614	$ 159,264	$ 159,265		
10	$ 49,680	0	$ 99,360	$ 99,361	$ 114,264	$ 114,265	$ 129,168	$ 129,169	$ 144,072	$ 144,073	$ 158,976	$ 158,977	$ 173,880	$ 173,881		

Co-Pay applies to following services only:

Mental Health:	**Alcohol and Drug:**
Pharmacological Management	Ambulatory Detoxification
Mental Health Assessment (Non-Physician)	Assessment
Mental Health Assessment (Physician)	Group Counseling
Individual Counseling	Individual Counseling
Group Counseling	Intensive Outpatient
	Medical/Somatic

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 primary criterion for what constitutes a specialized residential program or facility shall be that it is subject to licensure (or some comparable certification).

a. 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..
b. 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.
c. 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.
d. 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.
e. 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.
f. 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:

. "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.

a. 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.

   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.

a. 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:
    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.
    a. 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).
    b. 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.
    c. 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.
    d. 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.
    e. 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:
    Ultimate responsibility for resolving residency disputes shall rest with OhioMHAS, whose decisions shall be binding.
    a. 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.

b. Boards are expected to work out routine questions of residency among themselves without resorting to an official dispute resolution process.

c. 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.

d. 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.

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.)

APPENDIX II
SUMMARY OF O.M.B. CIRCULAR A-122

"Cost Principles for Non-Profit Organizations

A. Basic Considerations - To be allowable, costs must meet the following general criteria:
   1. Costs must be reasonable:
      a. Recognized as ordinary and necessary.
      b. Arms length transactions.
      c. Individuals concerned acted with prudence.
      d. Not deviating from established practices of the organization.

   2. Costs must be allocated to the grant, project, etc. In accordance with benefits received:
      a. Incurred specifically for the award.
      b. Benefits both award and other work can be reasonably distributed in proportion to benefits received.
      c. Necessary to overall operation - if no direct relationship to award can be shown.

B. Direct Costs
   1. Can be identified specifically with a particular grant, award, project, etc.
   2. Direct costs of minor amounts may be treated as indirect.
   3. Unallowable costs may be treated as direct costs for computation of overhead rates.

C. Indirect Costs
   1. Costs that have been incurred for common objectives but cannot be readily identified with a particular grant. *Only applicable with a HUD certified cost allocation plan.*

D. Allocation of Indirect Costs
   1. Simplified Method
      a. Used when major functions benefit from indirect costs to approximately the same degree.
      b. Distribution base may be total direct costs, direct salaries or other equitable distribution base.
   2. Multiple allocation base method:
      a. Used when major functions benefit in varying degrees from indirect costs.
      b. Costs separated into distinct groupings. Each grouping then allocated to benefiting functions by means of base which best measures relative results.

E. Selected Items of Cost
   1. Advertising - only advertising costs allowable are those associated with:
      a. Recruitment of personnel.
      b. Procurement of goods.
      c. Disposal of surplus materials.
   2. Bad debts - unallowable.
   3. Bonding costs - allowable.
   4. Communication costs - allowable.
   5. Compensation for personal services:
      a. Includes salaries, wages, director's and executive committee fees, incentive awards, fringe benefits, pension plan costs, location allowances and cost of, living differentials.
      b. Allowable provided they are reasonable.

c. May be direct or indirect. Fringe benefits in the form of vacation, sick pay, holidays, and authorized absences are allowable provided they are absorbed by all organization activities in proportion to relative time or effort devoted to each.
d. Fringe benefits in the form of social security, employee insurance, workman's compensation insurance, etc. Are allowable provided they are distributed in accordance with salaries and wages chargeable to particular awards and activities.
e. Charges to award for salaries and wages must be supported by documented, approved payroll records:
    i. Distribution must be supported by personnel activity reports (time sheets).
    ii. Time sheets must be maintained by all personnel whose compensation in whole, or in part, is charged to government awards.
    iii. Time sheets must reflect after-the-fact determination of actual activity of each employee.
    iv. Each time sheet must account for employees total time.
    v. Time sheets must indicate total number of hours worked each day.
    vi. Time sheets must be signed by employee and approved by supervisor.
    vii. Time sheets must be prepared at least monthly.

6. Contingency reserves - unallowable
7. Contributions - unallowable
8. Depreciation - allowable
9. Donated services:
    a. Not reimbursable.
    b. May be used in overhead computations in allocating indirect costs.
10. Employee morale, health, and welfare costs - allowable as indirect cost.
11. Entertainment costs - unallowable.
12. Equipment and other capital expenditures:
    Equipment - Personal property with a useful life of more than 1 year costing $5,000 or more per unit.
        a. Special purpose equipment - usable only for research, medical, scientific or technical activities - allowable as direct cost with prior approval of items costing over $5,000.
13. General purpose equipment – usable for other purposes
14. Depreciation allowable as indirect costs.
        a. Land, buildings or improvements.
            i. Unallowable as direct costs.
15. Fines and penalties - unallowable.
16. Idle facilities and idle capacity - unallowable.
17. Insurance and indemnification - allowable.
18. Labor relations costs - allowable
19. Losses on other awards - unallowable
20. Maintenance and repair costs - allowable
21. Materials and supplies - allowable
22. Meeting, conferences - allowable provided they do not involve entertainment costs
23. Membership, subscriptions and professional activity costs- allowable
24. Organization costs (incorporation fees, attorneys, accountants etc. in connection with establishment or reorganization of organization) - allowable
25. Overtime, premium pay - allowable as direct costs with prior approval.
26. Page charges in professional journals - (e-mail publications) - allowable
27. Participant support costs - allowable as direct costs with prior approval

28. Plant security costs - allowable.
29. Professional Service costs - allowable when reasonable in relation to services and not contingent upon recovery from government. In determining allowability, certain factors are relevant:
    a. Nature and scope of service in relation to service required.
    b. Necessity of contracting for service vs. Organization's own capability.
    c. Past patterns.
    d. Impact of government awards.
    e. Does proportion of government work to total organization work, justify incurring cost.
    f. Can service be performed more economically by hiring employee.
    g. Qualifications of individual performing service.
    h. Adequacy of contractual agreement.
    i. Retainer fees must be supported by evidence of services available.
30. Public information service costs - (pamphlets, new releases and other forms of disseminating information):
    a. Allowable as direct costs, if educational, or
    b. Allowable as indirect costs.
31. Publication and printing costs:
    a. Allowable as direct costs, if educational, or
    b. Allowable as indirect costs.
32. Rearrangement and alteration costs - allowable with prior approval.
33. Reconversion costs - (restoration or rehabilitation cost) - allowable with prior approval.
34. Recruiting costs - allowable.
35. Rental costs - allowable within certain limitations.
36. Royalties and other costs for user of patents and copyrights - allowable.
37. Severance Pay - allowable to the extent required by :
    a. Law
    b. Employer-employee agreement
    c. Established policy
    d. Circumstances of particular employment
38. Specialized service facilities - allowable within certain limitations.
39. Taxes - allowable unless exemptions from taxes are available.
40. Termination costs - (costs in connection with termination of award):
    a. For common items reasonably usable on organization's other work - allowable.
    b. Cost continuing after termination - allowable only if cannot be discontinued despite all reasonable efforts.
    c. Loss of value of special tooling etc. - allowable.
    d. Rental costs - (unexpired leases) - allowable
    e. Settlement expenses - generally allowable
41. Training and education costs - allowable
42. Travel costs:
    a. Airline travel allowable except first-class.

Request for Financial Assistance

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, that 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: _____

Patient or Applicant Name: _____

Address: _____ City: _____

Zip: _____ Home Phone Number: _____ Cell Phone Number _____

Gender: _____ Ethnicity: _____

THE FOLLOWING QUESTIONS MUST BE COMPLETED FOR FINANCIAL ASSISTANCE CONSIDERATION

1. **Were you an Ohio Resident at the time of your Hospital Services?** Yes ___ No ____
   a) If "NO", what state did you reside? _____
2. **Have you applied for Medicaid or other county assistance?** Yes ____ No _____
   a) If "YES" what date did you turn in application? _____
   b) If "YES" did you apply for Medicaid in a state other than Ohio? Yes ____ No _____
   If "YES", what state did you apply for coverage? _____
3. **Did you have Health Insurance Coverage(s) on the date of services?** 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 authorization being requested:

DA _____	MAT _____	High Deductible _____
Out Patient Treatment _____	Emergency _____	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	TOTAL 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 TOTAL INCOME AFTER TAXES ARE TAKEN OUT, AND INCLUDES BUT IS NOT LIMITED TO:
Employment Wages or Salaries (send 3 Months of Pay stubs) * Unemployment * Alimony * VA Benefits * Social Security (Before deductions) or award letter * Child Support * Pension or retirement * 401K * Workers Compensation award letter * any other income * if you are reporting zero income you must complete the support statement below to be considered for financial assistance * proof of checking/savings (or other assets) may be requested * food stamps are not counted as income buy should be listed on "Support Statement" line below

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

CERTIFICATION: BY SIGNING THIS DOCUMENT, I AFFIRM THE ANSERS 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 BOARD:

Request Approved Request Denied

Signature of MHRSB Director or Designee _____

Date of Approval _____

AGENCY SUMMARY REPORT

Board: _____
Agency: _____
Date of Review (mm/dd/yyyy): _____
Total Records Reviewed: _____

MEDICAL NECESSITY DOCUMENTATION REVIEW SUMMARY

Number Required	Number of Yes	Percent of Yes	Number of No	Percent of No

1. *Description of the client's symptoms:*
   Description of symptoms is in the record
   Quality Improvement indicated

2. *Description of the client's condition/functioning:*
   Description of condition/functioning is contained in the record
   Quality Improvement indicated

3. *Least restrictive setting:*
   Documentation contains consideration of a least restrictive setting appropriate to the needs of the client
   Quality Improvement indicated

4. *Diagnosis codes:*
   Documentation contains DSM IV or ICD-9 or their successor diagnosis code(s)
   Quality Improvement indicated

5. *ISP addresses the client's symptoms:*
   ISP addresses the client's symptoms
   Quality Improvement indicated

6. *Documentation of intervention(s) for each service goal:*
   Record contains documentation of interventions for each service goal
   Quality Improvement indicated

Exhibit 8

Number Required	Number of Yes	Percent of Yes	Number of No	Percent of No

7. *Documented outcomes for service goal(s):*
   The record contains stated outcome(s) for service goal(s)
   Quality Improvement indicated

8. *Client participation in the development of the ISP:*
   The client record contains at least one of the following:
   a) client/authorized person's signature on ISP indicating participation in development of the ISP, or
   b) progress notes indicating client/authorized person's participation in development of the ISP, or
   c) explanation of why client/authorized person did not participate in development of the ISP.
   Quality improvement indicated

9. *Service interventions for children/adolescents:*
   Service interventions addressing the identified developmental needs for children and adolescents, as specified in the ISP, are documented
   Quality Improvement indicated

10. *Involvement of family for children/adolescents:*
    Record contains documentation of family involvement for children/adolescents when ISP describes need for family involvement, or there is a description of why the family is not participating as expected
    Quality improvement indicated

AGENCY SUMMARY REPORT

INDIVIDUALIZED SERVICE PLAN REVIEW SUMMARY

Number Required	# Not Compliant	Percent Compliant

1. The ISP must be completed within five sessions or one month of admission, whichever is longer.
2. ISP contains specific services being provided.
3. The signature(s) of the agency staff member(s) responsible for developing or reviewing the ISP (whichever is appropriate for the review period), and the date on which it was developed or reviewed. (Unless the staff person qualifies as a supervisor, a supervisor signature is required for Medicaid.)
4. Documentation of the ISP review to reflect progress toward desired goals and updated at least every 90 days.
5. Evidence that the person served was involved in developing the ISP or periodic ISP review, whichever is appropriate for the testing period. (Documented refusal or inability will be marked as "Yes.")
6. Evidence that, as appropriate, family, parent, guardian, or significant other was involved in the ISP development or review, whichever is appropriate for the review period. (Documented refusal or inablility will be marked as "Yes.")

ISP Review Checklist

1. The treatment plan must be completed within five sessions or one month of admission; whichever is longer. **(Claims should be marked "ISP noncompliant" from due date until ISP was completed.)**

___ Yes ___ No ___ N/A

Comments: _____

2. Name(s) and/or description of all services being provided. Such service(s) shall be linked to a specific mental health need and treatment outcome.

___ Yes ___ No ___ N/A

Comments: _____

3. The signature(s) of the agency staff member(s) responsible for developing or reviewing the treatment plan (whichever is appropriate for the review period), and the date on which it was developed or reviewed. (Unless the staff person qualifies as a supervisor, a supervisor signature is required for Medicaid.)

___ Yes ___ No ___ N/A

Comments: _____

4. Documentation of the results of a periodic treatment plan review must occur at least annually.

___ Yes ___ No ___ N/A

Comments: _____

5. Evidence of the active participation of the person served in the periodic treatment plan review, the inability to participate, or refusal of the person served to participate and the reason(s) given.

___ Yes ___ No ___ N/A

Comments: _____

6. Evidence of the active participation of family members, legal guardian/custodian, and significant others, as appropriate, in the treatment plan development or in the plan review (whichever is appropriate for the review period).

___ Yes ___ No ___ N/A

Comments: _____

Section A

Determination for the Recovery of Funds

PLEASE CHECK ONLY ONE RESPONSE FOR EACH ELEMENT

1. Description of the client's symptoms:

   ☐ Description of symptoms is in the record

   ☐ **No** description of symptoms is contained in the record

2. Description of the client's condition/functioning:

   ☐ Description of condition/functioning is contained in the record

   ☐ **No** description of condition/functioning is contained in the record

3. Least restrictive setting:

   ☐ Documentation contains consideration of a least restrictive setting appropriate to the needs of the client

   ☐ Documentation contains **no** reference to consideration of a least restrictive setting

   Note: This category applies only to clients residing in facilities where mental health care is provided, and recovery of funds only applies to Medicaid services provided at the residential site.

4. Diagnoses codes:

   ☐ Documentation contains DSM IV or ICD-9, or their successor, diagnosis code(s)

   ☐ Documentation does **not** contain DSM IV or ICD-9, or their successor, diagnosis code(s)

5. ISP addresses the client's symptoms:

   ☐ ISP addresses the client's symptoms

   ☐ ISP does **not** address the client's symptoms

6. Documentation of intervention(s) for each service goal:

   ☐ The record contains documentation of interventions for each service goal

   ☐ The record does **not** contain documentation of interventions for each service goal

7. Documented outcomes for service goals:

   ☐ The record contains stated outcome(s) for service goal(s)

   ☐ The record does **not** state outcome(s) for service goal(s)

8. Client participation in the development of the ISP:

   ☐ The record contains at least one of the following:

   1) Client, or other authorized person's, signature on ISP indicating participation in development of ISP, or 2) progress notes indicating client, or other authorized person's, participation in development of ISP, or 3) an explanation of why the client or other authorized person did not participate in development of ISP

   ☐ The record does **not** contain at least one of the following:

   1) Client, or other authorized person's, signature on ISP indicating participation in development of ISP, or 2) progress notes indicating client, or other authorized person's, participation in development of ISP, or 3) an explanation of why the client or other authorized person did not participate in development of ISP

9. Service interventions for children and adolescents:

☐ Service interventions addressing the identified developmental needs for children and adolescents, as specified in ISP, are documented

☐ Service interventions addressing the identified developmental needs for children and adolescents, as specified in ISP, are **not** documented

10. Involvement of family for children and adolescents:

☐ Record contains documentation that the family has been involved for children and adolescents when ISP describes need for family involvement, or there is a description as to why the family is not participating as expected.

☐ Record does **not** contain documentation that the family has been involved for children and adolescents when the ISP describes need for family involvement, or there is no description as to why the family is not participating as expected.

Section B

Quality Improvement

1. Description of the client's symptoms:

   ☐ Description of symptoms is contained in the record, but quality improvement is indicated.

Comments:

2. Description of the client's condition/functioning:

   ☐ Description of condition/functioning is contained in the record, but quality improvement is indicated.

Comments:

3. Least restrictive setting:

   ☐ Documentation contains consideration of a least restrictive setting appropriate to the needs of the client, but quality improvement is indicated.

   Note: This category applies only to clients residing in facilities where mental health care is provided, and recovery of funds only applies to Medicaid services provided at the residential site.

Comments:

4. Diagnoses codes:

☐ Documentation contains DSM IV or ICD-9, or their successor, diagnosis code(s), but quality improvement is indicated.

Comments:

5. ISP addresses the client's symptoms:

☐ ISP addresses the client's symptoms, but quality improvement is indicated.

Comments:

6. Documentation of intervention(s) for each service goal:

☐ The record contains documentation of interventions for each service goal, but quality improvement is indicated.

Comments:

7. Documented outcomes for service goals:

☐ The record contains stated outcome(s) for service goal(s), but quality improvement is indicated.

Comments:

8. Client participation in the development of the ISP:

☐ The record contains at least one of the following, but quality improvement is indicated:

1) Client, or other authorized person's, signature on ISP indicating participation in development of ISP, or 2) progress notes indicating client, or other authorized person's, participation in development of ISP, or 3) an explanation of why the client or other authorized person did not participate in development of ISP

Comments:

9. Service interventions for children and adolescents:

☐ Service interventions addressing the identified developmental needs for children and adolescents, as specified in ISP, are documented, but quality improvement is indicated.

Comments:

10. Involvement of family for children and adolescents:

☐ Record contains documentation that the family has been involved for children and adolescents when the ISP describes need for family involvement, or there is no description as to why the family is not participating as expected, but quality improvement is indicated.

Comments:

5122:2-1-02 Client rights and grievance procedures.

Exhibit 9

(A) The purpose of this rule is to protect and enhance the rights of persons applying for or receiving mental health services by establishing specific rights of clients and procedures for responsive and impartial resolution of client grievances.

(B) The provisions of this rule are applicable to each contract agency and community mental health board.

(C) Definitions

(1) "Client" means an individual applying for or receiving mental health services from a board or mental health agency.

(2) "Client rights officer" means the individual designated by a mental health agency or board with responsibility for assuring compliance with the client rights and grievance procedure rule as implemented within each agency or board. For these purposes the individual holds the specific title of client rights officer.

(3) "Contract agency" means a public or private service provider with which a community mental health board enters into a contract for the delivery of mental health services. A board which is itself providing mental health services is subject to the same requirements and standards which are applicable to contract agencies, as specified in rule 5122:2-1-05 of the Administrative Code.

(4) "Grievance" means a written complaint initiated either verbally or in writing by a client or by any other person or agency on behalf of a client regarding denial or abuse of any client's rights.

(5) "Mental health services" means any of the services, programs, or activities named and defined in rule 5122:2-1-01 of the Administrative Code. Mental health services include both direct client services and community services. Direct client services are listed and defined in paragraphs (D)(1) to (D)(10) of rule 5122:2-1-01 of the Administrative Code. Community services are listed and defined in paragraphs (D)(11) to (D)(15) of rule 5122:2-1-01 of the Administrative Code.

(D) Client rights. Except for clients receiving forensic evaluation service as defined in paragraph (D)(9) of rule 5122:2-1-01 of the Administrative Code, from a certified forensic center, each client has all of the following rights as listed in paragraphs (D)(1) to (D)(22) of this rule. Rights of clients receiving only a forensic evaluation service from a certified forensic center are specified in paragraph (E) of this rule.

(1) The right to be treated with consideration and respect for personal dignity, autonomy, and privacy;

(2) The right to service in a humane setting which is the least restrictive feasible as defined in the treatment plan;

(3) The right to be informed of one's own condition, of proposed or current services, treatment or therapies, and of the alternatives;

(4) The right to consent to or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal. A parent or legal guardian may consent to or refuse any service, treatment or therapy on behalf of a minor client;

(5) The right to a current, written, individualized service plan that addresses one's own mental health, physical health, social and economic needs, and that specifies the provision of appropriate and adequate services, as available, either directly or by referral;

(6) The right to active and informed participation in the establishment, periodic review, and reassessment of the service plan;

(7) The right to freedom from unnecessary or excessive medication;

(8) The right to freedom from unnecessary restraint or seclusion;

(9) The right to participate in any appropriate and available agency service, regardless of refusal of one or more other services, treatments, or therapies, or regardless of relapse from earlier treatment in that or another service, unless there is a valid and specific necessity which excludes and/or requires the client's participation in other services. This necessity shall be explained to the client and written in the client's current service plan;

(10) The right to be informed of and refuse any unusual or hazardous treatment procedures;

(11) The right to be advised of and refuse observation by techniques such as one-way vision mirrors, tape recorders, televisions, movies, or photographs;

(12) The right to have the opportunity to consult with independent treatment specialists or legal counsel, at one's own expense;

(13) The right to confidentiality of communications and of all personally identifying information within the limitations and requirements for disclosure of various funding and/or certifying sources, state or federal statutes, unless release of information is specifically authorized by the ent or parent or legal guardian of a minor client or court-appointed guardian of the person of an adult client in accordance with rule 5122:2-3-11 of the Administrative Code;

(14) The right to have access to one's own psychiatric, medical or other treatment records, unless access to particular identified items of information is specifically restricted for that individual client for clear treatment reasons in the client's treatment plan. "Clear treatment reasons" shall be understood to mean only severe emotional damage to the client such that dangerous or self-injurious behavior is an imminent risk. The person restricting the information shall explain to the client and other persons authorized by the client the factual information about the individual client that necessitates the restriction. The restriction must be renewed at least annually to retain validity. Any person authorized by the client has unrestricted access to all information. Clients shall be informed in writing of agency policies and procedures for viewing or obtaining copies of personal records;

(15) The right to be informed in advance of the reason(s) for discontinuance of service provision, and to be involved in planning for the consequences of that event;

(16) The right to receive an explanation of the reasons for denial of service;

(17) The right not to be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, lifestyle, physical or mental handicap, developmental disability, or inability to pay;

(18) The right to know the cost of services;

(19) The right to be fully informed of all rights;

(20) The right to exercise any and all rights without reprisal in any form including continued and uncompromised access to service;

(21) The right to file a grievance; and

(22) The right to have oral and written instructions for filing a grievance.

(E) Client rights. Each client receiving a forensic evaluation service from a certified forensic center has the rights specified in paragraphs (E)(1) to (E)(12) of this rule.

(1) The right to be treated with consideration and respect for personal dignity;

(2) The right to be evaluated in a physical environment affording as much privacy as feasible;

(3) The right to service in a humane setting which is the least restrictive feasible if such setting is under the control of the forensic center;

(4) The right to be informed of the purpose and procedures of the evaluation service;

(5) The right to consent to or refuse the forensic evaluation services and to be informed of the probable consequences of refusal;

(6) The right to freedom from unnecessary restraint or seclusion if such restraint or seclusion is within the control of the forensic center;

(7) The right to be advised of and refuse observation by techniques such as one-way vision mirrors, tape recordings, televisions, movies, or photographs, unless ordered by the court, in which case the client must be informed of such technique;

(8) The right not to be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, lifestyle, physical or mental handicap, developmental disability, or inability to pay;

(9) The right to be fully informed of all rights;

(10) The right to exercise any and all rights without reprisal in any form;

(11) The right to file a grievance;

(12) The right to have oral and written instructions for filing a grievance including an explanation that the filing of a grievance is exclusively an administrative proceeding within the mental health system and will not affect or delay the outcome of the criminal charges.

(F) Client rights procedures

(1) Each agency and each board which itself provides mental health services must have a written client rights policy which contains the following:

(a) Specification of the client rights as listed in paragraphs (D)(1) to (D)(22) and/or (E)(1) to (E)(12) of this rule;

(b) The name, title, location, hours of availability, and telephone number of the client rights officer with a statement of that person's responsibility to accept and oversee the process of any grievance filed by a client or other person or agency on behalf of a client; and

(c) Assurance that staff will explain any and all aspects of client rights and the grievance procedure upon request.

(2) A copy of the client rights policy must be distributed to each applicant or client at the intake or next subsequent appointment in writing and orally. Each agency policy shall specify how distribution shall be accomplished, and shall include:

(a) Provision that in a crisis or emergency situation, the client or applicant shall be verbally advised of at least the immediately pertinent rights, such as the right to consent to or to refuse the offered treatment and the consequences of that agreement or refusal. Written copy and full verbal explanation of the client rights policy may be delayed to a subsequent meeting; and

(b) Provision that clients or recipients of the type of mental health services specified as "community services" (information and referral service, consultation service, mental health education service, prevention service, training service; see paragraphs (D)(11) to (D)(15) of rule 5122:2-1-01 of the Administrative Code) may have a copy and explanation of the client rights policy upon request.

, A copy of the client rights policy shall be posted in a conspicuous location in each building operated by the agency.

(4) Each agency shall provide that every staff person, including administrative and support staff, is familiar with all specific client rights and the grievance procedure.

(G) Grievance procedure

(1) Each agency and each board which itself provides mental health services must have a written grievance procedure which provides for the following:

(a) Assistance in filing the grievance if needed by the griever, investigation of the grievance on behalf of the griever, and agency representation for the griever at the agency hearing on the grievance if desired by the griever. The grievance procedure shall clearly specify the name, title, location, hours of availability, and telephone number of the person(s) designated to provide the above activities;

(b) An explanation of the process from the original filing of the grievance to the final resolution, which shall include reasonable opportunity for the griever and/or his designated representative to be heard by an impartial decision-maker;

(c) A specification of time lines for resolving the grievance not to exceed twenty working days from the date of filing the grievance;

(d) A specification that written notification and explanation of the resolution will be provided to the client, or to the griever if other than the client, with the client's permission;

(e) Opportunity to file a grievance within a reasonable period of time from the date the grievance occurred;

A statement regarding the option of the griever to initiate a complaint with any or all of several outside entities, specifically the community mental health board, the Ohio department of mental health, the Ohio legal rights service, the U.S. department of health and human services, and appropriate professional licensing or regulatory associations. The relevant addresses and telephone numbers shall be included;

(g) Provision for providing, upon request, all relevant information about the grievance to one or more of the organizations specified in paragraph (G)(1)(f) of this rule to which the griever has initiated a complaint.

(2) Each agency shall make provision for posting the grievance procedure in a conspicuous place and for distributing a copy of the written grievance procedure (see paragraph (G)(1) of this rule) to each applicant and each client, upon request.

(3) Each agency shall make provision for prompt accessibility of the client rights officer to the griever.

(4) Each agency shall provide alternative arrangements for situations in which the client rights officer is the subject of the grievance.

(5) Each agency shall provide that every staff person, including administrative, clerical, and support staff, has a clearly understood, specified, continuing responsibility to immediately advise any client or any other person who is articulating a concern, complaint, or grievance, about the name and availability of the agency's client rights officer and the complainant's right to file a grievance.

(6) Each agency shall provide for the client rights officer to take all necessary steps to assure compliance with the grievance procedure.

(H) Community mental health board procedure

(1) Each community mental health board shall assure in its community plan that each contract agency has a grievance procedure in place which meets the requirements of this rule.

(2) Each community mental health board must establish a procedure for addressing client rights complaints. This procedure must include:

(a) Provision for accessing agency information relevant to the complaint;

(b) Provision of written copy of the board's grievance procedure to be available on request;

(c) Specification of time lines for a resolution of the grievance, not to exceed twenty working days from the date the grievance is filed;

(d) Provision for written notification and explanation of the resolution to be provided to the client, or to the griever if other than the client, with the client's permission;

(e) A statement regarding the option of the griever to further grieve with any or all of the following: Ohio department of mental health, Ohio legal rights service, U.S. department of health and human services. Appropriate professional licensing or regulatory boards' relevant names, addresses, and telephone numbers shall be included;

(f) Provision for providing, upon request, relevant information about the grievance to one or more of the organizations specified in paragraph (H)(2)(e) of this rule to which the griever has initiated a complaint.

(I) Implementation and monitoring

(1) Any board or any agency may accomplish its responsibilities in regard to the provisions of this rule through utilization of its own staff or board members as appropriate, or through agreement with outside staff, agencies, or organizations, except that:

(a) Each agency and each board must assure prompt accessibility of the client rights officer.

(b) The utilization of outside persons must be clearly explained to clients, applicants, and grievers.

(2) The agency client rights officer shall assure the keeping of records of grievances received, the subject matter of the grievances, and the resolution of the grievances. The agency records shall be available for review by the community mental health board and the department of mental health upon request.

(3) The community mental health board shall review annually the implementation of the client rights policy and grievance procedures for each of its contract agencies, and shall receive annually from each agency the client rights officer's summary of the number of grievances received, type of grievances, and resolution status of grievances.

The board shall also keep records of grievances it receives, the subject of the grievances, and the resolution of each, and shall assure the availability of these records for review by the department of mental health upon request. The board shall summarize annually its records to include number of grievances received, types of grievances, and resolution status.

(4) The department of mental health shall periodically review the implementation of client rights policy and grievance procedures in each

board area. Within one hundred eighty days of the effective date of this rule, each board and agency shall send to the department of mental health its written client rights policy and grievance procedures for approval by the department. Subsequent substantive changes to such written policy and procedures shall also be submitted to and approved by the department before enactment.

e department of mental health shall receive from each community mental health board the annual summaries provided by the agencies to the board, and the board's own annual summary. The department shall prepare and distribute an annual report of grievance summaries.

R.C. 119.032 review dates: 01/09/2004 and 01/09/2009

Promulgated Under: 119.03

Statutory Authority: 5119.61, 5119.01

Rule Amplifies: 5119.61, 5119.01

Prior Effective Dates: 4/9/87

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) Benchmark: 45	#DIV/0!
(7)	Current Ratio -(Measures ability to meet short-term obligations); Benchmark 2.0	#DIV/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:

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.

(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

_____

MENTAL HEALTH AND RECOVERY SERVICES BOARD OF ALLEN, AUGLAIZE AND HARDIN COUNTIES ACCIDENT and INCIDENT INVESTGATION PLAN

POLICY:

It is the policy of the Mental Health and Recovery Services Board of Allen, Auglaize and Hardin Counties to provide a process whereby minor incidents, accidents, or injuries are reported are investigated.

A reportable incident is one which:

- Results in personal injury (including injuries requiring first aid, medical attention, lost time from work, or property damage)
- Involves a fire or explosion
- Occurs to any person on Board premises
- Occurs to any Board employee or volunteer during the course of his or her work on or off Board premises
- Occurs during the course of Board-sponsored events, on Board premises, or off Board premises when under the sponsorship of the Board

PROCEDURES:

1. Staff are to report incidents involving themselves, clients, volunteers, Board members or visitors according to this procedure.
2. All reportable incidents must be reported within 24 hours using the Board's Incident Report form.
3. The information requested in the Incident Report will include the following:
    a. Name and details of the person reporting the incident
    b. Date, time, and location of the incident
    c. Details, if known, of the injured person(s)
    d. Type of incident
4. The form is to be submitted to the Safety Officer (Executive Director)
5. If the medical emergency appears to be potentially life threatening, or if the person refuses referral due to inebriation or mental illness, the local police department can be contacted to assist the Board in securing medical assistance.
6. The safety officer will promptly investigate the circumstances of any accident and document action taken. The purpose of the investigation is to provide a systematic effort to gather all relevant facts, to establish responsibility, to identify trends that might be developing, and to determine why and how the incident occurred in order that conclusions and recommendations can be made about what can be done to provide a safer work environment and prevent a recurrence.
7. Staff injured (with a non-life threatening injury_ as a direct result of doing their job, must immediately report the injury to their supervisor or the Safety Officer.
8. In the case of a critical (life threatening) injury, the priority is to obtain prompt treatment for the individual involved. An ambulance will be summoned and the person taken to the closest emergency room.
9.

Name of person(s) involved: _____ Date of Report: _____

Name of person reporting/title: _____

MENTAL HEALTH AND RECOVERY SERVICES BOARD OF ALLEN, AUGLAIZE AND HARDIN COUNTIES
ACCIDENT and INCIDENT INVESTGATION PLAN

Date of Incident: _____ Time of Incident: _____

Location of Incident: _____

Witness(es): _____

1. Type of Incident:

__ Minor accident, injury, fall
__ Major accident, injury, fall
__ Illness, health, other medical problem
__ Lost or stolen property (state value and give brief description)
__ Verbal disagreement, threat, verbal aggression, hostility (non-Physical)
__ Workplace or Family Violence
__ "Near miss" incident or accident
__ Other (please list) _____

2. Describe the actual incident, include how it occurred, and casual factors (reasons for incident), if known. Use reverse or attach additional page if necessary.

3. Corrective actions (include what actions can and will be taken to prevent recurrence. Also include any recommendations requiring administrative approval)

4. Disposition: (Describe the outcome or what happened as a result of corrective actions taken):

Signature of person reporting: _____ Date: _____