

Georgia Department of Behavioral Health & Developmental Disabilities



PROVIDER MANUAL

FOR

**COMMUNITY MENTAL HEALTH,
DEVELOPMENTAL DISABILITIES AND
ADDICTIVE DISEASES
PROVIDERS**

FOR

**THE DEPARTMENT OF
BEHAVIORAL HEALTH &
DEVELOPMENTAL DISABILITIES**

FISCAL YEAR 2012

Effective Date: October 1, 2011

INTRODUCTION

The FY 2012 Provider Manual for the Department of Behavioral Health and Developmental Diseases (DBHDD) has been designed as an addendum to your contract/agreement with DBHDD to provide you structure for supporting and serving consumers residing in the state of Georgia.

Please Note: The Department of Behavioral Health and Developmental Disabilities continues the work of updating documents that were previously created when the Division of MHDDAD was part of the Department of Human Resources. Therefore, some forms, policies, and processes contained herein may still include references to the Department of Human Resources, yet they remain applicable for the Department of Behavioral Health and Developmental Disabilities.

SUMMARY OF CHANGES

A table listing the changes in the FY 2012 Provider Manual is provided for your convenience. Please click [here](#) to be linked to the Summary of Changes Table on page 6.

DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES

FY 2012 PROVIDER MANUAL

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SUMMARY OF CHANGES TABLE

UPDATED FOR OCTOBER 1, 2011

As a courtesy for Providers, this Summary of Changes is designed to guide the review of new and revised content contained in this updated version of the Provider Manual. The responsibility for thorough review of the Provider Manual content remains with the Provider.

Item #	Topic	Location	Summary of Changes
1	ACT Team Service Guidelines	Part I, Section I: MH & AD Consumer Eligibility, Orientation to Authorization Packages, Service Definitions and Guidelines	MOVED Psychosocial Rehabilitation (PSR) from Service Exclusions "Minimal Use" list (Item 2) to Item 1, allowing PSR as a resource to promote more engagement of ACT consumers in meaningful recovery interventions/opportunities.
2	Adult Residential: Independent	Part I, Section I, MH & AD Consumer Eligibility, Orientation to Authorization Packages, Service Definitions and Guidelines, Residential: Independent Guideline, D. Service Access	ADDED the following language in parentheses: (unless these services are otherwise required by a federal program/fund source supporting a specific individual).
3	DD Service Definition Titles	Part I, Section II Eligibility Service Definitions and Service Guidelines for DD Services	ADDED "NOW & COMP Waiver" to service definition titles for Individual Directed Goods and Services, Respite Services, and Natural Support Training Service.
4	Eligibility Service Definitions and Service Guidelines for DD Services	Part I, Section II Eligibility Service Definitions and Service Guidelines for DD Services	UPDATED office and division titles.

Item #	Topic	Location	Summary of Changes
5	Personal Care Home Service Definition	Part I, Section II Eligibility Service Definitions and Service Guidelines for DD Services	CHANGED the Personal Care Home (PCH) definition.
6	Respite Services/PCH capacity limit	Part I, Section II Eligibility Service Definitions and Service Guidelines for DD Services	REMOVED DBHDD exception to the PCH capacity limit.
7	Standards for All Providers: Utilization of Proxy Caregivers	Part II: Community Service Standards for All Providers	ADDED guidelines for utilization of proxy caregivers based on new Georgia Law. See item #s 16 and 21 in the rows below for specific details/locations.
8	Standards for All Providers: Language Consistency	Part II – Community Service Standards for All Providers	Throughout the Standards, ADDED the word, “/Agreement” (where it was not present before) to the word “Contract” for consistency. Throughout the Standards, REPLACED the word “consumer” with the word, “individual.”
9	Standards for All Providers: Website Corrections	Part II – Community Service Standards for All Providers	Due to DBHDD website redesign, UPDATED website addresses and content directions.
10	Standards for All Providers: Content Clarity	Part II – Community Service Standards for All Providers, specifically B.5, E.1.d., E.2.a-f, F.1.d., F.2., I.1., I.2.g., K.5.	MODIFIED language for clarity or corrected numbering. Content remains the same.
11	Standards for All Providers: Naming Change	Part II – Community Service Standards for All Providers	CHANGED all CSP references to CSU.

Item #	Topic	Location	Summary of Changes
12	Standards for All Providers: HIPAA	Part II – Community Service Standards for All Providers, specifically E.5.d.; H.2.e,j,k; M.3., O.11.a	UPDATED for additional clarity regarding documentation of consumer rights consistent federal law/interpretation. CHANGED and UPDATED information for HIPAA Privacy Practice Policy (under M 3 and O.11.a).
13	Standards for All Providers: Behavioral Support Services	Part II – Community Service Standards for All Providers, Section F. and I.	ADDED “consistent with Best Practices” to the heading for Behavioral Support Services. CLARIFIED/MODIFIED standard requirements in several areas of this section for clarity and for improved practice (F.1, 3, 4, 5 and I.7.v., I.8.ii).
14	Standards for All Providers: Policy Naming Conventions Updated	Part II – Community Service Standards for All Providers	Part II is UPDATED to reflect name changes of any policy cited in Part VI of this manual that had a recent name change.
15	Standards for All Providers: Quality Improvement	Part II – Community Service Standards for All Providers, H.3.	ADDED/MODIFIED items for clarity to the QI Performance Indicator process.
16	Standards for All Providers: Medication Management	Part II – Community Service Standards for All Providers	This section is REVISED . Significant Changes include the following: Section H, Quality Improvement: Over the Counter (OTC) medication added to PRN as a QI sample review element Section K: <ul style="list-style-type: none"> • Corrected numbering from FY12, Qtr 1 version • Clarified verbal order requirements (K.4.c, K.5.j). • Added the requirements for licensed DD provider agencies utilizing proxy caregivers to provide health maintenance activities. • Added Section V (For DD Providers utilizing Proxy Caregivers and Health Maintenance Activities) to standards that includes specific requirements needed for Proxy Caregivers. • Some “for example” items deleted, some added

Item #	Topic	Location	Summary of Changes
17	Standards for All Providers: Legal Issues in Assessment	Part II – Community Service Standards for All Providers, Section I	MOVED legal concerns from Item 3 to Item 2.
18	Standards for All Providers: Individualized Planning	Part II – Community Service Standards for All Providers, Section I	This section is REVISED . Significant Changes include the following: <ul style="list-style-type: none"> • I.10.a.v. added • I.14. Specific to DD providers, added specific requirements and training of staff for a crisis plans
19	Standards for All Providers: Infection Control	Part II – Community Service Standards for All Providers, Section J	In keeping with changes in healthcare administration, REPLACED the phrase “universal precaution” with the phrase “Standard Precaution.”
20	Standards for All Providers: Personal Funds	Part II – Community Service Standards for All Providers, Section N	Specific to DD providers - UPDATED requirements under #5 to meet DBHDD Policy revisions for Management/Supervision/Safeguarding of Possessions, Valuables, Personal Funds and Day to Day Living Expenses in DD Residential Services.
21	Standards for All Providers: Staffing	Part II – Community Service Standards for All Providers	This section is REVISED . Significant Changes include the following: <ul style="list-style-type: none"> • Added O.5.c.to address Proxy Caregivers • Added specific requirements for DD providers for adequate staffing patterns to meet service guidelines and professional designations. • Updated language in standards under #9 to adhere to DBHDD Policy, Criminal History Records Checks for Contractors. Deleted mandatory disqualification list of crimes that restricts employment as a contractor or contractor employee as it is already referenced in the policy. • Clarified only direct support volunteers and direct support consultants meet the training requirements outlined in the standards. •
22	Standards for All Providers: Professional Designations	Part II – Community Service Standards for All Providers, Section S	UPDATED Developmental Disability Professional (DDP) information to meet current requirements for this position and practice.

Item #	Topic	Location	Summary of Changes
23	Standards for Georgia Crisis System (GRSS-DD)	Part III, Section I: Standards for GRSS-DD	ADDED language regarding intake parameters for exceptional scenarios; and other various minor changes.
24	Standards for Host Homes/Life Sharing	Part III, Section II: Standards for Host Home/Life Sharing	ADDED procedures for transference of a Host Home and language clarifying conditions for converting a PCH or CLA to a Host Home.
25	Operational and Clinical Standards for ACT Teams	Part IV, Section I; ACT Operations Manual	UPDATED to align Admission Criteria with that found in Part I, Section I (items 2 and 3).
26	Documentation Guidelines for All Providers	Part IV, Section IV: Documentation Guidelines for All Providers	ADDED language to clarify that supervision for S/T's must be completed monthly; and other various minor edits.
27	Block Grant Funding Requirements	Part V: Block Grant Funding Requirements	DELETED outdated information related to reporting, funding, and data collection.
28	POLICY: Community Integration in Residential Service Options and Supervised Apartment Living Arrangements for Individuals with Developmental Disabilities	Part VI: General Policies and Procedures	CHANGED language from "participant" to "Individual" throughout the policy to be consistent with person-centered philosophy of the Division of DD and the field of DD.
29	POLICY: Health Risk Screening Tool (HRST)	Part VI: General Policies and Procedures	CHANGED language in various places to add clarity and improve responses of the various subsystems responsible for the effective completion and use of the HRST, as well as activities that are executed in relation to the screening tool.
30	POLICY: Payment by Individuals for Community Behavioral Health Services	Part VI: General Policies and Procedures	This policy replaces the previous policy on this topic (# 6204.101). This policy has been REVISED to improve clarity and address issues that have been raised by providers subsequent to the last revision. Fee scale has not been changed.

Item #	Topic	Location	Summary of Changes
31	POLICY: Process for Enrolling, Matching and Monitoring Host Homes/Life Sharing Sites for DBHDD Developmental Disabilities Community Service Providers	Part VI: General Policies and Procedures	<p>ADDED language as a 3rd bullet in Section F:</p> <p><i>The Individual or Family/Representative's termination of the relationship with an identified contracting provider agency, (which requires the termination of the site specific Medicaid Provider Number by the contracting provider agency).</i></p>
<p>The policy related to HIPAA and Protected Health Information (PHI) is going through MAJOR revisions. The old policy “Protection of Individually Identifiable Health Information” has been rescinded and a new policy “Confidentiality and HIPAA” has now been created as the primary policy. A separate policy is being developed for each protocol item under the old policy. The following 3 policies have been completed at this time. The other policies are under development and will be ready for future updates.</p>			
32	POLICY: Confidentiality and HIPAA	Part VI: General Policies and Procedures	This is a NEW ADDITION for the Provider Manual that replaces previous HIPAA information in the Provider Manual. This is part of an overall re-write of our HIPAA policies/ procedures in order to address all federal and state requirements. <i>The Authorization for Release of Information</i> form is removed from Protocol 3.200-10 and added as an attachment to this policy.
33	POLICY: Notice of Privacy Practices	Part VI: General Policies and Procedures	This is a NEW ADDITION for the Provider Manual. This policy has been developed to replace previous NPP information in the Provider Manual. This is part of an overall re-write of our HIPAA policies/ procedures in order to address all federal and state requirements.
34	POLICY: Reporting and Notification of Breaches	Part VI: General Policies and Procedures	This is a NEW ADDITION for the Provider Manual. This policy has been developed on Reporting and Notification of Breaches. This is part of an overall re-write of our HIPAA policies/ procedures in order to address all federal and state requirements. <i>The Privacy Violation Report</i> form is removed from Protocol 3.200-02 and added as an attachment to this policy.

PART I

Eligibility, Service Definition and Requirements

Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers

Fiscal Year 2012

(Section I & II Updated for October 1, 2011 Implementation)



**Georgia Department of Behavioral Health &
Developmental Disabilities**

October 2011

DBHDD

Part I

Eligibility, Service Definitions and Requirements

SECTION II

MH and AD Consumer Eligibility, Orientation to Authorization Packages, Service Definitions and Service Guidelines

Fiscal Year 2012

(Updated for October 1, 2011 Implementation)



**Georgia Department of Behavioral Health &
Developmental Disabilities**

October 2011

CONSUMER ELIGIBILITY- CHILD AND ADOLESCENT CORE CUSTOMER FOR MENTAL HEALTH AND ADDICTIVE DISEASE SERVICES

A. SERVICE ACCESS

Many youth/families approach the state service delivery system looking for help. Not everyone who seeks assistance is in need of mental health or addictive disease services. In order to efficiently and expeditiously address the needs of those seeking assistance, a quick assessment of the presenting circumstances is warranted. A brief assessment should be initiated by all community-based service providers on all youth who present for services or who are referred by the Georgia Crisis and Access Line (GCAL) for an evaluation. For the purposes of this definition, a brief assessment refers to a rapid determination of a youth's need for services and whether there are sufficient indications of a mental illness and/or substance related disorder to warrant further diagnostic assessment and admission to at least Brief Stabilization services.

1. If the youth does not have sufficient indications of a mental illness and/or substance related disorder, or if the youth does not appear to meet Core Customer functional criteria for at least Brief Stabilization services, then an appropriate referral to other services or agencies is provided.
2. If the youth does appear to have a mental illness and/or substance related disorder, and does appear to meet Core Customer functional criteria, then the youth may either begin in Brief Stabilization services or have their status as a Core Customer of Ongoing Support and Recovery services determined as a part of a more comprehensive assessment process (possibly resulting in the youth moving directly into Ongoing Services).

For all services, a provider must request a Prior Authorization via a MICP form. For additional information on the use of the MICP please see MICP User Guide available at www.apsero.com.

B. CORE CUSTOMER CLASSIFICATION AND ELIGIBILITY DETERMINATION

There are four variables for consideration to determine whether a youth qualifies as a "core customer" for child and adolescent mental health and addictive disease services.

1. **Age:** A youth must be under the age of 18 years old. Youth aged 18-21 years (children still in high school, in DJJ or DFCS custody or when it is otherwise developmentally/clinically indicated) may be served to assist with transitioning to adult services.
2. **Diagnostic Evaluation:** The state DBHDD system utilizes the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system to identify, evaluate and classify a youth's type, severity, frequency, duration and recurrence of symptoms. The diagnostic evaluation must yield information that supports an emotional disturbance and/or substance related disorder primary diagnosis (or diagnostic impression) on Axis I in accordance with the latest edition of the DSM. The diagnostic evaluation must be documented adequately to support the diagnosis.
3. **Functional/Risk Assessment:** Information gathered to evaluate a child/adolescent's ability to function and cope on a day-to-day basis comprises the functional/risk assessment. Such information includes child and family resource utilization and the child's role performance, social and behavioral skills, cognitive skills, communication skills, personal strengths and adaptive skills, needs and risks as related to an emotional disturbance, substance related disorder or co-occurring disorder. The functional/risk assessment must yield information that supports a behavioral health diagnosis (or diagnostic impression) on Axis I in accordance with the DSM.
4. **Financial Eligibility:** Please see **Policy: Payment for Community Mental Health and Addictive Diseases Services** located in Part IV of this Provider Manual.

C. PRIORITY FOR SERVICES

The following youth are priority for services:

1. The first priority group for services is:
 - Youth at risk of out-of home placements;
 - Youth who are in out of home placements; and,
 - Youth currently in a state operated psychiatric facility or a community-based crisis residential service including a crisis stabilization unit.
2. The second priority group for services is:
 - Youth with a history of one or more hospital admissions for psychiatric/addictive disease reasons within the past 3 years;
 - Youth with a history of one or more crisis stabilization unit admissions within the past 3 years;
 - Youth with a history of enrollment on an Intensive Family Intervention team within the past 3 years;
 - Youth with court orders to receive services;
 - Youth under the correctional community supervision with mental illness or substance use disorder or dependence;
 - Youth released from secure custody (county/city jails, state YDCs/RVDCs, diversion programs, forensic inpatient units) with mental illness or substance use disorder or dependence;
 - Pregnant youth;
 - Youth who are homeless; or,
 - IV drug Users.

The timeliness for providing these services is set within the agency's contract/agreement with the DBHDD.

D. EARLY INTERVENTION AND STABILIZATION- CHILD AND ADOLESCENT MENTAL HEALTH AND ADDICTIVE DISEASES

The length of Early Intervention and Stabilization services is 90 days or less. Early Intervention and Stabilization services are subject to the service and unit allowances in the Brief Registration package delineated in the Orientation to Services portion of this section of the Provider Manual:

Early Intervention and Stabilization services **must take place within a ninety (90) day timeframe**. Youth must be registered/authorized for Early Intervention and Stabilization services (complete Registration-type Multipurpose Information Consumer Profile [MICP]) prior to service provision (excluding any initial screening by the Agency). Providers have 48 hours from initial contact to submit the MICP Registration. While those registered in Early Intervention and Stabilization services, will not need the more comprehensive prior authorization for services ("Ongoing" MICP), a service plan must still be completed to guide the provision of services in accordance with the Department's standards and the provider's accrediting entity, and the plan must be maintained in the youth's record.

For any youth registered with a MICP Registration, a Diagnostic Impression is allowed for 30 days after the initial engagement with the youth and, after 30 days, the youth must have a verified diagnosis in order to continue to meet the diagnostic criteria and continue services.

Early Intervention: Indicates interventions taking place after a problem (e.g. an emotional disturbance and/or substance related disorder) is already suspected or identified, but that occur early enough to potentially avoid escalation of the problem into a crisis situation or into a chronic/significantly disabling disorder. In order for an youth to qualify for **Child and Adolescent Mental Health and Addictive Diseases Early Intervention services**, certain diagnostic and functional criteria must be met, including the following:

1. **Diagnostic-** The child or adolescent must have a primary diagnosis or diagnostic impression on Axis I, consisting of an emotional disturbance and/or substance related disorder.
2. **Functional-** The child/adolescent's level of functioning must meet **at least one** of the following criteria:
 - a. is affected by an emotional disturbance or substance related disorder;
 - b. has shown early indications of behaviors that could be disruptive to the community and the family/support system if behaviors intensified,
 - c. has shown early indications behaviors/functional problems that could cause risk of removal from the home if problems intensified;
 - d. has shown early indications of poor school performance (poor grades, disruptive behavior, lack of motivation, suspension);
 - e. has shown early indications of delinquent behaviors that could result in legal system involvement; and/or
 - f. has shown early indications of behavioral/functional problems that could result in multiple agency involvement if problems intensified.

Stabilization: Indicates interventions taking place after a problem has been identified (e.g. an emotional disturbance and/or substance related disorder) and has either developed into a crisis situation or become disabling enough to warrant at least short-term stabilization interventions. In order for a youth to qualify for **Child and Adolescent MENTAL HEALTH AND ADDICTIVE DISEASES STABILIZATION services**, certain diagnostic and functional criteria must be met, including the following:

1. **Diagnostic-** The child or adolescent must have a primary diagnosis or diagnostic impression (allowable for 30 days only) on Axis I, consisting of an emotional disturbance and/or substance related disorder.
2. **Functional -** The child/adolescent's level of functioning must meet **at least one** of the following criteria:
 - a. is significantly affected by a serious emotional disturbance or substance related disorder;
 - b. results in behaviors that demonstrate a risk of harm to self, others, or property;
 - c. causes a risk of removal from the home;
 - d. results in school problems such as poor grades, school failure, disruptive behavior, lack of motivation, drop out, suspension or expulsion;
 - e. results in legal system involvement;
 - f. indicates the need for detoxification services; and/or
 - g. is significantly disruptive to the community or the family/support system.

E. ONGOING SUPPORT AND TREATMENT- CHILD AND ADOLESCENT MENTAL HEALTH

Ongoing Support and Treatment: Indicates interventions taking place after an emotional disturbance of a severe and longer-term nature has been identified and has become disabling enough to warrant ongoing service provision to help support the child and family in order to improve the child's level of functioning and resilience. The length of Ongoing Support and Treatment services is anticipated to be longer than 90 days (though how much longer varies by medical necessity, need/s, resiliency, and biopsychosocial factors affecting functioning). A youth may either start out in Ongoing Support and Treatment services or be transitioned into this category at any point during or following Early Intervention and Stabilization services due to changes in clinical presentation, needs, circumstances or stressors. For a youth/family to qualify for **Child and Adolescent MENTAL HEALTH ONGOING SUPPORT AND TREATMENT** services, certain diagnostic and functional criteria must be met, including the following:

1. **Diagnostic-** The child/adolescent must have a primary diagnosis of a serious emotional disturbance on Axis I, (*for example*: major depression, an anxiety disorder, or other serious emotional disturbance). ***This must be a verified diagnosis, not just a diagnostic impression.*** The disturbance must have persisted for at least one year or be likely to persist for at least one year without treatment, and must require ongoing, longer-term support and treatment services. Without such services, out of home placement or hospitalization is probable.
2. **Functional-** The child/adolescent's ability to function has been significantly affected by the serious emotional disturbance to the extent that there is impairment in ability to function at an age appropriate level and difficulty with age appropriate role performance. Functional impairment must be demonstrated by ***one of the following three indicators***:
 - a. A total score of 60 or higher on the 8 subscales of the Child and Adolescent Functional Assessment Scale (CAFAS),

--OR--
 - b. **Either** a score of 20 or higher (*moderate to severe impairment*) on the "Behavior Toward Others", the "Self-Harmful Behavior" or the "Thinking" CAFAS subscale, or a score of 30 (*severe impairment*) on the "Moods/Emotions" CAFAS subscale,

--OR--
 - c. The child or adolescent has been in services for an extended period of time (six months or longer) with a qualifying Axis I diagnosis, but does not currently meet the functional criteria. Without the supports/services provided, the child/adolescent would *likely* be unable to maintain his or her current level of functioning to the extent that functioning would revert back to meeting the functional criteria.

F. ONGOING SUPPORT AND RECOVERY- CHILD AND ADOLESCENT ADDICTIVE DISEASES

Ongoing Support and Recovery: Indicates interventions taking place after a substance-related disorder has been identified and has become disabling enough to warrant ongoing service provision to assist in stabilizing/supporting the child and family, and to facilitate the child's recovery. The length of service is anticipated to be longer than 90 days (though how much longer varies by medical necessity, need/s, resiliency, and biopsychosocial factors affecting functioning/recovery). A youth may either start out in Ongoing Support and Recovery services or be transitioned into this category at any point during or following Early Intervention and Stabilization services due to changes in clinical presentation, needs, circumstances or stressors. For a person to qualify for **Child and Adolescent ADDICTIVE DISEASES ONGOING SUPPORT AND RECOVERY** services, certain diagnostic and functional criteria must be met, including the following:

1. **Diagnostic-** The child/adolescent must have a primary diagnosis on Axis I of a substance related disorder (excluding substance intoxication). Substances can refer to a drug of abuse, a medication or a toxin (Caffeine and nicotine are excluded). ***This must be a verified diagnosis, not just a diagnostic impression.***
2. **Functional-** The child/adolescent's ability to function has been significantly affected by the substance related disorder to the extent that there is impairment in ability to function at an age appropriate level and difficulty with age appropriate role performance. This functional difficulty must be demonstrated by ***one of the following indicators:***
 - a. A score of 20 or higher (moderate to severe impairment) on the 'Substance Abuse' subscale of the Child and Adolescent Functional Assessment Scale (CAFAS).

--OR--
 - b. The child or adolescent has been in services for an extended period of time (six months or longer) with a qualifying Axis I diagnosis, but does not currently meet the functional criteria. Without the supports/services provided, the child/adolescent would *likely* be unable to maintain his or her current level of functioning to the extent that functioning would revert back to meeting the functional criteria.

G. DIAGNOSTIC CATEGORIES APPROVED FOR STATE FUNDED SERVICES

1. Child and Adolescent Mental Health:

- a. Axis I disorders classified in the most recent version of the DSM.
- b. By definition, an Adjustment Disorder must resolve within 6 months of the termination of the stressor *or* its consequences.
- c. Exclusions: The following disorders are ***excluded*** unless co-occurring with a qualifying primary Axis I emotional disturbance or substance related disorder that is the focus of treatment:
 1. Tic disorders;
 2. Mental Retardation;
 3. Learning Disorders;
 4. Motor Skills Disorders;
 5. Communication Disorders;
 6. Organic Mental Disorders;
 7. Pervasive Developmental Disorders; and,
 8. V Codes

2. Child and Adolescent Addictive Diseases:

- a. Substance Related Disorders including but not limited to substance abuse, substance dependence, and substance withdrawal as classified in the most recent version of the DSM.
- b. The severity and duration of substance related disorders are not considered in regard to the Core Customer criteria (except as they may be inherent to the definition of a disorder).
- c. Exclusions: The following disorders are ***excluded:***
 1. Caffeine-Induced Disorders;
 2. Nicotine-Related Disorders; and,
 3. Substance Intoxication- only excluded for Ongoing Services.

NOTE: *The presence of co-occurring emotional disturbances, substance related disorders and/or developmental disabilities is not uncommon and typically results in a more complicated clinical presentation. Youth diagnosed with the excluded Axis I disorders listed above and/or with Axis II disorders may receive services **ONLY** when these disorders co-occur with a qualifying primary Axis I emotional*

disturbance or substance related disorder. The qualifying Axis I emotional disturbance or substance related disorder must be the presenting problem and the primary diagnosis/focus of treatment, and the youth must meet the functional criteria listed above.

H. CONTINUED REVIEW OF ELIGIBILITY

Eligibility will be reviewed as consumers' MICP service reauthorizations become due.

CONSUMER ELIGIBILITY- ADULT CORE CUSTOMER FOR MENTAL HEALTH AND ADDICTIVE DISEASE SERVICES

A. SERVICE ACCESS

Many individuals approach the state service delivery system looking for help. Not everyone who seeks assistance is in need of mental health or addictive disease services. In order to efficiently and expeditiously address the needs of those seeking assistance, a quick assessment of the presenting circumstances is warranted. A brief assessment should be initiated by all community-based service providers on all individuals who present for services or who are referred by the Georgia Crisis and Access Line (GCAL) for an evaluation. For the purposes of this definition, a brief assessment refers to a rapid determination of an individual's need for services and whether there are sufficient indications of a mental illness and/or substance related disorder to warrant further evaluation and admission to at least Brief Stabilization services.

1. If the individual does not have sufficient indications of a mental illness and/or substance related disorder, or if the individual does not appear to meet Core Customer functional criteria for at least Brief Stabilization services, then an appropriate referral to other services or agencies is provided.
2. If the individual does appear to have a mental illness and/or substance related disorder, and does appear to meet Core Customer functional criteria, then the individual may either begin in Brief Stabilization services or have their status as a Core Customer of Ongoing Support and Recovery services determined as a part of a more comprehensive assessment process (possibly resulting in the individual moving directly into Ongoing Services).

For all services, a provider must request a Prior Authorization via a MICP form. For additional information on the use of the MICP please see MICP User Guide available at www.apsero.com.

B. CORE CUSTOMER CLASSIFICATION AND ELIGIBILITY DETERMINATION

There are four variables for consideration to determine whether an individual qualifies as a "Core Customer" for adult mental health and addictive disease services.

1. **Age:** An individual must be over the age of 18 years old. Individuals under age 18 may be served in adult services if they are emancipated minors under Georgia Law, and if adult services are otherwise clinically/developmentally indicated.
2. **Diagnostic Evaluation:** The state DBHDD system utilizes the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system to identify, evaluate and classify an individual's type, severity, frequency, duration and recurrence of symptoms. The diagnostic evaluation must yield information that supports a psychiatric disorder and/or substance related disorder primary diagnosis (or diagnostic impression) on Axis I in accordance with the latest edition of the DSM. The diagnostic evaluation must be documented adequately to support the diagnostic impression/diagnosis.
3. **Functional/Risk Assessment:** Information gathered to evaluate an individual's ability to function and cope on a day-to-day basis comprises the functional/risk assessment. Such information includes the individual's resource utilization, role performance, social and behavioral skills, cognitive skills, communication skills, independent living skills, personal strengths and adaptive skills, needs and risks as related to a psychiatric disorder, substance related disorder or co-occurring disorder. The functional/risk assessment must yield information that supports a behavioral health diagnosis (or diagnostic impression) on Axis I in accordance with the DSM.

4. Financial Eligibility: Please see **Policy: Payment for Community Mental Health and Addictive Diseases Services** located in Part IV of this Provider Manual.

C. PRIORITY FOR SERVICES

The following individuals are the priority for ongoing support services:

1. The first priority group for services is individuals currently in a state operated psychiatric facility (including forensic individuals), state funded/paid inpatient services, a crisis stabilization unit or crisis residential program.
2. The second priority group for services is:
 - Individuals with a history of one or more hospital admissions for psychiatric/addictive disease reasons within the past 3 years;
 - Individuals with a history of one or more crisis stabilization unit admissions within the past 3 years;
 - Individuals with a history of enrollment on an Assertive Community Treatment team within the past 3 years;
 - Individuals with court orders to receive services (especially related to restoring competency);
 - Individuals under the correctional community supervision with mental illness or substance use disorder or dependence;
 - Individuals released from secure custody (county/city jails, state prisons, diversion programs, forensic inpatient units) with mental illness or substance use disorder or dependence;
 - Individuals aging out of out of home placements or who are transitioning from intensive C&A services, for whom adult services are clinically and developmentally appropriate.
 - Pregnant women;
 - Individuals who are homeless; or,
 - IV drug Users.

The timeliness for providing these services is set within the agency's contract/agreement with the DBHDD.

D. BRIEF STABILIZATION- ADULT MENTAL HEALTH AND ADDICTIVE DISEASES

The length of Brief Stabilization services is 90 days or less. Brief Stabilization services are subject to the service and unit allowances in the Brief Registration package delineated in the Orientation to Services portion of this section of the Provider Manual.

Brief Stabilization services must take place within a ninety (90) day timeframe. Individuals must be registered/authorized for Brief Stabilization services (complete Registration-type MICP) prior to service provision (excluding any initial screening by the Agency). Providers have 48 hours from initial contact to submit the MICP Registration. While those registered in Brief Stabilization services, will not need the more comprehensive prior authorization for services ("Ongoing" MICP), a service plan must still be completed to guide the provision of services in accordance with the Department's standards and the provider's accrediting entity, and the plan must be maintained in the consumer's record.

For any individual registered with a MICP Registration, a Diagnostic Impression is allowed for 30 days after the initial engagement with the individual and, after 30 days, the individual must have a verified diagnosis in order to continue to meet the diagnostic criteria and continue services.

Brief Stabilization indicates interventions taking place after a problem has been identified (e.g. a psychiatric disturbance/disorder and/or substance related disorder), which has either already developed into a crisis situation or has become disabling enough to warrant at least short-term, low intensity outpatient stabilization interventions. In order for an individual to qualify for Adult Mental Health and Addictive Diseases Brief Stabilization services, certain diagnostic **and** functional criteria must be met, including the following:

1. **Diagnostic-** The person must have a verified Axis I diagnosis or diagnostic impression of a mental illness and/or a substance related disorder.
2. **Functional-** Item **"a"** **AND** at least item **"b"** **OR** **"c"** must be present:
 - a. The person's level of functioning must be significantly affected by the presenting mental health and/or addictive disease issue; and one or more of the following:
 - b. The person displays behaviors that are significantly disruptive to the community, to the individual's family/support system, or to the individual's ability to maintain his or her current employment/schooling, housing or personal health/safety; **and/or**
 - c. The person displays behaviors that demonstrate a potential risk of harm to self or others.

E. ONGOING SUPPORT AND RECOVERY- ADULT MENTAL HEALTH

An individual may either begin in Ongoing Support and Recovery services or be transitioned from Brief services into Ongoing Support and Recovery services either during or following the 90 day Brief services allowable time period due to changes in clinical presentation, needs, circumstances/stressors, clinician's evolving understanding of the individual's clinical issues etc. An agency must complete and submit a MICP "New Episode" or "Ongoing" for approval for individuals for whom Ongoing Support and Recovery services are desired.

Ongoing Support and Recovery: Indicates interventions taking place after a psychiatric disorder of a severe and longer-term nature has been identified and has become disabling enough to warrant ongoing service provision to help support the individual in order to improve his or her level of functioning and recovery. The length of Ongoing Support and Recovery services varies based on individual service needs and biopsychosocial factors affecting functioning in accordance with service utilization guidelines. An individual may either start out in the Ongoing services category or be transitioned to this category at any point during or following Brief Stabilization services due to changes in clinical presentation, needs, circumstances or stressors etc. In order for an individual to qualify for Adult Mental Health Ongoing Support and Recovery Services, certain diagnostic **and** functional criteria must be met, including the following:

1. **Diagnostic-** The individual must have a verified Axis I diagnosis (**note:** not just a diagnostic impression) of a severe and persistent mental illness such as schizophrenia, major depression, bipolar disorder or other severely disabling mental disorder that requires ongoing and long-term support, treatment and recovery services. The prognosis indicates a long-term, severe disability. Without supports, hospitalization or other institutionalization (e.g. incarceration) is probable.
2. **Functional-** The individual's ability to function has been **significantly affected by the mental disorder** to the degree that there is impairment in activities of daily living with an inability to function independently in the community. This difficulty with activities of daily living and difficulty in functioning independently must be demonstrated **EITHER** by **both "a" and "b"** below, **OR** by **"c" alone**.
 - a. The individual's score on the Level Of Care Utilization System (LOCUS) indicates that the individual would be appropriate for a Level 1 level of care.

--AND--

- b. The individual has been in services for an extended period of time (six months or longer) with a qualifying Axis I diagnosis, and functioning does not currently meet the criteria for a LOCUS Level 2 or higher level of care. Without the supports/services provided, the individual would likely be unable to maintain his or her current level of recovery to the extent that his or her functioning would revert back to meeting the criteria for a LOCUS Level 2 or higher level of care.

--OR--

- c. The individual's score on the Level of Care Utilization System (LOCUS) indicates that the individual would be appropriate for a Level 2 or above level of care.

F. ONGOING SUPPORT AND RECOVERY- ADULT ADDICTIVE DISEASES

An individual may either begin in Ongoing Support and Recovery services or be transitioned from Brief services into Ongoing services either during or following the 90 day Brief services allowable time period due to changes in clinical presentation, needs, circumstances/stressors, clinician's evolving understanding of the individual's clinical issues etc. An agency must complete and submit a MICP "New Episode" or "Ongoing" form for approval for individuals for whom Ongoing Support and Recovery services are desired.

Ongoing Support and Recovery: Indicates interventions taking place after a substance-related disorder has been identified, and has become disabling enough to warrant ongoing service provision to help support the individual to improve his or her level of functioning and recovery. The length of Ongoing Support and Recovery services varies considering support and recovery needs and by other bio-psycho-social factors affecting functioning against criteria set forth in service utilization guidelines. In order for a person to qualify for **Adult ADDICTIVE DISEASE ONGOING SUPPORT AND RECOVERY services**, certain diagnostic and functional criteria must be met, including the following:

1. **Diagnostic-** The person has a verified Axis I diagnosis (**note:** not just a diagnostic impression) of a substance related disorder (excluding substance intoxication). Substances can refer to a drug of abuse, a medication or a toxin.
2. **Functional** - The individual's level of functioning has been significantly affected by the substance related disorder to the degree that there is a marked decrease in health and in ability to function. This decrease in health or in functioning must be demonstrated **EITHER** by **both "a" and "b"** below, **OR by "c" alone**.
 - a. The individual's score on the Level Of Care Utilization System (LOCUS) indicates that the individual would be appropriate for a Level 1 level of care.

--AND--

- b. The individual has been in services for an extended period of time (six months or longer) with a qualifying Axis I diagnosis, and functioning does not currently meet the criteria for a LOCUS Level 2 or higher level of care. Without the supports/services provided, the individual would likely be unable to maintain his or her current level of recovery to the extent that his or her functioning would revert back to meeting the criteria for a LOCUS Level 2 or higher level of care.

--OR--

- c. The individual's score on the Level Of Care Utilization System (LOCUS) indicates that the individual would be appropriate for a Level 2 or above level of care.

G. DIAGNOSTIC CATEGORIES APPROVED FOR STATE FUNDED SERVICES

1. Adult Mental Health:

- a. Schizophrenia and Other Psychotic Disorders
- b. Mood Disorders
- c. Anxiety Disorders
- d. Adjustment Disorders (By definition, an Adjustment Disorder must resolve within 6 months of the termination of the stressor or its consequences)
- e. Mental Disorders Due to a General Medical Condition Not Elsewhere Classified
- f. **Exclusions:** The following disorders are **excluded** unless co-occurring with a qualifying primary Axis I mental or substance related disorder that is the focus of treatment:
 1. Tic disorders,
 2. Mental Retardation
 3. Learning Disorders
 4. Motor Skills Disorders
 5. Communication Disorders
 6. Organic Mental Disorders
 7. Pervasive Developmental Disorders
 8. Personality Change Due to a General Medical Condition
 9. Mental Disorder NOS Due to a General Medical Condition
 10. V Codes

2. Adult Addictive Diseases

- a. Substance-Related Disorders including but not limited to substance abuse, substance dependence, and substance withdrawal.
- b. Note that severity and duration of substance related disorders are not considered in regard to the Core Customer criteria (except as they may be inherent to the definition of a disorder).
- c. Exclusions:
 1. Caffeine-Induced Disorders
 2. Nicotine-Related Disorders
 3. Substance Intoxication- only excluded for Ongoing Services.

NOTE: *The presence of co-occurring mental illnesses, substance related disorders and/or developmental disabilities is not uncommon and typically results in a more complicated clinical presentation. Individuals diagnosed with the excluded Axis I mental disorders listed above and/or with Axis II disorders may receive services **ONLY** when these disorders co-occur with a qualifying primary Axis I mental illness or substance related disorder. The qualifying Axis I mental illness or substance related disorder must be the presenting problem and the primary diagnosis/focus of treatment, and the individual must meet the functional criteria listed above.*

H. CONTINUED REVIEW OF ELIGIBILITY

Eligibility will be reviewed as individuals' MICP reauthorizations become due.

Mental Health and Addictive Disease

Orientation to Services

Overview of Service Packages

In order to make it easier for providers to request groups of services that are frequently provided concurrently, the DBHDD has created service packages which can be requested to support an individual. These packages work in a manner similar to the current Brief Registration package. When a request for a package is approved, the response includes authorization for all of the services in the package without the need for the provider to individually select each of the component services. In addition, when compared to services selected individually from the À la carte menu, packages may have different authorization periods and may authorize different quantities of units within the package to reflect the particular needs of the target group of individuals. In order to utilize a package, it is not necessary that the individual receive all of the services and/or units in the package (unless otherwise noted in a specific guideline for that service).

Orders and Treatment Plans

Orders for services and treatment plans must still indicate which specific services from the package are being requested for an individual. The treatment plan must reference the individual services and the frequency with which they will be provided. The order and treatment plan must conform to the requirements listed in the *Documentation Guidelines* in Part II, Section IV of this manual.

Adding Additional Services to Packages

If additional services are needed once a package is authorized, providers may add services by using an MICP Update request type. Providers should be aware that, if the number of days remaining on the package is greater than the length of the authorization period for the additional a' la carte service selected, the end date of the package's authorization period will be rolled back to reflect the shorter authorization period of the additional service. For example, if there are 200 days remaining on a Medication Maintenance package and Individual Counseling (180-day authorization period) is added, the end of the Medication Maintenance package will be rolled back to 180 days from the date Individual Counseling is added. If there had been 150 days remaining on the Medication Maintenance package at the time Individual Counseling was added, the length of authorization for both the Medication Maintenance package and the added Individual Counseling service would remain at 150 days. The only exception to this is the Crisis Stabilization Program service, which has an authorization period of 20 days and which will continue to "float" over any other services authorized and will not cause the authorization periods for other services to be rolled back.

The available packages are detailed below:

A. Brief Registration

The Brief Registration Package is designed to provide a comprehensive package of services that can be provided to new consumers for up to 90 days. It may be requested only through submission of a MICP Registration. This package includes the services determined to be essential to completing the initial assessments and individualized resiliency/recovery plan, crisis intervention services, and a brief period of therapy and skills training services. The following table lists the services, maximum daily unit limits, and maximum units currently available during the 90-day authorization period.

Package Code	Package Name	Service Groups Included	Service Group Name	Auth Period in Days	Max Auth Units	Max Daily Units
P0001	Brief Registration	10101	Beh Health Assmt & Serv Plan Development	90	32	24
		10102	Psychological Testing	90	5	5
		10103	Diagnostic Assessment	90	2	2
		10110	Crisis Intervention	90	20	16
		10120	Psychiatric Treatment	90	6	1
		10130	Nursing Assessment & Care	90	12	12
		10140	Medication Administration	90	6	1
		10150	Community Support	90	200	96
		10160	Individual Outpatient Services	90	8	1
		10170	Group Outpatient Services	90	480	16
		10180	Family Outpatient Services	90	32	8
		21202	Community Transition Planning	90	10	10

This package may only be requested for new consumers. It cannot be requested for existing consumers, cannot follow any existing MICP authorization, and must either be followed by a MICP Discharge or a MICP Ongoing request.

B. Medication Maintenance

This package is designed for the provider to request the units of service necessary to support an individual whose mental health or substance abuse problems are essentially stable and whose needs include ongoing medication management and relatively fewer supports. The authorization period for this package is 365 days and it may be requested by submission of a *MICP New Episode* or *MICP Ongoing* request with the **Medication Maintenance** package selected.

The following table lists the services, maximum daily unit limits, and maximum units currently available during the 365-day authorization period:

Package Code	Package Name	Service Groups Included	Service Group Name	Auth Period in Days	Max Auth Units	Max Daily Units
P0002	Medication Maintenance	10101	Beh Health Assmt & Serv Plan Development	365	6	6
		10103	Diagnostic Assessment	365	2	2
		10120	Psychiatric Treatment	365	6	1
		10130	Nursing Assessment & Care	365	8	8
		10140	Medication Administration	365	30	1
		10150	Community Support	365	48	48

C. Crisis Stabilization Program

This package is designed for use by providers that operate Crisis stabilization units of 16 beds or less off the grounds of a state hospital and bill Medicaid. Programs of greater than 16 beds or those on the grounds of a state hospital may **not** bill claims to Medicaid and should submit a MICP request for the individual Crisis Stabilization Unit service and submit encounters as instructed in the CSU service definition.

Providers that are eligible to bill Medicaid for services provided in a CSU may bill for the unbundled services listed in the package, up to the daily maximum for each service, and should also submit encounters for the CSU service as instructed in the service definition. Although not all services provided in a CSU are individually billable, the program expectations for services to be provided within CSUs have not changed. Providers of C&A CSU services may not bill **unbundled** service encounters through the C&A fee-for-service system for services provided within any Crisis Stabilization Unit due to the fact that this is a state-contracted service. Only CSU service encounters may be submitted for non-Medicaid eligible children in CSUs.

The following table lists the services, maximum daily unit limits, and maximum units currently available during the 20-day authorization period:

Package Code	Package Name	Service Groups Included	Service Group Name	Auth Period in Days	Max Auth Units	Max Daily Units
P0003	Crisis Stabilization Program	20101	Crisis Stabilization Program	20	20	1
		10101	Beh Health Assmt & Serv Plan Development	20	32	24
		10103	Diagnostic Assessment	20	2	2
		10110	Crisis Intervention	20	32	8
		10120	Psychiatric Treatment	20	20	1
		10130	Nursing Assessment & Care	20	80	5
		10140	Medication Administration	20	20	1
		10170	Group Outpatient Services	20	80	4

D. MH Intensive Outpatient (C&A)

This Intensive Outpatient package was designed to support agencies that provide services at an intensity that would be consistent with a C&A Mental Health day treatment model. Since the DBHDD was required by CMS to discontinue reimbursement for bundled day treatment services, providers have had to bill for the individual services provided within their programs.

The C&A package differs from the Adult package only in that it includes the state-funded Structured Activity Supports service. The following table lists the services, maximum daily unit limits, and maximum units currently available during the 180-day authorization period:

Service Group Code	Package Name	Service Groups Included	Service Name	Auth Period in Days	Max Auth Units	Max Daily Units
P0004	MH Intensive Outpatient (C&A)	10101	Beh Health Assmt & Serv Plan Development	180	32	24
		10102	Psychological Testing	180	10	5
		10103	Diagnostic Assessment	180	4	2
		10110	Crisis Intervention	180	24	16
		10120	Psychiatric Treatment	180	24	1
		10130	Nursing Assessment & Care	180	24	16
		10140	Medication Administration	180	40	1
		10150	Community Support	180	600	96
		10160	Individual Outpatient Services	180	36	1
		10170	Group Outpatient Services	180	1170	16
		10180	Family Outpatient Services	180	100	8
		20902	Structured Activity Supports	180	320	8

E. MH Intensive Outpatient (Adult)

The Intensive Outpatient package was designed to support agencies that provide services at an intensity that would be consistent with a day treatment model. Since the DBHDD was required by CMS to discontinue reimbursement for bundled day treatment services, providers have had to bill for the individual services provided within their programs.

The following table lists the services, maximum daily unit limits, and maximum units currently available during the 180-day authorization period:

Service Group Code	Package Name	Service Groups Included	Service Name	Auth Period in Days	Max Auth Units	Max Daily Units
P0005	MH Intensive Outpatient (Adults)	10101	Beh Health Assmt & Serv Plan Development	180	32	24
		10102	Psychological Testing	180	10	5
		10103	Diagnostic Assessment	180	4	2
		10110	Crisis Intervention	180	24	16
		10120	Psychiatric Treatment	180	24	1
		10130	Nursing Assessment & Care	180	24	16
		10140	Medication Administration	180	40	1
		10150	Community Support	180	600	96
		10160	Individual Outpatient Services	180	36	1
		10170	Group Outpatient Services	180	1170	16
		10180	Family Outpatient Services	180	100	8

F. SA Intensive Outpatient (Adolescent)

This Intensive Outpatient package was designed to support agencies that provide services at an intensity that would be consistent with a SA Adolescent day treatment model. Since the DBHDD was required by CMS to discontinue reimbursement for bundled day treatment services, providers have had to bill for the individual services provided within their programs.

The SA Adolescent package differs from the Adult package only in that it includes the state-funded Structured Activity Supports service. The following table lists the services, maximum daily unit limits, and maximum units currently available during the 180-day authorization period:

Service Group Code	Package Name	Service Groups Included	Service Name	Auth Period in Days	Max Auth Units	Max Daily Units
P0006	SA Intensive Outpatient (Adolescent)	10101	Beh Health Assmt & Serv Plan Development	180	32	24
		10103	Diagnostic Assessment	180	4	2
		10120	Psychiatric Treatment	180	12	1
		10130	Nursing Assessment & Care	180	48	16
		10150	Community Support	180	600	96
		10160	Individual Outpatient Services	180	36	1
		10170	Group Outpatient Services	180	1170	20
		10180	Family Outpatient Services	180	100	8
		20902	Structured Activity Supports	180	320	8

G. SA Intensive Outpatient (Adult)

The SA Intensive Outpatient package is designed to support agencies that provide services at an intensity that would be consistent with a day treatment model. Since the DBHDD was required by CMS to discontinue reimbursement for bundled day treatment services, providers have had to bill for the individual services provided within their programs.

The following table lists the services, maximum daily unit limits, and maximum units currently available during the 180-day authorization period:

Service Group Code	Package Name	Service Groups Included	Service Name	Auth Period in Days	Max Auth Units	Max Daily Units
P0007	SA Intensive Outpatient (Adults)	10101	Beh Health Assmt & Serv Plan Development	180	32	24
		10103	Diagnostic Assessment	180	4	2
		10120	Psychiatric Treatment	180	12	1
		10130	Nursing Assessment & Care	180	48	16
		10150	Community Support	180	600	96
		10160	Individual Outpatient Services	180	36	1
		10170	Group Outpatient Services	180	1170	20
		10180	Family Outpatient Services	180	100	8

H. Assertive Community Treatment

The Assertive Community Treatment package was constructed in FY11 to allow Assertive Community Treatment teams the opportunity to provide curriculum-based group supports to individuals who are enrolled recipients of the ACT team services/supports. The package format allows the DBHDD to track and monitor services for this specific set of services.

Package Code	Package Name	Service Groups Included	Service Group Name	Auth Period in Days	Max Auth Units	Max Daily Units
P0011	Assertive Community Treatment	20601	Assertive Community Treatment	90	240	60
		20603	ACT- Group Outpatient Services	90	96	8

I. Ready For Work (RFW) Services and Supports (Adult)

The Ready for Work packages are designed to allow RFW agencies to select a group of services specified in their contracts to support a very specific population (See Part I, Section V). The package format allows the DBHDD to track and monitor services for this specific set of services in an unbundled environment.

Service Group Code	Package Name	Service Groups Included	Service Name	Auth Period in Days	Max Auth Units	Max Daily Units	Medicaid/ State
P0008	RFW Intensive Outpatient	10101	Beh Health Assmt & Serv Plan Development	180	32	24	Both
		10103	Diagnostic Assessment	180	4	2	Both
		10120	Psychiatric Treatment	180	12	1	Both
		10130	Nursing Assessment & Care	180	48	16	Both
		10150	Community Support	180	600	48	Both
		10160	Individual Outpatient Services	180	36	1	Both
		10170	Group Outpatient Services	180	1170	20	Both
		10180	Family Outpatient Services	180	100	8	Both

Service Group Code	Package Name	Service Groups Included	Service Name	Auth Period in Days	Max Auth Units	Max Daily Units	Medicaid/ State
P0009	RFW Intensive Residential	20510	Structured Residential- RFW/TANF	180	180	1	State ¹
		10101	Beh Health Assmt & Serv Plan Development	180	32	24	Both
		10103	Diagnostic Assessment	180	4	2	Both
		10120	Psychiatric Treatment	180	24	1	Both
		10130	Nursing Assessment & Care	180	48	16	Both
		10140	Medication Administration	180	40	1	Both

¹ These services cannot be billed to Medicaid and should be billed as State Contracted Services or Fee for Service

Overview of Modifiers:

Certain services in the Service Guidelines contain specific modifiers. The following is a list of the modifiers included herein and their specific description:

MODIFIER DESCRIPTIONS

GT = Via Interactive audio and video telecommunication systems
HA = Child/Adolescent Program
HQ = Group Setting
HR = Family/Couple with client present
HS = Family/Couple without client present
HT = Multidisciplinary team
U1 = Practitioner Level 1
U2 = Practitioner Level 2
U3 = Practitioner Level 3
U4 = Practitioner Level 4
U5 = Practitioner Level 5
U6 = In-Clinic
U7 = Out-of-Clinic
UK = Collateral Contact

The following modifiers are State created and used on state services only:

H9 = Court-ordered
R1 = Residential Level 1 (State Code)
R2 = Residential Level 2 (State Code)
R3 = Residential Level 3 (State Code)
TB = Transitional Bed (State Code)
U2 = Crisis Stabilization Unit High Intensity (State Code)
ZH = From State Hospital (State Code)
ZC = From Crisis Stabilization Unit (State Code)
ZP = From PRTF - Psychiatric Residential Treatment Facility (State Code)
ZJ = From Jail / YDC / RYDC (State Code)
ZO = From Other Institutional Setting (State Code)

Mental Health and Addictive Disease

***Children and Adolescents'
CORE Benefit Package***

Behavioral Health Assessment

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Mental Health Assessment by a non-Physician	Practitioner Level 2, In-Clinic	H0031	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	H0031	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	H0031	U4	U6			\$20.30
	Practitioner Level 5, In-Clinic	H0031	U5	U6			\$15.13
	Practitioner Level 2, Out-of-Clinic	H0031	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	H0031	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	H0031	U4	U7			\$24.36
	Practitioner Level 5, Out-of-Clinic	H0031	U5	U7			\$18.15

Definition of Service: The Behavioral Health Assessment process consists of a face-to-face comprehensive clinical assessment with the individual, which must include the youth's perspective, and should include family/responsible caregiver(s) and others significant in the youth's life as well as collateral agencies/treatment providers.

The purpose of the Behavioral Health Assessment process is to gather all information needed in to determine the youth's problems, symptoms, strengths, needs, abilities and preferences, to develop a social (extent of natural supports and community integration) and medical history, to determine functional level and degree of ability versus disability, and to engage with collateral contacts for other assessment information. An age-sensitive suicide risk assessment shall also be completed. The information gathered should support the determination of a differential diagnosis and assist in screening for/ruling-out potential co-occurring disorders.

As indicated, information from medical, nursing, school, nutritional, etc. staff should serve as the basis for the comprehensive assessment and the resulting IRP.

The entire process should involve the child/youth as a full partner and should include assessment of strengths and resources as identified by the youth and his/her family.

Target Population

Children & Adolescents with a known or suspected mental health diagnosis and/or Substance-Related Disorder

Benefit Information	Available to all known or suspected Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	32 units (Combined with H0032 – Service Plan Development)
Re-Authorization*	32 units (Combined with H0032 – Service Plan Development)
Maximum Daily Units*	24 units (Combined with H0032 – Service Plan Development)
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 231 – C&A Mental Health 831 – C&A Addictive Diseases
Admission Criteria	1. A known or suspected mental illness or substance-related disorder; and 2. Initial screening/intake information indicates a need for further assessment; and 3. At least a preliminary indication that youth meets Core Customer eligibility.
Continuing Stay Criteria	The youth's situation/functioning has changed in such a way that previous assessments are outdated.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual has withdrawn or been discharged from service; or 3. Individual no longer demonstrates need for additional assessment.
Service Exclusions	None
Clinical Exclusions	None

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
2. As indicated, medical, nursing, peer, school, nutritional, etc. staff can provide information from records, and various multi-disciplinary resources to complete the comprehensive nature of the assessment and time spent gathering this information may be billed as long as the detailed documentation justifies the time and need for capturing said information.
3. An initial Behavioral Health Assessment is required within the first 30 days of service, with ongoing assessments completed as demanded by changes with an individual.
4. "Out-of-Clinic" may only be billed when:

- Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.
- If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following practitioners may provide Behavioral Health Assessment services:

- Practitioner Level 2: Psychologist, APRN, PA
- Practitioner Level 3: LCSW, LPC, LMFT, RN
- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (addictions counselors may only perform these functions related to treatment of addictive diseases).
- Practitioner Level 5: Certified Addiction Counselor-I, Registered Alcohol and Drug Technician (I, II, or III), Addiction Counselor Trainee with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases).

C. Clinical Operations

1. The individual consumer (and caregiver/responsible family members, etc., as appropriate) should actively participate in the assessment processes.

D. Service Access

1. Children/Families access this service when it has been determined through an initial screening that the youth has mental health or addictive disease concerns.
2. Behavioral Health Assessment may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system. This service may not be provided or billed via this code for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility.

E. Additional Medicaid Requirements

1. The daily maximum within a CSU for combined Behavioral Health Assessment and Service Plan Development is 24 units/day.

F. Reporting & Billing Requirements

1. All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual
2. In addition to the authorization produced through this service, documentation of clinical assessment findings from this service must also be completed and placed in the individual's chart as a Comprehensive Assessment.

Community Support							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Community Support	Practitioner Level 4, In-Clinic	H2015	U4	U6			\$20.30
	Practitioner Level 5, In-Clinic	H2015	U5	U6			\$15.13
	Practitioner Level 4, Out-of-Clinic	H2015	U4	U7			\$24.36
	Practitioner Level 5, Out-of-Clinic	H2015	U5	U7			\$18.15
	Practitioner Level 4, In-Clinic, Collateral Contact	H2015	UK	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic, Collateral Contact	H2015	UK	U5	U6		\$15.13
	Practitioner Level 4, Out-of-Clinic, Collateral Contact	H2015	UK	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic, Collateral Contact	H2015	UK	U5	U7		\$18.15

Definition of Service: Community Support services consist of rehabilitative, environmental support and resources coordination considered essential to assist a youth and family in gaining access to necessary services and in creating environments that promote resiliency and support the emotional and functional growth and development of the youth. The service activities of Community Support include:

- Assistance to the youth and family/responsible caregivers in the facilitation and coordination of the Individual Resiliency Plan (IRP) including providing skills support in the youth/family's self-articulation of personal goals and objectives;
- Planning in a proactive manner to assist the youth and family in managing or preventing crisis situations;
- Individualized interventions, which shall have as objectives:
 - 1) Identification, with the youth, of strengths which may aid him/her in achieving resilience, as well as barriers that impede the development of skills necessary for age-appropriate functioning in school, with peers, and with family;
 - 2) Support to facilitate enhanced natural and age-appropriate supports (including support/assistance with defining what wellness means to the youth in order to assist them with resiliency-based goal setting and attainment);
 - 3) Assistance in the development of interpersonal, community coping and functional skills (including adaptation to home, school and healthy social environments);
 - 4) Encouraging the development and eventual succession of natural supports in living, learning, working, other social environments;
 - 5) Assistance in the acquisition of skills for the youth to self-recognize emotional triggers and to self-manage behaviors related to the youth's identified emotional disturbance;
 - 6) Assistance with personal development, school performance, work performance, and functioning in social and family environment through teaching skills/strategies to ameliorate the effect of behavioral health symptoms;
 - 7) Assistance in enhancing social and coping skills that ameliorate life stresses resulting from the youth's emotional disturbance;

- 8) Service and resource coordination to assist the youth and family in gaining access to necessary rehabilitative, medical, social and other services and supports;
- 9) Assistance to youth and other supporting natural resources with illness understanding and self-management;
- 10) Any necessary monitoring and follow-up to determine if the services accessed have adequately met the youth's needs;
- 11) Identification, with the youth/family, of risk indicators related to substance related disorder relapse, and strategies to prevent relapse.

This service is provided to youth in order to promote stability and build towards age-appropriate functioning in their daily environment. Stability is measured by a decreased number of hospitalizations, by decreased frequency and duration of crisis episodes and by increased and/or stable participation in school and community activities. Supports based on the youth's needs are used to promote resiliency while understanding the effects of the emotional disturbance and/or substance use/abuse and to promote functioning at an age-appropriate level. The Community Support staff will serve as the primary coordinator of behavioral health services and will provide linkage to community; general entitlements; and psychiatric, substance use/abuse, medical services, crisis prevention and intervention services.

Target Population	Children and Adolescents with one of the following: Mental Health Diagnosis Substance-Related Disorder Co-Occurring Substance-Related Disorder and Mental Health Diagnosis Co-Occurring Mental Health Diagnosis and Mental Retardation/Developmental Disabilities Co-Occurring Substance-Related Disorder and Mental Retardation/Developmental Disabilities
Benefit Information	Available to Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	600 units
Re-Authorization*	600 units
Maximum Daily Units*	48 units
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 226 – C&A Mental Health 826 – C&A Addictive Diseases

Admission Criteria	<ol style="list-style-type: none"> 1. Individual must meet target population criteria as indicated above; and one or more of the following: 2. Individual may need assistance with developing, maintaining, or enhancing social supports or other community coping skills; or 3. Individual may need assistance with daily living skills including coordination to gain access to necessary rehabilitative and medical services
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet admission criteria; and 2. Individual demonstrates documented progress or maintenance of community skills relative to goals identified in the Individualized Resiliency Plan.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of Individualized Resiliency Plan have been substantially met; or 3. Individual/family requests discharge and the individual is not imminently in danger of harm to self or others; or 4. Transfer to another service is warranted by change in the individual's condition.
Service Exclusions	<ol style="list-style-type: none"> 1. Intensive Family Intervention and CSI may be provided concurrently during transition between these services for support and continuity of care for a maximum of four units of CSI per month. If services are provided concurrently, CSI should not be duplication of IFI services. This service must be adequately justified in the Individualized Resiliency Plan. 2. Assistance to the youth and family/responsible caregivers in the facilitation and coordination of the Individual Resiliency Plan (IRP) including providing skills support in the youth/family's self-articulation of personal goals and objectives can be billed as CSI; however, the actual plan development must be billed and provided in accordance with the service guideline for Service Plan Development. 3. The billable activities of Community Support do not include: <ul style="list-style-type: none"> • Transportation • Observation/Monitoring • Tutoring/Homework Completion • Diversionary Activities (i.e. activities/time during which a therapeutic intervention tied to a goal on the individual's treatment plan is not occurring)
Clinical Exclusions	<ol style="list-style-type: none"> 1. There is a significant lack of community coping skills such that a more intensive service is needed. 2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: <ul style="list-style-type: none"> • mental retardation • autism • organic mental disorder, or • traumatic brain injury

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. Community Support services must include a variety of interventions in order to assist the consumer in developing:
 - Symptom self-monitoring and self-management of symptoms
 - Strategies and supportive interventions for avoiding out-of-home placement for youth and building stronger family support skills and knowledge of the youth or youth's strengths and limitations
 - Relapse prevention strategies and plans
2. Community Support services focus on building and maintaining a therapeutic relationship with the youth and facilitating treatment and resiliency goals.
3. The organization must have policies and procedures for protecting the safety of staff that engage in these community-based service delivery activities.
4. Contact must be made with youth receiving Community Support services a minimum of twice each month. At least one of these contacts must be face-to-face and the second may be either face-to-face or telephone contact (denoted by the UK modifier) depending on the youth's support needs and documented preferences of the family.
5. At least 50% of CSI service units must be delivered face-to-face with the identified youth receiving the service and at least 80% of all face-to-face service units must be delivered in non-clinic settings over the authorization period (these units are specific to single individual consumer records and are not aggregate across an agency/program or multiple payors).
6. In the absence of the required monthly face-to-face contact **and** if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of two telephone contacts in that specified month (denoted by the UK modifier).
7. Unsuccessful attempts to make contact with the consumer are not billable.
8. When this service is provided to youth and their families, the child/adolescent consumer of service must clearly remain the target of service.
9. Any diagnosis given to a youth must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
10. When the primary focus of Community Support services for youth is medication maintenance, the following allowances apply:
 - a. These youth are not counted in the offsite service requirement or the consumer-to-staff ratio; and
 - b. These youth are not counted in the monthly face-to-face contact requirement; however, face-to-face contact is required every 3 months and monthly calls are an allowed billable service.
11. CSI is an individual intervention and may **not** be provided or billed for more than one consumer during the same time period.
12. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or

- Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.
- If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following practitioners may provide Community Support services:
 - Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 4 rate)
 - Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate)
 - Practitioner Level 3: LCSW, LPC, LMFT, RN (reimbursed at Level 4 rate)
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology
2. Under the documented supervision (organizational charts, supervisory notation, etc.) of one of the licensed/credentialed professionals above, the following staff may also provide Community Support:
 - Certified Peer Specialists
 - Paraprofessional staff
 - Certified Psychiatric Rehabilitation Professional
 - Certified Addiction Counselor-I
 - Registered Alcohol and Drug Technician (I,II, or III)
 - Addiction Counselor Trainee
3. Community Support practitioners may have the recommended consumer-to-staff ratio of 30 consumers per staff member and must maintain a maximum ratio of 50 consumers per staff member. Youth who receive only medication maintenance are not counted in the staff ratio calculation.

C. Clinical Operations

1. Community Support services provided to youth must include coordination with family and significant others and with other systems of care such as the school system, juvenile justice system, and child welfare and child protective services when appropriate to treatment and educational needs. This coordination is an essential component of Community Support and can be billed for up to 70 percent of the contacts when directly related to the support and enhancement of the youth's resilience. When this type of intervention is delivered, it shall be designated with a UK modifier.

2. Community Support providers must have the ability to deliver services in various environments, such as homes, schools, homeless shelters, or street locations. The provider should keep in mind that families may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. their school), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the youth in a way that may potentially embarrass the individual or breach the youth's privacy/confidentiality. Staff should be sensitive to and respectful of youth and family privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with a youth during their school time, choosing inconspicuous times and locations to promote privacy).
3. If services are performed in school setting during school hours:
 - a. Documentation must indicate that intervention is most effective when provided during school hours.
 - b. IRP should indicate how the intervention has been coordinated among family system, school, and provider.
4. The organization must have policies that govern the provision of services in natural settings and can document that it respects youth and/or families' right to privacy and confidentiality when services are provided in these settings.
5. The organization must have established procedures/protocols for handling emergency and crisis situations that describe methods for supporting youth as they transition to and from psychiatric hospitalization.
6. Each provider must have policies and procedures for the provision of individual-specific outreach services, including means by which these services and youth are targeted for such efforts.
7. The organization must have a Community Support Organizational Plan that addresses the following:
 - a. Description of the particular rehabilitation, resiliency and natural support development models utilized, types of intervention practiced, and typical daily schedule for staff
 - b. Description of the staffing pattern and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, or emergencies are accommodated, how case mix is managed, access, etc.
 - c. Description of the hours of operations as related to access and availability to the youth served; and
 - d. Description of how the plan for services is modified or adjusted to meet the needs specified in every Individualized Resiliency Plan
8. Utilization (frequency and intensity) of CSI should be directly related to the CAFAS and to the other functional elements of the youth's assessment. In addition, when clinical/functional needs are great, there should be complementary therapeutic services by licensed/credential professionals paired with the provision of CSI (individual, group, family, etc.).

D. Service Accessibility

1. Specific to the "Medication Maintenance Track," consumers who require more than 4 contacts per quarter for two consecutive quarters (as based upon clinical need) are expected to be re-evaluated with the CAFAS for enhanced access to CSI and/or other services. The designation of the CSI "medication maintenance track" should be lifted and exceptions stated above in A.10. are no longer applied.

2. Community Support may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
3. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility

E. Additional Medicaid Requirements

Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

1. When a billable collateral contact is provided, the H2015UK reporting mechanism shall be utilized. A collateral contact is classified as any contact that is not face-to-face with the individual.
2. All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Community Transition Planning							
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Community Transition Planning	Community Transition Planning (State Hospital)	T2038	ZH				\$20.92
	Community Transition Planning (Crisis Stabilization Unit)	T2038	ZC				\$20.92
	Community Transition Planning (PRTF)	T2038	ZP				\$20.92
	Community Transition Planning (Jail / Youth Detention Center)	T2038	ZJ				\$20.92
	Community Transition Planning(Other)	T2038	ZO				\$20.92

Definition of Service: Community Transition Planning is a service provided by Core and IFI providers to address the care, service, and support needs of children and adolescents with serious emotional disturbance and/or co-occurring disorders to ensure a coordinated plan of transition from a qualifying facility to the community. Each episode of Community Transition Planning must include contact with the consumer, family, or caregiver with a minimum of one (1) face-to-face contact with the consumer prior to release from a facility. Additional Transition Planning activities include: educating the consumer, family, and/or caregiver on service options offered by the chosen primary service agency; participating in facility treatment team meetings to develop a transition plan.

In partnership between other community service providers and the hospital/facility staff, the community service agency maintains responsibility for carrying out transitional activities either by the consumer's chosen primary service coordinator or by the service coordinator's designated Community Transition Liaison. Community Transition Planning may also be used for Community Support staff, ACT team members and Certified Peer Specialists who work with the consumer in the community or will work with the consumer in the future to maintain or establish contact with the consumer.

Community Transition Planning consists of the following interventions to ensure the youth, family, and/or caregiver transitions successfully from the facility to their local community:

- Establishing a connection or reconnection with the youth/parent/caregiver through supportive contacts while in the qualifying facility. By engaging with the youth, this helps to develop and strengthen a relationship. Educate the youth/parent/caregiver about local community resources and service options available to meet their needs upon transition into the community. This allows the youth/parent/caregiver to make self-directed, educated choices on those service options that they feel will best meet their needs.
- Participating in qualifying facility team meetings especially in person centered planning for those in an out-of-home treatment facility for longer than 60 days, to share hospital and community information related to estimated length of stay, present problems related to admission, discharge/release criteria, progress toward treatment goals, personal strengths, available supports and assets, medical condition, medication issues, and community treatment needs
- Linking the youth with community services including visits between the youth and the Community Support staff, or IFI team members who will be working with the youth/parent/caregiver in the community which improves the likelihood of the youth accepting services and working toward change

Target Population	Children and Adolescents with one of the following: Mental Health Diagnosis Substance Related Disorder Co-Occurring Substance-Related and Mental Health Diagnosis
Benefit Information	Available to Core Customers in need of Brief Stabilization or Ongoing Services. Requires a MICP Registration or MICP New Episode.
Utilization Criteria	Available to those currently in qualifying facilities who meet Core Customer Eligibility Definition
Unit Value	15 minutes
Reimbursement Rate	\$20.92 /unit
Initial Authorization	10 units
Re-Authorization	10 units
Authorization Period	90 days (Registration) 180 days (New Episode)
UAS: Budget and Expense Categories	262 – C&A Mental Health 862 – C&A Addictive Diseases (This is a FFS service and thus providers will not submit MIERS)
Admission Criteria	Individual who meet Core Customer Eligibility while in one of the following qualifying facilities: <ol style="list-style-type: none"> 1. State Operated Hospital 2. Crisis Stabilization Unit (CSU) 3. Psychiatric Residential Treatment Facility (PRTF) 4. Jail/Youth Development Center (YDC) 5. Other (ex: Community Psychiatric Hospital) <p>Note: Modifier on Procedure Code indicates setting in which the consumer is transitioning from.</p>
Continuing Stay Criteria	Same as above.
Discharge Criteria	<ol style="list-style-type: none"> 1. Individual/family requests discharge; or 2. Individual no longer meets Core Customer Eligibility; or 3. Individual is discharged from a qualifying facility.
Service Exclusions	None
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a co-occurring Behavioral Health condition: <ol style="list-style-type: none"> a. Developmental Disability without a co-occurring mental illness or addictive disease diagnosis b. Autism c. Organic Mental Disorder d. Traumatic Brain Injury

Additional Service Criteria:

A. Required Components

Prior to Release from a Qualifying Facility:

When the youth has had (a) a length of stay of 60 days or longer in a facility or (b) youth is readmitted to a facility within 30 days of discharge, a community transition plan in partnership with the facility is required. Evidence of planning shall be recorded and a copy of the Plan shall be included in both the youth's hospital and community record.

B. Staffing Requirements

1. A Master's/Bachelor's degree in behavioral or social science that is primarily psychological in nature under the supervision of a licensed practitioner; or
2. A Georgia Certified Peer Specialist or trained Paraprofessional under the supervision of a licensed practitioner; or
3. An LPN practicing under supervision in accordance with the Georgia Practice Acts.

C. Clinical Operations

Community Transition Planning activities shall include:

1. Telephone and Face-to-face contacts with youth/family/caregiver;
2. Participating in youth's clinical staffing(s) prior to their discharge from the facility;
3. Applications for youth resources and services prior to discharge from the facility including
 - a. Healthcare
 - b. Entitlements for which they are eligible
 - c. Education
 - d. Consumer Support Services
 - e. Applicable waivers, i.e., PRTF, and/or MRDD

D. Service Access

1. This service must be available 7 days a week (if the qualifying facility discharges or releases 7 days a week).
2. This service may be delivered via telemedicine technology or via telephone conferencing.

E. Reporting & Billing Requirements

1. There must be a minimum of one face-to-face with the youth prior to release from hospital or qualifying facility in order to bill for any telephone contacts.
2. Complete the Multipurpose Information Consumer Profile (MICP) information.
3. Providers must document services in accordance with the specifications for documentation requirements specified in PART II, Section V of the Provider Manual.

F. Documentation Requirements

1. A documented Community Transition Plan for:
 - a. Individuals with a length of stay greater than 60 days; or
 - b. Individuals readmitted within 30 days of discharge.
2. Documentation of all face-to-face and telephone contacts and a description of progress with Community Transition Plan implementation and outcomes.

Crisis Intervention							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Crisis Intervention	Practitioner Level 1, In-Clinic	H2011	U1	U6			\$58.21
	Practitioner Level 2, In-Clinic	H2011	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	H2011	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	H2011	U4	U6			\$20.30
	Practitioner Level 1, Out-of-Clinic	H2011	U1	U7			\$74.09
	Practitioner Level 2, Out-of-Clinic	H2011	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	H2011	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	H2011	U4	U7			\$24.36

Definition of Service: Services directed toward the support of a child who is experiencing an abrupt and substantial change in behavior which is usually associated with a precipitating situation and which is in the direction of severe impairment of functioning or a marked increase in personal distress. Crisis Intervention is designed to prevent out of home placement or hospitalization. Often, a crisis exists at such time as a child and/or his or her family/responsible caregiver(s) decide to seek help and/or the individual, family/responsible caregiver(s), or practitioner identifies the situation as a crisis. Crisis services are time-limited and present-focused in order to address the immediate crisis and develop appropriate links to alternate services. Services may involve the youth and his/her family/responsible caregiver(s) and/or significant other, as well as other service providers.

The current family-owned safety plan, if existing, should be utilized to help manage the crisis. Interventions provided should honor and be respectful of the child and family's wishes/choices by following the plan as closely as possible in line with appropriate clinical judgment. Plans/advanced directives developed during the Assessment/IRP process should be reviewed and updated (or developed if the individual is a new consumer) as part of this service to help prevent or manage future crisis situations.

Some examples of interventions that may be used to de-escalate a crisis situation could include: a situational assessment; active listening and empathic responses to help relieve emotional distress; effective verbal and behavioral responses to warning signs of crisis related behavior; assistance to, and involvement/participation of the individual (to the extent he or she is capable) in active problem solving planning and interventions; facilitation of access to a myriad of crisis stabilization and other services deemed necessary to effectively manage the crisis; mobilization of natural support systems; and other crisis interventions as appropriate to the individual and issues to be addressed.

Target Population	Children/Adolescents with known or suspected Mental Health issues and/or Substance Related Disorders Children/Adolescents experiencing a severe situational crisis
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Benefit Information	Available to all known or suspected Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	48 units
Re-Authorization*	48 units
Maximum Daily Units*	16 units
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 221 – C&A Mental Health 821 – C&A Addictive Diseases
Admission Criteria	1. Treatment at a lower intensity has been attempted or given serious consideration; and #2 and/or #3 are met: 2. Youth has a known or suspected mental health diagnosis or substance related disorder; or 3. Youth is at risk of harm to self, others and/or property. Risk may range from mild to imminent; and one or both of the following: a. Youth has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; or b. Youth demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities.
Continuing Stay Criteria	This service may be utilized at various points in the child's course of treatment and recovery, however, each intervention is intended to be a discrete time-limited service that stabilizes the individual and moves him/her to the appropriate level of care.
Discharge Criteria	1. Individual no longer meets continued stay guidelines; and 2. Crisis situation is resolved and an adequate continuing care plan has been established.
Service Exclusions	
Clinical Exclusions	Severity of clinical issues precludes provision of services at this level of care.

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. H2011 U6 is provided in clinic-based settings.
2. H2011 U7 is provided in out-of-clinic settings.

3. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
4. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following practitioners may provide Crisis Intervention services:
 - Practitioner Level 1: Physician/Psychiatrist
 - Practitioner Level 2: Psychologist, APRN, PA
 - Practitioner Level 3: LCSW, LPC, LMFT, RN
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state.

C. Clinical Operations

1. In any review of clinical appropriateness of this service, the mix of services offered to the individual is important. The use of crisis units will be looked at by the External Review Organization in combination with other supporting services. For example, if an individual presents in crisis and the crisis is alleviated within an hour but ongoing support continues, it is expected that 4 units of crisis will be billed and then some supporting service such as individual counseling will be utilized to support the individual during that interval of service.

D. Service Access

1. All crisis service response times for this service must be within 2 hours of the consumer or other constituent contact to the provider agency.
2. Services are available 24-hours per day, 7 days per week, and may be offered by telephone and/or face-to-face in most settings (e.g. home, school, community, clinic etc).
3. Crisis Intervention may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.

4. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility.

E. Additional Medicaid Requirements

1. This service must be billed as either In-Clinic or Out-of-Clinic Crisis Management/ Intervention for Medicaid recipients in accordance with A. above.
2. The daily maximum within a CSU for Crisis Intervention is 8 units/day.

F. Reporting & Billing Requirements

All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Diagnostic Assessment

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Psychiatric Diagnostic Examination	Practitioner Level 1, In-Clinic, Child Program	90801	HA	U1	U6		\$174.63
	Practitioner Level 1, Out-of-Clinic, Child Program	90801	HA	U1	U7		\$222.26
	Practitioner Level 1, Via interactive audio and video telecommunication systems, Child Program	90801	GT	HA	U1		\$174.63
	Practitioner Level 2, In-Clinic, Child Program	90801	HA	U2	U6		\$116.90
	Practitioner Level 2, Out-of-Clinic, Child Program	90801	HA	U2	U7		\$140.28
	Practitioner Level 2, Via interactive audio and video telecommunication systems, Child Program	90801	GT	HA	U2		\$116.90
Psychiatric Diagnostic Examination, Interactive	Practitioner Level 1, In-Clinic, Child Program	90802	HA	U1	U6		\$174.63
	Practitioner Level 1, Out-of-Clinic, Child Program	90802	HA	U1	U7		\$222.26
	Practitioner Level 1, Via interactive audio and video telecommunication systems, Child Program	90802	GT	HA	U1		\$174.63
	Practitioner Level 2, In-Clinic, Child Program	90802	HA	U2	U6		\$116.90
	Practitioner Level 2, Out-of-Clinic, Child Program	90802	HA	U2	U7		\$140.28
	Practitioner Level 2, Via interactive audio and video telecommunication systems, Child Program	90802	GT	HA	U2		\$116.90

Definition of Service: Psychiatric diagnostic interview examination includes a history; mental status exam; evaluation and assessment of physiological phenomena (including co-morbidity between behavioral and physical health care issues); psychiatric diagnostic evaluation (including assessing for co-occurring disorders and the development of a differential diagnosis); screening and/or assessment of any withdrawal symptoms for youth with substance related diagnoses; assessment of the appropriateness of initiating or continuing services; and a disposition. These are completed by face-to-face evaluation of the youth (which may include the use of telemedicine) and may include communication with family and other sources and the ordering and medical interpretation of laboratory or

other medical diagnostic studies.

Interactive diagnostic interview examinations are typically furnished to children and involve the use of physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and a patient as a result of expressive or receptive language deficits. Interactive diagnostic interview examinations are also used when a sign language interpreter or other language interpreter is utilized order to facilitate communication between the clinician and a consumer with a hearing impairment or with limited English proficiency.

Target Population	Youth with known or suspected Mental Illness or Substance Related Disorders
Benefit Information	Available to all known or suspected Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	1 encounter
Initial Authorization*	2 units
Re-Authorization*	2 units
Maximum Daily Units*	1 unit per procedure code
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 220 – C&A Mental Health 820 – C&A Addictive Diseases
Admission Criteria	1. Youth has a known or suspected mental illness or a substance-related disorder and has recently entered the service system; or 2. Youth is in need of annual assessment and re-authorization of service array; or 3. Youth has need of an assessment due to a change in clinical/functional status.
Continuing Stay Criteria	Individual's situation/functioning has changed in such a way that previous assessments are outdated.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual has withdrawn or been discharged from service; or 3. Individual no longer demonstrates need for continued diagnostic assessment.
Service Exclusions	None
Clinical Exclusions	None

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. Telemedicine may be utilized for an initial Psychiatric Diagnostic Examination as well as for ongoing Psychiatric Diagnostic Examination via the use of appropriate procedure codes with the GT modifier.
2. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
3. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day. If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following practitioners can provide a Psychiatric Diagnostic Examination:
 - Practitioner Level 1: Physician/Psychiatrist
 - Practitioner Level 2: Psychologist, APRN, PA

C. Clinical Operations

1. It is expected that youth and families will be treated as full partners in the treatment regimen/services planned and received. As such, it is expected that practitioners will fully discuss treatment options with youth and families and allow for individual choice when possible. Discussion of treatment options should include a full disclosure of the pros and cons of each option (e.g. full disclosure of medication/treatment regimen potential side effects, potential adverse reactions--including potential adverse reaction from not taking medication as prescribed, and expected benefits). If such full discussion/disclosure to the youth is not possible or advisable according to the clinical judgment of the practitioner, this should be documented in the youth's chart (including the specific information that was not discussed and a compelling rationale for lack of discussion/disclosure). The family/caregiver's role is an essential component of this dialogue.

D. Service Access

1. Diagnostic Assessment may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
2. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other

involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility

E. Additional Medicaid Requirements

The daily maximum within a CSU for Diagnostic Assessment (Psychiatric Diagnostic Interview) for children and adolescents is 2 units, Two units should be utilized only if it is necessary in a complex diagnostic case for the physician extender (PA or APRN) to call in the physician for an assessment of the child to corroborate or verify the correct diagnosis.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be adhered to.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Family Outpatient Services: Family Counseling

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Family – Behavioral health counseling and therapy (without client present)	Practitioner Level 2, In-Clinic	H0004	HS	U2	U6		\$38.97
	Practitioner Level 3, In-Clinic	H0004	HS	U3	U6		\$30.01
	Practitioner Level 4, In-Clinic	H0004	HS	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic	H0004	HS	U5	U6		\$15.13
	Practitioner Level 2, Out-of-Clinic	H0004	HS	U2	U7		\$46.76
	Practitioner Level 3, Out-of-Clinic	H0004	HS	U3	U7		\$36.68
	Practitioner Level 4, Out-of-Clinic	H0004	HS	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic	H0004	HS	U5	U7		\$18.15
Family -- Behavioral health counseling and therapy (with client present)	Practitioner Level 2, In-Clinic	H0004	HR	U2	U6		\$38.97
	Practitioner Level 3, In-Clinic	H0004	HR	U3	U6		\$30.01
	Practitioner Level 4, In-Clinic	H0004	HR	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic	H0004	HR	U5	U6		\$15.13
	Practitioner Level 2, Out-of-Clinic	H0004	HR	U2	U7		\$46.76
	Practitioner Level 3, Out-of-Clinic	H0004	HR	U3	U7		\$36.68
	Practitioner Level 4, Out-of-Clinic	H0004	HR	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic	H0004	HR	U5	U7		\$18.15
Family Psychotherapy without the patient present (appropriate license required)	Practitioner Level 2, In-Clinic	90846	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	90846	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	90846	U4	U6			\$20.30
	Practitioner Level 5, In-Clinic	90846	U5	U6			\$15.13
	Practitioner Level 2, Out-of-Clinic	90846	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	90846	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	90846	U4	U7			\$24.36
	Practitioner Level 5, Out-of-Clinic	90846	U5	U7			\$18.15
	Practitioner Level 2, In-Clinic	90847	U2	U6			\$38.97

Conjoint Family Psychotherapy with the patient present (appropriate license required)	Practitioner Level 3, In-Clinic	90847	U3	U6	\$30.01
	Practitioner Level 4, In-Clinic	90847	U4	U6	\$20.30
	Practitioner Level 5, In-Clinic	90847	U5	U6	\$15.13
	Practitioner Level 2, Out-of-Clinic	90847	U2	U7	\$46.76
	Practitioner Level 3, Out-of-Clinic	90847	U3	U7	\$36.68
	Practitioner Level 4, Out-of-Clinic	90847	U4	U7	\$24.36
	Practitioner Level 5, Out-of-Clinic	90847	U5	U7	\$18.15

Definition of Service: A counseling service shown to be successful with identified family populations, diagnoses and service needs, provided by a licensed/credentialed therapist. Services are directed toward achievement of specific goals defined by the individual youth and by the parent(s)/responsible caregiver(s) and specified in the Individualized Resiliency Plan (**Note:** Although interventions may involve the family, the focus or primary beneficiary of intervention must always be the individual consumer). Family counseling provides systematic interactions between the identified individual consumer, staff and the individual's family members directed toward the restoration, development, enhancement or maintenance of functioning of the identified consumer/family unit. This may include specific clinical interventions/activities to enhance family roles; relationships, communication and functioning that promote the resiliency of the individual/family unit. Specific goals/issues to be addressed though these services may include the restoration, development, enhancement or maintenance of:

- 1) cognitive processing skills;
- 2) healthy coping mechanisms;
- 3) adaptive behaviors and skills;
- 4) interpersonal skills;
- 5) family roles and relationships;
- 6) the family's understanding of the person's mental illness and substance-related disorders and methods of intervention, interaction and mutual support the family can use to assist their family member therapeutic goals.

Best practices such as Multi-systemic Family Therapy, Multidimensional Family Therapy, Behavioral Family Therapy, Functional Family Therapy or others appropriate for the family and issues to be addressed should be utilized in the provision of this service.

Target Population	Children & Adolescents with Mental Illness and/or Substance-Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.

Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	If a MICP Registration is submitted - 32 units (combined with Family Training) If a MICP New Episode is submitted - 60 units (combined with Family Training)
Reauthorization*	60 units (Family Training and Family Counseling combined)
Maximum Daily Units*	16 units (Family Training and Family Counseling combined)
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 230 – C&A Mental Health 830 – C&A Addictive Diseases
Admission Criteria	1. Individual must have an emotional disturbance and/or substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. Individual's level of functioning does not preclude the provision of services in an outpatient milieu; and 3. Individual's assessment indicates needs that may be supported by a therapeutic intervention shown to be successful with identified family populations and individual's diagnoses.
Continuing Stay Criteria	1. Individual continues to meet Admission Criteria as articulated above; and 2. Progress notes document progress relative to goals identified in the Individualized Resiliency Plan, but all treatment/support goals have not yet been achieved.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Resiliency Plan have been substantially met; or 3. Individual/family requests discharge and individual is not in imminent danger of harm to self or others; or 4. Transfer to another service is warranted by change in individual's condition; or 5. Individual requires more intensive services.
Service Exclusions	Intensive Family Intervention

Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health impairment precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. There is no outlook for improvement with this particular service 5. This service is not intended to supplant other services such as MR/DD Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 6. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a qualifying psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, and traumatic brain injury.
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**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality, and goals must be specified and agreed upon by the youth/family/caregiver.
2. The Individualized Resiliency Plan for the individual includes goals and objectives specific to the family for whom the service is being provided.
3. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
4. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.
 If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide behavioral health counseling and psychotherapy to families:
 - Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 2 rate)
 - Practitioner Level 2: Psychologist, CNS-PMH

- Practitioner Level 3: LCSW, LPC, LMFT, RN
- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (addiction counselors may only perform these functions related to treatment of addictive diseases).
- Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases).

C. Clinical Operations

1. Models of best practice delivery may include (as clinically appropriate) Multidimensional Family Therapy, Behavioral Family Therapy, Functional Family Therapy, and others as appropriate the family and issues to be addressed.

D. Service Access

1. Services may not exceed 16 Billable units (combined Family Counseling and Family Therapy) in a single day. If clinical need indicates this level of intensity, other services may need to be considered for authorization.
2. Family Counseling may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
3. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility
4. For the purposes of this specific service, the definition of family **excludes** employees of Child Caring Institution, employees of DJJ or employees of DFCS as recipients of service.

E. Additional Medicaid Requirements

Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.
2. If there are multiple family members in the Family Counseling session who are enrolled consumers for whom the focus of treatment is related to goals on their treatment plans, we recommend the following:

- a. Document the family session in the charts of each individual consumer for whom the treatment is related to a specific goal on the individual's IRP
- b. Charge the Family Counseling session units to one of the consumers.
- c. Indicate "NC" (No Charge) on the documentation for the other consumer(s) in the family session and have the note reflect that the charges for the session are assigned to another family member in the session.

Family Outpatient Services: Family Training

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Family Skills Training and Development	Practitioner Level 4, In-Clinic, without client present	H2014	HS	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic, without client present	H2014	HS	U5	U6		\$15.13
	Practitioner Level 4, Out-of-Clinic, without client present	H2014	HS	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic, without client present	H2014	HS	U5	U7		\$18.15
	Practitioner Level 4, In-Clinic, with client present	H2014	HR	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic, with client present	H2014	HR	U5	U6		\$15.13
	Practitioner Level 4, Out-of-Clinic, with client present	H2014	HR	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic, with client present	H2014	HR	U5	U7		\$18.15

Definition of Service: A therapeutic interaction shown to be successful with identified family populations, diagnoses and service needs, provided by qualified staff. Services are directed toward achievement of specific goals defined by the individual youth and by the parent(s)/responsible caregiver(s) and specified in the Individualized Resiliency Plan (note: although interventions may involve the family, the focus or primary beneficiary of intervention must always be the individual consumer).

Family training provides systematic interactions between the identified individual consumer, staff and the individual's family members directed toward the restoration, development, enhancement or maintenance of functioning of the identified consumer/family unit. This may include support of the family, as well as training and specific activities to enhance family roles; relationships, communication and functioning that promote the resiliency of the individual/family unit.

Specific goals/issues to be addressed through these services may include the restoration, development, enhancement or maintenance of:

- 1) illness and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed/helping a family member to take medication as prescribed);
- 2) problem solving and practicing functional support;
- 3) healthy coping mechanisms;
- 4) adaptive behaviors and skills;
- 5) interpersonal skills;

- 6) daily living skills;
- 7) resource access and management skills; and
- 8) the family's understanding of mental illness and substance related disorders, the steps necessary to facilitate recovery/resiliency, and methods of intervention, interaction and mutual support the family can use to assist their family member.

Target Population	Children & Adolescents with Mental Illness and/or Substance-Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	If a MICP Registration is submitted - 32 units (combined with Family Counseling) If a MICP New Episode is submitted - 60 units (combined with Family Counseling)
Reauthorization *	60 units (Family Training and Family Counseling combined)
Authorization Period*	180 days
Maximum Daily Units*	16 units (Family Training and Family Counseling combined)
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 230 – C&A Mental Health 830 – C&A Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must have an emotional disturbance and/or substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. Individual's level of functioning does not preclude the provision of services in an outpatient milieu; and 3. Individual's assessment indicates needs that may be supported by a therapeutic intervention shown to be successful with identified family populations and individual's diagnoses.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet Admission Criteria as articulated above; and 2. Progress notes document progress relative to goals identified in the Individualized Resiliency Plan, but all treatment/support goals have not yet been achieved.

Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Resiliency Plan have been substantially met; or 3. Individual/family requests discharge and individual is not in imminent danger of harm to self or others; or 4. Transfer to another service is warranted by change in individual's condition; or 5. Individual requires more intensive services.
Service Exclusions	Designated Crisis Stabilization Unit services and Intensive Family Intervention
Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health impairment precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. There is no outlook for improvement with this particular service 5. This service is not intended to supplant other services such as Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 6. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, and traumatic brain injury.

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality and goals must be specified and agreed upon by the youth/family/caregiver.
2. The Individualized Resiliency Plan for the individual includes goals and objectives specific to the youth and family for whom the service is being provided.
3. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
4. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or

- Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day. If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide skills training and development to families:

- Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 4 rate)
- Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate)
- Practitioner Level 3: LCSW, LPC, LMFT, RN (reimbursed at Level 4 rate)
- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology
- Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above

C. Clinical Operations

D. Service Access

1. Services may not exceed 16 Billable units (combined Family Counseling and Family Therapy) in a single day. If clinical need indicates this level of intensity, other services may need to be considered for authorization.
2. Family Training may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
3. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility
4. For the purposes of this specific service, the definition of family **excludes** employees of Child Caring Institution, employees of DJJ or employees of DFCS as recipients of service.

E. Additional Medicaid Requirements

Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual
2. If there are multiple family members in the Family Training session who are enrolled consumers for whom the focus of treatment in the group is related to goals on their treatment plans, we recommend the following:
 - a. Document the family session in the charts of each individual consumer for whom the treatment is related to a specific goal on the individual's IRP
 - b. Charge the Family Training session units to one of the consumers.
 - c. Indicate "NC" (No Charge) on the documentation for the other consumer(s) in the family session and have the note reflect that the charges for the session are assigned to another family member in the session.

Group Outpatient Services: Group Counseling

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Group – Behavioral health counseling and therapy	Practitioner Level 2, In-Clinic	H0004	HQ	U2	U6		\$8.50
	Practitioner Level 3, In-Clinic	H0004	HQ	U3	U6		\$6.60
	Practitioner Level 4, In-Clinic	H0004	HQ	U4	U6		\$4.43
	Practitioner Level 5, In-Clinic	H0004	HQ	U5	U6		\$3.30
	Practitioner Level 2, Out-of-Clinic	H0004	HQ	U2	U7		\$10.39
	Practitioner Level 3, Out-of-Clinic	H0004	HQ	U3	U7		\$8.25
	Practitioner Level 4, Out-of-Clinic	H0004	HQ	U4	U7		\$5.41
	Practitioner Level 5, Out-of-Clinic	H0004	HQ	U5	U7		\$4.03
	Practitioner Level 2, In-Clinic, Multi-family group, with client present	H0004	HQ	HR	U2	U6	\$8.50
	Practitioner Level 3, In-Clinic, Multi-family group, with client present	H0004	HQ	HR	U3	U6	\$6.60
	Practitioner Level 4, In-Clinic, Multi-family group, with client present	H0004	HQ	HR	U4	U6	\$4.43
	Practitioner Level 5, In-Clinic, Multi-family group, with client present	H0004	HQ	HR	U5	U6	\$3.30
	Practitioner Level 2, Out-of-Clinic, Multi-family group, with client present	H0004	HQ	HR	U2	U7	\$10.39
	Practitioner Level 3, Out-of-Clinic, Multi-family group, with client present	H0004	HQ	HR	U3	U7	\$8.25
	Practitioner Level 4, Out-of-Clinic, Multi-family group, with client present	H0004	HQ	HR	U4	U7	\$5.41
	Practitioner Level 5, Out-of-Clinic, Multi-family group, with client present	H0004	HQ	HR	U5	U7	\$4.03
	Practitioner Level 2, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U2	U6	\$8.50

	Practitioner Level 3, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U3	U6	\$6.60
	Practitioner Level 4, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U4	U6	\$4.43
	Practitioner Level 5, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U5	U6	\$3.30
	Practitioner Level 2, Out-of-Clinic, Multi-family group, without client present	H0004	HQ	HS	U2	U7	\$10.39
	Practitioner Level 3, Out-of-Clinic, Multi-family group, without client present	H0004	HQ	HS	U3	U7	\$8.25
	Practitioner Level 4, Out-of-Clinic, Multi-family group, without client present	H0004	HQ	HS	U4	U7	\$5.41
	Practitioner Level 5, Out-of-Clinic, Multi-family group, without client present	H0004	HQ	HS	U5	U7	\$4.03
Group Psychotherapy other than of a multiple family group (appropriate license required)	Practitioner Level 2, In-Clinic	90853	U2	U6			\$8.50
	Practitioner Level 3, In-Clinic	90853	U3	U6			\$6.60
	Practitioner Level 4, In-Clinic	90853	U4	U6			\$4.43
	Practitioner Level 5, In-Clinic	90853	U5	U6			\$3.30
	Practitioner Level 2, Out-of-Clinic	90853	U2	U7			\$10.39
	Practitioner Level 3, Out-of-Clinic	90853	U3	U7			\$8.25
	Practitioner Level 4, Out-of-Clinic	90853	U4	U7			\$5.41
	Practitioner Level 5, Out-of-Clinic	90853	U5	U7			\$4.03

Definition of Service: A therapeutic intervention or counseling service shown to be successful with identified populations, diagnoses and service needs. Services are directed toward achievement of specific goals defined by the youth and by the parent(s)/responsible caregiver(s) and specified in the Individualized Resiliency Plan. Services may address goals/issues such as promoting resiliency, and the restoration, development, enhancement or maintenance of:

- 1)cognitive skills;
- 2)healthy coping mechanisms;
- 3)adaptive behaviors and skills;
- 4)interpersonal skills
- 5)identifying and resolving personal, social, intrapersonal and interpersonal concerns.

Target Population	Individuals with Mental Illness and/or Substance-Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP

	New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	If a MICP Registration is submitted - 32 units If a MICP New Episode is submitted - 200 units
Re-Authorization*	200 units
Authorization Period*	180 days
Maximum Daily Units *	16 units for Brief Registration 20 units for Ongoing MICP
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 229 – C&A Mental Health 829 – C&A Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> Youth must have a primary emotional disturbance/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and The youth's level of functioning does not preclude the provision of services in an outpatient milieu; and The individual's resiliency goal/s that are to be addressed by this service must be conducive to response by a group milieu.
Continuing Stay Criteria	<ol style="list-style-type: none"> Youth continues to meet admission criteria; and Youth demonstrates documented progress relative to goals identified in the Individualized Resiliency Plan, but treatment goals have not yet been achieved.
Discharge Criteria	<ol style="list-style-type: none"> An adequate continuing care plan has been established; and one or more of the following: Goals of the Individualized Resiliency Plan have been substantially met; or Youth and family requests discharge and the youth is not in imminent danger of harm to self or others; or Transfer to another service/level of care is warranted by change in youth's condition; or Youth requires more intensive services.
Service Exclusions	See also below, Item A.2.

Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health issue precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. This service is not intended to supplant other services such as MR/DD Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 5. Youth with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, and traumatic brain injury.
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**(unless authorized as a part of a specific “package” which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality and goals must be specified and agreed upon by the youth/family/caregiver. If there are disparate goals between the youth and family, this is addressed clinically as part of the resiliency building plans and interventions.
2. When billed concurrently with IFI services, this service must be curriculum based and/or targeted to a very specific clinical issue (e.g. incest survivor groups, perpetrator groups, sexual abuse survivor groups).
3. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
4. “Out-of-Clinic” may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.
 If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide group counseling:
 - Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 2 rate)
 - Practitioner Level 2: Psychologist, CNS-PMH
 - Practitioner Level 3: LCSW, LPC, LMFT, RN
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT’s supervisee/trainee with at least a Bachelor’s degree in one of the helping professions such

as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (may only perform these functions related to treatment of addictive diseases).

- Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases).
2. Students and individuals working toward licensure as a professional counselor, social worker, or marriage and family therapist must work under direction and documented clinical supervision of a licensed professional in accordance with the rules of the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists. Agencies should refer to O.C.G.A. 43-10A-3 for the definitions of "direction" and "supervision" and the Documentation Guidelines included in this Provider Manual.
 3. The three specialties governed by the board referenced in B.2. above have different supervision requirements for individuals working toward licensure and it is the responsibility of the agency to ensure that the supervision requirements specified by the Board for the specialty (professional counseling, social work or marriage and family therapy) for which the individual is working toward licensure are met (also reference Documentation Guidelines included in this manual).
 4. Addiction counselor trainees may perform counseling as a trainee for a period of up to 3 years if they meet the requirements in O.C.G.A. 43-10A. This is limited to the provision of chemical dependency treatment under direction and supervision of a clinical supervisor approved by the certification body under which the trainee is seeking certification. Agencies should refer to O.C.G.A. 43-10A-3 for the definitions of "direction" and "supervision" and to the Documentation Guidelines set forth in this Provider Manual.
 5. The status of students, trainees, and individuals working toward licensure must be disclosed to the individuals receiving services from trainees and interns and signatures/titles of these practitioners must also include "S/T."
 6. Maximum face-to-face ratio cannot be more than 10 consumers to 1 direct service staff based on average group attendance

C. Clinical Operations

1. The membership of a multiple family group (H0004 HQ) consists of multiple family units such as a group of two or more parent(s) from different families either with (HR) or without (HS) participation of their child/children.
2. Practitioners and supervisors of those providing this service are expected to maintain knowledge and skills regarding group practice such as selecting appropriate participants for a particular group, working with the group to establish necessary group norms and goals, and understanding and managing group dynamics and processes.

D. Service Access

1. Group Counseling may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
2. This service may not be provided and billed for individuals who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or

- other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility
3. For the purposes of this specific service, when this service is provided to multi-family groups, the definition of family **excludes** employees of Child Caring Institution, employees of DJJ or employees of DFCS as recipients of service.

E. Additional Medicaid Requirements

The daily maximum within a CSU for combined Group Training/Counseling is 4 units/day.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Group Outpatient Services: Group Training

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Group Skills Training & Development	Practitioner Level 4, In-Clinic	H2014	HQ	U4	U6		\$4.43
	Practitioner Level 5, In-Clinic	H2014	HQ	U5	U6		\$3.30
	Practitioner Level 4, Out-of-Clinic	H2014	HQ	U4	U7		\$5.41
	Practitioner Level 5, Out-of-Clinic	H2014	HQ	U5	U7		\$4.03
	Practitioner Level 4, In-Clinic, with client present	H2014	HQ	HR	U4	U6	\$4.43
	Practitioner Level 5, In-Clinic, with client present	H2014	HQ	HR	U5	U6	\$3.30
	Practitioner Level 4, Out-of-Clinic, with client present	H2014	HQ	HR	U4	U7	\$5.41
	Practitioner Level 5, Out-of-Clinic, with client present	H2014	HQ	HR	U5	U7	\$4.03
	Practitioner Level 4, In-Clinic, without client present	H2014	HQ	HS	U4	U6	\$4.43
	Practitioner Level 5, In-Clinic, without client present	H2014	HQ	HS	U5	U6	\$3.30
	Practitioner Level 4, Out-of-Clinic, without client present	H2014	HQ	HS	U4	U7	\$5.41
	Practitioner Level 5, Out-of-Clinic, without client present	H2014	HQ	HS	U5	U7	\$4.03

Definition of Service: A therapeutic interaction shown to be successful with identified populations, diagnoses and service needs. Services are directed toward achievement of specific goals defined by the youth and by the parent(s)/responsible caregiver(s) and specified in the Individualized Resiliency Plan. Services may address goals/issues such as promoting resiliency, and the restoration, development, enhancement or maintenance of:

- 1) illness and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed);
- 2) problem solving skills;
- 3) healthy coping mechanisms;
- 4) adaptive skills;
- 5) interpersonal skills;
- 6) daily living skills;
- 7) resource management skills;
- 8) knowledge regarding emotional disturbance, substance related disorders and other relevant topics

that assist in meeting the youth's and family's needs; and 9) skills necessary to access and build community resources and natural support systems.	
Target Population	Individuals with Mental Illness and/or Substance-Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	If a MICP Registration is submitted - 32 units If a MICP New Episode is submitted - 200 units
Re-Authorization*	200 units
Maximum Daily Units*	16 units
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 229 – C&A Mental Health 829 – C&A Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> Youth must have a primary emotional disturbance/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and The youth's level of functioning does not preclude the provision of services in an outpatient milieu; and The individual's resiliency goal/s that are to be addressed by this service must be conducive to response by a group milieu.
Continuing Stay Criteria	<ol style="list-style-type: none"> Youth continues to meet admission criteria; and Youth demonstrates documented progress relative to goals identified in the Individualized Resiliency Plan, but treatment goals have not yet been achieved.
Discharge Criteria	<ol style="list-style-type: none"> An adequate continuing care plan has been established; and one or more of the following: Goals of the Individualized Resiliency Plan have been substantially met; or Youth and family requests discharge and the youth is not in imminent danger of harm to self or others; or Transfer to another service/level of care is warranted by change in youth's condition; or Youth requires more intensive services.
Service Exclusions	See also below, Item A.2.

Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health issue precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. This service is not intended to supplant other services such as MR/DD Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 5. Youth with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, and traumatic brain injury.
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**(unless authorized as a part of a specific “package” which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The functional goals addressed through this service must be specified and agreed upon by the youth/family/caregiver. If there are disparate goals between the youth and family, this is addressed clinically as part of the resiliency building plans and interventions.
2. When billed concurrently with IFI services, this service must be curriculum based and/or targeted to a very specific clinical issue (e.g. incest survivor groups, perpetrator groups, sexual abuse survivor groups).
3. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
4. “Out-of-Clinic” may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.
 If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide group training:
 - Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 4 rate)
 - Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate)

- Practitioner Level 3: LCSW, LPC, LMFT, RN (reimbursed at Level 4 rate)
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology
 - Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above
2. Maximum face-to-face ratio cannot be more than 10 consumers to 1 direct service staff based on average group attendance

C. Clinical Operations

1. Out-of-clinic group skills training is allowable and clinically valuable for some consumers; therefore, this option should be explored to the benefit of the consumer. In this event, staff must be able to assess and address the individual needs and progress of each consumer consistently throughout the intervention/activity (e.g. in an example of teaching 2-3 consumers to access public transportation in the community, group training may be given to help each consumer individually to understand the bus schedule in a way that makes sense to them, to address questions/concerns each may have about how to use the bus, perhaps to spend time riding the bus with the consumers and assisting each to understand and become comfortable with riding the bus in accordance with *individual* goals, etc).
2. The membership of a multiple family Group Training session (H2014 HQ) consists of multiple family units such as a group of two or more parent(s) from different families either with (HR) or without (HS) participation of their child/children.

D. Service Access

1. Group Training may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
2. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility

E. Additional Medicaid Requirements

The daily maximum within a CSU for combined Group Training/Counseling is 4 units/day.

F. Reporting & Billing Requirements

1. All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.
2. Out-of-clinic group skills training is denoted by the U7 modifier.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual

Individual Counseling

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately <u>20-30 minutes</u> face-to-face with patient	Practitioner Level 2, In-Clinic	90804	U2	U6			64.95
	Practitioner Level 3, In-Clinic	90804	U3	U6			50.02
	Practitioner Level 4, In-Clinic	90804	U4	U6			33.83
	Practitioner Level 5, In-Clinic	90804	U5	U6			25.21.
	Practitioner Level 2, Out-of-Clinic	90804	U2	U7			77.93
	Practitioner Level 3, Out-of-Clinic	90804	U3	U7			61.13
	Practitioner Level 4, Out-of-Clinic	90804	U4	U7			40.59
	Practitioner Level 5, Out-of-Clinic	90804	U5	U7			30.25
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately <u>45-50 minutes</u> face-to-face with patient	Practitioner Level 2, In-Clinic	90806	U2	U6			116.90
	Practitioner Level 3, In-Clinic	90806	U3	U6			90.03
	Practitioner Level 4, In-Clinic	90806	U4	U6			60.89
	Practitioner Level 5, In-Clinic	90806	U5	U6			45.38
	Practitioner Level 2, Out-of-Clinic	90806	U2	U7			140.28
	Practitioner Level 3, Out-of-Clinic	90806	U3	U7			110.04
	Practitioner Level 4, Out-of-Clinic	90806	U4	U7			73.07
	Practitioner Level 5, Out-of-Clinic	90806	U5	U7			54.46
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately <u>75-80 minutes</u> face-to-face with patient	Practitioner Level 2, In-Clinic	90808	U2	U6			194.84
	Practitioner Level 3, In-Clinic	90808	U3	U6			150.05
	Practitioner Level 4, In-Clinic	90808	U4	U6			101.48
	Practitioner Level 5, In-Clinic	90808	U5	U6			75.64
	Practitioner Level 2, Out-of-Clinic	90808	U2	U7			233.80
	Practitioner Level 3, Out-of-Clinic	90808	U3	U7			183.39
	Practitioner Level 4, Out-of-Clinic	90808	U4	U7			121.78
	Practitioner Level 5, Out-of-Clinic	90808	U5	U7			90.76
Individual psychotherapy,	Practitioner Level 2, In-Clinic	90810	U2	U6			64.95

interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately <u>20-30 minutes</u> face-to-face with patient	Practitioner Level 3, In-Clinic	90810	U3	U6	50.02
	Practitioner Level 4, In-Clinic	90810	U4	U6	33.83
	Practitioner Level 5, In-Clinic	90810	U5	U6	25.21
	Practitioner Level 2, Out-of-Clinic	90810	U2	U7	77.93
	Practitioner Level 3, Out-of-Clinic	90810	U3	U7	61.13
	Practitioner Level 4, Out-of-Clinic	90810	U4	U7	40.59
	Practitioner Level 5, Out-of-Clinic	90810	U5	U7	30.25
Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately <u>45-50 minutes</u> face-to-face with patient	Practitioner Level 2, In-Clinic	90812	U2	U6	116.90
	Practitioner Level 3, In-Clinic	90812	U3	U6	90.03
	Practitioner Level 4, In-Clinic	90812	U4	U6	60.89
	Practitioner Level 5, In-Clinic	90812	U5	U6	45.38
	Practitioner Level 2, Out-of-Clinic	90812	U2	U7	140.28
	Practitioner Level 3, Out-of-Clinic	90812	U3	U7	110.04
	Practitioner Level 4, Out-of-Clinic	90812	U4	U7	73.07
Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal	Practitioner Level 5, Out-of-Clinic	90812	U5	U7	54.46
	Practitioner Level 2, In-Clinic	90814	U2	U6	194.84
	Practitioner Level 3, In-Clinic	90814	U3	U6	150.05
	Practitioner Level 4, In-Clinic	90814	U4	U6	101.48
	Practitioner Level 5, In-Clinic	90814	U5	U6	75.64
Practitioner Level 2, Out-of-Clinic	90814	U2	U7	233.80	

communication, in an office or outpatient facility, approximately 75-80 minutes face-to-face with patient	Practitioner Level 3, Out-of-Clinic	90814	U3	U7	183.39
	Practitioner Level 4, Out-of-Clinic	90814	U4	U7	121.78
	Practitioner Level 5, Out-of-Clinic	90814	U5	U7	90.76

Definition of Service: A therapeutic intervention or counseling service shown to be successful with identified youth populations, diagnoses and service needs, provided by a qualified clinician. Techniques employed involve the principles, methods and procedures of counseling that assist the youth in identifying and resolving personal, social, vocational, intrapersonal and interpersonal concerns. Services are directed toward achievement of specific goals defined by the youth and by the parent(s)/responsible caregiver(s) and specified in the Individualized Resiliency Plan. These services address goals/issues such as promoting resiliency, and the restoration, development, enhancement or maintenance of:

- 1) the illness/emotional disturbance and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed);
- 2) problem solving and cognitive skills;
- 3) healthy coping mechanisms;
- 4) adaptive behaviors and skills;
- 5) interpersonal skills; and
- 6) knowledge regarding the emotional disturbance, substance related disorders and other relevant topics that assist in meeting the youth's needs.

Best/evidence based practice modalities may include (as clinically appropriate): Motivational Interviewing/Enhancement Therapy, Cognitive Behavioral Therapy, Behavioral Modification, Behavioral Management, Rational Behavioral Therapy, Dialectical Behavioral Therapy, Interactive Play Therapy, and others as appropriate to the individual and clinical issues to be addressed.

Target Population	Children/Adolescents with a Mental Illness/Emotional Disturbance and/or Substance-Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	1 encounter
Initial Authorization*	24 units

Re-Authorization*	24 units
Maximum Daily Units*	1 unit
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 228 – C&A Mental Health 828 – C&A Addictive Diseases
Admission Criteria	1. Youth must have a primary emotional disturbance/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. The youth's level of functioning does not preclude the provision of services in an outpatient milieu; and
Continuing Stay Criteria	1. Individual continues to meet admission criteria; and 2. Individual demonstrates documented progress relative to goals identified in the Individualized Resiliency Plan, but treatment goals have not yet been achieved.
Discharge Criteria	1. Adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Resiliency Plan have been substantially met; or 3. Individual/family requests discharge and individual is not in imminent danger of harm to self or others; or 4. Transfer to another service is warranted by change in individual's condition; or 5. Individual requires a service approach which supports less or more intensive need.
Service Exclusions	Designated Crisis Stabilization Unit services and Intensive Family Intervention
Clinical Exclusions	1. Severity of behavioral health disturbance precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. There is no outlook for improvement with this particular service 5. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder and traumatic brain injury.

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality and goals must be specified and agreed upon by the youth/family/caregiver.
2. Any diagnosis given to an individual must come from persons identified in

O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.

3. "Out-of-Clinic" may only be billed when:

- Travel by the practitioner is to a non-contiguous location; and/or
- Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
- Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
- Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.

If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide group training:

- Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 2 rate)
- Practitioner Level 2: Psychologist, CNS-PMH
- Practitioner Level 3: LCSW, LPC, LMFT, RN
- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (addiction counselors may only perform these functions related to treatment of addictive diseases).
- Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases).

2. Students and individuals working toward licensure as a professional counselor, social worker, or marriage and family therapist must work under direction and documented clinical supervision of a licensed professional in accordance with the rules of the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists. Agencies should refer to O.C.G.A. 43-10A-3 for the definitions of "direction" and "supervision" and the Documentation Guidelines included in this Provider Manual.

3. The three specialties governed by the board referenced in B.2. above have different supervision requirements for individuals working toward licensure and it is the responsibility of the agency to ensure that the supervision requirements specified by the Board for the specialty (professional

counseling, social work or marriage and family therapy) for which the individual is working toward licensure are met.

4. Addiction counselor trainees may perform counseling as a trainee for a period of up to 3 years if they meet the requirements in O.C.G.A. 43-10A. This is limited to the provision of chemical dependency treatment under direction and supervision of a clinical supervisor approved by the certification body under which the trainee is seeking certification. Agencies should refer to O.C.G.A. 43-10A-3 and to the Documentation Guidelines included in this Provider Manual for the definitions of "direction" and "supervision".
5. The status of students, trainees, and individuals working toward licensure must be disclosed to the individuals receiving services from trainees and interns and signatures/titles of these practitioners must also include "S/T."

C. Clinical Operations

Practitioners and supervisors of those providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based counseling practices.

D. Service Access

1. Individual Counseling may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
2. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility

E. Additional Medicaid Requirements

Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Medication Administration							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Comprehensive Medication Services	Practitioner Level 2, In-Clinic	H2010	U2	U6			\$33.40
	Practitioner Level 3, In-Clinic	H2010	U3	U6			\$25.39
	Practitioner Level 4, In-Clinic	H2010	U4	U6			\$17.40
	Practitioner Level 5, In-Clinic	H2010	U5	U6			\$12.97
	Practitioner Level 2, Out-of-Clinic	H2010	U2	U7			\$42.51
	Practitioner Level 3, Out-of-Clinic	H2010	U3	U7			\$33.01
	Practitioner Level 4, Out-of-Clinic	H2010	U4	U7			\$22.14
Therapeutic, prophylactic or diagnostic injection	Practitioner Level 2, In-Clinic	96372	U2	U6			\$33.40
	Practitioner Level 3, In-Clinic	96372	U3	U6			\$25.39
	Practitioner Level 4, In-Clinic	96372	U4	U6			\$17.40
	Practitioner Level 2, Out-of-Clinic	96372	U2	U7			\$42.51
	Practitioner Level 3, Out-of-Clinic	96372	U3	U7			\$33.01
	Practitioner Level 4, Out-of-Clinic	96372	U4	U7			\$22.14
Alcohol, and/or drug services, methadone administration and/or service (provision of the drug by a licensed program)	Practitioner Level 2, In-Clinic	H0020	U2	U6			\$33.40
	Practitioner Level 3, In-Clinic	H0020	U3	U6			\$25.39
	Practitioner Level 4, In-Clinic	H0020	U4	U6			\$17.40

Definition of Service: As reimbursed through this service, medication administration includes the act of introducing a drug (any chemical substance that, when absorbed into the body of a living organism, alters normal bodily function) into the body of another person by any number of routes including, but not limited to the following: oral, nasal, inhalant, intramuscular injection, intravenous, topical, suppository or intraocular. Medication administration requires a physician's order and must be administered by licensed or credentialed* medical personnel under the supervision of a physician or registered nurse in accordance with O.C.G.A.

This service does **not** cover the supervision of self-administration of medications (See Clinical Exclusions below).

The service must include:

1. An assessment, by the licensed or credentialed medical personnel administering the medication, of the youth's physical, psychological and behavioral status in order to make a recommendation regarding whether to continue the medication and/or its means of administration, and whether to refer the youth to the physician for a medication review.
2. Education to the youth and/or family/responsible caregiver(s), by appropriate licensed medical personnel, on the proper administration and monitoring of prescribed medication in accordance with the youth's resiliency plan.

For individuals who need opioid maintenance, the Opioid Maintenance service should be requested.

Target Population	Youth with SED Youth with Substance Related Disorders Youth with Co-occurring SED and Substance Related Disorders Youth with Co-occurring SED and MR/DD (if the medications are related to the SED issue) Youth with Co-occurring Substance Related Disorders and MR/DD (if the medications are related to the substance use/abuse issue)
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	1 encounter
Initial Authorization*	With the submission of MICP Registration - 6 units shared With the submission of MICP New Episode: H2010 & 96372 = 60 units shared
Re-Authorization*	H2010 & 96372 = 60 units shared
Maximum Daily Units*	1 unit
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 224 – C&A Mental Health 824 – C&A Addictive Diseases

Admission Criteria	<ol style="list-style-type: none"> 1. Youth presents symptoms that are likely to respond to pharmacological interventions; and 2. Youth has been prescribed medications as a part of the treatment array; and 3. Youth/family/responsible caregiver is unable to self-administer/administer prescribed medication because: <ol style="list-style-type: none"> a. Although the youth is willing to take the prescribed medication, it is in an injectable form and must be administered by licensed medical personnel; or b. Although youth is willing to take the prescribed medication, it is a Class A controlled substance which must be stored and dispensed by medical personnel in accordance with state law; or c. Administration by licensed/credentialed medical personnel is necessary because an assessment of the youth's physical, psychological and behavioral status is required in order to make a determination regarding whether to continue the medication and/or its means of administration and/or whether to refer the youth to the physician for a medication review. d. Due to the family/caregiver's lack of capacity there is no responsible party to manage/supervise self-administration of medication (refer youth/family for CSI and/or Family or Group Training in order to teach these skills)
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Youth continues to meet admission criteria.
Discharge Criteria	<ol style="list-style-type: none"> 1. Youth no longer needs medication; or 2. Youth/Family/Caregiver is able to self-administer, administer, or supervise self-administration medication; and 3. Adequate continuing care plan has been established.
Service Exclusions	<ol style="list-style-type: none"> 1. Does not include medication given as a part of Ambulatory Detoxification. Medication administered as part of Ambulatory Detoxification is billed as "Ambulatory Detoxification." 2. Must not be billed in the same day as Nursing Assessment 3. For individuals who need opioid maintenance, the Opioid Maintenance service should be requested.
Clinical Exclusions	<p>This service does not cover the supervision of self-administration of medications. Self-administration of medications can be done by anyone physically and mentally capable of taking or administering medications to himself/herself. Youth and adults with mental health issues, or developmental disabilities are very often capable of self administration of medications even if supervision by others is needed in order to adequately or safely manage self-administration of medication and other activities of daily living.</p>

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. There must be a physician's order for the medication and for the administration of the medication. The order must be in the youth's chart. Telephone orders are acceptable provided they are co-signed by the physician in accordance with DBHDD standards.
2. Documentation must support that the individual is being trained in the risks and benefits of the medications being administered and that symptoms are being monitored by the staff member administering the medication.
3. Documentation must support the medical necessity of administration by licensed/credentialed medical personnel rather than by the youth, family or caregiver.
4. Documentation must support that the youth AND family/caregiver is being trained in the principles of self-administration of medication and supervision of self-administration or that the youth/family/caregiver is physically or mentally unable to self-administer/administer. This documentation will be subject to scrutiny by the External Review Organization in reauthorizing services in this category.
5. This service does **not** include the supervision of self-administration of medication.
6. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
7. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.
 If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide comprehensive medication services:
 - Practitioner Level 2: Advanced Practice Registered Nurse (APRN), PA, Pharmacist
 - Practitioner Level 3: Registered Nurse (RN)
 - Practitioner Level 4: Licensed Practical Nurse (LPN)
 - Practitioner Level 5: Qualified Medication Aide (QMA) who works in a CLA
2. The following individuals can provide therapeutic, prophylactic or diagnostic injections:
 - Practitioner Level 2: Advanced Practice Registered Nurse (APRN), PA, Pharmacist
 - Practitioner Level 3: Registered Nurse (RN)

- Practitioner Level 4: Licensed Practical Nurse (LPN)
3. The following individuals can provide alcohol to drug services, methadone administration and/or service provision:
 - Practitioner Level 2: Advanced Practice Registered Nurse (APRN), PA, Pharmacist
 - Practitioner Level 3: Registered Nurse (RN)
 - Practitioner Level 4: Licensed Practical Nurse (LPN)
 4. Qualified Medication Aides working in a Community Living Arrangement (CLA) may administer medication only in a CLA.

C. Clinical Operations

1. Medication administration may not be billed for the provision of single or multiple doses of medication that a consumer has the ability to self-administer, either independently or with supervision by a caregiver, either in a clinic or a community setting. In a group home/CCI setting, for example, medications may be managed by the house parents or residential care staff and kept locked up for safety reasons. Staff may hand out medication to the residents but this does not constitute administration of medication for the purposes of this definition and, like other watchful oversight and monitoring functions, are not reimbursable treatment services.
2. If consumer/family requires training in skills needed in order to learn to manage his/her own medications and their safe self-administration and/or supervision of self-administration, this skills training service can be provided via the Community Support or Family/Group Training services in accordance with the person's individualized recovery/resiliency plan.
3. Foster parents are eligible for CSI or Family/Group Training in the supervision of medication self-administration by youth living in their care, but agency employees, including those working in residential settings such as group homes and CCIs, are not eligible for CSI or Family/Group Training in the supervision of medication self-administration by youth in their care.

D. Service Access

1. Medication Administration may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
2. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility.

E. Additional Medicaid Requirements

As in all other settings, the daily maximum within a CSU for Medication Administration is 1 unit/day.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Nursing Assessment and Health Services							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Nursing Assessment/ Evaluation	Practitioner Level 2, In-Clinic	T1001	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	T1001	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	T1001	U4	U6			\$20.30
	Practitioner Level 2, Out-of-Clinic	T1001	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	T1001	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	T1001	U4	U7			\$24.36
RN Services, up to 15 minutes	Practitioner Level 2, In-Clinic	T1002	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	T1002	U3	U6			\$30.01
	Practitioner Level 2, Out-of-Clinic	T1002	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	T1002	U3	U7			\$36.68
LPN/LVN Services, up to 15 minutes	Practitioner Level 4, In-Clinic	T1003	U4	U6			\$20.30
	Practitioner Level 4, Out-of-Clinic	T1003	U4	U7			\$24.36
Health and Behavior Assessment, Face-to-Face with the Patient, Initial Assessment	Practitioner Level 2, In-Clinic	96150	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	96150	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	96150	U4	U6			\$20.30
	Practitioner Level 2, Out-of-Clinic	96150	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	96150	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	96150	U4	U7			\$24.36
Health and Behavior Assessment, Face-to-Face with the Patient, Re- assessment	Practitioner Level 2, In-Clinic	96151	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	96151	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	96151	U4	U6			\$20.30
	Practitioner Level 2, Out-of-Clinic	96151	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	96151	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	96151	U4	U7			\$24.36

Definition of Service: This service requires face-to-face contact with the youth/family/caregiver to monitor, evaluate, assess, and/or carry out a physician's orders regarding the psychological and/or

physical problems and general wellness of the youth. It includes:

- 1) Providing nursing assessments and interventions to observe, monitor and care for the physical, nutritional, behavioral health and related psychosocial issues, problems or crises manifested in the course of the youth's treatment;
- 2) Assessing and monitoring the youth's response to medication(s) to determine the need to continue medication and/or to determine the need to refer the youth to a physician for a medication review;
- 3) Assessing and monitoring a youth's medical and other health issues that are either directly related to the mental health or substance related disorder, or to the treatment of the disorder (e.g. diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, seizures, etc);
- 4) Consulting with the youth's family/caregiver about medical, nutritional and other health issues related to the individual's mental health or substance related issues;
- 5) Educating the youth and family/responsible caregiver(s) on medications and potential medication side effects (especially those which may adversely affect health such as weight gain or loss, blood pressure changes, cardiac abnormalities, development of diabetes or seizures, etc);
- 6) Consulting with the youth and family/caregiver (s) about the various aspects of informed consent (when prescribing occurs/APRN)
- 7) Training for self-administration of medication; and
- 8) Venipuncture required to monitor and assess mental health, substance disorders or directly related conditions, and to monitor side effects of psychotropic medications, as ordered by a Licensed Physician, Physician Assistant or Advanced Practice Nurse.
- 9) Providing assessment, testing, and referral for infectious diseases.

Target Population	Youth with Mental Health issues/SED and/or Substance Related Disorders Individuals with Mental Health issues/SED and MR/DD Individuals with Substance Related Disorders and MR/DD
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	15 minutes
Initial Authorization*	With the submission of MICP Registration -12 units With the submission of MICP New Episode - 60 units
Re-Authorization*	60 units
Maximum Daily Units*	16 units (32 for Ambulatory Detox)
Authorization Period*	180 days

UAS: Budget and Expense Categories	<u>Core Services Provider</u> 223 – C&A Mental Health 823 – C&A Addictive Diseases
Admission Criteria	1. Youth presents with symptoms that are likely to respond to medical/nursing interventions; or 2. Youth has been prescribed medications as a part of the treatment array or has a confounding medical condition.
Continuing Stay Criteria	1. Youth continues to demonstrate symptoms that are likely to respond to or are responding to medical interventions; or 2. Youth exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; or 3. Youth demonstrates progress relative to medical/medication goals identified in the Individualized Resiliency Plan, but treatment goals have not yet been achieved.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Youth no longer demonstrates symptoms that are likely to respond to or are responding to medical/nursing interventions; or 3. Goals of the Individualized Resiliency Plan have been substantially met; or 4. Youth/family requests discharge and youth is not in imminent danger of harm to self or others.
Service Exclusions	Medication Administration, Opioid Maintenance
Clinical Exclusions	Routine nursing activities that are included as a part of ambulatory detoxification and medication administration/methadone administration.

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. Nutritional assessments indicated by a youth's confounding health issues might be billed under this code (96150, 96151). No more than 8 units specific to nutritional assessments can be billed for an individual within a year. This specific assessment must be provided by a Registered Nurse or by a Licensed Dietician (LD).
2. This service does **not** include the supervision of self-administration of medication.
3. Each nursing contact should document the checking of vital signs (Temperature, Pulse, Blood Pressure, Respiratory Rate, and weight, if medically indicated or if related to behavioral health symptom or behavioral health medication side effect) in accordance with general psychiatric nursing practice.
4. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
5. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or

- Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
- Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day. If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide nursing assessment and evaluation services:
 - Practitioner Level 2: Advanced Practice Registered Nurse (APRN)
 - Practitioner Level 3: Registered Nurse (RN)
 - Practitioner Level 4: Licensed Practical Nurse (LPN), Licensed Dietician (LD)
2. The following individuals can provide RN services:
 - Practitioner Level 2: Advanced Practice Registered Nurse (APRN)
 - Practitioner Level 3: Registered Nurse (RN)
3. The following individuals can provide LPN/LVN services:
 - Practitioner Level 4: Licensed Practical Nurse (LPN)
4. The following individuals can provide Health or Behavior Assessment (initial and reassessment) services:
 - Practitioner Level 2: Advanced Practice Registered Nurse (APRN)
 - Practitioner Level 3: Registered Nurse (RN), Licensed Dietician (LD)
 - Practitioner Level 4: Licensed Practical Nurse (LPN)

C. Clinical Operations

1. Venipuncture billed under this service must include documentation that includes canula size utilized, insertion site, number of attempts, location, and consumer tolerance of procedure.
2. All nursing procedures must include relevant consumer-centered, family-oriented education regarding the procedure.

D. Service Access

1. Nursing Assessment and Care may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.

2. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility

E. Additional Medicaid Requirements

The daily maximum within a CSU for Nursing Assessment and Health Services is 5 units/day.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Pharmacy & Lab

Definition of Service: Pharmacy and Lab Services include operating or purchasing services to order, package, and distribute prescription medications. It includes provision of assistance to consumers to access indigent medication programs, sample medication programs and payment for necessary medications when no other funding source is available. This service provides for appropriate lab work, such as drug screens and medication levels, to be performed. This service is to ensure that necessary medication and lab services are not withheld or delayed to consumers based on inability to pay.

Target Population	Individuals with Mental Illness or Substance Related Disorders
Benefit Information	Available to all Core Customers with emphasis on priority populations.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Unit Value	
Initial Authorization	
Re-Authorization	
Authorization Period	
UAS: Budget and Expense Categories	
Admission Criteria	Individual has been assessed by a prescribing professional to need a psychotropic, anti-cholinergic, addiction specific, or anti-convulsant (as related to behavioral health issue) medication and/or lab work required for persons entering services, and/or monitoring medication levels.
Continuing Stay Criteria	Individual continues to meet the admission criteria as determined by the prescribing professional
Discharge Criteria	1. Individual no longer demonstrates symptoms that are likely to respond to or are responding to pharmacologic interventions; or 2. Individual requests discharge and individual is not imminently dangerous or under court order for this intervention.
Service Exclusions	
Clinical Exclusions	

Additional Service Requirements:

A. Required Components

1. Service must be provided by a licensed pharmacy or through contract with a licensed pharmacy.

2. Agency must participate in any pharmaceutical rebate programs or pharmacy assistance programs that promote consumer access in obtaining medication.
3. Providers shall refer all consumers who have an inability to pay for medications or services to the local county offices of the Department's Division of Family and Children's Services for the purposes of determining Medicaid eligibility.

B. Staffing Requirements

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

Not a Medicaid Rehabilitation Option service. Medicaid recipients may access the general Medicaid pharmacy program as prescribed by the Department of Community Health.

F. Reporting & Billing Requirements

All applicable MICP and other DBHDD reporting requirements must be met.

Psychiatric Treatment

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately <u>20-30 minutes</u> face-to-face with patient with medical evaluation and management services.	Practitioner Level 1, In-Clinic, Child Program	90805	HA	U1	U6		\$97.02
	Practitioner Level 1, Out-of-Clinic, Child Program	90805	HA	U1	U7		\$123.48
	Practitioner Level 2, In-Clinic, Child Program	90805	HA	U2	U6		\$64.95
	Practitioner Level 2, Out-of-Clinic, Child Program	90805	HA	U2	U7		\$77.93
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately <u>45-50 minutes</u> face-to-face with patient with medical evaluation and management services.	Practitioner Level 1, In-Clinic, Child Program	90807	HA	U1	U6		\$174.63
	Practitioner Level 1, Out-of-Clinic, Child Program	90807	HA	U1	U7		\$222.26
	Practitioner Level 2, In-Clinic, Child Program	90807	HA	U2	U6		\$116.90
	Practitioner Level 2, Out-of-Clinic, Child Program	90807	HA	U2	U7		\$140.28

Pharmaceutical Management	Practitioner Level 1, In-Clinic, Child Program	90862	HA	U1	U6	\$58.21
	Practitioner Level 1, Via interactive audio and video telecommunication systems, Child Program	90862	GT	HA	U1	\$58.21
	Practitioner Level 1, Out-of-Clinic, Child Program	90862	HA	U1	U7	\$74.09
	Practitioner Level 2, In-Clinic, Child Program	90862	HA	U2	U6	\$38.97
	Practitioner Level 2, Via interactive audio and video telecommunication systems, Child Program	90862	GT	HA	U2	\$38.97
	Practitioner Level 2, Out-of-Clinic, Child Program	90862	HA	U2	U7	\$46.76

Definition of Service: The provision of specialized medical and/or psychiatric services that include, but are not limited to:

- a. Psychotherapeutic services with medical evaluation and management including evaluation and assessment of physiological phenomena (including co-morbidity between behavioral and physical health care issues);
- b. Assessment and monitoring of an individual's status in relation to treatment with medication,
- c. Assessment of the appropriateness of initiating or continuing services.

Youth must receive appropriate medical interventions as prescribed and provided by a physician (or physician extender) that shall support the individualized goals of resiliency as identified by the youth/family/caregiver and their Individualized Resiliency Plan (within the parameters of the youth/family's informed consent).

Target Population	Youth with SED or Substance Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	1 encounter
Initial Authorization*	12 units
Re-Authorization*	12 units
Maximum Daily Units*	1 unit (see Item F.1, and F.2. for exceptions)

Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 222 – C&A Mental Health 822 – C&A Addictive Diseases
Admission Criteria	1. Individual is determined to be in need of psychotherapy services and has confounding medical issues which interact with behavioral health diagnosis, requiring medical oversight; or 2. Individual has been prescribed medications as a part of the treatment array
Continuing Stay Criteria	1. Individual continues to meet the admission criteria; or 2. Individual exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; or 3. Individual continues to present symptoms that are likely to respond to pharmacological interventions; or 4. Individual continues to demonstrate symptoms that are likely to respond or are responding to medical interventions; or 5. Individual continues to require management of pharmacological treatment in order to maintain symptom remission.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual has withdrawn or been discharged from service; or 3. Individual no longer demonstrates symptoms that need pharmacological interventions.
Service Exclusions	
Clinical Exclusions	

**(unless authorized as a part of a specific “package” which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. Telemedicine may be utilized for an initial Psychiatric Diagnostic Examination as well as for ongoing Psychiatric Diagnostic Examination via the use of appropriate procedure codes with the GT modifier.
2. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a Physician’s Assistant (PA) or Advanced Practice Registered Nurse (APRN: Nurse Practitioner or Clinical Nurse Specialist—Psychiatry & Mental Health) working in conjunction with a physician with an approved job description or protocol.
3. “Out-of-Clinic” may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.

If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide individual psychotherapy face to face with medical evaluation and management services:

- Practitioner Level 1: Physician/Psychiatrist
- Practitioner Level 2: CNS-PMH (Clinical Nurse Specialist in Psychiatric/Mental Health)

2. The following individuals can provide pharmacological management:

- Practitioner Level 1: Physician/Psychiatrist
- Practitioner Level 2: PA or APRN (if authority to perform this task is delegated by physician through approved job description or protocol)

C. Clinical Operations

1. It is expected that youth and families will be treated as full partners in the treatment regimen/services planned and received. As such, it is expected that practitioners will fully discuss treatment options with youth and families and allow for individual choice when possible. Discussion of treatment options should include a full disclosure of the pros and cons of each option (e.g. full disclosure of medication/treatment regimen potential side effects, potential adverse reactions-- including potential adverse reaction from not taking medication as prescribed, and expected benefits). If such full discussion/disclosure to the youth is not possible or advisable according to the clinical judgment of the practitioner, this should be documented in the youth's chart (including the specific information that was not discussed and a compelling rationale for lack of discussion/disclosure). The family/caregiver's role is an essential component of this dialogue.

D. Service Access

1. Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site.
2. Psychiatric Treatment may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
3. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility

E. Additional Medicaid Requirements

1. The Daily maximum within a CSU for Pharmacologic Management is 1 unit/day.

2. Even if a physician providing behavioral health treatment and care also has his/her own Medicaid number, he/she should bill this code via the approved provider agency's Medicaid number through the Medicaid Category of Service (COS) 440.

F. Reporting & Billing Requirements

1. Within this service group, there is an allowance for when a U2 practitioner conducts an intervention and, because of clinical indicators presenting during this intervention, a U1 practitioner needs to provide another unit due to the concern of the U2 supervisee (e.g. Physician's Assistant provides and bills 90805U2U6 and because of concerns, requests U1 intervention following his/her billing of U2 intervention). The use of this practice should be rare and will be subject to additional utilization review scrutiny.
2. Within this service group, a second unit with a U1 modifier may be used in the event that a Telemedicine Psychiatric Treatment unit is provided and it indicates a need for a face-to-face assessment (e.g. 90862GTU1 is billed and it is clinically indicated that a face-to-face by an on-site physician needs to immediately follow based upon clinical indicators during the first intervention, then 90862U1, can also be billed in the same day).
3. All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be adhered to.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Psychological Testing

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Psychological Testing – Psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psycho-pathology e.g. MMP, Rorschach, WAIS (per hour of psychologist's or physician's time, both face-to-face with the patient and time interpreting test results and preparing the report)	Practitioner Level 2, In-Clinic	96101	U2	U6			155.87
	Practitioner Level 2, Out-of-Clinic	96101	U2	U7			187.04
Psychological Testing – Psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psycho-pathology e.g. MMP, Rorschach, WAIS) with qualified healthcare professional interpretation and report, administered by technician, per hour of technician time, face-to-face	Practitioner Level 3, In-Clinic	96102	U3	U6			120.04
	Practitioner Level 3, Out-of-Clinic	96102	U3	U7			146.71
	Practitioner Level 4, In-Clinic	96102	U4	U6			81.18
	Practitioner Level 4, Out-of-Clinic	96102	U4	U7			97.42

Definition of Service: Psychological testing consists of a face-to-face assessment of emotional functioning, personality, cognitive functioning (e.g. thinking, attention, memory) or intellectual abilities using an objective and standardized tool that has uniform procedures for administration and scoring and utilizes normative data upon which interpretation of results is based.

Psychological tests are only administered and interpreted by those who are properly trained in their

selection and application. The practitioner administering the test ensures that the testing environment does not interfere with the performance of the examinee and ensures that the environment affords adequate protections of privacy and confidentiality.

This service covers both the face-to-face administration of the test instrument(s) by a qualified examiner as well as the time spent by a psychologist or physician (with the proper education and training) interpreting the test results and preparing a written report.

Target Population	Children & Adolescents with a known or suspected mental health diagnosis and/or Substance-Related Disorder
Benefit Information	Requires a MICP Registration or MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	1 hour
Initial Authorization	5 units
Re-Authorization	5 units
Maximum Daily Units	5 units
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 232 – C&A Mental Health 832 – C&A Addictive Diseases
Admission Criteria	1. A known or suspected mental illness or substance-related disorder; and 2. Initial screening/intake information indicates a need for additional undetermined supports and recovery/resiliency planning; and 3. Youth meets Core Customer eligibility.
Continuing Stay Criteria	The youth's situation/functioning has changed in such a way that previous assessments are outdated.
Discharge Criteria	Each intervention is intended to be a discrete time-limited service that modifies treatment/support goals or is indicated due to change in illness/disorder.
Service Exclusions	None
Clinical Exclusions	None

Additional Service Criteria:

A. Required Components

1. There may be no more than one comprehensive battery of 96101 and 96102 provided to one individual within a year.

2. There may be no more than 10 combined hours of 96101 and 96012 provided to one individual within a year.
3. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
4. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

The following practitioners can perform Psychological Testing:

- Practitioner Level 2: Psychologist
- Practitioner Level 3: LCSW, LPC, LMFT in conjunction with Psychologist
- Practitioner Level 4: Psychologist's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state.

C. Clinical Operations

The individual consumer (and caregiver/responsible family members etc as appropriate) must actively participate in the assessment processes.

D. Service Access

1. Psychological Testing may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
2. This service may not be provided and billed for individuals who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility

E. Additional Medicaid Requirements

These services are performed in accordance with GA Practice Acts.

F. Reporting & Billing Requirements

All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual
2. In addition to the authorization produced through this service, documentation of clinical assessment findings from this service should also be completed and placed in the individual's chart.

Service Plan Development							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Service Plan Development	Practitioner Level 2, In-Clinic	H0032	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	H0032	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	H0032	U4	U6			\$20.30
	Practitioner Level 5, In-Clinic	H0032	U5	U6			\$15.13
	Practitioner Level 2, Out-of-Clinic	H0032	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	H0032	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	H0032	U4	U7			\$24.36
	Practitioner Level 5, Out-of-Clinic	H0032	U5	U7			\$18.15

Definition of Service: Children/Families access this service when it has been determined through an initial screening that the youth has mental health or addictive disease concerns. The Individualized Recovery/Resiliency Plan results from the Diagnostic and Behavioral Health Assessments and is required within the first 30 days of service, with ongoing plans completed as demanded by individual consumer need and/or by service policy.

The Individualized Recovery/Resiliency Planning process includes the individual's perspective, and should include family and/or significant others as well as collateral agencies/treatment providers/relevant individuals.

Information from a comprehensive assessment should ultimately be used to develop, together with the child and/or caretakers an Individualized Resiliency Plan that supports resilience and that is based on goals identified by the individual with parent(s)/responsible caregiver(s) involvement. As indicated, medical, nursing, peer, school, nutritional, etc staff should provide information from records, and various multi-disciplinary assessments for the development of the Individualized Resiliency Plan (IRP).

The cornerstone component of the child and adolescent Individualized Recovery/Resiliency Plan (IRP) involves a discussion with the child/adolescent and parent(s)/responsible caregiver(s) regarding what resiliency means to them personally (e.g. the child having more friends, improvement of behavioral health symptoms, staying in school, improved family relationships etc), and the development of goals (i.e. outcomes) and objectives that are defined by and meaningful to the child/adolescent based upon the individual's articulation of their recovery hopes. Concurrent with the development of the IRP, an individualized safety plan should also be developed, with the individual child and parent(s)/responsible caregiver(s) guiding the process through the free expression of their wishes and through their assessment of the components developed for the safety plan as being realistic for them.

The entire process should involve the child/youth as a full partner and should focus on service and resiliency goals/outcomes as identified by the individual and his/her family.

Recovery/Resiliency planning shall set forth the course of care by:

- Prioritizing problems and needs;
- Stating goals which will honor achievement of stated hopes, choice, preferences and desired outcomes of the youth/family;
- Assuring goals/objectives are related to the assessment;
- Defining goals/objectives that are individualized, specific, and measurable with achievable timeframes;
- Defining discharge criteria and desired changes in levels of functioning and quality of life to objectively measure progress;
- Transition planning at onset of service delivery;
- Selecting services and interventions of the right duration, intensity, and frequency to best accomplish these objectives;
- Assuring there is a goal/objective that is consistent with the service intent; and
- Identifying qualified staff who are responsible and designated for the provision of services.

Target Population	Children & Adolescents with a known or suspected mental health diagnosis and/or Substance-Related Disorder
Benefit Information	Available to all known or suspected Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 10-50: Resiliency Maintenance 60-90: Low Intensity Community-Based Services 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	32 units (Combined with H0031 – Behavioral Health Assessment)
Re-Authorization*	32 units (Combined with H0031 – Behavioral Health Assessment)
Maximum Daily Units*	24 units (Combined with H0031 – Behavioral Health Assessment)
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 231 – C&A Mental Health 831 – C&A Addictive Diseases
Admission Criteria	1. A known mental illness or substance-related disorder; and 2. Initial screening/intake information indicates a need for additional undetermined supports and recovery/resiliency planning; and 3. Youth meets Core Customer eligibility.
Continuing Stay Criteria	The youth's situation/functioning has changed in such a way that previous assessments are outdated.
Discharge Criteria	Each intervention is intended to be a discrete time-limited service that

	modifies treatment/support goals or is indicated due to change in illness/disorder.
Service Exclusions	None
Clinical Exclusions	None

**(unless authorized as a part of a specific “package” which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The service plan must include elements articulated in the Documentation Guideline chapter in this Provider Manual.
2. “Out-of-Clinic” may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day. If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following practitioners can perform Service Planning:
 - Practitioner Level 2: Psychologist, APRN, PA
 - Practitioner Level 3: LCSW, LPC, LMFT, RN
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT’s supervisee/trainee with at least a Bachelor’s degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC(II, III); CAC-I or Addiction Counselor Trainee with at least a Bachelor’s degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (addictions counselors may only perform these functions related to treatment of addictive diseases).
 - Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases).

C. Clinical Operations

1. The individual consumer (and caregiver/responsible family members etc as appropriate) should actively participate in planning processes.

2. The Individualized Resiliency Plan should be directed by the individual's/family's personal resiliency goals as defined by them.
3. Safety/crisis planning should be directed by the youth/family and their needs/wishes to the extent possible and clinically appropriate. Plans should not contain elements/components that are not agreeable to, meaningful for, or realistic for the youth/family and that the youth/family is therefore not likely to follow through with.
4. The Multipurpose Informational Consumer Profile (MICP) format for treatment planning does not meet the requirements for a comprehensive Individualized Recovery/Resiliency Plan and should not be used as such. Guidelines for treatment planning are contained in the "Documentation Guidelines" referenced above and in the DBHDD Standards contained in this Provider Manual.
5. For youth at or above age 17 who may need long-term behavioral health supports, plan elements should include transitional elements related to post-primary education, adult services, employment (supported or otherwise), and other transitional approaches to adulthood.

D. Service Access

1. Service Plan Development may not be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
2. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility

E. Additional Medicaid Requirements

The daily maximum within a CSU for combined Behavioral Health Assessment and Service Plan Development is 24 units/day.

F. Reporting & Billing Requirements

All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual
2. The initial authorization/IRP and each subsequent authorization/IRP must be completed within the time-period specified by DBHDD.
3. Every record must contain an IRP in accordance with these Service Guidelines and with the DBHDD Standards contained in this Provider Manual.

Mental Health and Addictive Disease

***Children and Adolescents'
SPECIALTY Benefit Package***

Behavioral Assistance							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Behavioral Assistance	Therapeutic Behavioral Services, Per 15 minutes	H2019					\$11.31
	Therapeutic Behavioral Services, Per 15 minutes, Group	H2019	HQ				\$2.83
	Therapeutic Behavioral Services, Per 15 minutes, In School	H2019	IS				\$11.31

Definition of Service: Behavioral Assistance provided by Core or IFI providers and is designed to support youth and their families in meeting behavioral goals in various community settings. Behavioral Assistance is targeted for children and adolescents who are at risk of out-of-home placement or who have returned home from residential placement and need flexible wrap-around supports to ensure safety and to support community integration. Behavioral Assistants aid the family in implementing safety plans and behavior management plans when youth are at risk for offending behaviors, aggression, and oppositional defiance. The service must be tied to specific treatment goals and be developed in coordination with the youth and family.

Behavioral Assistants provide support to youth and their families during periods when behaviors have been typically problematic, such as during morning preparation for school, at bedtime, after school or other times when there is evidence of a pattern of an escalation of problem behaviors. Behavior Assistance can be provided during times when a youth is transitioning from a PRTF, residential program, hospital or CSU and the family needs hands on support. It may be provided in school classrooms or on school busses for short periods of time to help a youth's transition from hospitals and residential settings but is not intended as a permanent solution to problem behaviors at school.

Behavioral Assistance provides the youth and family support in a variety of environments, i.e., the home, community, and after school recreation programs. The Behavioral Assistants have flexible schedules in response to individualized consumer and family needs. The service cannot be utilized to supplant parental supervision or as a substitute for routine child-care. The service is available during the day, evenings, on weekends, and on holidays. It may include time spent transporting a youth to an activity but will not allow for reimbursement for staff members to travel when the youth is not in the vehicle.

Behavioral Assistance may not be used to supplant other services, such as Community Support or Intensive Family Intervention. The service may be used as an adjunct to CSI or IFI when a clear and distinct behavioral challenge has been identified that threatens to disrupt the child's ability to live in the community or participate in school and community life. This service may be utilized in conjunction with CSI or IFI when the need for supervision, support and positive role modeling has been demonstrated in addition to the skills training offered by CSI or the clinical services and family training provided by IFI teams. IFI services require a specific team composition dedicated to the IFI team; therefore, a staff member who provides IFI services may not also provide Behavioral Assistance. CSI and Behavioral Assistance may be provided by a single staff member at different times, according to the type of service that is provided. For example, when a CSI staff member is training a child to follow a reward system as

part of a behavior plan, CSI would be billed. However, if a child's behavior is being monitored as part of a behavioral plan and no direct skills training occurs, Behavioral Assistance would be billed.

Behavioral Assistants work closely with the treatment team, attending clinical and supervision meetings, and work in a collaborative way with family members. This service cannot be used to supplant services provided through other funding mechanisms or through other agencies.

Target Population	C&A with SED C&A with AD Issues C&A with Co-occurring SED/AD
Benefit Information	Available to Youth identified as core customers who are: -enrolled in "regular" Medicaid due to disability and are receiving core and/or specialty services; or -are covered by the DBHDD's Fee-For-Service Core and/or IFI via contract or Provider Agreement with the DBHDD. This service is not available to consumers whose benefits are managed through CMOs or other insurance plans.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 100-130: High Intensity Community-Based Services
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization	320 units
Re-Authorization	320 units
Maximum Daily Units	96 units (32 units if receiving this service in a group setting/HQ or in a school setting/IS)
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Core Services Providers</u> 258-C&A Mental Health 858-C&A Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Children and adolescents who meet the target population and core services definition; and 2. Children and adolescents with multi-agency involvement; or 3. Children and adolescents at risk of going into residential support or detention; or 4. Children and adolescents and family need support and assistance in implementing a community safety plan; or 5. Children and adolescents and family need additional supports during a crisis period in order to be safely maintained in the home during periods of stabilization; or 6. Children and adolescents have behavioral challenges that require direct supervision in order to access community activities; or 5. Children and adolescents who are transitioning from hospitals, residential settings, PRTFs, or CSUs.
Continuing Stay Criteria	1. Individual continues to meet the admission criteria.

Discharge Criteria	<ol style="list-style-type: none"> 1. No longer meets admission criteria, and 2. Consumer is no longer at risk for out of home placement, and/or 3. Family has skills to support the child without assistance, or 4. Consumer or family/guardian requests discharge from service, or; 5. Consumer requires a more intensive level of supports than are available through this service
Service Exclusions	PRTF Individuals served through CMOs or other insurance plans
Clinical Exclusions	None

Additional Service Criteria:

A. Required Components

1. In any review of this service, the mix of services to support the consumer will be important. A combination of other therapeutic services such as CSI, individual, group, or family therapy or training is allowed. Services, interventions, and schedules must be planned with the consumer and family.
2. Behavioral Assistance is typically provided one-to-one; however, small groups up to 4 consumers to 1 staff member may occasionally participate together in community events, such as a special recreational event or an outing to a restaurant, museum, or park.
3. Collaboration between family, Behavioral Assistants and other members of the treatment team regarding activities, interventions, and service components is an on-going process.
4. The family's cultural, religious, and social preferences are considered in the development and implementation of any service plan.
5. The family's scheduling needs are emphatically considered in the provision of this service.
6. Behavioral Assistants respect the privacy, routines, and authority of the parent/caregiver, unless there is a suspicion of abuse, or neglect which must be reported as defined by agency policy.
7. Only Core or IFI providers may deliver this service.

B. Staffing Requirements

1. Bachelor's degree in a related field; or
2. Associate's degree with 1 year direct experience working with children or adolescents in a behavioral health setting; or
3. High School Diploma and 3 years direct experience working with children or adolescents in a behavioral health setting; and
4. Ability to communicate effectively with the family and consumer according to the intervention plan; and
5. Ability to communicate effectively in writing to prepare correspondence, reports, and progress notes.

C. Clinical Operations

1. Individualized behavioral support services must be related to the goals and objectives on the IRP. The Behavioral Assistant must engage in purposeful, goal related visits in the consumer's home or other community setting.
2. Behavioral Assistants must be supervised by a LCSW, LMSW, LPC, LAPC, LMFT, LAMFT, or Licensed Clinical Psychologist.
3. Behavioral Assistants must attend clinical meetings related to a consumer's treatment needs.

4. Parents/caregivers are partners with the Behavioral Assistant. The Behavioral Assistant does not relieve the family of parental responsibility or decision-making.
5. Children and Adolescents receiving this service are also enrolled in Core Services and/or IFI services.

D. Service Access

Behavioral Assistance is available during the day, evening, weekends, and holidays. Hours are determined by the specific needs of the consumer and family.

E. Additional Medicaid Requirements

This is not a Medicaid reimbursable service; ABD Medicaid recipients may receive this service, if medically necessary, but it shall be billed via encounter to the DBHDD.

F. Reporting & Billing Requirements

1. See Item E. above.
2. All applicable MICP and other required DBHDD reporting must be followed.

G. Documentation Requirements

1. As with all interventions, this intervention must be documented on the IRP and must be tied to a treatment goal. There must be a weekly summary note indicating progress towards IRP goals. In addition, a daily attendance log that captures the amount of time each consumer spent in the program and supports billing must be maintained. Any unusual or significant events must be documented and communicated to the program supervisor on the day of the occurrence. A current schedule of activities must be posted. All collateral contacts should be documented in the consumer's medical record.
2. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Community Based Inpatient Psychiatric and Substance Detoxification Services

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Psychiatric Health Facility Service, Per Diem		H2013					

Definition of Service: A short-term stay in a licensed and accredited community-based hospital for the treatment or rehabilitation of a psychiatric and/or substance related disorder. Services are of short duration and provide treatment for an acute psychiatric or behavioral episode. This service may also include Medically Managed Inpatient Detoxification at ASAM Level IV-D.

Target Population	Children and Adolescents with a SED Children and Adolescents with a Substance Related Disorder Children and Adolescents with Co-occurring SMI and a Substance Related Disorder
Benefit Information	Available to Core Customers in need of Ongoing Services and requires MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 190-240: Medically Managed Inpatient Residential (transition)
Ordering Practitioner	
Unit Value	Per Diem
Reimbursement Rate	Per negotiation
Initial Authorization	5 days
Maximum Daily Units	1 unit
Re-Authorization	3 days
Authorization Period	5 days
UAS: Budget and Expense Categories	C&A Crisis Services Provider 235 – C&A Mental Health 835 – C&A Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Youth with SED that is experiencing serious impairment; persistent, recurrent, severe, or major symptoms (such as psychoses); or who is experiencing major suicidal, homicidal or high risk tendencies as a result of the mental illness; or 2. Youth's need is assessed for 24/7 supports which must be one-on-one and may not be met by any service array which is available in the community; or 3. Youth is assessed as meeting diagnostic criteria for a Substance Related Disorder according to the latest version of the DSM; and one or more of the following: <ol style="list-style-type: none"> A. Youth is experiencing signs of severe withdrawal, or there is evidence (based on history of substance intake, age, gender,

	<p>previous withdrawal history, present symptoms, physical condition, and/or emotional/behavioral condition) that severe withdrawal syndrome is imminent; or</p> <p>B. Level IV-D is the only available level of service that can provide the medical support and comfort needed by the youth, as evidenced by:</p> <p>i. A detoxification regimen or Youth's response to that regimen that requires monitoring or intervention more frequently than hourly, or</p> <p>ii. The youth's need for detoxification or stabilization while pregnant, until she can be safely treated in a less intensive service.</p>
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Youth continues to meet admission criteria; and 2. Youth's withdrawal signs and symptoms are not sufficiently resolved to the extent that they can be safely managed in less intensive services;
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following; 2. Youth no longer meets admission and continued stay criteria; or 3. Family requests discharge and youth is not imminently dangerous to self or others; or 4. Transfer to another service/level of care is warranted by change in the individual's condition; or 5. Individual requires services not available in this level of care.
Service Exclusions	<p>This service may not be provided simultaneously to any other service in the service array excepting short-term access to services that provide continuity of care or support planning for discharge from this service.</p>
Clinical Exclusions	<p>Youths with any of the following unless there is clearly documented evidence of an acute psychiatric/addiction episode overlaying the primary diagnosis:</p> <ol style="list-style-type: none"> a. Autism b. Mental Retardation/Developmental Disabilities c. Organic Mental Disorder; or d. Traumatic Brain Injury

Additional Service Criteria:

A. Required Components

1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2
2. A physician's order in the individual's record is required to initiate detoxification services. Verbal orders or those initiated by a Physician's Assistant or Clinical Nurse Specialist are acceptable provided they are signed by the physician within 24 hours or the next working day.

B. Staffing Requirements

Only nursing or other licensed medical staff under supervision of a physician may provide detoxification services.

C. Clinical Operations

Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.

D. Service Access

E. Additional Medicaid Requirements

Not applicable. This is not a Medicaid billable service.

F. Reporting & Billing Requirements

All applicable MICP and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Community Transition Planning							
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Community Transition Planning	Community Transition Planning (State Hospital)	T2038	ZH				\$20.92
	Community Transition Planning (Crisis Stabilization Unit)	T2038	ZC				\$20.92
	Community Transition Planning (PRTF)	T2038	ZP				\$20.92
	Community Transition Planning (Jail / Youth Detention Center)	T2038	ZJ				\$20.92
	Community Transition Planning (Other)	T2038	ZO				\$20.92

If you are an IFI provider, you may provide this service to those youth who are working towards transition into the community (as defined in the CTP guideline) and are expected to receive services from the IFI team. Please refer to the Core Guidelines for the detail.

Crisis Stabilization Unit Services							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Behavioral Health; Short-term Residential (Non-Hospital Residential Treatment Program Without Room & Board, Per Diem)		H0018	HA	U2			209.22
Behavioral Health; Short-term Residential (Non-Hospital Residential Treatment Program Without Room & Board, Per Diem)		H0018	HA	TB	U2		

Definition of Service: This is a residential alternative to or diversion from inpatient hospitalization, offering psychiatric stabilization and detoxification services. The program provides medically monitored residential services for the purpose of providing psychiatric stabilization and substance detoxification services on a short-term basis. Specific services may include:

- 1) Psychiatric medical assessment;
- 2) Crisis assessment, support and intervention;
- 3) Medically Monitored Residential Substance Detoxification (at ASAM Level III.7-D).
- 4) Medication administration, management and monitoring;
- 5) Brief individual, group and/or family counseling; and
- 6) Linkage to other services as needed.

Services must be provided in a facility designated and certified by the DBHDD as an emergency receiving and evaluation facility

Target Population	Children and Adolescents experiencing: Severe situational crisis SED Substance-Related Disorders Co-Occurring Substance-Related Disorders and Mental Illness Co-Occurring Mental Illness and Mental Retardation Co-Occurring Substance-Related Disorders and Mental Retardation
Benefit Information	Available to Core Customers in need of Ongoing Services. Requires a MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential OR "clinical information to justify the service provided in the "justification text" on the MICP if CAFAS scores are higher/lower.
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)

Unit Value	1 day
Initial Authorization	20 units
Re-Authorization	
Maximum Daily Units	1 unit
Authorization Period	20 days
UAS: Budget and Expense Categories	<u>Crisis Services Provider</u> 234 – C&A Mental Health 834 – C&A Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Treatment at a lower level of care has been attempted or given serious consideration; and #2 and/or #3 are met: 2. Child/Youth has a known or suspected illness/disorder in keeping with target populations listed above; or 3. Child/Youth is experiencing a severe situational crisis which has significantly compromised safety and/or functioning; and one or more of the following: <ol style="list-style-type: none"> a. Child/Youth presents a substantial risk of harm or risk to self, others, and/or property or is so unable to care for his or her own physical health and safety as to create a life-endangering crisis. Risk may range from mild to imminent; or b. Child/Youth has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; or c. Child/youth demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities to manage the crisis; or d. For detoxification services, individual meets admission criteria for Medically Monitored Residential Detoxification.
Continuing Stay Criteria	This service may be utilized at various points in the child's course of treatment and recovery; however, each intervention is intended to be a discrete time-limited service that stabilizes the individual.
Discharge Criteria	<ol style="list-style-type: none"> 1. Child/youth no longer meets admission guidelines requirements; or 2. Crisis situation is resolved and an adequate continuing care plan has been established; or 3. Child/youth does not stabilize within the evaluation period and must be transferred to a higher intensity service.
Service Exclusions	None
Clinical Exclusions	<ol style="list-style-type: none"> 1. Youth is not in crisis. 2. Youth does not present a risk of harm to self or others or is able to care for his/her physical health and safety. 3. Severity of clinical issues precludes provision of services at this level of intensity.

Additional Service Criteria:

A. Required Components

1. Crisis Stabilization Units (CSU) providing medically monitored short-term residential psychiatric stabilization and detoxification services shall be designated by the Department as both an emergency receiving facility and an evaluation facility and must be surveyed and certified by the DBHDD.

2. In addition to all service qualifications specified in this document, providers of this service must adhere to and be certified under the *Provider Manual for Community Mental Health, Developmental Disability and Addictive Disorders "Core Requirements for All Providers"* and DBHDD "Core Requirements for Crisis Stabilization Programs Operated by Community Service Boards."
3. The maximum length of stay in a crisis bed is 14 adjusted days (excluding Saturdays, Sundays and state holidays) for children and adolescents.
4. The maximum length of stay in crisis AND transitional beds combined is 29 adjusted calendar days (excluding Saturdays, Sundays and state holidays).
5. Youth occupying transitional beds must receive services from outside the CSU (i.e. community-based services) on a daily basis.
6. Services must be provided in a facility designated as an emergency receiving and evaluation facility that is not also an inpatient hospital, a freestanding Institute for Mental Disease (IMD), or a licensed substance abuse detoxification facility.
7. A CSU must have documented operating agreements and referral mechanisms for psychiatric disorders, addictive disorders, and physical healthcare needs that are beyond the scope of the CSU and that require inpatient treatment. Operating agreements must delineate the type and level of service to be provided by the private or public inpatient hospital or treatment facility. These agreements must specifically address the criteria and procedures for transferring the youth to a designated treatment facility when the CPS is unable to stabilize the youth.

B. Staffing Requirements

1. A physician or a staff member under the supervision of a physician, practicing within the scope of State law, must provide Crisis Stabilization Unit (CSU) Services.
2. All services provided within the CPS must be delivered under the direction of a physician. A physician must conduct an assessment of new admissions, address issues of care, and write orders as required.
3. A CSU must employ a fulltime Nursing Administrator who is a Registered Nurse.
4. A CSU must have a Registered Nurse present at the facility at all times.
5. Staff-to-client ratios must be established based on the stabilization needs of clients being served and in accordance with the "Core Requirements for Crisis Stabilization Programs Operated by Community Service Boards."
6. Functions performed by Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Registered Nurses, and Licensed Practical Nurses must be performed within the scope of practice allowed by State law and Professional Practice Acts.

C. Clinical Operations

1. A physician must evaluate a child/youth referred to a CSU within 24 hours of the referral.
2. A CSU must follow the seclusion and restraint procedures included in the Department's "Core Requirements for Crisis Stabilization Programs operated by Community Service Boards."
3. For youth with co-occurring diagnoses including mental retardation/developmental disabilities, this service must target the symptoms, manifestations, and skills-development related to the identified behavioral health issue.
4. Youth served in transitional beds may access an array of community-based services in preparation for their transition out of the CSU, and are expected to engage in community-based services daily while in a transitional bed.

D. Service Access

E. Additional Medicaid Requirements

1. Effective July 1, 2007, Medicaid stopped paying a bundled daily rate for these services. Crisis Stabilization Units with 16 beds or less should bill individual services for Medicaid recipients.
2. The individual services listed below may be billed up to the daily maximum listed for services provided in a Crisis Stabilization Unit. Billable services and daily limits within CSUs are as follows:

Service	Daily Maximum Billable Units
Crisis Intervention	8 units
Diagnostic Assessment	2 units
Psychiatric Treatment	1 unit (Pharmacological Mgmt only)
Nursing Assessment and Care	5 units
Medication Administration	1 unit
Group Training/Counseling	4 units
Beh Health Assmnt & Serv. Plan Devel.	24 units
Medication Administration	1 unit

3. Medicaid claims for the services in E.2. above may **not** be billed for any service provided to Medicaid-eligible individuals in CSUs with greater than 16 beds.

F. Reporting & Billing Requirements

1. Providers must report information on all consumers served in CSUs no matter the funding source:
 - a. The CSU shall submit MICPs for all individuals served (state-funded, Medicaid funded, private pay, other third party payor, etc);
 - b. The CSU shall submit per diem encounters (H0018HAU2 or H0018HATBU2) for all individuals served (state-funded, Medicaid funded, private pay, other third party payor, etc) even if sub-parts cited in E.2 above are also billed as a claim to Medicaid;
 - c. Providers must designate either CSU bed use or transitional bed use in encounter submissions through the absence of or use of the TB modifier. TB represents "Transitional Bed."
2. Unlike all other DBHDD residential services, the start date of a CSU span encounter submission may be in one month and the end date may be in the next. The span of reporting must cover continuous days of service and the number of units must equal the days in the span.
3. All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

1. In order to report a per diem encounter, the consumer must have participated in the program for a minimum of 8 hours in the identified 12:00AM to 11:59PM day.
2. For individuals transferred to transitional beds, the date of transfer must be documented in a progress note and filed in the individual's chart.
3. Daily engagement in community-based services must also be documented in progress notes for those occupying transitional beds.

4. Specific to item E.2. above, the notes for the program must have documentation to support the per diem AND, if the program bills sub-parts to Medicaid (in accordance with E. above), each discrete service delivered must have documentation to support that sub-billable code (e.g. Group is provided for 1 hour, Group is billed for 1 hour, Group note is for 4 units at the 15 minute rate and meets all the necessary components of documentation for that sub-code).
5. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Intensive Family Intervention							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Intensive Family Intervention	Practitioner Level 3, In-Clinic	H0036	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	H0036	U4	U6			\$22.14
	Practitioner Level 5, In-Clinic	H0036	U5	U6			\$16.50
	Practitioner Level 3, Out-of-Clinic	H0036	U3	U7			\$41.26
	Practitioner Level 4, Out-of-Clinic	H0036	U4	U7			\$27.06
	Practitioner Level 5, Out-of-Clinic	H0036	U5	U7			\$20.17

Definition of Service: A service intended to improve family functioning by clinically stabilizing the living arrangement, promoting reunification or preventing the utilization of out of home therapeutic venues (i.e. psychiatric hospital, therapeutic foster care, psychiatric residential treatment facilities, or therapeutic residential intervention services) for the identified youth. Services are delivered utilizing a team approach and are provided primarily to youth in their living arrangement and within the family system. Services promote a family-based focus in order to:

- Defuse the current behavioral health crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence;
- Ensure linkage to needed community services and resources; and
- Improve the individual child's/adolescent's ability to self-recognize and self-manage behavioral health issues, as well as the parents'/responsible caregivers' capacity to care for their children.

Services should include crisis intervention, intensive supporting resources management, individual and/or family counseling/training, and other rehabilitative supports to prevent the need for out-of-home placement or other more intensive/restrictive services. Services are based upon a comprehensive, individualized assessment and are directed towards the identified youth and his or her behavioral health needs/strengths and goals as identified in the Individualized Resiliency Plan.

Services shall also include resource coordination/acquisition to achieve the youth's and their family's goals and aspirations of self-sufficiency, resiliency, permanency, and community integration.

Target Population	Children and Adolescents with SED and/or Substance Related Disorders.
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Benefit Information	Available to Core Customers in need of Ongoing Services and requires a MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 100-130: High Intensity Community-Based Services 140-180: Medically Monitored Community Residential (transition) 190-240: Medically Managed Community Residential (transition) 190-240: Medically Managed Inpatient Residential (transition)
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization	288 units
Re-Authorization	288 units
Maximum Daily Units	48 Units is the standard maximum
Authorization Period	90 days
UAS: Budget and Expense Categories	<u>Intensive Treatment Services Provider</u> 253 – C&A Mental Health 853 – C&A Addictive Diseases
Admission Criteria	<p>1. Youth has a diagnosis and duration of symptoms which classify the illness as SED (youth with SED have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet DSM diagnostic criteria and results in a functional impairment which substantially interferes with or limits the child's role or functioning in the family, school, or community activities) and/or is diagnosed with a Substance Related Disorder;</p> <p>and one or more of the following:</p> <p>2. Youth has received documented services through other services such as Core Services and exhausted less intensive out-patient programs. Treatment at a lower intensity has been attempted or given serious consideration, but the risk factors for out-of-home placement are compelling (see item G.1. below); The less intensive services previously provided must be documented in the clinical record (even if it via by self-report of the youth and family). or</p> <p>3. Youth and/or family has insufficient or severely limited resources or skills necessary to cope with an immediate behavioral health crisis; or</p> <p>4. Youth and/or family behavioral health issues are unmanageable in traditional outpatient treatment and require intensive, coordinated clinical and supportive intervention; or</p> <p>5. Because of behavioral health issues, the youth is at immediate risk of out-of-home placement or is currently in out-of-home placement (non-institutional-See D.3. and D.4. below) and reunification is imminent (therefore, intensive work needs to begin with the youth and family regarding the youth's treatment goals); or</p> <p>6. Because of behavioral health issues, the youth is at immediate risk of</p>

	legal system intervention or is currently involved with DJJ for behaviors/issues related to SED and/or the Substance-related disorder.
Continuing Stay Criteria	1. Same as above.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Youth no longer meets the admission criteria; or 3. Goals of the Individualized Resiliency Plan have been substantially met; or 4. Individual and family request discharge, and the individual is not imminently dangerous; or 5. Transfer to another service is warranted by change in the individual's condition; or 6. Individual requires services not available within this service.
Service Exclusions	<p>Not offered in conjunction with Individual Counseling, Family Counseling/Training, Crisis Intervention Services, and/or Crisis Stabilization Unit, PRTF, or inpatient hospitalization.</p> <p>May utilize Community Support for continuity of care.</p> <p>This service may not be provided to youth who reside in a congregate setting in which the caregivers are paid (such as group homes, child caring institutions, intensive residential treatment facilities, or any other living environment that is not comprised of family, guardians, or other more permanent caregivers). A short-term exception would be if the youth were preparing for transition back to a single-family unit, the family member is present during the intervention, and the service is directed to supporting the unification/reunification of the youth and his/her identified family/caregiver and takes place in that home and community.</p> <p>The billable activities of IFI do not include:</p> <ol style="list-style-type: none"> 1) Transportation 2) Observation/Monitoring 3) Tutoring/Homework Completion 4) Diversionary Activities (i.e. activities without therapeutic value)
Clinical Exclusions	<ol style="list-style-type: none"> 1. Youth with any of the following unless there is clearly documented evidence of an acute psychiatric/addiction episode overlaying the primary diagnosis: <ol style="list-style-type: none"> a. Autism Spectrum Disorders including Asperger's Disorder (any youth currently enrolled June 30, 2010 shall remain eligible throughout current authorization. b. Mental Retardation/Developmental Disabilities c. Organic Mental Disorder; or d. Traumatic Brain Injury 2. Youth can effectively and safely be treated at a lower intensity of service. This service may not be used in lieu of family preservation and post-adoption services for youth who do not meet the admission criteria for IFI.

Additional Service Criteria: (Elements below which are different from the FY10 version of this definition will be effective 8/1/2010)

A. Required Components:

1. The organization has established procedures/protocols for handling emergency and crisis situations that describe methods for intervention with youth who require psychiatric hospitalization.
2. Each Intensive Family Intervention (IFI) provider must have policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff that engage in outreach activities.
3. The organization must have an Intensive Family Intervention Organizational Plan that addresses the description of:
 - Particular evidence-based family preservation, resource coordination, crisis intervention and wraparound service models utilized (MST, DBT, MDFT, etc), types of intervention practiced. The organization must show documentation that each staff member is trained in the model for in-home treatment (i.e., certification, ongoing supervision provided by the training entity, documentation of annual training in the model).
 - The organization must have demonstrable evidence that they are working towards fidelity to the model that they have chosen (via internal Quality Assurance documentation, staff training documentation, etc). There should not be an eclectic approach to utilizing models. Fidelity to the chosen model is the expectation for each IFI team. If an agency chooses to develop a plan which incorporates more than one evidenced-based model within the organization, there must be a particular evidenced-based model chosen for each IFI team (e.g. an agency administers 3 teams, 2 which will adhere to one model, one to another model). Documentation of training for each staff person on the evidenced-based in-home model they will be utilizing in the provision of services should exist in their personnel files. Some models do not have the stringent staffing requirements that this service requires. The expectation is that staffing patterns in accordance with the specific model used are in compliance with staffing requirements noted in this service definition
 - Hours of operation, the staff assigned, and types of services provided to consumers, families, parents, and/or guardians,
 - How the plan for services is modified or adjusted to meet the needs specified in each Individualized Resiliency Plan, and
4. At least 60% of service units must be provided face-to-face with children and their families, and 80% of all face-to-face service units must be delivered in non-clinic settings over the authorization period.
5. At least 50% of IFI face-to-face units must include the child (identified consumer). However, when the child is not included in the face-to-face contacts, the focus of the contacts must remain on the child and their goals as identified on their IRP.
6. Documentation of how the team works with the family and other agencies/support systems (such as LIPTs, provider agencies, etc) to build a clinically oriented transition and discharge plan is required and should be documented in the clinical record of the consumer.
7. IFI is an individual intervention and may not be provided or billed for more than 1 youth at the same time (including siblings); however, youth participating in an IFI program may receive group skills training and/or group counseling in keeping with his/her individual recovery plan. Siblings who are each authorized to receive IFI must receive individualized services, but family interventions can be

done jointly, with only one bill being submitted to the payor (For example, Sibling 1 and Sibling 2 are being seen for 2 units with the parents. Sibling 1 and Sibling 2 each have the documentation in both records, but only one claim for 2 units of reimbursement may be submitted to the payor source.)

8. IFI is intended to be provided to youth/families in their living arrangement. Services provided in school settings are allowable up to 3 hours/week as a general rule and the clinical record shall include documentation of partnership with the school. Exceptions to this 3 hours/week should be documented to include approval by the IFI Team Leader of clinical need (CAFAS scores, recent discharge from inpatient hospitalization, PRTF, CSU, etc.). The record should indicate why a specific intervention took place in the school during school hours instead of after school in the home or community. Youth receiving this service must never be taken out of the classroom for the convenience of the service provider. IFI should not supplant what schools must provide for support of a child based on the IEP.
9. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following practitioners can provide Intensive Family Intervention within the scope of the team definition which is defined in this Section:
 - Practitioner Level 2: Psychologist, CNS-PMH (reimbursed at Level 3 rate)
 - Practitioner Level 3: LCSW, LPC, LMFT, RN
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (addictions counselors may only perform counseling functions related to treatment of addictive diseases).
 - Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above

2. Intensive Family Intervention is provided by a team consisting of the family and the following practitioners:
 - One fulltime Team Leader who is licensed (and/or certified as a CAC II if the target population is solely diagnosed with substance related disorders) by the State of Georgia under the Practice Acts and has at least 3 years of experience working with children with serious emotional disturbances. LAMFT, LMSW, LAPC staff do not qualify for this position. The team leader must be actively engaged in the provision of the IFI service in the following manner:
 - (a) convene, at least weekly, team meetings that serve as the way to staff a child with the team, perform case reviews, team planning, and to provide for the team supervision and coordination of treatment/supports between and among team members. When a specific plan for a specific youth results from this meeting, there shall be an administrative note made in the youth's clinical record. In addition, there should exist a log of meeting minutes from this weekly team meeting that documents team supervision. In essence, there should be two documentation processes for these meetings; one child specific in the clinical record, and the other a log of meeting minutes for each team meeting that summarizes the team supervision process. This supervision and team meeting process is not a separately-billable activity, but the cost is accounted for within the rate methodology and supports the team approach to treatment. Weekly time for group supervision and case review is scheduled and protected.
 - (b) meet at least twice a month with families face-to-face or more often as clinically indicated.
 - (c) provide weekly, individual, clinical supervision to each IFI team member (outside of the weekly team meeting) for all services provided by that member of the IFI team. The individual supervision process is to be one-on-one supervision, documented in a log, with appropriate precautions for consumer confidentiality and indicating date/time of supervision, issues addressed, and placed in the personnel file for the identified IFI team staff.
 - (d) be dedicated to a single IFI team ("Dedicated" means that the team leader works with only one team at least 32 hours/week [up to 40 hours/week] and is a full-time employee of the agency [not a subcontractor/1099 employee]). The Team Leader will be available 24/7 to IFI staff for emergency consultation and supervision as needed.
 - Two to three fulltime equivalent paraprofessionals who work under the supervision of the Team Leader.
 - The team may also include an additional mental health professional, substance abuse professional or paraprofessional. The additional staff may be used .25 percent between 4 teams.
3. To facilitate access for those families who require it, the specialty IFI providers must have access to psychiatric and psychological services, as provided by a Physician, Psychiatrist or a Licensed Psychologist (via contract or referral agreement). These contracts or agreements must be kept in the agency's administrative files and be available for review.
4. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices. Some examples of best/evidence based practice components/models are multi-systemic therapy, multidimensional family therapy, dialectic behavioral therapy and others as appropriate to the child, family and issues to be addressed. Their personnel files must indicate documentation of training and/or certification in the evidenced-based model chosen by the organization. There shall be training documentation indicating the evidenced-

based in-home practice model each particular staff person will be utilizing in the provision of services.

5. The IFI Team's family-to-staff ratio must not exceed 12 families for teams with two paraprofessional, and 16 families for teams with three paraprofessionals (which is the maximum limit which shall not be exceeded at any given time). The staff-to-family ratio takes into consideration evening and weekend hours, needs of special populations, and geographic areas to be covered.
6. Documentation must demonstrate that at least 2 team members (one of whom must be licensed/credentialed) are providing IFI services in the support of each consumer served by the team in each month of service. One of these team members must be appropriately licensed/credentialed to provide the professional counseling and treatment modalities/interventions needed by the consumer and must provide these modalities/interventions as clinically appropriate according to the needs of the consumer.
7. It is critical that IFI team members are fully engaged participants in the supports of the served individuals. To that end, no more than 50% of staff can be "contracted"/1099 team members. Team members must work for only one IFI organization at a time and cannot be providing this service when they are a member of another team because they cannot be available as directed by families need or for consumer crises while providing on-call services for another program.
8. When a team is newly starting, there may be a period when the team does not have a "critical mass" of individuals to serve. During this time, a short-term waiver may be granted to the agency's team by the DBHDD Regional Coordinator/s for the counties served. The waiver request may address the part-time nature of a team leader and the paraprofessionals serving less than consumer-load capacity. For example, a team may only start by serving 4-6 families (versus full capacity 12-16 families) and therefore could request to have the team leader serve ½ time and a single paraprofessional. A waiver of this nature will not be granted for any time greater than 6 months. The waiver request to a Regional Coordinator must include:
 - (a) the agency's plan for building consumer capacity (not to exceed 6 months)
 - (b) the agency's corresponding plan for building staff capacity which shall be directly correlated to the item above

The Regional Coordinator has the authority to approve these short-term waivers and must copy APS Healthcare on its approval and/or denial of these waiver requests. No extension on these waivers will be granted.

9. It is understood that there may be periodic turn-over in the Team Leader position; however, the service fails to meet model-integrity in the absence of a licensed/credentialed professional to provide supervision, therapy, oversight of Individualized Recovery/Resiliency Plans, and team coordination. Understanding this scenario, an IFI team who loses a Team Leader must provide the critical functions articulated via one of the following means:
 - Documentation that there is a temporary contract for Team Leader who meets the Team Leader qualifications; or
 - Documentation that there is another fully licensed/credentialed professional who meets the Team Leader qualifications and is currently on the team providing the Team Leader functions temporarily (this would reduce the team staff to either 2 or 3 members based on the numbers of families served by the team); or
 - Documentation that there is another fully licensed/credentialed professional who meets the Team Leader qualifications and is currently employed by the agency providing the Team Leader functions temporarily (this professional would devote a minimum of 15-20 hours/week

- to supervision, therapy, oversight of Individualized Recovery/Resiliency Plans, and team coordination); or
- Documentation that there is an associate-licensed professional who could work full-time dedicated to therapy, oversight of Individualized Recovery/Resiliency Plans, and team coordination with a fully licensed/credentialed professional supporting the team for 5 hours/week for clinical supervision.

For this to be allowed, the agency must be able to provide documentation that recruitment is underway. Aggressive recruitment shall be evidenced by documentation in administrative files of position advertising. In the event that a position cannot be filled within 60 days OR in the event that there is no ability to provide the coverage articulated in this item (B.8.), there shall be notification to the State DBHDD Office and the Regional Coordinator of the intent to cease billing for the IFI service.

10. IFI providers may not share contracted team members with other IFI agencies. Staff may not work part-time for one agency and part-time with another agency due to the need for staff availability in accord with the specific needs, requirements, and requests of the families served. Team members must be dedicated to each specific team to ensure intensity, consistency, and continuity for the consumers served.

C. Clinical Operations:

1. In-home services include consultation with the individual, parents, or other caregivers regarding medications, behavior management skills, and dealing with the responses of the individual, other caregivers and family members, and coordinating with other child-serving treatment providers.
2. Individuals receiving this service must have a qualifying and verified diagnosis present in the medical record prior to the initiation of services. The verified diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
3. The Individualized Resiliency Plan must be individualized, strengths-based, and not developed from a template used for other consumers and their families. Team services are individually designed for each family, in full partnership with the family, to minimize intrusion and maximize independence.
4. Intensive Family Intervention must be provided through a team approach (as evidenced in documentation) and flexible services designed to address concrete therapeutic and environmental issues in order to stabilize a situation quickly. Services are family-driven, child focused, and focus on developing resiliency in the child. They are active and rehabilitative, and delivered primarily in the home or other locations in the community. Services are initiated when there is a reasonable likelihood that such services will lead to specific, observable improvements in the individual's functioning (with the family's needs for intensity and time of day as a driver for service delivery).
5. Service delivery must be preceded by a thorough assessment of the child and the family in order to develop an appropriate and effective treatment plan. This assessment must be clearly documented in the clinical record.
6. IFI services provided to children and youth must be coordinated with the family and significant others and with other systems of care such as the school system, the juvenile justice system, and children's protective services when appropriate to treatment and educational needs.
7. IFI providers must have the ability to deliver services in various environments, such as homes (birth, kin, adoptive, and foster), schools, homeless shelters, or street locations. The provider

should keep in mind that youth/families may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. parents' place of employment or school), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the individual in a way that may potentially embarrass the individual or breach the individual's privacy/confidentiality. Staff should be sensitive to and respectful of youth's privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with a youth during their school time, mutually agree upon a meeting time during the day that is the least conspicuous from the youth's point of view).

8. The organization must have policies that govern the provision of services in natural settings and can document that it respects the youth's and/or family's right to privacy and confidentiality when services are provided in these settings
9. When a projected discharge date for the service has been set, the youth may begin to receive more intensified Community Support services two weeks prior to IFI discharge for continuity of care purposes only.
10. When there is a crisis situation identified or there is potential risk of youth harm to self or others, there must be documentation that a licensed/credentialed practitioner is involved in that crisis resolution.
11. The IFI organization will be expected to develop and demonstrate comprehensive crisis protocols and policies, and must adhere to all safety planning criteria as specified below. Safety planning with the family must be evident at the beginning of treatment, and must include evidence that safety needs are assessed for all youth and families. The family shall be a full participant in the safety planning, and all crisis stabilization steps will be clearly identified. All parties involved, including community partners, will need to know the plan and who is responsible for supporting its implementation. When aggression is an issue within the family, a written safety plan must be developed and signed by the parents/caregivers, staff, youth, and other agency staff involved in the plan. Safety plans should also include natural supports and should not rely exclusively on professional resources. This plan must be given to the family, other agency staff, the youth, and a copy kept in the consumer's record.
12. Service delivery should be organized in a way such that there is a high frequency of services delivered at the onset of support and treatment and a tapering off as the youth moves toward discharge. As it applies to the specific youth, this shall be documented in the record.

D. Service Accessibility

1. Services must be available 24 hours a day, 7 days a week, through on-call arrangements with practitioners skilled in crisis intervention. A team response is preferable when a family requires face-to-face crisis intervention.
2. Due to the intensity of the service, providers must offer a minimum of 3 contacts per week with the youth/family except during periods where service intensity is being tapered toward the goal of transition to another service or discharge.
3. Intensive Family Intervention may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
4. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility

5. Services provided for over 6 hours on any given day must be supported with rigorous reasons in the documentation. Anything over 6 hours would need to relate to a crisis situation and the support administrative documentation should spell out the reasons for extended hours and be signed by the Team Leader.

E. Additional Medical Requirements

Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

1. If admission criteria #2 is utilized to establish admission, notation of other services provision intensity/failure should be documented in the record (even if it is self-reported by the youth/family).
2. As the team, youth, and family work toward discharge, documentation must indicate planning with the youth/family for the supports and treatment needed post-discharge from the IFI service. Referrals to subsequent services should be a part of this documentation.
3. In addition to all the references within this service guideline, providers must also document services in accordance with the specifications for documentation requirements specified in Part II, Section IV of the Provider Manual.

Outdoor Therapeutic Program							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Therapeutic Camping, Overnight		T2036					

Definition of Service: The Outdoor Therapeutic Program is a therapeutic wilderness program for troubled youth. The mission of the OTP is to operate a program that promotes growth through challenge, education, positive reinforcement and nurturing to youth and families who are deemed most in need and likely to benefit.

Referral to this program is appropriate for youth who have social, emotional, or behavioral problems in their homes, schools, and communities. Many of the youth have poor school performance, family problems, and peer relationship problems. All youth enrolled in the program are assessed by gathering information from the referral sources (sponsors) and parents or legal guardians. From the assessment process, an individualized service plan is developed with the youth, parents and referral "sponsor" to guide the youth in the program. The newly admitted youth join an existing group of peers and counselors living in a wilderness setting. Each group is an autonomous community with campers learning to accept and share responsibility for basic living requirements. Skills in teamwork, compromise and leadership emerge and develop, as campers must learn to cooperate in order for the camp community to function. The counselors provide guidance and suggestions, but the group members are responsible for planning and accomplishing the required chores and for maintaining group cohesiveness.

Target Population	Youth who are experiencing social, emotional or behavioral problems
Benefit Information	Requires a MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	N/A
Unit Value	1 day
Initial Authorization	90 days
Maximum Daily Units	1 unit
Re-Authorization	90 days
Authorization Period	90 days
UAS: Budget and Expense Categories	<u>Residential Services Provider</u> 250 – C&A Mental Health 850 – C&A Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> Youth has serious social, emotional or behavioral problems; and Youth has poor school performance, family problems, and/or peer relationship problems; and Youth has exhausted other less restrictive, community based options as demonstrated by documentation from multiple community resources Level of functioning precludes provision of services in less restrictive services Full scale IQ of 70 or higher

	6. Psychological evaluation within past 24 months
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Youth has behavior that continues to create a risk for more restrictive placement despite efforts and youth and family needs more time in the program to acquire social, functional improvements 2. Continued presence of presenting problems associated with placement. 3. Continuing stay criteria will be reviewed every 90 days. The maximum length of stay shall be 9 months. If the program is not successful within this designated amount of time, other intensive support options should be tried as alternatives.
Discharge Criteria	<ol style="list-style-type: none"> 1. No longer meets admission criteria 2. Refuses to participate in program activities 3. Alternative placement is available 4. Adequate aftercare plan have been established 5. Family/guardian requests discharge 6. Youth requires services not available through this program
Service Exclusions	Community Inpatient Services, IFI
Clinical Exclusions	<ol style="list-style-type: none"> 1. Presence of any behaviors that require a more intensive level of service due to dangerousness to self or others 2. Refuses to participate in program activities.

Additional Service Criteria:

A. Required Components

1. The Outdoor Therapeutic Camps are state-operated and administered by the DBHDD.
2. The newly admitted youth join an existing group of peers and counselors living in a wilderness setting. Each group is an autonomous community with campers learning to accept and share responsibility for basic living requirements.
3. Each camp has the capacity for 40-44 youth, ranging in age from age 12-17.
4. Staff arranges home visits/passes, when appropriate, each month to visit with their families or agency sponsors.
5. Youth typically stay in the program between 3 and 9 months, with an average length of stay of 6 months.
6. Linkages with other child-serving agencies and community supports should be clearly described within the comprehensive program descriptions.
7. There is a fully accredited school program at each camp, which is regularly monitored by the Department of Education. School attendance is required for each group and each camper is expected to demonstrate effort toward improving school behavior and school skills. Instruction is based on the Georgia Performance Standards and the assessed academic level of each camper. Teachers are certified in Special Education and one core subject area.
8. The program is accredited as an Outdoor Wilderness Program through the Council on Accreditation.
9. There will be offered 20 hours per week for school/vocational assignments.
10. There will be daily goal setting and group meetings.
11. There will be 3 meals, 1 snack, and recreation time each day.

B. Staffing Requirements

1. Two camp counselors are with each group of ten to eleven campers around the clock to monitor and supervise youth, as well as to provide training and support whenever needed.
2. Outdoor Therapeutic Camps each have four groups of ten to eleven campers. The staff to youth ratio for each group must be no less than 2:11.
3. A Camp Director who has a minimum of a bachelor's degree and experience supervising groups must supervise services.
4. The program will have one registered nurse on staff at each site that provides nursing assessment, and medication monitoring of administration under physician's orders.
5. All direct care staff must have an understanding of and ability to assess symptoms, medication issues, and behaviors in order to identify situations that require additional interventions.
6. The camp must have an educational supervisor and teachers to meet the educational needs of the campers.
7. The camp must have staff called "Family Workers" who coordinate services and help develop individualized service plans and communicate with the families, referring agencies/sponsors and provide parent/family training and education.
8. The program will refer youth who have behavioral health needs to core providers or private providers of behavioral health services and the legal guardian will have the choice of which behavioral health provider is selected. Camp staff will assist in making arrangements for youth who have identified behavioral health needs to have appointments/sessions with the outside behavioral health provider.
9. Services must have staff who has proficiency in working with the target population, with families as partners, and with local systems of care between child-serving agencies and providers of other service. They must have training and demonstrate proficiency in cultural competence as related to youth and families who are culturally different from them.
10. Staff must be trained in evidenced based practices specific to wilderness adventure-based interventions with youth/families who are experiencing social, emotional or behavioral problems.

C. Clinical Operations

1. Skills in teamwork, compromise and leadership emerge and develop, as campers must learn to cooperate in order for the camp community to function. The counselors provide guidance and suggestions, but the group members are responsible for planning and accomplishing the required chores and for maintaining group cohesiveness.
2. The most effective counseling is provided in sessions called "groups" that are called by individual campers or counselors at any time a camper's behavior or attitude is having a negative impact on the group and its goals. Campers also call "groups" to express and share feelings with other campers and to resolve conflicts.
3. Campers participate in outdoor, experiential adventure-based activities such as hiking, canoeing, caving and ropes course skills building on site and off-site as planned and scheduled by program staff.
4. When appropriate and applicable, families participate in monthly parent and family training and educational groups at camp and have opportunities to learn new parenting skills while their child is at camp.
5. Services must operate in accordance with all identified safety and health standards.
6. Services must be evidence-based, strength-based, family-driven and youth-guided and system of care oriented.
7. Discharge planning is conducted monthly and is addressed through daily monitoring of the youth's progress towards established goals in the service plan.

D. Service Access

1. Referrals are made directly to the Outdoor Therapeutic Program. The service team reviews and screens each referral to determine that the youth is appropriate and can benefit from the service. The service team also ensures that other less restrictive resources and services have been exhausted in the community. Referrals come directly from the DJJ for youth who are committed to DJJ, the Division of Family & Children Services (DFCS) for youth who are in DFCS custody and from DBHDD for youth who are in parental custody and are deemed likely to benefit from the service and other resources have been exhausted.
2. Services are available 24/7, which include monthly home visits. Youth have home visits/passes, when appropriate and applicable for family reunification goals and to practice new skills in their homes and communities.

E. Billing/Reporting Requirements

1. Youth enrolled in this service are reported through MICP enrollment and reporting mechanisms.
2. On the MICP, the required diagnostic field can be populated with 799.99 if there is no available diagnosis to report.
3. On the MICP, the required CAFAS field can be populated with 0 if there is no available CAFAS score to report.

F. Documentation Requirements

1. Documentation must reflect the activities that the youth and families participate in by date, time, and duration. Weekly documentation must indicate counselor's notes on each individual goals and objectives. Weekly group notes must be individualized and placed in each youth's medical record. Weekly documentation must reflect progress towards the resolution of presenting problems, and progress towards being fully re-integrated into school and community activities.
2. Quarterly documentation must address discharge planning progress and coordination with other agencies and the family towards this end.
3. Family Workers must coordinate with the outside behavioral health providers, such as core providers or private providers for clinical service goals and objectives that may be applicable for youth enrolled in the wilderness program. Agencies with legal custody or family members with legal custody are given choices about which provider of behavioral health services are available to serve the needs of the youth.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Structured Activity Supports							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Structured Activity Supports		SAS01					\$2.11

Definition of Service: Structured Activity Support Services provide children and adolescents who are core customers with homework assistance, leisure, and recreational activities. Services can be provided for up to two hours a day and are offered only in conjunction with treatment services, i.e. individual counseling, group training or counseling, and/or family training/counseling. For example, consumers receive one hour of group therapy and remain at the facility to participate in Structured Activity Supports or consumers arrive at the facility, participate in a recreational activity, receive assistance with homework, and then participate in a group therapy session. Services are to be utilized as an adjunct to clinical services, providing support to youth who have significant behavioral health problems and who need structured activities in addition to treatment services. Services are primarily group-based and are intended to provide consumers with opportunities for positive socialization experiences and skill building. Services will provide the child or adolescent with experiences and supports that will enable them to develop skills to become fully integrated into their communities and to develop positive and emotionally satisfying peer relationships. Services are planned in partnership with the youth and family and are designed to assist consumers in progressing toward treatment goals identified in the IRP.

Recreational and leisure activities may include group sports, games or hobbies and are designed to promote pro-social behaviors, competence and confidence in working and playing with others, and a positive attitude toward physical activities as an important component of a healthy and satisfying life. Play activities are also important to the development of positive relationships with adults. Diversionary activities that do not encourage interaction with consumers and staff, such as watching entertainment videos or movies, are not allowed. Homework assistance may be provided for consumers to improve or maintain academic achievement and to ensure that consumers complete school assignments. The service assists consumers according to level of need in an atmosphere of support. Homework assistance activities provide academic enrichment and skill building. It is designed to help children perform well in school, increase their experiences of success in academics, and internalize learning and academic goal attainment as positive experiences and is not simply monitoring youths while they complete their homework.

Youth typically attend Structured Activity Supports from three to five days a week. This service may be billed only when offered in conjunction (on the same day) with individual counseling, group training, group counseling, family training, and/or family counseling. It is primarily facility-based, although activities may involve excursions into the community for recreation.

Target Population	C&A with SED C&A with AD Issues C&A with Co-occurring SED/AD
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Benefit Information	Available to Core Customers enrolled in MRO or Fee-For-Services Core Services and in need of Ongoing Services and requires a MICP.
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 100-130: High Intensity Community-Based Services *May be used for consumers transitioning to the community from structured residential settings even when the CAFAS score is below 60.
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization	1248 units
Re-Authorization	1248 units
Maximum Daily Units	8 units
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 270 – C&A Mental Health 870 – C&A Addictive Diseases
Admission Criteria	1. Individual must meet target population criteria as indicated above; and 2. Individual needs assistance with developing, maintaining, or enhancing social supports or other community coping skills; and 3. Individual needs assistance with daily living skills including homework assistance and social activity supervision
Continuing Stay Criteria	1. Individual continues to meet admission criteria; and 2. Individual demonstrates documented progress or maintenance of community skills relative to goals identified in the Individualized Resiliency Plan.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of Individualized Resiliency Plan have been substantially met; or 3. Individual/family requests discharge or 4. Transfer to another service is warranted by change in the individual's condition.
Service/Clinical Exclusions	PRTF Individuals served through CMOs or other insurance plans

Additional Service Criteria:

A. Required Components

1. Because this service must be offered in conjunction with individual counseling, family training/counseling, or group training/counseling, it may only be provided by providers offering the whole range of core services as defined in a DBHDD "Core Services" Provider Agreement/Contract.
2. This service is facility-based, although excursions into the community are allowed.
3. Structured Activity Supports are provided in small groups up to 1:5 staff to child ratio according to the specific educational and behavioral support needs of the child or adolescent.
4. Collaboration occurs with parents and/or school personnel regarding homework assignments and recreational and leisure activity needs.

5. Structured Activity Supports staff providing homework assistance must be familiar with best and promising practices in homework assistance and out-of-school learning programs and these practices, i.e. positive support and reinforcement, creating an organized homework environment, and communicating with teachers and parents must be evident. (Information about effective homework assistance is available on the Internet.)
6. Structured Activity Supports uses a wide range of materials that are appropriate for youth and will provide further enhancement in the development of recreation, leisure, and homework skills.
7. Direct supervision of computer use and/or blocking software must be ensured by program staff in order to protect youth from inappropriate material on the Internet.

B. Staffing Requirements

1. Program planning and supervision must be provided by a staff member with a master's degree in behavioral sciences. This supervisor must be on-site and available to the program during the hours it is in operation. The supervisor must accompany the group during off-site activities.
2. Because this service may be provided for extended periods of time, adequate supervision must be present at all times. A staff to consumer ratio of at least 1 staff member for 5 children must be maintained.
3. Direct services may be provided by paraprofessionals with experience serving children and adolescents in behavioral health settings.

C. Clinical Operations

1. Individualized services must be provided to the consumer and must be related to goals identified on the IRP.
2. This service is provided on the same day that the consumer is scheduled for individual therapy, group training or counseling and/or family training/counseling. For example, the child has group therapy and after that service participates in Structured Activity Supports with other consumers. Under no circumstance may a child receive this service as a stand alone, but instead must be provided Structured Activity Supports in conjunction with having participated in a clinical service on the same day.
3. Structured Activity Support Services must be coordinated with the parent/caregiver, the school system, and other child-serving agencies when appropriate and indicated regarding the consumer's homework and recreational/leisure needs.

D. Service Access

1. Structured Activity Services must be available at least 2 days per week and up to 6 days a week according to the needs of consumers and the capacity of the Provider agency.
2. Structured Activity Services is primarily facility-based but may involve excursions into the community.
3. This service may not be used to supplant or duplicate other support/supervision/activity services that are funded through other sources. For example, a residential program where structured group activities are program expectations may not supplant residential programming with this service.

E. Additional Medicaid Requirements

This is not a Medicaid reimbursable service.

F. Reporting & Billing Requirements

All applicable MICP and other required DBHDD reporting must be followed.

G. Documentation Requirements

1. As with all interventions, this intervention must be documented on the IRP and must be tied to a treatment goal. There must be a weekly summary note indicating progress towards IRP goals. In addition, a daily attendance log that captures the amount of time each consumer spent in the program and supports billing must be maintained. Any unusual or significant events must be documented and communicated to the program supervisor on the day of the occurrence. A current schedule of activities must be posted. All collateral contacts should be documented in the consumer's medical record.
2. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Structured Residential Supports							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Structured Residential	Child Program	H0043	HA				As negotiated

Definition of Service: Structured Residential Supports (formerly Rehabilitation Supports for Individuals in Residential Alternatives, Levels 1 & 2) are comprehensive rehabilitative services to aid youth in developing daily living skills, interpersonal skills, and behavior management skills; and to enable youth to learn about and manage symptoms; and aggressively improve functioning/behavior due to SED, substance abuse, and/or co-occurring disorders. This service provides support and assistance to the youth and caregivers to identify, monitor, and manage symptoms; enhance participation in group living and community activities; and, develop positive personal and interpersonal skills and behaviors to meet the youth's developmental needs as impacted by his/her behavioral health issues.

Services are delivered to youth according to their specific needs. Individual and group activities and programming must consist of services to develop skills in functional areas that interfere with the ability to live in the community, participate in educational activities; develop or maintain social relationships; or participate in social, interpersonal, recreational or community activities.

Rehabilitative services must be provided in a licensed residential setting (see A.2.) with no more than 16 individuals and must include supportive counseling, psychotherapy and adjunctive therapy supervision, and recreational, problem solving, and interpersonal skills development. All facilities providing residential rehabilitative supports must be staffed 24 hours a day, 7 days a week.

Target Population	Children & Adolescents with Serious Emotional Disturbance, Children & Adolescents with Substance Abuse Issues, Children & Adolescents with Co-Occurring Substance Abuse and Mental Illness Children & Adolescents with Co-Occurring Mental Illnesses and MR/DD. Children & Adolescents with Co-Occurring Substance Related Disorders and MR/DD.
Benefit Information	Available to Core Customers in need of Ongoing Services and requires a MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with CAFAS scores:</u> 140-180: Medically Monitored Community Residential 190-240: Medically Managed Community Residential 190-240: Medically Managed Inpatient Residential or clinical justification is explained in the justification text on the MICP for lower CAFAS scores
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	1 day
Initial Authorization	180 days

Re-Authorization	180 days
Maximum Daily Units	1 unit
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Residential Services Provider</u> 244 – C&A Mental Health 844 – C&A Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Youth must have symptoms of a SED or a substance related disorder; and one or more of the following: 2. Youth's symptoms/behaviors indicate a need for continuous monitoring and supervision by 24-hour staff to ensure safety; or 3. Youth/family has insufficient or severely limited skills to maintain an adequate level of functioning, specifically identified deficits in daily living and social skills and/or community/family integration; or 4. Youth has adaptive behaviors that significantly strain the family's or current caretaker's ability to adequately respond to the youth's needs; or 5. Youth has a history of unstable housing due to a behavioral health issue or a history of unstable housing which exacerbates a behavioral health condition.
Continuing Stay Criteria	Youth continues to meet Admissions Criteria.
Discharge Criteria	<ol style="list-style-type: none"> 1. Youth/family requests discharge; or 2. Youth has acquired rehabilitative skills to independently manage his/her own housing; or 3. Transfer to another service is warranted by change in youth's condition
Service Exclusions	Cannot be billed on the same day as Crisis Stabilization Unit.
Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of identified youth issues precludes provision of services in this service 2. Youth with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, or traumatic brain injury. 3. Youth is actively using unauthorized drugs or alcohol (which should not indicate a need for discharge, but for a review of need for more intensive services). 4. Youth can effectively and safely be supported with a lower intensity service.

Additional Service Criteria:

A. Required Components:

1. The organization must have an executive director or program director charged with the responsibility for day-to-day management of the organization.
2. If applicable, the organization must be licensed by the Georgia Department of Human Services/CCI or the Department of Community Health/HRF to provide residential services to youth with SED and/or substance abuse diagnosis. If the agency does not have a license/letter from either the DHS/CCI or DCH/HRF related to operations, there must be enough administrative documentation to support the non-applicability of a license.

3. The residential program must provide a structured and supported living environment 24 hours a day, 7 days a week.
4. Structured Residential Supports must provide at least 5 hours per week of structured programming and/or services.

B. Staffing Requirements:

1. Any Level 5 and higher practitioner may provide all Residential Rehabilitation Services.
2. If applicable, facilities must comply with any staffing requirements set forth for mental health and substance abuse facilities by the Office of Regulatory Services (see A.2).
3. An independently licensed practitioner or CACII/MAC/CADC must provide clinical supervision for all Residential Support Services. This person is available for emergencies 24 hours/7 days a week.
4. The organization that provides direct residential services must have written policies and procedures for selecting and hiring residential and clinical staff in accordance with their applicable license/accreditation/certification.
5. The organization must have a mechanism for ongoing monitoring of staff licensure, certification, or registration such as an annual confirmation process concurrent with a performance evaluation that includes repeats of screening checks outlined above.

C. Clinical Operations

1. The organization must have a written description of the Structured Residential Support services it offers that includes, at a minimum, the purpose of the service; the intended population to be served; treatment modalities provided by the service; level of supervision and oversight provided; and typical treatment objectives and expected outcomes.
2. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
3. Structured Residential Supports assist youth in developing daily living skills that enable them to manage the symptoms and behaviors linked to their psychiatric or addictive disorder. Services must be delivered to individuals according to their specific needs. Individual and group activities and programming consists of services geared toward developing skills in functional areas that interfere with the youth's ability to participate in the community, retain school tenure, develop or maintain social relationships, or age-appropriately participate in social, interpersonal, or community activities.
4. Structured Residential Supports must include symptom management or supportive counseling; behavioral management; medication education, training and support; support, supervision, and problem solving skill development; development of community living skills that serve to promote age-appropriate utilization of community-based services; and/or social or recreational skill training to improve communication skills, manage symptoms, and facilitate age-appropriate interpersonal behavior.

D. Service Access

E. Additional Medicaid Requirements

This is not a Medicaid-billable service.

F. Reporting & Billing Requirements

All applicable MICP and other DBHDD reporting requirements must be adhered to.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.
2. The organization must develop and maintain sufficient written documentation to support the Structured Residential Support Services for which billing is made. This documentation, at a minimum, must confirm that the individual for whom billing is requested was a resident of the residential service on the date of service. The youth's record must also include each week's programming/service schedule in order to document the provision of the required amount of service.
3. Weekly progress notes must be entered in the youth's record to enable the monitoring of the youth's progress toward meeting treatment and rehabilitation goals and to reflect the Individualized Resiliency Plan implementation. Each note must be signed and dated and must include the professional designation of the individual making the entry.
4. Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for the Rehabilitation Service being delivered.

H. Facilities Management (applicable to traditional residential settings such as group homes, treatment facilities, etc)

1. Structured Residential Supports may only be provided in facilities that have no more than 16 beds.
2. Each residential facility must be arranged and maintained to provide adequate measures for the health, safety, access and well being of the residents.
3. Each residential facility must comply with all relevant fire safety codes.
4. All areas of the residential facility must appear clean, safe, appropriately equipped, and furnished for the services delivered.
5. The organization must comply with the Americans with Disabilities Act.
6. The organization must maintain a written evacuation plan to be used in the case of fire or other disaster. An appropriate written certificate of compliance must be obtained indicating that all applicable fire and safety code requirements have been satisfied. Periodic fire drills must be conducted.
7. Evacuation routes must be clearly marked by exit signs.
8. The program must be responsible for providing physical facilities that are structurally sound and that meet all applicable federal, state, and local regulations for adequacy of construction, safety, sanitation, and health.

Substance Abuse Intensive Outpatient Package (C&A): (SA Adolescent Day Treatment)

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
See Item E.1. Below							

Definition of Service: A time limited multi-faceted approach treatment service for adolescents who require structure and support to promote resiliency and achieve and sustain recovery from substance related disorders. These specialized services are available after school and/or weekends and include:

1. Behavioral Health Assessment
2. Nursing Assessment
3. Psychiatric Treatment
4. Diagnostic Assessment
5. Community Support
6. Individual Counseling
7. Group Counseling (including psycho-educational groups focusing, relapse prevention and recovery)
8. Family Counseling/Psycho-Educational Groups for Family Members
9. Structured Activity Supports

These services are to be available at least 5 days per week to allow youth's access to support and treatment within his/her community, school, and family. These services are to be age appropriate and providers are to use best/evidenced based practices for service delivery to adolescent consumers. Intense coordination with schools and other child serving agencies is mandatory. This service promotes resiliency and recovery from substance abuse disorders incorporating the basic tenets of clinical practice. These services should follow Adolescent ASAM Level Guidelines. These guidelines are as follows: II.1 (at least 6 hours of structured programming per week); II.2 (at least 9 hours per week); II.3 (at least 12 hours per week); II.4 (at least 15 hours per week); and II.5 (at least 20 hours of structured activity per week). The maximum number of units that can be billed differs depending on the individual service. Please refer to the table below or in the Mental Health and Addictive Disease Orientation to Authorization Packages Section of this manual.

A consumer may have variable length of stay. The level of care should be determined as a result of consumers' multiple assessments. It is recommended that individuals attend at a frequency appropriate to their level of need. Ongoing clinical assessment should be conducted to determine step down in level of care.

Target Population	Adolescents with substance abuse related disorders, including those with co-occurring mental illness and secondary development disability
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Benefit Information	available to all ongoing core customers, requires a MICP New Episode or Ongoing Authorization
Utilization Criteria	<u>Available to those with CAFAS Scores</u> 100-130: High Intensity Community Based Services 140-180: Medically Monitored Community Residential (transition) 190-240: Medically Managed Community Residential (transition) 190-240: Medically Managed Inpatient Residential (transition)
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	See Authorization/Group Package Detail
Initial Authorization	See Authorization/Group Package Detail
Re-Authorization	See Authorization/Group Package Detail
Maximum Daily Units	See Authorization/Group Package Detail
Authorization Period	180 Days
UAS: Budget and Expense Categories	See Authorization/Group Package Detail
Admission Criteria	<ol style="list-style-type: none"> 1. A DSM IV diagnosis of Substance Abuse or Dependence or substance-related disorder with a co-occurring DSM IV-TR diagnosis of mental illness and 2. Consumer meets the age criteria for adolescent treatment; and 3. Youth's biomedical conditions are stable or are being concurrently addressed (if applicable) and one or more of the following: <ol style="list-style-type: none"> a. Youth is currently unable to maintain behavioral stability for more than a 72 hour period, as evidenced by distractibility, negative emotions, or generalized anxiety or b. Youth has a diagnosed emotional/behavioral disorder that requires monitoring and/or management due to a history indicating a high potential for distracting the individual from recovery/treatment, or c. There is a likelihood of drinking or drug use without close monitoring and structured support d. The substance use is incapacitating, destabilizing or causing the individual anguish or distress and the individual demonstrates a pattern of alcohol and/or drug use that has resulted in a significant impairment of interpersonal, occupational and/or educational <p>See also Adolescent ASAM Level II continued service criteria</p>
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Youth continues to meet admission criteria 1, 2, and/or 3 or 2. Youth is responding to treatment as evidenced by progress towards goals, but has not yet met the full expectation of the objectives or 3. Youth begins to recognize and understand his/her responsibility for addressing his/her illness, but still requires services and strategies to sustain personal responsibility and progress in treatment or 4. Youth recognizes and understands relapse triggers, but has not developed sufficient coping skills to interrupt or postpone gratification or to change related inadequate impulse control behaviors or

	<p>5. Youth's substance seeking behaviors, while diminishing, have not been reduced sufficiently to support function outside of a structure treatment environment</p>
Discharge Criteria	<p>An adequate continuing care or discharge plan is established and linkages are in place; and one or more of the following:</p> <ol style="list-style-type: none"> 1. Goals of the treatment plan have been substantially met; or 2. Youth's problems have diminished in such a way that they can be managed through less intensive services; or 3. Youth recognizes the severity of his/her drug/alcohol usage and is beginning to apply the skills necessary to maintain recovery by accessing appropriate community supports 4. Clinical staff determines that youth no longer needs ASAM Level II and is now eligible for aftercare and/or transitional services <p>Transfer to a higher level of service is warranted by change in the</p> <ol style="list-style-type: none"> 1. Youth's condition or nonparticipation; or 2. The youth refuses to submit to random drug screens; or 3. Youth's exhibits symptoms of acute intoxication and/or withdrawal or 4. The youth requires services not available at this level or 5. Youth has consistently failed to achieve essential treatment objectives despite revisions to the treatment plan and advice concerning the consequences of continues alcohol/drug use to such an extent that no further process is likely to occur <p>See also Adolescent ASAM Level II discharge criteria</p>
Service Exclusions	<ol style="list-style-type: none"> 1. Substance Abuse C&A Intensive Outpatient Package cannot be offered at the same time as C&A Mental Health IOP Package. Documentation must indicate efforts to minimize duplication of services and effectively transition the individual to the appropriate services. This combination of services is subject to review by the External Review Organization.
Clinical Exclusions	<ol style="list-style-type: none"> 1. Youth manifests overt physiological withdrawal symptoms 2. Youth with any of the following unless there is clearly documented evidence of an acute psychiatric/addiction episode overlaying primary diagnosis <ol style="list-style-type: none"> a. Autism b. Developmental Disabilities c. Organic mental disorder d. Traumatic Brain Injury

A. Required Components

1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. The program provides structured treatment or therapeutic services, utilizing activity schedules as part of its operational method, i.e., plans or schedules of days or times of day for certain activities. The program should also utilize group and/or individual counseling and/or therapy.

3. Best/evidence based practice must be utilized. Some examples are motivational interviewing, behavioral family therapy, functional family therapy, brief strategic family therapy, cognitive behavioral therapy, seven challenges, teen MATRIX and ACRA.
4. The program utilizes methods, materials, settings, and outside resources appropriate to the developmental and cognitive levels, capabilities, age, and gender of participants.
5. The program utilizes methods, materials, approaches, activities, settings, and outside resources appropriate for and targeted to individuals with co-occurring disorders of mental illness and substance abuse and targeted to individuals with co-occurring and substance abuse when such individuals are referred to the program.
6. The program conducts random drug screening and uses the results of these tests for marking consumers' progress toward goals and for service planning.
7. The program is provided over a period of several weeks or months and often follows detoxification or residential services and should be evident in individual youth records.
8. Intense coordination with schools and other child serving agencies is mandatory.
9. This service must operate at an established site approved to bill Medicaid for services. However, limited individual or group activities may take place off-site in natural community settings as is appropriate to each individual's treatment plan.
 - a. Narcotics Anonymous (NA) and/or Alcoholics Anonymous (AA) meetings offsite may be considered part of these limited individual or group activities for billing purposes only when time limited and only when the purpose of the activity is introduction of the participating individual to available NA and/or AA services, groups or sponsors. NA and AA meetings occurring during the SA C&A Intensive Outpatient Package may not be counted toward the billable hours for any individual outpatient services, nor may billing related to these meetings be counted beyond the basic introduction of an individual to the NA/AA experience.
10. This service may operate in the same building as other services; however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the SA Intensive Outpatient Services is in
11. Adequate space, equipment, furnishings, supplies, and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for participating individuals' use within the Substance Abuse C&A Intensive Outpatient package must not be substantially different from that provided for other uses for similar numbers of individuals.

B. Staffing Requirements

1. The program must be under the clinical supervision of a **Level 4 or above** who is onsite a minimum of 50% of the hours the service is in operation.
2. Services must be provided by staff who are at least:
 - a. An LAPC, LMSW, CACII, CADC, CCADC, and Addiction Counselor Trainee with supervision
 - b. Paraprofessionals, RADTs under the supervision of a Level 4 or above
3. It is necessary for all staff who treat "co-occurring capable" services to have basic knowledge in the Georgia DBHDD Suggested Best Practices catering co-occurring consumers
4. Programs must have documentation that there is one Level 4 staff (excluding Addiction Counselor Trainee) that is "co-occurring capable." This person's knowledge must go beyond basic understanding and must demonstrate actual staff capabilities in using that knowledge for individuals with co-occurring disorders. Personnel documentation should demonstrate that this staff

person has received a minimum of 4 hours of training in co-occurring treatment within the past 2 years.

5. There must be at least a Level 4 on-site at all times the service is in operation, regardless of the number of individuals participating.
6. The maximum face-to-face ratio cannot be more than 10 youths to 1 direct program staff based on average daily attendance of individuals in the program.
7. A physician and/or a Registered Nurse or a Licensed Practical Nurse with appropriate supervision must be available to the program either by a physician and/or nurse employed by the agency, through a contract with a licensed practitioner, or by written referral or affiliation agreement with another agency or agencies that offer such services.
 - a. The physician is responsible for addiction and psychiatric consultation, assessment, and care (including but not limited to ordering medications and/or laboratory testing) as needed.
 - b. The nurse is responsible for nursing assessments, health screening, medication administration, health education, and other nursing duties as needed.
8. Staff identified in B.2.a. may be shared with other programs as long as they are available as required for supervision and clinical operations and as long as their time is appropriately allocated to staffing ratios for each program.

C. Clinical Operations

1. It is expected that the transition planning for less intensive service will begin at the onset of these services. Documentation must demonstrate this planning.
2. Consumers receiving the Substance Abuse C&A Intensive Outpatient Package must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis.
3. Services are to be age appropriate with each youth and address the needs of C&A which will include an educational component, relapse prevention/refusal skills, healthy coping mechanisms and sober social activities.
4. Each consumer must be provided assistance in the development and acquisition of needed skills and resources necessary to achieve sobriety and/or reduction in abuse and maintenance of recovery.
5. Substance Abuse C&A Intensive Outpatient Package must offer a range of skill-building and recovery activities within the program.

The functions/activities of the Substance Abuse C&A Intensive Outpatient Package include but are not limited to:

- a. **Group Outpatient Services:**
 - i. Age appropriate psycho-educational activities focusing on the disease of addiction, prevention, and recovery
 - ii. Therapeutic group treatment and counseling
 - iii. Linkage to natural supports and self-help opportunities
- b. **Individual Outpatient Services**
 - i. Individual counseling
 - ii. Individualized treatment, service, and recovery planning
- c. **Family Outpatient Services**
 - i. Family education and engagement focusing on adolescent developmental issues and impact of addiction on the family

- ii. Interpersonal skills building including family communication and developing relationships with healthy individuals
 - d. **Community Support**
 - e. Educational/Vocational readiness and support
 - i. Services/resources coordination unless provided through another service provider
 - ii. Community living skills
 - iii. Linkage to health care
 - f. **Structured Activity Supports**
 - i. Leisure and social skill-building activities without the use of substances
 - g. **Behavioral Health Assessment & Service Plan Development and Diagnostic Assessment**
 - i. Assessment and reassessment
 - h. **Pharmacy/Labs (Core providers may report costs via "Pharmacy/Lab")**
 - i. Drug screening/toxicology examinations
- 6. In addition to the above required activities within the program, the following must be offered as needed either within the program or through referral to/or affiliation with another agency or practitioner, and may be billed in addition to the billing for Substance Abuse C&A Intensive Outpatient Package:
 - i. Community Support –for housing, legal and other issues
 - j. Individual counseling in exceptional circumstances for traumatic stress and other mental illnesses for which special skills or licenses are required
 - k. Physician assessment and care
 - l. Psychological testing
 - m. Health screening (Nursing Assessment & Care)
- 7. The program must have a Substance Abuse C&A Intensive Outpatient Services Organizational Plan addressing the following:
 - n. The philosophical model of the program and the expected outcomes for program participants (i.e., harm reduction, abstinence, beginning of or maintaining individually defined recovery, employment readiness, relapse prevention, stabilization and treatment of those with co-occurring disorders).
 - o. The schedule of activities and hours of operations.
 - p. Staffing patterns for the program.
 - q. How assessments will be conducted.
 - r. How staff will be trained in the administration of addiction services and technologies.
 - s. How staff will be trained in the recognition and treatment of substance abuse and treatment in an adolescent population
 - t. How services for individuals with co-occurring disorders will be flexible and will include services and activities addressing both mental health and substance abuse issues of varying intensities and dosages based on the symptoms, presenting problems, functioning, and capabilities of such individuals.
 - u. How individuals with co-occurring disorders who cannot be served in the regular program activities will be provided and/or referred for time-limited special integrated services that are co-occurring enhanced as described in the Georgia Suggested Best Practices
 - v. How services will be coordinated with the substance abuse array of services including assuring or arranging for appropriate referrals and transitions.
 - w. How the requirements in these service guidelines will be met.

D. Service Access

1. This package is to be available at least 5 days per week to allow youth's access to support and treatment within his/her community, school, and family.
2. These services should follow Adolescent ASAM Level Guidelines II.1 (at least 6 hours of structured programming per week) and II.5 (at least 20 hours of structured activity per week).

E. Additional Medicaid Requirements

The Substance Abuse C&A Intensive Outpatient Package allows providers to select all services that will be offered in a substance abuse outpatient setting. Billable services and daily limits within SA C&A Intensive Outpatient are as follows:

Service	Maximum Authorization Units	Maximum Daily Units
Behavioral Health Assessment & Service Plan Development	32	24
Diagnostic Assessment	4	2
Psychiatric Treatment	12	1
Nursing Assessment & Care	48	16
Community Support	600	96
Individual Outpatient Services	36	1
Group Outpatient Services	1170	20
Family Outpatient Services	100	8
Structured Activity Support	320	8

F. Billing/Reporting Requirements

1. The maximum number of units that can be billed differs depending on the individual service.
2. All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

1. Provider must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.
2. Every admission and assessment must be documented.
3. Progress notes must include written daily documentation of important occurrences; level of functioning; acquisition of skills necessary for recovery; progress on goals identified in the IRP including acknowledgement of addiction, progress toward recovery and use/abuse reduction and/or abstinence; use of drug screening results by staff; and evaluation of service effectiveness.
4. Daily attendance of each youth participating in the program must be documented showing the number of units in attendance for billing purposes.
5. Documentation of a structured activity support is also required (see specific guideline for detail).

GEORGIA DBHDD – BEST PRACTICE SUGGESTIONS

PRINCIPLES AND STAFF CAPABILITIES FOR SERVICES WITH CO-OCCURRING DISORDERS – April 17, 2002

Principles

1. Services for persons with co-occurring disorders should be integrated, rather than sequential. That is, they should be structured to deal with both disorders at once rather than requiring one disorder or one set of symptoms to be dealt with before services for the other can begin.
2. Psychosocial Rehabilitation (PSR) programs and Substance Abuse (SA) Day Services programs will be initially encouraged and eventually required to work toward becoming “co-occurring capable,” that is, able to deal flexibly with the issues of persons with co-occurring disorders.
3. “Co-occurring enhanced” services are time limited and go beyond co-occurring capable services and programs. They are characterized by the following:
 - Additional or special assessments requiring additional training or competencies, perhaps utilizing additional or specialized assessment tools;
 - Special training, experience, licensure, certification, or other qualifications of staff beyond basic recognition and general capabilities of addressing the needs of persons with co-occurring disorders within a larger program (see recommended staff capabilities below);
 - Availability of addictionologist and/or MAC, CACII, or CADC consultation;
 - Availability of psychiatric consultation and/or medication management;
 - Availability of crisis services if needed, either directly or through an interagency agreement with a mobile crisis service;
 - Additional staff to client ratio beyond the minimum requirements for a limited period of time, in order to deal effectively with individuals needing more intense or more frequent services than those offered in a co-occurring capable day services program; and
 - Additional programming intensity or specialized approaches or activities requiring significant adjustments to the usual day services activities to assure adequate dosing, frequency, and integration of services for individuals with co-occurring disorders.
4. Programs that provide PSR or SA Day Services will be required to either provide or arrange for co-occurring enhanced integrated services for adults with co-occurring disorders until those individuals can move back into regular co-occurring capable day services. Adults with co-occurring disorders should not be expected to simply adapt to usual or routine PSR or SA Day Services activities.
5. Co-occurring enhanced day services may be provided within a larger SA Day Services or PSR program, may be a separate day services program within a larger agency, or may be a stand-alone service provider.
6. An adult with serious and persistent mental illness and a co-occurring substance abuse disorder should be served in a co-occurring capable or co-occurring enhanced PSR program. Adults with substance abuse or dependence who also have a co-occurring mental health needs that do not rise to the level of serious and persistent mental illness should be served in a co-occurring capable or co-occurring enhanced SA Day Services.
7. An adult with serious and persistent mental illness whose symptoms are stable enough so that Intensive Day Treatment is not indicated; whose cognitive functioning is high enough to participate in and benefit from a co-occurring capable SA Day Services program without distraction; whose coping skills and abilities are sufficiently intact to allow attention to his/her substance abuse; and who can

understand the emotional concerns related to the negative consequences and effects of addiction should be allowed to choose service in a SA Day Services program. An adult with serious and persistent mental illness may not be refused service in an SA Day Services program simply because he/she is seriously and persistently mentally ill. Likewise, a seriously and persistently mentally ill adult may not be refused service in a PSR program simply because he/she is abusing or dependent on alcohol or other drugs.

8. Adults with serious and persistent mental illness whose symptoms, cognition, functioning, or coping skills are sufficiently impaired to prevent participation or benefit from a co-occurring capable day services program but who meet the admission criteria for either PSR or SA Day Services, must be served by a co-occurring enhanced PSR or SA Day Services program.
9. The service guidelines for PSR Services and for SA Day Services will include the same requirements about cross training and capabilities of staff to recognize and treat adults with co-occurring disorders.
10. DMHM RSA will work to ensure that there is no financial disincentive to serving individuals with co-occurring disorders in any particular day services program.
12. Basic knowledge necessary for all staff serving persons with mental illness or substance abuse in "co-occurring capable" day services must include the content areas below. For programs that are "co-occurring enhanced," this knowledge must go beyond basic understanding and must demonstrate actual staff competencies in using that knowledge to serve adults with co-occurring disorders.
13. PSR and SA Day Services Program Managers and staff are encouraged to become familiar with ASAM Patient Placement Criteria – 2R and current evidence-based practices literature about serving adults with co-occurring disorders.

GEORGIA DBHDD – BEST PRACTICES SUGGESTIONS

Staff Knowledge and Capabilities
About
Serving Persons with Co-Occurring Disorders

Necessary Capabilities For Substance Abuse Staff	Necessary Capabilities For Mental Health Staff
<ul style="list-style-type: none"> • knowledge of mental illness diagnoses, symptoms, and cognitive impairments where applicable; • medications used to treat various types of mental illness and their effects, including undesired medication side effects and the effects of discontinuing these medications; • assessment of mental illness; • likely coping strategies of individuals with mental illness, including use and abuse of substances, • concept of role of family members and psychoeducational approaches for working collaboratively with them; • motivational counseling for clients who are not ready to take full responsibility for self-management and recovery from substance abuse; • behavioral counseling for those who are actively working on recovery; • denial about mental illness or its symptoms, while respecting and encouraging individual choice and responsibility; • individual strategies for preventing symptom exacerbation; and • difference between recovery and engagement concepts in mental health and in substance abuse. 	<ul style="list-style-type: none"> • knowledge of substances of abuse and how they affect mental illnesses; • symptoms of withdrawal from various types of substances of abuse; • complications of interactions between psychotropic medications and substances of abuse, especially in detoxification and withdrawal processes; • assessment of substance abuse; • special considerations in assessing substance abuse in adults who have symptoms associated with a mental illness or who are taking or are candidates for taking prescribed medications for a diagnosed mental illness; • motivational counseling to use with clients who appear to be unmotivated for substance abuse treatment; • behavioral substance abuse counseling for those who are motivated to work toward abstinence; • denial and its role in addiction; • methods for overcoming denial while respecting and encouraging individual choice and responsibility; • relapse prevention strategies for persons with addictions; and • difference between recovery and engagement concepts in substance abuse and in mental health.

Mental Health and Addictive Disease Services

Adults' CORE Benefit Package

Behavioral Health Assessment

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Mental Health Assessment by a non-Physician	Practitioner Level 2, In-Clinic	H0031	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	H0031	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	H0031	U4	U6			\$20.30
	Practitioner Level 5, In-Clinic	H0031	U5	U6			\$15.13
	Practitioner Level 2, Out-of-Clinic	H0031	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	H0031	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	H0031	U4	U7			\$24.36
	Practitioner Level 5, Out-of-Clinic	H0031	U5	U7			\$18.15

Definition of Service: The Behavioral Health Assessment process consists of a face-to-face comprehensive clinical assessment with the individual, which must include the individual's perspective, and may also include consumer-identified family and/or significant others as well as interviews with collateral agencies/treatment providers (including Certified Peer Specialists who have been working with consumers on goal discovery) and other relevant individuals.

The purpose of the assessment process is to determine the individual's problems, strengths, needs, abilities and preferences, to develop a social (extent of natural supports and community integration) and medical history, to determine functional level and degree of ability versus disability, and to engage with collateral contacts for other assessment information. A suicide risk assessment shall also be completed. The information gathered should support the determination of a differential diagnosis and assist in screening for/ruling-out potential co-occurring disorders.

As indicated, information from medical, nursing, peer, vocational, nutritional, etc. staff should serve as the basis for the comprehensive assessment and the resulting IRP.

The entire process should involve the individual as a full partner and should include strengths and resources as identified by the individual.

Target Population	An adult with a known or suspected mental health diagnosis and/or substance-related disorder.
Benefit Information	Available to all known or suspected Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential

	5: Medically Monitored Community Residential 6: Medically Managed Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	32 units (Combined with H0032 – Service Plan Development)
Re-Authorization*	32 units (Combined with H0032 – Service Plan Development)
Maximum Daily Units*	24 units (Combined with H0032 – Service Plan Development)
Authorization Period*	180 days
UAS: Budget and Expense Categories	Adult Core Services Provider 131 – Adult Mental Health 731 – Adult Addictive Diseases
Admission Criteria	1. Individual has a known or suspected mental illness or substance-related disorder; and 2. Initial screening/intake information indicates a need for further assessment; and 3. It is expected that individual meets Core Customer eligibility.
Continuing Stay Criteria	Individual's situation/functioning has changed in such a way that previous assessments are outdated.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual has withdrawn or been discharged from service; or 3. Individual no longer demonstrates need for continued behavioral health assessment.
Service Exclusions	Assertive Community Treatment
Clinical Exclusions	None

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
2. As indicated and with consumer permission, medical, nursing, peer, nutritional, etc. staff can provide information from records, and various multi-disciplinary resources to complete the comprehensive nature of the assessment and time spent gathering this information may be billed as long as the detailed documentation justifies the time and need for capturing said information
3. An initial Behavioral Health Assessment is required within the first 30 days of service, with ongoing assessments completed as demanded by changes with an individual.
4. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or

- Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
- Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day. If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following practitioners may provide Behavioral Health Assessment services:

- Practitioner Level 2: Psychologist, APRN, PA
- Practitioner Level 3: LCSW, LPC, LMFT, RN
- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (addictions counselors may only perform these functions related to treatment of addictive diseases).
- Practitioner Level 5: Certified Addiction Counselor-I, Registered Alcohol and Drug Technician (I, II, or III), Addiction Counselor Trainee with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases).

C. Clinical Operations

The individual consumer (and caregiver/responsible family members etc as appropriate) should actively participate in the assessment processes.

D. Service Access

1. Individuals access this service when it has been determined through an initial screening that the person has suspected mental health or addictive disease needs.
2. Behavioral Health Assessment may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
3. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings.

E. Additional Medicaid Requirements

The daily maximum within a CSU for combined Behavioral Health Assessment and Service Plan Development is 24 units/day.

F. Reporting & Billing Requirements

All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.
2. In addition to the authorization, documentation of clinical assessment findings from this service should also be completed and placed in the individual's chart as a Comprehensive Assessment.

Community Support

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Community Support Services	Practitioner Level 4, In-Clinic	H2015	U4	U6			\$20.30
	Practitioner Level 5, In-Clinic	H2015	U5	U6			\$15.13
	Practitioner Level 4, Out-of-Clinic	H2015	U4	U7			\$24.36
	Practitioner Level 5, Out-of-Clinic	H2015	U5	U7			\$18.15
	Practitioner Level 4, In-Clinic, Collateral Contact	H2015	UK	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic, Collateral Contact	H2015	UK	U5	U6		\$15.13
	Practitioner Level 4, Out-of-Clinic, Collateral Contact	H2015	UK	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic, Collateral Contact	H2015	UK	U5	U7		\$18.15

Definition of Service: Community Support services consist of rehabilitative skills building, the development of environmental supports and resources coordination considered essential to assist a person in improving functioning, gaining access to necessary services and in creating environments that promote recovery and support the emotional and functional improvement of the individual. The service activities of Community Support include:

- Assistance to the person and other identified recovery partners in the facilitation and coordination of the Individual Recovery Plan (IRP) including providing skills support in the person's self-articulation of personal goals and objectives;
- Planning in a proactive manner to assist the person in managing or preventing crisis situations;
- Individualized interventions, which shall have as objectives:
 - 1) Identification, with the person, of strengths which may aid him/her in achieving recovery, as well as barriers that impede the development of skills necessary for functioning in work, with peers, and with family/friends;
 - 2) Support to facilitate enhanced natural supports (including support/assistance with defining what wellness means to the person in order to assist them with recovery-based goal setting and attainment);
 - 3) Assistance in the development of interpersonal, community coping and functional skills (which may include adaptation to home, adaptation to work, adaptation to healthy social environments, learning/practicing skills such as personal financial management, medication self-monitoring, symptom self-monitoring, etc);
 - 4) Encouraging the development and eventual succession of natural supports in living, learning, working, other social environments;
 - 5) Assistance in the acquisition of skills for the person to self-recognize emotional triggers and to

- self-manage behaviors related to the behavioral health issue;
- 6) Assistance with personal development, work performance, and functioning in social and family environments through teaching skills/strategies to ameliorate the effect of behavioral health symptoms;
 - 7) Assistance in enhancing social and coping skills that ameliorate life stresses resulting from the person's mental illness/addiction;
 - 8) Service and resource coordination to assist the person in gaining access to necessary rehabilitative, medical, social and other services and supports;
 - 9) Assistance to the person and other supporting natural resources with illness understanding and self-management (including medication self-monitoring);
 - 10) Any necessary monitoring and follow-up to determine if the services accessed have adequately met the person's needs;
 - 11) Identification, with the individual and named natural supporters, of risk indicators related to substance related disorder relapse, and strategies to prevent relapse.

This service is provided in order to promote stability and build towards functioning in their daily environment. Stability is measured by a decreased number of hospitalizations, by decreased frequency and duration of crisis episodes and by increased and/or stable participation in community/work activities. Supports based on the person's needs are used to promote recovery while understanding the effects of the mental illness and/or substance use/abuse and to promote functioning. The Community Support staff will serve as the primary coordinator of behavioral health services and will provide linkage to community; general entitlements; and psychiatric, substance use/abuse, medical services, crisis prevention and intervention services.

Target Population	Individuals with one of the following: Mental Health Diagnosis Substance-Related Disorder Co-Occurring Substance-Related Disorder and Mental Health Diagnosis, Co-Occurring Mental Health Diagnosis and Mental Retardation/Developmental Disabilities Co-Occurring Substance-Related Disorder and Mental Retardation/Developmental Disabilities
Benefit Information	Available to Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Managed Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	600 units

Re-Authorization*	600 units
Maximum Daily Units*	48 units
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 126 – Mental Health 726 – Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must meet target population criteria as indicated above; and one or more of the following: 2. Individual may need assistance with developing, maintaining, or enhancing social supports or other community coping skills; or 3. Individual may need assistance with daily living skills including coordination to gain access to necessary rehabilitative and medical services
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet admission criteria; and 2. Individual demonstrates documented progress or maintenance of community skills relative to goals identified in the Individualized Resiliency Plan.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual requests discharge and the individual is not in imminent danger of harm to self or others; or 4. Transfer to another service/level of care is warranted by change in individual's condition; or 5. Individual requires more intensive services.
Service Exclusions	
Clinical Exclusions	<ol style="list-style-type: none"> 1. There is a significant lack of community coping skills such that a more intensive service is needed. 2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: <ul style="list-style-type: none"> • mental retardation • autism • organic mental disorder, or • traumatic brain injury

**(unless authorized as a part of a specific “package” which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. Community Support services must include a variety of interventions in order to assist the consumer in developing:
 - Symptom self-monitoring and self-management of symptoms
 - Strategies and supportive interventions for avoiding out-of-community treatment for adults and building stronger knowledge of the adult's strengths and limitations

- Relapse prevention strategies and plans
2. Community Support services focus on building and maintaining a therapeutic relationship with the individual and facilitating treatment and recovery goals.
 3. The organization must have policies and procedures for protecting the safety of staff that engage in these community-based service delivery activities.
 4. Contact must be made with the individual receiving Community Support services a minimum of twice each month. At least one of these contacts must be face-to-face and the second may be either face-to-face or telephone contact (denoted by the UK modifier) depending on the individual's support needs and documented preferences.
 5. At least 50% of CSI service units must be delivered face-to-face with the identified individual receiving the service and at least 80% of all face-to-face service units must be delivered in non-clinic settings over the authorization period (these units are specific to single individual consumer records and are not aggregate across an agency/program or multiple payors).
 6. In the absence of the required monthly face-to-face contact **and** if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of two telephone contacts in that specified month (denoted by the UK modifier).
 7. Unsuccessful attempts to make contact with the consumer are not billable.
 8. Any diagnosis given to a youth must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
 9. When the primary focus of Community Support services for is medication maintenance, the following allowances apply:
 - a. These consumers are not counted in the offsite service requirement or the consumer-to-staff ratio; and
 - b. These consumers are not counted in the monthly face-to-face contact requirement; however, face-to-face contact is required every 3 months and monthly calls are an allowed billable service.
 10. CSI is an individual intervention and may **not** be provided or billed for more than one consumer during the same time period.
 11. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.
 If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following practitioners may provide Community Support services:
 - Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 4 rate)
 - Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate)

- Practitioner Level 3: LCSW, LPC, LMFT, RN (reimbursed at Level 4 rate)
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CPS, PP, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology
2. When provided by one of the practitioners cited below, must be under the documented supervision (organizational charts, supervisory notation, etc.) of one of the licensed/credentialed professionals above:
 - Certified Peer Specialists
 - Paraprofessional staff
 - Certified Psychiatric Rehabilitation Professional
 - Certified Addiction Counselor-I
 - Registered Alcohol and Drug Technician (I,II, or III)
 - Addiction Counselor Trainee
 3. Community Support practitioners may have the recommended consumer-to-staff ratio of 30 consumers per staff member and must maintain a maximum ratio of 50 consumers per staff member. Youth who receive only medication maintenance are not counted in the staff ratio calculation.

C. Clinical Operations

1. Community Support may include (with the permission of the Adult consumer) coordination with family and significant others and with other systems/supports (e.g., work, religious entities, corrections, aging agencies, etc) when appropriate for treatment and recovery needs. Coordination is an essential component of Community Support and can be billed for up to 70 percent of the contacts when directly related to the support and enhancement of the person's recovery.
2. Community Support providers must have the ability to deliver services in various environments, such as homes, homeless shelters, or street locations. The provider should keep in mind that individuals may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. their place of employment), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the individual in a way that may potentially embarrass the individual or breach the individual's privacy/confidentiality. Staff should be sensitive to and respectful of individuals' privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with an individual during their work time, if the consumer wishes, mutually agree upon a meeting place nearby that is the least conspicuous from the individual's point of view).
3. The organization must have policies that govern the provision of services in natural settings and can document that it respects individuals' rights to privacy and confidentiality when services are provided in these settings.
4. The organization must have established procedures/protocols for handling emergency and crisis situations that describe methods for supporting individuals as they transition to and from psychiatric hospitalization/crisis stabilization.

5. Each provider must have policies and procedures for the provision of individual-specific outreach services, including means by which these services and individuals are targeted for such efforts.
6. The organization must have a Community Support Organizational Plan that addresses the following:
 - description of the particular rehabilitation, recovery and natural support development models utilized, types of intervention practiced, and typical daily schedule for staff
 - description of the staffing pattern and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, or emergencies are accommodated, case mix, access, etc.
 - description of the hours of operations as related to access and availability to the individuals served and
 - description of how the plan for services is modified or adjusted to meet the needs specified in every Individualized Recovery Plan
7. Utilization (frequency and intensity) of CSI should be directly related to the LOCUS and to the other functional elements in the person's assessment. In addition, when clinical/functional needs are great, there should be complementary therapeutic services by licensed/credential professionals paired with the provision of CSI (individual, group, family, etc.).

D. Service Accessibility

1. Specific to the "Medication Maintenance Track," consumers who require more than 4 contacts per quarter for two consecutive quarters (as based upon clinical need) are expected to be re-evaluated with the LOCUS for enhanced access to CSI and/or other services. The designation of the CSI "medication maintenance track" should be lifted and exceptions stated above in A.10 are no longer applied.
2. Community Support may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
3. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings.

E. Additional Medicaid Requirements

Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

1. When a billable collateral contact is provided, the UK reporting modifier shall be utilized. A collateral contact is classified as any contact that is not face-to-face with the individual.
2. All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Community Transition Planning							
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Community Transition Planning	Community Transition Planning (State Hospital)	T2038	ZH				\$20.92
	Community Transition Planning (Crisis Stabilization Unit)	T2038	ZC				\$20.92
	Community Transition Planning (Jail /Prison)	T2038	ZJ				\$20.92
	Community Transition Planning(Other)	T2038	ZO				\$20.92

Definition of Service: Community Transition Planning is a service for contracted Core and ACT providers to address the care, service, and support needs of adults with mental illness and/or addictive diseases to ensure a coordinated plan of transition from a qualifying facility to the community. Each episode of Community Transition Planning must include contact with the consumer and their identified family with a minimum of one (1) face-to-face contact with the consumer prior to release from the state hospital/facility. Additional Transition Planning activities include: educating the consumer and their identified family on service options offered by the chosen primary service agency; participating in state hospital or facility treatment team meetings to develop a transition plan, and making collateral contacts with other agencies and community resources when indicated.

In partnership between other community service providers and the hospital/facility staff, the community service agency maintains responsibility for carrying out transitional activities either by the consumer's chosen primary service coordinator or by the service coordinator's designated Community Transition Liaison. Community Transition Planning may also be used for Community Support staff, ACT team members and Certified Peer Specialists who work with the consumer in the community or will work with the consumer in the future to maintain or establish contact.

Community Transition Planning consists of the following interventions to ensure the person transitions successfully from the facility to their local community:

- Establishing a connection or reconnection with the person through supportive contacts while in the qualifying facility. By engaging with the person, this helps to develop and strengthen a foundation for the therapeutic relationship.
- Educate the person and his/her identified supports about local community resources and service options available to meet their needs upon transition into the community. This allows the person to make self-directed, educated choices on those service options that they feel will best meet their needs and increases the likelihood of post-facility engagement.
- Participating in qualifying facility team meetings especially in person centered planning for those in a treatment facility for longer than 60 days, to share hospital and community information related to estimated length of stay, present problems related to admission, discharge/release criteria, progress toward treatment goals, personal strengths, available supports and assets, medical condition, medication issues, and community treatment needs.

- Linking the adult with community services including visits between the person and the Community Support staff, ACT team members and/or Certified Peer Support Specialists who will be working with the consumer in the community (including visits and telephone contacts between the consumer and the community-based providers).

Target Population	Adults with one of the following: Mental Health Diagnosis Substance Related Disorder Co-Occurring Substance-Related Disorder and Mental Health Diagnosis
Benefit Information	Available to Core Customers in need of Brief Stabilization or Ongoing Services. Requires a MICP Registration or MICP New Episode.
Utilization Criteria	Available to those currently in state hospitals and other qualifying facilities who meet Core Customer Eligibility Definition
Unit Value	15 minutes
Reimbursement Rate	\$20.92 /unit
Initial Authorization	10 units
Re-Authorization	10 units
Authorization Period	90 days (Registration) 180 days (New Episode)
UAS: Budget and Expense Categories	Core Service Providers 162 – Adult Mental Health 762 – Adult Addictive Diseases ACT Providers 152 – Adult Mental Health (include with MIER for ACT)
Admission Criteria	Individual who meet Core Customer Eligibility while in one of the following qualifying facilities: 1. State Operated Hospital 2. Crisis Stabilization Unit (CSU) 3. Jail/Prison 4. Other (ex: Community Psychiatric Hospital) Note: Modifier on Procedure Code indicates setting in which the consumer is transitioning from.
Continuing Stay Criteria	Same as above.
Discharge Criteria	1. Individual/family requests discharge; or 2. Individual no longer meets Core Customer Eligibility; or 3. Individual is discharged from a state hospital or qualifying facility.
Service Exclusions	None

Clinical Exclusions	<p>Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a co-occurring Behavioral Health condition:</p> <ol style="list-style-type: none"> a. Developmental Disability without a co-occurring mental illness or addictive disease diagnosis b. Autism c. Organic Mental Disorder d. Traumatic Brain Injury
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Additional Service Criteria:

A. Required Components

Prior to Release from a State Hospital or Qualifying Facility:

When the person has had (a) a length of stay of 60 days or longer in a facility or (b) youth is readmitted to a facility within 30 days of discharge, a community transition plan in partnership with the facility is required. Evidence of planning shall be recorded and a copy of the Plan shall be included in both the adult's hospital and community records.

B. Staffing Requirements

1. A Master's/Bachelor's degree in behavioral or social science that is primarily psychological in nature under the supervision of a licensed practitioner; **or**
2. A Georgia Certified Peer Specialist or trained Paraprofessional under the supervision of a licensed practitioner; **or**
3. An LPN practicing under supervision in accordance with the Georgia Practice Acts.

C. Clinical Operations

Community Transition Planning activities shall include:

1. Telephone and Face-to-face contacts with consumer and their identified family;
2. Participating in consumer's clinical staffing(s) prior to their discharge from the facility;
3. Applications for consumer resources and services prior to discharge from the facility including:
 - a. Healthcare
 - b. Entitlements (i.e., SSI, SSDI) for which they are eligible
 - c. Self-Help Groups and Peer Supports
 - d. Housing
 - e. Employment, Education, Training
 - f. Consumer Support Services

D. Service Access

1. This service must be available 7 days a week (if the state hospital/qualifying facility discharges or releases 7 days a week).
2. This service may be delivered via telemedicine technology or via telephone conferencing.

E. Reporting & Billing Requirements

1. There must be a minimum of one face-to-face with the youth prior to release from hospital or qualifying facility in order to bill for any telephone contacts.

2. Complete the Multipurpose Information Consumer Profile (MICP) information
3. Providers must document services in accordance with the specifications for documentation requirements specified in PART II, Section V of the Provider Manual.

F. Documentation Requirements

1. A documented Community Transition Plan for:
 - a. Individuals with a length of stay greater than 60 days; or
 - b. Individuals readmitted within 30 days of discharge.
2. Documentation of all face-to-face and telephone contacts and a description of progress with Community Transition Plan implementation and outcomes.

Crisis Intervention							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Crisis Intervention	Practitioner Level 1, In-Clinic	H2011	U1	U6			\$58.21
	Practitioner Level 2, In-Clinic	H2011	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	H2011	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	H2011	U4	U6			\$20.30
	Practitioner Level 1, Out-of-Clinic	H2011	U1	U7			\$74.09
	Practitioner Level 2, Out-of-Clinic	H2011	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	H2011	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	H2011	U4	U7			\$24.36

Definition of Service: Services directed toward the support of an individual who is experiencing an abrupt and substantial change in behavior which is usually associated with a precipitating situation and which is in the direction of severe impairment of functioning or a marked increase in personal distress. Crisis Intervention is designed to prevent out of community placement or hospitalization. Often, a crisis exists at such time as an individual consumer and his or her identified natural resources decide to seek help and/or the individual, identified natural resources, or practitioner identifies the situation as a crisis. Crisis services are time-limited and present-focused in order to address the immediate crisis and develop appropriate links to alternate services. Services may involve the individual consumer and the individual's family and/or significant other, as well as other service providers.

The individual's current behavioral health care advanced directive, if existing, should be utilized to help manage the crisis. Interventions provided should honor and respect the individual's wishes/choices by following the plan/advanced directive as closely as possible in line with appropriate clinical judgment. Plans/advanced directives developed during the Behavioral Health Assessment/IRP process should be reviewed and updated (or developed if the individual is a new consumer) as part of those services to help prevent or manage future crisis situations.

Some examples of interventions that may be used to de-escalate a crisis situation could include: a situational assessment; active listening and empathic responses to help relieve emotional distress; effective verbal and behavioral responses to warning signs of crisis related behavior; assistance to, and involvement/participation of the individual (to the extent he or she is capable) in active problem solving planning and interventions; facilitation of access to a myriad of crisis stabilization and other services deemed necessary to effectively manage the crisis; mobilization of natural support systems; and other crisis interventions as appropriate to the individual and issues to be addressed.

Target Population	Adults with Mental Health issues and/or Substance Related Disorders Adults experiencing a severe situational crisis
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP

	New Episode.
Utilization Criteria	Available to those with LOCUS scores: 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Monitored Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	16 units
Re-Authorization*	16 units <i>Any use beyond 16 units will not be denied but will trigger an immediate retrospective review.</i>
Maximum Daily Units*	16 units
Authorization Period	180 days
UAS: Budget and Expense Categories	Adult Core Services Provider 121– Adult Mental Health 721 – Adult Addictive Diseases
Admission Criteria	1. Treatment at a lower intensity has been attempted or given serious consideration; and #2 and/or #3 are met: 2. Individual has a known or suspected mental health diagnosis or Substance Related Disorder; or 3. Individual is at risk of harm to self, others and/or property. Risk may range from mild to imminent; and one or both of the following: 4. Individual has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; or 5. Individual demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities.
Continuing Stay Criteria	This service may be utilized at various points in the individual's course of treatment and recovery, however, each intervention is intended to be a discrete time-limited service that stabilizes the individual and moves him/her to the appropriate level of care.
Discharge Criteria	1. Individual no longer meets continued stay guidelines; and 2. Crisis situation is resolved and an adequate continuing care plan has been established.
Service Exclusions	
Clinical Exclusions	Severity of clinical issues precludes provision of services at this level of care.

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
2. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following practitioners may provide Crisis Intervention services:
 - Practitioner Level 1: Physician/Psychiatrist
 - Practitioner Level 2: Psychologist, APRN, PA
 - Practitioner Level 3: LCSW, LPC, LMFT, RN
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state.

C. Clinical Operations

In any review of clinical appropriateness of this service, the mix of services offered to the individual is important. The use of crisis units will be looked at by the External Review Organization in combination with other supporting services. For example, if an individual presents in crisis and the crisis is alleviated within an hour but ongoing support continues, it is expected that 4 units of crisis will be billed and then some supporting service such as individual counseling will be utilized to support the individual during that interval of service

D. Service Access

1. All crisis service response times for this service must be within 2 hours of the consumer or other constituent contact to the provider agency.
2. Services are available 24-hours per day, 7 days per week, and may be offered by telephone and/or face-to-face in any setting (e.g. home, jail, hospital, clinic etc).
3. Crisis Intervention may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.

4. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings.

E. Additional Medicaid Requirements

The daily maximum within a CSU for Crisis Intervention is 8 units/day.

F. Billing/Reporting Requirements

1. This service must be billed as either In-Clinic or Out-of-Clinic Crisis Management/ Intervention for Medicaid recipients in accordance with A. above.
2. Any use of a telephonic intervention must be coded/reported with a U6 modifier as the person providing the telephonic intervention is not expending the additional agency resources in order to be in the community where the person served is at during the time of crisis.
3. All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Diagnostic Assessment

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Psychiatric Diagnostic Examination	Practitioner Level 1, In-Clinic	90801	U1	U6			\$174.63
	Practitioner Level 1, Out-of-Clinic	90801	U1	U7			\$222.26
	Practitioner Level 1, Via interactive audio and video telecommunication systems	90801	GT	U1			\$174.63
	Practitioner Level 2, In-Clinic	90801	U2	U6			\$116.90
	Practitioner Level 2, Out-of-Clinic	90801	U2	U7			\$140.28
	Practitioner Level 2, Via interactive audio and video telecommunication systems	90801	GT	U2			\$116.90
Psychiatric Diagnostic Examination, Interactive	Practitioner Level 1, In-Clinic	90802	U1	U6			\$174.63
	Practitioner Level 1, Out-of-Clinic	90802	U1	U7			\$222.26
	Practitioner Level 1, Via interactive audio and video telecommunication systems	90802	GT	U1			\$174.63
	Practitioner Level 2, In-Clinic	90802	U2	U6			\$116.90
	Practitioner Level 2, Out-of-Clinic	90802	U2	U7			\$140.28
	Practitioner Level 2, Via interactive audio and video telecommunication systems	90802	GT	U2			\$116.90

Definition of Service: Psychiatric diagnostic interview examination includes a history; mental status exam; evaluation and assessment of physiological phenomena (including co-morbidity between behavioral and physical health care issues); psychiatric diagnostic evaluation (including assessing for co-occurring disorders and the development of a differential diagnosis); screening and/or assessment of

any withdrawal symptoms for individuals with substance related diagnoses; assessment of the appropriateness of initiating or continuing services; and a disposition. These are completed by face-to-face evaluation of the individual (which may include the use of telemedicine) and may include communication with family and other sources, as well as the ordering and medical interpretation of laboratory or other medical diagnostic studies.

Interactive diagnostic interview examinations are typically furnished to children (but may be justified for use with adults) and involve the use of physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and a patient as a result of expressive or receptive language deficits. Interactive diagnostic interview examinations are also used when a sign language interpreter or other language interpreter is utilized order to facilitate communication between the clinician and an individual with a hearing impairment or with limited English proficiency.

Target Population	Adults with known or suspected Mental Illness or Substance Related Disorders
Benefit Information	Available to all known or suspected Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Monitored Inpatient Residential
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	1 encounter
Initial Authorization*	2 units
Re-Authorization*	2 units
Maximum Daily Units*	1 unit per procedure code
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 120 – Mental Health 720 – Addictive Diseases
Admission Criteria	1. Individual has a known or suspected mental illness or a substance-related disorder and has recently entered the service system; or 2. Individual is in need of annual assessment and re-authorization of service array; or 3. Individual has need of an assessment due to a change in clinical/functional status.
Continuing Stay Criteria	Individual's situation/functioning has changed in such a way that previous assessments are outdated.

Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: a. Individual has withdrawn or been discharged from service; or a. Individual no longer demonstrates need for additional assessment.
Service Exclusions	Not offered in conjunction with Intensive Day Treatment or ACT
Clinical Exclusions	Services defined as a part of ACT and Intensive Day Treatment.

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. Telemedicine may be utilized for an initial Psychiatric Diagnostic Examination as well as for ongoing Psychiatric Diagnostic Examination via the use of appropriate procedure codes with the GT modifier.
2. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol. **Note:** Diagnostic evaluations conducted by psychologists are covered under Behavioral Health Assessment service.
3. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.

If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

The following practitioners can provide a Psychiatric Diagnostic Examination:

- Practitioner Level 1: Physician/Psychiatrist
- Practitioner Level 2: Psychologist, APRN, PA

C. Clinical Operations

It is expected that the individual will be treated as a full partner in the treatment regimen/services planned and received. As such, it is expected that practitioners will fully discuss treatment options and allow for individual choice when possible. Discussion of treatment options should include a full disclosure of the pros and cons of each option (e.g. full disclosure of medication/treatment regimen potential side effects, potential adverse reactions--including potential adverse reaction from not taking medication as prescribed, and expected benefits).

D. Service Access

1. Diagnostic Assessment may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
2. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings.

E. Additional Medicaid Requirements

1. The daily maximum within a CSU for Diagnostic Assessment (Psychiatric Diagnostic Interview) for adults is 2 units. Two units should be utilized only if it is necessary in a complex diagnostic case for the physician extender (PA or APRN) to call in the physician for an assessment of the individual to corroborate or verify the correct diagnosis.
2. Nutritional Assessments which were billed to the Diagnostic Assessment service definition prior to July 1, 2006 are no longer be encompassed under this code. Please see the Nursing Assessment and Care definition.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be adhered to.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Family Outpatient Services: Family Counseling

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Family – Behavioral health counseling and therapy (without client present)	Practitioner Level 2, In-Clinic	H0004	HS	U2	U6		\$38.97
	Practitioner Level 3, In-Clinic	H0004	HS	U3	U6		\$30.01
	Practitioner Level 4, In-Clinic	H0004	HS	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic	H0004	HS	U5	U6		\$15.13
	Practitioner Level 2, Out-of-Clinic	H0004	HS	U2	U7		\$46.76
	Practitioner Level 3, Out-of-Clinic	H0004	HS	U3	U7		\$36.68
	Practitioner Level 4, Out-of-Clinic	H0004	HS	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic	H0004	HS	U5	U7		\$18.15
Family -- Behavioral health counseling and therapy (with client present)	Practitioner Level 2, In-Clinic	H0004	HR	U2	U6		\$38.97
	Practitioner Level 3, In-Clinic	H0004	HR	U3	U6		\$30.01
	Practitioner Level 4, In-Clinic	H0004	HR	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic	H0004	HR	U5	U6		\$15.13
	Practitioner Level 2, Out-of-Clinic	H0004	HR	U2	U7		\$46.76
	Practitioner Level 3, Out-of-Clinic	H0004	HR	U3	U7		\$36.68
	Practitioner Level 4, Out-of-Clinic	H0004	HR	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic	H0004	HR	U5	U7		\$18.15
Family Psychotherapy without the patient present (appropriate license required)	Practitioner Level 2, In-Clinic	90846	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	90846	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	90846	U4	U6			\$20.30
	Practitioner Level 5, In-Clinic	90846	U5	U6			\$15.13
	Practitioner Level 2, Out-of-Clinic	90846	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	90846	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	90846	U4	U7			\$24.36
	Practitioner Level 5, Out-of-Clinic	90846	U5	U7			\$18.15

Conjoint Family Psychotherapy with the patient present (appropriate license required)	Practitioner Level 2, In-Clinic	90847	U2	U6	\$38.97
	Practitioner Level 3, In-Clinic	90847	U3	U6	\$30.01
	Practitioner Level 4, In-Clinic	90847	U4	U6	\$20.30
	Practitioner Level 5, In-Clinic	90847	U5	U6	\$15.13
	Practitioner Level 2, Out-of-Clinic	90847	U2	U7	\$46.76
	Practitioner Level 3, Out-of-Clinic	90847	U3	U7	\$36.68
	Practitioner Level 4, Out-of-Clinic	90847	U4	U7	\$24.36
	Practitioner Level 5, Out-of-Clinic	90847	U5	U7	\$18.15

Definition of Service: A therapeutic intervention or counseling service shown to be successful with identified family populations, diagnoses and service needs, provided by a qualified clinician or practitioner. Services are directed toward achievement of specific goals defined with/by the individual consumer and targeted to the consumer-identified family and specified in the Individualized Recovery Plan (note: although interventions may involve the family, the focus or primary beneficiary of intervention must always be the individual consumer). Family counseling provides systematic interactions between the identified individual consumer, staff and the individual's identified family members directed toward the restoration, development, enhancement or maintenance of functioning of the identified consumer/family unit. This includes support of the family and specific therapeutic interventions/activities to enhance family roles, relationships, communication and functioning that promote the recovery of the individual. Specific goals/issues to be addressed though these services may include the restoration, development, enhancement or maintenance of:

1. processing skills;
2. healthy coping mechanisms;
3. adaptive behaviors and skills;
4. interpersonal skills;
5. family roles and relationships;
6. the family's understanding of mental illness and substance related disorders, the steps necessary to facilitate recovery, and methods of intervention, interaction and mutual support the family can use to assist their family member.

Best practices such as Multi-systemic Family Therapy, Multidimensional Family Therapy, Behavioral Family Therapy, Functional Family Therapy or others appropriate for the family and issues to be addressed should be utilized in the provision of this service.

Target Population	Individuals with Mental Illness and/or Substance-Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Monitored Inpatient Residential

Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	If a MICP Registration is submitted -32 units (combined with Family Training) If a MICP New Episode is submitted - 60 units (combined with Family Training)
Reauthorization*	60 units (Family Training and Family Counseling combined)
Maximum Daily Units*	8 units (Family Training and Family Counseling combined)
Authorization Period*	180 days
UAS: Budget and Expense Categories	Adult Core Services Provider 130 – Adult Mental Health 730 – Adult Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must have a mental illness and/or substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. Individual's level of functioning does not preclude the provision of services in an outpatient milieu; and 3. Individual's assessment indicates needs that may be supported by a therapeutic intervention shown to be successful with identified family populations and individual's diagnoses.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet Admission Criteria as articulated above; and 2. Progress notes document progress relative to goals identified in the Individualized Recovery Plan, but all treatment/support goals have not yet been achieved.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual requests discharge and individual is not in imminent danger of harm to self or others; or 4. Transfer to another service is warranted by change in individual's condition; or 5. Individual requires more intensive services.
Service Exclusions	ACT
Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health impairment precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. This service is not intended to supplant other services such as MR/DD Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various

	<p>community settings.</p> <p>5. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder and traumatic brain injury.</p>
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**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality and goals must be specified and agreed upon by the individual.
2. Couples counseling is included under this service code as long as the counseling is directed toward the identified consumer and his/her goal attainment as identified in the Individualized Recovery Plan.
3. The Individualized Recovery Plan for the individual includes goals and objectives specific to the consumer-identified family for whom the service is being provided.
4. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
5. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.

If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

The following individuals can provide behavioral health counseling and psychotherapy to families:

- Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 2 rate)
- Practitioner Level 2: Psychologist, CNS-PMH
- Practitioner Level 3: LCSW, LPC, LMFT, RN
- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling,

psychology, or criminology (addiction counselors may only perform these functions related to treatment of addictive diseases).

- Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases).

C. Clinical Operations

Models of best practice delivery may include (as clinically appropriate) Multidimensional Family Therapy, Behavioral Family Therapy, Functional Family Therapy, and others as appropriate the family and issues to be addressed.

D. Service Access

1. Services may not exceed 8 Billable units (combined Family Counseling and Family Therapy) in a single day. If clinical need indicates this level of intensity, other services may need to be considered for authorization.
2. Family Counseling may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
3. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings.

E. Additional Medicaid Requirements

Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

H. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.
2. If there are multiple family members in the Family Counseling session who are enrolled consumers for whom the focus of treatment is related to goals on their treatment plans, we recommend the following:
 - a. Document the family session in the charts of each individual consumer for whom the treatment is related to a specific goal on the individual's IRP
 - b. Charge the Family Counseling session units to one of the consumers.
 - c. Indicate "NC" (No Charge) on the documentation for the other consumer(s) in the family session and have the note reflect that the charges for the session are assigned to another family member in the session.

Family Outpatient Services: Family Training

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Family Skills Training and Development	Practitioner Level 4, In-Clinic, without client present	H2014	HS	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic, without client present	H2014	HS	U5	U6		\$15.13
	Practitioner Level 4, Out-of-Clinic, without client present	H2014	HS	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic, without client present	H2014	HS	U5	U7		\$18.15
	Practitioner Level 4, In-Clinic, with client present	H2014	HR	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic, with client present	H2014	HR	U5	U6		\$15.13
	Practitioner Level 4, Out-of-Clinic, with client present	H2014	HR	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic, with client present	H2014	HR	U5	U7		\$18.15

Definition of Service: A therapeutic interaction shown to be successful with identified family populations, diagnoses and service needs. Services are directed toward achievement of specific goals defined by the individual consumer and targeted to the consumer-identified family and specified in the Individualized Recovery Plan (note: although interventions may involve the family, the focus or primary beneficiary of intervention must always be the individual consumer). Family training provides systematic interactions between the identified individual consumer, staff and the individual's identified family members directed toward the enhancement or maintenance of functioning of the identified consumer/family unit. This may include support of the family, as well as training and specific activities to enhance functioning that promote the recovery of the individual. Specific goals/issues to be addressed though these services may include the restoration, development, enhancement or maintenance of:

1. illness and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed);
2. problem solving and practicing functional skills;
3. healthy coping mechanisms;
4. adaptive behaviors and skills;
5. interpersonal skills;
6. daily living skills;
7. resource access and management skills; and
8. the family's understanding of mental illness and substance related disorders, the steps necessary to facilitate recovery, and methods of intervention, interaction and mutual support the family can use to assist their family member.

Target Population	Individuals with Mental Illness and/or Substance-Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Monitored Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	If a MICP Registration is submitted -32 units (combined with Family Counseling) If a MICP New Episode is submitted - 60 units (combined with Family Counseling)
Reauthorization*	60 units (Family Training and Family Counseling combined)
Maximum Daily Units*	8 units (Family Training and Family Counseling combined)
Authorization Period*	180 days
UAS: Budget and Expense Categories	Adult Core Services Provider 130 – Adult Mental Health 730 – Adult Addictive Diseases
Admission Criteria	1. Individual must have a mental illness and/or substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. Individual's level of functioning does not preclude the provision of services in an outpatient milieu; and 3. Individual's assessment indicates needs that may be supported by a therapeutic intervention shown to be successful with identified family populations and individual's diagnoses.
Continuing Stay Criteria	1. Individual continues to meet Admission Criteria as articulated above; and 2. Progress notes document progress relative to goals identified in the Individualized Recovery Plan, but all treatment/support goals have not yet been achieved.

Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual requests discharge and individual is not in imminent danger of harm to self or others; or 3. Transfer to another service is warranted by change in individual's condition; or 4. Individual requires more intensive services.
Service Exclusions	ACT
Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health impairment precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. There is no outlook for improvement with this particular service. 5. This service is not intended to supplant other services such as Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 6. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder and traumatic brain injury.

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality and goals must be specified and agreed upon by the individual.
2. The Individualized Recovery Plan for the individual includes goals and objectives specific to the consumer-identified family for whom the service is being provided.
3. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
4. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.

If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

The following individuals can provide skills training and development to families:

- Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 4 rate)
- Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate)
- Practitioner Level 3: LCSW, LPC, LMFT, RN (reimbursed at Level 4 rate)
- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology
- Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above

C. Clinical Operation

D. Service Access

1. Services may not exceed 8 Billable units (combined Family Counseling and Family Therapy) in a single day. If clinical need indicates this level of intensity, other services may need to be considered for authorization.
2. Family Training may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
3. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings.

E. Additional Medicaid Requirements

Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

2. If there are multiple family members in the Family Training session who are enrolled consumers for whom the focus of treatment in the group is related to goals on their treatment plans, we recommend the following:
 - a. Document the family session in the charts of each individual consumer for whom the treatment is related to a specific goal on the individual's IRP
 - b. Charge the Family Training session units to **one** of the consumers.
 - c. Indicate "NC" (No Charge) on the documentation for the other consumer(s) in the family session and have the note reflect that the charges for the session are assigned to another family member in the session.

Group Outpatient Services: Group Counseling

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Group – Behavioral health counseling and therapy	Practitioner Level 2, In-Clinic	H0004	HQ	U2	U6		\$8.50
	Practitioner Level 3, In-Clinic	H0004	HQ	U3	U6		\$6.60
	Practitioner Level 4, In-Clinic	H0004	HQ	U4	U6		\$4.43
	Practitioner Level 5, In-Clinic	H0004	HQ	U5	U6		\$3.30
	Practitioner Level 2, Out-of-Clinic	H0004	HQ	U2	U7		\$10.39
	Practitioner Level 3, Out-of-Clinic	H0004	HQ	U3	U7		\$8.25
	Practitioner Level 4, Out-of-Clinic	H0004	HQ	U4	U7		\$5.41
	Practitioner Level 5, Out-of-Clinic	H0004	HQ	U5	U7		\$4.03
	Practitioner Level 2, In-Clinic, Multi-family group, with client present	H0004	HQ	HR	U2	U6	\$8.50
	Practitioner Level 3, In-Clinic, Multi-family group, with client present	H0004	HQ	HR	U3	U6	\$6.60
	Practitioner Level 4, In-Clinic, Multi-family group, with client present	H0004	HQ	HR	U4	U6	\$4.43
	Practitioner Level 5, In-Clinic, Multi-family group, with client present	H0004	HQ	HR	U5	U6	\$3.30
	Practitioner Level 2, Out-of-Clinic, Multi-family group, with client present	H0004	HQ	HR	U2	U7	\$10.39
	Practitioner Level 3, Out-of-Clinic, Multi-family group, with client present	H0004	HQ	HR	U3	U7	\$8.25
	Practitioner Level 4, Out-of-Clinic, Multi-family group, with client present	H0004	HQ	HR	U4	U7	\$5.41
	Practitioner Level 5, Out-of-Clinic, Multi-family group, with client present	H0004	HQ	HR	U5	U7	\$4.03
	Practitioner Level 2, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U2	U6	\$8.50

	Practitioner Level 3, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U3	U6	\$6.60
	Practitioner Level 4, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U4	U6	\$4.43
	Practitioner Level 5, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U5	U6	\$3.30
	Practitioner Level 2, Out-of-Clinic, Multi-family group, without client present	H0004	HQ	HS	U2	U7	\$10.39
	Practitioner Level 3, Out-of-Clinic, Multi-family group, without client present	H0004	HQ	HS	U3	U7	\$8.25
	Practitioner Level 4, Out-of-Clinic, Multi-family group, without client present	H0004	HQ	HS	U4	U7	\$5.41
	Practitioner Level 5, Out-of-Clinic, Multi-family group, without client present	H0004	HQ	HS	U5	U7	\$4.03
Group Psychotherapy other than of a multiple family group (appropriate license required)	Practitioner Level 2, In-Clinic	90853	U2	U6			\$8.50
	Practitioner Level 3, In-Clinic	90853	U3	U6			\$6.60
	Practitioner Level 4, In-Clinic	90853	U4	U6			\$4.43
	Practitioner Level 5, In-Clinic	90853	U5	U6			\$3.30
	Practitioner Level 2, Out-of-Clinic	90853	U2	U7			\$10.39
	Practitioner Level 3, Out-of-Clinic	90853	U3	U7			\$8.25
	Practitioner Level 4, Out-of-Clinic	90853	U4	U7			\$5.41
	Practitioner Level 5, Out-of-Clinic	90853	U5	U7			\$4.03

Definition of Service: A therapeutic intervention or counseling service shown to be successful with identified populations, diagnoses and service needs, provided in a group format by a qualified clinician or practitioner. Services are directed toward achievement of specific goals defined by the individual consumer and specified in the Individualized Recovery Plan. Services may address goals/issues such as promoting recovery, and the restoration, development, enhancement or maintenance of:

- 1) cognitive processing skills;
- 2) healthy coping mechanisms;
- 3) adaptive behaviors and skills;
- 4) interpersonal skills;
- 5) identifying and resolving personal, social, intrapersonal and interpersonal concerns

Target Population	Individuals with Mental Illness and/or Substance-Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.

Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Monitored Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	If a MICP Registration is submitted - 32 units If a MICP New Episode is submitted - 200 units <i>(unless authorized as a part of a specific "package" which changes the authorization parameters)</i>
Re-Authorization*	200 units
Maximum Daily Units*	20 units
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 129 – Adult Mental Health 729 – Adult Addictive Diseases
Admission Criteria	1. Individual must have a primary mental illness/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. The individual's level of functioning does not preclude the provision of services in an outpatient milieu; and 3. The individual's recovery goal/s which are to be addressed by this service must be conducive to response by a group milieu.
Continuing Stay Criteria	1. Individual continues to meet admission criteria; and 2. Individual demonstrates documented progress relative to goals identified in the Individualized Recovery Plan, but treatment goals have not yet been achieved.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual requests discharge and individual is not in imminent danger of harm to self or others; or 4. Transfer to another service/level of care is warranted by change in individual's condition; or 5. Individual requires more intensive services.
Service Exclusions	See also below, Item A.2. and A.3.

Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health impairment precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. This service is not intended to supplant other services such as MR Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 5. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder and traumatic brain injury.
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**(unless authorized as a part of a specific “package” which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality and goals must be specified and agreed upon by the individual.
2. Group outpatient services should very rarely be offered in addition to day services such as Psychosocial Rehabilitation. Any exceptions must be clinically justified in the record and may be subject to scrutiny by the external review organization. Exceptions in offering group outpatient services external to day services include such sensitive and targeted clinical issue groups as incest survivor groups, perpetrator groups, and sexual abuse survivors groups. When an exception is clinically justified, services must not duplicate day services activities.
3. When billed concurrently with ACT services, group counseling must be curriculum-based.
4. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
 - D> “Out-of-Clinic” may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.

If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide group counseling:
 - Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 2 rate)

- Practitioner Level 2: Psychologist, CNS-PMH
 - Practitioner Level 3: LCSW, LPC, LMFT, RN
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (may only perform these functions related to treatment of addictive diseases).
 - Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases).
2. Students and individuals working toward licensure as a professional counselor, social worker, or marriage and family therapist must work under direction and documented clinical supervision of a licensed professional in accordance with the rules of the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists. Agencies should refer to O.C.G.A. 43-10A-3 for the definitions of "direction" and "supervision" and the Documentation Guidelines included in this Provider Manual.
 3. The three specialties governed by the board referenced in B.2. above have different supervision requirements for individuals working toward licensure and it is the responsibility of the agency to ensure that the supervision requirements specified by the Board for the specialty (professional counseling, social work or marriage and family therapy) for which the individual is working toward licensure are met (also reference Documentation Guidelines included in this manual).
 4. Addiction counselor trainees may perform counseling as a trainee for a period of up to 3 years if they meet the requirements in O.C.G.A. 43-10A. This is limited to the provision of chemical dependency treatment under direction and supervision of a clinical supervisor approved by the certification body under which the trainee is seeking certification. Agencies should refer to O.C.G.A. 43-10A-3 for the definitions of "direction" and "supervision" and to the Documentation Guidelines set forth in this Provider Manual.
 5. The status of students, trainees, and individuals working toward licensure must be disclosed to the individuals receiving services from trainees and interns and signatures/titles of these practitioners must also include "S/T."
 6. Maximum face-to-face ratio cannot be more than 10 consumers to 1 direct service staff based on average group attendance

C. Clinical Operations

1. The membership of a multiple family group (H0004 HQ) consists of multiple family units such as a group of two or more parent(s) from different families either with (HR) or without (HS) participation of their child/children.
2. Practitioners and supervisors of those providing this service are expected to maintain knowledge and skills regarding group practice such as selecting appropriate participants for a particular group, working with the group to establish necessary group norms and goals, and understanding and managing group dynamics and processes.

D. Service Access

1. Group Counseling may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
2. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings.

E. Additional Medicaid Requirements

The daily maximum within a CSU for combined Group Training/Counseling is 4 units/day.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Group Outpatient Services: Group Training

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Group Skills Training & Development	Practitioner Level 4, In-Clinic	H2014	HQ	U4	U6		\$4.43
	Practitioner Level 5, In-Clinic	H2014	HQ	U5	U6		\$3.30
	Practitioner Level 4, Out-of-Clinic	H2014	HQ	U4	U7		\$5.41
	Practitioner Level 5, Out-of-Clinic	H2014	HQ	U5	U7		\$4.03
	Practitioner Level 4, In-Clinic, with client present	H2014	HQ	HR	U4	U6	\$4.43
	Practitioner Level 5, In-Clinic, with client present	H2014	HQ	HR	U5	U6	\$3.30
	Practitioner Level 4, Out-of-Clinic, with client present	H2014	HQ	HR	U4	U7	\$5.41
	Practitioner Level 5, Out-of-Clinic, with client present	H2014	HQ	HR	U5	U7	\$4.03
	Practitioner Level 4, In-Clinic, without client present	H2014	HQ	HS	U4	U6	\$4.43
	Practitioner Level 5, In-Clinic, without client present	H2014	HQ	HS	U5	U6	\$3.30
	Practitioner Level 4, Out-of-Clinic, without client present	H2014	HQ	HS	U4	U7	\$5.41
	Practitioner Level 5, Out-of-Clinic, without client present	H2014	HQ	HS	U5	U7	\$4.03

Definition of Service: A therapeutic interaction shown to be successful with identified populations, diagnoses and service needs. Services are directed toward achievement of specific goals defined by the individual and specified in the Individualized Resiliency Plan. Services may address goals/issues such as promoting recovery, and the restoration, development, enhancement or maintenance of:

- 1) illness and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed);
- 2) problem solving skills;
- 3) healthy coping mechanisms;
- 4) adaptive skills;
- 5) interpersonal skills;
- 6) daily living skills;
- 7) resource management skills;
- 8) knowledge regarding mental illness, substance related disorders and other relevant topics that

	assist in meeting the youth's and family's needs; and 9) skills necessary to access and build community resources and natural support systems.
Target Population	Individuals with Mental Illness and/or Substance-Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Monitored Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization*	If a MICP Registration is submitted - 32 units (combined with Group Counseling) If a MICP New Episode is submitted - 200 units (combined with Group Counseling)
Re-Authorization*	200 units
Maximum Daily Units*	16 units
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 129 – Adult Mental Health 729 – Adult Addictive Diseases
Admission Criteria	1. Individuals must have a primary mental illness/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. The individual's level of functioning does not preclude the provision of services in an outpatient milieu; and 3. The individual's resiliency goal/s that are to be addressed by this service must be conducive to response by a group milieu.
Continuing Stay Criteria	1. Individual continues to meet admission criteria; and 2. Individual demonstrates documented progress relative to goals identified in the Individualized Recovery Plan, but treatment goals have not yet been achieved.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual requests discharge and the individual is not in imminent danger of harm to self or others; or 4. Transfer to another service/level of care is warranted by change in individual's condition; or 5. Individual requires more intensive services.

Service Exclusions	See also below, Item A.2.
Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health issue precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. This service is not intended to supplant other services such as MR/DD Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 5. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, traumatic brain injury.

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The functional goals addressed through this service must be specified and agreed upon by the individual.
2. Group outpatient services should very rarely be offered in addition to day services such as Psychosocial Rehabilitation. Any exceptions must be clinically justified in the record and may be subject to scrutiny by the external review organization. Exceptions in offering group outpatient services external to day services include such sensitive and targeted clinical issue groups as incest survivor groups, perpetrator groups, and sexual abuse survivors groups. When an exception is clinically justified, services must not duplicate day services activities.
3. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
4. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.

If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide group training:
 - Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 4 rate)

- Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate)
 - Practitioner Level 3: LCSW, LPC, LMFT, RN (reimbursed at Level 4 rate)
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology
 - Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above
2. Maximum face-to-face ratio cannot be more than 10 consumers to 1 direct service staff based on average group attendance

C. Clinical Operations

1. Practitioners providing this service are expected to maintain knowledge and skills regarding group practice such as selecting appropriate participants for a particular group, working with the group to establish necessary group norms and goals, and understanding and managing group dynamics and processes.
2. Out-of-clinic group skills training is allowable and clinically valuable for some consumers; therefore, this option should be explored to the benefit of the consumer. In this event, staff must be able to assess and address the individual needs and progress of each consumer consistently throughout the intervention/activity (e.g. in an example of teaching 2-3 consumers to access public transportation in the community, group training may be given to help each consumer individually to understand the bus schedule in a way that makes sense to them, to address questions/concerns each may have about how to use the bus, perhaps to spend time riding the bus with the consumers and assisting each to understand and become comfortable with riding the bus in accordance with *individual* goals, etc).

D. Service Access

1. Group Training may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
2. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings.

E. Additional Medicaid Requirements

The daily maximum within a CSU for combined Group Training/Counseling is 4 units/day.

F. Reporting & Billing Requirements

1. All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.
2. If this service is provided out-of-clinic, a U7 modifier is utilized on the claim/encounter submission.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Individual Counseling

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, <u>approx-irately 20-30 minutes</u> face-to-face with patient	Practitioner Level 2, In-Clinic	90804	U2	U6			64.95
	Practitioner Level 3, In-Clinic	90804	U3	U6			50.02
	Practitioner Level 4, In-Clinic	90804	U4	U6			33.83
	Practitioner Level 5, In-Clinic	90804	U5	U6			25.21.
	Practitioner Level 2, Out-of-Clinic	90804	U2	U7			77.93
	Practitioner Level 3, Out-of-Clinic	90804	U3	U7			61.13
	Practitioner Level 4, Out-of-Clinic	90804	U4	U7			40.59
	Practitioner Level 5, Out-of-Clinic	90804	U5	U7			30.25
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, <u>approx-imately 45-50 minutes</u> face-to-face with patient	Practitioner Level 2, In-Clinic	90806	U2	U6			116.90
	Practitioner Level 3, In-Clinic	90806	U3	U6			90.03
	Practitioner Level 4, In-Clinic	90806	U4	U6			60.89
	Practitioner Level 5, In-Clinic	90806	U5	U6			45.38
	Practitioner Level 2, Out-of-Clinic	90806	U2	U7			140.28
	Practitioner Level 3, Out-of-Clinic	90806	U3	U7			110.04
	Practitioner Level 4, Out-of-Clinic	90806	U4	U7			73.07
	Practitioner Level 5, Out-of-Clinic	90806	U5	U7			54.46
Individual Psychotherapy, insight oriented, behavior-	Practitioner Level 2, In-Clinic	90808	U2	U6			194.84
	Practitioner Level 3, In-Clinic	90808	U3	U6			150.05
	Practitioner Level 4, In-Clinic	90808	U4	U6			101.48

modifying and/or supportive in an office or outpatient facility, approximately <u>75-80 minutes</u> face-to-face with patient	Practitioner Level 5, In-Clinic	90808	U5	U6	75.64
	Practitioner Level 2, Out-of-Clinic	90808	U2	U7	233.80
	Practitioner Level 3, Out-of-Clinic	90808	U3	U7	183.39
	Practitioner Level 4, Out-of-Clinic	90808	U4	U7	121.78
	Practitioner Level 5, Out-of-Clinic	90808	U5	U7	90.76
Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately <u>20-30 minutes</u> face-to-face with patient	Practitioner Level 2, In-Clinic	90810	U2	U6	64.95
	Practitioner Level 3, In-Clinic	90810	U3	U6	50.02
	Practitioner Level 4, In-Clinic	90810	U4	U6	33.83
	Practitioner Level 5, In-Clinic	90810	U5	U6	25.21
	Practitioner Level 2, Out-of-Clinic	90810	U2	U7	77.93
	Practitioner Level 3, Out-of-Clinic	90810	U3	U7	61.13
	Practitioner Level 4, Out-of-Clinic	90810	U4	U7	40.59
	Practitioner Level 5, Out-of-Clinic	90810	U5	U7	30.25
Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other	Practitioner Level 2, In-Clinic	90812	U2	U6	116.90
	Practitioner Level 3, In-Clinic	90812	U3	U6	90.03
	Practitioner Level 4, In-Clinic	90812	U4	U6	60.89
	Practitioner Level 5, In-Clinic	90812	U5	U6	45.38

mechanisms of non-verbal communication, in an office or outpatient facility, approximately <u>45-50 minutes</u> face-to-face with patient	Practitioner Level 2, Out-of-Clinic	90812	U2	U7	140.28
	Practitioner Level 3, Out-of-Clinic	90812	U3	U7	110.04
	Practitioner Level 4, Out-of-Clinic	90812	U4	U7	73.07
	Practitioner Level 5, Out-of-Clinic	90812	U5	U7	54.46
Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately <u>75-80 minutes</u> face-to-face with patient	Practitioner Level 2, In-Clinic	90814	U2	U6	194.84
	Practitioner Level 3, In-Clinic	90814	U3	U6	150.05
	Practitioner Level 4, In-Clinic	90814	U4	U6	101.48
	Practitioner Level 5, In-Clinic	90814	U5	U6	75.64
	Practitioner Level 2, Out-of-Clinic	90814	U2	U7	233.80
	Practitioner Level 3, Out-of-Clinic	90814	U3	U7	183.39
	Practitioner Level 4, Out-of-Clinic	90814	U4	U7	121.78
	Practitioner Level 5, Out-of-Clinic	90814	U5	U7	90.76

Definition of Service: A therapeutic intervention or counseling service shown to be successful with identified populations, diagnoses and service needs, provided by a qualified clinician. Techniques employed involve the principles, methods and procedures of counseling that assist the person in identifying and resolving personal, social, vocational, intrapersonal and interpersonal concerns. Services are directed toward achievement of specific goals defined by the individual consumer and specified in the Individualized Recovery Plan. These services address goals/issues such as promoting recovery, and the restoration, development, enhancement or maintenance of:

- 1) illness and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed);
- 2) problem solving and cognitive skills;
- 3) healthy coping mechanisms;

- 4) adaptive behaviors and skills;
- 5) interpersonal skills; and
- 6) knowledge regarding mental illness, substance related disorders and other relevant topics that assist in meeting the individual's or the support system's needs.

Best/evidence based practice modalities may include (as clinically appropriate): Motivational Interviewing/Enhancement, Cognitive Behavioral Therapy, Behavioral Modification, Behavioral Management, Rational Behavioral Therapy, Dialectical Behavioral Therapy, and others as appropriate to the individual and clinical issues to be addressed.

Target Population	Individuals with Mental Illness and/or Substance-Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Monitored Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	1 encounter
Initial Authorization*	24 units
Re-Authorization*	24 units
Maximum Daily Units*	1 unit
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 128 – Adult Mental Health 728 – Adult Addictive Diseases
Admission Criteria	1. Individual must have a primary mental illness/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. The individual's level of functioning does not preclude the provision of services in an outpatient milieu
Continuing Stay Criteria	1. Individual continues to meet admission criteria; and . 2. Individual demonstrates documented progress relative to goals identified in the Individualized Recovery Plan, but treatment goals have not yet been achieved.

Discharge Criteria	<ol style="list-style-type: none"> 1. Adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual requests discharge and individual is not in imminent danger of harm to self or others; or 4. Transfer to another service is warranted by change in individual's condition; or 5. Individual requires a service approach that supports less or more intensive need.
Service Exclusions	ACT and Crisis Stabilization Unit services
Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health impairment precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder and traumatic brain injury.

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality and goals must be specified and agreed upon by the individual.
2. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
3. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.

If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide group training:
 - Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 2 rate)

- Practitioner Level 2: Psychologist, CNS-PMH
 - Practitioner Level 3: LCSW, LPC, LMFT, RN
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (addiction counselors may only perform these functions related to treatment of addictive diseases).
 - Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases).
2. Students and individuals working toward licensure as a professional counselor, social worker, or marriage and family therapist must work under direction and documented clinical supervision of a licensed professional in accordance with the rules of the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists. Agencies should refer to O.C.G.A. 43-10A-3 for the definitions of "direction" and "supervision" and the Documentation Guidelines included in this Provider Manual.
 3. The three specialties governed by the board referenced in B.2. above have different supervision requirements for individuals working toward licensure and it is the responsibility of the agency to ensure that the supervision requirements specified by the Board for the specialty (professional counseling, social work or marriage and family therapy) for which the individual is working toward licensure are met.
 4. Addiction counselor trainees may perform counseling as a trainee for a period of up to 3 years if they meet the requirements in O.C.G.A. 43-10A. This is limited to the provision of chemical dependency treatment under direction and supervision of a clinical supervisor approved by the certification body under which the trainee is seeking certification. Agencies should refer to O.C.G.A. 43-10A-3 and to the Documentation Guidelines included in this Provider Manual for the definitions of "direction" and "supervision".
 5. The status of students, trainees, and individuals working toward licensure must be disclosed to the individuals receiving services from trainees and interns and signatures/titles of these practitioners must also include "S/T."

C. Clinical Operations

Practitioners and supervisors of those providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based counseling practices.

D. Service Access

1. Individual Counseling may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
2. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings.

E. Additional Medicaid Requirements

Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Legal Skills / Competency Training						
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4	Rate
Patient Education, Not otherwise Classified, Non-Physician Provider, Individual per Session	S9445	H9				
Patient Education, Not otherwise Classified, Non-Physician Provider, Group per Session	S9446	H9				

Definition of Service: A therapeutic interaction shown to be successful with mentally ill or developmentally disabled individuals involved with the criminal justice system. Services are directed toward achievement of specific goals defined in a Court Order and/or pretrial forensic report. Services will address goals/issues related to development or restoration of skills related to competency to stand trial. This would include some or all of the following:

- 1) Communication skills that enable the individual to effectively convey information to another
- 2) Listening skills that allow the individual to summarize information heard, maintain attention, and identify false statements
- 3) Decision making skills to aid in responding to well-explained alternatives
- 4) Knowledge of the role of courtroom participants and procedures
- 5) Understanding of the adversarial nature of legal proceedings and one's role as a defendant

Target Population	Individuals with Mental Illness and/or Developmental Disabilities and/or Substance-Related Disorders who have been found Incompetent to Stand Trial.
Benefit Information	Available to anyone with a court order for competency restoration. Does not currently require a MICP.
Utilization Criteria	Available to anyone with a court order for competency restoration.
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes (1 Session = 1 Unit = 15 minutes)
Reimbursement Rate	\$16.69
Initial Authorization	N/A
Re-Authorization	N/A
Authorization Period	N/A
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 161 – Adult Mental Health 761 – Adult Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Individuals must have a court order authorizing community restoration for competency and 2. The individual's level of functioning does not preclude the provision of services in an outpatient milieu.

Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to be incompetent to stand trial or individual is presently competent, but needs additional intervention or refresher sessions to maintain competency until trial; and 2. Individual remains under a court order that authorizes competency restoration.
Discharge Criteria	<ol style="list-style-type: none"> 1. Individual is presently competent to stand trial as determined by a DHR Forensic Evaluator or judge and not in need of ongoing training to maintain competency for trial. 2. Individual continues to be incompetent to stand trial and it has been determined by a DHR Forensic Evaluator or judge that the individual is not restorable or 3. Individual has participated in this service for 12 consecutive months; or 4. Transfer to another service/level of care is warranted by change in individual's condition; or 5. Individual requires more intensive services.
Service Exclusions	See Below
Clinical Exclusions	<ol style="list-style-type: none"> 1. Individual presents significant and imminent risk to self or other such that a more intensive level of service is needed.

Additional Service Criteria:

A. Required Components

1. The functional goals addressed through this service must be specified.
2. Any services in excess of 3 hours in a given day (combination of individual legal/competency skills training, group legal/competency skills training) may be subject to scrutiny by the external review organization.
3. Provider shall notify DHR Evaluator Contact of decompensation in consumer mental status or need for more intensive services.
4. Provider shall notify DHR Evaluator Contact in a timely manner of either of the following situations:
 - a. the individual appears to have attained competency
 - b. it is determined that the individual has achieved maximum benefits
5. Practitioners are to utilize accepted or established competency training materials consistent with best practices. (Practitioners may request sample materials from DBHDD's Office of Forensic Services and may submit proposed materials for review.)

B. Staffing Requirements

1. Training is provided by staff with a minimum education of bachelor's degree.
2. Individual: Maximum consumer to staff ratio cannot be more than one consumer to one direct service staff.
Group: Maximum consumer to staff ratio cannot be more than 10 consumers to one direct service staff.
3. Practitioners providing this service are expected to maintain knowledge and skills regarding group training and competency restoration.

C. Clinical Operations

D. Service Access

1. Consumers will be referred by the Director of Forensic Services or designee at the state hospital in the catchment area of the provider.
2. The provider shall notify the referring state hospital if the consumer appears to be competent, is not likely to ever become competent, or appears to be in need of more intensive mental health services.

E. Additional Medicaid Requirements

This is not a Medicaid reimbursable service.

F. Reporting & Billing Requirements

1. All applicable DBHDD reporting requirements must be met.
2. Provider shall report to DBHDD's Office of Forensic Services quarterly (March 31, June 30, September 30, and December 31) the names of consumers served and for each consumer, the date and type of service (individual or group) and the number of 15-minute units delivered (e.g. 60 minute group = 4 units of S9446 H9)

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of this Provider Manual

Medication Administration							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Comprehensive Medication Services	Practitioner Level 2, In-Clinic	H2010	U2	U6			\$33.40
	Practitioner Level 3, In-Clinic	H2010	U3	U6			\$25.39
	Practitioner Level 4, In-Clinic	H2010	U4	U6			\$17.40
	Practitioner Level 5, In-Clinic	H2010	U5	U6			\$12.97
	Practitioner Level 2, Out-of-Clinic	H2010	U2	U7			\$42.51
	Practitioner Level 3, Out-of-Clinic	H2010	U3	U7			\$33.01
	Practitioner Level 4, Out-of-Clinic	H2010	U4	U7			\$22.14
Therapeutic, prophylactic or diagnostic injection	Practitioner Level 2, In-Clinic	96372	U2	U6			\$33.40
	Practitioner Level 3, In-Clinic	96372	U3	U6			\$25.39
	Practitioner Level 4, In-Clinic	96372	U4	U6			\$17.40
	Practitioner Level 2, Out-of-Clinic	96372	U2	U7			\$42.51
	Practitioner Level 3, Out-of-Clinic	96372	U3	U7			\$33.01
	Practitioner Level 4, Out-of-Clinic	96372	U4	U7			\$22.14
Alcohol, and/or drug services, methadone administration and/or service (provision of the drug by a licensed program)	Practitioner Level 2, In-Clinic	H0020	U2	U6			\$33.40
	Practitioner Level 3, In-Clinic	H0020	U3	U6			\$25.39
	Practitioner Level 4, In-Clinic	H0020	U4	U6			\$17.40
<p>Definition of Service: As reimbursed through this service, medication administration includes the act of introducing a drug (any chemical substance that, when absorbed into the body of a living organism, alters normal bodily function) into the body of another person by any number of routes including, but not limited to the following: oral, nasal, inhalant, intramuscular injection, intravenous, topical, suppository or intraocular. Medication administration requires a physician's order and must be administered by licensed or credentialed* medical personnel under the supervision of a physician or registered nurse in accordance with O.C.G.A.</p>							

This service does **not** cover the supervision of self-administration of medications (See Clinical Exclusions below).

The service must include:

1. An assessment, by the licensed or credentialed medical personnel administering the medication, of the individual's physical, psychological and behavioral status in order to make a recommendation regarding whether to continue the medication and/or its means of administration, and whether to refer the individual to the physician for a medication review.
2. Education to the individual and/or family/responsible caregiver(s), by appropriate licensed medical personnel, on the proper administration and monitoring of prescribed medication in accordance with the youth's resiliency plan.

For individuals who need opioid maintenance, the Opioid Maintenance service should be requested

Target Population	Individuals with Mental Illness Individuals with Substance Related Disorders Individuals with Co-occurring Mental Illness and Substance Related Disorders Individuals with Co-occurring Mental Illness and MR/DD Individuals with Co-occurring Substance Related Disorders and MR/DD
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Monitored Inpatient Residential
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	1 encounter
Initial Authorization*	With the submission of MICP Registration - 6 units shared With the submission of MICP New Episode: H2010 & 96372= 60 units shared
Re-Authorization*	H2010 & 96372= 60 units shared
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 124 – Adult Mental Health 724 – Adult Addictive Diseases

<p>Admission Criteria</p>	<ol style="list-style-type: none"> 1. Individual presents symptoms that are likely to respond to pharmacological interventions; and 2. Individual has been prescribed medications as a part of the treatment array; and 3. Individual /family/responsible caregiver is unable to self-administer/administer prescribed medication because: <ol style="list-style-type: none"> a. Although the individual is willing to take the prescribed medication, it is in an injectable form and must be administered by licensed medical personnel; or b. Although individual is willing to take the prescribed medication, it is a Class A controlled substance which must be stored and dispensed by medical personnel in accordance with state law; or c. Administration by licensed/credentialed medical personnel is necessary because an assessment of the individual's physical, psychological and behavioral status is required in order to make a determination regarding whether to continue the medication and/or its means of administration and/or whether to refer the individual to the physician for a medication review. d. Due to the family/caregiver's lack of capacity there is no responsible party to manage/supervise self-administration of medication (refer individual /family for CSI and/or Family or Group Training in order to teach these skills)
<p>Continuing Stay Criteria</p>	<p>Individual continues to meet admission criteria.</p>
<p>Discharge Criteria</p>	<ol style="list-style-type: none"> 1. Individual no longer needs medication; or 2. Individual is able to self-administer medication; and 3. Adequate continuing care plan has been established
<p>Service Exclusions</p>	<ol style="list-style-type: none"> 1. Does not include medication given as a part of Ambulatory Detoxification. Medication administered as part of Ambulatory Detoxification is billed as "Ambulatory Detoxification." 2. Must not be billed in the same day as Nursing Assessment. 3. Must not be billed while enrolled in ACT except if this Medication Administration service is utilized only for the administration of methadone (for Medicaid recipients). 4. May not be billed in conjunction with Intensive Day Treatment (Partial Hospitalization).
<p>Clinical Exclusions</p>	<p>This service does not cover the supervision of self-administration of medications. Self-administration of medications can be done by anyone physically and mentally capable of taking or administering medications to himself/herself. Youth and adults with mental health issues, or developmental disabilities are very often capable of self-administration of medications even if supervision by others is needed in order to adequately or safely manage self-administration of medication and other activities of daily living.</p>

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. There must be a physician's order for the medication and for the administration of the medication. The order must be in the individual's chart. Telephone/verbal orders are acceptable provided they are signed by the physician in accordance with DBHDD standards.
2. Documentation must support that the individual is being trained in the risks and benefits of the medications being administered and that symptoms are being monitored by the staff member administering the medication.
3. Documentation must support the medical necessity of administration by licensed/credentialed medical personnel rather than by the individual, family or caregiver.
4. Documentation must support that the individual is being trained in the principle of self-administration of medication or that the individual is physically or mentally unable to self-administer. This documentation will be subject to scrutiny by the External Review Organization in reauthorizing services in this category.
5. This service does **not** include the supervision of self-administration of medication.
6. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
7. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide comprehensive medication services:
 - Practitioner Level 2: Advanced Practice Registered Nurse (APRN), PA, Pharmacist
 - Practitioner Level 3: Registered Nurse (RN)
 - Practitioner Level 4: Licensed Practical Nurse (LPN)
 - Practitioner Level 5: Qualified Medication Aide (QMA) who works in a CLA
2. The following individuals can provide therapeutic, prophylactic or diagnostic injections:
 - Practitioner Level 2: Advanced Practice Registered Nurse (APRN), PA, Pharmacist

- Practitioner Level 3: Registered Nurse (RN)
 - Practitioner Level 4: Licensed Practical Nurse (LPN)
3. The following individuals can provide alcohol to drug services, methadone administration and/or service provision:
 - Practitioner Level 2: Advanced Practice Registered Nurse (APRN), PA, Pharmacist
 - Practitioner Level 3: Registered Nurse (RN)
 - Practitioner Level 4: Licensed Practical Nurse (LPN)
 4. Qualified Medication Aides working in a Community Living Arrangement (CLA) may administer medication only in a CLA.

C. Clinical Operations

1. Medication administration may not be billed for the provision of single or multiple doses of medication that a consumer has the ability to self-administer, either independently or with supervision by a caregiver, either in a clinic or a community setting. In a group home/CCI setting, for example, medications may be managed by the house parents or residential care staff and kept locked up for safety reasons. Staff may hand out medication to the residents but this does not constitute administration of medication for the purposes of this definition and, like other watchful oversight and monitoring functions, are not reimbursable treatment services.
2. If consumer/family requires training in skills needed in order to learn to manage his/her own medications and their safe self-administration and/or supervision of self-administration, this skills training service can be provided via the Community Support or Family/Group Training services in accordance with the person's individualized recovery/resiliency plan.

D. Service Access

1. Medication Administration may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
2. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings.

E. Additional Medicaid Requirements

As in all other settings, the daily maximum within a CSU for Medication Administration is 1 unit/day.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Nursing Assessment and Health Services

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Nursing Assessment/ Evaluation	Practitioner Level 2, In-Clinic	T1001	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	T1001	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	T1001	U4	U6			\$20.30
	Practitioner Level 2, Out-of-Clinic	T1001	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	T1001	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	T1001	U4	U7			\$24.36
RN Services, up to 15 minutes	Practitioner Level 2, In-Clinic	T1002	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	T1002	U3	U6			\$30.01
	Practitioner Level 2, Out-of-Clinic	T1002	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	T1002	U3	U7			\$36.68
LPN/LVN Services, up to 15 minutes	Practitioner Level 4, In-Clinic	T1003	U4	U6			\$20.30
	Practitioner Level 4, Out-of-Clinic	T1003	U4	U7			\$24.36
Health and Behavior Assessment, Face-to-Face with the Patient, Initial Assessment	Practitioner Level 2, In-Clinic	96150	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	96150	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	96150	U4	U6			\$20.30
	Practitioner Level 2, Out-of-Clinic	96150	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	96150	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	96150	U4	U7			\$24.36
Health and Behavior Assessment, Face-to-Face with the Patient, Re- assessment	Practitioner Level 2, In-Clinic	96151	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	96151	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	96151	U4	U6			\$20.30
	Practitioner Level 2, Out-of-Clinic	96151	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	96151	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	96151	U4	U7			\$24.36

Definition of Service: This service requires face-to-face contact with the individual to monitor, evaluate, assess, and/or carry out a physician's orders regarding the physical and/or psychological problems of the individual. It includes:

- 1) Providing nursing assessments and interventions to observe, monitor and care for the physical,

- nutritional, behavioral health and related psychosocial issues, problems or crises manifested in the course of an individual's treatment;
- 2) Assessing and monitoring individual's response to medication(s) to determine the need to continue medication and/or to determine the need to refer the individual to a physician for a medication review;
 - 3) Assessing and monitoring an individual's medical and other health issues that are either directly related to the mental health or substance related disorder, or to the treatment of the disorder (e.g. diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, seizures, etc);
 - 4) Consulting with the individual and individual-identified family and significant other(s) about medical, nutritional and other health issues related to the individual's mental health or substance related issues;
 - 5) Educating the individual and any identified family about potential medication side effects (especially those which may adversely affect health such as weight gain or loss, blood pressure changes, cardiac abnormalities, development of diabetes or seizures, etc);
 - 6) Consulting with the individual and the individual-identified family and significant other(s) about the various aspects of informed consent (when prescribing occurs/APRN);
 - 7) Training for self-administration of medication; and
 - 8) Venipuncture required to monitor and assess mental health, substance disorders or directly related conditions, and to monitor side effects of psychotropic medications, as ordered by a Licensed Physician, Physician Assistant or Advanced Practice Nurse.
 - 9) Providing assessment, testing, and referral for infectious diseases.

Target Population	Individuals with Mental Health issues/Serious Mental Illness and/or Substance Related Disorders Individuals with Mental Health issues/Serious Mental Illness and MR/DD Individuals with Substance Related Disorders and MR/DD
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Managed Residential
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	15 minutes
Initial Authorization*	With the submission of MICP Registration -12 units With the submission of MICP New Episode- 60 units
Re-Authorization*	60 units
Maximum Daily Units*	16 units (32 for Ambulatory Detox)
Authorization Period*	180 days

UAS: Budget and Expense Categories	<u>Core Services Provider</u> 123 – Adult Mental Health 723 – Adult Addictive Diseases
Admission Criteria	1. Individual presents with symptoms that are likely to respond to medical/nursing interventions; or 2. Individual has been prescribed medications as a part of the treatment array or has a confounding medical condition.
Continuing Stay Criteria	1. Individual continues to demonstrate symptoms that are likely to respond to or are responding to medical interventions; or 2. Individual exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; or 3. Individual demonstrates progress relative to goals identified in the Individualized Recovery Plan, but treatment goals have not yet been achieved.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual no longer demonstrates symptoms that are likely to respond to or are responding to medical/nursing interventions; or 3. Goals of the Individualized Recovery Plan have been substantially met; or 4. Individual requests discharge and individual is not in imminent danger of harm to self or others.
Service Exclusions	ACT, Medication Administration, Opioid Maintenance.
Clinical Exclusions	Routine nursing activities that are included as a part of medication administration/methadone administration

**(unless authorized as a part of a specific “package” which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. Nutritional assessments indicated by an individual's confounding health issues may be billed under this code (96150, 96151). No more than 8 units specific to nutritional assessments can be billed for an individual within a year. This specific assessment must be provided by a Registered Nurse or by a Licensed Dietician.
2. This service does **not** include the supervision of self-administration of medication.
3. Each nursing contact should document the checking of vital signs (Temperature, Pulse, Blood Pressure, Respiratory Rate, and weight, if medically indicated or if related to behavioral health symptom or behavioral health medication side effect) in accordance with general psychiatric nursing practice.
4. Nursing assessments should assess health risks, health indicators, and health conditions given that behavioral health conditions, behavioral health medications, and physical health are intertwined. Personal and family history of Diabetes, Hypertension, and Cardiovascular Disease should be explored as well as tobacco use history, substance use history, blood pressure status, and Body Mass Index (BMI). Any sign of major health concerns should yield a medical referral to a primary health care physician/center.
5. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a

physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.

E> "Out-of-Clinic" may only be billed when:

- Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.
- If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide nursing assessment and evaluation services:

- Practitioner Level 2: Advanced Practice Registered Nurse (APRN)
- Practitioner Level 3: Registered Nurse (RN),
- Practitioner Level 4: Licensed Practical Nurse (LPN), Licensed Dietician (LD)

2. The following individuals can provide RN services:

- Practitioner Level 2: Advanced Practice Registered Nurse (APRN)
- Practitioner Level 3: Registered Nurse (RN)

3. The following individuals can provide LPN/LVN services:

- Practitioner Level 4: Licensed Practical Nurse (LPN)

4. The following individuals can provide Health or Behavior Assessment (initial and reassessment) services:

- Practitioner Level 2: Advanced Practice Registered Nurse (APRN)
- Practitioner Level 3: Registered Nurse (RN), Licensed Dietician (LD)
- Practitioner Level 4: Licensed Practical Nurse (LPN)

C. Clinical Operations

1. Venipuncture billed under this service must include documentation that includes canula size utilized, insertion site, number of attempts, location, and consumer tolerance of procedure.
2. All nursing procedures must include relevant consumer centered education regarding the procedure.

D. Service Access

1. Nursing Assessment and Health Services may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
2. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings.

E. Additional Medicaid Requirements

The daily maximum within a CSU for Nursing Assessment and Health Services is 5 units/day.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Pharmacy & Lab

Definition of Service: Pharmacy and Lab Services include operating or purchasing services to order, package, and distribute prescription medications. It includes provision of assistance to consumers to access indigent medication programs, sample medication programs and payment for necessary medications when no other funding source is available. This service provides for appropriate lab work, such as drug screens and medication levels, to be performed. This service is to ensure that necessary medication and lab services are not withheld or delayed to consumers based on inability to pay.

Target Population	Individuals with Mental Illness or Substance Related Disorders
Benefit Information	Available to all Core Customers with emphasis on priority populations.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Managed Residential
Unit Value	
Initial Authorization	
Re-Authorization	
Authorization Period	
UAS: Budget and Expense Categories	
Admission Criteria	Individual has been assessed by a prescribing professional to need a psychotropic, anti-cholinergic, addiction specific, or anti-convulsant (as related to behavioral health issue) medication and/or lab work required for persons entering services, and/or monitoring medication levels.
Continuing Stay Criteria	Individual continues to meet the admission criteria as determined by the prescribing professional
Discharge Criteria	1. Individual no longer demonstrates symptoms that are likely to respond to or are responding to pharmacologic interventions; or 2. Individual requests discharge and individual is not imminently dangerous or under court order for this intervention.
Service Exclusions	
Clinical Exclusions	

Additional Service Requirements:

A. Required Components

1. Service must be provided by a licensed pharmacy or through contract with a licensed pharmacy.
2. Agency must participate in any pharmaceutical rebate programs or pharmacy assistance programs that promote consumer access in obtaining medication.

3. Providers shall refer all consumers who have an inability to pay for medications or services to the local county offices of the Department's Division of Family and Children's Services for the purposes of determining Medicaid eligibility.

B. Staffing Requirements

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

Not a Medicaid Rehabilitation Option "service." Medicaid recipients may access the general Medicaid pharmacy program as prescribed by the Department of Community Health.

F. Reporting & Billing Requirements

All applicable MICP and other DBHDD reporting requirements must be met.

Psychiatric Treatment

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately <u>20-30 minutes</u> face-to-face with patient with medical evaluation and management services.	Practitioner Level 1, In-Clinic	90805	U1	U6			97.02
	Practitioner Level 1, Out-of-Clinic	90805	U1	U7			123.48
	Practitioner Level 2, In-Clinic	90805	U2	U6			64.95
	Practitioner Level 2, Out-of-Clinic	90805	U2	U7			77.93
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately <u>45-50 minutes</u> face-to-face with patient with medical evaluation and management services.	Practitioner Level 1, In-Clinic	90807	U1	U6			174.63
	Practitioner Level 1, Out-of-Clinic	90807	U1	U7			222.26
	Practitioner Level 2, In-Clinic	90807	U2	U6			116.90
	Practitioner Level 2, Out-of-Clinic	90807	U2	U7			140.28
Pharma-	Practitioner Level 1, In-Clinic	90862	U1	U6			58.21

cological Management	Practitioner Level 1, Via interactive audio and video telecommunication systems	90862	GT	U1		58.21
	Practitioner Level 1, Out-of-Clinic	90862		U1	U7	74.09
	Practitioner Level 2, In-Clinic	90862		U2	U6	38.97
	Practitioner Level 2, Via interactive audio and video telecommunication systems	90862	GT		U2	38.97
	Practitioner Level 2, Out-of-Clinic	90862		U2	U7	46.76

Definition of Service: The provision of specialized medical and/or psychiatric services that include, but are not limited to:

- a. Psychotherapeutic services with medical evaluation and management including evaluation and assessment of physiological phenomena (including co-morbidity between behavioral and physical health care issues);
- b. Assessment and monitoring of an individual's status in relation to treatment with medication,
- c. Assessment of the appropriateness of initiating or continuing services.

Individuals must receive appropriate medical interventions as prescribed and provided by a physician (or physician extender) that shall support the individualized goals of recovery as identified by the individual and their Individualized Recovery Plan (within the parameters of the person's informed consent).

Target Population	Individuals with Mental Illness or Substance Related Disorders
Benefit Information	Available to all Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Managed Residential
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	Unit=1 encounter
Initial Authorization*	12 units
Re-Authorization*	12 units
Maximum Daily Units	1 unit (see qualifier in definition below)
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 122 – Adult Mental Health 722 – Adult Addictive Diseases

Admission Criteria	<ol style="list-style-type: none"> 1. Individual is determined to be in need of psychotherapy services and has confounding medical issues which interact with behavioral health diagnosis, requiring medical oversight; or 2. Individual has been prescribed medications as a part of the treatment array
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet the admission criteria; or 2. Individual exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; or 3. Individual continues to present symptoms that are likely to respond to pharmacological interventions; or 4. Individual continues to demonstrate symptoms that are likely to respond or are responding to medical interventions; or 5. Individual continues to require management of pharmacological treatment in order to maintain symptom remission.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual has withdrawn or been discharged from service; or 3. Individual no longer demonstrates symptoms that need pharmacological interventions.
Service Exclusions	Not offered in conjunction with ACT
Clinical Exclusions	Services defined as a part of ACT

**(unless authorized as a part of a specific "package" which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. Telemedicine may be utilized for an initial Psychiatric Diagnostic Examination as well as for ongoing Psychiatric Diagnostic Examination via the use of appropriate procedure codes with the GT modifier.
2. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a Physician's Assistant (PA) or Advanced Practice Registered Nurse (APRN: Nurse Practitioner or Clinical Nurse Specialist—Psychiatry & Mental Health) working in conjunction with a physician with an approved job description or protocol.
3. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.

If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following individuals can provide individual psychotherapy face to face with medical evaluation and management services:
 - Practitioner Level 1: Physician/Psychiatrist
 - Practitioner Level 2: CNS-PMH (Clinical Nurse Specialist in Psychiatric/Mental Health)
2. The following individuals can provide pharmacological management:
 - Practitioner Level 1: Physician/Psychiatrist
 - Practitioner Level 2: PA or APRN (if authority to perform this task is delegated by physician through approved job description or protocol)

C. Clinical Operations

1. In accordance with recovery philosophy, it is expected that individuals will be treated as full partners in the treatment regimen/services planned and received. As such, it is expected that practitioners will fully discuss treatment options with individuals and allow for individual choice when possible. Discussion of treatment options should include a full disclosure of the pros and cons of each option (e.g. full disclosure of medication/treatment regimen potential side effects, potential adverse reactions--including potential adverse reaction from not taking medication as prescribed, and expected benefits). If such full discussion/disclosure is not possible or advisable according to the clinical judgment of the practitioner, this should be documented in the individual's chart (including the specific information that was not discussed and a compelling rationale for lack of discussion/disclosure).
2. Assistive tools, technologies, worksheets, etc. can be used by the served individual to facilitate communication about treatment, symptoms, improvements, etc. with the treating practitioner.

D. Service Access

1. Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site.
2. Psychiatric Treatment may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
3. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings.

E. Additional Medicaid Requirements

1. The daily maximum within a CSU for Pharmacologic Management is 1 unit/day.
2. Even if a physician also has his/her own Medicaid number, the physician providing behavioral health treatment and care through this code should bill via the approved provider agency's Medicaid number through the Medicaid Category of Service (COS) 440.

F. Reporting & Billing Requirements

1. Within this service group, a second unit with a U1 modifier may be used in the event that a Telemedicine Psychiatric Treatment unit is provided and it indicates a need for a face-to-face assessment (e.g. 90862GTU1 is billed and it is clinically indicated that a face-to-face by an on-site physician needs to immediately follow based upon clinical indicators during the first intervention, then 90862U1, can also be billed in the same day).
2. Within this service group, there is an allowance for when a U2 practitioner conducts an intervention and, because of clinical indicators presenting during this intervention, a U1 practitioner needs to provide another unit due to the concern of the U2 supervisee (e.g. Physician's Assistant provides and bills 90805U2U6 and because of concerns, requests U1 intervention following his/her billing of U2 intervention). The use of this practice should be rare and will be subject to additional utilization review scrutiny.
3. All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Psychological Testing							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Psychological Testing – Psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psycho-pathology e.g. MMP, Rorschach, WAIS (per hour of psychologist's or physician's time, both face-to-face with the patient and time interpreting test results and preparing the report)	Practitioner Level 2, In-Clinic	96101	U2	U6			155.87
	Practitioner Level 2, Out-of-Clinic	96101	U2	U7			187.04
Psychological Testing – Psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psycho-pathology e.g. MMP, Rorschach, WAIS) with qualified healthcare professional interpretation and report, administered by technician, per hour of technician time, face-to-face	Practitioner Level 3, In-Clinic	96102	U3	U6			120.04
	Practitioner Level 3, Out-of-Clinic	96102	U3	U7			146.71
	Practitioner Level 4, In-Clinic	96102	U4	U6			81.18
	Practitioner Level 4, Out-of-Clinic	96102	U4	U7			97.42

Definition of Service: Psychological testing consists of a face-to-face assessment of emotional functioning, personality, cognitive functioning (e.g. thinking, attention, memory) or intellectual abilities using an objective and standardized tool that has uniform procedures for administration and scoring and utilizes normative data upon which interpretation of results is based.

Psychological tests are only administered and interpreted by those who are properly trained in their selection and application. The practitioner administering the test ensures that the testing environment does not interfere with the performance of the examinee and ensures that the environment affords

adequate protections of privacy and confidentiality.

This service covers both the face-to-face administration of the test instrument(s) by a qualified examiner as well as the time spent by a psychologist or physician (with the proper education and training) interpreting the test results and preparing a written report.

Target Population	Individuals with a known or suspected mental health diagnosis and/or Substance-Related Disorder
Benefit Information	Requires a MICP Registration or MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Monitored Inpatient Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	1 hour
Initial Authorization	5 units
Re-Authorization	5 units
Maximum Daily Units	5 units
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 132 – Adult Mental Health 732 – Adult Addictive Diseases
Admission Criteria	1. A known or suspected mental illness or substance-related disorder; and 2. Initial screening/intake information indicates a need for additional undetermined supports and recovery/resiliency planning; and 3. Individual meets Core Customer eligibility.
Continuing Stay Criteria	The Individual's situation/functioning has changed in such a way that previous assessments are outdated.
Discharge Criteria	Each intervention is intended to be a discrete time-limited service that modifies treatment/support goals or is indicated due to change in illness/disorder.
Service Exclusions	None
Clinical Exclusions	None

Additional Service Criteria:

A. Required Components

1. There may be no more than one comprehensive battery of 96101 and 96102 provided to one individual within a year.
2. There may be no more than 10 combined hours of 96101 and 96012 provided to one individual within a year.

3. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
4. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

The following practitioners can perform Psychological Testing:

- Practitioner Level 2: Psychologist
- Practitioner Level 3: LCSW, LPC, LMFT in conjunction with Psychologist
- Practitioner Level 4: Psychologist's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state.

C. Clinical Operations

The individual consumer (and caregiver/responsible family members etc as appropriate) must actively participate in the assessment processes.

D. Service Access

1. Psychological Testing may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
2. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings.

E. Additional Medicaid Requirements

These services are performed in accordance with GA Practice Acts.

F. Reporting & Billing Requirements

All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

2. In addition to the authorization produced through this service, documentation of clinical assessment findings from this service should also be completed and placed in the individual's chart.

Service Plan Development							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Service Plan Development	Practitioner Level 2, In-Clinic	H0032	U2	U6			\$38.97
	Practitioner Level 3, In-Clinic	H0032	U3	U6			\$30.01
	Practitioner Level 4, In-Clinic	H0032	U4	U6			\$20.30
	Practitioner Level 5, In-Clinic	H0032	U5	U6			\$15.13
	Practitioner Level 2, Out-of-Clinic	H0032	U2	U7			\$46.76
	Practitioner Level 3, Out-of-Clinic	H0032	U3	U7			\$36.68
	Practitioner Level 4, Out-of-Clinic	H0032	U4	U7			\$24.36
	Practitioner Level 5, Out-of-Clinic	H0032	U5	U7			\$18.15

Definition of Service: Individuals access this service when it has been determined through an assessment that the individual has mental health or addictive disease concerns. The Individualized Recovery Plan results from the Diagnostic and Behavioral Health Assessments and is required within the first 30 days of service, with ongoing plans completed as demanded by individual consumer need and/or by service policy.

Information from a comprehensive assessment should ultimately be used to develop with the individual an Individualized Recovery Plan that supports resilience and that is based on goals identified by the individual. Friends, family and other natural support resources may be included at the discretion and direction of the individual for whom services and supports are being planned. Also, as indicated, medical, nursing, peer support, community support, school, nutritional staff, etc. should provide information from records, and various multi-disciplinary assessments for the development of the Individualized Recovery Plan (IRP).

The Individualized Recovery Planning process includes the individual's perspective, and should include family and/or significant others as well as collateral agencies/treatment providers/relevant individuals.

The cornerstone component of the adult Individualized Recovery Plan (IRP) involves a discussion with the individual regarding what recovery means to him/her personally (e.g. getting/keeping a job, having more friends/improved relationships, improvement of behavioral health symptoms, etc.), and the development of goals (i.e. outcomes) and objectives that are defined by and meaningful to the individual based upon the individual's articulation of their recovery hopes. Concurrent with the development of the IRP, the individual should be offered the opportunity to develop an Advanced Directive for behavioral healthcare with the individual guiding the process through the free expression of their wishes and through his/her assessment of the components developed for the Advanced Directive as being realistic for him/her.

The entire process should involve the individual as a full partner and should focus on service and recovery goals/outcomes as identified by the individual.

Recovery planning shall set forth the course of care by:

- Prioritizing problems and needs;
- Stating goals which will honor achievement of stated hopes, choice, preferences and desired outcomes of the individual;
- Assuring goals/objectives are related to the assessment;
- Defining goals/objectives that are individualized, specific, and measurable with achievable timeframes;
- Defining discharge criteria and desired changes in levels of functioning and quality of life to objectively measure progress;
- Transition planning at onset of service delivery;
- Selecting services and interventions of the right duration, intensity, and frequency to best accomplish these objectives;
- Assuring there is a goal/objective that is consistent with the service intent; and
- Identifying qualified staff who are responsible and designated for the provision of services.

Target Population	Individuals with a known or suspected Mental Illness or Substance Related Disorders
Benefit Information	Available to all known or suspected Core Customers. Requires a MICP Registration or a MICP New Episode.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Managed Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value*	15 minutes
Initial Authorization*	32 units (Combined with H0031 – Behavioral Health Assessment)
Re-Authorization*	32 units (Combined with H0031 – Behavioral Health Assessment)
Maximum Daily Units*	24 units (Combined with H0031 – Behavioral Health Assessment)
Authorization Period*	180 days
UAS: Budget and Expense Categories	<u>Core Services Provider</u> 131 – Adult Mental Health 731 – Adult Addictive Diseases
Admission Criteria	1. A known or suspected mental illness or substance-related disorder; and 2. Initial screening/intake information indicates a need for additional undetermined supports and recovery/resiliency planning; and 3. Individual meets Core Customer eligibility.
Continuing Stay Criteria	The individual's situation/functioning has changed in such a way that previous assessments are outdated.

Discharge Criteria	Each intervention is intended to be a discrete time-limited service that modifies treatment/support goals or is indicated due to change in illness/disorder.
Service Exclusions	Assertive Community Treatment
Clinical Exclusions	None

**(unless authorized as a part of a specific “package” which changes the authorization parameters)*

Additional Service Criteria:

A. Required Components

1. The service plan must include elements articulated in the Documentation Guideline chapter in this Provider Manual.
2. “Out-of-Clinic” may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.

If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

The following practitioners can perform Service Planning:

- Practitioner Level 2: Psychologist, APRN, PA
- Practitioner Level 3: LCSW, LPC, LMFT, RN
- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT’s supervisee/trainee with at least a Bachelor’s degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC(II, III); CAC-I or Addiction Counselor Trainee with at least a Bachelor’s degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (addictions counselors may only perform these functions related to treatment of addictive diseases).
- Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases).

C. Clinical Operations

1. The individual consumer (and any other consumer-identified natural supports) should actively participate in planning processes.

2. The Individualized Recovery Plan should be directed by the individual's personal recovery goals as defined by that individual.
3. Advanced Directive/crisis planning shall be directed by the individual served and their needs/wishes to the extent possible and clinically appropriate. Plans should not contain elements/components that are not agreeable to, meaningful for, or realistic for the youth/family and that the youth/family is, therefore, not likely to follow through with.
4. The Multipurpose Informational Consumer Profile (MICP) format for treatment planning does not meet the requirements for a comprehensive Individualized Recovery Plan and should not be used as such. Guidelines for treatment planning are contained in the "Documentation Guidelines" in Part II, Section V of this Manual and in the DBHDD Standards for Community Providers contained in this Provider Manual.

D. Service Access

1. Service Plan Development may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.
2. This service may not be provided and billed for individuals who are involuntarily detained awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings.

E. Additional Medicaid Requirements

The daily maximum within a CSU for combined Behavioral Health Assessment and Service Plan Development is 24 units/day.

F. Reporting & Billing Requirements

All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be followed.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual
2. The initial authorization/IRP and each subsequent authorization/IRP must be completed within the time-period specified by DBHDD.
3. Every record must contain an IRP in accordance with these Service Guidelines and with the DBHDD Standards contained in this Provider Manual.

Mental Health and Addictive Disease Services

Adults' SPECIALTY Benefit Package

Ambulatory Substance Abuse Detoxification							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Alcohol And/Or Drug Services; Ambulatory Detoxification	Practitioner Level 2, In-Clinic	H0014	U2	U6			38.97
	Practitioner Level 3, In-Clinic	H0014	U3	U6			30.01
	Practitioner Level 4, In-Clinic	H0014	U4	U6			20.30

Definition of Service: This service is the medical monitoring of the physical process of withdrawal from alcohol or other drugs in an outpatient setting for those individuals with an appropriate level of readiness for behavioral change and level of community/social support. It is indicated when the individual experiences physiological dysfunction during withdrawal, but life or significant bodily functions are not threatened.

This service must reflect ASAM (American Society of Addiction Medication) Levels I-D (Ambulatory Without Extended On-Site Monitoring) and II-D (Ambulatory With Extended Onsite Monitoring) and focuses on rapid stabilization and entry into the appropriate level of care/treatment based upon the ASAM guidelines placement criteria. These services may be provided in traditional Outpatient, Intensive Outpatient, Day Treatment, Intensive Day Treatment or other ambulatory settings.

Target Population	Adults and Older Adolescents with a diagnosis of one of the following: 303.00 291.81 291.0 292.89 292.0
Benefit Information	Available to Core Customers in need of Ongoing Services Requires MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 4: Medically-monitored Non-Residential
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	15 minutes
Initial Authorization	60 units
Re-Authorization	60 units
Maximum Daily Units	32 units
Authorization Period	30 days
UAS: Budget and Expense Categories	Addictive Disease Detoxification Services Provider 766 – Adult Addictive Diseases 866- C&A Addictive Diseases (for older adolescents)
Admission Criteria	Individual has a Substance Related Disorder (ASAM PPC-2, Dimension-1) that is incapacitating, destabilizing or distressing. If the severity is incapacitating, there must be sufficient optimization in other dimensions of

	<p>the individual's life to provide for safe detoxification in an outpatient setting, and individual meets the following three criteria:</p> <ol style="list-style-type: none"> 1. Individual is experiencing signs and symptoms of withdrawal, or there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition, and/or emotional/behavioral condition) that withdrawal is imminent; and the individual is assessed to be at minimal (Level I-D) to moderate (Level II-D) risk of severe withdrawal syndrome outside the program setting and can safely be managed at this service level; and 2. Individual has no incapacitating physical or psychiatric complications that would preclude ambulatory detoxification services; and 3. Individual is assessed as likely to complete needed detoxification and to enter into continued treatment or self-help recovery as evidenced by: 1) Individual or support persons clearly understand and are able to follow instructions for care, and 2) Individual has adequate understanding of and expressed interest to enter into ambulatory detoxification services, or 3) Individual has adequate support services to ensure commitment to completion of detoxification and entry into ongoing treatment or recovery, or 4) Individual evidences willingness to accept recommendations for treatment once withdrawal has been managed.
Continuing Stay Criteria	Individual's withdrawal signs and symptoms are not sufficiently resolved so that the individual can participate in self-directed recovery or ongoing treatment without the need for further medical or detoxification monitoring.
Discharge Criteria	<ol style="list-style-type: none"> 1. Adequate continuing care plan has been established; and one or more of the following; 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual/family requests discharge and individual is not imminently dangerous; or 4. Withdrawal signs and symptoms have failed to respond to treatment and have intensified (as confirmed by higher scores on CIWA-Ar or other comparable standardized scoring system) such that transfer to a more intensive level of detoxification service is indicated, or 5. Individual has been unable to complete Level I-D/II-D despite an adequate trial.
Service Exclusions	ACT, Nursing Assessment and Medication Administration (Medication administered as a part of Ambulatory Detoxification is not to be billed separately as Medication Administration.)
Clinical Exclusions	<ol style="list-style-type: none"> 1. Substance Abuse issue has incapacitated the individual in all aspects of daily living, there is resistance to treatment as in ASAM Dimension 4, relapse potential is high (Dimension 5), and the recovery environment is poor (Dimension 6). 2. Concomitant medical condition and/or other behavioral health issues warrant inpatient/residential treatment. 3. This service code does not cover detoxification treatment for cannabis, amphetamines, cocaine, hallucinogens and phencyclines.

Additional Service Criteria:

A. Required Components

1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. A physician's order in the individual's record is required to initiate ambulatory detoxification services. Verbal orders or those initiated by a Physician's Assistant or Clinical Nurse Specialist are acceptable provided the physician signs them within 24 hours or the next working day.
3. Programmatic philosophy must reflect emphasis on the development of a Plan of Care, which provides services in the least restrictive most empowering setting. This is an essential consideration for each individual's plan of care. This empowers individuals by fostering independence.

B. Staffing Requirements

1. Services must be provided under supervision of a physician.
 - a. The following individuals can provide Alcohol and/or drug services, Ambulatory Detoxification:
 - Practitioner Level 1: Physician/Psychiatrist (may be billed at the Level 2 rate or under any evaluation service encompassed under the Psychiatric Treatment service group)
 - Practitioner Level 2: PA or APRN
 - Practitioner Level 3: Registered Nurse (RN)
 - Practitioner Level 4: Licensed Practical Nurse (LPN)

C. Clinical Operations

1. The severity of the individual's symptoms, level of supports needed, and the physician's authorization for the service will determine the setting, as well as the amount of nursing and physician supervision necessary during the withdrawal process. The individual may or may not require medication, and 24-hour nursing services are not required. However, there is a contingency plan for "after hours" concerns/emergencies.
2. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
3. In order for this service to have best practice impact, the Individualized Recovery/Resiliency Plan should consider group and individual counseling and training to fully support recovery.

D. Service Access

E. Additional Medicaid Requirements

Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Assertive Community Treatment							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Assertive Community Treatment	Practitioner Level 1, In-Clinic	H0039	U1	U6			\$32.46
	Practitioner Level 2, In-Clinic	H0039	U2	U6			\$32.46
	Practitioner Level 3, In-Clinic	H0039	U3	U6			\$32.46
	Practitioner Level 4, In-Clinic	H0039	U4	U6			\$32.46
	Practitioner Level 5, In-Clinic	H0039	U5	U6			\$32.46
	Practitioner Level 1, Out-of-Clinic	H0039	U1	U7			\$32.46
	Practitioner Level 2, Out-of-Clinic	H0039	U2	U7			\$32.46
	Practitioner Level 3, Out-of-Clinic	H0039	U3	U7			\$32.46
	Practitioner Level 4, Out-of-Clinic	H0039	U4	U7			\$32.46
	Practitioner Level 5, Out-of-Clinic	H0039	U5	U7			\$32.46
	Practitioner Level 1, Via interactive audio and video telecommunication systems	H0039	GT	U1			\$32.46
	Practitioner Level 1, Via interactive audio and video telecommunication systems	H0039	GT	U2			\$32.46
	Multidisciplinary Team Meeting	H0039	HT				\$0

Definition of Service: ACT is an Evidence Based Practice that is client-centered, recovery-oriented, and a highly intensive community based service for individuals who have severe and persistent mental illness. The individual's mental illness has significantly impaired his or her functioning in the community. The individual has been unsuccessfully treated in the traditional mental health service system because of his/her high level of mental health acuity. The use of the traditional clinic based services for the individual in the past or present have usually been greater than 8 hours of service per month. The recipient may have experienced chronic homelessness and/or criminal justice involvement; and may have had multiple or extended stays in state psychiatric/public hospitals. ACT provides a variety of interventions twenty-four (24) hours, seven days a week. The service utilizes a multidisciplinary mental health team from the fields of psychiatry, nursing, psychology, social work, substance abuse, and vocational rehabilitation; additionally, a Certified Peer Specialist is an active member of the ACT Team providing assistance with the development of natural supports, promoting socialization, and the strengthening of community living skills. The ACT Team works as one organizational unit providing community based interventions that are rehabilitative, intensive, integrated, and stage specific. Services emphasize social inclusiveness through relationship building and the active involvement in assisting individuals to achieve a stable and structured life style. The service providers must develop programmatic goals that clearly articulate the use of best/evidence-based practices for ACT recipients

using co-occurring and trauma-informed service delivery and support. Practitioners of this service are expected to maintain knowledge and skills according to the current research trends in best/evidence-based practices. .ACT is a unique treatment model in which the majority of mental health services are directly provided internally by the ACT program in the recipient's natural environment. ACT services are individually tailored with each consumer to address his/her preferences and identified goals, which are the basis of the Individualized Recovery Plan. Based on the needs of the individual, services may include (in addition to those services provided by other systems):

1. Assistance to facilitate the individual's active participation in the development of the Individualized Recovery Plan (IRP);
2. Psycho educational and instrumental support to individuals and their identified family;
3. Crisis planning (WRAP), assessment, support and intervention;
4. Psychiatric assessment and care; nursing assessment and care; psychosocial and functional assessment which includes identification of strengths, skills, resources and needs;
5. Curriculum-based group treatment;
6. Individualized interventions, which may include:
 - a. Identification, with the consumer, of barriers that impede the development of skills necessary for independent functioning in the community; as well as existing strengths which may aid the individual in recovery and goal achievement;
 - b. Support to facilitate recovery (including emotional/therapeutic support/assistance with defining what recovery means to the individual in order to assist individual with recovery-based goal setting and attainment);
 - c. Service and resource coordination to assist the individual with the acquisition and maintenance of recovery capital (i.e. gaining access to necessary internal and external rehabilitative, medical and other services) required for recovery initiation and self-maintenance;
 - d. Family counseling/training for individuals and their families (as related to the person's IRP);
 - e. Assistance to develop both mental illness and physical health symptom monitoring and illness self-management skills in order to identify and minimize the negative effects of symptoms which interfere with the individual's daily living (may include medication administration and/or observation and assistance with self- medication motivation and skills) and to promote wellness;
 - f. Assistance with accessing entitlement benefits and financial management skill development;
 - g. Motivational assistance to develop and work on goals related to personal development and school or work performance;
 - h. Substance abuse counseling and intervention (e.g. motivational interviewing, stage based interventions, refusal skill development, cognitive behavioral therapy, psycho educational approaches, instrumental support such as helping individual relocate away from friends/neighbors who influence drug use, relapse prevention planning and techniques etc);
 - i. Individualized, restorative one-to-one psychosocial rehabilitation and skill development, including assistance in the development of interpersonal/social and community coping and functional skills (i.e. adaptation/functioning in home, school and work environments);
 - j. Psychotherapeutic techniques involving the in depth exploration and treatment of interpersonal and intrapersonal issues, including trauma issues; and
 - k. Any necessary monitoring and follow-up to determine if the services accessed have

adequately met the individual's needs.

Individuals receiving this intensive level of community support are expected to experience increased community tenure and decreased frequency and/or duration of hospitalization/crisis services. Through individualized, team-based supports, it is expected that individuals will achieve housing stability, decreased symptomatology (or a decrease in the debilitating effects of symptoms), improved social integration and functioning, and increased movement toward self-defined recovery.

Target Population	Adults with Serious and Persistent Mental Illness, Adult with Co-Occurring Substance Related Disorders and Serious and Persistent Mental Illness Adults with Co-Occurring Serious and Persistent Mental Illness and MR/DD
Benefit Information	Available to Core Customers in need of Ongoing Services Requires MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential (transition) 6: Medically Managed Residential (transition)
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	15 minutes
Initial Authorization	240 units
Re-Authorization	240 units
Maximum Daily Units	96 units
Authorization Period	90 days
UAS: Budget and Expense Categories	<u>Intensive Treatment Services Provider</u> 152 – Adult Mental Health
Admission Criteria	<ol style="list-style-type: none"> 1. Individuals with severe and persistent mental illness that seriously impairs the ability to live in the community. Priority is given to people recently discharged from an institutional setting with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder) or bipolar disorder, because these illnesses more often cause long-term psychiatric disability; and 2. Individuals with significant functional impairments as demonstrated by the need for assistance in 3 or more of the following areas which despite support from a care giver or behavioral health staff (i.e. Community Support) continues to be an area that the individual cannot complete: <ol style="list-style-type: none"> a. Maintaining personal hygiene; b. meeting nutritional needs; c. caring for personal business affairs; d. obtaining medical, legal, and housing services; e. recognizing and avoiding common dangers or hazards to self and possessions; f. persistent or recurrent failure to perform daily living tasks except

	<p>with significant support or assistance from others such as friends, family, or other relatives;</p> <p>g. Employment at a self-sustaining level or inability to consistently carry out homemaker roles (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks and responsibilities);</p> <p>h. Maintaining a safe living situation (e.g. evicted from housing, or recent loss of housing, or imminent risk of loss of housing);</p> <p style="text-align: center;">and</p> <p>3. Past (within 180 days of admission) or current response to other community-based intensive behavioral health treatment has shown minimal effectiveness (i.e. Psychosocial Rehabilitation, CSI, etc). Admission documentation must include evidence of this criterion;</p> <p style="text-align: center;">and</p> <p>4. Individuals with two or more of the following problems that are indicators of continuous high-service needs (i.e., greater than 8 hours of service per month):</p> <p>a. High use of acute psychiatric hospitals or crisis/emergency services including mobile, in-clinic or crisis residential (e.g., 3 or more admission per year) or extended hospital stay (60 days within the past year) or psychiatric emergency services.</p> <p>b. Persistent, recurrent, severe, or major symptoms that place the individual at risk for harm to self or others (e.g. command hallucinations, suicidal ideation or gestures, homicidal ideation or gestures, self harm).</p> <p>c. Coexisting substance use disorder of significant duration (e.g., greater than 6 months) or co-diagnosis of substance abuse (ASAM Levels \geq I, II.1, II.5, III.3., III.5).</p> <p>d. High risk for or a recent history of criminal justice involvement because of mental illness (e.g., arrest and incarceration).</p> <p>e. Chronically homeless defined as a) continuously homeless for one full year; OR b) having at least four (4) episodes of homelessness within the past three (3) years.</p> <p>f. Residing in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available [NOTE: Medicaid may not be billed for services provided while in an inpatient facility-see Community Transition Planning service],</p> <p>g. Inability to participate in traditional clinic-based services (must evidence of multiple agency trials if this is one of the only requirements met on the list)</p> <p style="text-align: center;">and</p> <p>5. A lower level of service/support has been tried or considered and found inappropriate at this time.</p>
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Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual meets the requirements above; and 2. Continued inability to participate in traditional clinic-based services or a community setting at a less intensive level of service/supports; and/or 3. Substandard housing, homeless, or at imminent risk of becoming homeless due to functional impairments associated with behavioral health issues.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: <ol style="list-style-type: none"> a. Individual no longer meets admission criteria; or b. Goals of the Individualized Recovery Plan have been substantially met; or c. Individual requests discharge and is not in imminent danger of harm to self or others, or d. Transfer to another service/level of care is warranted by a change in individual's condition, or e. Individual requires services not available in this level of care.
Service Exclusions	<ol style="list-style-type: none"> 1. ACT is a comprehensive team intervention and most services are excluded, with the exceptions of <ul style="list-style-type: none"> • Peer Supports, • Residential Supports, • Community Transition Planning (to be utilized as a person is transitioning to/from an inpatient setting, jail, or CSP) • Group Training/Counseling (within parameters listed in Section A), and • Supported Employment • Psychosocial Rehabilitation 2. On an individual basis, up to four (4) weeks of some services may be provided to ACT consumers to facilitate a smooth transition from ACT to these other community services. A transition plan must be adequately documented in the Individualized Recovery Plan and clinical record. These service are: <ul style="list-style-type: none"> • Community Support • Behavioral Health Assessment • Service Plan Development • Diagnostic Assessment • Physician Assessment (specific to engagement only) • Individual Counseling (specific to engagement only) 3. ACT recipients who also receive a DBHDD Residential Service may not receive ACT-provided skills training which is a part of the "residential" service. The ACT provider shall be in close coordination with the Residential provider such that there is no duplication of services supports/efforts. 4. Those receiving Medicaid DD Waivers are excluded from the service.
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition

	overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, substance-related disorder.
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Additional Service Criteria:

A. Required Components

1. Assertive Community Treatment must include a comprehensive and integrated set of medical and psychosocial services provided in non-office settings 80% of the time by a mobile multidisciplinary team. The team must provide community support services interwoven with treatment and rehabilitative services and regularly scheduled team meetings which will be documented in the served individual's medical record.
2. The Treatment Team Meetings must be held a minimum of 3 times a week and time dedicated to discussion of support to a specific individual must be documented in the log of the Treatment Team Meetings as indicated in Section G. Each consumer must be discussed, even if briefly, in each Treatment Team Meeting. The Treatment Team Meetings are to review the status of all consumers and the outcome of the most recent staff contacts, develop a master staff work schedule for the day's activities, and all ACT team members are expected to attend; exception of nonattendance can be made and documented by the Team Leader. Effective 7/1/11, the psychiatrist must participate at least one time/week in the ACT team meetings.
3. Services and interventions must be individually tailored to the needs, goals, preferences and assets of the individual with the goals of maximizing independence and recovery as defined by the consumer.
4. At least 80% of all service units must involve face-to-face contact with consumers. Eighty percent (80%) or more of face-to-face service units must be provided outside of program offices in locations that are comfortable and convenient for consumers (including the individual's home, based on individual need and preference and clinical appropriateness).
5. During the course of treatment, it is recommended that the ACT Team provide for some individuals at least 5 face-to-face contacts per week based on the persons mental health acuity. However, all individuals participating in ACT must receive a minimum of 12 face-to-face contacts per month. The Team must see each individual at least once a month for symptom assessment/management and management of medications.
6. During discharge transition, it is recommended that the ACT Team provide at least 3 face-to-face contacts per week for most individuals on an ongoing basis. All individuals participating in ACT transitioning must receive a minimum of 4 face-to-face contacts per month. The Team must see each individual at least once a month for symptom assessment/management and medication management.
7. Service may be delivered by a single team member to 2 ACT consumers at the same time if their goals are compatible, however, this cannot be a standard practice. Services cannot be offered to more than 2 individuals at a time (exception: Item A.8.).
8. ACT recipients can receive limited Group Training/Counseling (up to 8 units/week) when a curriculum-based therapeutic group is offered such as Dialectical Behavioral Therapy (DBT), Motivational Enhancement, or Integrative Dual Diagnosis Treatment (IDDT). For this to be allowable, the ACT participants must have clinical needs and recovery goals that justify intervention by staff trained in the implementation of the specific curriculum-based therapy.
 - a. This group may be offered to no more than 10 ACT participants at one time and must be directed by no fewer than 2 staff in order to be billed as a Group.
 - b. This group contains no less than 3 consumers and no more than 10 consumers.

- c. Only ACT consumers are permitted to attend these group services.
 - d. Acceptable group practitioners are those on the ACT team who meet the practitioner levels as follows:
 - Practitioner Level 1: Physician/Psychiatrist
 - Practitioner Level 2: Psychologist, CNS-PMH
 - Practitioner Level 3: LCSW, LPC, LMFT, RN
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (may only perform these functions related to treatment of addictive diseases).
 - Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases).
 - e. ACT groups must be led by more than one practitioner.
 - i. If there are 2 practitioners leading the group who are the same practitioner level (i.e. two U3 practitioners), then each may split the responsibility for documentation and singly sign a note. In this situation, there must be evidence in the note of who was the co-leader of that group to document the compliance expectations for two practitioners.
 - ii. If a group is facilitated by two practitioners who are not the same U-level (i.e. one is a U3 and one is a U4), then these co-leaders may split the responsibility for documenting group progress notes. If the lower-leveled practitioner writes the progress note, the upper level person's practitioner level can be billed if the higher practitioner-leveled person co-signs the note. If the higher level practitioner writes the note, then he/she shall document the co-leaders participation and can solely sign that note.
9. "Out-of-Clinic" may only be billed when:
- Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.

If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following practitioners can provide Assertive Community Treatment:
 - Practitioner Level 1: Physician/Psychiatrist
 - Practitioner Level 2: Psychologist, APRN, PA
 - Practitioner Level 3: LCSW, LPC, LMFT, RN
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's
Supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-I, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPRP, CPS, or Addiction Counselor Trainees with Master's or Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (addictions counselors may only perform counseling functions related to treatment of addictive diseases).
 - Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above
2. Assertive Community Treatment Team members must include:
 - (1 FT Employee required) A fulltime Team Leader who is the clinical and administrative supervisor of the team and also functions as a practicing clinician on the team; this individual must have at least 2 years of documented experience working with adults with a SPMI and one of the following qualifications to be an "independently licensed practitioner." It is expected that the practicing ACT Team Leader provides direct services at least 50% of the time. The Team Leader must be a FT employee and dedicated to only the ACT team.
 - Physician
 - Psychologist
 - Physician's Assistant
 - APRN
 - RN with a 4-year BSN
 - LCSW
 - LPC
 - LMFT
 - (Variable: 4-1.0 FTE required) Depending on consumer enrollment, a full or part time Psychiatrist who:
 - provides clinical and crisis services to all team consumers with emphasis in delivering services in the recipient's natural environment,
 - works with the team leader to monitor each individual's clinical and medical status and response to treatment, and
 - directs psychopharmacologic and medical treatment (at a minimum, must provide monthly medication management for each consumer),
 - must provide a minimum of 16 hours per week of direct support to the ACT team/ACT consumers
 - the psychiatrist must participate in at least one time/week in the ACT team meetings

The psychiatrist to ACT consumer ratio must not be greater than 1:100 and the psychiatrist. Thus, with 1-50 consumers, the requirement for the agency is to have a Psychiatrist at least 16 hours per week providing support to the team consumers. Effective 01/01/12, with 51-75 consumers, the ACT agency must have .75 FTE psychiatrist providing support to the team and

- with 76-100 consumers, the ACT agency must have 1 FTE psychiatrist providing support to the team.
- (1 Fulltime Employee) One Registered Nurse per 1-50 consumers who provides nursing services for all consumers and works with the team to monitor each individual's physical health, clinical status and response to treatment. Effective 01/01/12, the ACT agency must employ a second RN in order to meet full-fidelity. The second RN is expected to work .75 FTE when the agency serves 51-75 consumers and, with 76- 100 consumers, the second RN is expected to work 1 FTE.
 - (1/2 FTE minimum) A 1/2 to fulltime equivalent substance abuse practitioner who holds a CACI (or an equally recognized SA certification equivalent or higher) and assesses the need for and provides and/or accesses substance abuse treatment and supports for team consumers. If any single team serves 50 or more individuals with a co-occurring SA issue, then there must be 1 FTE on the team.
 - (1 FT employee) A full-time practitioner licensed to provide psychotherapy/counseling under the practice acts or a person with an associate license who is supervised by a fully licensed clinician, and provides individual and group support to team consumers (this position is in addition to the Team Leader).
 - (1 FTE) One FTE Certified Peer Specialist who is fully integrated into the team and promotes consumer self-determination and decision-making and provides essential expertise and consultation to the entire team to promote a culture in which each client's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation and community self-help activities.
 - (2 FTEs) Two paraprofessional mental health workers who provide rehabilitation and support services under the supervision of a Licensed Clinician. The sum of the FTE counts for the following two bullets must equal 2 FTEs.
 - (1/2 to 1 FTE) One of these staff must be a Vocational Rehabilitation Specialist. A VRS is a person with a minimum of one year verifiable vocational rehabilitation experience. This person may be a ½ FTE if the team serves less than 50 individuals.
 - (1 to 1 ½) FTE Other Paraprofessional
3. It is critical that ACT team members build a sound relationship with and fully engage in supporting the served individuals. To that end, no more than 1/3 of the team can be "contracted"/1099 team members.
 4. The ACT team maintains a small consumer-to-clinician ratio, of no more than 10 consumers per staff member. This does not include the psychiatrist, program assistant/s, transportation staff, or administrative personnel. Staff-to-consumer ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be served.
 5. Documentation must demonstrate that all team members are engaged in the support of each consumer served by the team including the "time-in" and "time-out" for each staff intervention (excluding the SAP if substance related issues have been ruled out).
 6. At least one ACT RN must be dedicated to a single ACT team. "Dedicated" means that the RN works with only one team at least 32 hours/week (up to 40 hours/week) and is a full-time employee of the agency (not a subcontractor/1099 employee). The Team RN must be dedicated to a single ACT team. "Dedicated" means that the team leader works with only one team at least 32 hours/week (up to 40 hours/week) and is a full-time employee of the agency (not a subcontractor/1099 employee). See also B.2., bullet 3.

C. Clinical Operations

1. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The verified diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
2. ACT Teams must incorporate assertive engagement techniques to identify, engage, and retain the most difficult to engage consumers which include using street outreach approaches and legal mechanisms such as outpatient commitment and collaboration with parole and probation officers.
3. Because ACT-eligible individuals may be difficult to engage, the initial treatment/recovery plan for an individual may be more generic at the onset of treatment/support. It is expected that the treatment plan be individualized and recovery-oriented after the team becomes engaged with the individual and comes to know the individual. The allowance for "generic" content of the IRP shall not extend beyond one initial authorization period.
4. Because many individuals served may have a mental illness and co-occurring addiction disorder, the ACT team may not discontinue services to any individual based solely upon a relapse in his/her addiction recovery.
5. ACT Teams must be designed to deliver services in various environments, such as homes, schools, homeless shelters, and street locations. The provider should keep in mind that individuals may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. their place of employment or school), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the individual in a way that may potentially embarrass the individual or breach the individual's privacy/confidentiality. Staff should be sensitive to and respectful of individuals' privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with an individual during their work time, mutually agree upon a meeting place nearby that is the least conspicuous from the individual's point of view).
6. The organization must have policies that govern the provision of services in natural settings and can document that it respects consumers' and/or families' right to privacy and confidentiality when services are provided in those settings.
7. Each ACT provider must have policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff that engage in outreach activities.
8. The organization must have established procedures/protocols for handling emergency and crisis situations that describe methods for supporting and handling individuals who require psychiatric hospitalization and/or crisis stabilization.
9. The organization must have an Assertive Community Treatment Organizational Plan that addresses the following descriptions:
 - a. Particular rehabilitation, recovery and resource coordination models utilized, types of intervention practiced, and typical daily schedule for staff
 - b. Staffing pattern and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated
 - c. Hours of operation, the staff assigned, and types of services provided to consumers, families, and/or guardians
 - d. How the plan for services is modified or adjusted to meet the needs specified in the Individualized Recovery Plan

- e. Inter-team communication plan regarding consumer support (e.g., e-mail, team staffings, staff safety plan such as check-in protocols etc.)
 - f. A physical health management plan
 - g. How the organization will integrate consumers into the community including assisting consumers in preparing for employment
 - h. How the organization (team) will respond to crisis for individuals served.
10. The ACT team is expected to work with informal support systems at least 2 to 4 times a month with or without the consumer present to provide support and skill training as necessary to assist the consumer in his or her recovery (i.e., family, landlord, employers, probation officers). If the consumer is not an engaged participant in this contact, the service shall not be billed.
11. For the individuals which the ACT team supports, the ACT team must be involved in all hospital admissions and hospital discharges. The agency will be reviewed for fidelity by the standard that the ACT team will be involved with 95% of all hospital admissions and hospital discharges. This is evidenced by documentation in the clinical record for the individual.
12. The entire ACT team is responsible for completing the ACT Comprehensive Assessment for newly enrolled consumers. The ACT Comprehensive Assessment results from the information gathered and analyzed are used to establish immediate and longer-term service needs with each consumer and to set goals and develop the first individualized treatment plan. Because of the complexity of the mental illness and the need to build trust with the served individual, the comprehensive mental health, addiction, and functional assessments may take up to 60 days. It is expected that when a person identifies and allows his/her natural supports to be partners in recovery that they will be fully involved in assessment activities and ACT team documentation will demonstrate this participation. The ACT Comprehensive Assessment shall (at a minimum) include:
- a. Psychiatric History, Mental Status/Diagnosis
 - b. Physical Health
 - c. Substance Abuse assessment
 - d. Education and Employment
 - e. Social Development and Functioning
 - f. Family Structure and Relationships
13. Treatment and recovery support to the individual is provided in accordance with a Treatment Plan. Treatment Planning shall be in accordance with the following:
- a. The Individual Treatment Team (ITT) is responsible for providing much of the consumer's treatment, rehabilitation, and support services and is charged with the development and continued adaptation of the person's recovery plan (along with that person as an active participant). The ITT is a group or combination of three to five ACT staff members who together have a range of clinical and rehabilitation skills and expertise. The ITT members are assigned by the team leader to work collaboratively with a consumer and his/her family and/or natural supports in the community by the time of the first treatment planning meeting or thirty days after admission. The core members are the primary practitioner and at least one clinical or rehabilitation staff person who shares case coordination and service provision tasks for each consumer. ITT members are assigned to take separate service roles with the consumer as specified by the consumer and the ITT in the treatment plan.
 - b. The Treatment Plan Review is a thorough, written summary describing the consumer's and the ITT's evaluation of the consumer's progress/goal attainment, the effectiveness of the interventions, and satisfaction with services since the last person-centered treatment plan.
 - c. Treatment Planning Meeting is a regularly scheduled meeting conducted under the supervision of the team leader and the psychiatric prescriber. The purpose of these

meetings is for the staff, as a team, and the consumer and his/her family/natural supports, to thoroughly prepare for their work together. The group meets together to present and integrate the information collected through assessment in order to learn as much as possible about the consumer's life, his/her experience with mental illness, and the type and effectiveness of the past treatment they have received. The presentations and discussions at these meetings make it possible for all staff to be familiar with each consumer and his/her goals and aspirations and for each consumer to become familiar with each ITT staff person. The treatment plan shall be reevaluated and adjusted accordingly via the Treatment Planning Meeting prior to each reauthorization of service (Documentation is guided by elements G.2. and G.3. below).

14. Effective July 1, 2011, each ACT team shall stagger consumer admissions from (e.g., 4-6 consumers per month) to gradually build up capacity to serve no more than 70-100 consumers.
15. It is expected that 90% or more of the consumers have face to face contact with more than one staff member in a 2 week period.

D. Service Accessibility

1. Services must be available by ACT Team staff skilled in crisis intervention 24 hours a day, 7 days a week with emergency response coverage, including psychiatric services. Answering devices/services/Georgia Crisis and Access Line do not meet the expectation of "emergency response."
2. The team must be able to rapidly respond to early signs of relapse and decompensation and must have the capability of providing multiple contacts daily to individuals in acute need.
3. An ACT staff member must provide this on-call coverage.
4. There must be documented evidence that service hours of operation include evening, weekend and holiday hours.
5. Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. The ACT Physician may use telemedicine to provide this service by using the code above with the GT modifier.

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Billing/Reporting Requirements

1. All applicable Medicaid, MICP, and other DBHDD reporting requirements must be met.
2. All time spent between 2 or more team practitioners discussing a served individual must be reported as H0039HT. While this claim/encounter is reimbursed at \$0, it is imperative that the team document these encounters (see Section G. below) to demonstrate program integrity AND submit the claim/encounter for this so this service can be included in future rate setting.
3. The following elements (at a minimum) shall be documented in the clinical record and shall be accessible to the DBHDD monthly as requested:
 - Served individual's employment status;
 - Served individual's residential status (including homelessness);
 - Served individual's involvement with criminal justice system/s;

- Served individual's interactions with crisis support services (including acute psychiatric hospitals, emergency room visits, crisis stabilization program interactions, etc.).
4. ACT may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or crisis stabilization program with greater than 16 beds), jail, or prison system.
 5. The ACT team can provide and bill for Community Transition Planning as outlined in the Guideline for this service. This includes supporting individuals who are eligible for ACT and are transitioning from Jail/Prison.
 6. When group services are provided via an ACT team to an enrolled ACT-recipient, then the encounter shall be submitted as a part of the ACT package defined in the **Orientation to Services** section of Part I, Section 1 of this manual.
 7. Each ACT program shall provide monthly outcomes data as defined by the DBHDD. The outcomes form will be emailed by the 10th of every month to dbhdd.ACT@dhr.state.ga.us.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section IV of the Provider Manual and in keeping with this section G.
2. All time spent between 2 or more team practitioners discussing a served individual must be documented in the medical record as H0039HT. While this claim/encounter is reimbursed at \$0, it is imperative that the team document these encounters to demonstrate program integrity AND submit the claim/encounter for this so this service can be included in future rate setting. HT documentation parameters include:
 - a. If the staff interaction is specific to a single consumer for 15 minutes, then the H0039HT code shall be billed to that consumer (through claims or encounters).
 - b. If the staff interaction is for multiple consumers served and is for a minimum single 15 minute unit and:
 - 1) the majority of time is for a single individual served, then the claim/encounter shall be submitted attached to the individual's name who was the focus of this staffing conversation; or
 - 2) the time is spent discussing multiple consumers (with no one consumer being the focus of the time), then the team should create a rotation list (see below) in which a different consumer would be selected for each of these staffing notes in order to submit claims and account for this staffing time, and
 - c. An agency is not required to document every staff-to-staff conversation in the individual's medical record; however every attempt should be made to accurately document the time spent in staffing or case conferencing for individual consumers. The exceptions (which shall be documented in a medical record) are:
 - when the staffing conversation modifies an individual's treatment planning or intervention strategy,
 - when observations are discussed that may lead to treatment or intervention changes, and/or that change the course of treatment
3. The ACT team must have documentation (e.g., notebook, binder, file, etc.) which contains all H0039HT staffing interactions (which shall become a document for audit purposes, and by which claims/encounters can be revoked-even though there are no funds attached). In addition to the requirements in Section G.2.above, a log of staff meetings is required to document staff meetings as outlined in Section A.2. The documentation notebook shall include:

- 1) the team's protocol for submission of H0039HT encounters (how the team is accounting for the submissions of H0039HT in accordance with the above);
 - 2) the protocol for staffings which occur ad hoc (e.g. team member is remote supporting a consumer and calls a clinical supervisor for a consult on support, etc.);
 - 3) date of staffing;
 - 4) time start/end for the "staffing" interaction;
 - 5) if a regular team meeting, names of team participants involved in staffing (signed/certified by the team leader or team lead designee in the absence of the team leader);
 - 6) if ad hoc staffing note, names of the team participants involved (signed by any one of the team members who is participating);
 - 7) name all of individuals discussed/planned for during staffing;
 - 8) minimal documentation of content of discussion specific to each consumer (1-2 sentences is sufficient).
4. All expectations set forth in this "Additional Service Components" section shall be documented in the record in a way which demonstrates compliance with the said items.

Community Based Inpatient Psychiatric and Substance Detoxification Services							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Psychiatric Health Facility Service, Per Diem		H2013					Per negotiation

Definition of Service: A short-term stay in a licensed and accredited community-based hospital for the treatment or habilitation of a psychiatric and/or substance related disorder. Services are of short duration and provide treatment for an acute psychiatric or behavioral episode. This service may also include Medically Managed Inpatient Detoxification at ASAM Level IV-D.

Target Population	Adults with a serious mental illness Adults with a Substance Related Disorder Adults with Co-occurring SMI and a Substance Related Disorder
Benefit Information	Available to Core Customers in need of Ongoing Services Requires MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 6: Medically Managed Residential
Ordering Practitioner	
Unit Value	1 day
Initial Authorization	5 days
Re-Authorization	3 days
Maximum Daily Units	1 unit
Authorization Period	5 days
UAS: Budget and Expense Categories	Adult Crisis Services Provider 135 – Adult Mental Health 735 – Adult Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Individual with serious mental illness/SED that is experiencing serious impairment; persistent, recurrent, severe, or major symptoms (such as psychoses); or who is experiencing major suicidal, homicidal or high risk tendencies as a result of the mental illness; or 2. Individual's need is assessed for 24/7 supports which must be one-on-one and may not be met by any service array which is available in the community; or 3. Individual is assessed as meeting diagnostic criteria for a Substance Related Disorder according to the latest version of the DSM; and one or more of the following: <ol style="list-style-type: none"> A. Individual is experiencing signs of severe withdrawal, or there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition, and/or emotional/behavioral condition) that severe

	<p>withdrawal syndrome is imminent; or</p> <p>B. Level IV-D is the only available level of service that can provide the medical support and comfort needed by the individual, as evidenced by:</p> <ul style="list-style-type: none"> i. A detoxification regimen or individual's response to that regimen that requires monitoring or intervention more frequently than hourly, or ii. The individual's need for detoxification or stabilization while pregnant, until she can be safely treated in a less intensive service.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet admission criteria; and 2. Individual's withdrawal signs and symptoms are not sufficiently resolved to the extent that they can be safely managed in less intensive services;
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual no longer meets admission and continued stay criteria; or 3. Individual requests discharge and individual is not imminently dangerous to self or others; or 4. Transfer to another service/level of care is warranted by change in the individual's condition; or 5. Individual requires services not available in this level of care.
Service Exclusions	<p>This service may not be provided simultaneously to any other service in the service array excepting short-term access to services that provide continuity of care or support planning for discharge from this service.</p>
Clinical Exclusions	<p>Individuals with any of the following unless there is clearly documented evidence of an acute psychiatric/addiction episode overlaying the primary diagnosis:</p> <ul style="list-style-type: none"> a. Autism b. Mental Retardation/Developmental Disabilities c. Organic Mental Disorder; or d. Traumatic Brain Injury

Additional Service Criteria:

A. Required Components

1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2
2. A physician's order in the individual's record is required to initiate detoxification services. Verbal orders or those initiated by a Physician's Assistant or Clinical Nurse Specialist are acceptable provided the physician signs them within 24 hours or the next working day.

B. Staffing Requirements

Detoxification services must be provided only by nursing or other licensed medical staff under supervision of a physician.

C. Clinical Operations

Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.

D. Service Access

E. Additional Medicaid Requirements

Not applicable. Not a Medicaid billable service.

F. Reporting & Billing Requirements

All applicable MICP and other DBHDD reporting requirements must be met.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Community Transition Planning							
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Community Transition Planning	Community Transition Planning (State Hospital)	T2038	ZH				\$20.92
	Community Transition Planning (Crisis Stabilization Unit)	T2038	ZC				\$20.92
	Community Transition Planning (Jail / Youth Detention Center)	T2038	ZJ				\$20.92
	Community Transition Planning(Other)	T2038	ZO				\$20.92

If you are an ACT provider, you may also bill this service. Please refer to the Core Guidelines for the detail.

Consumer/Family Assistance							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Mental Health Services, Not Otherwise Specified		H0046					Variable in accordance with Items C.6. below

Definition of Service: Individuals may need a range of goods and community support services to fully benefit from mental health and addictive disease services. This time-limited service consists of goods and services purchased/procured on behalf of the consumer (e.g. purchase of a time-limited mentor, a utility deposit to help an individual move into the community and/or their own housing, environmental modification to the individual's home to enhance safety and ability to continue living independently etc) that will help promote individual functional enhancement to the benefit of the individual and his/her behavioral health stability. The goods/services procured must provide a *direct and critical* benefit to the individualized needs of the consumer, in accordance with the IRP, and lead to an enhancement of specific positive behaviors/skills/resources that will allow the individual to leave an institution and/or achieve a more independent living status, or prevent an imminent crisis or out-of-home placement (e.g. eviction, homelessness, loss of independent living, loss of ability or resources needed to maintain the individual's living in the home, etc). This service is intended to be of short duration and is not intended to pay for/provide ongoing service programming through the provider agency.

Target Population	Adults defined as Core Customers of Ongoing Services who are diagnosed with: Mental Illness Substance Related Disorders Co-Occurring Mental Illness and Substance Related Disorders Co-Occurring Mental Illness/Substance Related Disorders and Mental Retardation/Developmental Disabilities
Benefit Information	Available to Core Customers in need of Ongoing Services. Requires a MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Managed Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	Variable in accordance with Items C.6. below
Initial Authorization	While the actual assistance should be very short-term in nature, this service can be authorized as part of a 180 day Recovery plan. Financial max \$2000/\$5000 (see Clinical Operations section below)

Re-Authorization	One within a single fiscal year.
Maximum Daily Units	
Authorization Period	180 days
UAS: Budget and Expense Categories	Adult Consumer/Family Support Services Provider 137 – Adult Mental Health 737 – Adult Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must meet Core Customer criteria for Ongoing services, and 2. Individual must be in need of a specific good or service that will directly improve functioning (e.g. directly lead to an enhancement of specific positive behaviors/skills/resources that will allow the individual to leave an institution and/or achieve a more independent living status), or prevent a crisis or out-of home placement (e.g. eviction, homelessness, loss of independent living, loss of ability or resources needed to maintain the individual's living in the home, etc.), and 3. Individual or provider must exhaust all other possible resources for obtaining the needed goods/services—this service provides payment of last resort, and 4. Individual has not received this service for more than one other episode of need during the current fiscal year.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual must continue to meet Core Customer criteria for Ongoing services, and 2. Individual must continue to be in need of the same specific good or service as when enrolled in Consumer/Family Assistance, that will directly improve functioning (e.g. directly lead to an increase in specific positive behaviors/skills/resources that will allow the individual to leave an institution and/or obtain more independent living), or prevent a crisis or out-of home placement (e.g. eviction, homelessness, loss of independent living, loss of ability or resources needed to maintain the individual's living in the home, etc.), and 3. Individual or provider must continue to lack any other possible resources for obtaining the needed goods/services.
Discharge Criteria	<ol style="list-style-type: none"> 1. Individual no longer meets Core Customer criteria for Ongoing services, or 2. Individual no longer continues to be in need of the good or service, or 3. Individual has received the good in the allotted amount or service for the allotted timeframe as described below in "Additional Service Criteria" # 3, or 4. The individual requests discontinuance of the service.
Service Exclusions	<ol style="list-style-type: none"> 1. Goods and services that are included as a part of other services the individual is enrolled in or could be enrolled in are excluded.
Clinical Exclusions	

Additional Service Criteria:

A. Required Components

B. Staffing Requirements

1. This service must not pay for the regular staffing of specific programs or services in the provider's agency.
2. Service may pay for a 1:1 mentor, etc for an individual consumer, within the following limits:
 - a. Other means are not available to pay for the mentor, etc., such as state funding, Medicaid, self-pay or private insurance.
 - b. The mentor, etc. cannot be used to supplement the staffing of any program or service in the provider agency.
 - c. The mentor, etc. cannot be used as a 1:1 staff for the consumer during the times the consumer is attending other programming/services offered by the provider agency.

C. Clinical Operations

1. This service must not pay for transportation to MH/DD/AD services.
2. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
3. This service must not pay for the operating, programmatic, or administrative expenses of any other program or service offered by the provider agency.
4. Individual cannot receive this service for more than two episodes of need per fiscal year.
5. Services obtained (e.g. a mentor, etc.) are intended to be of short duration and must be provided through this service for no longer than 3 months, or until the direct consumer benefit is realized, whichever occurs sooner.
6. Each type of necessary good obtained through this service is intended to be of short duration and must be purchased for no longer/in no greater amount than is reasonably necessary to avoid/resolve the immediate crisis or achieve the targeted increase in functioning. Some items have specific limits that cannot be surpassed during a single episode of need. The least duration and/or amount necessary of such items should be provided. Except for individuals leaving institutions as described below, up to:
 - one month's rental/mortgage assistance;
 - one month's assistance with utilities and/or other critical bills;
 - one housing deposit;
 - one month's supply of groceries (for the individual);
 - one month of medications;
 - one assistive device (unless a particular device is required in multiple according to commonly understood definition/practice such as a hearing aide for each ear, a one month supply of diabetic supplies etc);
 - one to two weeks' worth of clothing.

Similar guidelines should be used with other items not on this list.

* Individuals leaving an institution after a stay of at least 60 days who have had their benefits suspended or who do not yet have income or other benefits established may need greater assistance than the allowances indicated above for rent, bills, groceries and other items/services.

7. The maximum yearly monetary limit for this service is \$2000 per individual per fiscal year except for individuals who have left an institution after a 60-day stay. For such individuals, multiple months of rent, bills, groceries, services etc may be purchased, at a maximum yearly monetary

limit of \$5000 per individual per fiscal year. This amount will be controlled by the Third Party Administrator (when operational) and the availability of funds.

8. Eligibility for the Consumer/Family Assistance service does not equate to an entitlement to the service. Prioritizing eligible individuals to receive services is the responsibility of the service provider. A standard protocol must be utilized by the service provider to assess and approve the individual's needs in regard to 1) the criticalness of the need(s) in terms of the individual's functioning and ability to return to/remain in the community, and 2) the individual's or provider's ability to obtain the needed goods or services through other viable means.

D. Service Access

E. Additional Medicaid Requirements

Not applicable. Not a Medicaid billable service.

F. Reporting & Billing Requirements

1. The agency must submit a monthly report on expenditures in a specified format (and upon request at anytime) to the DBHDD.
2. All applicable DBHDD reporting requirements.

G. Documentation Requirements

1. Documentation that authorized goods/services are not available through other viable means must be made in the individual's chart.
2. Details regarding the goods/services procured and resulting benefit to the individual consumer must be documented in the individual's chart.

H. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Crisis Stabilization Unit Services							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Behavioral Health; Short-term Residential (Non-Hospital Residential Treatment Program Without Room & Board, Per Diem)		H0018	U2				Per negotiation and specific to Medicaid, see item E.2. below.
Behavioral Health; Short-term Residential (Non-Hospital Residential Treatment Program Without Room & Board, Per Diem)		H0018	TB	U2			Per negotiation

Definition of Service: This is a residential alternative to or diversion from inpatient hospitalization, offering psychiatric stabilization and detoxification services. The program provides medically monitored residential services for the purpose of providing psychiatric stabilization and substance detoxification services on a short-term basis. Specific services may include:

- 1) Psychiatric medical assessment;
- 2) Crisis assessment, support and intervention;
- 3) Medically Monitored Residential Substance Detoxification (at ASAM Level III.7-D).
- 4) Medication administration, management and monitoring;
- 5) Brief individual, group and/or family counseling; and
- 6) Linkage to other services as needed.

Services must be provided in a facility designated and certified by the DBHDD as an emergency receiving and evaluation facility

Target Population	Adults experiencing: Severe situational crisis Severe Mental Illness Substance-Related Disorders Co-Occurring Substance-Related Disorders and Mental Illness Co-Occurring Mental Illness and Mental Retardation Co-occurring Substance-Related Disorders and Mental Retardation,
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Benefit Information	Available to Core Customers in need of Ongoing Services. Requires a MICP New Episode Request or Update Request.
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 4: Medically Monitored Non-Residential (residential detoxification only) 5: Medically Monitored Community Residential 6: Medically Managed Residential (with ERO Care Management Review)
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	1 day
Initial Authorization	20 units
Re-Authorization	
Maximum Daily Units	1 unit
Authorization Period	20 Days
UAS: Budget and Expense Categories	Adult Crisis Services Provider 134 – Adult Mental Health 734 – Adult Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Treatment at a lower level of care has been attempted or given serious consideration; and #2 and/or #3 are met: 2. Individual has a known or suspected illness/disorder in keeping with target populations listed above; or 3. Individual is experiencing a severe situational crisis which has significantly compromised safety and/or functioning; and one or more of the following: 4. Individual presents a substantial risk of harm to self, others, and/or property or is so unable to care for his or her own physical health and safety as to create a life-endangering crisis. Risk may range from mild to imminent; or 5. Individual has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; or 6. Individual demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities to manage the crisis; or 7. For detoxification services, individual meets admission criteria for Medically Monitored Residential Detoxification.
Continuing Stay Criteria	This service may be utilized at various points in the individual's course of treatment and recovery; however, each intervention is intended to be a discrete time-limited service that stabilizes the individual.
Discharge Criteria	<ol style="list-style-type: none"> 1. Individual no longer meets admission guidelines requirements; or 2. Crisis situation is resolved and an adequate continuing care plan has been established; or 3. Individual does not stabilize within the evaluation period and must be transferred to a higher intensity service.
Service Exclusions	This is a comprehensive service intervention that is not to be provided with any other service(s), except for the following: <ul style="list-style-type: none"> • Methadone Administration

Clinical Exclusions	<ol style="list-style-type: none"> 1. Individual is not in crisis. 2. Individual does not present a risk of harm to self or others or is able to care for his or her own physical health and safety. 3. Severity of clinical issues precludes provision of services at this level of intensity.
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Additional Service Criteria:

A. Required Components

1. Crisis Stabilization Units (CSU) providing medically monitored short-term residential psychiatric stabilization and detoxification services shall be designated by the Department as both an emergency receiving facility and an evaluation facility and must be surveyed and certified by the DBHDD.
2. In addition to all service qualifications specified in this document, providers of this service must adhere to and be certified under the *Provider Manual for Community Mental Health, Developmental Disability and Addictive Disorders* "Core Requirements for All Providers" and DBHDD "Core Requirements for Crisis Stabilization Programs Operated by Community Service Boards."
3. Individual referred to a CSU must be evaluated by a physician within 24 hours of the referral.
4. The maximum length of stay in a crisis bed is 10 adjusted days (excluding Saturdays, Sundays and state holidays) for adults (an adult occupying a transitional bed may remain in the CSU for an unlimited number of additional days if the date of transfer and length of stay in the transitional bed is documented).
5. Individuals occupying transitional beds must receive services from outside the CSU (i.e. community-based services) on a daily basis.
6. Services must be provided in a facility designated as an emergency receiving and evaluation facility that is not also an inpatient hospital, a freestanding Institute for Mental Disease (IMD), or a licensed substance abuse detoxification facility.
7. All services provided within the CSU must be delivered under the direction of a physician. A physician must conduct an assessment of new admissions, address issues of care, and write orders as required.

B. Staffing Requirements

1. Crisis Stabilization Unit (CSU) Services must be provided by a physician or a staff member under the supervision of a physician, practicing within the scope of State law.
2. A CSU must employ a fulltime Nursing Administrator who is a Registered Nurse.
3. A CSU must have a Registered Nurse present at the facility at all times.
4. Staff-to-client ratios must be established based on the stabilization needs of clients being served and in accordance with the "Core Requirements for Crisis Stabilization Programs Operated by Community Service Boards."
5. Functions performed by Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Registered Nurses, and Licensed Practical Nurses must be performed within the scope of practice allowed by State law and Professional Practice Acts.

C. Clinical Operations

1. CSU must have documented operating agreements and referral mechanisms for psychiatric disorders, addictive disorders, and physical healthcare needs that are beyond the scope of the CSU and that require inpatient treatment. Operating agreements must delineate the type and level

of service to be provided by the private or public inpatient hospital or treatment facility. These agreements must specifically address the criteria and procedures for transferring an individual to a designated treatment facility when the CSU is unable to stabilize the individual.

2. CSUs must follow the seclusion and restraint procedures included in the Department's "Core Requirements for Crisis Stabilization Programs operated by Community Service Boards."
3. For individuals with co-occurring diagnoses including mental retardation/developmental disabilities, this service must target the symptoms, manifestations, and skills-development related to the identified behavioral health issue.
4. Individuals served in transitional beds may access an array of community-based services in preparation for their transition out of the CSU, and are expected to engage in community-based services daily while in a transitional bed.

D. Service Access

E. Additional Medicaid Requirements

1. Effective July 1, 2007, Medicaid stopped paying a bundled daily rate for this service. Crisis Stabilization Units with 16 beds or less should bill individual services for Medicaid recipients.
2. The individual services listed below may be billed up to the daily maximum listed for services provided in a Crisis Stabilization Unit. Billable services and daily limits within CSUs are as follows:

Service	Daily Maximum Billable Units
Crisis Intervention	8 units
Diagnostic Assessment	2 units
Psychiatric Treatment	1 unit (Pharmacological Mgmt only)
Nursing Assessment and Care	5 units
Medication Administration	1 unit
Group Training/Counseling	4 units
Beh Health Assmnt & Serv. Plan Devel.	24 units
Medication Administration	1 unit

3. Medicaid claims for the services in E.2. above may **not** be billed for any service provided to

F. Reporting & Billing Requirements

1. Providers must report information on all consumers served in CSUs no matter the funding source:
 - a. The CSU shall submit MICPs for all individuals served (state-funded, Medicaid funded, private pay, other third party payor, etc);
 - b. The CSU shall submit per diem encounters (H0018HAU2 or H0018HATBU2) for all individuals served (state-funded, Medicaid funded, private pay, other third party payor, etc) even if sub-parts cited in E.2 above are also billed as a claim to Medicaid;
 - c. Providers must designate either CSU bed use or transitional bed use in encounter submissions through the presence or absence of the TB modifier. TB represents "Transitional Bed."
2. Unlike all other DBHDD residential services, the start date of a CSU span encounter submission may be in one month and the end date may be in the next. The span of reporting must cover continuous days of service and the number of units must equal the days in the span.
3. All other applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

1. In order to report a per diem encounter, the consumer must have participated in the program for a minimum of 8 hours in the identified 12:00AM to 11:59PM day
2. For individuals transferred to transitional beds, the date of transfer must be documented in a progress note and filed in the individual's chart.
3. Specific to item F.1. above, the notes for the program must have documentation to support the per diem AND, if the program bills sub-parts to Medicaid (in accordance with E. above), each discrete service delivered must have documentation to support that sub-billable code (e.g. Group is provided for 1 hour, Group is billed for 1 hour, Group note is for 4 units at the 15 minute rate and meets all the necessary components of documentation for that sub-code).
4. Daily engagement in community-based services must also be documented in progress notes for those occupying transitional beds.
5. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Housing Supplements							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Housing Supplements		ROOM1					Actual cost

Definition of Service: This is a rental/housing subsidy that must be justified by a personal consumer budget. This may include a one-time rental payment to prevent eviction/homelessness.

Target Population	Adults experiencing: Severe and Persistent Mental Illness Substance-Related Disorders Co-Occurring Substance-Related Disorders and Mental Illness Co-Occurring Mental Illness and Mental Retardation Co-occurring Substance-Related Disorders and Mental Retardation
Benefit Information	Available to Core Customers in need of Ongoing Services and requires a MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Managed Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	Unit=1 day
Initial Authorization	180 days
Re-Authorization	180 days
Maximum Daily Units	
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Residential Services Provider</u> 148- Adult Mental Health 748 - Adult Addictive Diseases
Admission Criteria	1. Individual meets target population as identified above; and 2. Based upon a personal budget, individual has a need for financial support for a living arrangement.
Continuing Stay Criteria	1. Individual continues to meet admission criteria as defined above; and 2. Individual has developed a Recovery goal to develop natural supports that promote the family/caregiver-management of these needs.
Discharge Criteria	Individual requests discharge; or Individual has acquired natural supports that supplant the need for this service.
Service Exclusions	None

Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, traumatic brain injury.
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A. Documentation Requirements

1. If the individual supported is sharing rent with another person, then the agency may only utilize and report the assistance provided to the identified served individual (rounded to the nearest dollar).
2. The individual clinical record must have documentation of the actual payment by the agency to the leaser/landlord. A receipt for this payment must also be kept in the clinical record.

Opioid Maintenance Treatment							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Alcohol and/or Drug Services; Methadone Administration and/or Service (Provision of the drug by a licensed program)		H0020	U2	U6			33.40
		H0020	U3	U6			25.39
		H0020	U4	U6			17.40

Definition of Service: An organized, usually ambulatory, addiction treatment service for opiate-addicted individuals. (For Medicaid consumers, the actual administration of the opioid maintenance medication is conducted under the Medication Administration service code). The nature of the services provided (such as dose, level of care, length of service or frequency of visits) is determined by the patient's clinical needs, but such services always include regularly scheduled psychosocial treatment sessions and daily medication visits within a structured program. Services function under a defined set of policies and procedures, including admission, discharge and continued service criteria stipulated by state law and regulation and the federal regulations at FDA 21 CFR Part 291. Length of service varies with the severity of the individual's illness, as well as his or her response to and desire to continue treatment. Treatment with methadone or LAAM is designed to address the individual's need to achieve changes in his or her level of functioning, including elimination of illicit opiate and other alcohol or drug use. To accomplish such change, the Individualized Recovery/Resiliency Plan must address major lifestyle, attitudinal and behavioral issues that have the potential to undermine the goals of recovery and inhibit the individual's ability to cope with life. The Individualized Recovery/Resiliency Plan should also include individualized treatment, resource coordination, and personal health education specific to addiction recovery (including education about human immunodeficiency virus [HIV], tuberculosis [TB], and sexually transmitted diseases [STD]).

Target Population	Individuals with a diagnosis of Opioid Dependence.
Benefit Information	Available to all Ongoing Core Customers. Requires MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	1 encounter
Initial Authorization	With the submission of MICP New Episode: 180 units
Re-Authorization	180 units
Maximum Daily Units	1 unit
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Opioid Maintenance Treatment Provider</u> 763 – Adult Addictive Diseases

Admission Criteria	Must meet criteria established by the Georgia Regulatory body for opioid administration programs (Department of Human Resources, Office of Regulatory Services) and the Food and Drug Administration's guidelines for this service.
Continuing Stay Criteria	Must meet criteria established by the Georgia Regulatory body for opioid administration programs (Department of Human Resources, Office of Regulatory Services) and the Food and Drug Administration's guidelines for this service.
Discharge Criteria	Must meet criteria established by the Georgia Regulatory body for opioid administration programs (Department of Human Resources, Office of Regulatory Services) and the Food and Drug Administration's guidelines for this service.
Service Exclusions	
Clinical Exclusions	

Additional Service Criteria:

A. Required Components

1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. Must meet and follow criteria established by the Georgia regulatory body for opioid administration programs (Department of Human Resources, Office of Regulatory Services) and the Food and Drug Administration's guidelines for this service.

B. Staffing Requirements

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

Core providers who are approved to bill Medication Administration may bill H0020 for Medicaid recipients who receive this service.

F. Reporting & Billing Requirements

All applicable MICP and other DBHDD reporting requirements must be met.

G. Documentation Requirements

1. If medically necessary for the individual, the Individualized Recovery/Resiliency Plan should also include individualized treatment, resource coordination, and personal health education specific to addiction recovery (including education about human immunodeficiency virus [HIV], tuberculosis [TB], and sexually transmitted diseases [STD]).
2. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Peer Support Services							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Peer Support Services	Practitioner Level 4, In-Clinic	H0038	HQ	U4	U6		\$4.43
	Practitioner Level 5, In-Clinic	H0038	HQ	U5	U6		\$3.30
	Practitioner Level 4, Out-of-Clinic	H0038	HQ	U4	U7		\$5.41
	Practitioner Level 5, Out-of-Clinic	H0038	HQ	U5	U7		\$4.03

Definition of Service: This service provides structured activities within a peer support center that promote socialization, recovery, wellness, self-advocacy, development of natural supports, and maintenance of community living skills. Activities are provided between and among individuals who have common issues and needs, are consumer motivated, initiated and/or managed, and assist individuals in living as independently as possible. Activities must promote self-directed recovery by exploring consumer purpose beyond the identified mental illness, by exploring possibilities of recovery, by tapping into consumer strengths related to illness self-management (including developing skills and resources and using tools related to communicating recovery strengths, communicating health needs/concerns, self-monitoring progress), by emphasizing hope and wellness, by helping consumers develop and work toward achievement of specific personal recovery goals (which may include attaining meaningful employment if desired by the individual), and by assisting consumers with relapse prevention planning. A Consumer Peer Support Center may be a stand-alone center or housed as a "program" within a larger agency, and must maintain adequate staffing support to enable a safe, structured recovery environment in which consumers can meet and provide mutual support.

Target Population	Adults with serious mental illness or co-occurring mental illness and substance related disorders Adolescents transitioning into adulthood with SED or co-occurring SED and substance related disorders
Benefit Information	Available to all Ongoing Core Customers. Requires a MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	15 minutes
Initial Authorization	3600 units
Re-Authorization	3600 units
Maximum Daily Units	96

Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Peer Support Services Provider</u> 138 – Adult Mental Health 738 – Adult Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must have a primary mental health issue; and one or more of the following: 2. Individual requires and will benefit from support of peer professionals for the acquisition of skills needed to manage symptoms and utilize community resources; or 3. Individual may need assistance to develop self-advocacy skills to achieve decreased dependency on the mental health system; or 4. Individual may need assistance and support to prepare for a successful work experience; or 5. Individual may need peer modeling to take increased responsibilities for his/her own recovery; or 6. Individual needs peer supports to develop or maintain daily living skills.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet admission criteria; and 2. Progress notes document progress relative to goals identified in the Individualized Recovery/Resiliency Plan, but treatment/recovery goals have not yet been achieved.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Consumer/family requests discharge; or 4. Transfer to another service/level is more clinically appropriate.
Service Exclusions	Crisis Stabilization Unit (however, those utilizing transitional beds within a Crisis Stabilization Unit may access this service).
Clinical Exclusions	<ol style="list-style-type: none"> 1. Individuals diagnosed with a Substance-Related Disorder and no other concurrent mental illness; or 2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, or traumatic brain injury

Additional Service Criteria:

A. Required Components

1. A Peer Supports service may operate as a program within:
 - A freestanding Peer Support Center
 - A Peer Support Center that is within a clinical service provider
 - A larger clinical or community human service provider administratively, but with complete programmatic autonomy.
2. A Peer Supports service must be operated for no less than 3 days a week, no less than 12 hours a week, no less than 4 hours per day, typically during day, evening and weekend hours. Any agency may offer additional hours on additional days in addition to these minimum requirements.

3. The governing board of a freestanding Peer Center must be composed of 75% consumers and represent the cultural diversity of the population of the community being served. The board is encouraged to have either board members or operating relationships with someone with legal and accounting expertise. For programs that are part of a larger organizational structure that is not consumer led and operated, the Peer Supports Program must have an advisory body with the same composition as a freestanding Peer Center's board. The board or advisory committee must have the ability to develop programmatic descriptions and guidelines (consistent with state and federal regulations, accreditation requirements, and sponsoring agency operating policies), review and comment on the Peer Support Program's budgets, review activity offerings, and participate in dispute resolution activities for the program.
4. Individuals participating in the service at any given time must have the opportunity to participate in and make decisions about the activities that are conducted or services offered within the Peer Supports program, and about the schedule of those activities and services, as well as other operational issues.
5. Regardless of organizational structure, the service must be directed and led by consumers themselves.
6. Peer Supports may include meals or other social activities for purpose of building peer relationships, but meals cannot be the central or core activity offered. The focus of the service must be skill maintenance and enhancement and building individual consumer's capacity to advocate for themselves and other consumers.
7. Peer Supports cannot operate in isolation from the rest of the programs within the facility or affiliated organization. The Program Leader must be able to call multidisciplinary team meetings regarding a participating individual's needs and desires, and a Certified Peer Specialist providing services for and with a participating individual must be allowed to participate in multidisciplinary team meetings.
8. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or
 - Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
 - Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day.If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The following practitioners can provide Peer Support Services:
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; and CPSs and PPs with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology.

- Practitioner Level 5: CPS and PP under supervision of a Physician, Psychologist, LCSW, LPC, LMFT, RN, APRN, PA, LMSW, LAPC, or LAMFT
2. The individual leading and managing the day-to-day operations of the program, the Program Leader, must be a Georgia-certified Peer Specialist, who is a CPRP or can demonstrate activity toward attainment of the CPRP credential.
 3. The Program Leader must be employed by the sponsoring agency at least 0.5 FTE.
 4. The Program Leader and Georgia-certified Peer Specialists in the Peer Supports program may be shared with other programs as long as the Program Leader is present at least 75% of the hours the Peer Supports program is in operation, and as long as the Program Leader and the Georgia-certified Peer Specialists are available as required for supervision and clinical operations, and as long as they are not counted in consumer to staff ratios for 2 different programs operating at the same time.
 5. Services must be provided and/or activities led by staff who are Georgia-certified Peer Specialists or other consumers under the supervision of a Georgia-certified Peer Specialist. A specific activity may be led by someone who is not a consumer but is an invited guest.
 6. There must be at least 2 Georgia-certified Peer Specialists on staff either in the Peer Supports Program or in a combination of Peer Supports and other programs and services operating within the agency.
 7. The maximum face-to-face ratio cannot be more than 30 consumers to 1 Certified Peer Specialist based on average daily attendance in the past three (3) months of consumers in the program.
 8. The maximum face-to-face ratio cannot be more than 15 consumers to 1 direct service/program staff, based on the average daily attendance in the past three (3) months of consumers in the program.
 9. All staff must have an understanding of recovery and psychosocial rehabilitation principles as defined by the Georgia Consumer Council and psychosocial rehabilitation principles published by USPRA and must possess the skills and ability to assist other consumers in their own recovery processes.

C. Clinical Operations

1. This service must operate at an established site approved to bill Medicaid for services. However, individual or group activities may take place offsite in natural community settings as appropriate for the Individualized Recovery Plan (IRP) developed by each consumer with assistance from the Program Staff.
2. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
3. This service may operate in the same building as other day services; however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the Peer Supports program is in operation except as noted above.
4. Adequate space, equipment, furnishings, supplies, and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for consumer use within the Peer Supports program must not be substantially different from space provided for other uses for similar numbers of individuals.

5. Staff of the Peer Supports Program must be treated as equal to any other staff of the facility or organization and must be provided equivalent opportunities for training (both mandated and offered) and pay and benefits competitive and comparable to other staff based on experience and skill level.
6. When this service is used in conjunction with Psychosocial Rehabilitation and ACT, documentation must demonstrate careful planning to maximize the effectiveness of this service as well as appropriate reduction in service amounts. Utilization of this service in conjunction with these services is subject to review by the External Review Organization.
7. Consumers should set their own individualized goals and assess their own skills and resources related to goal attainment. Goals are set by exploring strengths and needs in the consumer's living, learning, social, and working environments. Goal attainment should be supported through a myriad of approaches (e.g. coaching approaches, assistance via technology, etc.)
8. Implementation of services may take place individually or in groups.
9. Each consumer must be provided the opportunity for peer assistance in the development and acquisition of needed skills and resources necessary to achieve stated goals.
10. A Peer Supports Program must offer a range of skill-building and recovery activities developed and led by consumers. These activities must include those that will most effectively support achievement of the consumer's rehabilitation and recovery goals.
11. The program must have a Peer Supports Organizational Plan addressing the following:
 - A service philosophy reflecting recovery principles as articulated by the Georgia Consumer Council, August 1, 2001. This philosophy must be actively incorporated into all services and activities and:
 - (a) View each individual as the director of his/her rehabilitation and recovery process
 - (b) Promote the value of self-help, peer support, and personal empowerment to foster recovery
 - (c) Promote information about mental illness and coping skills
 - (d) Promote peer-to-peer training of individual skills, social skills, community resources, and group and individual advocacy
 - (e) Promote the concepts of employment and education to foster self-determination and career advancement
 - (f) Support each individual to "get a life" using community resources to replace the resources of the mental health system no longer needed
 - (g) Support each individual to fully integrate into accepting communities in the least intrusive environment that promote housing of his/her choice
 - (h) Actively seek ongoing consumer input into program and service content so as to meet each individual's needs and goals and foster the recovery process
 - A description of the particular consumer empowerment models utilized, types of activities offered, and typical daily activities and schedule. If offered, meals must be described as an adjunctive peer relationship building activity rather than as a central activity.
 - A description of the staffing pattern, plans for staff who have or will have achieved Certified Peer Specialist and CPRP credentials, and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated.
 - A description of how consumer staff within the agency are given opportunities to meet with or otherwise receive support from other consumers (including Georgia-certified Peer Specialists) both within and outside the agency.

- A description of how consumers are encouraged and supported to seek Georgia certification as a Peer Specialist through participation in training opportunities and peer or other counseling regarding anxiety following certification.
 - A description of test-taking skills and strategies, assistance with study skills, information about training and testing opportunities, opportunities to hear from and interact with consumers who are already certified, additional opportunities for consumer staff to participate in clinical team meetings at the request of a consumer, and the procedure for the Program Leader to request a team meeting.
 - A description of the hours of operation, the staff assigned, and the types of services and activities provided for and by consumers as well as for families, parents, and/or guardians.
 - A description of the program's decision-making processes including how consumers direct decision-making about both individual and program-wide activities and about key policies and dispute resolution processes.
 - A description of how consumers participating in the service at any given time are given the opportunity to participate in and make decisions about the activities that are conducted or services offered within the Peer Supports program, about the schedule of those activities and services, and other operational issues.
 - A description of the space, furnishings, materials, supplies, transportation, and other resources available for individuals participating in the Peer Supports services.
 - A description of the governing body and/or advisory structures indicating how this body/structure meets requirements for consumer leadership and cultural diversity.
 - A description of how the plan for services and activities is modified or adjusted to meet the needs specified in each IRP.
 - A description of how consumer requests for discharge and change in services or service intensity are handled.
12. Assistive tools, technologies, worksheets, etc. can be used by the Peer Support staff to work with the served individual to improve his/her communication about treatment, symptoms, improvements, etc. with treating behavioral health and medical practitioners.

D. Service Access

Peer Supports may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.

E. Additional Medicaid Requirements

Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.
2. Each 15 minute unit of service provided must be documented within the individual's medical record. Although there is no single prescribed format for documentation (a log may be used), the following elements **MUST** be included for every unit of service provided:
 - a. the specific type of intervention must be documented

- b. the date of service must be named
- c. the number of unit(s) of service must be named
- d. the practitioner level providing the service/unit must be named

For example, a group led by a Practitioner Level 4 that lasts 1 hour should be documented as 4 units of H0038HQU4U6 and the intervention type should be noted (such as "Enhancement of Recovery Readiness" group).

3. Weekly progress notes must document the individual's progress relative to functioning and skills related to the person-centered goals identified in his/her IRP. This progress note aligns the weekly activities reported on the daily log or in daily notes to the stated interventions on the individualized recovery plan, and documents progress toward goals. The progress note may be written by any practitioner who provided services over the course of that week.
4. If a daily log format is utilized, the consumer and Program Supervisor are required to sign the log once per week. The Supervisor's signature is an attestation that the daily activities documented did indeed occur over the course of that week. The consumer should also sign the log (if the consumer refuses, documentation of his/her refusal would be indicated in the weekly summary).
5. While billed in increments, the Peer Support service is a program model. Daily time in/time out is tracked for while the person is present in the program, but due to time/in out not being required for each intervention, the time in/out may not correlate with the units billed as the time in/out will include breaks taken during the course of the program. However, the units noted on the log should be consistent with the units billed and, if noted, on the weekly progress note. If the units documented are not consistent, the most conservative number of units will be utilized and may result in a billing discrepancy.
6. A provider shall only record units in which the consumer was actively engaged in services. Meals and breaks must not be included in the reporting of units of service delivered. Should a consumer leave the program or receive other services during the range of documented time in/time out for Peer Support hours, the absence should be documented on the log.

Psychosocial Rehabilitation							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Psychosocial Rehabilitation	Practitioner Level 4, In-Clinic	H2017	U4	U6			\$4.43
	Practitioner Level 5, In-Clinic	H2017	U5	U6			\$3.30
	Practitioner Level 4, Out-of-Clinic	H2017	U4	U7			\$5.41
	Practitioner Level 5, Out-of-Clinic	H2017	U5	U7			\$4.03

Definition of Service: A therapeutic, rehabilitative, skill building and recovery promoting service for individuals to gain the skills necessary to allow them to remain in or return to naturally occurring community settings and activities. Services include, but are not limited to:

- 1) Individual or group skill building activities that focus on the development of skills to be used by individuals in their living, learning, social and working environments,
- 2) Social, problem solving and coping skill development;
- 3) Illness and medication self-management;
- 4) Prevocational skills (for example: preparing for the workday; appropriate work attire and personal presentation including hygiene and use of personal effects such as makeup, jewelry, perfume/cologne etc as appropriate to the work environment; time management; prioritizing tasks; taking direction from supervisors; appropriate use of break times and sick/personal leave; importance of learning and following the policies/rules and procedures of the workplace; workplace safety; problem solving/conflict resolution in the workplace; communication and relationships with coworkers and supervisors; resume and job application development; on-task behavior and task completion skills such as avoiding distraction from work tasks, following a task through to completion, asking for help when needed, making sure deadlines are clarified and adhered to, etc; learning common work tasks or daily living tasks likely to be utilized in the workplace such as telephone skills, food preparation, organizing/filing, scheduling/participating in/leading meetings, computer skills etc) and
- 5) Recreational activities/leisure skills that improve self-esteem and recovery.

The programmatic goals of the service must be clearly articulated by the provider, utilizing a best/evidence based model for service delivery and support. These best/evidence based models may include: the Boston University Psychosocial Rehabilitation approach, the Lieberman Model, the International Center for Clubhouse Development approach, or blended models/approaches in accordance with current psychosocial rehabilitation research. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based models and practices for psychosocial rehabilitation.

This service is offered in a group setting, though individual activities are allowable within the service when more circumstantially appropriate. Group activities and interventions should be made directly relevant to the needs, desires and IRP goals of the individual participants (i.e. an additional activity/group should be made available as an alternative to a particular group for those individuals who do not need or wish to be in that group, as clinically appropriate).

This service may be provided as a step-down from intensive day treatment. Services must be provided in a clinic or other facility-based setting and available at least 25 hours per week. This service is offered for a maximum of 5 hours per day.

Target Population	Adults with Serious Mental Illness Adults with a Co-Occurring Serious Mental Illness and Substance Related Disorder Adults with a Co-Occurring Serious Mental Illness and MR/DD
Benefit Information	Available to all Ongoing Core Customers. Requires a MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential (transition) 5: Medically Monitored Community Residential (transition)
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	Unit=15 minutes
Initial Authorization	450 units
Re-Authorization	450 units
Maximum Daily Units	5 units
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>MH Day Services Provider</u> 155 – Adult Mental Health
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must have primary behavioral health issues (including those with a co-occurring substance abuse disorder or MR/DD) and present a low or no risk of danger to themselves or others; and one or more of the following: 2. Individual lacks many functional and essential life skills such as daily living, social skills, vocational/academic skills and/or community/family integration; or 3. Individual needs frequent assistance to obtain and use community resources.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Primary behavioral health issues that continue to present a low or no imminent risk of danger to themselves or others (or is at risk of moderate to severe symptoms); and one or more of the following: 2. Individual improvement in skills in some but not all areas; or 3. If services are discontinued there would be an increase in symptoms and decrease in functioning

<p>Discharge Criteria</p>	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual has acquired a significant number of needed skills; or 3. Individual has sufficient knowledge and use of community supports; or 4. Individual demonstrates ability to act on goals and is self sufficient or able to use peer supports for attainment of self sufficiency; or 5. Consumer/family need a different level of care; or 6. Consumer/family requests discharge.
<p>Service Exclusions</p>	<ol style="list-style-type: none"> 1. Cannot be offered in conjunction with SA Day Services. 2. Service can be offered while enrolled in a Crisis Stabilization Unit in a limited manner when documentation supports this combination as a specific need of the individual. Time and intensity of services in PSR must be at appropriate levels when PSR is provided in conjunction with other services. (This will trigger a review by the External Review Organization). This service cannot be offered in conjunction with Medicaid MR Waiver services.
<p>Clinical Exclusions</p>	<ol style="list-style-type: none"> 1. Individuals who require one-to-one supervision for protection of self or others. 2. Individual has primary diagnosis of substance abuse, developmental disability, autism, or organic mental disorder without a co-occurring DSM IV mental disorder diagnosis. 3. Legal status requiring a locked facility.

Additional Service Criteria:

A. Required Components

1. This service must operate at an established site approved to bill Medicaid for services. However, individual or group activities should take place offsite in natural community settings as is appropriate to the participating consumer's Individualized Recovery Plan.
2. This service may operate in the same building as other day-model services; however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the PSR program is in operation except as described above.
3. Adequate space, equipment, furnishings, supplies and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for consumer use within the PSR program must not be substantially different from that provided for other uses for similar numbers of individuals.
4. A PSR program must be operated for no less than 25 hours a week, typically during day, evening and weekend hours. No more than 5 hours per day may be billed for any one consumer.
5. A PSR program must operate to assist individuals in attaining, maintaining, and utilizing the skills and resources needed to aid in their own rehabilitation and recovery.
6. "Out-of-Clinic" may only be billed when:
 - Travel by the practitioner is to a non-contiguous location; and/or
 - Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or

- Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or
- Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day. If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

B. Staffing Requirements

1. The program must be under the direct programmatic supervision of a Certified Psychiatric Rehabilitation Practitioner (CPRP)¹, or staff who can demonstrate activity toward attainment of certification (an individual can be working toward attainment of the certification for up to one year under a non-renewable waiver which will be granted by the DBHDD Regional Coordinator). For purposes of this service "programmatic supervision" consists of the day-to-day oversight of the program as it operates (including elements such as maintaining the required staffing patterns, staff supervision, daily adherence to the program model, etc.)
2. Additionally, the program must be under the clinical oversight of an independently licensed practitioner (this should include meeting with the programmatic leadership on a regular basis to provide direction and support on whether the individuals in the program are clinically improving, whether the design of the program promotes recovery outcomes, etc.).
3. The following practitioners can provide psychosocial rehabilitation services:
 - Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 4 rate)
 - Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate)
 - Practitioner Level 3: LCSW, LPC, LMFT, RN (reimbursed at Level 4 rate)
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CPS, PP, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology
 - Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above
4. There must be a CPRP with a Bachelor's Degree present at least 80% of all time the service is in operation regardless of the number of consumers participating.
5. The maximum face-to-face ratio cannot be more than 12 consumers to 1 direct service/program staff (including CPRPS) based on average daily attendance of consumers in the program.

6. At least one CPRP (or someone demonstrating activity toward attainment of certification) must be onsite face-to-face at all times (either the supervising CPRP or other CPRP staff) while the program is in operation regardless of the number of consumers participating. All staff are encouraged to seek and obtain the CPRP credential. All staff must have an understanding of recovery and psychosocial rehabilitation principles as published by USPRA and must possess the skills and ability to assist individuals in their own recovery processes.
7. Basic knowledge necessary for all staff serving individuals with mental illness or substance abuse in "co-occurring capable" day services must include the content areas in Georgia DBHDD Suggested Best Practices: Principles and Staff Capabilities for Day Services Serving Adults with Co-Occurring Disorders of Substance Abuse and Mental Illness.
8. Programs must have documentation that there is one staff person that is "co-occurring capable." This person's knowledge must go beyond basic understanding and must demonstrate actual staff capabilities in using that knowledge for individuals with co-occurring disorders. Personnel documentation should demonstrate that this staff person has received a minimum of 4 hours of training in co-occurring treatment within the past 2 years.
9. If the program does not employ someone who meets the criteria for a MAC, CACII, and/or CADC, then the program must have documentation of access to an addictionologist and/or one of the above for consultation on addiction-related disorders as co-occurring with the identified mental illness.

C. Clinical Operations

1. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
2. Rehabilitation services facilitate the development of an individual's skills in the living, learning, social, and working environments, including the ability to make decisions regarding: self-care, management of illness, life work, and community participation. The services promote the use of resources to integrate the individual into the community.
3. Rehabilitation services are consumer driven and are founded on the principles and values of individual choice and active involvement of individuals in their rehabilitation. Through the provision of both formal and informal structures consumers are able to influence and shape service development.
4. Rehabilitation services must include education on self-management of symptoms, medications and side effects; identification of rehabilitation preferences; setting rehabilitation goals; and skills teaching and development.
5. All individuals should participate in setting individualized goals for themselves and in assessing their own skills and resources related to goal attainment. Goals are set by exploring strengths and needs in the individual's living, learning, social, and working environments. Implementation of services may take place individually or in groups.
6. Each individual must be provided assistance in the development and acquisition of needed skills and resources necessary to achieve stated goals.
7. PSR programs must offer a range of skill-building and recovery activities from which individuals choose those that will most effectively support achievement of the individual's rehabilitation and recovery goals. These activities must be developed based on participating individual's input and

stated interests. Some of these activities should be taught or led by consumers themselves as part of their recovery process.

8. A PSR program must be capable of serving individuals with co-occurring disorders of mental illness and substance abuse utilizing integrated methods and approaches that address both disorders at the same time (e.g. groups and occasional individual interventions utilizing approaches to co-occurring disorders such as motivational interviewing/building motivation to reduce or stop substance use, stage based interventions, refusal skill development, cognitive behavioral techniques, psychoeducational approaches, relapse prevention planning and techniques etc). For those individuals whose substance abuse and dependence makes it difficult to benefit from the PSR program, even with additional or modified methods and approaches, the PSR program must offer co-occurring enhanced services or make appropriate referrals to specialty programs specifically designed for such individuals.
9. The program must have a PSR Organizational Plan addressing the following:
 - a. Philosophical principles of the program must be actively incorporated into all services and activities including²:
 - i. View each individual as the director of his/her rehabilitation process
 - ii. Solicit and incorporate the preferences of the individuals served
 - iii. Believe in the value of self-help and facilitate an empowerment process
 - iv. Share information about mental illness and teach the skills to manage it
 - v. Facilitate the development of recreational pursuits
 - vi. Value the ability of each individual with a mental illness to seek and sustain employment and other meaningful activities in a natural community environment
 - vii. Help each individual to choose, get, and keep a job (or other meaningful daily activity)
 - viii. Foster healthy interdependence
 - ix. Be able to facilitate the use of naturally occurring resources to replace the resources of the mental health system
 - b. Services and activities described must include attention to the following:
 - i. Engagement with others and with community
 - ii. Encouragement
 - iii. Empowerment
 - iv. Consumer Education and Training
 - v. Family Member Education and Training
 - vi. Assessment
 - vii. Financial Counseling
 - viii. Program Planning
 - ix. Relationship Development
 - x. Teaching
 - xi. Monitoring
 - xii. Enhancement of vocational readiness
 - xiii. Coordination of Services
 - xiv. Accommodations
 - xv. Transportation
 - xvi. Stabilization of Living Situation
 - xvii. Managing Crises
 - xviii. Social Life

² Adapted from Best Practices in Psychosocial Rehabilitation, edited by Hughes and Weinstein.

- xix. Career Mobility
 - xx. Job Loss
 - xxi. Vocational Independence
- c. A description of the particular rehabilitation models utilized, types of interventions practiced, and typical daily activities and schedule.
 - d. A description of the staffing pattern, plans for staff who will achieve CPRP credentials, and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated.
 - e. A description of how the program will assure that it is co-occurring capable and how it will adjust or make appropriate referrals for individuals needing a co-occurring enhanced PSR program.
 - f. A description of the hours of operation, the staff assigned, and the types of services and activities provided for consumers, families, parents, and/or guardians including how consumers are involved in decision-making about both individual and program-wide activities.
 - g. A description of how the plan for services and activities will be modified or adjusted to meet the needs specified in each IRP.
 - h. A description of services and activities offered for education and support of family members.
 - i. A description of how consumer requests for discharge and change in services or service intensity are handled and resolved.

D. Service Access

1. A PSR program must be operated for no less than 25 hours a week, typically during day, evening and weekend hours. No more than 5 hours per day may be billed for any one consumer.
2. Psychosocial Rehabilitation may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or Crisis Stabilization Unit with greater than 16 beds), jail, or prison system.

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting & Billing Requirements

1. Units of service by practitioner level must be aggregated daily before claim submission
2. All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.
2. Each 15 minute unit of service provided must be documented within the individual's medical record. Although there is no single prescribed format for documentation (a log may be used), the following elements **MUST** be included for every unit of service provided:
 - a. the specific type of intervention must be documented
 - b. the date of service must be named
 - c. the number of unit(s) of service must be named
 - d. the practitioner level providing the service/unit must be named

For example, a group led by a Practitioner Level 4 that lasts 1 hour should be documented as 4 units of H0017U4U6 and the intervention type should be noted (such as "Enhancement of Recovery Readiness" group).

3. Weekly progress notes must document the individual's progress relative to functioning and skills related to the person-centered goals identified in his/her IRP. This progress note aligns the weekly activities reported on the daily log or in daily notes to the stated interventions on the individualized recovery plan, and documents progress toward goals. The progress note may be written by any practitioner who provided services over the course of that week.
4. If a daily log format is utilized, the consumer and Program Supervisor are required to sign the log once per week. The Supervisor's signature is an attestation that the daily activities documented did indeed occur over the course of that week. The consumer should also sign the log (if the consumer refuses, documentation of his/her refusal would be indicated in the weekly summary).
5. While billed in increments, the PSR service is a program model. Daily time in/time out is tracked for while the person is present in the program, but due to time/in out not being required for each intervention, the time in/out may not correlate with the units billed as the time in/out will include breaks taken during the course of the program. However, the units noted on the log should be consistent with the units billed and, if noted, on the weekly progress note. If the units documented are not consistent, the most conservative number of units will be utilized and may result in a billing discrepancy.
6. A provider shall only record units in which the consumer was actively engaged in services. Meals and breaks must not be included in the reporting of units of service delivered. Should a consumer leave the program or receive other services during the range of documented time in/time out for PSR hours, the absence should be documented on the log.
7. When this service is used in conjunction with Crisis Stabilization Units, Peer Supports, and ACT (on a limited basis), documentation must demonstrate careful planning to maximize the effectiveness of this service as well as appropriate reduction in service amounts of PSR. Utilization of psychosocial rehabilitation in conjunction with these services is subject to additional review by the External Review Organization.

Residential: Independent Residential Services					
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Supported Housing (Mental Health)	H0043	R1			
Supported Housing (Addictive Diseases)	H0043	HF	R1		

Definition of Service: Independent Residential Service provides scheduled residential service to a consumer who requires a low level of residential structure to maintain stable housing, continue with their recovery, and increase self-sufficiency. This residential placement will be of the consumer's choice and may be fully integrated in the community in a scattered site individual residence.

Independent Residential Services may only be provided by a DBHDD Contracted Provider.

Target Population	Adults aged 18 or older with 1. Serious Mental Illness, Addictive Diseases or Co-occurring Mental Illness and Addictive Diseases Diagnoses and 2. Demonstrates the need for scheduled residential visits and mild assistance with residential responsibilities.
Utilization Criteria	Available to those eligible for core customer Ongoing Support and Recovery services.
Benefit Information	<u>Available to those with a LOCUS Level of Care:</u> 1: Recovery Maintenance and Health Management 2: Low Intensity Community Based Services 3: High Intensity Community Based Services 4: Medically Monitored Non-residential Services
Unit Value	Unit= 1 day
Reimbursement Rate	N/A
Initial Authorization	180 units
Re-Authorization	180 units
Maximum Daily Units	1 unit
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Residential Services Provider</u> 141– Adult Mental Health 744 – Adult Addictive Diseases
Admission Criteria	1. Individual must meet target population as indicated above, and 2. Individual demonstrates ability to live with minimal supports and 3. Individual, states a preference to live independently.
Continuing Stay Criteria	Consumer continues to benefit from and require minimal community supports.
Discharge Criteria	1. Consumer, or appropriate legal representative, no longer desires service, or 2. Consumer no longer meets program and/or housing criteria.

Service Exclusions	None.
Clinical Exclusions	1. Individuals with the following conditions are excluded from admission unless there is documented evidence of a psychiatric condition: developmentally disabled persons who do not have co-occurring mental illness or substance abuse issues, autism, organic mental disorder, or traumatic brain injury.

Additional Service Criteria:

A. Required Components

1. The organization must have an executive director or program director charged with the responsibility for day-to-day management of the organization.
2. If applicable, the organization must be licensed by the Georgia Office of Regulatory Services to provide residential services to consumers with mental illness and/or substance abuse diagnosis.
3. The Independent Residential Service provides scheduled visits to a consumer's apartment or home to assist with residential responsibilities.
4. Services must be provided at a time that accommodates consumers' needs, which may include during evenings, weekends, and holidays.
5. This service requires a minimum of 1 face-to-face contact with the consumer in their home each week (see also D. for an exception).
6. Independent Residential Services may only be provided within a supportive housing program or within the consumer's own apartment or home.
7. There must be a written Residential Crisis Response Plan that guides the residential provider's response to an individual's crisis episode while receiving residential services that diverts the loss of housing and promotes housing stability. This plan shall be developed in partnership with the individual and offer 24/7 access to a residential services specialist in the event of a crisis.

B. Staffing Requirements

1. Residential Managers may be persons with at least 2 years experience providing MH or AD services and with at least a high school diploma; however, this person must be supervised by a licensed staff member (including LMSW, LAMFT, LAPC or 4 year RN).
2. Persons with high school diplomas, GEDs, or higher degrees may provide direct support services under the supervision of a Residential Manager.
3. A staff person must be available 24/7 to respond to emergency calls within one hour.
4. A minimum of one staff per 35 consumers may not be exceeded.

C. Program Operations

1. The organization must have a written description of the Independent Residential Service offered that includes, at a minimum, the purpose of the service; the intended population to be served; service philosophy/model; level of supervision and oversight provided; and outcome expectations for its residents.
2. The focus of Independent Residential Service is to view each consumer as the director of his/her own recovery; to promote the value of self-help and peer support; to provide information about mental illness and coping skills; to promote social skills, community

- resources, and individual advocacy; to promote employment and education to foster self-determination and career advancement; to support each consumer in using community resources to replace the resources of the mental health system no longer needed; to support each consumer to fully integrate into scattered site residential placement or in housing of his or her choice; and to provide necessary support and assistance to the consumer that furthers recovery goals, including transportation to appointments and community activities that promote recovery.
3. The Goal of Independent Residential Supports is to fully integrate the consumer into an accepting community in the least intrusive environment that promotes housing of his/her choice.
 4. The outcomes of Independent Residential Supports will focus on recovery, housing, employment and meaningful life in the community. These outcomes will be measured based upon:
 - a. Reduction in hospitalizations;
 - b. Reduction in incarcerations;
 - c. Maintenance of housing stability;
 - d. Participation in education, vocational training or gainful employment, if this is a goal in the Individualized Recovery plan;
 - e. Participation in community meetings and other social and recreational activities;
 - f. Participation in activities that promote recovery and community integration.

D. Service Access

In addition to receiving Independent Residential Services, consumers should be linked to adult mental health and/or addictive disease services, as applicable, including Core or Private psychiatrist and Specialty services; however, individuals served shall not lose this support as a result of his/her choice to opt out of other behavioral health support/treatment services (unless these services are otherwise required by a federal program/fund source supporting a specific individual).

E. Additional Medicaid Requirements

This is not a Medicaid reimbursable service.

F. Reporting & Billing Requirements

1. All applicable MICP and other DBHDD reporting requirements must be met.
2. Each month, the provider must submit a Monthly Residential Service Report developed by the Department that identifies the actual utilization of independent residential services including amount spent, number of units occupied, and number of individuals served.

G. Documentation Requirements

1. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A. Practice Acts as qualified to provide a diagnosis.
2. Providers must document services in accordance with the specifications for documentation found in "Documentation Guidelines" in Part II, Section IV of this manual.
3. The organization must develop and maintain sufficient written documentation to support the Independent Residential Services for which billing is submitted. This documentation, at a minimum, must confirm that the individual for whom billing is requested was enrolled in the Independent Residential Services on the billing date and that residential contact and support

- services are being provided at least once per week. The individual's record must also include each week's programming/service schedule in order to document the provision of the personal support activities.
4. Providers must provide documentation that demonstrates compliance with a minimum of 1 face-to-face contact per week, which includes date and time in/time out.
 5. Weekly progress notes must be entered in the individual's record to enable the monitoring of the individual's progress toward recovery goals and to reflect the Individualized Recovery Plan implementation. The individual's record should include health issues or concerns and how they are being addressed, appointments for psychiatric and medical care that are scheduled for the consumer, attendance at other treatments such as addictive diseases counseling that staff may be assisting the consumer to attend, assistance provided to the consumer to help him or her reach recovery goals and the consumer's participation in other recovery activities.
 6. Each note must be signed and dated and must include the professional designation of the individual making the entry.
 7. Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for Independent Residential Services being delivered.

Residential: Intensive Residential Services

HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Supported Housing (Mental Health)	H0043	R3			
Supported Housing (Addictive Diseases)	H0043	HF	R3		

Definition of Service: Intensive Residential Service provides around the clock assistance to consumers within a residential setting that assists them to successfully maintain housing stability in the community, continue with their recovery, and increase self-sufficiency.

Intensive Residential Service may only be delivered by a DBHDD Contracted Provider.

Target Population	Adults aged 18 or older with 1. Serious Mental Illness, Addictive Disease Issues, or Co-occurring Mental Illness and Addictive Diseases Diagnosis and 2. Frequent psychiatric hospitalizations, i.e., more than 2 admissions in the last year and/or lengthy admission in the last year (more than 30 days); or 3. Frequent incarcerations, i.e., more than 2 incarcerations in the last year or lengthy incarceration in the last year (more than 60 days) or 4. Those who require a highly supportive environment with 24/7 awake staff to divert from going to a more intensive level of care.
Utilization Criteria	Available to those eligible for Core Customer Ongoing Support and Recovery services.
Benefit Information	<u>Available to those with a LOCUS Level Of Care :</u> 3: High Intensity Community Based Services 4: Medically Monitored Non-Residential Services 5: Medically Monitored Residential Services
Unit Value	Unit= 1 day
Reimbursement Rate	N/A
Initial Authorization	180 units
Re-Authorization	180 units
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Residential Services Provider</u> 143 – Adult Mental Health 744 – Adult Addictive Diseases
Admission Criteria	Individual must meet target population as indicated above and have a Core Provider, ACT Provider, or private psychiatrist; and one or more of the following: 1. Individual's symptoms/behaviors indicate a need for continuous monitoring and supervision by 24/7 awake staff to ensure safety; or 2. Individual has insufficient or severely limited skills needed to maintain stable housing and had failed using less intensive residential supports.

Continuing Stay Criteria	Individual continues to meet Admission Criteria
Discharge Criteria	<ol style="list-style-type: none"> 1. Individual can effectively and safely be supported with a more appropriate level of service due to change in individual's level of functioning; or 2. Individual or appropriate legal representative, requests discharge.
Service Exclusions	None
Clinical Exclusions	<ol style="list-style-type: none"> 1. Individuals with the following conditions are excluded from admission unless there is documented evidence of psychiatric condition: developmentally disabled persons who do not have co-occurring mental illness or substance abuse issues, autism, organic mental disorder, or traumatic brain injury.

Additional Service Criteria:

A. Required Components

1. The organization must have an executive director or program director charged with the responsibility for day-to-day management of the organization.
2. If applicable, the organization must be licensed by the Georgia Office of Regulatory Services to provide residential services to consumers with mental illness and/or substance abuse diagnosis.
3. The residential program must provide a structured and supported living environment 24 hours a day, 7 days a week with AWAKE staff on-site at all times.
4. Intensive Residential Service must provide a minimum of 5 hours per week of skills training programming relevant to the consumer's Individual Recovery Plan (IRP).
5. There must be a written Residential Crisis Response Plan that guides the residential provider's response to an individual's crisis episode while receiving residential services that diverts the loss of housing and promotes housing stability. This plan shall be developed in partnership with the individual and offer 24/7 access to a residential services specialist in the event of a crisis.

B. Staffing Requirements

1. Residential Managers may be persons with at least 2 years experience providing MH or AD services and at least a high school diploma; however this person must be directly supervised by a licensed staff member (including LMSW, LAMFT, LAPC, or 4-year RN).
2. Persons with high school diplomas, GEDs or higher, who have completed the paraprofessional training required for DBHDD contracted organizations and under the supervision of a Residential Manager may perform residential services.
3. A minimum of at least one (1) awake on-site staff 24/7.

C. Program Operations

1. The organization must have a written description of the Intensive Residential Service offered that includes, at a minimum, the purpose of the service; the intended population to be served; service philosophy/model, level of supervision and oversight provided; and outcome expectations for its residents.
2. Intensive Residential Service assists those individuals with an intensive need for personal supports and skills training to restore, develop, or maintain skills in functional areas in order to live meaningful lives in the community; develop or maintain social relationships, and participate in social,

interpersonal, vocational, recreational or community activities. Services must be delivered to consumers relevant to their individualized Recovery Plan.

3. Intensive Residential Service must provide a minimum of 5 hours of skills training and/or support activities per week that relate to the individual's IRP.

Skills Training may include interpersonal skills training; coping skills/problem solving; symptom identification and management; cooking; maintaining a residence; using public transportation; shopping; budgeting and other needed skills training as identified in the IRP.

Support Activities may include daily contacts by Intensive Residential Service staff daily to monitor physical and mental health needs; crisis intervention when needed; assistance with scheduling of medical and mental health appointments; the supervision of the self-administration of medications; transportation to medical/dental/mental health/employment/recreational activities; participation in community activities; and other needed supports as identified in the IRP.

D. Service Access

In addition to receiving Intensive Residential Services, consumers will be linked to adult mental health services including Core or private psychiatrist or Specialty Services.

E. Additional Medicaid Requirements

This is not a Medicaid reimbursable service.

F. Reporting & Billing Requirements

1. All applicable MICP and other DBHDD reporting requirements must be met.
2. Each month, the provider must submit a Monthly Residential Service Report developed by the Department that identifies the actual utilization of intensive residential services including amount spent, number of units occupied, and number of individuals served.

G. Documentation Requirements

1. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A. Practice Acts as qualified to provide a diagnosis.
2. Providers must document services in accordance with the specifications for documentation found in "Documentation Guidelines" in Part II, Section IV of this document.
3. The organization must develop and maintain sufficient written documentation to support the Intensive Residential Service for which billing is made. This documentation, at a minimum, must confirm that the individual for whom billing is requested was a resident of the Intensive Residential Service on the date of service. The individual's record must also include each week's programming/service schedule in order to document the provision of the required amount of skills training and support activities.
4. Weekly progress notes must be entered in the individual's record to enable the monitoring of the individual's progress toward IRP and recovery goals.
5. The record should include health issues and how they are being addressed; appointments for psychiatric and medical care that are scheduled for the consumer; attendance at other treatments such as addictive diseases counseling that staff may be assisting consumer to attend; assistance provided to the consumer to help him or her reach recovery goals; and the consumer's participation in other recovery activities.

6. Each note must be signed and dated and must include the professional designation of the individual making the entry.
7. Documentation must be legible and concise and include the printed name and the signature of the service provider. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for the Intensive Residential Service being delivered.

H. Facilities Management (applicable to traditional residential settings such as group homes, Treatment facilities, etc.)

1. Each resident facility must be arranged and maintained to provide adequate measures for the health, safety, access and well being of the residents.
2. Each resident facility must comply with all relevant safety codes.
3. All areas of the residential facility must be clean, safe, appropriately equipped, and furnished for the services delivered.
4. The facility must comply with the Americans with Disabilities Act.
5. The facility must maintain a written evacuation plan to be used in the case of fire or other disaster. An appropriate written certification of compliance must be obtained indicating that all applicable fire and safety code requirements have been satisfied. Periodic fire and other safety drills must be conducted.
6. Evacuation routes must be clearly marked by exit signs.
7. The program must be responsible for providing physical facilities that are structurally sound and that meet all applicable federal, state, and local regulations for adequacy of construction, safety, sanitation, and health.

**Residential:
Semi-Independent Residential Services**

HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Supported Housing (Mental Health)	H0043	R2			
Supported Housing (Addictive Diseases)	H0043	HF	R2		

Definition of Service: Semi-Independent Residential Service on-site programming for consumers within a residential setting to assist them to successfully maintain stable housing, continue with their recovery, and increase self-sufficiency.

Semi Independent Residential Services may only be provided by a DBHDD Contracted Provider.

Target Population	Adults aged 18 or older with 1. Serious Mental Illness, Addictive Disease Issues, or Co-occurring Mental Illness and Addictive Diseases Diagnoses and 2. Demonstrates the need for 24/7 available staff support, daily contact, and moderate assistance with residential responsibilities.
Utilization Criteria	Available to those eligible for Core Customer Ongoing Support and Recovery services.
Benefit Information	<u>Available to those with a LOCUS Level Of Care:</u> 2. Low Intensity Community based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential Services
Unit Value	Unit= 1 day
Reimbursement Rate	N/A
Initial Authorization	180 units
Re-Authorization	180 units
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Residential Services Provider</u> 142- Adult Mental Health 744 Adult Addictive Diseases
Admission Criteria	1. Individual must meet target population as indicated above; and one or more of the following: 2. Individual's symptoms/behaviors indicate a need for moderate skills training and personal supports; or 3. Individual has limited skills needed to maintain stable housing and has failed using a less intensive residential service; or 4. Individual requires frequent medication assistance to prevent relapse.
Continuing Stay Criteria	Individual continues to meet Admission Criteria
Discharge Criteria	1. Individual can effectively and safely be supported with a more appropriate level of service due to change in individual's level of functioning; or 2. Individual or appropriate legal representative requests discharge.

Service Exclusions	None
Clinical Exclusions	1. Individuals with the following conditions are excluded from admission unless there is documented evidence of psychiatric condition: developmentally disabled persons who do not have co-occurring mental illness or substance abuse issues, autism, organic mental disorder, or traumatic brain injury.

Additional Service Criteria:

A. Required Components

1. The organization must have an executive director or program director charged with the responsibility for day-to-day management of the organization.
2. If applicable, the organization must be licensed by the Georgia Office of Regulatory Services to provide residential services to consumers with mental illness and/or substance abuse diagnosis.
3. The residential program must provide a supported living environment 24 hours, 7 days a week. Staff will be on-site for at least 36 hours each week to accommodate residents' needs. There must be an emergency response plan when staff is not scheduled on-site.
4. Within the required 36 hours of staffing coverage, Semi-Independent Residential Service must provide a minimum of 3 hours per week of skills training and/or personal support relevant to the consumer's Individualized Recovery Plan.
5. There must be a written Residential Crisis Response Plan that guides the residential provider's response to an individual's crisis episode while receiving residential services that diverts the loss of housing and promotes housing stability. This plan shall be developed in partnership with the individual and offer 24/7 access to a residential services specialist in the event of a crisis.

B. Staffing Requirements

1. Residential Managers may be persons with at least 2 years experience providing MH or AD services and at least a high school diploma; however, this person must be directly supervised by a licensed staff member (including LMSW, LAMFT, LAPC or 4 year RN).
2. Persons with high school diplomas, GEDs, or higher, who have completed the paraprofessional training required for DBHDD contracted organizations may provide direct support services under the supervision of a Residential Manager.
3. A staff person must be available 24/7 to respond to emergency calls within one (1) hour.
4. A staff person must be on site at least 36 hours a week.

C. Program Operations

1. The organization must have a written description of the Semi-Independent Residential Service offered that includes, at a minimum, the purpose of the service; the intended population to be served; level of supervision and oversight provided; and outcome expectations for its residents.
2. The focus of Semi-Independent Residential Service is to view each consumer as the director of his/her own recovery; to promote the value of self-help and peer support; to provide information about mental illness and coping skills; to promote social skills, community resources, and individual advocacy; to promote employment and education to foster self-determination and career advancement; to support each consumer in using community

- resources to replace the resources of the mental health system no longer needed; and to support each consumer to fully integrate into scattered site residential placement or in housing of his or her choice, and to provide necessary support and assistance to the consumer that furthers recovery goals, including transportation to appointments and community activities that promote recovery.
3. The Goal of Semi-Independent Residential Supports is to further integrate the consumer into an accepting community in the least intrusive environment that promotes housing of his/her choice.
 4. The outcomes of Semi-Independent Residential Supports will focus on recovery, housing, employment, and meaningful life in the community. These outcomes will be measured based upon:
 - a. Reduction in hospitalizations;
 - b. Reduction in incarcerations;
 - c. Maintenance of housing stability;
 - d. Participation in education, vocational training or gainful employment, if this is a goal in the Individualized Recovery Plan;
 - e. Participation in community meetings and other social and recreational activities;
 - f. Participation in activities that promote recovery and community integration.
 5. Semi-Independent Residential Service assists those individuals who will benefit from a moderate level of personal support and skill training to restore, develop, or maintain skills in functional areas in order to live meaningful lives in the community; develop or maintain social relationships; and participate in social, interpersonal, recreational or community activities. Services must be delivered to individuals according to their IRP.
 6. Semi-Independent Residential Service provides at least 36 hours of on-site residential service and a minimum of 3 hours of direct skills training and/or individual support each week. This level of residential service shall include:

Skill Training Activities such as budgeting, shopping, menu planning and food preparation, leisure skill development, maintaining a residence, using public transportation, symptom identification and management, medication self-administrating training, and other needed skills training as identified in the IRP.

AND

Personal Support Activities such as daily face-to-face contact with the consumer by Residential Service staff to ensure needs are being met; supportive counseling; crisis intervention as needed; tracking of appointments, assistance with transportation to appointments, shopping, employment, academics, recreational and support activities, and other needed supports as identified in the IRP

D. Service Access

In addition to receiving Semi Independent Residential Services, consumers will be linked to adult mental health and/or addictive disease services including Core or private Psychiatrist or Specialty services.

E. Additional Medicaid Requirements

This is not a Medicaid reimbursable service.

F. Reporting & Billing Requirements

1. All applicable MICP and other DBHDD reporting requirements must be met.

2. Each month, the provider must submit a Monthly Residential Service Report developed by the Department that identifies the actual utilization of semi-independent residential services including amount spent, number of units occupied, and number of individuals served.

G. Documentation Requirements

1. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A. Practice Acts as qualified to provide a diagnosis.
2. Providers must document services in accordance with the specifications for documentation found in "Documentation Guidelines" in Part II, Section IV of this manual.
3. The organization must develop and maintain sufficient written documentation to support that Semi-Independent Residential Services were provided to the individual, as defined herein and according to billing. This documentation must confirm that the individual for whom billing is requested was a resident of the Semi-Independent Residential Services on the date billed. The individual's record must also include each week's programming/ service schedule in order to document provision of the required amount of skill training and personal support activities.
4. Providers must provide documentation that demonstrates compliance with a minimum of 3 hours each week of skills training and personal support activities, which include date, and time in/time out of contact.
5. Weekly progress notes must be entered in the individual's record to enable the monitoring of the individual's progress toward meeting treatment and rehabilitation goals and to reflect the Individualized Recovery Plan implementation.
6. The record should include health issues or concerns and how they are being addressed, appointments for psychiatric and medical care that are scheduled for the consumer, attendance at other treatments, such as addictive diseases counseling that staff may be assisting the consumer to attend, assistance provided to the consumer to help him or her reach recovery goals, and the consumer's participation in other recovery activities.
7. Each note must be signed and dated and must include the professional designation of the individual making the entry.
8. Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for Semi-Independent Residential Services being delivered.

H. Facilities Management (applicable to traditional residential settings such as group homes, Treatment facilities, etc.)

1. Each resident facility must be arranged and maintained to provide adequate measures for the health, safety, access and well being of the residents.
2. Each resident facility must comply with all relevant safety codes.
3. All areas of the residential facility must be clean, safe, appropriately equipped, and furnished for the services delivered.
4. The facility must comply with the Americans with Disabilities Act.
5. The facility must maintain a written evacuation plan to be used in the case of fire or other disaster. An appropriate written certification of compliance must be obtained indicating that all applicable fire and safety code requirements have been satisfied. Periodic fire and other safety drills must be conducted.
6. Evacuation routes must be clearly marked by exit signs.

7. The program must be responsible for providing physical facilities that are structurally sound and that meet all applicable federal, state, and local regulations for adequacy of construction, safety, sanitation, and health.

Residential Substance Detoxification							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Alcohol and/or Other Drug Services; Sub-acute Detoxification (Residential Addiction Program Outpatient)		H0012					\$85.00

Definition of Service: Residential Substance Detoxification is an organized and voluntary service that may be delivered by appropriately trained staff who provide 24-hour per day, 7 day per week supervision, observation and support for individuals during detoxification. Residential detoxification is characterized by its emphasis on medical monitoring and/or on peer/social support, and should reflect a range of residential detoxification service intensities from ASAM (American Society of Addiction Medication) Level III.2D to III.7D. These levels provide care for individuals whose intoxication/withdrawal signs and symptoms may only require 24-hour supervision, observation and support by appropriately trained staff with an emphasis on peer/social support that cannot be provided by the individual's natural support system, or that are sufficiently severe enough to require 24-hour medically monitored withdrawal management and support from medical and nursing professionals in a permanent facility with inpatient beds. All programs at these levels rely on established clinical protocols to identify individuals who are in need of medical services beyond the capacity of the facility and to transfer such individuals to more appropriate levels of service.

Target Population	Adults and Older Adolescents with a diagnosis of one of the following: 303.00 291.81 291.0 292.89 292.0
Benefit Information	Available to all Ongoing Core Customers. Requires a MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential 5: Medically Monitored Community Residential 6: Medically Managed Residential
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	Unit=1 day (per diem)
Initial Authorization	30 days
Maximum Daily Units	1 unit
Re-Authorization	
Authorization Period	30 days

UAS: Budget and Expense Categories	<u>Addictive Diseases Detoxification Services Provider</u> 765 – Adult Addictive Diseases 865 – C&A Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Individual has a Substance Related Disorder as defined in the latest version of the DSM (ASAM PPC-2, Dimension-1 and is experiencing signs of severe withdrawal, or there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition, and/or emotional/behavioral condition) that severe withdrawal syndrome is imminent; and is assessed as manageable at this level of service; and 2. There is strong likelihood that the individual will not complete detoxification at another level of service and enter into continued treatment or self-help recovery as evidenced by one of the following: <ol style="list-style-type: none"> a. individual requires medication and has recent history of detoxification at a less intensive service level, marked by past and current inability to complete detoxification and enter continuing addiction treatment; individual continues to lack skills or supports to complete detoxification, or b. individual has a recent history of detoxification at less intensive levels of service marked by inability to complete detoxification or enter into continuing addiction treatment and continues to have insufficient skills to complete detoxification, or c. individual has co-morbid physical or emotional/behavioral condition that is manageable in a Level III.7-D setting but which increases the clinical severity of the withdrawal and complicates detoxification.
Continuing Stay Criteria	Individual's withdrawal signs and symptoms are not sufficiently resolved so that the individual can be managed in a less intensive service.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual requests discharge and individual is not in imminent danger of harm to self or others; or 4. Individual's signs and symptoms of withdrawal have failed to respond to treatment and have intensified (as confirmed by higher scores on the CIWA-Ar or other comparable standardized scoring system), such that transfer to a Level IV-D detoxification service is indicated.
Service Exclusions	ACT, Nursing Assessment and Medication Administration (Medication administered as a part of Residential Detoxification is not to be billed as Medication Administration.)
Clinical Exclusions	Concomitant medical condition and/or other behavioral health issues warrant inpatient treatment or Crisis Stabilization Unit admission.

Additional Service Criteria:

A. Required Components

1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. A physician's order in the individual's record is required to initiate a detoxification regimen.
3. Medication administration may be initiated only upon the order of a physician.
4. Verbal orders or those initiated by a Physician's Assistant or Clinical Nurse Specialist are acceptable provided they are signed by the physician within 24 hours or the next working day.

B. Staffing Requirements

1. Services must be provided by a combination of nursing, other licensed medical staff, and other residential support under supervision of a physician.
2. In programs that are designed to target older adolescents, staffing patterns must reflect staff expertise in the delivery of services to that age population. In addition, higher staffing ratios would be expected in these programs related to supervision.

C. Clinical Operations

1. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.

D. Service Access

E. Additional Medicaid Requirements

1. For Medicaid recipients, certain individual services may be billed to Medicaid if the individual is receiving this service as a part of a Crisis Stabilization Unit (see CSU service description for billable services).
2. For those CSUs that bill Medicaid, the program bed capacity is limited to 16 beds.

F. Reporting & Billing Requirements

All applicable MICP and other DBHDD reporting requirements must be met.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Respite							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Respite Care Services, Not in the Home (Out of Home), Per Diem		H0045					\$56.00
Unskilled Respite Care, Not Hospice (In Home), Per Diem		S5151					\$56.00

Definition of Service: Respite services are brief periods of support or relief from current debilitating situations for individuals with mental illnesses and/or substance related disorders. Respite is provided: (1) when an individual is experiencing a psychiatric, substance related or behavioral crisis and needs structured, short-term support; (2) consumer-identified natural supports are unable to provide necessary illness-management support and thus the individual is in need of additional support or relief; or (3) when the individual and his/her identified natural supports experience the need for therapeutic relief from the stresses of their mutual cohabitation. Respite may be provided in-home (i.e. provider delivers service in individual's home) or out-of-home (individual receives service outside of their home), and may include day activities as well as overnight activities/accommodations as appropriate to the situation.

Target Population	Adults experiencing: Severe and Persistent Mental Illness Substance-Related Disorders Co-Occurring Substance-Related Disorders and Mental Illness Co-Occurring Mental Illness and Mental Retardation Co-occurring Substance-Related Disorders and Mental Retardation
Benefit Information	Available to all Ongoing Core Customers. Requires a MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 2: Low Intensity Community-Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	1 day
Initial Authorization	While the actual respite should be very short-term in nature, this service can be authorized as part of a 180 day Recovery/Resiliency plan. A maximum of 30 days may be provided to a single individual in a single authorization period.
Re-Authorization	180 days
Maximum Daily Units	1 unit
Authorization Period	180 days

UAS: Budget and Expense Categories	<u>Consumer/Family Support Services Provider</u> 136 – Adult Mental Health 736 – Adult Addictive Diseases
Admission Criteria	<ol style="list-style-type: none"> 1. Individual meets target population as identified above; and 2. Individual has a need for short-term support which could delay or prevent the need for out-of-home placement or higher levels of service intensity (such as acute hospitalization); and one or more of the following: 3. Individual has a circumstance which destabilizes his/her current living arrangement and the provision of this service would provide short-term relief and support of the individual; or 4. The consumer-identified natural supports network has an immediate need for support and relief from its role of supporting the individual in his/her behavioral health crises 5. The consumer-identified natural supports network has an immediate need to participate in an emergency event during which lack of support may cause the individual a setback in his/her Recovery plan.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet admission criteria as defined above; and 2. Individual has developed a Recovery goal to develop natural supports that promote the self/family-management of these needs.
Discharge Criteria	<ol style="list-style-type: none"> 1. Individual requests discharge; or 2. Individual has acquired natural supports that supplant the need for this service.
Service Exclusions	Traditional 24/7 Residential Supports
Clinical Exclusions	<ol style="list-style-type: none"> 1. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, traumatic brain injury. 2. Individual is actively using unauthorized drugs or alcohol (which should not indicate a need for discharge, but for a review of need for more intensive services).

Additional Service Criteria:

A. Required Components

B. Staffing Requirements

C. Clinical Operations

Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.

D. Service Access

A maximum of 30 days may be provided to a single individual in a single authorization period.

E. Additional Medicaid Requirements

Not applicable. Not a Medicaid-billable service.

F. Reporting & Billing Requirements

All other applicable MICP and DBHDD reporting requirements must be met.

G. Documentation Requirements

Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

Substance Abuse Intensive Outpatient (SA Day Treatment)

HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
See Item E.1. Below					

Definition of Service: A time limited multi-faceted approach treatment service for adults who require structure and support to achieve and sustain recovery from substance related disorders. These services are available during the day and evening hours to enable individuals to maintain residence in their community, continue to work or go to school and to be a part of their family life. The following elements of this service model will include:

1. Behavioral Health Assessment
2. Psychiatric Treatment
3. Nursing Assessment
4. Diagnostic Assessment
5. Community Support
6. Individual Counseling
7. Group Counseling (including psycho-educational groups focusing, relapse prevention and recovery)
8. Family Counseling/Training (including psychoeducation) for Family Members

The SA Intensive Outpatient Package emphasizes reduction in use and abuse of substances and/or continued abstinence; the negative consequences of substance abuse; development of social support network and necessary lifestyle changes; educational skills; vocational skills leading to work activity by reducing substance abuse as a barrier to employment; social and interpersonal skills; improved family functioning; the understanding of addictive disease; and the continued commitment to a recovery and maintenance program.

Services are provided according to individual needs and goals as articulated in the treatment plan. The programmatic goal of the service must be clearly articulated by the provider, utilizing the best/evidenced based practices for the service delivery and support that are based on the population(s) and issues to be addressed. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices.

Target Population	Adult Core Customers with substance abuse disorders, including those with co-occurring mental illness, or Developmental Disabilities
Benefit Information	Requires a MICP New Episode Request or Update request (to add as a single service to an existing authorization)

Utilization Criteria	<u>Available to those with LOCUS scores:</u> 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential (transition) 5: Medically Monitored Community Residential (transition) 6: Medically Managed Residential (transition)
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner)
Unit Value	See Authorization Package/Service Group Detail
Initial Authorization	See Authorization Package/Service Group Detail
Re-Authorization	See Authorization Package/Service Group Detail
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Addictive Disease Day Services Provider</u> Report UAS Codes as associated with unbundled services in Item E1 below.
Admission Criteria	<ol style="list-style-type: none"> 1. A DSM IV diagnosis of Substance Abuse or Dependence or substance-related disorder with a co-occurring DSM IV diagnosis of mental illness or DD; and 2. The individual is able to function in a community environment even with impairments in social, medical, family, or work functioning; and 3. The individual is sufficiently motivated to participate in treatment; and 4. One or more of the following: <ol style="list-style-type: none"> a. The substance use is incapacitating, destabilizing or causing the individual anguish or distress and the individual demonstrates a pattern of alcohol and/or drug use that has resulted in a significant impairment of interpersonal, occupational and/or educational functioning; or b. The individual's substance abuse history after previous treatment indicates that provision of outpatient services alone (without an organized program model) is not likely to result in the individual's ability to maintain sobriety; or c. There is a reasonable expectation that the individual can improve demonstrably within 3-6 months; or d. The individual is assessed as needing ASAM Level II or III.1; or e. The individual has no significant cognitive and/or intellectual impairments that will prevent participation in and benefit from the services offered and has sufficient cognitive capacity to participate in and benefit from the services offered; or f. The individual is not actively suicidal or homicidal, and the individual's crisis, and/or inpatient needs (if any) have been met prior to participation in the program.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. The individual's condition continues to meet the admission criteria. 2. Progress notes document progress in reducing use and abuse of substances; developing social networks and lifestyle changes; increasing educational, vocational, social and interpersonal skills; understanding addictive disease; and/or establishing a commitment to a recovery and maintenance program, but the overall goals of the treatment plan have not

	<p>been met.</p> <p>3. There is a reasonable expectation that the individual can achieve the goals in the necessary reauthorization time frame.</p>
Discharge Criteria	<p>An adequate continuing care or discharge plan is established and linkages are in place; and one or more of the following:</p> <ol style="list-style-type: none"> 1. Goals of the treatment plan have been substantially met; or 2. Consumer recognizes the severity of his/her drug/alcohol usage and is beginning to apply the skills necessary to maintain recovery by accessing appropriate community supports 3. Clinical staff determines that consumer no longer needs ASAM Level II and is now eligible for aftercare and/or transitional services <p>Transfer to a higher level of service is warranted by change in the</p> <ol style="list-style-type: none"> 1. Individual's condition or nonparticipation; or 2. The individual refuses to submit to random drug screens; or 3. Consumer exhibits symptoms of acute intoxication and/or withdrawal or 4. The individual requires services not available at this level or 5. Consumer has consistently failed to achieve essential treatment objectives despite revisions to the treatment plan and advice concerning the consequences of continues alcohol/drug use to such an extent that no further process is likely to occur
Service Exclusions	<p>Services cannot be offered with Mental Health Intensive Outpatient Package or Psychosocial Rehabilitation. When offered with ACT, documentation must indicate efforts to minimize duplication of services and effectively transition the individual to the appropriate services. This combination of services is subject to review by the External Review Organization</p>

Additional Service Criteria:

A. Required Components

1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. The program provides structured treatment or therapeutic services, utilizing activity schedules as part of its operational method, i.e., plans or schedules of days or times of day for certain activities.
3. These services should be scheduled and available at least 5 hours per day, 4 days per week (20 hrs/week), with no more than 2 consecutive days without service availability for high need individuals (ASAM Level II.5). For programs that have a lower intensity program Level, it should be at least ASAM Level II.1 which includes 9 hours of programming per week.
4. The program utilizes methods, materials, settings, and outside resources appropriate to the developmental and cognitive levels, capabilities, age, gender, and culture of participants.
5. The program utilizes methods, materials, approaches, activities, settings, and outside resources appropriate for and targeted to individuals with co-occurring disorders of mental illness and substance abuse and targeted to individuals with co-occurring developmental disabilities and substance abuse when such individuals are referred to the program.

6. The program conducts random drug screening and uses the results of these tests for marking participant's progress toward goals and for service planning.
7. The program is provided over a period of several weeks or months and often follows detoxification or residential services.
8. This service must operate at an established site approved to bill Medicaid for services. However, limited individual or group activities may take place off-site in natural community settings as is appropriate to each individual's treatment plan. (Narcotics Anonymous (NA) and/or Alcoholics Anonymous (AA) meetings offsite may be considered part of these limited individual or group activities for billing purposes only when time limited and only when the purpose of the activity is introduction of the participating individual to available NA and/or AA services, groups or sponsors. NA and AA meetings occurring during the SA Intensive Outpatient package may not be counted toward the billable hours for any individual outpatient services, nor may billing related to these meetings be counted beyond the basic introduction of an individual to the NA/AA experience.).
9. This service may operate in the same building as other services; however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the SA Intensive Outpatient Services is in operation.
10. Adequate space, equipment, furnishings, supplies, and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for participating individuals' use within the Substance Abuse Intensive Outpatient package must not be substantially different from that provided for other uses for similar numbers of individuals.

B. Staffing Requirements

1. The program must be under the clinical supervision of a **Level 4 or above** who is onsite a minimum of 50% of the hours the service is in operation.
2. Services must be provided by staff who are:
 - a. Level 4 (LAPC, LMSW, CACII, CADC, CCADC and Addiction Counselor Trainee with supervision)
 - b. Level 5 (Paraprofessionals, high school graduates) under the supervision of an Level 4 or above
3. It is necessary for all staff who provide this "co-occurring capable" service to have basic knowledge in the Georgia DBHDD content areas in the Suggested Best Practices Principles and Staff Capabilities for Services Serving Individuals with Co-Occurring Disorders document included in this Provider Manual
4. Programs must have documentation that there is one Level 4 staff (excluding Addiction Counselor Trainee) that is "co-occurring capable." This person's knowledge must go beyond basic understanding and must demonstrate actual staff capabilities in using that knowledge for individuals with co-occurring disorders. Personnel documentation should demonstrate that this staff person has received a minimum of 4 hours of training in co-occurring treatment within the past 2 years.
5. There must be at least a Level 4 practitioner on-site at all times the service is in operation, regardless of the number of individuals participating.
6. The maximum face-to-face ratio cannot be more than 12 individuals to 1 direct program staff based on average daily attendance of individuals in the program.
7. The maximum face-to-face ratio cannot be more than 20 individuals to 1 SAP based on average daily attendance of individuals in the program.

8. A physician and/or a Registered Nurse or a Licensed Practical Nurse with appropriate supervision must be available to the program either by a physician and/or nurse employed by the agency, through a contract with a licensed practitioner, or by written referral or affiliation agreement with another agency or agencies that offer such services.
 - a. The physician is responsible for addiction and psychiatric consultation, assessment, and care (including but not limited to ordering medications and/or laboratory testing) as needed.
 - b. The nurse is responsible for nursing assessments, health screening, medication administration, health education, and other nursing duties as needed.
9. Level 4 staff may be shared with other programs as long as they are available as required for supervision and clinical operations and as long as their time is appropriately allocated to staffing ratios for each program.

C. Clinical Operations

1. It is expected that the transition planning for less intensive service will begin at the onset of these services. Documentation must demonstrate this planning.
2. Consumers receiving the Substance Abuse Intensive Outpatient Package must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis (Level 1).
3. A consumer may have variable length of stay. The level of care should be determined as a result of consumers' multiple assessments. It is recommended that individuals attend at a frequency appropriate to their level of need. Ongoing clinical assessment should be conducted to determine step down in level of care.
4. Each consumer should participate in setting individualized goals for themselves and in assessing their own skills and resources related to sobriety, use/abuse, and maintaining recovery. Goals are set by exploring strengths and needs in the consumer's living, learning, social, and working environments. Implementation of services may take place individually or in groups.
5. Each consumer must be provided assistance in the development and acquisition of needed skills and resources necessary to achieve sobriety and/or reduction in abuse and maintenance of recovery.
6. Substance Abuse Intensive Outpatient Package must offer a range of skill-building and recovery activities within the program.
7. The following the services must be included in the SA Intensive Outpatient Package. Many of these activities are reimbursable through Medicaid.

The activities include but not limited to:

a. Group Outpatient Services:

- I. Psycho-educational activities focusing on the disease of addiction prevention, the health consequences of addiction, and recovery
- II. Therapeutic group treatment and counseling
- III. Leisure and social skill-building activities without the use of substances
- IV. Linkage to natural supports and self-help opportunities

b. Individual Outpatient Services

- I. Individual counseling
- II. Individualized treatment, service, and recovery planning
- III. Linkage to health care

c. Family Outpatient Services

- I. Family education and engagement

- d. **Community Support**
 - I. Vocational readiness and support
 - II. Service coordination unless provided through another service provider
 - e. **Behavioral Health Assessment & Service Plan Development and Diagnostic Assessment**
 - I. Assessment and reassessment
 - f. **Services not covered by Medicaid**
 - I. Drug screening/toxicology examinations
8. In addition to the above required activities within the program, the following must be offered as needed either within the program or through referral to/ or affiliation with another agency or practitioner, and may be billed in addition to the billing for Substance Abuse Intensive Outpatient Package:
 - a. Community Support– for housing, legal and other issues
 - b. Individual counseling in exceptional circumstances for traumatic stress and other mental illnesses for which special skills or licenses are required
 - c. Physician assessment and care
 - d. Psychological testing
 - e. Health screening.
 9. The program must have a Substance Abuse Intensive Outpatient Services Organizational Plan addressing the following:
 - a. The philosophical model of the program and the expected outcomes for program participants (i.e., harm reduction, abstinence, beginning of or maintaining individually defined recovery, employment readiness, relapse prevention, stabilization and treatment of those with co-occurring disorders).
 - b. The schedule of activities and hours of operations.
 - c. Staffing patterns for the program.
 - d. How the activities listed above in Items 4 and 5 will be offered and/or made available to those individuals who need them, including how that need will be determined.
 - e. How assessments will be conducted.
 - f. How staff will be trained in the administration of addiction services and technologies.
 - g. How staff will be trained in the recognition and treatment of co-occurring disorders of mental illness and substance abuse pursuant to the Georgia Best Practices
 - h. How services for individuals with co-occurring disorders will be flexible and will include services and activities addressing both mental health and substance abuse issues of varying intensities and dosages based on the symptoms, presenting problems, functioning, and capabilities of such individuals.
 - i. How individuals with co-occurring disorders who cannot be served in the regular program activities will be provided and/or referred for time-limited special integrated services that are co-occurring enhanced as described in the Georgia Suggested Best Practices
 - j. How services will be coordinated with the substance abuse array of services including assuring or arranging for appropriate referrals and transitions.
 - k. How the requirements in these service guidelines will be met.

D. Service Access

The package is offered at least 5 hours per day at least 4 days per week with no more than 2 consecutive days between offered services, and distinguishes between those individuals needing between 9 and 20 hours per week of structured services per week (ASAM Level II.1) and those

needing 20 hours or more of structured services per week (ASAM Level II.5 or III.1) in order to begin recovery and learn skills for recovery maintenance. The program may offer services a minimum of only 3 hours per day for only 3 days per week with no more than 2 consecutive days between offered services if only individuals at ASAM Level II.1 are served.

E. Additional Medicaid Requirements

1. Effective July 1, 2009 Medicaid stopped paying a bundled daily rate for Substance Abuse Day Services. These services now will be unbundled and billed per service. As mentioned above Substance Abuse Intensive Outpatient Package allows providers to select all services that will be offered in a substance abuse outpatient setting. Billable services and daily limits within SA Intensive Outpatient Package are as follows:

Service	Maximum Authorization Units	Maximum Daily Units
Behavioral Health Assessment & Service Plan Development	32	24
Diagnostic Assessment	4	2
Psychiatric Treatment	12	1
Nursing Assessment & Care	48	16
Community Support	600	96
Individual Outpatient Services	36	1
Group Outpatient Services	1170	20
Family Outpatient Services	100	8

F. Reporting/Billing Requirements

1. All applicable Medicaid, MICP, ERO, and other DBHDD reporting requirements must be met.
2. The maximum number of units that can be billed differs depending on the individual service. Please refer to the table below or in the Mental Health and Addictive Disease Orientation to Authorization Packages Section of this manual.
3. Approved providers of this service may submit claims/encounters for the unbundled services listed in the package, up to the daily maximum amount for each service. Program expectations are that this model follow the content of this Service Guideline as well as the clearly defined service group elements.

G. Documentation Requirements

1. Provider must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.
2. Every admission and assessment must be documented.
3. Progress notes must include written daily documentation of important occurrences; level of functioning; acquisition of skills necessary for recovery; progress on goals identified in the IRP including acknowledgement of addiction, progress toward recovery and use/abuse reduction and/or abstinence; use of drug screening results by staff; and evaluation of service effectiveness.
4. Daily attendance of each individual participating in the program must be documented showing the number of hours in attendance for billing purposes.
5. This service may be offered in conjunction with ACT or Crisis Residential Services for a limited time to transition consumers from one service to the more appropriate one. When this service is

used in conjunction with ACT or Crisis Residential services, documentation must demonstrate careful planning to maximize the effectiveness of this service as well as an appropriate reduction in service amounts of the service to be discontinued. Utilization of Substance Abuse Day Services in conjunction with these services is subject to review by the External Review Organization.

Supported Employment					
HIPAA Transaction Code	Code Detail	Code	Mod1	Mod2	Rate
Supported Employment		H2024			\$410.00

Definition of Service: In line with current best practice, this service emphasizes that a rapid job search and placement approach be prioritized above traditional prevocational training or traditional vocational rehabilitation. Job development, placement and training are for people who, due to the severity of their disabilities, need support to locate, choose, obtain, learn and maintain a job. Services include supports to choose and obtain paid employment in competitive wage, individual-based community jobs, as well as brief training support to learn the specific job skills/tasks necessary to perform and retain a particular job. Services are provided to any individual interested in obtaining employment, regardless of the degree of disability, and with particular attention and consideration to the individual's interests, strengths, needs, capabilities, priorities, concerns, previous work experiences and informed choice (**i.e. job placement should be individualized**).

Once a job is obtained, brief on-the-job training and support is available through this service to assist individuals in learning the job-specific skills/tasks necessary to successfully performing the new job.

It is expected that service staff will maintain regular, meaningful collaboration with the individual's mental health/substance abuse treatment team.

Managers and staff are encouraged to become familiar with evidence-based practice on Supported Employment such as the SAMHSA (Substance Abuse and Mental Health Services Administration Supported Employment Toolkit that provides guidelines and practices that enhance outcomes for consumers). Website for SAMHSA toolkit is:

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/employment>

Services may be provided in a variety of settings and must meet the following specific service criteria:

- 1) Employment is paid;
- 2) Employment provides opportunities to interact with people who do not have disabilities;
- 3) Training includes brief teaching/modeling of the specific skills/tasks necessary to perform the job; and
- 4) Regular, meaningful collaboration with the mental health/substance abuse treatment team is maintained.

Moreover, the service should maintain a focus on the individual's long-term career goals if a career is important to the individual, and attempt to place the individual in a job accordingly, rather than simply placing the individual in the easiest, lowest requirement job available. Jobs may be full or part time, and frequent opportunities for individuals to interact with non-disabled co-workers during the performance of their jobs or during breaks, working hour meals or travel to and from work is an important benefit. More than one individual consumer with a disability could work for the same employer and still be considered to receive this service, as long as consumers are not grouped within the work site. Wages must be paid in compliance with all applicable Department of Labor requirements.

The programmatic goals of this service must be clearly articulated by the provider, utilizing best/evidence based practices for employment services. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices.

Target Population	Adults and Older Adolescents with a: Mental Illness Substance Related Disorder Co-Occurring Substance-Related Disorder and Mental Illness, Co-Occurring Mental Illness and Mental Retardation/Developmental Disabilities Co-Occurring Substance-Related Disorder and Mental Retardation/Developmental Disabilities
Benefit Information	Available to all Ongoing Core Customers. Requires a MICP New Episode Request or Update Request (to add as a single service to an existing authorization).
Utilization Criteria	<u>Available to those with LOCUS scores:</u> 2: Low Intensity Community-Based Services* 3: High Intensity Community-Based Services *Those who enter this service with a LOCUS score of 2 may continue to receive the service at LOCUS level 1 with ERO approval.
Ordering Practitioner	Physician, Psychologist, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner), LPC, LMFT, LCSW
Unit Value	1 month – Weekly documentation via daily attendance or weekly time sheet.
Initial Authorization	180 days
Re-Authorization	180 days
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Employment Services Provider</u> 139 – Adult Mental Health 739 – Adult Addictive Diseases
Admission Criteria	1. Individuals who meet the target population criteria and indicate an interest through Recovery Planning in establishing or enhancing work skills; and 2. Individuals for whom behavioral health issues have caused unemployment or underemployment.
Continuing Stay Criteria	1. Individuals who meet the target population criteria and indicate an interest through Recovery Planning in establishing or enhancing work skills; and 2. Individuals for whom behavioral health issues have caused unemployment or underemployment; and 3. Individual demonstrates documented progress relative to goals identified in the Individualized Recovery Plan for employment, but employment goals have not yet been achieved.
Discharge Criteria	1. Goals of the Individualized Recovery Plan related to employment have

	been substantially met; or 2. Individual requests a discharge from this support.
Service Exclusions	
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder.

Additional Service Criteria:

A. Required Components

1. The programmatic goals of this service must be clearly articulated by the provider, utilizing best/evidence based practices for employment services.
2. Wages must be paid in compliance with all applicable Department of Labor requirements.

B. Staffing Requirements

Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices.

C. Clinical Operations

1. Individuals should be encouraged to be as involved and self-directed in the job location and placement process as possible (e.g. the individual should call a potential employer to inquire about a job rather than staff calling when possible (which may entail coaching the individual), and the individual should be offered assistance—though not advice-- from staff in making the personal decision about whether or not to disclose his or her disability to a potential employer).
2. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol

D. Service Access

E. Additional Medicaid Requirements

Not Applicable. Not a Medicaid-billable service.

F. Reporting & Billing Requirements

1. All applicable MICP and other DBHDD reporting requirements must be met.
2. A monthly, standardized report may be required by the DBHDD to monitor outcomes.

G. Documentation Requirements

1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.

GEORGIA DBHDD – BEST PRACTICE SUGGESTIONS

PRINCIPLES AND STAFF CAPABILITIES FOR SERVICES FOR ADULTS WITH CO-OCCURRING DISORDERS – April 17, 2002

Principles

11. Services for persons with co-occurring disorders should be integrated, rather than sequential. That is, they should be structured to deal with both disorders at once rather than requiring one disorder and one set of symptoms to be dealt with before services for the other can begin.
12. Psychosocial Rehabilitation (PSR) programs and Substance Abuse (SA) Day Services programs will be initially encouraged and eventually required to work toward becoming “co-occurring capable,” that is, able to deal flexibly with the issues of persons with co-occurring disorders.
13. “Co-occurring enhanced” services are time limited and go beyond co-occurring capable services and programs. They are characterized by the following:
 - Additional or special assessments requiring additional training or competencies, perhaps utilizing additional or specialized assessment tools;
 - Special training, experience, licensure, certification, or other qualifications of staff beyond basic recognition and general capabilities of addressing the needs of persons with co-occurring disorders within a larger program (see recommended staff capabilities below);
 - Availability of addictionologist and/or MAC, CACII, or CADC consultation;
 - Availability of psychiatric consultation and/or medication management;
 - Availability of crisis services if needed, either directly or through an interagency agreement with a mobile crisis service;
 - Additional staff to client ratio beyond the minimum requirements for a limited period of time, in order to deal effectively with individuals needing more intense or more frequent services than those offered in a co-occurring capable day services program; and
 - Additional programming intensity or specialized approaches or activities requiring significant adjustments to the usual day services activities to assure adequate dosing, frequency, and integration of services for individuals with co-occurring disorders.
14. Programs that provide PSR or SA Day Services will be required to either provide or arrange for co-occurring enhanced integrated services for adults with co-occurring disorders until those individuals can move back into regular co-occurring capable day services. Adults with co-occurring disorders should not be expected to simply adapt to usual or routine PSR or SA Day Services activities.
15. Co-occurring enhanced day services may be provided within a larger SA Day Services or PSR program, may be a separate day services program within a larger agency, or may be a stand-alone service provider.
16. An adult with serious and persistent mental illness and a co-occurring substance abuse disorder should be served in a co-occurring capable or co-occurring enhanced PSR program. Adults with substance abuse or dependence who also have a co-occurring mental health needs that do not rise to the level of serious and persistent mental illness should be served in a co-occurring capable or co-occurring enhanced SA Day Services.
17. An adult with serious and persistent mental illness whose symptoms are stable enough so that Intensive Day Treatment is not indicated; whose cognitive functioning is high enough to participate in and benefit from a co-occurring capable SA Day Services program without distraction; whose coping

skills and abilities are sufficiently intact to allow attention to his/her substance abuse; and who can understand the emotional concerns related to the negative consequences and effects of addiction should be allowed to choose service in a SA Day Services program. An adult with serious and persistent mental illness may not be refused service in an SA Day Services program simply because he/she is seriously and persistently mentally ill. Likewise, a seriously and persistently mentally ill adult may not be refused service in a PSR program simply because he/she is abusing or dependent on alcohol or other drugs.

18. Adults with serious and persistent mental illness whose symptoms, cognition, functioning, or coping skills are sufficiently impaired to prevent participation or benefit from a co-occurring capable day services program but who meet the admission criteria for either PSR or SA Day Services, must be served by a co-occurring enhanced PSR or SA Day Services program.
19. The service guidelines for PSR Services and for SA Day Services will include the same requirements about cross training and capabilities of staff to recognize and treat adults with co-occurring disorders.
20. DBHDD will work to ensure that there is no financial disincentive to serving individuals with co-occurring disorders in any particular day services program.
14. Basic knowledge necessary for all staff serving persons with mental illness or substance abuse in "co-occurring capable" day services must include the content areas below. For programs that are "co-occurring enhanced," this knowledge must go beyond basic understanding and must demonstrate actual staff competencies in using that knowledge to serve adults with co-occurring disorders.
15. PSR and SA Day Services Program Managers and staff are encouraged to become familiar with ASAM Patient Placement Criteria – 2R and current evidence-based practices literature about serving adults with co-occurring disorders.

GEORGIA DBHDD – BEST PRACTICES SUGGESTIONS

Staff Knowledge and Capabilities
About
Serving Persons with Co-Occurring Disorders

Necessary Capabilities for Substance Abuse Staff	Necessary Capabilities for Mental Health Staff
<ul style="list-style-type: none"> • knowledge of mental illness diagnoses, symptoms, and cognitive impairments where applicable; • medications used to treat various types of mental illness and their effects, including undesired medication side effects and the effects of discontinuing these medications; • assessment of mental illness; • likely coping strategies of individuals with mental illness, including use and abuse of substances, • concept of role of family members and psychoeducational approaches for working collaboratively with them; • motivational counseling for clients who are not ready to take full responsibility for self-management and recovery from substance abuse; • behavioral counseling for those who are actively working on recovery; • denial about mental illness or its symptoms, while respecting and encouraging individual choice and responsibility; • individual strategies for preventing symptom exacerbation; and • difference between recovery and engagement concepts in mental health and in substance abuse. 	<ul style="list-style-type: none"> • knowledge of substances of abuse and how they affect mental illnesses; • symptoms of withdrawal from various types of substances of abuse; • complications of interactions between psychotropic medications and substances of abuse, especially in detoxification and withdrawal processes; • assessment of substance abuse; • special considerations in assessing substance abuse in adults who have symptoms associated with a mental illness or who are taking or are candidates for taking prescribed medications for a diagnosed mental illness; • motivational counseling to use with clients who appear to be unmotivated for substance abuse treatment; • behavioral substance abuse counseling for those who are motivated to work toward abstinence; • denial and its role in addiction; • methods for overcoming denial while respecting and encouraging individual choice and responsibility; • relapse prevention strategies for persons with addictions; and • difference between recovery and engagement concepts in substance abuse and in mental health.

Part I

Eligibility, Service Definitions and Requirements

SECTION II

***Eligibility, Service
Definitions and Service
Guidelines for
Developmental Disabilities
Services***

Fiscal Year 2012

(Updated for October 1, 2011 Implementation)



**Georgia Department of Behavioral Health &
Developmental Disabilities**

October 2011

Eligibility for Developmental Disabilities Services

To be eligible for Developmental Disabilities Services, individuals must meet disability and financial criteria. One of the Department of Behavioral Health and Developmental Disabilities (DBHDD) Regional Offices determines disability eligibility for individuals residing in that region. The Department of Family and Children Services (DFCS) determines financial and Medicaid eligibility for services which are funded through Medicaid Waiver resources. Eligibility for the Medicaid waiver programs is determined by DBHDD Regional Offices in accordance with waiver policies.

To be eligible for **developmental disabilities services, an individual must meet the eligibility criteria below.** The contractor will deliver services to individuals who meet the following criteria:

A. Most in Need: The individual demonstrates:

1. Substantial risk of harm to self or others; or
2. Substantial inability to demonstrate community living skills at an age-appropriate level; or
3. Substantial need for supports to augment or replace insufficient or unavailable natural resources

AND

B. Diagnosis:

1. **Developmental Disability:** The individual meets the following diagnostic criteria for a developmental disability, which is a severe, chronic disability of the individual, as determined by a professional licensed to do so:
 1. Is attributable to a significant intellectual disability, or any combination of a significant intellectual disability and physical impairments;
 2. Is manifested before the individual attains age 22;
 3. Is likely to continue indefinitely;
 4. Results in substantial functional limitations in three or more of the following areas of major life activities:
 - a. Self-care;
 - b. Receptive and expressive language;
 - c. Learning;
 - d. Mobility;
 - e. Self-direction; and
 - f. Capacity for independent living; and
 5. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance, which are of lifelong or extended duration and are individually planned and coordinated.

OR

- C. **Mental Retardation:** The individual has a diagnosis of mental retardation based on assessment findings of significantly subaverage general intellectual functioning and significantly impaired adaptive functioning.

Mental Retardation/Developmental Disabilities Services Definitions NOW & COMP Waiver Services¹

¹Individuals have the option to self-direct NOW services with the exception of Financial Support Services, Prevocational, and Support Coordination. The co-employer, participant-direction option is available under the NOW for Community Access, Community Guide, Community Living Support, Respite, Supported Employment, and Transportation.

Individuals have the option to self-direct COMP services with the exception of Community Residential Alternative, Financial Support Services, Prevocational, and Support Coordination. The co-employer, participant-direction option is available under the COMP for Community Access, Community Guide, Community Living Supports, Supported Employment, and Transportation.

Behavioral Supports Consultation

NOW & COMP Waiver

HIPAA Transaction Code	Code	Mod1 Self D	Mod2	Mod3	Mod4
Behavioral Supports Consultation	H2019	UC			

Definition of Service: Individuals can choose the self-direction option with Behavioral Supports Consultation Services.

Behavioral Supports Consultation Services are professional consultation services that assist the individual with significant, intensive challenging behaviors that interfere with activities of daily living, social interaction, work, or similar situations. These services consist of behavioral supports professional evaluation, training, and intervention services. Evaluation services by the Behavioral Supports professional consultant include functional assessment of behavior and other diagnostic assessment of behavior. Training and intervention services by the Behavioral Supports professional consultant comprise direct skills training of individuals as well as family education and training on Positive Behavioral Supports.

Behavioral Supports Consultation Services provide for the development of Behavior Supports plans for the acquisition or maintenance of appropriate behaviors for community living and behavioral intervention for the reduction of maladaptive behaviors. Intervention modalities described in plans must relate to the identified behavioral needs of the waiver individual, and specific criteria for remediation of the behavior must be established and specified in the plan. Behavioral Supports Consultation Services may not be provided to individuals receiving Community Residential Alternative Services in the Comprehensive Supports Waiver (COMP).

Behavioral Supports Consultation services are provided by appropriately qualified individuals with expertise in behavioral supports evaluation and services for people with developmental disabilities. These services may be provided in an individual's own or family home, the Behavioral Supports Consultant's office, outpatient clinics, facilities in which Community Access or Prevocational Services are provided, Supported Employment work sites, or other community settings specific to community-based behavioral supports goals specified in the Individual Service Plan.

ADDITIONAL SERVICE INFORMATION:

1. Providers of Behavioral Supports Consultation services must comply with the guidelines and requirements for the provision of behavioral supports to individuals with developmental disabilities in the DHR, MHDDAD Guidelines for Supporting Adults with Challenging Behaviors in Community Settings and Behavioral Supports Guidelines (see Guidelines in Appendix D) in the delivery of these services; providers rendering Behavioral Supports Consultation services to individuals under the age of eighteen years must comply with any guidelines and requirements in these DBHDD Guidelines that are applicable to children and adolescents with developmental disabilities.

Revised August 12, 2011

2. Providers can provide Behavioral Supports Consultation Services at facilities where Community Access and Prevocational Services are rendered; however, the services must be documented and billed separately, and any waiver individual receiving multiple services may not receive these services at the same time of the same day.

Community Access Services					
NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2 Self D	Mod3 Co Emp	Mod4
Community Access Group	T2025	HQ	UC	UA	
Community Access Individual	T2025	UB	UC	UA	

Definition of Service:

Community Access Services are designed to assist the individual in acquiring, retaining, or improving self-help, socialization, and adaptive skills required for active community participation and independent functioning *outside* the individual's home or family home. These services are interventions in the areas of social, emotional, physical, and intellectual development and may include training in the areas of daily living skills (including leisure/recreation skills); communication training; mobility training; programming to reduce inappropriate and/or maladaptive behaviors; and training in the use of common community resources.

The emphasis of training will be on assisting the individual in increasing self help, socialization skills, skills or daily living and adaptive skills required for active community participation and independent functioning outside the individual's home or family home. These activities include accompanying individuals to the grocery store, or eating establishments; teaching an individual how to participate in appropriate social and recreational activities; and assessing other activities of community living.

The services typically occur during the day but may also take place in the evenings and weekends. Community Access services are individually planned to meet the individual's needs and preferences for active community participation. These services are provided in either community-based or facility-based settings but not in the Individual's home, family home, or any other residential setting.

The intended outcome of these services is to improve the individual's access to the community through increased skills and/or less paid supports.

Community Access Group services are provided to individual individuals or to groups of individuals. Community Access Group services are provided to groups of individuals, with a staff to individual ratio of one to two or more. The staff to individual ratio for Community Access Group services cannot exceed one (1) to ten (10). Community Access Individual services are provided to an individual, with a one-to-one staff to individual ratio. Community Access Services Providers offer (or arrange when needed) any of the Community Access Services that are needed by the individuals served and specified in the individuals' Individual Service Plans.

The following Community Access Services are offered:

- Community Access Group**
- Community Access Individual**

ADDITIONAL SERVICE INFORMATION:

1. Service design is based on self-determination principles and evidenced based practices, which support individuals to express their choices and direct their services.
2. Service design and implementation encourage and build on existing social networks and natural sources of support and result in increased interdependence, contribution and inclusion in community life.
3. Services and planning meetings shall be scheduled to accommodate individual and family needs.
4. Provider shall collaborate with the Regional Office Intake and Evaluation and Planning List Administrators, and Support Coordination agencies in the development of the Individual Support Plan and implementation of the Support Intensity Scale for each individual in service. Contractor's direct support staff will directly participate in both the ISP and the SIS.
5. Provider shall have the capacity (by staff expertise or through contract) to support individuals with complex behavioral and or medical needs.
6. Service design shall be outcome based with focus on self-determination principles and evidence based practices that continually support individuals towards responsible citizenship.
7. Providers rendering facility-based Community Access and other services (e.g., Prevocational Services and adult therapy services) can provide these services in the same facility; however, the services must be documented and billed separately, and any waiver individual receiving multiple services may not receive these services at the same time of the same day.

Community Guide NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Community Guide Self Directed	H2015	UC			
Community Guide Co-Employer	H2015	UA			

Definition of Service: Community Guide Services are direct assistance to individuals in skills building and information in meeting participant-direction responsibilities. These services are available **only** for individuals who choose the participant-direction option for service delivery. The individual, with the Support Coordinator, determines the amount of Community Guide Services, if any, and the specific services that the Community Guide will provide. The specific Community Guide Services for the individual are specified in the Individual Service Plan. Individuals may elect to receive Community Guide Services, and when elected, individuals choose their Community Guide.

Community Guide Services are individualized services designed to assist individuals in meeting their responsibilities in the individual-direction option for service delivery. Community Guides provide information, direct assistance, and training to individuals in support of Individual direction. The intended outcome of these services is to improve the individual's knowledge and skills for individual direction.

Community Guides assist and train individuals to build the skills required for individual direction, such as exploring and brokering available community resources, problem solving, and decision-making, being an effective employer of support workers, developing and managing the individual budget, and record keeping. Information provided by the Community Guide helps the individual's understanding of provider qualifications, record keeping, and other individual-direction responsibilities.

The scope, intensity, and frequency of Community Guide Services may change over time, based on the needs of the Individual.

ADDITIONAL SERVICE INFORMATION:

1. Community Guide Services are only for individuals who opt for participant-direction.
2. The individual determines the amount of Community Guide Services, if any, and the specific services that the Community Guide will provide.
3. The specific Community Guide Services for the individual are specified in the Individual Service Plan.
4. Individuals may elect to receive Community Guide Services, and when elected, individuals choose their Community Guide.

Revised August 12, 2011

5. The need for Community Guide Services must be related to the individual disability and tied to a specific goal in the Intake and Evaluation Team approved Individual Service Plan (ISP).

Community Residential Alternative Services

COMP Waiver

HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Community Residential Alternative	T2033				

Definition of Service:

Community Residential Alternative (CRA) services are targeted for Individuals who require intense levels of support. These services are a range of interventions with a particular focus on training and support in one or more of the following areas: eating and drinking, toileting, personal grooming and health care, dressing, communication, interpersonal relationships, mobility, home management, and use of leisure time. CRA Services are individually planned and tailored to meet the specific needs of the Individual and to accommodate fluctuations in his or her needs for various services.

CRA services include assistance with and/or training in activities of daily living, such as bathing, dressing, grooming, other personal hygiene, feeding, toileting, transferring, and other similar tasks. These services also include training and/or assistance in household care, such as meal preparation, clothes laundering, bed-making, housecleaning, simple home repair, yard care, and other similar tasks. CRA services consist of medically related services, such as basic first aid, arranging and transporting Individuals to medical appointments, assisting with therapeutic exercises, and assisting with or supervising self-administration of medication. These services also consist of implementing behavioral support plans designed for Individuals to reduce inappropriate and/or maladaptive behaviors and to acquire alternative adaptive skills and behaviors. CRA Services include transportation to all other waiver services specified in the Individual Service Plan and as needed to facilitate the individual's participation in personal shopping, recreation and other community activities.

Individuals receive CRA services in small group settings of four or less, in host home/life sharing situations for adults 19 years and above, or foster home for Individuals under the age of 19 years through an approved foster home operating under a licensed Child Placing Agency. CRA Services may not be provided to individuals living in their own or family homes.

Community Residential Alternative Services is provided to individuals who live in one of the following settings:

1. "Host Home" (Lifesharing). A home where an individual, who receives services, resides in an owner occupied home where the owner/family is funded to include the individual with the disability into their household routines and provide training and supervision. **This is an unlicensed setting for two adults (19 years or above) receiving community residential alternative services.** For CRA services rendered in life sharing/host home settings to individuals under the age of 19 years, the provider agency must have a Department of Human Services, Office of Residential Child Care license from the Department of Community Health, Division of Healthcare Facility Regulations. These homes can only serve a maximum of two (2) individuals under the age of 19 years at a time and can only serve individuals receiving services through the COMP Waiver.

2. Community Living Arrangement (CLA). Agencies providing this community residential alternative service must have a Community Living Arrangement License from the Office of Regulatory Services. **If anyone in the home receives Medicaid Waiver funding no more than four people may reside in the home, unless granted an exception by the Office of DD.**
3. Personal Care Home (PCH) Agencies providing this community residential alternative service must have a Personal Care Home Permit from the Department of Community Health, Division of Healthcare Facility Regulation. PCH permits for the provision of CRA services are no longer accepted in applications to provide CRA services. PCH agencies enrolled to provide CRA services prior to January 1, 2011 may continue to provide CRA services. No more than four (4) individuals may reside in a PCH if anyone in the home receives Medicaid Waiver funding, unless an exception has been granted by the Division of Developmental Disabilities. New homes will not be granted this exception

The services provided, the frequency and intensity of services are specific to the individual receiving services as detailed in his/her Individual Services Plan (ISP).

ADDITIONAL SERVICE INFORMATION:

1. Service design and implementation encourage and build on existing social networks and natural sources of support and result in increased interdependence, contribution and inclusion in community life.
2. The selection of living environments shall include consideration of opportunities for community inclusion of individuals receiving services, individual choice (including preference to be close to family) and distance from other homes (e.g. apartments, house) of individuals receiving services to assure that individuals with developmental disabilities are not grouped in a conspicuous manner.
3. Daily and weekly rhythms and routines shall be directly related to individual's needs, interests and preferences.
4. Service design shall be outcome based with focus on self-determination principles and evidence based practices that continually support individuals towards responsible citizenship.
5. Provider shall collaborate with the Regional Office Intake and Evaluation staff and Planning List Administration staff and Support Coordination agencies in the development of the Individual Support Plan and implementation of the Support Intensity Scale for each individual in service. The Contractor's direct support staff will directly participate in both the ISP and the SIS.
6. The Provider **must** have Regional Office approval before moving individual(s) to a new address. Emergency relocation plans identified in the Individual Service Plans is acceptable as prior approval for moving to a new location in emergencies. Each individual Community Residential Alternative site must be individually enrolled.
7. Provider will adhere to Policy on Personal Spending and Protection of Funds for individuals receiving community residential alternative services. See Part IV.
8. Provider shall have the capacity (by staff expertise or through contract) to support individuals with complex behavioral and or medical needs.
9. A health exam is required for each individual in residential services on an annual basis. See Part I Section IV for the Annual Health Form to be used to document the annual health exam and maintained in the individual's record.

Community Living Support Services NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2 Self D	Mod3 Comp	Mod4
Community Living Support Services 15 Minutes	T2025	U5	UC	UA	
Community Living Supports Daily (COMP only)	T2025	U6	UC	UA	

Definition of Service: Individuals can choose the self-direction OR co-employer options with CLS services.

Community Living Support (CLS) Services are individually tailored supports that assist with the acquisition, retention, or improvement in skills related to an Individual's continued residence in his or her own or family home. Personal care/assistance may be a component part of CLS services but may not comprise the entirety of the services. CLS services are offered to Individuals who live in their own or family home.

CLS services include training and assistance with activities of daily living (ADLs), such as bathing, dressing, toileting, and transferring, and with instrumental activities of daily living (IADLs), such as personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, and medication and money management. These services include transportation to facilitate the individual's participation in grocery or personal shopping, banking, and other community activities that support continued residence of the individual in his or her own or family home. CLS services may include medically related services, such as basic first aid, arranging and transporting individuals to medically appointments, accompanying individuals on medical appointments, documenting an individual's food and/or liquid intake or output, reminding individuals to take medication, and assisting with or supervising self-administration of medication.

Personal care/assistance may be a component part of CLS services but may not be the only service provided to an Individual. The amount of personal care/assistance is specific to the individual needs of the individual, as determined by the Supports Intensity Scale, the Health Risk Screening Tool, and other person-centered assessment data. The individual amount of personal care/assistance provided the individual is specified in the individual Service Plan.

A personal assistance retainer is a component of Community Living Support Services. This retainer allows continued payment to personal caregivers under the waiver for the following: (1) up to seven (7) days from the date of each admission to a general hospital or nursing facility, including ICF/MR and skilled nursing facilities; and (2) up to thirty (30) days per year for other absences of the individual from his or her home, such as vacations and family/relative visits.

CLS services are only for individuals who live in their own or family home. The types and intensity of services provided are specific to the individual and detailed in his or her Individual Service Plan.

ADDITIONAL SERVICE INFORMATION:

1. Service design and implementation encourage and build on existing social networks and natural sources of support and result in increased interdependence, contribution and inclusion in community life.
2. **Daily and weekly rhythms and routines shall be directly related to individual's needs, interests and preferences.**
3. Service design shall be outcome based with focus on self-determination principles and evidence based practices that continually support individuals towards responsible citizenship.
4. Provider shall collaborate with the Regional Office Intake and Evaluation and Planning List Administration staff and Support Coordination agencies in the development of the Individual Support Plan and implementation of the Support Intensity Scale for each individual in service. Provider's direct support staff will directly participate in both the ISP and the SIS.
5. Provider shall have the capacity (by staff expertise or through contract) to support individuals with complex behavioral and or medical needs.
6. **Personal Assistance Retainer Documentation:** Providers, except for providers of participant-directed services, must document the following in the record of each individual for whom a personal assistance retainer is a component of Community Living Support Services: (1) Beginning and end date of absence, (2) Reason for absence, (3) Scheduled days and units per day for Community Living Support Services as specified in the ISP.
7. **Provider agencies must have a Private Home Care Provider License from the Department of Community Health (DCH), Division of Healthcare Facility Regulations (HFR) if providing covered services as required by DCH/HFR.**

Financial Support Services					
NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Financial Support Services	T2040	UC			

Definition of Service:
 Financial Support Services (FSS) are designed to perform fiscal and related finance functions for the Individual or representative who elects the participant-direction option for service delivery and supports. FSS assure that the funds to provide services and supports, outlined in the Individual Service Plan (ISP) and to be implemented through a self-directed approach are managed and distributed as intended.

Additional Service Information:

1. Financial Support Services are provided by a Fiscal Intermediary Agency (FIA) established as a legally recognized entity in the United States, qualified and registered to do business in the state of Georgia, and approved as a Medicaid provider by the Department of Community Health (DCH.).
2. Financial Support Services are mandatory and integral to participant-direction through a fiscal intermediary.
3. Financial Support Services are not available to individuals who choose the Co-Employer model for self-directed services and supports.
4. Financial Support Services are provided by agencies that do not provide any other Medicaid services in Georgia.

Individual Directed Goods and Services NOW & COMP Waiver

HIPAA Transaction Code	Code	Mod1	Mod2 Self D	Mod3	Mod4
Individual Directed Goods and Services (NOW only)	T2025	U7	UC		

Definition of Service:

Individual Directed Goods and Services are goods and services not otherwise provided through the NOW or the Medicaid State Plan, but are identified by the waiver individual/representative who opts for -direction and the Support Coordinator or interdisciplinary team. These services are available **only** for individuals who choose the participant-direction option for service delivery. Individual Directed Goods and Services must be clearly linked to an assessed need of the individual due to his or her disability and be documented in the individual's Individual Service Plan.

Individual Directed Goods and Services are purchased from the participant-directed budget and cover services that include improving and maintaining the individual's opportunities for full membership in the community. Goods and services purchased under this coverage may not circumvent other restrictions on NOW services, including the prohibition against claiming for the costs of room and board. Individual Directed Goods and Services must be authorized by the operating agency prior to service delivery.

The Individual Directed Goods and Services must:

Decrease the need for other Medicaid services; AND

Not be available through another source, including the individual not having the funds to purchase the item or service; AND

Promote inclusion in the community; OR

Increase the individual's safety in the home environment.

The individual/representative must submit a request to the Support Coordinator for the goods or service to be purchased that includes the supplier/vendor name and identifying information and the cost of the service/goods. A paid invoice or receipt that provides clear evidence of the purchase must be on file in the Individual's records to support all goods and services purchased. Authorization for these services requires Support Coordinator documentation that specifies how the Individual Directed Goods and Services meet the above-specified criteria for these services. Individuals receiving flexible support coordination are required to follow these same procedures.

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ADDITIONAL SERVICE INFORMATION:

1. Individual Directed Goods and Services are provided by vendors with the applicable Georgia business license as required by the local, city or county government in which the services are provided.

Supported Employment NOW & COMP Waiver

HIPAA Transaction Code	Code	Mod1	Mod2 Self D	Mod3 CoEmp	Mod4
Supported Employment Individual	T2019	UB	UC	UA	
Supported Employment Group	T2019	HQ	UC	UA	

Definition of Service: Individuals can choose the self-direction or co-employer options with Supported Employment Services.

Supported Employment services are ongoing supports that enable individuals, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. The scope and intensity of Supported Employment supports may change over time, based on the needs of the individual. Supported Employment services are conducted in a variety of settings, particularly work sites where individuals without disabilities are employed.

Individuals who receive Supported Employment services must require long-term, direct, or indirect job-related support in job supervision, adapting equipment, adapting behaviors, transportation assistance, peer support, and/or personal care assistance during the work day. Supported Employment services consist of activities needed to obtain and sustain paid work by individuals, including job location, job development, supervision, training, and services and supports that assist individuals in achieving self-employment through the operation of a business, including helping the individual identify potential business opportunities, assisting in the development of a business plan, identifying the supports that are necessary for the individual to operate a business, and ongoing assistance, counseling and guidance once the business has been launched. These services do not include the supervisory activities rendered as a normal part of the business setting.

The planned outcomes of these services are to increase the hours worked by each individual toward the goal of forty hours per week and to increase the wages of each individual toward the goal of increased financial independence. Supported Employment services are based on the individual individual's needs, preferences, and informed choice. These services allow for flexibility in the amount of support an individual receives over time and as needed in various work sites.

Supported Employment Group services are provided to groups of individuals, with a staff to individual ratio of one to two or more. The staff to individual ratio for Supported Employment Group services cannot exceed one (1) to ten (10). Supported Employment Individual services are provided to an individual, with a one-to-one staff to individual ratio.

ADDITIONAL SERVICE INFORMATION:

1. Supported Employment may be provided in individual or group settings. When contracts or Memorandums of Agreement require providers to report the types of settings in which Supported Employment has occurred, providers will report those settings using the following categories:

Community Based Employment Services – Individual
Community Based Employment Services – Group

2. Service design is based on self-determination principles and evidenced based practices, which support individuals to express their choices and direct their services.
3. Provider supports individuals receiving services to experience meaningful days by assuring that activities are directly related to the individual's interests and preferences as documented in the ISP.
4. Service design and implementation encourage and build on existing social networks and natural sources of support and result in increased interdependence, contribution and inclusion in community life.
5. Provider shall assure that individuals (and/or their families, as appropriate) have accurate and individualized information regarding the impact and value of employment and wages on benefits.
6. Service shall be aimed at increased opportunities for meaningful adult career development with focus towards paid employment.
7. Services and planning meetings shall be scheduled to accommodate individual and family needs.
8. Provider shall collaborate with the Regional Office Intake and Evaluation and Planning List Administrators, and Support Coordination agencies in the development of the Individual Support Plan and implementation of the Support Intensity Scale for each individual in service. Contractor's direct support staff will directly participate in both the ISP and the SIS.
9. The SIS will contribute to, but not determine exclusively, the nature of the employment goals identified in the ISP as they shall always be primarily identified through person-centered planning and discovery.
10. Provider shall have the capacity (by staff expertise or through contract) to support individuals with complex behavioral and or medical needs.
11. Service design shall be outcome based with focus on self-determination principles and evidence based practices that continually support individuals towards responsible citizenship.
12. Group Supported Employment Services: a staff to individual ratio of one to two or more, not to exceed one (1) to ten (10).
13. Individual Supported Employment Services: a one-to-one staff to individual ratio.

Prevocational NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2 Self D	Mod3 Co Emp	Mod4
Prevocational Services	T2015				

Definition of Service:

Prevocational Services prepare an individual for paid or unpaid employment. These services are for the individual not expected to be able to join the general work force within one year as documented in the Individual Service Plan. If compensated, individuals are paid in accordance with the requirements of Part 525 of the Fair Labor Standards Act.

Prevocational Services occur in facility-based settings or at community sites outside the facility for small groups of individuals, called mobile crews, who travel from the facility to these community sites. Mobile crews receive Prevocational Services by performing tasks, such as cleaning or landscaping, at community sites other than the individual's home or family home or any residential setting.

The emphasis of Prevocational Services is directed to habilitative rather than explicit employment objectives. These services include teaching individuals concepts necessary to perform effectively in a job in the community. Activities included in these services are directed at teaching concepts such as rule compliance, attendance, task completion, problem solving, endurance, work speed, work accuracy, increased attention span, motor skills, safety, and appropriate social skills.

The intended outcome of these services is to prepare the individual for paid or unpaid employment through increased skills. Prevocational Services are individually planned to meet the Individual's needs for preparation for paid or unpaid employment. These services are provided either facility-based or at community sites other than the individual's home or family home or any other residential setting.

Prevocational Services are provided to groups of individuals at a facility or to small groups of individuals who travel to sites outside the facility, referred to as mobile crews. The staff to individual ratio for facility-based Prevocational Services cannot exceed one (1) to ten (10). The staff to individual ratio for Mobile Crew Prevocational Services cannot exceed one (1) to six (6).

ADDITIONAL SERVICE INFORMATION:

1. Service design is based on self-determination principles and evidenced based practices, which support individuals to express their choices and direct their services.
2. Service design and implementation encourage and build on existing social networks and natural sources of support and result in increased interdependence, contribution and inclusion in community life.
3. Provider shall assure that individuals (and/or their families, as appropriate) have accurate and individualized information regarding the impact and value of wages on benefits.
4. Service shall be aimed at increased opportunities for meaningful adult career development with focus towards paid employment.

5. Services and planning meetings shall be scheduled to accommodate individual and family needs.
6. Provider shall collaborate with the Regional Office Intake and Evaluation and Planning List Administrators, and Support Coordination agencies in the development of the Individual Support Plan and implementation of the Support Intensity Scale for each individual in service. Contractor's direct support staff will directly participate in both the ISP and the SIS.
7. Provider shall have the capacity (by staff expertise or through contract) to support individuals with complex behavioral and or medical needs.
8. Service design shall be outcome based with focus on self-determination principles and evidence based practices that continually support individuals towards responsible citizenship.
9. Providers rendering facility-based Prevocational Services and other services (e.g., Community Access Services and adult therapy services) can provide these services in the same facility; however, the services must be documented and billed separately, and any waiver individual receiving multiple services may not receive these services at the same time of the same day.

Respite Services					
NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Respite Care Services 15 Minutes	S5150				
Respite Care Services Overnight	S5151				

Definition of Service:

Respite Services provide brief periods of support or relief for caregivers of individuals with disabilities. Respite is provided in the following situations:

When families or the usual caretakers are in need of additional support or relief;

When the individual needs relief or a break from the caretaker;

When an individual is experiencing a crisis and needs structured, short-term support;

When relief from care giving is necessitated by unavoidable circumstances, such as a family emergency.

Planned or scheduled respite, or Maintenance Respite, provides brief periods of support or relief for caregivers or Individuals. Respite Services might also be needed to respond to emergency situations. Emergency/Crises Respite is intended to be a short term service for an individual experiencing a crisis (usually behavioral) and requires a period of structured support, or when respite services are necessitated by unavoidable circumstances, such as a family emergency. Maintenance Respite and Emergency/Crises Respite may be provided In-Home (provider delivers service in the individual's home) or Out-Of-Home (The individual receives service outside of their home).

Respite Services may be provided in the individual's own or family home, or outside the individual's home in a private residence of a Respite Services provider (i.e., a home that is owned or rented by the provider or an employee of the provider) or in a licensed Personal Care Home. Respite Services include short-term services during a day or overnight services.

ADDITIONAL SERVICE INFORMATION:

1. Provider agencies that render in-home Respite Services must hold a Private Home Care license if providing services as required by DCH/HFR.
2. Provider agencies that render out-of-home Respite Services in a Personal Care Home must have a Personal Care Home license.
3. Respite Services in personal care homes can only be rendered in personal care homes in which *all* residents are adults with developmental disabilities.
4. Respite Services provided in Personal Care Homes serve no more than a total of four (4) individuals at a time.

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5. Respite Services provided in the private residence of a provider serve no more than one (1) individual in the home at a time.
6. DBHDD may grant an exception of the private residence capacity limit up to two (2) individuals when serving *only* individuals under the age of 18.

Specialized Services					
NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1 Self D	Mod2	Mod3	Mod4
Specialized Medical Supplies	T2028	UC			
Specialized Medical Equipment	T2029	UC			
Vehicle Adaptation	T2039	UC			
Environmental Accessibility Adaptation	S5165	UC			

Definition of Service: Specialized Medical Supplies (SMS) Services include various supplies which enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. SMS consist of food supplements, special clothing, diapers, bed wetting protective chucks, and other supplies that are specified in the Individual Service Plan and are not available under the Medicaid State Plan. Ancillary supplies necessary for the proper functioning of approved devices are also included in this service.

Specialized Medical Equipment (SME) Services include various devices, controls or appliances which are designed to enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. SME services also include assessment or training needed to assist individuals with mobility, seating, bathing transferring, security, or other skills such as operating a wheelchair, locks, door openers, or side lyers. These services additionally consist of customizing a device to meet an individual's needs.

Vehicle Adaptation Services include various adaptations and technical assistance to individually or family owned vehicles which are designed to enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. Vehicle Adaptations are limited to a individual's or his or her family's privately owned vehicle and include such things as a hydraulic lift, ramps, special seats and other interior modifications to allow for access into and out of the vehicle as well as safety while moving. The adapted or to be adapted vehicle must be the individual's primary means of transportation.

Environmental Accessibility Adaptation Services include adaptations and technical assistance to individually or family owned private residences which are designed to enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. These services include physical adaptations to the individual's or family's home which are necessary to ensure the health, welfare and safety of the individual, or enable the individual to function with greater independence in the home and without which, the individual would require institutionalization. Environmental Accessibility Adaptations consist of the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the individual, and are of direct medical or remedial benefit to the individual.

ADDITIONAL SERVICE INFORMATION:

1. Specialized Medical Supplies services must be documented to be the payer of last resource. The DME program prior approval process is used to determine medical necessity for medical supplies. The NOW and COMP do not cover items that have been denied through the DME and other programs for lack of medical necessity. Providers for Specialized Medical Supplies should refer to the Department of Community Health, Division of Medical Assistance, Part II, Policies and Procedures for Durable Medical Equipment, Part II, Policies and Procedures for Orthotics and Prosthetics and Part III, Hearing Services for additional information about coverage of these services.
2. Specialized Medical Equipment services must be documented to be the payer of last resource. The DME program prior approval process is used to determine medical necessity for medical equipment. The NOW and COMP do not cover items that have been denied through the DME and other programs for lack of medical necessity.
3. Individuals may choose the self-direction option with Specialized Medical Equipment Services. Providers for Specialized Medical Equipment should refer to the Department of Community Health, Division of Medical Assistance, Part II, Policies and Procedures for Durable Medical Equipment, Part II, Policies and Procedures for Orthotics and Prosthetics and Part III, Hearing Services for additional information about coverage of these services.
4. Any item billed under Vehicle Adaptation Services must not be available under the State Medicaid plan. These services must also be documented to be the payer of last resource. The NOW and COMP do not cover items that have been denied through the DME and other programs for lack of medical necessity.
5. Any item billed under Environmental Accessibility Adaptation Services must not be available under the State Medicaid Plan. These services must also be documented to be the payer of last resource. The NOW and COMP do not cover items that have been denied through the DME and other programs for lack of medical necessity.

Natural Support Training Service

NOW & COMP Waiver

HIPAA Transaction Code	Code	Mod1	Mod2 Self D	Mod3	Mod4
Natural Support Training Service	T2025	UD	UC		

Definition of Service: Individuals can choose the self-direction option with Natural Support Training Services.

Natural Support Training (NST) Services provide training and education to individuals who provide **unpaid** support, training, companionship, or supervision to individuals. For purposes of this service, individual is defined as any individual, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship, or support to an individual served on the waiver. These services must relate to the individual individual's needs due to his or her disability and tie to a specific goal in the Individual Service Plan. All training for individuals who provide unpaid support to the individual provided through NST Services must be included in the Individual's ISP.

NST Services include individualized training of families and members of the individuals' natural support networks for the acquisition or enhancement of their ability to support the waiver individual. This training consists of instruction about treatment regimens and other services included in the ISP. NST Services comprise training on the use of equipment as specified in the ISP. There services may include updates in training required to maintain the individual safely at home. NST Services encompass the costs of registration and training fees associated with formal instruction in areas relevant to the individual's disability needs identified in the ISP. These services do not include the costs of travel, meals, and overnight lodging to attend a training event or conference.

NST Services are provided by Developmental Disability Professionals (see Provider Manual for definition). These services may be provided in an individual's own or family home, the Developmental Disability Professional's office, outpatient clinics, Supported Employment work sites, or other community settings specific to community-based Natural Support Training goals specified in the Individual Service Plan.

ADDITIONAL SERVICE INFORMATION:

1. NST Services must not duplicate any family education or training provided through Adult Physical Therapy Services, Adult Occupational Therapy Services, Adult Speech and Language Therapy Services, or Behavioral Supports Consultation Services.
2. NST Services may not occur simultaneously or on the same day as Adult Physical Therapy Services, Adult Occupational Therapy Services, Adult Speech and Language Therapy Services, or Behavioral Supports Consultation Services.

Therapy Services					
NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2 Self D	Mod3	Mod4
Adult Occupational Therapy	97003		UC		
	97530	GO	UC		
	97533	GO	UC		
Adult Physical Therapy	97001		UC		
	97110		UC		
Adult Speech and Language Therapy	92506		UC		
	92507	GN	UC		
	92609		UC		

Definition of Service: Individual can choose self-direction option with these therapies.

Adult Occupational Therapy Services are evaluation and therapeutic services that are not otherwise covered by Medicaid State Plan services. These services address the occupational therapy needs of the adult individual that result from his or her developmental disability. Adult Occupational Therapy Services include occupational therapy evaluation, individual/family education, occupational therapy activities to improve functional performance, and sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands. Adult Occupational Therapy Services are provided by a Georgia licensed occupational therapist and by order of a physician. These services may be provided in an individual's own or family home, the Occupational Therapist's office, outpatient clinics, facilities in which Community Access or Prevocational Services are provided, Supported Employment work sites, or other community settings specific to community-based therapy goals specified in the Individual Service Plan. Adult Occupational Therapy Services may not be provided to individuals receiving Community Residential Alternative Services in the Comprehensive Supports Waiver.

Adult Physical Therapy Services are evaluation and therapeutic services that are not otherwise covered by Medicaid State Plan services. These services address the physical therapy needs of the adult individual that result from his or her developmental disability. Adult Physical Therapy Services include physical therapy evaluation, individual/family education, and therapeutic exercises to develop sitting and standing balance, strength and endurance, and range of motion and flexibility. Adult Physical Therapy Services also consist of muscle strengthening and endurance to facilitate transfers from wheelchairs and the use of other equipment. Adult Physical Therapy Services are provided by a Georgia licensed physical therapist and by order of a physician. These services may be provided in an individual's own or family home, the Physical Therapist's office, outpatient clinics, facilities in which Community Access or Prevocational Services are provided, Supported Employment work sites, or other community settings specific to community-based therapy goals specified in the Individual Service Plan. Adult Physical Therapy Services may not be provided to individuals receiving Community Residential Alternative Services in the Comprehensive Supports Waiver.

Adult Speech and Language Therapy Services cover evaluation and therapeutic services that are not

otherwise covered by Medicaid State Plan services. These services address the speech and language therapy needs of the adult individual that result from his or her developmental disability. Adult Speech and Language Therapy Services include the evaluation of speech language, voice, and language communication, auditory processing, and/or aural rehabilitation status. Adult Speech and Language Therapy Services also consist of individual/family education, speech language therapy, and therapeutic services for the use of speech-generating devices, including programming and modification. Adult Speech and Language Therapy Services are provided by a Georgia licensed speech and language pathologist and by order of a physician. These services may be provided in an individual's own or family home, the Speech and Language Pathologist's office, outpatient clinics, facilities in which Community Access or Prevocational Services are provided, Supported Employment work sites, or other community settings specific to community-based therapy goals specified in the Individual Service Plan. Adult Speech and Language Therapy Services may not be provided to individuals receiving Community Residential Alternative Services in the Comprehensive Supports Waiver.

ADDITIONAL SERVICE INFORMATION:

1. Services must be provided by a Georgia licensed individual in the specific therapy discipline.
2. Provider agencies must have available a sufficient number of employees or professionals under contract that are Georgia licensed individuals in the specific therapy discipline.

Support Coordination NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Support Coordination	T2022				

Definition of Service:

Support Coordination services are a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for individuals. Support Coordination services include the following:

- Assessment and Periodic Reassessment
- Development and Periodic Revision of the Individual Service Plan
- Referral and Related Activities
- Monitoring and Follow-up Activities

Support Coordination services assist individuals in coordinating all services, whether Medicaid reimbursed services or services provided by other funding sources. These services include completing the Individual Service Plan (ISP) document and any revisions, and monitoring the implementation of the ISP and the health and welfare of individuals. The frequency of Support Coordination services is based on the individual needs of the individual and as required to address any identified health and safety risks or service provider issues.

Support Coordination services are provided by agencies that employ a sufficient number of Support Coordinators to meet the Support Coordination services needs of individuals served by the agency. Support Coordinators assure the completion of the written ISP document and any revisions. Support Coordinators are also responsible for monitoring the implementation of the ISP, the health and welfare of individuals, and the quality and outcome of services. Monitoring includes direct observation, review of documents, and follow up to ensure that services plans have the intended effect and that approaches to address challenging behaviors, medical and health needs, and skill acquisition are coordinated in their approach and anticipated outcome. Support Coordinators are also responsible for the ongoing evaluation of the satisfaction of individuals and their families with the ISP and its implementation. Support Coordinators assist individuals and their families or representatives in making informed decisions about the participant-direction option and assist those who opt for participant-direction with enrollment in this option.

ADDITIONAL SERVICE INFORMATION:

1. Support Coordination is provided by Support Coordination Agencies only.
2. Provider agencies rendering Support Coordination services must:

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- Have at minimum five (5) years experience in providing case management services for individuals with MR/DD, and demonstrate success in supporting individuals in community inclusion and person centered planning;
- Have established working relationships with local advocacy groups, experience advocating for individuals in the community, and preparing individuals for self advocacy;
- Have experience and demonstrated success with person centered outcome based planning, and developing plans based on the individual's choices and support needs identified in the Supports Intensity Scale;
- Have experience with measuring quality of services and satisfaction with services, ensuring that the services that are provided are consistent with quality measures and expectations of the individual;
- Demonstrate experience in serving diverse cultural and socioeconomic populations.

Transportation Services					
NOW & COMP Waiver					
HIPAA Transaction Code	Code	Mod1	Mod2	Mod3	Mod4
Transportation – Trip	T2003				
Transportation – Trip – Self Directed	T 2003	UC			
Transportation – Trip – Co-Employer	T 2003	UA			
Transportation Commercial Carrier, Multi Pass	T 2004				
Transportation Commercial Carrier, Multi Pass Self Directed	T 2004	UC			

Definition of Service: Individuals may choose the participant-direction or co-employer options with Transportation Services.

Transportation Services enable waiver individuals to access non-medical services, activities, resources, and organizations typically utilized by the general population. These services are only provided as independent, stand-alone waiver services when transportation is not otherwise included as an element of another waiver service. Transportation services are not intended to replace available formal or informal transit options for individuals. Whenever possible, family, neighbors, friends or community agencies, which can provide this service, without charge, are to be utilized. The need for Transportation Services and the unavailability of other resources for transportation must be documented in the Individual Service Plan (ISP).

Transportation Services provide transportation for the individual to waiver services and other community services, activities, resources, and organizations typically utilized by the general population. These services include:

One-way or round trips provided by Georgia licensed drivers and/or DD Service Agencies; and

Transit by commercial carrier available to the community at large.

Transportation Services must not be available under the Medicaid Non-Emergency Transportation Program, State Plan, Individual with Disabilities Education Act (IDEA), or the Rehabilitation Act. These services do not include transit provided through Medicaid non-emergency transportation. Transportation Services are not available to transport an individual to school (through 12th grade). These services do not include transportation that is included as an element of another waiver service as follows:

- Community Living Support Services
- Prevocational Services
- Supported Employment Group Services
- Community Access Group or Individual Services, which entail activities and settings primarily utilized by people with disabilities, such as transportation to and from a Mental Retardation Service

Center or other day center.

Transportation Services are only for individuals who do not have formal or informal transit options available. The type and amount of Transportation Services provided are specific to the individual and detailed in his or her Individual Service Plan.

ADDITIONAL SERVICE INFORMATION:

1. Individual Providers rendering Transportation Services must hold a valid Class C license as defined by the Georgia Department of Driver Services (or any allowable other state license per Department of Community Health, Division of Medical Assistance policy).
2. DD Service Provider Agency driver staff providing Transportation Services must hold the class of license appropriate to the vehicle operated as defined by the Georgia Department of Driver Services (or any allowable other state license per Department of Community Health, Division of Medical Assistance policy).

PART III OF THE PROVIDER MANUAL CONTAINS OPERATIONAL STANDARDS FOR:

Georgia Crisis Response System (GCRS-DD)
Host Home/Life-Sharing
Family Support Services

Part I

Eligibility, Service Definitions and Requirements

SECTION III

***Developmental Disabilities
Intake Screening and Annual
Health Forms***

Fiscal Year 2012



**Georgia Department of Behavioral Health &
Developmental Disabilities**

October 2011

DBHDD

Georgia DHR Division of MHDDAD Developmental Disabilities
Intake Screening Summary

- Initial Family Supports Screening: Date: / /
- Initial Intake and Evaluation Screening: Date: / /

I. Personal and Demographic Information

Name:			
	* First	* Middle	* Last
Address:			
	* Street/Apartment number (if applicable)		* City
			() -
	* County	* State	* Zip code * Telephone:
* Marital Status:	* Gender:	* Race:	* Ethnicity (Hispanic/Latino Origin)
<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	<input type="checkbox"/> M <input type="checkbox"/> F	Select One...	Select One...
* Birth date:	/ /	* SSN#:	- - * Medicaid #:
MHID#:		* Primary Diagnosis:	Select One...
Supporting Documentation Included:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Secondary Diagnosis:	
Legal Status:	<input type="checkbox"/> Minor <input type="checkbox"/> Competent	<input type="checkbox"/> Legally Incompetent (Documentation Required)	
Legal Guardian: (if applicable)		Relationship to Consumer:	
Address:		Telephone #:	() -

* Primary Contact for Correspondence:		* Relationship to Consumer:	
* Address:		* Telephone:	() -
Next of Kin:		Relationship to Consumer:	
Address:		Telephone #:	() -

*Date of Contacts	*Contact Successful (Person Spoke With)	*No Answer	*Left Message	*Date of Appointment:	*Location of Appointment
/ /		Select One...	Select One...	/ /	
/ /		Select One...	Select One...	/ /	
/ /		Select One...	Select One...	/ /	
Appointment	Select One...		Individuals Present	<input type="checkbox"/> Applicant <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Family <input type="checkbox"/> Other:	

**Georgia DHR Division of MHDDAD Developmental Disabilities
Intake Screening Summary**

<i>* Sensory Impairments:</i>	<i>* English Proficiency</i>
Select One...	Select One...

II. Services currently receiving:

<i>Generic</i>	<input type="checkbox"/> Early Intervention	<input type="checkbox"/> Source	<input type="checkbox"/> CCSP	<input type="checkbox"/> School	<input type="checkbox"/> Other (specify)
<i>GIA</i>	<input type="checkbox"/> Family Support (specify)	<input type="checkbox"/> Day Services (specify)	<input type="checkbox"/> Residential (specify)	<input type="checkbox"/> Other (specify)	
<i>Waiver</i>	<input type="checkbox"/> MRWP (specify)				
	<input type="checkbox"/> CHSS (specify)				
Comments:					

III. Programs & Placements

<i>* Prior Placement (Check all that apply)</i>			
<input type="checkbox"/> Own Home	<input type="checkbox"/> Homeless	<input type="checkbox"/> Other Service/Program Option	<input type="checkbox"/> SWSH
<input type="checkbox"/> Gracewood	<input type="checkbox"/> Group Home	<input type="checkbox"/> Surrogate Home	<input type="checkbox"/> GRH-Atlanta
<input type="checkbox"/> Bainbridge (historical)	<input type="checkbox"/> Out of State	<input type="checkbox"/> DFCS Custody	<input type="checkbox"/> West Central Regional
<input type="checkbox"/> Rome Regional	<input type="checkbox"/> Brook Run (historical)	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Incarcerated
<input type="checkbox"/> Central State	<input type="checkbox"/> GRH-Savannah	<input type="checkbox"/> Rivers Crossing (historical)	<input type="checkbox"/> Other

IV. * Provided Information on (Check all that were provided):

<i>State Resources</i>	<i>Advocacy Groups / Other Resources</i>	
<input type="checkbox"/> Voc Rehab	<input type="checkbox"/> Unlock the Waiting List	<input type="checkbox"/> Local Community contacts
<input type="checkbox"/> Division of Aging	<input type="checkbox"/> Family Connections	<input type="checkbox"/> Respite Provider
<input type="checkbox"/> DFCS	<input type="checkbox"/> Parent to Parent	<input type="checkbox"/> Division of Aging
<input type="checkbox"/> Family Support Provider	<input type="checkbox"/> Emory Autism Center	<input type="checkbox"/> Support Coordination
<input type="checkbox"/> CMS	<input type="checkbox"/> SOURCE	<input type="checkbox"/> United Way
<input type="checkbox"/> Who to contact for PL changes (Regional Office)	<input type="checkbox"/> Marcus Institute	
	<input type="checkbox"/> Other	
Comments:		

Georgia DHR Division of MHDDAD Developmental Disabilities
Intake Screening Summary

DOCUMENTATION OF NEED FOR SERVICES

Immediate Need (person needs service immediately):

- Death of the caregiver with no other supports (i.e., other family) available.
- Caregiver incapacitated with no other supports (i.e., other family) available (due to physical or psychological reasons).
- Caregiver unable or unwilling to continue providing care (Person dropped off; caregiver not found).
- Current placement poses an immediate danger to health and/or safety of the individual or others.
- Other family crisis with no caregiver support available.
Specify: _____

Short Term Need (person needs services within 6 months): Y/N

Level 1 Short Term Need (1 - 5)

- 1. There has been a death or other family crisis in the family, significantly jeopardizing the capacity of the caregiver to provide care.
- 2. Caregiver is ill and will soon be unable to continue providing care .
- 3. Person has behavioral issues posing potential serious bodily harm to self or others or behavior is likely to come to the attention of law enforcement.
- 4. Individual's health or behavioral needs have increased and needs cannot be met by current caregivers. Without additional support health and/or safety are jeopardized.

Level 2 Short Term Need (6 - 11)

- 5. Caregiver is ill and will soon be unable to continue to provide care.
- 6. Person has a caregiver(s) who would be unable to work if services are not provided. Person is losing eligibility for DFCS support within the next 6 month
- 7. Person is scheduled to leave jail, prison, DJJ or MHDDAD Forensic services in the next 6 months and does not have an adequate natural support system.
- 8. Caregiver has diminished capacity to meet needs.
- 9. Behavioral issues are moderate to severe but do not currently pose a danger to self or others.
- 10. Person is "aging out" of DFCS residential placement within 6 months and does not have an adequate support system.

Level 3 Short Term Need (12 - 15)

- 11. Inappropriate placement, awaiting proper placement (can manage for a short term).
- 12. Person has an aging caregiver (age 60+) who will soon not be able to continue providing care.
- 13. Person has exited special education or will exit within next 6 months and needs day/employment services
- 14. Circumstances or person or caregiver demonstrate clear need for alternative living arrangements within 6 months. Specify:

**Georgia DHR Division of MHDDAD Developmental Disabilities
Intake Screening Summary**

Planning for Long Term need (person needs services 6 months or more in the future)

- Person is eligible, is not currently in need of services, but will need service if something happens to the caregiver
- Known need for service more than a year away.
Specify: _____
Enter date (/ /)
- Person is "aging out" of DFCS residential placement 6 months to 3 years in the future
Enter date (/ /)
- Person is leaving jail, prison, or other criminal justice setting 6 months or more in the future and will need services when he/she returns to the community.
Enter date (/ /)

V. * Screening Recommendations for Services

<i>Services Needed – Long Term</i>				
<input type="checkbox"/> Residential	<input type="checkbox"/> Day Program	<input type="checkbox"/> Supported Employment	<input type="checkbox"/> Personal Supports	
<input type="checkbox"/> Respite	<input type="checkbox"/> Day Hab	<input type="checkbox"/> NSE	<input type="checkbox"/> Self Directed NSE	<input type="checkbox"/> Family Supports
<input type="checkbox"/> Other (specify): _____				

<i>Services Needed – Short Term</i>				
<input type="checkbox"/> Residential	<input type="checkbox"/> Day Program	<input type="checkbox"/> Supported Employment	<input type="checkbox"/> Personal Supports	
<input type="checkbox"/> Respite	<input type="checkbox"/> Day Hab	<input type="checkbox"/> NSE	<input type="checkbox"/> Self Directed NSE	<input type="checkbox"/> Family Supports
<input type="checkbox"/> Other (specify): _____				
* Eligibility:	* Services:	* More information Needed to determine eligibility:		
Select One...	Select One...	Select One...		

VI. Service Recommendations

* Recommendation/Comments:

	/ /
<i>Staff Completing the Screening (Include Name, Credentials, Position, Title)</i>	<i>Date of Screening</i>

Georgia DHR Division of MHDDAD Developmental Disabilities
Intake Screening Summary

VII. * Regional I&E Office Preliminary Determination

<i>Services Needed – Long Term</i>				
<input type="checkbox"/> Residential	<input type="checkbox"/> Day Program	<input type="checkbox"/> Supported Employment	<input type="checkbox"/> Personal Supports	
<input type="checkbox"/> Respite	<input type="checkbox"/> Day Hab	<input type="checkbox"/> NSE	<input type="checkbox"/> Self Directed NSE	<input type="checkbox"/> Family Supports
<input type="checkbox"/> Other (specify):				

<i>Services Needed – Short Term</i>				
<input type="checkbox"/> Residential	<input type="checkbox"/> Day Program	<input type="checkbox"/> Supported Employment	<input type="checkbox"/> Personal Supports	
<input type="checkbox"/> Respite	<input type="checkbox"/> Day Hab	<input type="checkbox"/> NSE	<input type="checkbox"/> Self Directed NSE	<input type="checkbox"/> Family Supports
<input type="checkbox"/> Other (specify):				

* Eligibility:	* Services:	* More information Needed to determine eligibility:
Select One...	Select One...	Select One...

* Recommendations/Comments:

	/ /
<i>Regional I&E Signature</i>	<i>Date of Determination</i>

Georgia DHR Division of MHDDAD Developmental Disabilities
Intake Screening Summary

VIII. Clinical Information

* Reason for Referral:	
<p><i>Document changes in support needs/living situation/health/etc. that contributed to the request for services at this time (include current daily activities), as well as services to be considered:</i></p>	

* Communication:				
<input type="checkbox"/> No Impairment noted	<input type="checkbox"/> Single Words or Gestures	<input type="checkbox"/> Unable to communicate verbally	<input type="checkbox"/> American Sign Language	<input type="checkbox"/> Utilizes Language Technology
* Referral Source (Check all that apply):				
<input type="checkbox"/> Self	<input type="checkbox"/> DFCS	<input type="checkbox"/> Clergy	<input type="checkbox"/> Physician	<input type="checkbox"/> General Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> State Hospital	<input type="checkbox"/> Criminal Court	<input type="checkbox"/> School	<input type="checkbox"/> Law Enforcement
<input type="checkbox"/> Juvenile Justice	<input type="checkbox"/> Access/Crisis Line	<input type="checkbox"/> Support Coordinator	<input type="checkbox"/> Service Provider	<input type="checkbox"/> Regional Office
Contact Person:		Telephone #:	() -	

* Special Population (Check all that apply):				
<input type="checkbox"/> Vision Impairment	<input type="checkbox"/> Veteran	<input type="checkbox"/> HIV +	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> SSI/Disabled
<input type="checkbox"/> Pregnant	<input type="checkbox"/> IV Drug User	<input type="checkbox"/> None/Not Reported		
* Has the individual previously received MH/AD Brief/Stabilization Services?		<input type="checkbox"/> Yes		<input type="checkbox"/> No
		Date of Last Contact: / /		
		Month/Year		

* Payor/Funding Source (Check all that apply)			
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare	<input type="checkbox"/> Peachcare	<input type="checkbox"/> Champus
<input type="checkbox"/> DJJ	<input type="checkbox"/> DFCS	<input type="checkbox"/> State Contracted Svcs	<input type="checkbox"/> Medicaid Waiver
<input type="checkbox"/> Self Pay	<input type="checkbox"/> Private Insurance If Private, please specify:		

Sources of Information:		
<input type="checkbox"/> Applicant	<input type="checkbox"/> Residential Staff	<input type="checkbox"/> Chart/Records
<input type="checkbox"/> Day Support Staff	<input type="checkbox"/> Support Coordinator	<input type="checkbox"/> Family/Legal Guardian

Georgia DHR Division of MHDDAD Developmental Disabilities
Intake Screening Summary

IX. Financial Status

<i>Current Expenses:</i>	<i>May require help with:</i>	<i>Assisted by</i>
Select One...	<input type="checkbox"/> Purchases	Select One...
	<input type="checkbox"/> Budgeting	
	<input type="checkbox"/> Bills	
<i>House Hold Income (Monthly Gross)</i>		<i>Number of Individuals in Household</i>

X. Educational History

<i>Education Status:</i>				
Select One...				
<i>Check All Completed or Current:</i>				
<input type="checkbox"/> Elementary	<input type="checkbox"/> Middle/Jr. High	<input type="checkbox"/> High School	<input type="checkbox"/> Pursuing GED	<input type="checkbox"/> College
<input type="checkbox"/> Special Education # of years:				
<input type="checkbox"/> * Number of years of Education Completed:				
<input type="checkbox"/> Other (specify):				

XI. Family/Residential/Social/Recreational Supports

<i>Significant life events (within past 2 years) which impact current physical and mental status:</i>	
<i>Current Natural Support System/Community Involvement:</i>	
<i>Check all that apply</i>	<i>Frequency of Contact/Describe</i>
<i>Family</i> <input type="checkbox"/> Not applicable	<input type="checkbox"/> Mother
	<input type="checkbox"/> Father
	<input type="checkbox"/> Grandparents
	<input type="checkbox"/> Siblings
	<input type="checkbox"/> Other
<i>Community Involvement:</i> <input type="checkbox"/> Not applicable	<input type="checkbox"/> Church
	<input type="checkbox"/> Social Clubs
	<input type="checkbox"/> Sports
	<input type="checkbox"/> Other:

Georgia DHR Division of MHDDAD Developmental Disabilities
Intake Screening Summary

Describe individual's current living situation (include family makeup/involvement/home environment):

Select One...

XII. Functional Abilities/Activities of Daily Living

Rate (using this number system) current functional ability to accomplish the following daily living activities/skills and provide details below:

1: Total Assistance Needed 2: Assistance by more than one person 3: Assistance with one person
4: Needs Assistive/Adaptive Equipment 5: Performs with Verbal Prompts 6: Independent

Rate	Task	Rate	Task	Rate	Task	Rate	Task	Rate	Task
	Eating		Dressing		Bathing		Toileting		Grooming
	Walking		Transfer		Meal Prep		Housekeeping		Money Management
	Nutritional Habits		Shopping		Health Monitoring		Medication Administration & Management		Laundry
	Mobility		Travel						

Description of Skills

XIII. Developmental History & Milestones

Prenatal History and noted Developmental Delays: (include at what age, loss/improvement of skills etc.)

Milestones

<i>Approximate Age Individual when:</i>	<i>Sat unassisted</i>		<i>Crawled</i>		<i>Walked</i>	
	<i>Talked</i>		<i>Toilet Trained</i>			

Georgia DHR Division of MHDDAD Developmental Disabilities
Intake Screening Summary

XIV. Behavioral Assessment

<i>Check all that apply</i>	<i>Frequency/Describe</i>			
<i>Self Injurious Behaviors</i> <input type="checkbox"/> Not applicable	<input type="checkbox"/> Biting			
	<input type="checkbox"/> Scratching			
	<input type="checkbox"/> Head banging			
	<input type="checkbox"/> Other:			
<i>Aggressive Behaviors</i> <input type="checkbox"/> Not applicable	<input type="checkbox"/> Physical towards others			
	<input type="checkbox"/> Verbal			
	<input type="checkbox"/> Sexual			
<i>Touching Behaviors</i> <input type="checkbox"/> Not applicable	<input type="checkbox"/> Inappropriate Greetings			
	<input type="checkbox"/> Hugging			
	<input type="checkbox"/> Kissing			
<i>Inappropriate Behaviors</i> <input type="checkbox"/> Not applicable	<input type="checkbox"/> Self-stimulation	<input type="checkbox"/> Towards Others	<input type="checkbox"/> Displays in Public	<input type="checkbox"/> Other
<i>Other Behaviors & Symptoms</i> <input type="checkbox"/> Not applicable	<input type="checkbox"/> Hypersomnia	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Reclusive
	<input type="checkbox"/> Destructive	<input type="checkbox"/> Hoarding	<input type="checkbox"/> Excessive Complaints	<input type="checkbox"/> Anxious
	<input type="checkbox"/> Angry	<input type="checkbox"/> Bladder Incontinence	<input type="checkbox"/> Uncooperative	<input type="checkbox"/> Refuses Medications
	<input type="checkbox"/> Irritable	<input type="checkbox"/> Bowel Incontinence	<input type="checkbox"/> Stealing	<input type="checkbox"/> Requires Restraints
	<input type="checkbox"/> Confused	<input type="checkbox"/> Suspicious	<input type="checkbox"/> Restless	<input type="checkbox"/> Wandering
	Ideations: <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal	Plan: Means:	Attempts <input type="checkbox"/> Suicide <input type="checkbox"/> Homicidal	# of Times: Method:
<i>* Type of Substances Used</i>	<i>* Employment Status</i>	<i>Reason not in work force</i>	<i>Non-Competitive Work</i>	
Select One...	Select One...	Select One...	Select One...	
<i>Additional Information: (include any psychiatric symptoms/history noted)</i>				

Georgia DHR Division of MHDDAD Developmental Disabilities
Intake Screening Summary

XV. Legal Status

<i>* Legal Status</i> <i>(Check one)</i>	<input type="checkbox"/> Voluntary		<input type="checkbox"/> Involuntary	
<i>Legal Custody</i> <i>(Check all that apply)</i>	<input type="checkbox"/> DFCS Custody		<input type="checkbox"/> Other Court-Appointed Guardian	
<i>Legal Involvement</i> <i>(Check all that apply)</i>	<input type="checkbox"/> DFCS	<input type="checkbox"/> Juvenile Justice	<input type="checkbox"/> Treatment Court (MH/AD)	<input type="checkbox"/> Probate Court
	<input type="checkbox"/> Jail/Law Enforcement	<input type="checkbox"/> Adult Criminal Court	<input type="checkbox"/> Adult Probation	<input type="checkbox"/> Parole
<i>Agency Requiring Consumer to Obtain Services</i> <i>(Check all that apply)</i>	<input type="checkbox"/> DFCS	<input type="checkbox"/> Juvenile Justice	<input type="checkbox"/> Treatment Court (MH/AD)	<input type="checkbox"/> Probate Court
	<input type="checkbox"/> Jail/Law Enforcement	<input type="checkbox"/> Adult Criminal Court	<input type="checkbox"/> Adult Probation	<input type="checkbox"/> Parole
<i>* Justice System Involvement</i>	Has consumer been involved with criminal/juvenile justice system in the past year? (Includes arrests, probation, parole, commitments, adjudications, diversions, or awaiting sentencing) <input type="checkbox"/> Yes <input type="checkbox"/> No			
<i>* Arrests</i>	Number of arrests, regardless of nature of offense or outcome, in the past 30 days.			

	/ /
<i>Staff Completing the Screening (Include Name, Credentials, Position, Title)</i>	<i>Date of Screening</i>

ANNUAL HEALTH EXAMINATION

PART I: To be completed by the provider agency prior to the physician visit

Full Name		Preferred Name		Gender
Address		City	County	Zip
Telephones	Home	Work/Day	Other	
Age	DOB	Race/Ethnicity	Marital Status	
Religious Preference		Legal Status: Guardian		

Contacts/Next of Kin (if minor or adjudicated, parent or legal guardian)

Name	Relationship	Legal Guardian Y N	
Address			
Telephones	Home	Work	Cell

Allergies (if none specify NKA)

Type of Allergy	Specific Allergy
Medication	
Food	
Insect Bites/Stings	
Other Allergies	

Current Medication Summary: List all medications currently ordered for the person.

Medication Name	Dosage/Route/Frequency	Purpose of Medication	Ordered By	Original Date Ordered	Specific Concerns

Illness/ Surgery/Hospitalization Date Illness/surgery/Hospitalization Date

Chronic and ongoing medical issues, including how it affects the person's life.

Description of the issue or concern causing the physician visit including how it is affecting the person. Bring tracking documents if applicable, such as vital signs, frequent use of PRN medications, etc.

Additional information that might be pertinent to the issue, concern or that would be helpful to know about the person

Part I completed by _____ Date _____

+++++

Part II: To be completed by Physician, Physician's Assistant, MD completing annual health exam

SUMMARY OF FINDINGS

TREATMENTS ORDERED

MEDICATIONS ORDERED

INSTRUCTIONS/PRECAUTIONS/LIMITATIONS

FOLLOW-UP REQUIRED INCLUDING RETURN VISIT

ADDITIONAL COMMENTS.

Date _____
Health Care Staff Signature _____
(MD, Physician's Assistant, Nurse Practitioner)

PART III: Agency Review of Annual Health Exam. Describe follow-up within provider agency.

Date _____
Staff Signature/Title _____

Part I

Eligibility, Service Definitions and Requirements

SECTION IV

***Consumer Eligibility, Service
Definition and Service
Guidelines***

For

Other Specialty Services

Fiscal Year 2012



**Georgia Department of Behavioral Health
& Developmental Disabilities**

October 2011

Treatment Court Services

Definition of Service: Treatment Courts are specialized judicial forums designed to facilitate treatment for first-time, non-violent offenders with addictive diseases and/or mental illness. Treatment Courts combine intense judicial supervision, comprehensive substance abuse and/or mental health treatment, random and frequent drug testing, incentives and sanctions, clinical case management and ancillary services. A variety of different services are available through treatment courts:

- Treatment Courts – Screening, Outreach & Crisis Services
- Treatment Courts – Outpatient Services
- Treatment Courts – Day & Employment Services
- Treatment Courts – Residential Services

Please refer to the service definitions following for details.

Treatment Courts: Screening, Crisis & Outreach Services (Mental Health & Addictive Diseases)

Definition of Service: The intent of these services is to assess the needs of individuals served, development service plan, refer to appropriate services, and address crisis situations as needed. These services may include: initial screening, diagnostic evaluation, outreach referral and/or crisis intervention.

Target Population:	Adults with mental health and/or substance abuse issues who are directed to services through treatment courts.
Expected Benefit:	Reduction of symptoms and improvement in quality of life resulting in decreased or no involvement with the criminal justice system.
UAS: Budget and Expense Categories	115 – Adult Mental Health 715 – Adult Addictive Diseases

Additional Service Information:

1. Providers who deliver screening, crisis and outreach services under Treatment Court contracts should report expenses for those services using the appropriate UAS budget codes listed above, not the 100 or 700 budget codes.
2. Screening, crisis and outreach services provided under Treatment Court contracts should be reported to MHMRIS using only the subunits listed above and no other subunits.
3. A provider may report screening, crisis and outreach expenses and services using budget codes and subunits other than those listed above only for services that are not provided under Treatment Court contracts.

Treatment Courts: Outpatient Services (Mental Health & Addictive Diseases)

Definition of Service: These services shall be provided as needed to individuals receiving services through treatment courts and may include: individual, group and family counseling, ambulatory detoxification, community support services, physician and nursing assessment to address the issues that led to involvement in the criminal justice system.

Target Population:	Adults with mental health and/or substance abuse issues who are directed to services through treatment courts.
Expected Benefit:	Reduction of symptoms and improvement in quality of life resulting in decreased or no involvement with the criminal justice system.
UAS: Budget and Expense Categories	115 – Adult Mental Health 715 – Adult Addictive Diseases

Additional Service Information:

1. Providers who deliver outpatient services under Treatment Court contracts should report expenses for those services using the appropriate UAS budget codes listed above, not the 100 or 700 budget codes.
2. Outpatient services provided under Treatment Court contracts should be reported to MHMRIS using only the subunits listed above and no other subunits.
3. A provider may report outpatient expenses and services using budget codes and subunits other than those listed above only for services that are not provided under Treatment Court contracts.

Treatment Courts: Day & Employment Services (Mental Health & Addictive Diseases)

Definition of Service: These services are intended for individuals with more severe issues and may include the following services: substance abuse day treatment, peer support, psychosocial rehabilitation services and community-based employment services.

Target Population:	Adults with mental health and/or substance abuse issues who are directed to services through treatment courts.
Expected Benefit:	Reduction of symptoms and improvement in quality of life resulting in decreased or no involvement with the criminal justice system.
UAS: Budget and Expense Categories	115 – Adult Mental Health 715 – Adult Addictive Diseases

Additional Service Information:

1. Providers who deliver day and employment services under Treatment Court contracts should report expenses for those services using the appropriate UAS budget codes listed above, not the 100 or 700 budget codes.
2. Day and employment services provided under Treatment Court contracts should be reported to UAS using only the categories above.

3. A provider may report day and employment expenses and services using budget codes and subunits other than those listed above only for services that are not provided under Treatment Court contracts.

Treatment Courts: Residential Services (Mental Health & Addictive Diseases)
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Definition of Service: These services shall be provided to individuals served by treatment courts and may include a wide variety of residential treatment options based on the needs of the individual served.

Target Population:	Adults with mental health and/or substance abuse issues who are directed to services through treatment courts.
Expected Benefit:	Reduction of symptoms and improvement in quality of life resulting in decreased or no involvement with the criminal justice system.
UAS: Budget and Expense Categories	115 – Adult Mental Health 715 – Adult Addictive Diseases

Additional Service Information:

1. Providers who deliver residential services under Treatment Court contracts should report expenses for those services using the appropriate UAS budget codes listed above, not the 100 or 700 budget codes.
2. Residential services provided under Treatment Court contracts should be reported to MHMRIS using only the subunits listed above and no other subunits.
3. A provider may report residential expenses and services using budget codes and subunits other than those listed above only for services that are not provided under Treatment Court contracts.

Ready For Work: Outpatient Services							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
See Item E.2. Below							

Definition of Service: Ready for Work Intensive Outpatient Services will provide comprehensive gender specific treatment for addiction, beginning with ASAM level II.5 (at least 20 hours/week) that includes: substance abuse treatment, group and individual therapy, outreach, parenting, family involvement, recovery group attendance, psycho education, pharmacotherapy, relapse prevention, trauma groups, and ongoing treatment and aftercare. All components of gender specific treatment should be included. This program is designed for those who meet the TANF needy family definition in order to promote employment, parenting and other life skills. Limited slots are available for Non-TANF individual's who meet the most in need criteria or core customer definition and would benefit from gender specific services.

The services that the Ready for Work Intensive Outpatient Package will include are as follows:

1. Behavioral Health Assessment
2. Nursing Assessment
3. Psychiatric Treatment
4. Diagnostic Assessment
5. Consumer Support Services
6. Individual Counseling
7. Group Counseling (including psycho-educational groups focusing, relapse prevention and recovery)
8. Family Counseling/Psycho-Educational Groups for Family Members

RFW Providers that are eligible to bill Medicaid for services provided in an outpatient program may bill for the unbundled services listed in the package, up to the daily maximum amount for each service. Although not all services provided in outpatient services are Medicaid billable, the program expectations for services are clearly defined in the Ready For Work Manual.

A consumer may have variable length of stay. The level of care should be determined as a result of consumers' multiple assessments. It is recommended that individuals attend at a frequency appropriate to their level of need. Ongoing clinical assessment should be conducted to determine step down in level of care and/or addition of other ancillary services.

In addition to the MHDDAD Provider Manual guidelines, all RFW Providers must adhere to the Ready for Work Program Manual.

Target Population	Adult women who are diagnosed with substance abuse disorders who may or may not be receiving TANF cash assistance, a child welfare case, or have children in their custody
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Benefit Information	Available to all ongoing core customers, requires a MICP New Episode Request or Update request (to add as a single service to an existing authorization)
Utilization Criteria	<u>Available to those with LOCUS Scores:</u> 2: Low Intensity Community Based Services 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential (transition)
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner).
Unit Value	See Item E.2.
Initial Authorization	180 days
Re-Authorization	180 days
Maximum Daily Units	See Item E.2.
Authorization Period	180 days
UAS: Budget and Expense Categories	Adult Addictive Diseases: SAPT BG: 620 TANF: 621 State Funds: 622
Admission Criteria	<ol style="list-style-type: none"> 1. A DSM IV diagnosis of Substance Abuse or Dependence or substance-related disorder with a co-occurring DSM IV diagnosis of mental illness 2. Substance abuse is a barrier to employability 3. The individual would benefit from participating in a women's program to process gender specific issues associated with addiction and recovery <p>TANF Criteria:</p> <ol style="list-style-type: none"> 1. Consumer must meet the DFCS definition for "Needy Family". To meet this definition the individuals must meet one of three non-financial criteria and one financial requirement <ol style="list-style-type: none"> a. Current TANF Recipients- Individuals with active TANF cash assistance cases b. Former TANF Recipients- Individuals whose TANF assistance with terminated within the previous twelve months due to employment c. Families at Risk- Individuals with active DFCS child protective cases 2. Financial Criteria. The limit for the RFW program is set at 235% of the Federal Poverty Level for individuals who are not eligible for TANF cash assistance. <p>Non-TANF Criteria: Consumers determined to be Non-TANF and not eligible for services in the above criteria but do meet the core customer definition may be served with limited service slots funded with SAPTBG Federal funds. A consumer is determined Non-TANF if:</p> <ol style="list-style-type: none"> 1. A woman pregnant for the first time 2. A woman who has lost parental custody of her children, i.e. is not

	<p>working on reunification</p> <p>3. A woman who is not associated with DFCS (TANF or CPS), meets core customer definition and would benefit from gender specific treatment</p> <p>Prioritization Criteria for Eligible Recipients</p> <ol style="list-style-type: none"> 1. Pregnant women will be given priority status for admission to this program. If no slots are available for this program, preference must be given to admitting her to another appropriate program, even if out of catchment area. If a provider is unable to admit a pregnant consumer, provider must place her on a waiting list and within 48 hours pregnant consumer must be in a program. 2. High priority is given to women who meet the Needy Family Definition. <p>Preference is to be given to those women who are in a condition to benefit most from the services and opportunities provided by this program.</p>
<p>Continuing Stay Criteria</p>	<ol style="list-style-type: none"> 1. The individual's condition continues to meet the admission criteria. 2. Progress notes document progress in reducing use and abuse of substances; developing social networks and lifestyle changes; increasing educational, vocational, social and interpersonal skills; understanding addictive disease; and/or establishing a commitment to a recovery and maintenance program, but the overall goals of the treatment plan have not been met. 3. There is a reasonable expectation that the individual can achieve the goals in the necessary time frame.
<p>Discharge Criteria</p>	<p>An adequate continuing care or discharge plan is established and linkages are in place; and one or more of the following:</p> <ol style="list-style-type: none"> 1. Goals of the treatment plan have been substantially met; or 2. Consumer recognizes the severity of her drug/alcohol usage and is beginning to apply the skills necessary to maintain recovery by accessing appropriate community supports 3. If a consumer is involved with DFCS or another referring agency a discharge staffing should be completed in collaboration both RFW and other referring organization. 4. Receiving recommended prenatal care if pregnant 5. Deliver a drug free baby if pregnant 6. If consumer is staffed to be discharged before clinically appropriate, a clinical staffing must be completed and provide the following information: documented reason for early discharge, and an aftercare plan. <p>Transfer to a higher level of service is warranted if:</p> <ol style="list-style-type: none"> 1. Individual's condition or nonparticipation; or 2. The individual refuses to submit or has positive random drug screens; or 3. Consumer exhibits symptoms of acute intoxication and/or

	<p>withdrawal or</p> <ol style="list-style-type: none"> 4. The individual requires services not available at this level or 5. Consumer has consistently failed to achieve essential treatment objectives despite revisions to the treatment plan and advice concerning the consequences of continues alcohol/drug use to such an extent that no further process is likely to occur
Service Exclusions	Services cannot be offered with Mental Health Intensive Outpatient Package, Psychosocial Rehabilitation, or other Residential treatment service.
Clinical Exclusions	<ol style="list-style-type: none"> 1. If an individual is actively suicidal or homicidal 2. Women should have no cognitive and/or intellectual impairments which will prevent them from participating in and benefiting from the recommended level of care 3. Detoxification and inpatient needs must be met prior to admission to the program (alternative provider and/or community resources should be used to serve women with acute treatment needs) 4. Women must be medically stable to treat on an outpatient basis

A. Required Components

1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. Ready For Work Intensive Outpatient Services must have at least 3 levels of care. II.5 (20 hrs/week), II.1 (10 or more hrs), and Level I (9 or less hours). Hours of operation should be accommodating for consumers who work (i.e. evening/weekend hours)
3. Evidence based practices are to be utilized. These may include Motivational Interviewing/Enhancement, stage-based interventions, refusal skill development, Cognitive Behavioral Therapy, Matrix model, TREM. Relapse prevention planning and techniques, and others as appropriate to the individual and issues to be addressed. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices.
4. The program provides structured treatment or therapeutic services, utilizing activity schedules as part of its operational method, i.e., plans or schedules of days or times of day for certain activities. The program should also utilize group and/or individual counseling and/or therapy.
5. The program utilizes methods, materials, settings, and outside resources appropriate to the developmental and cognitive levels, capabilities, age, and gender of participants.
6. The program utilizes methods, materials, approaches, activities, settings, and outside resources appropriate for and targeted to individuals with co-occurring disorders of mental illness and substance abuse and targeted to individuals with co-occurring developmental disabilities and substance abuse when such individuals are referred to the program.
7. The program conducts random drug screening and uses the results of these tests for marking consumers' progress toward goals and for service planning.
8. This service must operate at an established site approved to bill Medicaid for services. However, limited individual or group activities may take place off-site in natural community settings as is appropriate to each individual's treatment plan.

- a. Narcotics Anonymous (NA) and/or Alcoholics Anonymous (AA) meetings offsite may be considered part of these limited individual or group activities for billing purposes only when time limited and only when the purpose of the activity is introduction of the participating individual to available NA and/or AA services, groups or sponsors. NA and AA meetings occurring during the SA Intensive Outpatient package may not be counted toward the billable hours for any individual outpatient services, nor may billing related to these meetings be counted beyond the basic introduction of an individual to the NA/AA experience.
9. RFW services may operate in the same building as other services; however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the RFW Intensive Outpatient Services is in operation.
10. Adequate space, equipment, furnishings, supplies, and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for participating individuals' use within the Substance Abuse Intensive Outpatient package must not be substantially different from that provided for other uses for similar numbers of individuals.

B. Staffing Requirements

1. The program must be under the clinical supervision of a **Level 4 or above** who is onsite a minimum of 50% of the hours the service is in operation.
2. Services must be provided by staff who are:
 - a. Level 4 (LAPC, LMSW, CACII, CADC, CCADC and Addiction Counselor Trainee with supervision)
 - b. Level 5 (Paraprofessionals, high school graduates) under the supervision of an Level 4 or above
3. Programs must have documentation that there is one Level 4 staff that is "co-occurring capable." This person's knowledge must go beyond basic understanding and must demonstrate actual staff capabilities in using that knowledge for individuals with co-occurring disorders. Personnel documentation should demonstrate that this staff person has received a minimum of 5 hours/year of training in co-occurring treatment. Effective January 1, 2010, programs must have documentation that there is at least 1 level 4 staff (excluding an Addiction Counselor Trainee) that is "co-occurring capable."
4. There must be at least a Level 4 on-site at all times the service is in operation, regardless of the number of individuals participating.
5. The maximum face-to-face ratio cannot be more than 12 individuals to 1 direct program staff based on average daily attendance of individuals in the program.
6. A physician and/or a Registered Nurse or a Licensed Practical Nurse with appropriate supervision must be available to the program either by a physician and/or nurse employed by the agency, through a contract with a licensed practitioner, or by written referral or affiliation agreement with another agency or agencies that offer such services.
 - a. The physician is responsible for addiction and psychiatric consultation, assessment, and care (including but not limited to ordering medications and/or laboratory testing) as needed. The nurse is responsible for nursing assessments, health screening, medication administration, health education, and other nursing duties as needed.

7. Level 4 staff may be shared with other programs as long as they are available as required for supervision and clinical operations and as long as their time is appropriately allocated to staffing ratios for each program.

C. Clinical Operations

1. It is expected that the transition planning for less intensive service will begin at the onset of RFW services. Documentation must demonstrate this planning.
2. Consumers receiving RFW Outpatient services must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis.
3. Each consumer should participate in setting individualized goals for themselves and in assessing their own skills and resources related to sobriety, use/abuse, and maintaining recovery. Goals are set by exploring strengths and needs in the consumer's living, learning, social, and working environments. Implementation of services may take place individually or in groups.
4. As mentioned above RFW Outpatient Services must have different phases of treatment for consumers. These levels are to be assessed regularly and highly individualized. In the beginning phase of treatment, the consumers are to receive intensive substance abuse treatment and when clinically appropriate receive less substance abuse services and more wrap around services. Primary work or work related activities should be implemented in to treatment no later than 90 days from admission. Services to include documentation of an assessment of work skills, abilities, and all work activities taking place, and if clinically appropriate the initiation of work activities. If not clinically appropriate for a consumer to engage in work related activities, it must be documented.

The following services must be included in the Ready For Work Outpatient Program, many of these activities are reimbursable through Medicaid. RFW Services are required to have a multitude of wrap around services, see RFW Provider manual for a description.

The activities include but are not limited to:

- a. **Group Outpatient Services:**
 - i. Psycho-educational activities focusing on the disease of addiction prevention, the health consequences of addiction, and recovery
 - ii. Therapeutic group treatment and counseling
 - iii. Parenting groups
 - iv. Trauma group
 - v. Linkage to natural supports and self-help opportunities
- b. **Individual Outpatient Services**
 - i. Individual counseling
 - ii. Individualized treatment, service, and recovery planning
- c. **Family Outpatient Services**
 - i. Family education and engagement
 - ii. Nurturing parenting
- d. **Community Support Individual**
 - i. Vocational readiness and support
 - ii. Service coordination unless provided through another service provider
 - iii. Life skills training (i.e. education on healthy eating habits, hygiene)

- iv. Continuing Care: Providers need to have at least 7 contacts per month one of which must be a face-to-face interaction with a consumer (If CSI is billed as a discrete service it must meet that guideline's additional requirements)
 - v. Linkage to health care
 - e. **Behavioral Health Assessment & Service Plan Development and Diagnostic Assessment**
 - i. Assessment and reassessment
 - ii. Service Plan Development
 - f. **Services not covered by Medicaid**
 - i. Drug screening/toxicology examinations
 - ii. Transportation
 - iii. Work Activities
5. In addition to the above required activities within the program, the following must be offered as needed either within the program or through referral to/or affiliation with another agency or practitioner, and may be billed in addition to the billing for Substance Abuse Intensive Outpatient Package:
- a. Individual counseling in exceptional circumstances for traumatic stress and other mental illnesses for which special skills or licenses are required
 - b. Physician assessment and care
 - c. Psychological testing
 - d. Health screening
6. The program must have a Ready for Work Outpatient Services Organizational Plan addressing the following:
- a. The philosophical model of the program and the expected outcomes for program participants (i.e., harm reduction, abstinence, beginning of or maintaining individually defined recovery, employment readiness, relapse prevention, stabilization and treatment of those with co-occurring disorders).
 - b. The schedule of activities and hours of operations.
 - c. Staffing patterns for the program.
 - d. How assessments will be conducted.
 - e. How staff will be trained in the administration of addiction services and technologies.
 - f. How staff will be trained in the recognition and treatment of co-occurring disorders of mental illness and substance abuse pursuant to the Georgia Best Practices
 - g. How services for individuals with co-occurring disorders will be flexible and will include services and activities addressing both mental health and substance abuse issues of varying intensities and dosages based on the symptoms, presenting problems, functioning, and capabilities of such individuals.
 - h. How individuals with co-occurring disorders who cannot be served in the regular program activities will be provided and/or referred for time-limited special integrated services that are co-occurring enhanced as described in the Georgia Suggested Best Practices
 - i. How services will be coordinated with the substance abuse array of services including assuring or arranging for appropriate referrals and transitions.
 - j. How the requirements in these service guidelines will be met.

D. Service Access

The package is offered at least 5 hours per day at least 4 days per week with no more than 2 consecutive days between offered services, and distinguishes between those individuals needing between 9 and 20 hours per week of structured services per week (ASAM Level II.1) and those needing 20 hours or more of structured services per week (ASAM Level II.5 or III.1) in order to begin recovery and learn skills for recovery maintenance.

E. Additional Medicaid Requirements

1. Work activities referenced in Item C.4. may not be billed to the Medicaid authority via services identified in E.2. below.
2. RFW Outpatient providers that are Medicaid approved and serving Medicaid consumers shall utilize the RFW Intensive Outpatient Package. This allows providers to select all services that will be offered in a substance abuse outpatient setting. Billable services and daily limits within RFW Intensive Outpatient Package are as follows:

Package	Service Group	Maximum Authorization Units	Maximum Daily Units
RFW Intensive Outpatient	Behavioral Health Assessment & Service Plan Development	32	24
P0008	Diagnostic Assessment	4	2
	Psychiatric Treatment	12	1
	Nursing Assessment & Care	48	16
	Community Support Individual	600	48
	Individual Outpatient Services	36	1
	Group Outpatient Services	1170	20
	Family Outpatient Services	100	8

F. Billing/Reporting Requirements

1. All applicable Medicaid, MICP, and other DBHDD reporting requirements must be met.
2. Under the "Package," each service must meet the requirements of the Service Group in order for the service to be billed (refer to Part I, Section I of this manual)

G. Documentation Requirements

1. Provider must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.
2. Every admission and assessment must be documented.
3. Progress notes must include written daily documentation of important occurrences; level of functioning; acquisition of skills necessary for recovery; progress on goals identified in the IRP including acknowledgement of addiction, progress toward recovery and use/abuse reduction and/or abstinence; use of drug screening results by staff; and evaluation of service effectiveness. Clinicians are to sign and date each note.
4. Daily attendance of each individual participating in the program must be documented showing the number of units in attendance for billing purposes.

5. This service may be offered in conjunction with ACT or Crisis Residential Services for a limited time to transition consumers from one service to the more appropriate one. When this service is used in conjunction with ACT or Crisis Residential services, documentation must demonstrate careful planning to maximize the effectiveness of this service as well as an appropriate reduction in service amounts of the service to be discontinued. Utilization of Ready for Work Outpatient Services with these services is subject to review by the External Review Organization.

Ready For Work Independent Living Supports (SafePort, TANF A/P)							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
See Item E.2. Below							
<p>Definition of Service: Ready for Work Independent Living Support Services will provide comprehensive gender specific treatment for addiction, beginning with ASAM level II.5 (at least 20 hours/week) that includes: substance abuse treatment, group and individual therapy, outreach, parenting, family involvement, recovery group attendance, psycho education, pharmacotherapy, relapse prevention, trauma groups, and ongoing treatment and aftercare. All components of gender specific treatment should be included. This program is designed for those who meet the TANF needy family definition in order to promote employment, parenting and other life skills. Limited slots are available for Non-TANF individual's who meet the most in need criteria or core customer definition and would benefit from gender specific services. Independent Living Support Services must have safe and secure housing for consumers. This housing can be funded through another organization or state agency. Independent living services can utilize the Substance Abuse Intensive Outpatient Package.</p> <p>The services that the RFW Intensive Outpatient Package will include are as follows:</p> <ol style="list-style-type: none"> 1. Behavioral Health Assessment 2. Nursing Assessment 3. Psychiatric Treatment 4. Diagnostic Assessment 5. Consumer Support Individual Services 6. Individual Counseling 7. Group Counseling (including psycho-educational groups focusing, relapse prevention and recovery) 8. Family Counseling/Psycho-Educational Groups for Family Members <p>RFW Providers that are eligible to bill Medicaid for services provided in an outpatient program may bill for the unbundled services listed in the package, up to the daily maximum amount for each service. Although not all services provided in outpatient services are Medicaid billable, the program expectations for services are clearly defined in the Ready For Work Manual.</p> <p>A consumer may have variable length of stay. The level of care should be determined as a result of consumers' multiple assessments. It is recommended that individuals attend at a frequency appropriate to their level of need. Ongoing clinical assessment should be conducted to determine step down in level of care and/or addition of other ancillary services.</p> <p>In addition to the MHDDAD Provider Manual guidelines, all RFW Providers must adhere to the Ready for Work Program Manual.</p>							

Target Population	Adult women who are diagnosed with substance abuse disorders who may or may not be receiving TANF cash assistance, a child welfare case, or have children in their custody
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Benefit Information	Available to all ongoing core customers, requires a MICP New Episode Request or Update request (to add as a single service to an existing authorization)
Utilization Criteria	<u>Available to those with LOCUS Scores:</u> 3: High Intensity Community-Based Services 4: Medically Monitored Non-Residential (transition) 5: Medically Monitored Residential Services
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner).
Unit Value	See Item E.2.
Initial Authorization	180 days
Re-Authorization	180 days
Maximum Daily Units	See Item E.2.
Authorization Period	180 days
UAS: Budget and Expense Categories	See Item E.2. and <u>Adult Addictive Diseases: 627, 626</u>
Admission Criteria	<ol style="list-style-type: none"> 1. A DSM IV diagnosis of Substance Abuse or Dependence or substance-related disorder with a co-occurring DSM IV diagnosis of mental illness 2. Substance abuse is a barrier to employability 3. The individual would benefit from participating in a women's program to process gender specific issues associated with addiction and recovery <p>TANF Criteria:</p> <ol style="list-style-type: none"> 1. Consumer must meet the DFCS definition for "Needy Family". To meet this definition the individuals must meet one of three non-financial criteria and one financial requirement <ol style="list-style-type: none"> a. Current TANF Recipients- Individuals with active TANF cash assistance cases b. Former TANF Recipients- Individuals whose TANF assistance with terminated within the previous twelve months due to employment c. Families at Risk- Individuals with active DFCS child protective cases 2. Financial Criteria. The limit for the RFW program is set at 235% of the Federal Poverty Level for individuals who are not eligible for TANF cash assistance. <p>Non-TANF Criteria: Consumers determined to be Non-TANF and not eligible for services in the above criteria but do meet the core customer definition may be served with limited service slots funded with SAPTBG Federal funds. A consumer is determined Non-TANF if:</p> <ol style="list-style-type: none"> 1. A woman pregnant for the first time 2. A woman who has lost parental custody of her children, i.e. is not

	<p>working on reunification</p> <p>3. A woman who is not associated with DFCS (TANF or CPS), meets core customer definition and would benefit from gender specific treatment</p> <p>Prioritization Criteria for Eligible Recipients</p> <ol style="list-style-type: none"> 1. Pregnant women will be given priority status for admission to this program. If no slots are available for this program, preference must be given to admitting her to another appropriate program, even if out of catchment area. If a provider is unable to admit a pregnant consumer, provider must place her on a waiting list and within 48 hours pregnant consumer must be in a program. 2. High priority is given to women who meet the Needy Family Definition. <p>Preference is to be given to those women who are in a condition to benefit most from the services and opportunities provided by this program.</p>
<p>Continuing Stay Criteria</p>	<ol style="list-style-type: none"> 1. The individual's condition continues to meet the admission criteria. 2. Progress notes document progress in reducing use and abuse of substances; developing social networks and lifestyle changes; increasing educational, vocational, social and interpersonal skills; understanding addictive disease; and/or establishing a commitment to a recovery and maintenance program, but the overall goals of the treatment plan have not been met. 3. There is a reasonable expectation that the individual can achieve the goals in the necessary time frame.
<p>Discharge Criteria</p>	<p>An adequate continuing care or discharge plan is established and linkages are in place; and one or more of the following:</p> <ol style="list-style-type: none"> 1. Goals of the treatment plan have been substantially met; or 2. Consumer recognizes the severity of her drug/alcohol usage and is beginning to apply the skills necessary to maintain recovery by accessing appropriate community supports 3. If a consumer is involved with DFCS or another referring agency a discharge staffing should be completed in collaboration both RFW and other referring organization. 4. Receiving recommended prenatal care if pregnant 5. Deliver a drug free baby if pregnant 6. If consumer is staffed to be discharged before clinically appropriate, a clinical staffing must be completed and provide the following information: documented reason for early discharge, and an aftercare plan. <p>Transfer to a higher level of service is warranted if:</p> <ol style="list-style-type: none"> 1. Individual's condition or nonparticipation; or 2. The individual refuses to submit or has positive random drug screens; or 3. Consumer exhibits symptoms of acute intoxication and/or

	<p>withdrawal or</p> <ol style="list-style-type: none"> 4. The individual requires services not available at this level or 5. Consumer has consistently failed to achieve essential treatment objectives despite revisions to the treatment plan and advice concerning the consequences of continues alcohol/drug use to such an extent that no further process is likely to occur
Service Exclusions	Services cannot be offered with Mental Health Intensive Outpatient Package, Psychosocial Rehabilitation or any Residential treatment service.
Clinical Exclusions	<ol style="list-style-type: none"> 1. If an individual is actively suicidal or homicidal 2. Women should have no cognitive and/or intellectual impairments which will prevent them from participating in and benefiting from the recommended level of care 3. Detoxification and inpatient needs must be met prior to admission to the program (alternative provider and/or community resources should be used to serve women with acute treatment needs) 4. Women must be medically stable.

A. Required Components

1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. RFW Independent Living Services are mandated to have safe and secure housing for consumers. This housing may be funded through other state agencies or organizations.
3. Ready For Work Independent Living Services must have at least 3 levels of care. II.5 (20 hrs/week), II.1 (10 or more hrs), and Level I (9 or more hours). Hours of operation should be accommodating for consumers who work (i.e. evening/weekend hours)
4. Evidence based practices are to be utilized. These may include Motivational Interviewing/Enhancement, stage-based interventions, refusal skill development, Cognitive Behavioral Therapy, Matrix model, TREM. Relapse prevention planning and techniques, and others as appropriate to the individual and issues to be addressed. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices.
5. The program provides structured treatment or therapeutic services, utilizing activity schedules as part of its operational method, i.e., plans or schedules of days or times of day for certain activities. The program should also utilize group and/or individual counseling and/or therapy.
6. The program utilizes methods, materials, settings, and outside resources appropriate to the developmental and cognitive levels, capabilities, age, and gender of participants.
7. The program utilizes methods, materials, approaches, activities, settings, and outside resources appropriate for and targeted to individuals with co-occurring disorders of mental illness and substance abuse and targeted to individuals with co-occurring developmental disabilities and substance abuse when such individuals are referred to the program.
8. The program conducts random drug screening and uses the results of these tests for marking consumers' progress toward goals and for service planning.

9. This service must operate at an established site approved to bill Medicaid for services. However, limited individual or group activities may take place off-site in natural community settings as is appropriate to each individual's treatment plan.
 - a. Narcotics Anonymous (NA) and/or Alcoholics Anonymous (AA) meetings offsite may be considered part of these limited individual or group activities for billing purposes only when time limited and only when the purpose of the activity is introduction of the participating individual to available NA and/or AA services, groups or sponsors. NA and AA meetings occurring during the SA Intensive Outpatient package may not be counted toward the billable hours for any individual outpatient services, nor may billing related to these meetings be counted beyond the basic introduction of an individual to the NA/AA experience.
10. RFW services may operate in the same building as other services; however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the RFW Independent Living Services is in operation.
11. Adequate space, equipment, furnishings, supplies, and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for participating individuals' use within the Substance Abuse Intensive Outpatient package must not be substantially different from that provided for other uses for similar numbers of individuals.

B. Staffing Requirements

1. The program must be under the clinical supervision of a **Level 4 or above** who is onsite a minimum of 50% of the hours the service is in operation.
2. Services must be provided by staff who are:
3. Level 4 (LAPC, LMSW, CACII, CADC, CCADC and Addiction Counselor Trainee with supervision)
4. Level 5 (Paraprofessionals, high school graduates) under the supervision of an Level 4 or above
5. Programs must have documentation that there is one Level 4 staff that is "co-occurring capable." This person's knowledge must go beyond basic understanding and must demonstrate actual staff capabilities in using that knowledge for individuals with co-occurring disorders. Personnel documentation should demonstrate that this staff person has received a minimum of 4 hours of training in co-occurring treatment within the past 2 years. Effective January 1, 2010, programs must have documentation that there is at least 1 level 4 staff (excluding an Addiction Counselor Trainee) that is "co-occurring capable.
6. There must be at least a Level 4 on-site at all times the service is in operation, regardless of the number of individuals participating.
7. The maximum face-to-face ratio cannot be more than 12 individuals to 1 direct program staff based on average daily attendance of individuals in the program.
8. A physician and/or a Registered Nurse or a Licensed Practical Nurse with appropriate supervision must be available to the program either by a physician and/or nurse employed by the agency, through a contract with a licensed practitioner, or by written referral or affiliation agreement with another agency or agencies that offer such services.
9. The physician is responsible for addiction and psychiatric consultation, assessment, and care (including but not limited to ordering medications and/or laboratory testing) as

needed. The nurse is responsible for nursing assessments, health screening, medication administration, health education, and other nursing duties as needed.

10. Level 4 staff may be shared with other programs as long as they are available as required for supervision and clinical operations and as long as their time is appropriately allocated to staffing ratios for each program.

C. Clinical Operations

1. It is expected that the transition planning for less intensive service will begin at the onset of RFW services. Documentation must demonstrate this planning.
2. Consumers receiving RFW Independent Living Services (SA Intensive Outpatient Package) must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis.
3. Each consumer should participate in setting individualized goals for themselves and in assessing their own skills and resources related to sobriety, use/abuse, and maintaining recovery. Goals are set by exploring strengths and needs in the consumer's living, learning, social, and working environments. Implementation of services may take place individually or in groups.
4. As mentioned above, RFW Independent Living Services must have different phases of treatment for consumers. These levels are to be assessed regularly and highly individualized. In the beginning phase of treatment, the consumers are to receive intensive substance abuse treatment and when clinically appropriate receive less substance abuse services and more wrap around services. Primary work or work related activities should be implemented in to treatment no later than 90 days from admission. Services to include documentation of an assessment of work skills, abilities, and all work activities taking place, and if clinically appropriate the initiation of work activities. If not clinically appropriate for a consumer to engage in work related activities, it must be documented.

The following services must be included in the Ready For Work Independent Living Support Program., Many of these activities are reimbursable through Medicaid. RFW Services are required to have a multitude of wrap around services, see RFW Provider manual for a description.

The activities include but are not limited to:

a. Group Outpatient Services:

- i. Psycho-educational activities focusing on the disease of addiction prevention, the health consequences of addiction, and recovery
- ii. Therapeutic group treatment and counseling
- iii. Parenting groups
- iv. Trauma group
- v. Linkage to natural supports and self-help opportunities

b. Individual Outpatient Services

- i. Individual counseling
- ii. Individualized treatment, service, and recovery planning

c. Family Outpatient Services

- i. Family education and engagement

- ii. Nurturing parenting
 - d. **Community Support Individual**
 - i. Vocational readiness and support
 - ii. Service coordination unless provided through another service provider
 - iii. Life skills training (i.e. education on healthy eating habits, hygiene)
 - iv. Continuing Care: Providers need to have at least 7 contacts per month one of which must be a face-to-face interaction with a consumer (If CSI is billed as a discrete service it must meet that guideline's additional requirements)
 - v. Linkage to health care
 - e. **Behavioral Health Assessment & Service Plan Development and Diagnostic Assessment**
 - i. Assessment and reassessment
 - ii. Service Plan Development
 - f. **Services not covered by Medicaid**
 - i. Drug screening/toxicology examinations
 - ii. Transportation
 - iii. Work Activities
5. In addition to the above required activities within the program, the following must be offered as needed either within the program or through referral to/or affiliation with another agency or practitioner, and may be billed in addition to the billing for Substance Abuse Intensive Outpatient Package:
- a. Individual counseling in exceptional circumstances for traumatic stress and other mental illnesses for which special skills or licenses are required
 - b. Physician assessment and care
 - c. Psychological testing
 - d. Health screening
6. The program must have a Ready for Work Independent Living Supports Organizational Plan addressing the following:
- a. The philosophical model of the program and the expected outcomes for program participants (i.e., harm reduction, abstinence, beginning of or maintaining individually defined recovery, employment readiness, relapse prevention, stabilization and treatment of those with co-occurring disorders).
 - b. The schedule of activities and hours of operations.
 - c. Staffing patterns for the program.
 - d. How assessments will be conducted.
 - e. How staff will be trained in the administration of addiction services and technologies.
 - f. How staff will be trained in the recognition and treatment of co-occurring disorders of mental illness and substance abuse pursuant to the Georgia Best Practices
 - g. How services for individuals with co-occurring disorders will be flexible and will include services and activities addressing both mental health and substance abuse issues of varying intensities and dosages based on the symptoms, presenting problems, functioning, and capabilities of such individuals.
 - h. How individuals with co-occurring disorders who cannot be served in the regular program activities will be provided and/or referred for time-limited special

integrated services that are co-occurring enhanced as described in the Georgia Suggested Best Practices

- i. How services will be coordinated with the substance abuse array of services including assuring or arranging for appropriate referrals and transitions.
- j. How the requirements in these service guidelines will be met.

D. Service Access

The SA Intensive Outpatient package is offered at least 5 hours per day at least 4 days per week with no more than 2 consecutive days between offered services, and distinguishes between those individuals needing between 9 and 20 hours per week of structured services per week (ASAM Level II.1) and those needing 20 hours or more of structured services per week (ASAM Level II.5 or II.1) in order to begin recovery and learn skills for recovery maintenance.

E. Additional Medicaid Requirements

- 1. Work activities referenced in Item C.4. may not be billed to the Medicaid authority via services identified in E.2. below.
- 2. RFW Independent Living supports provided by an approved Medicaid provider for a Medicaid consumer shall utilize RFW Intensive Outpatient Package. This allows providers to select all services that will be offered in a substance abuse outpatient setting. Billable services and daily limits within RFW Intensive Outpatient Package are as follows:

Package	Service Group	Maximum Authorization Units	Maximum Daily Units
RFW Intensive Outpatient	Behavioral Health Assessment & Service Plan Development	32	24
P0008	Diagnostic Assessment	4	2
	Psychiatric Treatment	12	1
	Nursing Assessment & Care	48	16
	Community Support Individual	600	48
	Individual Outpatient Services	36	1
	Group Outpatient Services	1170	20
	Family Outpatient Services	100	8

F. Billing/Reporting Requirements

- 1. All applicable Medicaid, MICP, and other DBHDD reporting requirements must be met.
- 2. Under the "Package," each service must meet the requirements of the Service Group in order for the service to be billed (refer to Part I, Section I of this manual)

G. Documentation Requirements

- 1. Provider must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.
- 2. Every admission and assessment must be documented.
- 3. Progress notes must include written daily documentation of important occurrences; level of functioning; acquisition of skills necessary for recovery; progress on goals identified in the IRP including acknowledgement of addiction, progress toward recovery and use/abuse

- reduction and/or abstinence; use of drug screening results by staff; and evaluation of service effectiveness. Clinicians are to sign and date each note.
4. Daily attendance of each individual participating in the program must be documented showing the number of units in attendance for billing purposes.
 5. This service may be offered in conjunction with ACT or Crisis Residential Services for a limited time to transition consumers from one service to the more appropriate one. When this service is used in conjunction with ACT or Crisis Residential services, documentation must demonstrate careful planning to maximize the effectiveness of this service as well as an appropriate reduction in service amounts of the service to be discontinued. Utilization of Ready for Work Independent Services with these services is subject to review by the External Review Organization.

Ready For Work Residential Services							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
See Package Detail in Section F. below.							

Definition of Service: Ready for Work Residential Services will provide comprehensive gender specific treatment for addiction, beginning with ASAM level III.5 (at least 25 hours/week) through level I. Services include: substance abuse treatment, group and individual therapy, outreach, parenting, family involvement, recovery group attendance, psycho education, pharmacotherapy, relapse prevention, trauma groups, and ongoing treatment and aftercare. All components of gender specific treatment should be included. This program is designed for those who meet the TANF needy family definition in order to promote employment, parenting and other life skills. Therapeutic child care services are required for Residential programs. Limited slots are available for Non-TANF individual's who meet the most in need criteria or core customer definition and would benefit from gender specific services.

The services that the RFW Residential Package will include are as follows:

1. Structured Residential RFW/TANF
2. Beh Health Assmt & Serv Plan Dev
3. Diagnostic Assessment
4. Psychiatric Treatment
5. Nursing Assessment and Care
6. Medication Administration

A consumer may have variable length of stay. The level of care should be determined as a result of consumers' multiple assessments. It is recommended that individuals attend at a frequency appropriate to their level of need. Ongoing clinical assessment should be conducted to determine step down in level of care and/or addition of other ancillary services.

In addition to the MHDDAD Provider Manual guidelines, all RFW Providers must adhere to the Ready for Work Program Manual.

Target Population	Adult women who are diagnosed with substance abuse disorders who may or may not be receiving TANF cash assistance, a child welfare case, or have children in their custody
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Benefit Information	Available to all ongoing core customers, requires a MICP New Episode Request or Update request (to add as a single service to an existing authorization)
Utilization Criteria	<u>Available to those with LOCUS Scores:</u> 4: Medically Monitored Non-Residential 5: Medically Monitored Residential Services
Ordering Practitioner	Physician, Physician's Assistant, Advanced Practice Registered Nurse (Clinical Nurse Specialist or Nurse Practitioner).
Unit Value	1 day
Initial Authorization	180 days
Re-Authorization	180 days
Maximum Daily Units	1 unit
Authorization Period	180 days
UAS: Budget and Expense Categories	<u>Adult Addictive Diseases:</u> SAPT Block Grant: 624 TANF: 625 State-funded: 626
Admission Criteria	<ol style="list-style-type: none"> 1. A DSM IV diagnosis of Substance Abuse or Dependence or substance-related disorder with a co-occurring DSM IV-TR diagnosis of mental illness 2. Substance abuse is a barrier to employability 3. The individual would benefit from participating in a women's program to process gender specific issues associated with addiction and recovery <p>TANF Criteria:</p> <ol style="list-style-type: none"> 1. Consumer must meet the DFCS definition for "Needy Family". To meet this definition the individuals must meet one of three non-financial criteria and one financial requirement 2. Current TANF Recipients- Individuals with active TANF cash assistance cases 3. Former TANF Recipients- Individuals whose TANF assistance with terminated within the previous twelve months due to employment 4. Families at Risk- Individuals with active DFCS child protective cases 5. Financial Criteria. The limit for the RFW program is set at 235% of the Federal Poverty Level for individuals who are not eligible for TANF cash assistance. <p>Non-TANF Criteria:</p> <p>Consumers determined to be Non-TANF and not eligible for services in the above criteria but do meet the core customer definition may be served with limited service slots funded with SAPTBG Federal funds. A consumer is determined Non-TANF if:</p> <ol style="list-style-type: none"> 1. A woman pregnant for the first time 2. A woman who has lost parental custody of her children, (i.e. is not working on reunification)

	<p>3. A woman who is not associated with DFCS (TANF or CPS), meets core customer definition and would benefit from gender specific treatment</p> <p>Prioritization Criteria for Eligible Recipients</p> <ol style="list-style-type: none"> 1. Pregnant women will be given priority status for admission to this program. If no slots are available for this program, preference must be given to admitting her to another appropriate program, even if out of catchment area. If a provider is unable to admit a pregnant consumer, provider must place her on a waiting list and within 48 hours pregnant consumer must be in a program. 2. High priority is given to women who meet the Needy Family Definition. 3. Preference is to be given to those women who are in a condition to benefit most from the services and opportunities provided by this program.
<p>Continuing Stay Criteria</p>	<ol style="list-style-type: none"> 1. The individual's condition continues to meet the admission criteria. 2. Progress notes document progress in reducing use and abuse of substances; developing social networks and lifestyle changes; increasing educational, vocational, social and interpersonal skills; understanding addictive disease; and/or establishing a commitment to a recovery and maintenance program, but the overall goals of the treatment plan have not been met. 3. There is a reasonable expectation that the individual can achieve the goals in the necessary time frame.
<p>Discharge Criteria</p>	<p>An adequate continuing care or discharge plan is established and linkages are in place; and one or more of the following:</p> <ol style="list-style-type: none"> 1. Goals of the treatment plan have been substantially met; or 2. Consumer recognizes the severity of her drug/alcohol usage and is beginning to apply the skills necessary to maintain recovery by accessing appropriate community supports 3. If a consumer is involved with DFCS or another referring agency a discharge staffing should be completed in collaboration both RFW and other referring organization. 4. Receiving recommended prenatal care if pregnant 5. Deliver a drug free baby if pregnant 6. If consumer is staffed to be discharged before clinically appropriate, a clinical staffing must be completed and provide the following information: documented reason for early discharge, and an aftercare plan. <p>Transfer to a higher level of service is warranted if:</p> <ol style="list-style-type: none"> 1. The individual refuses to submit or has positive random drug screens; or 2. Consumer exhibits symptoms of acute intoxication and/or withdrawal or

	<ol style="list-style-type: none"> 3. The individual requires services not available at this level or 4. Consumer has consistently failed to achieve essential treatment objectives despite revisions to the treatment plan and advice concerning the consequences of continues alcohol/drug use to such an extent that no further process is likely to occur
Service Exclusions	Services cannot be offered with Mental Health Intensive Outpatient Package, SA Intensive Outpatient Package, RFW Outpatient Package, Psychosocial Rehabilitation, or other residential treatment service .
Clinical Exclusions	<ol style="list-style-type: none"> 1. If an individual is actively suicidal or homicidal with a plan and intent 2. Women should have no cognitive and/or intellectual impairments which will prevent them from participating in and benefiting from the recommended level of care 3. Detoxification and inpatient needs must be met prior to admission to the program (alternative provider and/or community resources should be used to serve women with acute treatment needs) 4. Women must be medically stable in order to reside in a group living conditions and participate in treatment

Additional Service Criteria:

A. Required Components

1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. Ready For Work Residential Services must have at least 3 levels of care. III.5 (25 hrs/week), III.3 (10 to 20), and Level III.1 (5 or less hours). Hours of operation should be accommodating for consumers who work (i.e. evening/weekend hours)
3. Evidence based practices are to be utilized. These may include Motivational Interviewing/Enhancement, stage-based interventions, refusal skill development, Cognitive Behavioral Therapy, Matrix model, TREM. Relapse prevention planning and techniques, and others as appropriate to the individual and issues to be addressed. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices.
4. The program provides structured treatment or therapeutic services, utilizing activity schedules as part of its operational method, i.e., plans or schedules of days or times of day for certain activities. The program should also utilize group and/or individual counseling and/or therapy.
5. Therapeutic Childcare Services are required for Ready For Work Residential Services. See the Ready For Work Manual for specific details of these services
6. The program utilizes methods, materials, settings, and outside resources appropriate to the developmental and cognitive levels, capabilities, age, and gender of participants.
7. The program utilizes methods, materials, approaches, activities, settings, and outside resources appropriate for and targeted to individuals with co-occurring disorders of mental illness and substance abuse and targeted to individuals with co-occurring developmental disabilities and substance abuse when such individuals are referred to the program.

8. The program conducts random drug screening and uses the results of these tests for marking consumers' progress toward goals and for service planning.
9. An adequate and safe living environment must be provided for dependent children age 13 and younger that includes therapeutic child care services. After school and weekend programming should be available.
10. This service must operate at an established site approved to bill for services. However, limited individual or group activities may take place off-site in natural community settings as is appropriate to each individual's treatment plan.
11. RFW services may operate in the same building as other services; however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the RFW Residential Services are in operation.
12. Adequate space, equipment, furnishings, supplies, and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for participating individuals' use within the Ready For Work Residential Services must not be substantially different from that provided for other uses for similar numbers of individuals.

B. Staffing Requirements

1. The program must be under the clinical supervision of a **Level 4 or above** who is onsite a minimum of 50% of the hours the service is in operation.
2. Services must be provided by staff who are:
 - a. Level 4 (LAPC, LMSW, CACII, CADC, CCADC and Addiction Counselor Trainee with supervision) or practitioners with a higher credential
 - b. Level 5 (Paraprofessionals, high school graduates) under the supervision of an Level 4 or above
3. Programs must have documentation that there is one Level 4 staff that is "co-occurring capable." This person's knowledge must go beyond basic understanding and must demonstrate actual staff capabilities in using that knowledge for individuals with co-occurring disorders. Personnel documentation should demonstrate that this staff person has received a minimum of 5 hours/year of training in co-occurring treatment.
4. There must be at least a Level 4 on-site at all times the service is in operation, regardless of the number of individuals participating.
5. The maximum face-to-face ratio cannot be more than 12 individuals to 1 direct program staff based on average daily attendance of individuals in the program.
6. A physician and/or a Registered Nurse or a Licensed Practical Nurse with appropriate supervision must be available to the program either by a physician and/or nurse employed by the agency, through a contract with a licensed practitioner, or by written referral or affiliation agreement with another agency or agencies that offer such services.
7. The physician is responsible for addiction and psychiatric consultation, assessment, and care (including but not limited to ordering medications and/or laboratory testing) as needed. The nurse is responsible for nursing assessments, health screening, medication administration, health education, and other nursing duties as needed.
8. Level 4 staff may be shared with other programs as long as they are available as required for supervision and clinical operations and as long as their time is appropriately allocated to staffing ratios for each program.

C. Clinical Operations

1. It is expected that the transition planning for less intensive service will begin at the onset of RFW Residential Services. Documentation must demonstrate this planning.
2. Consumers receiving RFW Residential Services must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis (Level 1).
3. Each consumer should participate in setting individualized goals for themselves and in assessing their own skills and resources related to sobriety, use/abuse, and maintaining recovery. Goals are set by exploring strengths and needs in the consumer's living, learning, social, and working environments. Implementation of services may take place individually or in groups.
4. As mentioned above RFW Residential Services must have different phases of treatment for consumers. These levels are to be assessed regularly and highly individualized. In the beginning phase of treatment, the consumers are to receive intensive substance abuse treatment and when clinically appropriate receive less substance abuse services and more wrap around services. An appropriate step-down service shall include recommending/referring outpatient services. Continuing Care: Providers need to have at least 7 contacts per month one of which must be a face to face interaction with a consumer.
5. Primary work or work related activities should be implemented in to treatment no later than 90 days from admission. Services to include documentation of an assessment of work skills, abilities, and all work activities taking place, and if clinically appropriate the initiation of work activities. If not clinically appropriate for a consumer to engage in work related activities, it must be documented.
6. The following the services must be included in the Ready For Work Residential Package.. RFW Services are required to have a multitude of wrap around services, see RFW Provider manual for a description.

The activities include but not limited to:

- Psycho-educational activities focusing on the disease of addiction prevention, the health consequences of addiction, and recovery
- Therapeutic group treatment and counseling
- Parenting groups
- Trauma group
- Linkage to natural supports and self-help opportunities
- Individual counseling
- Individualized treatment, service, and recovery planning
- Linkage to health care
- Family education and engagement
- Nurturing parenting
- Vocational readiness and support
- Service coordination unless provided through another service provider
- Life skills training (i.e. education on healthy eating habits, hygiene)
- Assessment and reassessment
- Drug screening/toxicology examinations

- Transportation
 - Individual counseling in exceptional circumstances for traumatic stress and other mental illnesses for which special skills or licenses are required
 - Physician assessment and care
 - Psychological testing
 - Health screening
7. The program must have a Ready for Work Residential Services Organizational Plan addressing the following:
- a. The philosophical model of the program and the expected outcomes for program participants (i.e., harm reduction, abstinence, beginning of or maintaining individually defined recovery, employment readiness, relapse prevention, stabilization and treatment of those with co-occurring disorders).
 - b. The schedule of activities and hours of operations.
 - c. Staffing patterns for the program.
 - d. How assessments will be conducted.
 - e. How staff will be trained in the administration of addiction services and technologies.
 - f. How staff will be trained in the recognition and treatment of co-occurring disorders of mental illness and substance abuse pursuant to the Georgia Best Practices
 - g. How services for individuals with co-occurring disorders will be flexible and will include services and activities addressing both mental health and substance abuse issues of varying intensities and dosages based on the symptoms, presenting problems, functioning, and capabilities of such individuals.
 - h. How individuals with co-occurring disorders who cannot be served in the regular program activities will be provided and/or referred for time-limited special integrated services that are co-occurring enhanced as described in the Georgia Suggested Best Practices
 - i. How services will be coordinated with the substance abuse array of services including assuring or arranging for appropriate referrals and transitions.
 - j. How the requirements in these service guidelines will be met.

D. Service Access

Services are to be offered at least 5 hours per day at least 5 days per week with no more than 2 consecutive days between offered services, and distinguishes between those individuals needing between levels.

E. Additional Medicaid Requirements

The provider, via its DBHDD RFW contract, is paid for the complete set of services defined here. If the provider agency is a Medicaid-approved provider and is serving a Medicaid consumer, then it may bill Medicaid for the services provided only up to the "admission" to the RFW Residential program.

F. Reporting Requirements

All applicable Medicaid, MICP, and other DBHDD reporting requirements must be met.

Service Group Code	Package Name	Service Groups Included	Service Name	Auth Period in Days	Max Auth Units	Max Daily Units	Medicaid/ State
P0009	RFW Intensive Residential	20510	Structured Residential- RFW/TANF	180	180	1	State ¹
		10101	Beh Health Assmt & Serv Plan Development	180	32	24	Both
		10103	Diagnostic Assessment	180	4	2	Both
		10120	Psychiatric Treatment	180	24	1	Both
		10130	Nursing Assessment & Care	180	48	16	Both
		10140	Medication Administration	180	40	1	Both

G. Documentation Requirements

1. Provider must document services in accordance with the specifications for documentation requirements specified in Part II, Section V of the Provider Manual.
2. Every admission and assessment must be documented.
3. Progress notes must include daily logs of attendance. Daily attendance of each individual participating in the program must be documented showing.
4. Written weekly summaries of important occurrences; level of functioning; acquisition of skills necessary for recovery; progress on goals identified in the treatment plan including acknowledgement of addiction, progress toward recovery and use/abuse reduction and/or abstinence; use of drug screening results by staff; and evaluation of service effectiveness. Clinicians are to sign and date.
5. This documentation must confirm that the consumer was a resident of the Ready For Work Residential Program on that day.

Ready For Work Transitional Housing Service							
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
TBD							

Definition of Service: Ready for Work Transitional Housing Service provides a safe, stable, drug free residence for no more than 6 months to a TANF eligible woman or a woman who is involved with a Child Protective Service case and her dependent children. The environment should be gender specific and can include dependent children between birth and 18 years old. This service also includes aftercare programming that consists of no more than 9 hours per week. Aftercare Programming must include: continuing care groups (relapse prevention, gradual transitioning back into the community), linkage within the community (i.e. 12 step groups, health care) with intensive case management, life skills (i.e. parenting, budgeting, healthy eating habits, etc.), job skills/ job readiness groups, transportation, consumer oversight in residences and random drug screens (at least 2 per month). Transitional housing is to be a step down in service from Ready for Work residential or outpatient programs; thus, a successful completion of Ready for Work residential, outpatient, or at least an ASAM level II program is necessary.

Length of stay can be 1-6 months if clinically appropriate.

Target Population	Adult Women (and their dependent children) who are diagnosed with substance abuse disorder(s) AND who are TANF Eligible OR have an active Child Protective Service (CPS) case with Dept of Family and Children Services (DFCS)
Benefit Information	Available for DFCS involved women and their dependent children, requires a MICP Update Request (to add as a single service to an existing authorization)
Utilization Criteria	<u>Available to those with LOCUS Scores:</u> 1: Recovery Maintenance and Health Maintenance 2: Low Intensity Community Based Services
Ordering Practitioner	Licensed Professionals (LPC, LCSW, LAPC, LMSW), Certified Professionals (MAC, CACII, CCADC, CADC)
Unit Value	1 Day
Initial Authorization	180 Days
Re-Authorization	n/a
Maximum Daily Units	1 Unit
Authorization Period	180 Days
UAS: Budget and Expense Categories	<u>Adult Addictive Diseases</u> TANF: 630

Admission Criteria	<ol style="list-style-type: none"> 1. DSM IV diagnosis of Substance Dependence or Abuse 2. DFCS Involvement (Meets TANF Needy Family Definition or has an open CPS case) 3. Successfully completed a Ready For Work Residential, Outpatient, or an ASAM Level II Program 4. Alcohol and drug free and stable on medications (if applicable) 5. Substance Abuse has been a barrier in self-sufficiency (parenting and employment) in the past 6. The individual would benefit from participating in a women's transitional housing program to receive supportive services while transitioning back into the community
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual's condition continues to meet the admission criteria 2. Found and/or maintaining employment, but continues to need supportive services and stable living environment 3. Participation in aftercare programming and remaining alcohol and drug free
Discharge Criteria	<p>A discharge plan must be established with the following:</p> <ol style="list-style-type: none"> 1. Linkage of consumer with community (i.e. self help groups, mental physical health needs) 2. Stable living environment 3. Plans and arrangements for children (i.e. school enrollment, childcare) 4. Employment <p>Transfer to a higher level of service is warranted if:</p> <ol style="list-style-type: none"> 1. Individual's condition or nonparticipation; or 2. The individual refuses to submit or has positive random drug screens; or 3. Consumer exhibits symptoms of acute intoxication and/or withdrawal or 4. The individual requires services not available at this level or 5. Consumer has consistently failed to achieve essential objectives despite revisions to the treatment plan and advice concerning the consequences of continues alcohol/drug use to such an extent that no further process is likely to occur
Service Exclusions	<p>Transitional Housing Services cannot be offered with Ready For Work Residential or Outpatient Packages or any other substance abuse services.</p>
Clinical Exclusions	<ol style="list-style-type: none"> 1. If an individual is actively suicidal or homicidal 2. Women should have no cognitive and/or intellectual impairments which will prevent them from participating in and benefiting from the recommended level of care 3. Detoxification and inpatient needs must be met prior to admission to the program (alternative provider and/or community resources should be used to serve women with acute treatment needs) 4. Women must be medically stable

Additional Service Criteria:

A. Required Components

1. The Contractor shall provide a safe, stable, drug free residence and utilities (power and water) for no more than 6 months to a TANF eligible woman or a woman who is involved with a Child Protective Service case and her dependent children.
 - a) If children are residing with their mother, provider must childproof the home and provide a safe play area.
 - b) The transitional home must provide a bathroom for every four residents and a tub/shower for every eight residents.
 - c) The home must provide a living room, a dining area, a kitchen and a bedroom for all residents
 - d) Staff persons are checked for previous criminal history, must have basic training in first aid, cardiopulmonary resuscitation
 - e) Providers must be mindful of the placement of a family that has older children (ages 12-18) taking into consideration trauma, privacy, and gender issues. Clinical teams must evaluate age appropriateness of housing situation taking in consideration ages of children 12 years and older.
2. ASAM Level I services must be provided to all participants in transitional housing for no more than 9 hours per week. Consumers in this level of care shall not count for a providers' outpatient or residential TANF consumers. The aftercare for transitional housing service can be Provider's Ready For Work Aftercare program; however, this programming must provide the services listed below.
 - a) These topics must be a part of Transitional Housing Services:
 - i. Relapse prevention,
 - ii. Linkage within the community (i.e. 12 step groups, health care)
 - iii. intensive case management (transitioning out of treatment),
 - iv. Life skills (i.e. parenting, budgeting, healthy eating habits, etc.),
 - v. Job skills/ job readiness groups
 - vi. Randomized drug screens (at least 2 per month)
 - b) This is a step down level in the continuum of care. Women in this phase of treatment should have more independence with support.
 - i. Consumer should have a comprehensive case management in the first 2 months and then a gradual tapering of services
 - ii. Staff should be available for empowerment and supervision and to complete randomized (or as clinically appropriate). Room/apartment checks should be completed as a clinical tool to hold consumers accountable.
 - c) Transportation must be provided for the consumers, this may include public transportation fare, staff transporting consumers using agency vehicles, and/or providing gas for consumer's automobile.
3. Providers should continue to work with the consumers' DFCS case workers to ensure consistency of care

B. Staffing Requirements

1. The program must be under the clinical supervision of a level 4(LAPC, LMSW, CACII, CADC, CCADC and Addiction Counselor Trainees) or above

2. Aftercare Services must be provided by staff who are at least a level 5 (RADT, CACI, paraprofessionals)
3. Staff who are providing case management should be a professional, paraprofessional, and/or sober and in recovery for at least 1 year.

C. Clinical Operations

1. Transitional Housing Services should provide a schedule for aftercare programming and to ensure stability and consistency for consumers
2. Transitional Housing Services may be in the same apartment complex or building as the residential services; however, the living space designated to transitional housing must be distinctly different. Consumers who are in the Residential or Outpatient treatment must not be living in the same apartment as a consumer in transitional housing services
3. Food and shopping must be completed by consumers, providers should not provide food, charge, or collect money/EBT cards
4. Medications and medical needs should be the responsibility of the consumer. The provider should not hold or dispense medications to consumers in Transitional Housing Services
5. Each Consumer should participate in setting individualized goals for themselves and in assessing their own skills and resources related to sobriety, use/abuse, and maintaining recovery. Goals are set by exploring strength and needs in the consumer's living, learning social and working environments.
6. Transitional Housing Services must have a written organizational plan addressing the following:
 7. Schedule of Activities and hours
 8. Staffing Patterns of the Program
 9. Policies and Procedures
 10. House Rules for Consumers
11. A consumer must be in a slot for at least 16 consecutive days of the month for the full reimbursement. If a consumer is in a slot for 7-15 days, providers shall be reimbursed for half of the reimbursement.

D. Service Access

Aftercare services are to be offered at during the evenings and/or weekends to accommodate consumers' work schedules

E. Additional Medicaid Requirements

Medicaid does not reimburse for this service

F. Reporting Requirements

1. Department requires providers to provide information regarding the consumer information. The reporting form has been supplied to the providers by the Division. This report must be submitted by the 10th of the following month. The consumers that providers count for the transitional housing service program must not be counted in the provider's regular TANF reporting.
2. All applicable DBHDD reporting requirements must be met

G. Documentation Requirements

1. Providers must document weekly summaries of consumers' progress
2. Results of Drug screens must be documented
3. Admissions and discharges must be captured.

PART II

Community Service Standards for All Providers

Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers

Fiscal Year 2012

(Standards for All Providers updated for October 1, 2011 Implementation)



**Georgia Department of Behavioral Health &
Developmental Disabilities**

October 2011

DBHDD

THE DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES STANDARDS FOR ALL PROVIDERS FY 2012

VISION: A SATISFYING, INDEPENDENT LIFE WITH DIGNITY AND RESPECT

It is the vision of the Department of Behavioral Health and Developmental Disabilities (DBHDD) that every person who participates in our services leads a satisfying, independent life with dignity and respect.

BEHAVIORAL HEALTH SERVICES

The DBHDD is working to implement the vision found in President George W. Bush's *New Freedom Initiative on Mental Health*, which says:

"We are committed to a future where recovery is the expected outcome and when mental illness can be prevented or cured. We envision a nation where everyone with a mental illness will have access to early detection and the effective treatment and supports essential to live, work, learn and participate fully in their community."

For children and adolescents, DBHDD is working to provide services, support, care and treatment that are family-driven and youth-guided that supports the resiliency of the individual child or youth within their natural environment.

DEVELOPMENTAL DISABILITY SERVICES

The DBHDD believes it is critical that services, supports, treatment and care respect the vision of the individual. Each agency or organization must incorporate this belief and practice into its service delivery to support individuals with intellectual and developmental disabilities in living a meaningful life in the community. Specifically, the provider must ensure:

- Person-centered service planning and delivery that address what is important to and for individuals
- Capacity and capabilities, including qualified and competent providers and staff
- Participant safeguards
- Satisfactory participant outcomes
- Systems of care that have the infrastructure necessary to provide coordinated services, supports, treatment and care
- Participants rights and responsibilities
- Participant access

The Standards that follow are applicable to DBHDD or organizations that provide services to individuals that are financially supported in whole or in part by funds authorized through DBHDD, regardless of the age or disability of the individual served.

Participant self-determination includes freedom, authority and responsibility and is considered key to achieving the vision of *a satisfying, independent life with dignity and respect for everyone*.

ORGANIZATIONAL PRACTICES

A. The Organization Clearly Describes Available Services, Supports, Care and Treatment

1. The organization has a description of its services, supports, care and treatment that includes a description of:
 - a. The population served;
 - b. How the organization plans to strategically address the needs of those served; and
 - c. Services available to potential and current individuals.
2. The organization details the desired expectation of the services, supports, care and treatment offered and the outcomes for each of these services.
3. The level and intensity of services, supports, care and treatment offered is:
 - a. Within the scope of the organization;
 - b. According to benchmarked practices; and
 - c. Timely as required by individual need.
4. The program description identifies staff to individual served ratios for each service offered:
 - a. Ratios reflect the needs of consumers served, implementation of behavioral procedures, best practice guidelines and safety considerations.
 - b. Ratios reflect considerations such as licensure waivers, special (exceptional) rates reflecting unique individual care needs, etc.
5. Children seventeen and younger may not be served with adults unless the children are residing with their parents or legal guardians in residential programs such as the Ready for Work program.
 1. Emancipated minors and juveniles who are age 17 years may be served with adults when their life circumstances demonstrate they are more appropriately served in an adult environment.
 2. Situations representing exceptions to this standard must have written documentation from the DBHDD Regional office.
 - i. Exceptions must demonstrate that it would be disruptive to the living configuration and relationships to disturb the 'family' make-up of those living together

B. Strong Operational Procedures Support the Organization, Its Staff and Individuals Served

1. Applicable statutory requirements, rules, regulations, licensing, accreditation, and contractual/agreement requirements are evident in organizational policies, procedures and practices.
2. The organization has internal structures that support good business practices.
 - a. There are clearly stated current policies and procedures for all aspects of the operation of the organization;
 - b. Policies and corresponding procedures direct the practice of the organization; and
 - c. Staff is trained in organization policies and procedures.
3. The organization has administrative and clinical structures that are clear and that support individual care.
 - a. Administrative and clinical structures promote unambiguous relationships and responsibilities.
4. Organizations that provide developmental disabilities services must participate in the Georgia Developmental Disabilities Provider Information websites. The addresses are (1) www.dbhdd.ga.gov and (2) www.georgiaddproviders.org/ (**Providers** Tab, then select Toolkit).
5. There is a written budget which includes expenses and revenue that serves as a plan for managing resources.

- a. Utilization of fiscal resources is assessed in Quality Improvement processes and/or by the Board of Directors.
- 6. The organization policy must state explicitly in writing whether research is conducted or not on individuals served by the organization.
 - a. If the organization wishes to conduct research involving individuals, a research design shall be developed and must be approved by:
 - i. The agency's governing authority; and
 - ii. The Regional Coordinator for the DBHDD; and
 - iii. The Institutional Review Board operated by the Department of Community Health (DCH) and its policies regarding the Protection of Human Subjects found in DBHDD directive herein.
 - b. The Research design shall include:
 - i. A statement of rationale;
 - ii. A plan to disclose benefits and risks of research to the participating person;
 - iii. A commitment to obtain written consent of the persons participating; and
 - iv. A plan to acquire documentation that the person is informed that they can withdraw from the research process at any time.
 - c. The organization using unusual medication and investigational experimental drugs shall be considered to be doing research.
 - i. Policies and procedures governing the use of unusual medications and unusual investigational and experimental drugs shall be in place;
 - ii. Policies, procedures, and guidelines for research promulgated by the DCH Institutional Review Board shall be followed;
 - iii. The research design shall be approved and supervised by a physician; and
 - iv. Information on the drugs used shall be maintained including:
 - 1. Drug dosage forms;
 - 2. Dosage range;
 - 3. Storage requirements;
 - 4. Adverse reactions; and
 - 5. Usage and contraindications.
 - v. Pharmacological training about the drug(s) shall be provided to nurses who administer the medications; and
 - vi. Drugs utilized shall be properly labeled.
 - d. If research is conducted, there is evidence that involved individuals are:
 - i. Fully aware of the risks and benefits of the research;
 - ii. Have documented their willingness to participate through full informed consent; and
 - iii. Can verbalize their wish to participate in the research. If the individual is unable to verbalize or otherwise communicate this information, there is evidence that a legal representative, guardian or guardian ad litem has received this information and consented accordingly.

OUTCOME OF SERVICES

C. Individuals receive Services, Supports, Care or Treatment that result in a Satisfying Independent Life with Dignity and Respect

- 1. Services, supports, care or treatment approaches support the individual in:

- a. Living in the most integrated community setting appropriate to the individual's requirement, preferences and level of independence;
- b. Exercising meaningful choices about living environments, providers of services received, the types of supports, and the manner by which services are provided; and
- c. Obtaining quality services in a manner as consistent as possible with community living preferences and priorities.

D. Respect for the Dignity of the Individual is demonstrated

1. Access to appropriate services, supports, care and treatment is available regardless of:
 - a. Age;
 - b. Ethnicity;
 - c. Gender;
 - d. Religion;
 - e. Social status;
 - f. Physical disability;
 - g. Mental disability;
 - h. Payer source; or
2. There are no barriers in accessing the services, supports, care and treatment offered by the organization, including but not limited to:
 - a. Geographic;
 - b. Architectural;
 - c. Communication:
 - i. Language access is provided to individuals with limited English proficiency or who are sensory impaired;
 - ii. All applicable DBHDD policies regarding Limited English Proficiency and Sensory Impairment are followed.
 - d. Attitudinal;
 - e. Procedural; and
 - f. Organizational scheduling or availability.
3. There is evidence of organizational person-centered planning and service delivery.
4. Sensitivity to individual's differences and preferences is evident.
5. Practices and activities that reduce stigma are implemented.
6. Interactions with individuals demonstrate:
 - a. Respect;
 - b. Careful listening; and
 - c. Are positive and supportive.

E. Human and Civil Rights are maintained

1. The organization has policies and promotes practices that:
 - a. Do not discriminate;
 - b. Promote receiving equitable supports from the organization;
 - c. Provide services, supports, care and treatment in the least restrictive environment;
 - d. Emphasize the use of teaching functional communication and using least restrictive interventions; and
 - e. Incorporate Clients Rights or Patients Rights Rules found at, www.dbhdd.ga.gov as applicable to the organization; and
 - f. Delineates the rights and responsibilities of persons served.
2. In policy and practice, the organization makes it clear that under no circumstances will the following occur:
 - a. Threats (overt or implied);
 - b. Corporal punishment;
 - c. Fear-eliciting procedures;

- d. Abuse or neglect of any kind;
 - e. Withholding nutrition or nutritional care; or
 - f. Withholding of any basic necessity such as clothing, shelter, rest or sleep.
3. Grievance, complaint and appeals of internal and external policies and processes are clearly written in language accessible to individuals served and are promulgated and consistent with all applicable DBHDD policies regarding *Complaints and Grievances* regarding community services. Notice of procedures is provided to individuals, staff and other interested parties, and providers maintain records of all complaints and grievances and the resolutions of same.
4. Federal and state laws and rules are evident in policy and practice including, but not limited to:
- a. **For all community based programs**, practices promulgated by DBHDD or the Rules and Regulations for Clients Rights, Chapter 290-4-9 are incorporated into the care of individuals served. Issues addressed include but are not limited to the right to:
 - i. Care in the least restrictive environment;
 - ii. Humane treatment or habilitation that affords protection from harm, exploitation or coercion.
 - iii. Unless adjudicated incompetent by a court of law, be considered legally competent for any purpose without due process of law, including to maintain:
 - 1. Civil;
 - 2. Political
 - 3. Personal; and
 - 4. Property rights.
 - b. **For all crisis stabilization units serving adults, children or youth**, practices promulgated by DBHDD or the Rules and Regulations for Patients Rights, Chapter 290-4-6 are incorporated into the care of adults, children and youth served in crisis stabilization units. Issues addressed include but are not limited to the right to:
 - i. Care in the least restrictive environment;
 - ii. Humane treatment or habilitation that affords protection from harm, exploitation or coercion;
 - iii. Unless adjudicated incompetent by a court of law, be considered legally competent for any purpose without due process of law, including:
 - 1. Civil;
 - 2. Political
 - 3. Personal; or
 - 4. Property rights.
 - c. **For all programs serving individuals with substance use and abuse issues**, in addition to practices promulgated by DBHDD or the Rules and Regulations for Clients Rights, Chapter 290-4-9, confidentiality procedures for substance abuse individual records comply with 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, Final Rule (June 9, 1987), or subsequent revisions thereof.
 - i. All substance abuse individuals are provided written notice about the confidentiality of substance abuse records at the time of admission or soon thereafter when the individual is capable of rational communication;
 - ii. This notification is documented in the individual's record; and
 - iii. The individual's signature on the notification form serves as documentation of notification.
5. All individuals are informed about their rights and responsibilities:

- a. At the onset of services, supports, care and treatment;
 - b. At least annually during care;
 - c. Through information that is readily available, well prepared and written using language accessible and understandable to the individual; and
 - d. Evidenced by the individual's or legal guardian signature on notification.
6. All individuals determine how their right to confidentiality will be addressed, including but not limited to who they wish to be informed about their services, supports, care and treatment.

F. Behavioral Support Services are addressed consistent with Best Practices

1. In policy, procedures and practice, the organization makes it clear whether and under what circumstances the following restrictive interventions can be implemented based on the service(s) provided by the organization and licensure requirements. In all cases, federal and state laws and rules are followed and include but are not limited to the following:
 - a. Use of adaptive supportive devices or medical protective devices;
 - i. May be used in any service, support, care and treatment environment; and
 - ii. Use is defined by a physician's order (order not to exceed six calendar months).
 - iii. Written order to include rationale and instructions for the use of the device.
 - iv. Authorized in the individual service plan (ISP).
 - v. Are used for medical and/or protective reason (s) and not for behavior control.
 - b. Time out (used only in DD or C&A services):
 - i. Under no circumstance is egress restricted;
 - ii. Time out periods must be brief, not to exceed 15 minutes;
 - iii. Procedure for time-out utilization incorporated in behavior plan;
 - iv. Reason justification and implementation for time out utilization documented.
 - c. Personal restraint (also known as manual hold or manual restraint): The application of physical force, without the use of any device, for the purpose of restricting the free movement of a person's body;
 - i. May be used in all community settings except residential settings licensed as Personal Care Homes;
 - ii. Circumstances of use must represent an emergency safety intervention of last resort affecting the safety of the individual or of others;
 - iii. Brief handholding (less than 10 seconds) support for the purpose of providing safe crossing, safety or stabilization does not constitute a personal hold;
 - iv. If permitted, Personal Restraint (ten seconds or more), shall not exceed five (5) minutes and this intervention is documented.
 - d. Physical restraint (also known as mechanical restraint): A device attached or adjacent to the individual's body that one cannot easily remove and that restricts freedom of movement or normal access to one's body or body parts.
 - i. Prohibited in community settings **except** in community programs designated as crisis stabilization units for adults, children or youth;
 - ii. Circumstances of use in behavioral health, crisis stabilization units must represent an emergency safety intervention of last resort affecting the safety of the individual or of others.
 - e. Seclusion: The involuntary confinement of an individual alone in a room or in any area of a room where the individual is prevented from leaving,

regardless of the purpose of the confinement. The practice of "restrictive time-out" (RTO is seclusion and may not be utilized except in compliance with the requirement related to seclusion. The phrase "prevented from leaving" includes not only the use of a locked door, but also the use of physical or verbal control to prevent the individual from leaving.

- i. Seclusion may be used in the community **only** in programs designated as crisis stabilization programs for adults, children or adolescents;
 - ii. Circumstances of use in behavioral health crisis stabilization programs must represent an emergency safety intervention of last resort affecting the safety of the individual or of others;
 - iii. Is not permitted in developmental disabilities services.
- f. **Chemical restraint may never be used under any circumstance.** Chemical restraint is defined as a medication or drug that is:
- i. Not a standard treatment for the individual's medical or psychiatric condition;
 - ii. Used to control behavior;
 - iii. Used to restrict the individual's freedom of movement.
- g. Examples of chemical restraint are the following:
- i. The use of over the counter medications such as Benadryl for the purpose of decreasing an individual's activity level during regular waking hours;
 - ii. The use of an antipsychotic medication for a person who is not psychotic but simply 'pacing' or mildly agitated.
- h. PRN antipsychotic and mood stabilizer medications for behavior control are not permitted. See Part II, Section 1; Appendix 1 for list of medications.
2. When individuals demonstrate challenging behaviors the approach to developing a behavior support plan and treatment should be consistent with the *Guidelines for Supporting Adults with Challenging Behaviors in Community Settings and/or Best Practice Standards for Behavioral Support Services* (www.dbhdd.ga.gov). Care is taken to determine what the function of each challenging behavior serves for that individual in his/her environment while also considering:
- a. Physiological issues such as possible medical and psychiatric issues; including physical disabilities such as difficulty seeing, hearing, or ambulating;
 - b. Social issues such as lack of available, inclusive social networks;
 - c. Psychological issues;
 - d. Environmental issues such as staffing concerns;
 - e. The need for a crisis/safety plan.
3. All organizations must have the capacity to address individuals' behavioral needs. If the cause of the challenging behavior cannot be determined or satisfactorily addressed by the provider, there should be evidence of consultation with an outside professional who is licensed or qualified through education, supervised training and experience to address the behavior needs of the individual.
4. A behavior support plan must be developed for individuals with developmental disabilities who receive psychotropic medications for symptoms other than a Mental Illness or Epilepsy and is intended to reduce the need for those medications over time.
5. The provider insures authors of BSP are properly qualified to develop interventions. Those authoring such plans should minimally meet DDP and/or professional criteria as a Psychologist, Behavioral Specialist or a Board Certified Behavior Analyst.

G. Integration into the Larger Natural Community is Evident

1. Inclusion and community integration is supported and evident.

2. Individuals have responsibilities in the community such as employment, volunteer activities, church and civic membership and participation, school attendance, and other age-appropriate activities
3. The organization has community partnerships that demonstrate input and involvement by:
 - a. Advocates;
 - b. The person served;
 - c. Families; and
 - d. Business and community representatives.
4. The organization makes known its role, functions and capacities to the community including other organizations as appropriate to its array of services, supports, care and treatment as a basis for:
 - a. Joint planning efforts;
 - b. Continuity in cooperative service delivery, including the educational system;
 - c. Provider networking;
 - d. Referrals; and
 - e. Sub-contracts.

H. Quality Improvement Processes and Management of Risk to Individuals, Staff and Others is a Priority

1. There is a well-defined quality improvement plan for assessing and improving organizational quality. The organization is able to demonstrate how:
 - a. Issues are identified;
 - b. Solutions are implemented;
 - c. New or additional issues are identified and managed on an ongoing basis;
 - d. Internal structures minimize risks for individuals and staff; and
 - e. Processes used for assessing and improving organizational quality are identified.
2. Areas of risk to persons served and to the organization are identified based on services, supports, treatment or care offered including, but not limited to:
 - a. Incidents;
 - i. There is evidence that incidents are reported to the DBHDD Office of Incident Management and Investigation as required by DBHDD Policy, *Reporting and Investigating Deaths and Critical Incidents in Community Services*;
 - b. Accidents;
 - c. Complaints;
 - d. Grievances;
 - e. Individual Rights Violations;
 - i. There is documented evidence that any restrictive interventions utilized must be reviewed by the organization's Rights Committee;
 - f. Practices that limit freedom of choice or movement;
 - g. Medication Management;
 - h. Infection Control;
 - i. Behavior Support Plan tracking and monitoring;
 - j. Breaches of Confidentiality; and
 - k. Health and Human Rights of persons with Developmental disabilities.
3. Indicators of performance are in place for assessing and improving organizational quality. The organization is able to demonstrate:
 - a. The indicators of performance established for each issue;
 - i. The method of routine data collection;
 - ii. The method of routine measurement;
 - iii. The method of routine evaluation;
 - iv. Target goals/expectations for each indicator;

- b. Outcome Measurements determined and reviewed for each indicator on a quarterly basis;
- c. Distribution of Quality Improvement findings on a quarterly basis to:
 - 1. Individuals served or their representatives as indicated;
 - 2. Organizational staff;
 - 3. The governing body; and
 - 4. Other stakeholders as determined by the governance authority.
- 4. The organization's practice of cultural diversity competency is evident by:
 - a. Staff articulating an understanding of the social, cultural, religious and other needs and differences unique to the individual;
 - b. Staff honoring these differences and preferences (such as worship or dietary preferences) in the daily care of the individual; and
 - c. The inclusion of cultural competency in Quality Improvement processes.
- 5. At least five per cent (5%) of records of persons served are reviewed each quarter. Records of individuals who are "at risk" are included. Reviews include these determinations:
 - a. That the record is:
 - i. Organized;
 - ii. Complete;
 - iii. Accurate; and
 - iv. Timely
 - b. Whether services are based on assessment and need;
 - c. That individuals have choices;
 - d. Documentation of service delivery including individuals' responses to services and progress toward ISP goals;
 - e. Documentation of health service delivery;
 - f. Medication management and delivery, including the use of PRN /OTC medications; and their effectiveness;
 - g. That approaches implemented for persons with challenging behaviors are addressed as specified in the *Guidelines for Supporting Adults with Challenging Behaviors in Community Settings*. When a behavioral support plan is necessary, providers of developmental disabilities services develop these plans in accordance with the *Best Practice Standards for Behavioral Support Service* (www.dbhdd.georgia.gov).
- 6. Record reviews should be kept for a period of at least two years.
- 7. Appropriate utilization of human resources is assessed, including but not limited to:
 - a. Competency;
 - b. Qualifications;
 - c. Numbers and type of staff, for example, a behavior specialist, required based on the services, supports, treatment and care needs of persons served; and
 - d. Staff to individual ratios.
- 8. The organization has an advisory board made up of citizens, local business providers, individuals and family members. The Board:
 - a. Meets at least semi-annually;
 - b. Reviews items such as but not limited to:
 - i. Policies;
 - ii. Risk management reports; and
 - iii. Budgetary issues.
 - c. Provides objective guidance to the organization.

I. A Holistic Approach to Services, Supports, Care and Treatment that Enhances the Individual's Capacity to Lead a Satisfying, Independent Life

1. Individualized services, supports, care and treatment determinations are made on the basis of an assessment of needs with the individual. The purpose of the assessment is to determine the individual's hopes, dreams or vision for their life and to determine how best to assist the individual in reaching those hopes, dreams or vision, including determining appropriate staff to deliver these services.
2. Assessments should include but are not limited to the following:
 - a. The individual's:
 - i. Hopes and dreams, or personal life goals;
 - ii. Perception of the issue(s) of concern;
 - iii. Strengths;
 - iv. Needs;
 - v. Abilities; and
 - vi. Preferences.
 - b. Medical history;
 - c. A current health status report or examination in cases where:
 - i. Medications or other ongoing health interventions are required;
 - ii. Chronic or confounding health factors are present;
 - iii. Medication prescribed as a part of DBHDD services has research indicating necessary surveillance of the emergence of diabetes, hypertension, and/or cardiovascular disease;
 - iv. Allergies or adverse reactions to medications have occurred; or
 - v. Withdrawal from a substance is an issue.
 - d. Appropriate diagnostic tools such as impairment indices, psychological testing, or laboratory tests;
 - e. Social history;
 - f. Family history;
 - g. School records (for school age individuals);
 - h. Collateral history from family or persons significant to the individual, if available.
 - i. NOTE that when collateral history is taken, information about the individual **may not be shared** with the person giving the collateral history unless the individual has given specific written consent; and
 - i. Review of legal concerns including:
 - ii. Advance directives;
 - iii. Legal competence;
 - iv. Legal involvement of the courts;
 - v. Legal status as it relates to Title 37; and
 - vi. Legal status as adjudicated by a court.
3. Additional assessments should be performed or obtained by the provider if required to fully inform the services, supports, care and treatment provided. These may include but are not limited to:
 - a. Assessment of trauma or abuse;
 - b. Suicide risk assessment;
 - c. Functional assessment;
 - d. Cognitive assessment;
 - e. Behavioral assessments;
 - f. Spiritual assessment;
 - g. Assessment of independent living skills;
 - h. Cultural assessment;
 - i. Recreational assessment;
 - j. Educational assessment;
 - k. Vocational assessment; and
 - l. Nutritional assessment;

4. The individual is informed of the findings of the assessments in a language he or she can understand.
5. An individualized service plan or individualized recovery plan is developed with the guidance of an in-field professional (Refer to the *Standards for All Providers* for definitions related to in-field professionals).
 - a. Individuals direct decisions that impact their lives;
 - b. Others assisting in the development of the individualized plan are persons who:
 - i. Are significant in the life of the individual;
 - ii. Have a historical perspective of the wishes and preferences of the individual;
 - iii. The individual gives consent to have input from family and friends, if desired; and
 - iv. Will deliver the specific services, supports, care and treatment identified in the plan.
 1. For individuals with coexisting, complex and confounding needs, cross disciplinary approaches to planning should be used;
 2. Planning should be facilitated by professional(s) qualified to plan or provide supports to persons with this level of complexity;
 3. Representatives of other agencies outside of the DBHDD or providers affecting the daily life of the individual should be present and participating.
6. Each individualized plan should be:
 - a. Driven by the individual;
 - b. Focused on outcomes the individual wishes to achieve;
 - c. Fully explained to the individual using language he or she can understand; and
 - d. Agreed to by the individual.
7. Components of the plan are:
 - a. Statement(s) of goals or desired outcomes;
 - b. Documented objectives that are:
 - i. **Specific**
 - ii. **Measurable**
 - iii. **Achievable**
 - iv. **Relevant**
 - v. **Realistic**
 - vi. **Time-limited** with specified target dates
 - c. Specific services, supports, care and treatment to be provided related to each goal or outcome;
 - d. The frequency or intensity that the specific service, support, care and treatment will be given or provided;
 - e. Identification of staff responsible to deliver or provide the specific service, support, care and treatment;
 - f. A page for signature, title and date by participants (including the individual) that is attached to the plan, indicating participant presence;
 - i. There is evidence of involvement in the plan of all professionals providing services, supports, care and treatment to the individual;
 - g. Clear authorization of the plan;
 - i. Refer to definitions of service included in this Provider Manual to determine who must authorize the plan:
 1. Part I, Section I: *MH and AD Consumer Eligibility, Service Definitions and Service Guidelines*;

2. Part I, Section II: *DD Consumer Eligibility, Access and Planning List, Service Definitions and Service Guidelines.*
- ii. A physician must authorize the plan when it includes medical care and treatment or as required by Georgia Department of Community Health Division of Medical Assistance, Part II Policies and Procedures for Comprehensive Support Waiver Program (COMP) and New Option Waiver Program (NOW): *Protocol for Physician Signature is in waiver manual:*
- iii. When more than one physician is involved in individual care, there is evidence that a RN or MD has reviewed all in-field information to assure there are no contradictions or inadvertent contraindications within the care and treatment orders or plan.
- iv. When a behavior support plan is used to reduce challenging behaviors, there must be evidence that the following issues have been addressed. The plan is:
 1. Individualized;
 2. Based on a functional assessment;
 3. One that has ruled out medical causes;
 4. Developed and overseen by a qualified professional (Refer to the *Standards for All Providers* for definitions related to in-field professionals);
 5. Inclusive of rationale for the following:
 - a. Use of identified approaches;
 - b. The timing of their use;
 - c. An assessment of the impact on personal choice of the individual;
 - d. The targeted behavior; and
 - e. How the targeted behavior will be recognized for success.
 6. Implemented by trained and competent staff;
 7. Has monitoring plans and termination criteria;
 8. Consent provided by the individual and/or his or her legal guardian;
 9. Discussed with the individual and family/natural supports (as permitted by the individual);
 10. Developed in accordance with Best Practice Standards for Behavioral Supports Services for providers of developmental disabilities services (www.dbhdd.ga.gov).
- v. Intrusive or restrictive procedures must be clearly justified through documentation of less restrictive procedures ineffectiveness and/or the need for more intrusive procedures due to the safety or health risks presented by the targeted behaviors. These procedures are authorized, incorporated into the safety BSP, approved by ISP interdisciplinary team, reviewed by organization's Rights Committee and supervised by qualified professional (s) and may not be in conflict with federal or state laws, rules, regulations or standards;
- vi. Refer and adhere to all federal and state laws and rules, department standards to include but not limit to the document *Guidelines for Supporting Adults with Challenging Behaviors in Community Settings* and the Best Practice Standards for Behavioral Support Services when developing a behavior support plan (www.dbhdd.ga.gov).

8. Documents to be incorporated by reference into an individualized plan include but are not limited to:
 - a. Medical updates as indicated by physician orders or notes;
 - b. Addenda as required when a portion of the plan requires reassessment;
 - c. A personal crisis plan which directs in advance the individual's desires/wishes/plans/objectives in the event of a crisis;
 - d. A behavior support plan for individuals demonstrating:
 - i. challenging behaviors; and/or
 - ii. with a Developmental Disability who receive psychotropic medications for symptom management other than that of a mental illness or epilepsy.
 - e. Wellness Recovery Action Plan (WRAP);
 - f. Safety Plan.
9. The intent of the development of the ISP is a process that focuses on the individual's hopes, dreams and vision of a "life well-lived." Information included within this individualized plan should be presented as a single plan describing the individual's service/support needs within a daily life versus a daily service. Support networks should work closely together to identify issues of risk and needed supports to address those risks while never losing sight that the individual is at the center of the planning process and included in all discussions.
10. Individualized plans or portions of the plan must be reassessed as indicated by the following:
 - a. Changing needs, circumstances and responses of the individual, including but not limited to:
 - i. Any life change;
 - ii. Change in provider;
 - iii. Change of address;
 - iv. Change in frequency of service; and
 - v. Change in medical, behavioral, cognitive or, physical status;
 - b. As requested by the individual;
 - c. As required for re-authorization;
 - d. At least annually;
 - e. When goals are not being met.
11. There is evidence that the person's data from tracking sheets and learning logs have been reviewed, analyzed for trends, and summarized to determine progress toward goals at least quarterly.
12. Wellness of individuals is facilitated through:
 - a. Advocacy;
 - b. Individual care practices;
 - c. Education;
 - d. Sensitivity to issues affecting wellness including but not limited to:
 - i. Gender;
 - ii. Culture; and
 - iii. Age.
 - e. Incorporation of wellness goals within the individual plan.
13. Policies, procedures and practice describe processes for referral of the individual based on ongoing assessment of individual need:
 - a. Internally to different programs or staff; or
 - b. Externally to services, supports, care and treatment not available within the organization including, but not limited to:
 - i. Health care for:
 1. Routine assessment such as annual physical examinations;
 2. Chronic medical issues;
 3. Ongoing psychiatric issues;

4. Acute and emergent needs;
 - a. Medical
 - b. Psychiatric
 - ii. Diagnostic testing such as psychological testing or labs; and
 - iii. Dental services.
14. Specific to Behavioral Health services, providers must work with each enrolled individual to develop and implement, as needed, a crisis plan. Providers must have a process in place to provide after-hours accessibility and have the ability to respond, face-to-face as clinically indicated, to crisis situations that occur with enrolled individuals in a timely manner per the contact/agreement with DBHDD. The Georgia Crisis and Access Line (GCAL) are not to be used as the crisis or after hour's access for enrolled individuals. However, providers may utilize GCAL in order to gain access to higher levels of care (e.g. Crisis Stabilization Units, other inpatient services, etc.) or facilitate coordination with Georgia Emergency Management Agency services (i.e. 911).
15. Specific to Developmental Disabilities services, providers must have processes in place to implement crisis intervention as needed. The staff must be trained to respond to a crisis situation that occurs at the service site and, have a crisis plan at a minimum addresses:
 - a. Approved Interventions to be utilized by staff;
 - b. Availability of additional resources to assist in diffusing the crisis;
 - c. If the acute crisis presents a substantial risk of imminent harm to self and others, include community based crisis services as an alternative to emergency room care, institutional placement, and/or law enforcement involvement (including incarceration); and
 - d. Protocols to access community-based crisis services to include the Georgia Crisis Response Systems.

J. Infection Control Practices are Evident in Service Settings

1. The organization, at a minimum, has a basic Infection Control Plan that includes the following:
 - a. Standard Precautions;
 - b. Hand washing protocols;
 - c. Proper disposal of biohazards, such as needles, lancets, scissors, tweezers, and other sharp instruments; and
 - d. Management of common illness likely to be emergent in the particular service setting;
2. The organization has effective cleaning and maintenance procedures sufficient to maintain a sanitary and comfortable environment that prevents the development and transmission of infection.
3. The organization adheres to policies and procedures for controlling and preventing infections in the service setting. Staff is trained and monitored to ensure infection control policies and procedures are followed.
4. All staff adheres to Standard Precautions and follows the organization's written policies and procedures in infection control techniques.
5. The organization's infection control plan is reviewed bi-annually for effectiveness and revision, if necessary.
6. The organization has available the quantity of bed linens and towels, etc. essential for the proper care of individuals at all times. These items are washed, stored, and transported in a manner that prevents the spread of infection.
7. Routine laundering of an individual's clothing and personal items is done separately from the belongings of other individuals.

8. Procedures for the prevention of infestation by insects, rodents or pests shall be maintained and conducted continually to protect the health of individuals served.
9. The organization ensures that an individual's personal hygiene items, such as toothbrushes, hairbrushes, razors, nail clippers, etc., are maintained separately and in a sanitary condition.
10. Any pets living in the service setting must meet the following requirements:
 - a. No vicious animals shall be kept;
 - b. All animals must be inoculated for rabies annually;
 - c. Exotic animals must be obtained from federally approved sources; and
 - d. Parrots and Psittacine family birds must be USDA inspected and banded.

K. Organizations having Oversight for Medication or that Administer Medication Follow Federal and State Laws, Rules, Regulations and Best Practice Guidelines

1. A copy of the physician (s) order or current prescription dated/signed within the past year is placed in the individual's record for every medication administered or self-administered with supervision. These include:
 - a. Regular, on-going medications;
 - b. Controlled substances;
 - c. Over-the-counter medications;
 - d. PRN (when needed) medications; or
 - e. Discontinuance order.
2. A valid physician's order must contain:
 - a. The individual's name;
 - b. The name of the medication;
 - c. The dose;
 - d. The route;
 - e. The frequency;
 - f. Special instructions, if needed; and
 - g. The physician's signature.
 - h. A copy of the Medical Office Visit Record with the highlighted physician's medication order may also be kept as documentation.
3. Anti-psychotic medications must be prescribed by a psychiatrist or psychiatric nurse practitioner.
4. The organization has written policies, procedures, and practices for all aspects of medication management including, but not limited to:
 - a. Prescribing: requires the comparison of the physician's medication prescription to the label on the drug container and to the Medication Administration Record (MAR) to ensure they are all the same before each medication is administered or supervised self-administration is done.
 - b. Ordering: describes the process by which medication orders are filled by a pharmacy.
 - c. Authenticating orders: describes the required time frame for actual or faxed physician's signature on telephone or verbal orders accepted by a licensed nurse;
 - d. Procuring medication and refills: procuring initial prescription medication and over-the-counter drugs within twenty-four hours of prescription receipt, and refills before twenty-four hours of the exhaustion of current drug supply.
 - e. Labeling: includes the Rights of Medication Administration
 - f. Storing: includes prescribed medications, floor stock drugs, refrigerated drugs, and controlled substances.
 - g. Security: signing out a dose for an individual, and at a minimum, a daily inventory for controlled medications and floor stock medications; and daily temperature logs for locked, refrigerated medications are required.

- h. Storage, inventory, dispensing and labeling of sample medications: requires documented accountability of these substances at all stages of possession.
 - i. Dispensing: describes the process allowed for pharmacists and/or physicians only. Includes the verification of the individual's medications from other agencies and provides a documentation log with the pharmacist's or physician's signature and date when the drug was verified.
 - j. Supervision of individual self-administration: includes all steps in the process from verifying the physician's medication order to documentation and observation of the individual for the medication's effects. Makes clear that staff members may not administer medications unless licensed to do so, and the methods staff members may use to supervise or assist, such as via hand-over-hand technique, when an individual self-administers his/her medications.
 - k. Administration of medications includes all aspects of the process to be done from verifying the physician's medication order, to who can administer the medications, to documentation and observation of the individual for the medication's effects. Administration of medications may be done only by those who are licensed in this state to do so.
 - l. Recording: includes the guidelines for documentation of all aspects of medication management. This includes adding and discontinuing medication, charting scheduled and as needed medications, observations regarding the effects of drugs, refused and missing doses, making corrections, and a legend for recording. The legend includes initials, signature, and title of staff member.
 - m. Disposal of discontinued or out-of-date medication: includes an environmentally friendly method or disposal by pharmacy.
 - n. Education to the individual and family (as desired by the individual) regarding all medications prescribed and documentation of the education provided in the clinical record;
5. Organizational policy, procedures and documented practices stipulate that:
- a. Only licensed medical personnel can directly administer medication;
 - i. In homes licensed as Community Living Arrangements, staff may directly administer medications if:
 - 1. The staff member has completed a course in a Department of Technical Adult Education (DTAE) school and is certified as a Certified Nursing Assistant (CNA) and Qualified Medication Aide (QMA);
 - 2. The staff member has satisfactorily passed the NCLEX-style exam for QMAs; and
 - 3. An RN supervises the staff member.
 - ii. In homes licensed as Community Living Arrangements under Community Living Arrangement Rules 290-9-37-.01 through .25, staff may appropriately administer epinephrine for anaphylactic reaction, insulin required for diabetes, suppositories for ameliorating serious seizure activity, and medications through a nebulizer under the following conditions:
 - 1 The Community Living Arrangement shall have written protocol for the administration of the medication as ordered by a physician for a resident;
 - 2 The staff shall have been trained by a licensed nurse or physician's assistant in the written protocol and proper technique for the administration of the medication as ordered by a physician for a resident;

3. The written protocol and staff training shall be updated annually; and
 4. A licensed nurse or physician's assistant shall verify the training and ability of the unlicensed staff member by signing and dating a copy of the written protocol. The signed and dated copy shall be kept in the file of the staff member.
- iii. In homes licensed as Personal Care Homes under Personal Care Home Rules 111-8-62-.01 through .25, all medications required by a resident shall be self-administered by the resident except when a resident, although generally capable of self-administration, requires administration of oral or topical medication by or under supervision of a functionally literate staff person, through arrangements made by the resident or the home. Injectable medications may only be self-administered or administered by an appropriately licensed person with the following exceptions:
1. Administration of epinephrine under established medical protocol by a staff person to residents with a known anaphylactic reaction; and
 2. Administration of insulin under established medical protocol by a staff person provided that the resident's personal physician has designated a staff person or persons who have been trained and are qualified to administer the insulin to that particular resident. The statement from the resident's physician certifying which staff person or persons have been trained must be maintained in the resident's file.
- iv. Licensed DD provider agencies, including co-employer agencies utilizing proxy caregivers to provide Health Maintenance activities, must meet the Rules and Regulations for Proxy Caregivers in Licensed Healthcare facilities to include but not limited to:
1. Have a written informed consent in the individual's record that designate the selected proxy care giver to receive training to provide the health care activities outlined in the physician's written order working under a nurse protocol agreement or job description;
 2. Demonstrate knowledge and skills to perform the health maintenance activities in the written plan;
 3. Health maintenance activities to be implemented by the proxy caregiver are clearly defined in the written care plan and a copy provided for the proxy care giver;
 4. The organization's policy, procedures, and documented practices clearly defines what health maintenance activities can or cannot be provided and that delivery of such activities are specified for each individual
- b. Only physicians or pharmacists may re-package or dispense medications.
1. This includes the re-packaging of medications into containers such as "day minders" and medications that are sent with the individual when the individual is away from his residence.
 2. Note that an individual capable of independent self-administration of medication may be coached in setting up their personal "day minder".
- c. There are safeguards utilized for medications known to have substantial risk or undesirable effects, including but not limited to:
1. Storage;

2. Handling;
 3. Insuring appropriate lab testing or assessment tools accompany the use of the medication
 4. Obtaining and maintaining copies of appropriate lab testing and assessment tools that accompany the use of the medications prescribed from the individual's physician for the individual's clinical record, or at a minimum, documenting in the clinical record the requests for the copies of these tests and assessments.
- d. Education regarding the risks and benefits of the medication is documented and explained in language the individual can understand. Medication education provided by the organization's staff should be documented in the clinical record. Informed consent for the medication is the responsibility of the physician; however, the organization obtains and maintains copies of these, or at a minimum, documents its request for copies of these in the clinical record
 - e. Where medications are self-administered, protocols are defined for training to support individual self-administration of medication.
 - f. Staff is educated regarding:
 - i. Medications taken by individuals, including the benefits and risks;
 - ii. Monitoring and supervision of individual self-administration of medications;
 - iii. The individual's right to refuse medication;
 - iv. Documentation of medication requirements.
 - g. There are protocols for the handling of licit and illicit drugs brought into the service setting. This includes confiscating, reporting, documenting, educating, and appropriate discarding of the substances.
 - h. Requirements for safe storage of medication are as required by law includes single and double locks, shift counting of the medications, individual dose sign-out recording, documented planned destruction, refrigeration and daily temperature logs.
 - i. The organization defines requirements for timely notification to the prescribing professional regarding:
 - i. Drug reactions;
 - ii. Medication problems;
 - iii. Medication errors; and
 - iv. Refusal of medication by the individual.
 - j. When the organization allows verbal orders from physicians, those orders will be authenticated:
 - i. Within 72 hours by fax with the physicians signature on the page (including electronic signature);
 - ii. The fax must be maintained in the individual's record;
 - k. There are practices for regular and ongoing physician review of prescribed medications including, but not limited to:
 - i. Appropriateness of the medication;
 - ii. Documented need for continued use of the medication;
 - iii. Monitoring of the presence of side effects;

(Individuals on medications likely to cause tardive dyskinesia are monitored at prescribed intervals using an Abnormal Involuntary Movement Scale (AIMS testing))
 - iv. Monitoring of therapeutic blood levels, if required by the medication such as Blood Glucose testing, Dilantin blood

- levels and Depakote blood levels; such as kidney or liver function tests;
- v. Ordering specific monitoring and treatment protocols for Diabetic, hypertensive, seizure disorder, and cardiac individuals, especially related to medications prescribed and required vital sign parameters for administration;
- vi Writing medication protocols for specific individuals in:
 - 1. Homes licensed as Community Living Arrangements or Personal Care Homes for identified staff members to administer:
 - a) epinephrine for anaphylactic reaction;
 - b) insulin required for diabetes;
 - c) suppositories for ameliorating serious seizure activity; and
 - d) medications through a nebulizer under conditions described in the Community Living Arrangement Rule 290-9-37-.20 (2).
 - vi Monitoring of other associated laboratory studies.
- 1. For organizations that secure their medications from retail pharmacy, there is a biennial assessment of agency practice of management of medications **at all sites housing medications**. An independent licensed pharmacist or licensed registered nurse conducts the assessment. The report shall include, but may not be limited to:
 - a) A written report of findings, including corrections required;
 - b) A photocopy of the pharmacist license or a photocopy of the license of the Registered Nurse;
 - c) A statement of attestation from the independent licensed pharmacist or licensed Registered Nurse that all issues have been corrected.
- m. For organizations that employ a licensed pharmacist, there is a biennial assessment of agency practice of management of medications **at all sites housing medications**. A licensed pharmacist or licensed registered nurse conducts the assessment. The report shall include, but may not be limited to:
 - i A written report of findings, including corrections required;
 - ii A photocopy of the pharmacist license or a photocopy of the license of the Registered Nurse.
 - iii. A statement of attestation from the independent licensed pharmacist or licensed Registered Nurse that all issues have been corrected.
- n. For organizations that conduct any of the appropriate laboratory test on-site, documented evidence is provided that the organization's Clinical Laboratory Improvement Amendment (CLIA) Waiver is current. Refer to the list of waived tests updated January 15, 2010 on the Centers for Medicaid and Medicare Services website.
- 6. The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right:
 - a. Right person: includes the use of at least two identifiers and verification of the physician's medication order with the label on the prescription drug container and the MAR entry to ensure that all are the same every time

- before a medication is taken via self-administration or administered by a licensed staff member. The amount of the medication should make sense as to the volume of liquid or number of tablets to be taken.
- b. Right medication: includes verification of the medication order with the label on the prescription drug container and the MAR entry to verify that all are the same every time before a medication is taken via self-administration or administered by a licensed staff member. The medication is inspected for expiration date. Insulin should be verified with another person prior to administering.
 - c. Right time: includes the times the agency schedules medications, or the specific physician's instructions related to the drug.
 - d. Right dose: includes verification of the physician's medication order with the label on the prescription drug container and the Medication Administration Record entry to ensure that all are the same every time before a medication is taken via self-administration or administered by a licensed staff member. The amount of the medication should make sense as to the volume of liquid or number of tablets to be taken.
 - e. Right route: includes the method of administration.
 - f. Right position: individual should be assisted to assume the correct position for the medication method or route to ensure its proper effect, instillation, and retention.
 - g. Right documentation; and
 - h. Right to refuse medications: includes staff responsibilities to encourage compliance, document the refusal, and report the refusal to the administration, nurse administrator, and physician.
7. There are policies and procedures governing documentation of self-administration or administration of medication.
 8. A Medication Administration Record is in place for each calendar month that an individual takes or receives medication:
 - a. Documentation of routine, ongoing medications occur in one discreet portion of the MAR and include but may not be limited to:
 - i. Documentation by calendar month that is sequential according to the days of the month;
 - ii. A listing of all medications taken or administered during that month including a full replication of information in the physician's order for each medication:
 1. Name of the medication;
 2. Dose as ordered;
 3. Route as ordered;
 4. Time of day as ordered; and
 5. Special instructions accompanying the order, if any, such as but not limited to:
 - 5 Must be taken with meals;
 - 6 Must be taken with fruit juice;
 - 7 May not be taken with milk or milk products.
 - iii. If the individual is to take or receive the medication more than one time during one calendar day:
 1. Each time of day must have a corresponding line that permits as many entries as there are days in the month;
 - iv. All lines representing days and times preceding the beginning or ending of an order for medications shall be marked through with a single line;
 - v. When a physician discontinues (D/C) a medication order, that discontinuation is reflected by:

1. The entry of "D/C" at the date and time representing the discontinuation; followed by
 2. A mark through of all lines representing days and times that were discontinued.
- b. Documentation of medications that are taken or received on a periodic basis, including over the counter medications, occur in a separate discreet portion of the MAR and include but may not be limited to:
- i. A listing of each medication taken or received on a periodic basis during that month including a full replication of information in the physician's order for each medication:
 1. Name of the medication;
 2. Dose as ordered;
 3. Route as ordered;
 4. Purpose of the medication
 5. Frequency that the medication may be taken
 - ii. The date and time the medication is taken or received is documented for each use.
 - iii. When 'prn' or 'as needed' medication is used, the PRN medications shall be documented on the same MAR after the routine medications and clearly marked as "PRN" and the effectiveness is documented.
- c. Each MAR shall include a legend that clarifies:
- i. Identity of authorized staff initials using full signature and title;
 - ii. Reasons that a medication may be not given, is held or otherwise not received by the individual, such as but not limited to:
 1. "H" = Hospital
 2. "R" = Refused
 3. "NPO" = Nothing by mouth
 4. "HM" = Home Visit
 5. "DS" = Day Service

L. Person Centered Focus is Evident in Documentation

1. The individual's record is a legal document that is current, comprehensive and includes those persons who are:
 - a. Assessed;
 - b. Served;
 - c. Supported;
 - d. Cared for; or
 - e. Treated.
2. Information in the record is:
 - a. Organized;
 - b. Complete;
 - c. Current;
 - d. Meaningful;
 - e. Succinct; and
 - f. Essential to:
 - i. Provide adequate and accurate services, supports, care and treatment;
 - ii. Tell an accurate story of services, supports, care and treatment rendered and the individual's response;
 - iii. Protect the individual; their rights; and
 - iv. Comply with legal regulation.
 - g. Dated, timed, and authenticated with the authors identified by name, credential and by title;
 - i. Notes entered retroactively into the record after an event or a shift must be identified as a "late entry";

- ii. Documentation is to be done each shift or service contact by staff providing the service;
 - iii. If notes are voice recorded and typed or a computer is used to write notes that are printed, each entry must be dated and the physical documentation must be signed and dated by the staff writing the note. Notes should then be placed in the individual's record;
 - iv. If handwritten notes are transcribed electronically at a later date, the former should be kept to demonstrate that documentation occurred on the day billed.
 - h. Written in black or blue ink;
 - i. Red ink may be used to denote allergies or special precautions;
 - j. Corrected as legally prescribed by:
 - i. Drawing a single line through the error;
 - ii. Labeling the change with the word "error";
 - iii. Inserting the corrected information; and
 - iv. Initialing and dating the correction.
- 3. At a minimum, the individual's information shall include:
 - a. The name of the individual, precautions, allergies (or no known allergies - NKA) and "volume #x of #y" on the front of the record;
 - i. Note that the individual's name, allergies and precautions must also be flagged on the medication administration record;
 - b. Individual's identification and emergency contact information;
 - c. Financial information;
 - d. Rights, consent and legal information including but not limited to:
 - i. Consent for service;
 - ii. Release of information documentation;
 - iii. Any psychiatric or other advanced directive;
 - iv. Legal documentation establishing guardianship;
 - v. Evidence that individual rights are reviewed at least one time a year;
 - vi. Evidence that individual responsibilities are reviewed at least one time a year; and
 - vii. Legal status as it relates to Title 37.
 - e. Pertinent medical information;
 - f. Screening information and assessments, including but not limited to:
 - i. Functional, psychosocial and diagnostic assessments;
 - g. Individual service plan or individual recovery plan, including:
 - i. Identified outcomes or goals (in measurable terms);
 - ii. Interventions or activities occurring to achieve the goals;
 - iii. The individual's response to the interventions or activities (progress notes, tracking sheets, learning logs or data);
 - iv. A projected plan to modify or decrease the intensity of services, supports, care and treatment as goals are achieved; and
 - v. Discharge planning is begun at the time of admission that includes specific objectives to be met prior to decreasing the intensity of service or discharge.
 - h. Discharge summary information provided to the individual at the time of discharge that includes:
 - i. Strengths, needs, preferences and abilities of the individual;
 - ii. Services, supports, care and treatment provided;
 - iii. Achievements;
 - iv. Necessary plans for referral; and,
 - v. Service or organization to which the individual was discharged, if applicable.

1. A dictated or hand-written summary of the course of services, supports, treatment or care incorporating the discharge summary information must be placed in the record within 30 days of discharge.
 - i. Progress notes or Learning Logs (for DD individuals) describing progress toward goals, including:
 - i. Implementation of interventions specified in the plan;
 - ii. The individual's response to the intervention or activity based on data.
 - j. Event notes documenting:
 - i. Issues, situations or events occurring in the life of the individual;
 - ii. The individual's response to the issues, situations or events;
 - iii. Relationships and interactions with family and friends, if applicable;
 - iv. Missed appointments including:
 1. Findings of follow-up; and,
 2. Strategies to avoid future missed appointments.
 - k. Records or reports from previous or other current providers;
 - l. Correspondence.
4. Documentation in the record reflects intensity of the services, supports, care and treatment.
 - a. Frequency and style of documentation are appropriate to the frequency and intensity of services, supports, care and treatment;
 - b. Documentation includes record of contacts with persons involved in other aspects of the individual's care, including but not limited to internal or external referrals.
 5. The individual's response to the services, supports, care and treatment is a consistent theme in documentation.
 6. There is a process for ongoing communication between staff members working with the same individuals in different programs, activities, schedules or shifts.
 7. Assessments, ISPs, and documentation required by Medicaid are to be retained in the individuals' records for three years.
 8. For a review of documentation requirements in power point form, see www.dbhdd.gov; Provider Information; Provider Toolkit.

M. The Organization Maintains a System of Information Management that Protects Individual Information and that is Secure, Organized and Confidential

1. The organization has clear policies, procedures, and practices that support secure, organized and confidential management of information, to include electronic individual records if applicable.
2. Maintenance and transfer of both written and spoken information is addressed:
 - a. Personal individual information;
 - b. Billing information; and
 - c. All service related information.
3. The organization has a HIPAA Privacy Practice Policy that clearly gives the individual a right to adequate notice of the use and disclosure of their protected health information. The notice should contain mandatory elements required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II). In addition, the organization should address:
 - a. HIPAA Privacy Rules, as outlined at 45 CFR Parts 160 and 164 are specifically reviewed with staff and individuals;
 - b. Appointment of the Privacy Officer;
 - c. Training to be provided to all staff;
 - d. Posting of the Notice of Privacy Practices in a prominent place;

- e. Maintenance of the individual's signed acknowledgement of receipt of Privacy Notice in their record.
4. A record of all accounting of disclosures of Personal Health Information (PHI) should be kept in the medical record and available to the individual for 6 years from the current date. Accounting must include:
 - a. Date of disclosure
 - b. Name of entity or person who received the Personal Health Information;
 - c. A brief description of the Personal Health Information disclosed
 - d. A copy of written request disclosure
 - e. Written authorization from the individual or legal guardian to disclose PHI.
5. Confidentiality protocols and if applicable, includes procedures for substance abuse individual records comply with 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, Final Rule (June 9, 1987).
6. Authorization for release of information is obtained when individual information is to be released or shared between organizations or with others outside the organization. All applicable DBHDD policies and procedures and HIPAA Privacy Rules (45 CFR parts 160 and 164) related to disclosure and authorization of protected health information are followed. Information contained in each release of information must include:
 - a. Specific information to be released or obtained;
 - b. The purpose for the authorization for release of information;
 - c. To whom the information may be released or given;
 - d. The time period that the release authorization remains in effect (reasonable based on the topic of information, generally not to exceed a year); and,
 - e. A statement that authorization may be revoked at any time by the individual in advance of the exchange of information;
7. Exceptions to use of a release of information are clear in policy:
 - a. Release if required or permitted by law;
 - b. Release is authorized by law as a valid exception;
 - c. A valid court order or subpoena is served;
 - d. When required to share individual information with the DBHDD or any provider under contract or LOA with the DBHDD for the purpose of meeting your own obligations to the department; or
 - e. In the case of an emergency treatment situation, Protected Health Information (PHI) can be released to a health care provider.
8. The organization has written operational procedures, consistent with legal requirements governing the retention, maintenance and purging of records.
 - a. Records are safely secured, maintained, and retained for a minimum of six (6) years from the date of its creation or the date when last in effect (whichever is later);
 - b. Protocols for all records to be returned to the contracting regions after specified retention period or termination of contract/agreement.
9. The organization has written policy, protocols and documented practice of how information in the record is transferred when an individual is relocated or discharged from service to include but not limited to:
 - a. A complete certified copy of the record to the Department or the provider who will assume service provision, that includes individual's personal information, billing information, service related information such as current medical physician orders, medications, behavior plans as deemed necessary for the purposes of individual's continuity of care and treatment;

- b. In addition unused Special Medical Supplies (SMS), funds, personal belongings, burial accounts
- c. The time frames by which transfer of documents and personal belongings will be completed.

N. The Personal Funds of an Individual are managed by the individual and are protected

1. Policies and clear accountability practices regarding individual valuables and finances comply with all applicable DBHDD policies and Social Security Guide for Organizational and /or Representative Payees regarding management of personal needs spending accounts for individuals served.
2. Providers are encouraged to utilize persons outside the organization to serve as “representative payee” such as, but not limited to:
 - a. Family
 - b. Other person of significance to the individual
 - c. Other persons in the community not associated with the agency
3. The agency is able to demonstrate documented effort to secure a qualified, independent party to manage the individual’s valuables and finances when the person served is unable to manage funds and there is no other person in the life of the individual who is able to assist in the management of individual valuables or funds.
4. Individual funds cannot be co-mingled with the agency’s funds or other individuals’ funds.
5. Specific to Developmental Disabilities Services, if individual’s funds are not personally managed by the individual, a mechanism is in place for the review of funds by the individual or his or her representative:
 - a. At least once a quarter;
 - b. To include a review of the bank statement of funds received (including date of deposit, fund source), funds spent (date and source with receipt) and balance of funds available;
 - c. Documentation of individual review shall be maintained;
 - d. Review and update of other financial assets such as annuity accounts, personal belongings and burial funds.
6. The personal funds of all individuals served in Developmental Disabilities Community Residential Alternatives (CRA) shall adhere to all Federal and State rules and regulations And DBHDD Policy for Management/Supervision/Safeguarding of Possessions, Valuables, Personal Funds and Day to Day Living Expenses in Developmental Disabilities Residential Services.

O. Individuals are provided Services, Supports, Care and Treatment by Staff who are properly Licensed, Credentialed, Trained, and who are Competent

1. Unless otherwise specified by DBHDD Policy or within the contract/agreement with the Department, one or more professionals in the field must be attached to the organization as employees of the organization or as consultants on contract.
 - a. The professional(s) attached to the organization have experience in the field of expertise best suited to address the needs of the individual(s) served.
 - i. Refer to of the *Standards for All Providers* for discussion of qualified professionals.
 - ii. Information regarding the professional(s) that must be attached to specific services may also be found at:
 1. Part I, Section I: *MH and AD Consumer Eligibility, Service Definitions and Service Guidelines*;
 2. Part I, Section II: *DD Consumer Eligibility, Access and Planning List, Service Definitions and Service Guidelines*.

- b. When medical, psychiatric services involving medication or detoxification services are provided, the organization receives direction for that service from a professional with experience in the field, such as medical director, physician consultant, psychiatrist or addictionologist.
- 2. Organizational policy and practice demonstrates that appropriate professional staff shall conduct the following services, supports, care and treatment, including but not limited to:
 - a. Overseeing the services, supports, care and treatment provided to individuals;
 - b. Supervising the formulation of the individual service plan or individual recovery plan;
 - c. Conducting diagnostic, behavioral, functional and educational assessments;
 - d. Designing and writing behavior support plans;
 - e. Implementing assessment, care and treatment activities as defined in professional practice acts; and
 - f. Supervising high intensity services such as screening or evaluation, assessment, partial hospitalization, and ambulatory or residential crisis services.
- 3. a. Specific to Behavioral Health Core and Specialty Services, providers must ensure an adequate staffing pattern to provide access to services. Providers should reference the Service Guideline for staffing requirements of Specialty Services. The below are minimum staffing requirements of Core Providers:
 - 1. Medical Director/Psychiatrist that is on site a minimum of 10 hours weekly
 - 2. RN that is on site a minimum of 10 hours weekly
 - 3. Licensed Clinicians (LCSW, LPC, LAMFT)
 - 4. MAC, CACII, CADC, CCADC, or GCADC (II, III)
 - 5. Certified Peer Specialist (applicable for Adult Core Services only)
 - 6. Paraprofessionals
- 3. b. Specific to Developmental Disabilities Services, providers must ensure an adequate staffing pattern to provide access to services in accordance with service guidelines and professional designations. Refer to Service Guidelines in this Provider Manual for specific staffing requirements.
- 4. The type and number of professional staff attached to the organization are:
 - a. Properly licensed or credentialed in the professional field as required;
 - b. Present in numbers to provide adequate supervision to staff;
 - c. Present in numbers to provide services, supports, care and treatment to individuals as required;
 - d. Experienced and competent in the profession they represent; and
 - e. In 24 hour or residential care settings, at least one staff trained in BCLS and first aid is scheduled at all times on each shift.
- 5. The type and number of all other staff attached to the organization are:
 - a. Properly trained or credentialed in the professional field as required;
 - b. Paraprofessionals working in mental health and addictive diseases services must demonstrate mastery of each topic area within the Standard Training Requirements in Essential Learning. This includes paraprofessionals in all community programs, including those affiliated with the regional hospitals. Additional information regarding the Standard Training Requirement for Paraprofessionals can be found in Section U of this document;
 - c. DD providers using Proxy Caregivers must receive training that includes knowledge and skills to perform any identified specialized health maintenance activity. Additional information regarding Proxy Caregivers can be found in Section V of this document;
 - d. Present in numbers to provide services, supports, care and treatment to

- disqualification, “conviction” does not include treatment under Georgia First Offender Act or a plea of Nolo Contendere).
10. The organization has policies, procedures and documentation practices detailing all human resources practices, including but not limited to:
 - a. Processes for determining staff qualifications including:
 - i. License or certification status;
 - ii. Training;
 - iii. Experience; and
 - iv. Competence.
 - b. Processes for managing personnel information and records including but not limited to:
 - i. Criminal records checks (including process for reporting CRC status change) and
 - ii. Drivers license checks.
 - c. Provisions for and documentation of:
 - i. Timely orientation of personnel and development;
 - ii. Periodic assessment and development of training needs;
 1. Development of activities responding to those needs; and
 - iii. Annual work performance evaluations.
 - d. Provisions for sanctioning and removal of staff when:
 - i. Staff are determined to have deficits in required competencies;
 - ii. Staff is accused of abuse, neglect or exploitation.
 11. All staff, direct support volunteers, and direct support consultants shall be trained and show evidence of competence in the following:
 - a. Orientation requirements are specified for all staff and are provided **prior to direct contact with individuals** and are as follows:
 - i. The purpose, scope of services, supports, care and treatment offered including related policies and procedures;
 - ii. HIPAA and Confidentiality of individual information, both written and spoken;
 - iii. Rights and Responsibilities of individuals;
 - v. Requirements for recognizing and reporting suspected abuse, neglect or exploitation of any individual:
 1. To the DBHDD;
 2. Within the organization;
 3. To appropriate regulatory or licensing agencies; and,
 4. To law enforcement agencies.
 - b. Within the first sixty (60) days from date of hire, all staff having direct contact with individuals shall receive the following training including, but not limited to:
 - i. Person centered values, principles and approaches;
 - ii. A Holistic approach to care of the individual;
 - iii. Medical, physical, behavioral and social needs and characteristics of the persons served;
 - iv. Human Rights and responsibilities (*);
 - v. Promoting positive, appropriate and responsive relationships with persons served, their families and stakeholders;
 - vi. The utilization of:
 - 1 Communication Skills (*);
 - 2 Applied Behavior Analysis (*) and
 - 3 Crisis intervention techniques to de-escalate challenging and unsafe behaviors (*)

- i. Nationally benchmarked techniques for safe utilization of emergency interventions of last resort (if such techniques are permitted in the purview of the organization);
 - vii. Ethics, cultural preferences and awareness;
 - viii. Fire safety (*);
 - ix. Emergency and disaster plans and procedures (*);
 - x. Techniques of Standard Precautions, including:
 - 1. Preventative measures to minimize risk of HIV;
 - 2. Current information as published by the Centers for Disease Control (CDC); and
 - 3. Approaches to individual education.
 - xi. CPR/AED through the American Heart Association or the American Red Cross.
 - 1. All medically licensed staff (nurses, physicians, psychiatrists, dentists, and CNAs) are required to have the Professional Rescuers level of training (Basic Life Support for Healthcare Providers and AED or CPR/AED for the Professional Rescuer).
 - 2. All other staff should have the Lay Rescuers level of training (Heartsaver CPR and AED or CPR/AED).
 - xii. First aid and safety;
 - xiii. Basic cardiac life support (BCLS) includes both written and hands on competency training required.
 - xiv. Specific individual medications and their side effects (*);
 - xv. Services, support, care and treatment specific topics appropriate to the care of persons served, such as but not limited to:
 - 1. Symptom management;
 - 2. Principles of recovery relative to individuals with mental illness;
 - 3. Principles of recovery relative to individuals with addictive disease;
 - 4. Principles of recovery and resiliency relative to children and youth; and
 - 5. Relapse prevention.
 - c. A minimum of 16 hours of training must be completed annually to include the trainings noted by an asterisk (*) in 11.b. (iv); 11.b (iv, vi, ix, x, xii).
12. The organization details in policy by job classification:
 - a. Training that must be refreshed annually;
 - b. Additional training required for professional level staff;
 - c. Additional training/recertification (if applicable) required for all other staff.
13. Regular review and evaluation of the performance of all staff is evident at least annually.
 - a. The evaluation should occur annually;
 - b. Managers who are clinically, administratively and experientially qualified conduct evaluations.
14. It is evident that the organization demonstrates administration of personnel policies without discrimination.

P. The Service Environment Demonstrates Respect for the Persons Served and is Appropriate to the Services Provided

- 1. Services are provided in an appropriate environment that is respectful of persons supported or served. The environment is:
 - a. Clean;

- b. Age appropriate;
 - c. Accessible (individuals who need assistance with ambulation shall be provided bedrooms that have access to a ground level exit to the outside or have access to exits with easily negotiable ramps or accessible lifts. The home shall provide at least two (2) exits, remote from each other that are accessible to the individuals served).
 - d. Individual's rooms are personalized
 - e. Adequately lighted, ventilated, and temperature controlled.
2. There is sufficient space, equipment and privacy to accommodate:
 - a. Accessibility;
 - b. Safety of persons served and their families or others;
 - c. Waiting;
 - d. Telephone use for incoming and outgoing calls that is accessible and maintained in working order for persons served or supported; and
 - e. To provide identified services and supports.
 3. The environment is safe:
 - a. All local and state ordinances are addressed;
 - i. Copies of inspection reports are available;
 - ii. Licenses or certificates are current and available as required by the site or the service.
 4. There is evidence of compliance with state and county of residence fire and life safety codes for the following:
 - i. Installation of Fire alarm system meets safety code;
 - ii. Fire drills are conducted for individuals and staff;
 1. Once a month at alternating times; including
 2. Twice a year during sleeping hours if residential services.
 3. All fire drills shall be documented with staffing involved
 4. DBHDD maintains the right to require an immediate demonstration of a fire drill during any on-site visit.
 5. Policies, plans and procedures are in place that addresses emergency evacuation, relocation preparedness and Disaster Response. Supplies needed for emergency evacuation are maintained in a readily accessible manner, including individuals' information, family contact information and current copies of physician's orders for all individual's medications.
 - a. Plans include detailed information regarding evacuating, transporting, and relocating individuals that coordinate with the local Emergency Management Agency and at a minimum address:
 - i. Medical emergencies;
 - ii. Missing persons;
 1. Georgia's Mattie's Call Act provides for an alert system when an individual with developmental disabilities, dementia, or other cognitive impairment is missing. Law requires residences licensed as Personal Care Homes to notify law enforcement within 30 minutes of discovering a missing individual.
 - iii. Natural disasters known to occur, such as tornadoes, snow storms or floods;
 - iv. Power failures;
 - v. Continuity of medical care as required; and
 - vi. Notifications to families or designees.
 - b. On a regular basis, emergency preparedness notice and plans are:
 - i. Reviewed annually ;
 - ii. Tested at least quarterly for emergencies that occur locally on a less frequent basis such as but not limited to flood, tornado or hurricane;

- iii. Drilled with more frequency if there is a greater potential for the emergency.
- 6. Residential living support service options;
 - a. Are integrated and established within residential neighborhoods;
 - b. Are single family units;
 - c. Have space for informal gatherings;
 - d. Have personal space and privacy for persons supported; and
 - e. **Are understood to be the “home” of the person supported or served.**
- 7. Video cameras may be used in common areas of programs that are not personal residences such as Crisis Stabilization Units where visualization of blind areas is necessary for an individual’s safety. Cameras **may not be used** in the following instances:
 - a. In an individual’s personal residence;
 - b. In lieu of staff presence; or
 - c. In the bedroom of individuals, as it is an invasion of privacy and is strictly prohibited.
- 8. There are policies, procedures, and practices for transportation of persons supported or served in residential services and in programs that require movement of persons served from place to place.
 - a. Policies and procedures apply to all vehicles used, including:
 - i. Those owned or leased by the organization;
 - ii. Those owned or leased by subcontractors; and
 - iii. Use of personal vehicles of staff.
 - b. Policies and procedures include, but are not limited to:
 - i. Authenticating licenses of drivers;
 - ii. Proof of insurance;
 - iii. Routine maintenance;
 - iv. Requirements for evidence of driver training;
 - v. Safe transport of persons served;
 - vi. Requirements for maintaining attendance of person served while in vehicles;
 - vii. Safe use of lift;
 - viii. Availability of first aid kits;
 - ix. Fire suppression equipment; and
 - x. Emergency preparedness.
- 9. Access is promoted at service sites deemed as intake, assessment or crisis programs through:
 - a. Clearly labeled exterior signs; and
 - b. Other means of direction to service and support locations as appropriate.

Q. The Organization that Contracts with Other Organizations Ensures the Affiliate’s Compliance and Capacity to Provide Care (Including Host Homes)

- 1. The organization remains responsible for the affiliate’s compliance with:
 - a. Contract/Agreement requirements;
 - b. Standards of practice and specified requirements in the Provider Manual for the Department of BHDD, including *Standards for All Providers*;
 - c. Licensure requirements;
 - d. Accreditation or standard compliance requirements; and
 - e. Quality improvement and risk reduction activities.
- 2. The affiliate’s capacity to provide quality care is monitored, including:
 - a. Financial oversight and management of individual funds;
 - b. Staff competency and training;
 - c. Mechanisms that assure care is provided according to the plan of care for each individual served; and

- d. The requirement for a Host Home Study when contracting with a Host Home provider.
3. There is evidence of active oversight of the affiliate's capacity and compliance.
4. A report shall be made quarterly to the agency's Board of Directors regarding:
 - a. Services provided by affiliate;
 - b. Quality of performance of the affiliate.
5. A report shall be made to the DBHDD Regional Office prior to the end of the first quarter and third quarter of the fiscal year that includes:
 - a. Name of the affiliate or contractor;
 - b. Contact name for affiliate or contractor;
 - c. Contact information for affiliate or contractor;
 - d. Disability group(s) served;
 - e. Specific service(s) provided;
 - f. Number of persons in service; and
 - g. Annualized amount paid to affiliate.

R. Faith or Denominationally Based Organizations who receive Federal or State Monies address issues specific to being a Faith or Denominationally Based Organization in their Policies and Practice

1. Individuals or recipients of services are informed about the following issues relative to faith or denominationally based organizations:
 - a. Its religious character;
 - b. The individual's freedom not to engage in religious activities;
 - c. Their right to receive services from an alternative provider;
 - i. The organization shall, within a reasonable time after the date of such objection, refer the individual to an alternative provider.
2. If the organization provides employment that is associated with religious criteria, the individual must be informed.
3. In no case may federal or state funds be used to support any inherently religious activities, such as but not limited to:
 - a. Inherently religious activities;
 - b. Religious instruction; or
 - c. Proselytizing.
4. Organizations may use space in their facilities to provide services, supports, care and treatment without removing religious art, icons, scriptures or other symbols.
5. In all cases, rules found at 42 CFR Parts 54, 54a and 45 CFR Parts 96, 260 and 1050 *Charitable Choice Provisions and Regulations: Final Rules* shall apply.

S. PROFESSIONAL DESIGNATIONS. When the requirement for a degree in a course of study is referenced, the degree must be from an accredited college or university.

1. Developmental Disability Professional (DDP) requirements:

DDP services rendered by a provider agency must be provided by a qualified individual DDP, employed by or under professional contract with the provider agency.

At least one agency employee or professional under contract with the agency must:

- Be a Developmental Disability Professional (DDP)
- Have responsibility for overseeing the delivery of waiver services to participants

The same individual may serve as the agency director, nurse and/or DDP, provided the employee meets the qualification and or designation of each position. However, the duties of shared roles for each position must be separately delivered and documented. A change in approved and designated DDP must be reported by the agency to the Department of Behavioral Health and Developmental Disabilities via the DBHDD Provider Network Management Office. Information to be reported must include:

- Updated and current Resume
- Name of individual
- Name of provider agency and contact name of person requesting change of information
- Hours of work, or contract with DDP

The Developmental Disability Professional will deliver their services utilizing a Person-Centered Focus.

Each Developmental Disability Professional (DDP) has a specified schedule or contract with sufficient hours per week to meet the duties of the DDP and level of need for individuals receiving services, which includes but are not limited to:

1. Overseeing the services and supports provided to participants that include;
 - a. The agency DDP monitors and/or participates in the implementation and delivery of the Individual Service Plan (ISP).
 - b. The agency DDP supervises the delivery of service and ensures the strategies reflect the goals and objectives of the ISP.
 - c. The agency DDP monitors the progress toward achievement of goals in the ISP, and makes recommendations for modifications to the ISP, as appropriate.
2. Supervising the formulation of the participant's plan for delivery of all waiver services provided to the participant by the provider, on an annual basis subsequent to ISP development and after any ISP addendum that includes, but is not limited to;
 - a. Ensuring the implementation strategies reflect the ISP and the needs of the participant
 - b. The agency DDP participates in the development of the ISP
3. Conducting functional assessments to support formulation of the participant's plan for delivery of all waiver services that include: and
 - a. The Health Risk Screening Tool
 - b. The Supports Intensity Scale
 - c. Functional Behavioral Analysis
 - d. And others as needed or required
4. Supervising high intensity services that address health and safety risks for the participants that include.
 - a. The agency DDP is involved in reviewing and/or writing, and the implementation and effectiveness of the Behavior Support Plan
 - b. The agency DDP is involved in reviewing and/or writing, and the implementation and effectiveness of the Crisis Plan
 - c. The agency DDP is involved in identifying ongoing supports as needed (medical and/or behavioral) in collaboration with appropriate personnel

The provider will be responsible for monitoring and ensuring the DDP meets his/her above assigned responsibilities utilizing the below performance indicators.

Performance Indicators of the responsibilities listed above (1-4) are as follows:

- a. Active participation in the planning meeting documented in either the meeting minutes/notes and/or progress notes prior to ISP meeting.
- b. Documented contact with the SC prior to the ISP date.
- c. Consulted with, supervised, and provided guidance to direct support staff regarding implementation of the services.
- d. The DDP will complete documentation in any individual's record for any of the above responsibilities. This documentation should include the signature, title/credentials, timed (start and end time of delivery of service) and date.
- e. The DDP will complete, or assure the completion of required agency assessments, included, but not limited to, HRST and SIS, within the given time frame.

For additional details regarding documentation requirements, refer to New Options or Comprehensive (NOW/COMP) Medicaid manual(s) Part II, Chapter 1100.

Hours scheduled and worked must be sufficient to meet the individual needs of each participant served by the provider. The provision of DDP oversight and service provision must be documented in the participant's record. **A DDP is not scheduled to work only on a PRN basis.**

NOTE: DDP direct service provision and oversight for a participant with an approved exceptional rate is in addition to the above requirements and as specified in the letter of approval for the exceptional rate.

Required Trainings for All Developmental Disabilities Professionals

All Developmental Disabilities Professionals must be trained in all required trainings identified in Part II, DBHDD Community Standards for All Providers, Current FY DBHDD Provider Manual located at www.dbhdd.ga.gov.

Other required trainings for DDPs in their first year of employment include:

- Individual Service Planning
- Supports Intensity Scale
- Health Risk Screening Tool

The provider agency must also document the participation of each DDP in a minimum of 8 hours per year of additional DBHDD sponsored or other training in the area of developmental disabilities, not listed above or included in the Community Standards for All Providers.

The following professionals qualify to be a Developmental Disability Professional:

- i. **Advanced Practice Nurse:** A registered professional nurse licensed in the State of Georgia, who meets those educational, practice, certification requirements, OR any combination of such requirements, as specified by the Georgia Board of Nursing AND includes certified nurse midwives, nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists in psychiatric/mental health, AND others recognized by the board AND who have one year experience in treating persons with intellectual/developmental

disabilities in a medical setting or a community based setting for delivery of nursing services.

- ii. **Behavior Specialist:** A behavior specialist who has completed of a Master's degree in psychology, school psychology, counseling, vocational rehabilitation or a related field which included one course in psychometric testing and two courses in any combination of the following: behavior analysis or modification, therapeutic intervention, counseling, or psychosocial assessment, AND one year of individualized treatment programming, monitoring and observing behavior; collecting and recording behavioral observations in a treatment setting and developing and implementing behavior management plans for individuals with intellectual disabilities OR developmental disabilities OR completion of a Bachelor's degree in psychology, counseling, OR a related field which included one course in psychometric testing and two courses in any combination of the following: behavior analysis or modification, counseling, learning theory or psychology of adjustment AND two years of individualized treatment programming, monitoring and observing behavior; collecting and recording behavioral observations in a treatment setting and developing and implementing behavior management plans for individuals with intellectual/developmental disabilities.
- iii. **Board Certified Behavior Analyst (BCBA):** A BCBA who has completed a Master's degree, with 225 hours of approved graduate coursework, AND 1500 hours of experience in the field with 5% of those hours being supervised by a BCBA, AND has received a passing score on the Behavior Analyst Certification Board Exam, AND maintains a prescribed number of continuing educations units annually, AND has specialized training in developmental disabilities as evidenced by college coursework or practicum/internship experience OR one year of experience in providing services to individuals with intellectual/developmental disabilities.
- iv. **Educator:** An educator with a degree in education from an accredited program that includes a concentration in Special Education in college coursework OR teaching certificate in Special Education, AND one year of classroom experience in teaching individuals with intellectual/developmental disabilities.
- v. **Human Service Professional:** A human services professional with a bachelor's degree in social work OR a bachelor's degree in human services field other than social work (including the study of human behavior, human development or basic human care needs) AND with specialized training OR one year of experience in providing human services to individuals with intellectual/developmental disabilities.
- vi. **Master's or Doctoral Degree Holders:** A person with a Masters or Doctoral degree in one of the behavioral OR social sciences AND with specialized training in developmental disabilities as evidenced by college coursework OR practicum/internship experience OR one year of experience in providing services to individuals with intellectual/developmental disabilities.
- vii. **Physical or Occupational Therapist:** A physical or occupational therapist licensed in the State of Georgia, who has specialized training in developmental disabilities as evidenced by college coursework OR practicum/internship experience OR one year of experience in treating individuals with intellectual/developmental disabilities.
- viii. **Physician:** A physician licensed in the State of Georgia to practice medicine or osteopathy AND with specialized training in developmental disabilities OR one year of experience in treating individuals with intellectual/developmental disabilities in a medical setting.

- ix. **Physician's Assistant:** A skilled person qualified by academic and practical training to provide patients' services not necessarily within the physical presence but under the personal direction or supervision of a physician, AND who has one year experience in treating individuals with intellectual/developmental disabilities in a medical setting.
- x. **Psychologist:** A holder of a Doctoral degree from an accredited university or college, AND who is licensed in the state of Georgia AND who has specialized training in developmental disabilities OR one year of experience in evaluating or providing psychological services to individuals with intellectual/developmental disabilities.
- xi. **Registered Nurse (Associate Degree or Diploma):** A registered nurse who is authorized by a license to practice nursing as a registered professional nurse, who holds an associate or diploma degree in nursing, AND who has three years of experience, two of which are in treating individuals with intellectual/developmental disabilities in a medical setting or a community-based setting for delivery of nursing services.
- xii. **Registered Nurse (Bachelor Degree):** A registered nurse who is authorized by license to practice nursing as a registered professional nurse AND who holds a Bachelor's degree in nursing with one year experience in treating individuals with intellectual/developmental disabilities in a medical setting or a community-based setting for delivery of nursing services.
- xiii. **Speech Pathologist or Audiologist:** A speech pathologist or audiologist licensed in the State of Georgia, who has specialized training in developmental disabilities as evidenced by college coursework or practicum/internship experience OR one year of experience in treating individuals with intellectual/developmental disabilities.
- xiv. **Therapeutic Recreation Specialist:** A therapeutic recreation specialist who graduated from an accredited program AND who has specialized training in developmental disabilities as evidenced by college coursework OR practicum/internship experience OR one year experience in providing therapeutic recreational services to individuals with intellectual/developmental disabilities.

2. Behavioral Health Practitioners.

Table of Practitioners for Community BH Provider Agencies:

Professional Title	Minimum Level of Education/Degree/ Experience Required	License/ Certification Required	Requires Supervision?	State Code
Physician (M.D., D.O., etc.)	Graduate of medical or osteopathic college	Licensed by the Georgia Composite Board of Medical Examiners	No. Additionally, can supervise others	43-34-20 to 43-34-37
Psychiatrist (M.D., etc.)	Graduate of medical or osteopathic college and a residency in psychiatry approved by the American Board of Psychiatry and Neurology	Licensed by the Georgia Composite Board of Medical Examiners	No. Additionally, can supervise others	43-34-20 to 43-34-37
Physician's Assistant (PA)	Completion of a physician's assistant training program approved by the Georgia Composite Board of Medical Examiners -- at least 1 year of experience in behavioral healthcare required to supervise CPRP, CPS, or PP staff	Licensed by the Georgia Composite Board of Medical Examiners	Physician delegates functions to PA through Board-approved job description.	43-34-100 to 43-34-108

Professional Title	Minimum Level of Education/Degree/ Experience Required	License/ Certification Required	Requires Supervision?	State Code
Advanced Practice Registered Nurse (APRN): Clinical Nurse Specialist/Psychiatric-Mental Health (CNS-PMH) and Nurse Practitioner (NP)	R.N. and graduation from a post-basic education program for Nurse Practitioners Master's degree or higher in nursing for the CNS/PMH -- Nurse Practitioners must have at least 1 year of experience in behavioral healthcare to supervise CPRP, CPS, or PP staff	Current certification by American Nurses Association, American Nurses Credentialing Center or American Academy of Nurse Practitioners and authorized as an APRN by the Georgia Board of Nursing	Physician delegates advanced practice functions to APRN, CNS-PMH, NP through Board-approved nurse protocol agreements.	43-26-1 to 43-26-13, 360-32
Licensed Pharmacist (LP)	Graduated and received an undergraduate degree from a college or school of pharmacy; completed a Board-approved internship and passed an examination.	Licensed by the Georgia State Board of Pharmacy	No	26-4
Registered Nurse (RN)	Georgia Board of Nursing-approved nursing education program -- at least 1 year of experience in behavioral healthcare required to supervise CPRP, CPS, or PP	Licensed by the Georgia Board of Nursing	By a physician	43-26-1 to 46-23-13
Licensed Practical Nurse (LPN)	Graduation from a nursing education program approved by the Georgia Board of Licensed Practical Nursing.	Licensed by Georgia Board of Licensed Practical Nursing	By a Physician or RN	43-26-30 to 43-26-43
Licensed Dietician (LD)	- Bachelor's degree or higher with a degree in dietetics, human nutrition, food and nutrition, nutrition education or food systems management. - Satisfactory completion of at least 900 hours of supervised experience in dietetic practice	Licensed by Georgia Board of Licensed Dieticians	No	43-11A-1 to 43-11A-19
Qualified Medication Aide (OMA)	Completion of a prescribed course conducted by the Georgia Department of Technical and Adult Education and pass examination for qualified medication aides approved by the Georgia Board of Licensed Practical Nursing.	Certified by the Georgia Board of Licensed Practical Nursing	Supervised by RN performing certain medication administration tasks as delegated by RN or LPN.	43-26-50 to 43-26-60
Psychologist (PhD)	Doctoral Degree	Licensed by the Georgia Board of Examiners of Psychologists	No. Additionally, can supervise others	43-39-1 to 43-39-20
Licensed Clinical Social Worker (LCSW)	Masters degree in Social Work plus 3 years' supervised full-time work in the practice of social work after the Master's degree.	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	No. Additionally, can supervise others	43-10A
Licensed Professional Counselor (LPC)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	No. Additionally, can supervise others	43-10A
Licensed Marriage and Family Therapist (LMFT)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	No. Additionally, can supervise others	43-10A

Professional Title	Minimum Level of Education/Degree/ Experience Required	License/ Certification Required	Requires Supervision?	State Code
Licensed Master's Social Worker (LMSW)	Master's degree in Social Work	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	Works under direction and supervision of an appropriately licensed/credentialed professional.	43-10A
Licensed Associate Professional Counselor (LAPC)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	Works under direction and supervision of an appropriately licensed/credentialed professional	43-10A
Licensed Associate Marriage and Family Therapist (LAMFT)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	Works under direction and supervision of an appropriately licensed/credentialed professional	43-10A
Certified Clinical Alcohol and Drug Counselor (CCADC)	Master's degree; Also requires minimum of 2 years or 4,000 hours experience in direct alcohol and drug abuse treatment with individual and/or group counseling and a total of 270 hours of addiction-specific education and 300 hours of supervised training.	Certification by the Alcohol and Drug Certification Board of Georgia; International Certification and Reciprocity Consortium / Alcohol and Other Drug Abuse (IC&RC)	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Georgia Certified Alcohol and Drug Counselor Level III (GCADC III)	Master's degree; Also must have been certified by a national organization and have taken a written and oral examination in the past and must have been continuously certified for a period of 2 years; Must meet the standards outlined in the Ga. Code rules posted on the licensing board website: Perform the 12 core functions; Education and training; Supervised practicum; Experience and supervision	Certification by the Alcohol and Drug Certification Board of Georgia (ADACB-GA)	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Master Addiction Counselor (MAC) National Board of Certified Counselors (NBCC)	Master's Degree Documentation of a minimum of 12 semester hours of graduate coursework in the area of OR 500 CE hours specifically in addictions. Three years supervised experience as an addictions counselor at no fewer than 20 hours per week. Two of the three years must have been completed after the counseling master's degree was conferred. A passing score on the Examination for Master Addictions Counselors (EMAC).	Certification by the National Board of Certified Counselors (NBCC) Nationally Certified Counselor (NCC) credential – must be Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7

Professional Title	Minimum Level of Education/Degree/ Experience Required	License/ Certification Required	Requires Supervision?	State Code
Master Addiction Counselor, (MAC) through National Association of Alcohol and Drug Counselors, (NAADC)	Master's degree; 500 contact hours of specific alcoholism and drug abuse counseling training). Three years full-time or 6,000 hours of supervised experience, two years or 4,000 hours of which must be post master's degree award. Passing score on the national examination for the MAC	Certification by the National Association Alcohol & Drug Counselors' Current state certification /licensure in alcoholism and/or drug abuse counseling. Passing score on the national examination for the MAC	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Certified Alcohol and Drug Counselor (CADC)	Bachelor' s degree; Also requires minimum of 2 years or 4,000 hours experience in direct alcohol and drug abuse treatment with individual and/or group counseling and a total of 270 hours of addiction-specific education and 300 hours of supervised training	Certification by the Alcohol and Drug Certification Board of Georgia (ADACB-GA) International Certification and Reciprocity Consortium / Alcohol and Other Drug Abuse (IC&RC)	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Georgia Certified Alcohol and Drug Counselor II (GCADC II)	Bachelors degree; Must be certified by a national organization and have taken a written and oral examination; Must have been continuously certified for a period of 2 years; Must meet the standards outlined in the Ga. Code rules posted on the licensing board website: Perform the 12 core functions; Education and training; Supervised practicum; Experience and supervision	Certification by the Alcohol and Drug Certification Board of Georgia (ADACB-GA)	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Certified Addiction Counselor, Level II (CAC-II)	Bachelor's degree; Requires 3 years of experience in practice of chemical dependency/abuse counseling; 270 hours education in addiction field; and 144 hours clinical supervision	Certification by the Georgia Addiction Counselors' Association	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Certified Addiction Counselor, Level I (CAC-I)	High School Diploma/Equivalent; Requires 2 years of experience in the practice of chemical dependency/abuse counseling; 180 hours education in addiction field; and 96 hours clinical supervision.	Certification by the Georgia Addiction Counselors' Association	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment, Under supervision of a Certified Clinical Supervisor	43-10A-7

Professional Title	Minimum Level of Education/Degree/ Experience Required	License/ Certification Required	Requires Supervision?	State Code
Registered Alcohol and Drug Technician I, II, III (RADT-I, RADT-II, RADT-III)	High school diploma or its equivalent and must be enrolled in a junior college, college or university. Must document a minimum of one (1) year or two thousand (2000) hours experience of direct service (alcohol and drug counseling). Once the RADT has completed 30 college credit hours he/she is eligible to take the ICRC written exam. Upon passing the ICRC Written exam, a RADT-II certificate is issued. Once the RADT-II has completed 60 college credit hours, he/she is eligible to take the oral case presentation. Upon successful completion of the oral case presentation, receives a RADT-III certificate is issued. Upon completion of BS degree and experience a CADC will be issued	Registered/certified by the Alcohol and Drug Certification Board of	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment, Under supervision of a Certified Clinical Supervisor; CADC; CCADC, LPC, LCSW	43-10A-7
Addiction Counselor Trainees (ACT)	High school diploma/equivalent and actively pursuing certification as CAC-I, CAC-II, RADT I, II, III; CADC or CCADC or other addiction counselor certification recognized by practice acts.	Employed by an agency or facility that is licensed to provide addiction counseling	Under supervision of a Certified Clinical Supervisor (CCS); CADC; CCADC	
Certified Psychiatric Rehabilitation Professional (CPRP)	High school diploma/equivalent, Associates Degree, Bachelor's Degree, Graduate Degree with required experience working in Psychiatric Rehabilitation (varies by level and type of degree)	Certified by the US Psychiatric Rehabilitation Association (USPRA, formerly IASPRS)	Under supervision of an appropriately licensed/credentialed professional	
Certified Peer Specialist (CPS)	High school diploma/equivalent	Certification by the Georgia Certified Peer Specialist Project Requires a minimum of 40 hours of Certified Peer Specialist Training, and successful completion of a certification exam.	Services shall be limited to those not requiring licensure, but are provided under the supervision of an appropriately licensed/credentialed professional.	
Paraprofessional (PP)	Completion of Standardized Training Requirement for Paraprofessionals approved by the Department of Community Health (includes training provided by the organization and on-line training provided via Essential Learning.)	Completion of a minimum of 46 hours of paraprofessional training and successful completion of all written exams and competency-based skills demonstrations.	Under supervision of an appropriately licensed/credentialed professional	

Professional Title	Minimum Level of Education/Degree/ Experience Required	License/ Certification Required	Requires Supervision?	State Code
Psychologist/LCSW/ LPC/LMFT's supervisee/trainee (S/T)	Minimum of a Bachelor's degree and one or more of the following: <ul style="list-style-type: none"> a. Registered toward attaining an associate or full licensure; b. In pursuit of a Master's degree that would qualify the student to ultimately qualify as a licensed practitioner; c. Not registered, but is acquiring documented supervision toward full licensure (signed attestation by practitioner and supervisor to be on file with personnel office) 	Under supervision in accordance with the GA Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists or enrolled in a practicum with an accredited educational Master's degree program which provides supervision as a part of a curriculum which is the foundation toward licensure	Under supervision of a licensed Psychologist/LCSW, LPC, or LMFT in accordance with the GA Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists or enrolled in a practicum with an accredited educational Master's degree program which provides supervision as a part of a curriculum which is the foundation toward licensure	43-10A
Vocational Rehabilitation Specialist	Minimum of one year verifiable vocational rehabilitation experience.	Employed by an agency that is DBHDD approved to provide ACT.	Under supervision of an ACT team leader who is either a physician, psychologist, PA, APRN, RN with a 4-year BSN, LCSW, LPC, or LMFT.	

T. WAIVERS TO STANDARDS

The organization may not exempt itself from any of these standards or any portion of the provider manual. All requests for waivers of these standards must be done in accordance with Policy #9.102 Requests for Waivers of the Standards for Mental Health, Developmental Disabilities and Addictive Diseases, found herein Part VI.

U. STANDARD TRAINING REQUIREMENT FOR PARAPROFESSIONALS

In addition to the training requirements defined in this document, the Department of Behavioral Health and Developmental Disabilities (DBHDD) requires that all behavioral health paraprofessionals complete the Standard Training Requirement. These trainings provide useful information necessary to fulfill requirements for delivering DBHDD behavioral health services and supports, while also providing paraprofessionals with access to information that will help them be more effective on the job. Demonstrated mastery of each topic area within the Standard Training Requirement is necessary in order for paraprofessionals to provide both state-funded and Medicaid-reimbursable behavioral health services.

The Standard Training Requirement for Paraprofessionals requires that paraprofessionals complete agency-based training as well as targeted, online trainings. In total, each paraprofessional must complete 46 hours of training (29 hours via online courses and 17 hours provided by the organization). In addition, a set number of training hours must be dedicated to specific subject areas. The number of required training hours is by subject area is outlined below.

Subject Area	TOTAL	Required via	Required via
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	Required Hours	Online Courses	Agency-Based Training
Corporate Compliance	2	1	1
Cultural Competence	2	2	
Documentation	5	3	2
First Aid/CPR	6	0	6
Mental Illness – Addictive Disorders	8	8	0
Pharmacology & Medication Self-Admin	2	2	0
Professional Relationships	2	2	0
Recovery Principles	2	2	0
Safety/ Crisis De-escalation	10	4	6
Explanation of Services	1	0	1
Service Coordination	4	3	1
Suicide Risk Assessment	2	2	0
Total Required Hours	46	29	17

At this time, there is no annual or continued training requirement related to the Standard Training Requirement for Paraprofessionals. However, it should be noted that all providers must comply with all training requirements outlined the Standards for All Providers.

Online Courses for Paraprofessionals via Essential Learning

The required online training hours must be completed through the online training programs provided by DBHDD. DBHDD contracts with a national provider, Essential Learning, for the online training and education component of this requirement. Essential Learning provides free, 24/7 access to course content at <http://training.essentiallearning.com/GeorgiaMHAD>. This content is only available to behavioral health providers who have an executed contract or agreement with DBHDD.

In order to gain initial access to the Essential Learning courses, agencies must designate an Essential Learning liaison to assign paraprofessionals for the training. The liaison plays a key role in the successful use of the online curriculum. The liaisons have supervisor rights and can add and delete learners from the system. The liaisons may also assign courses in the Learning Catalog based on the particular need within their organization. Your organization may decide to allow learners to choose their own courses within the required topic areas or to assign learners to complete particular courses that best fit your organization’s needs. Providers must ensure that the Essential Learning Courses assigned will meet compliance with the required number of hours per Subject Area (above). Once the paraprofessional has been given a username and password by the provider’s liaison, s/he can go online and access the available courses and exams in the learning catalog.

The chart below displays the courses available within the Standard Training Requirement for Paraprofessionals which may be satisfied via Essential Learning. A total of 29 hours of online training is necessary to fulfill the training requirement and many subjects offer several courses that can meet the criteria.

Subject Area	Courses available to fulfill online training requirement	Online Hours available per Course
Corporate Compliance	Corporate Compliance and Ethics for	1

Subject Area	Courses available to fulfill online training requirement	Online Hours available per Course	
(Must complete at least 1 hour of online training)	Paraprofessionals		
Cultural Competence (Must complete at least 2 hours of online training)	Cultural Diversity: What it Means to be Culturally Competent for Paraprofessionals	1.5	
	Cultural Issues in Mental Health Treatment for Paraprofessionals	2	
Documentation (Must complete at least 3 hours of online training)	Essential Components of Documentation for Paraprofessionals	6	
Mental Illness – Addictive Disorders (Must choose at least 8 hours of online training)	Bipolar Disorder in Children and Adolescents	1	
	Depressive Disorder in Children and Adolescents	3	
	Overview of Bipolar Disorder for Paraprofessionals	2	
	Overview of Mental Health Issues in Older Adults for Paraprofessionals	3	
	Mood Disorders in Adults – A Summary for Paraprofessionals	1	
	Overview of Family Psychoeducation – Evidenced Based Practices	1.5	
	Overview of Severe Persistent Mental Illness for Paraprofessionals	1.5	
	People with Serious Mental Illness for Paraprofessionals	3.0	
	Understanding Schizophrenia for Paraprofessionals	2	
	Alcohol and the Family for Paraprofessionals	2.5	
	Understanding the Addictive Process: An Overview for Paraprofessionals	2	
	Co-Occurring Disorders: An Overview for Paraprofessionals	1.5	
	Pharmacology and Medication Self Admin (Must choose at least 2 hours of online training)	Overview of Medications for Paraprofessionals	2
		Medication Administration and Monitoring for Paraprofessionals	4
Professional Relationships (Must complete at least 2 hours of online training)	Therapeutic Boundaries for Paraprofessionals	2	
Recovery Principles (Must choose at least 2 hours of online training)	WRAP – One on One	3	
	Path to Recovery	2	
Safety/Crisis De-escalation (Must complete at least 4 hours of online training)	Abuse, Neglect and Incident Reporting*	2	
	Crisis Management for Paraprofessionals	3	
Service Coordination (Must choose at least 3 hours of online training)	Case Management Basics for Paraprofessionals	3	
	Coordinating Primary Care for People with Severe Mental Illness for Paraprofessionals	7.5	
	Supported Employment	6	
Suicide Risk Assessment (Must choose at least 2 hours of online training)	In Harms Way: Suicide in America	1	
	Suicide Prevention	2	
	Suicide the Forever Decision	3	
Total Hours of Available Course Content		75	

Providing Services as a Paraprofessional

The following individuals must complete the Standard Training Requirement in order to provide services as a Paraprofessional:

- a. Individuals who are not licensed or do not hold an approved credential, regardless of education level. For example, an individual with a Masters in Social Work but not a license would need to complete the Standard Training Requirement.
- b. Contract employees providing outsourced services who fall within the paraprofessional criterion
- c. Individuals who have not yet completed the certification process to be Certified Peer Specialists
- d. Individuals who may be eligible in the future to be licensed or certified but who are not yet licensed or certified
- e. Individuals providing Psychiatric Residential Treatment Facility services but not staff providing services through foster care, Intensive Crisis Stabilization Program, and child & adolescent group homes

Individuals who are working towards licensure and meet the qualifications of a Supervisee/Trainee as defined in the Standards for All Providers must also complete the Standard Training Requirement.

Paraprofessional staff members must complete the Standard Training Requirements within the new hire orientation guidelines for their organization but no later than **90 days after hire**. Staff may provide and bill for services during this 90 days. If the Standard Training Requirement is not completed after 90 days, the individual may not bill until s/he fulfills the requirement. Any services that are provided outside of the 90 day grace period by an uncertified paraprofessional are subject to recoupment.

If an individual would like to bill a service for which they are not an approved practitioner, they may bill as a paraprofessional (providing that a paraprofessional is an approved practitioner). In order to do so they must have completed the Standard Training Requirement. When documenting this service, the noted credential of the practitioner must match the practitioner level billed. For example, if an LPN would like to provide Community Support Individual (a service for which s/he is not an approved practitioner), s/he could bill as a paraprofessional and would therefore need to be in compliance with the Standard Training Requirement. The LPN would document his/her credentials as “LPN and PP” when billing at the paraprofessional rate.

Documentation for the Standard Training Requirement

Documentation of compliance must be available for each paraprofessional. An orientation agenda/checklist/spreadsheet with the name of the employee, date of topic, training, and number of hours must be available and is required for audit purposes. Proof of course completion should be kept in a personnel file for both agency-provided training as well as online training. This may be documented via a certificate or transcript generated online by Essential Learning or by the “live” course provider.

Auditors may verify the information provided on the tracking sheet by viewing the training certificates. If this information is not available, services billed by the paraprofessional will be subject to recoupment. The date of hire must also be available for review.

If further questions or clarifications are needed regarding the Standard Training Requirement, please email questions to: RegistrationMHDDAD@dbhdd.ga.gov

V. For DD providers utilizing Proxy Caregivers and Health Maintenance Activities:

Licensed provider agencies, including co-employer agencies, must abide by the Rules and Regulations for Proxy Caregivers Used in Licensed Healthcare Facilities, Chapter 111-8-100. The policies and procedures specified below are applicable to all providers:

Health Maintenance Activities Definition: Health maintenance activities, which are limited to those activities that, but for a disability, a person could reasonably be expected to do for himself or herself. Such activities are typically taught by a registered professional nurse, but may be taught by an attending physician, advanced practice registered nurse, physician assistant, or directly to a person and are part of ongoing care. Health maintenance activities are those activities that do not include complex care such as administration of intravenous medications, central line maintenance (i.e., daily management of a central line, which is intravenous tubing inserted for continuous access to a central vein for administering fluids and medicine and for obtaining diagnostic information), and complex wound care; do not require complex observations or critical decisions; can be safely performed and have reasonably precise, unchanging directions; and have outcomes or results that are reasonably predictable. Any activity that requires nursing judgment is not a health maintenance activity. Health maintenance activities are specified for an individual participant in written orders of the attending physician, advanced practice registered nurse, or physician assistant.

1. Written Plan of Care Requirements: Health maintenance activities are as defined in the written plan of care that implements the written orders of the attending physician, advanced practice registered nurse, or physician assistant and specifies the frequency of training and evaluation requirements for the proxy caregiver, including additional training when changes in the written plan of care necessitate added duties for which such proxy caregiver had not previously been trained. The written plan of care is established by a registered professional nurse, or by an attending physician, advanced practice registered nurse, or physician assistant. This written plan of care for health maintenance activities must be maintained in the participant's record and available for the proxy caregiver.
2. Written Informed Consent: A participant or individual legally authorized to act on behalf of the participant must complete a written informed consent designating a proxy caregiver and delegating responsibility to such proxy caregiver to receive training and to provide health maintenance activities to the participant pursuant to the written orders of an attending physician, or an advanced practice registered nurse or physician assistant working under a nurse protocol agreement or job description.
3. Requirements for Individuals Providing Health Maintenance Activities: Individuals who provide health maintenance activities in accordance with the above conditions must meet the following:
 - a. Be selected by the participant or a person legally authorized to act on behalf of the participant to serve as the participant's proxy caregiver.
 - b. Receive training by an attending physician, advanced practice registered nurse, physician assistant, or registered nurse that teaches the proxy caregiver the necessary knowledge and skills to perform the health maintenance activities documented in the participant's written plan of care as defined above. The training must include the knowledge and skills to perform any identified specialized procedures for the participant.

- c. Demonstrate to the trainer (i.e., attending physician, advanced practice registered nurse, physician assistant, or registered nurse) the necessary knowledge and skills to perform the health maintenance activities documented in the participant's written plan of care as defined above. The training must include the knowledge and skills to perform any identified specialized procedures for the participant.
- 4.. Non-Covered Health Maintenance Activities: Health maintenance activities that meet any of the following are non-covered:
- a. Complex care such as administration of intravenous medications, central line maintenance, and complex wound care.
 - b. Provided by an individual without written informed consent designating that individual as a proxy caregiver and delegating responsibility to such proxy caregiver to receive training.
 - c. Provided without the written orders of an attending physician, or an advanced practice registered nurse or physician assistant working under a nurse protocol agreement of job description, respectively, pursuant to Georgia Code Section 43-34-25 or 43-34-23.
 - d. Provided without a written plan of care as defined above.

Provided by individuals who do not meet the requirements specified above.

Appendix I:

Antipsychotic Medications	
Generic	Trade
Aripiprazole	Abilify
Chlorpromazine	Thorazine
Chlorprothixene	Taractan
Clozapine	Clozaril
Fluphenazine	Permitil, Prolixin*
Haloperidol	Haldol*
Loxapine	Loxitane
Mesoridazine	Serentil
Molindone	Lidone, Moban
Olanzapine	Zyprexa
Paliperidone	Invega*
Perphenazine	Trilafon
Pimozide (for Tourette's)	Orap
Quetiapine	Seroquel
Risperidone	Risperdal*
Thioridazine	Mellaril
Thiothixene	Navane
Trifluoperazine	Stelazine
Trifluopromazine	Vesprin
Ziprasidone	Geodon
Mood Stabilizer Medications	

Generic	Trade
Lithium Carbonate	Eskalith
Divalproex Sodium	Lithonate
Tiagabine	Depakote
Levetiracetam	Gabatril
Lamotrigine	Keppra
Gabapentin	Lamitcal
Carbamazepine	Neurontin
Oxcarbazepine	Tegretol
Topiramate	Trileptal
Zonisamide	Topamax
Verapamil	Zonegran
Clonidine	Calan
Propranolol	Catapres
Mexiletine	Inderal
Guanfacine	Mexitil
	Tenex

*Also has a sustained release injectable form

PART III

Community Service Standards Specific for Developmental Disabilities Services

**Provider Manual for
Community Mental Health,
Developmental Disabilities and
Addictive Diseases
Providers**

Fiscal Year 2012

(Sections I and II Updated for October 1, 2011 Implementation)



**Georgia Department of Behavioral Health &
Developmental Disabilities**

October 2011

Part III

Community Service Standards Specific for Developmental Disabilities Services

SECTION I

Operational and Clinical Standards for Georgia Crisis Response System (GCRS-DD)

Fiscal Year 2012

(Updated for October 1, 2011 Implementation)



**Georgia Department of Behavioral Health &
Developmental Disabilities**

October 2011

Department of Behavioral Health and Developmental Disabilities
Operational and Clinical Standards for Georgia Crisis Response System
(GCRS-DD)

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DESCRIPTION

The goal of this system is to provide time-limited home and community based crisis services that support individuals with developmental disabilities in the community, and provide alternatives to institutional placement, emergency room care, and/or law enforcement involvement (including incarceration). These community based crisis services and homes are provided on a time-limited basis to ameliorate the presenting crisis. The system is to be utilized as a measure of last resort for an individual undergoing an acute crisis that presents a substantial risk of imminent harm to self or others.

The Georgia Crisis Response System includes intake, dispatch, referral, and crisis services components. An essential part of this system is the assessment of the individual situation to determine the appropriate response to the crisis. Entry into the system takes place through the Single Point of Entry (SPOE) system. Intake personnel determine if an individual meets the requirements for entry into the system and initiate the appropriate dispatch or referral option. If a Developmental Disability (DD) Mobile Crisis Team is dispatched to the crisis location, this team assesses the need for a referral or crisis services. Crisis services occur through intensive on-site or off-site supports. These crisis supports are provided on a time-limited to ameliorate the crisis.

A. GENERAL REQUIREMENTS

In addition to the Georgia Crisis Response System Standards, Developmental Disabilities (DD) crisis service providers must comply with the *State of Georgia, Department of Behavioral Health and Developmental Disabilities (DBHDD) Community Service Standards Part II, Section I, Standards for All Providers* with the exception of the following:

Physical restraints also known as mechanical restraints, as defined in the *Standards for All Providers*, may not be used by the crisis services provider. As stipulated in the *Standards for All Providers*, chemical restraints may never be used under any circumstance by the Crisis Service Provider. A personal restraint also known as a manual hold or manual restraint is used in accordance with the *Standards for All Providers*.

The following standards are applicable to DBHDD or organizations that provide crisis response services to individuals, family members, care-givers, and/or DD waiver service provider agencies that activate the Georgia Crisis Response System.

1. The system is to be utilized as a measure of last resort for an individual undergoing an acute crisis that presents a substantial risk of imminent harm to self or others. The preference is not to transfer an individual to an out-of-home setting, but to provide additional supports in the home.
2. Crisis Response System staff are to coordinate with provider agencies of individuals currently receiving services, who access the Crisis Response System, on a case by case basis to assess and recommend needed changes in services.
3. Training records are to be maintained, which document that all Crisis Response System staff have participated in training and passed an examination demonstrating their competence in all crisis protocols and relevant applicable trainings as listed below:
 - a. Single Point of Entry (SPOE) staff
 - i. Mobile crisis dispatch criteria
 - ii. Telephonic crisis intervention

- b. Mobile team members and intensive support staff
 - i. Assessing the crisis
 - ii. Onsite operations
 - iii. Referral decision criteria
 - iv. Required crisis intervention curriculum
 1. Crisis Prevention Institute (CPI) *www.crisisprevention.com*
 2. Handle with Care Behavior Management System, Inc. *www.handlewithcare.com*
 3. Mindset *www.mindsetconsulting.net*
 4. Safe Crisis Management *ww.jkmtraining.com*
 5. Human Empowerment Leadership Principles (HELP) *www.capscanhelp.com*
 6. Professional Crisis Management (PCM) *ww.pcma.com*
 7. Safety- Care (QBS, Inc) *www.qbscompanies.com*
 - v. Cardiopulmonary Resuscitation (CPR)
 - vi. First aid
 - vii. Documentation standards and expectations
4. Clinical intervention decisions are made to ensure the least restrictive interventions and placements likely to be successful are utilized as evidenced by assessments that justify the need for any restrictive interventions and/or placements (including intensive in-home supports or intensive out-of-home supports).
5. Plans intended to modify behavior over time (not including crisis plans) are not developed unless appropriate behavioral assessments are completed, and the personnel who develop the plans are able to provide follow-up activities.
6. Discharge Planning should begin at intake and continue throughout utilization of the Crisis Response System. The discharge planning process should include collaboration with all applicable parties, family members/care-givers, providers, Support Coordination Agency, Planning List Administrator, Regional Intake and Evaluation (I & E) Teams. The social work staff in the Crisis Response System must coordinate this process with the oversight of the LCSW assigned to the Mobile Crisis Team.
7. Transportation must be provided by DD Mobile Crisis Teams, in-home support, and/or out-of-home support staff for an individual, who needs to be transported to the crisis homes, emergency facilities, and/or back to their place of residence once discharged from this Crisis Response System level of care.
8. The Georgia Crisis Response System serves children and adults with developmental disabilities aged 5 years and above who meet eligibility criteria as defined in Section B.

B. Intake Requirements

The Georgia Crisis Response System is designed for individuals with developmental disabilities in need of Behavioral Health and Developmental Disabilities (BHDD) crisis services. A person with developmental disabilities in need of BHDD crisis services is an individual who:

- Has documented evidence of a diagnosis of an intellectual disability prior to age 18 years or other closely related developmental disability prior to age 22 years, for individuals currently on the

planning list or in DD services; screening indicative of a developmental disability for other individuals; AND

- Presents a substantial risk of imminent harm to self or others; AND
- Is in need of immediate care, evaluation, stabilization or treatment due to the substantial risk; AND
- Is someone for whom there currently exists no available, appropriate community supports to meet the needs of the person.

The following are requirements for the Single Point of Entry (SPOE):

1. The dispatch operator for the SPOE should attempt to ameliorate the crisis situation through telephonic crisis intervention.
 - a. When successful in resolving the crisis:
 - i. For individuals without a waiver, state funds or planning list services, within 24 hours the SPOE is to make a referral to the Regional I&E Team for review.
 - ii. For individuals with a waiver, state funds or planning list services, within 24 hours the SPOE is to notify the Regional Office and DD service provider, if applicable. If the call originates from a DD service provider, the SPOE is to engage that provider during the resolution of the crisis.
 - b. When unsuccessful in resolving the crisis and face-to-face intervention is needed, the SPOE must provide documentation to support the need for the dispatch of the DD Mobile Crisis Team. The SPOE is to contact immediately the Regional Office, the support coordination agency, and the DD service provider if applicable.
2. When the DD Mobile Crisis Team is dispatched, the SPOE must provide the team pertinent clinical information including but not limited to:
 - a. Demographics
 - b. Crisis location
 - c. Crisis description
 - d. Current medical status
 - e. Status in Case Management Information System (CIS) (if applicable)
 - i. Support coordination contact information
 - ii. Planning List Administrator (PLA) contact information
 - iii. Summary of progress notes for the last 30 days
 - iv. New Options Waiver (NOW)/Comprehensive (COMP) waiver status
 - v. Current behavioral interventions

All information provided to the DD Mobile Crisis Team by SPOE must be sufficient to allow the team to ensure that appropriate staff members are dispatched to the crisis.

3. Once the SPOE (Behavioral Health Line) contacts the appropriate crisis provider within a specific region, and it is determined that the crisis provider is unable to immediately dispatch a Mobile Crisis Team, all resources available to that provider must be utilized to remedy the crisis situation within the required 1.5 hours; including the use of in-home crisis supports team.
 - a. If that crisis provider is not able to appropriately address the crisis in 1.5 hours, they are to inform the SPOE and include the reason for not being able to meet the 1.5 hour response

requirement. Upon receipt of this information, the SPOE must contact the nearest crisis provider for dispatch.

- b. The newly dispatched crisis provider may be located within the same region or across regional lines. If the mobile crisis response is provided by an out-of-area team, **and** either in-home or out-of-home supports are required after the initial crisis has been supported, the individual is to be transitioned to the in-area crisis provider for ongoing supports.
 - c. When an individual experiences a crisis outside their region of residence, the SPOE must dispatch the Mobile Crisis Team for the region where the crisis is occurring.
 - d. The Mobile Crisis Team for that region is to assess the situation to determine if additional in-home or out-of-home supports are required, subsequent to the initial stabilization.
 - e. If additional in-home or out-of-home supports are required, subsequent to the initial stabilization, the initial Mobile Crisis Team is to work in conjunction with the crisis provider within the region of residence, to insure that the individual receives the supports in their home region.
- 4 The DD Mobile Crisis Team is to request of the SPOE's (Behavioral Health Line) shift supervisor immediate access to the Consumer Information System (CIS) for the individual in crisis. The SPOE Behavioral Health Line shift supervisor is to respond, by providing CIS information for all individuals in crisis and who are listed in the CIS.

C. DD Mobile Crisis Team Requirements

1. A minimum of three team members, including one Licensed Clinical Social Worker (LCSW), a behavior specialist, and a direct support staff will respond to each dispatch of the DD Mobile Crisis Team. Other possible team members may include a registered nurse, an additional social worker (MSW), safety officer, or additional direct support staff. In addition, a physician will be available for consultation if needed.
2. All licensed or certified team members are required to comply with the DBHDD Policy, *Professional Licensing and Certification Requirements of Practice Act*, maintaining valid/current license or certification.
3. The LCSW on the DD Mobile Crisis Team is to provide at a minimum, oversight to the operation of the team and is responsible for ensuring that the appropriate team members are dispatched or are available for consultation based on the clinical data provided by the SPOE.
4. The DD Mobile Crisis Team is to:
 - a. Respond and arrive on site within 1 ½ hours of the SPOE dispatch.
 - b. Address the crisis situation to mitigate any risk to health and safety of the individual and/or others.

- c. Rule out any medical causes, through consultation with available medical professionals, which might be contributing to the crisis prior to recommending any intensive crisis supports involving behavioral interventions.
5. The DD Mobile Crisis Team members are responsible for completing comprehensive assessment(s) of the current crisis situation. This assessment process must include interviews with the individual, care providers and/or family members, observation of the current environment, and review of behavior and individual support plans. The LCSW on the team is responsible for ensuring that the assessment process is thorough and complete.
6. Reasonable and relatively simple environmental modifications that do not require continuing programmatic efforts are considered before intensive crisis supports and/or a behavior plan is recommended or implemented.
7. When the DD Mobile Crisis Team makes a disposition, the LCSW communicates all recommendations within 24 hours to all applicable parties (Families/Caregivers, Support Coordination Agencies, Provider Agencies, and/or Regional Office I & E Teams).
8. When the DD Mobile Crisis Team completes services in the home, the LCSW or a designated social worker (MSW) on the team completes a written discharge plan that must:
 - a. Minimally include:
 - i. Summary of precipitating events
 - ii. Clinical interventions
 - iii. Response to clinical interventions
 - iv. Recommendations for continued interventions
 - v. Referral for additional supports (if applicable).
 - b. Be executed and documented within a 24-hour period after a disposition has been determined.
9. Crisis Response System providers must develop and maintain DD Mobile Crisis Team protocols for On-Site Operations. The protocols must include detailed description of its processes that include at a minimum:
 - a. On-Site Stabilization, including intensive in-home supports and professional consultation
 - b. Referral and/or transport to intensive out-of-home crisis supports
 - c. Referral to hospital emergency department

D. Intensive Crisis Support Services Requirements

Intensive Crisis Supports are specialized services that provide time-limited care and intervention to an individual due to his or her need for support and protection of other(s) living with him or her. These supports provide specific intervention and case management strategies directed towards enabling the recipient to remain in the community. The outcome of these services should enhance the current family member's or provider's ability to meet the needs of the recipient.

1. With the oversight of the LCSW, the DD Mobile Crisis Team determines and documents the existing level of crisis that requires the initiation of Intensive Crisis Supports.

- a. The criteria to receive Intensive In-Home Supports include:
 - i. The DD Mobile Crisis Team is not able to mitigate the crisis in a reasonable amount of time OR
 - ii. The crisis was resolved but environmental variables and/or the individual's lack of adaptive behavioral responses make another crisis imminent AND
 - iii. The caregiver or DD service provider is not capable of providing necessary intervention and protection for the individual or others living with the individual AND
 - iv. The Intensive Crisis Supports will enable the individual to avoid institutional placement (such as a placement in a behavioral health hospital, nursing home, jail or correctional facility).
 - b. The criteria to receive Intensive Out-Of-Home Supports include:
 - i. All of the intensive in-home supports criteria AND
 - ii. The safety of others living in the home with the individual or others living in the community cannot be maintained through the use of Intensive In-Home Supports with written justification based on clinical observation and/or assessment OR
 - iii. Extensive environmental modifications are needed as a result of the crisis and the individual cannot safely reside in the home with Intensive In-Home Supports while modifications are completed.
2. When behavioral interventions are necessary, Crisis Response personnel follow applicable *Best Practice Standards for Behavioral Support Services*. For adults, *The Guidelines for Supporting Adults with Challenging Behavior in Community Settings* provides additional information to consider when conducting behavioral assessments (The standards and guidelines are found at www.dbhdd.ga.gov Provider Information: Provider Toolkit).
 3. The Crisis Response System provider must maintain and develop protocols that describe processes for the provision of both In-Home and Out-of-Home Intensive Crisis Supports. The description must include the following processes at a minimum:
 - a. Accessing Intensive Crisis Supports;
 - b. Types of Intensive Crisis Supports it plans to provide;
 - c. Procedures for utilizing Intensive Crisis Supports both in and out of the individual's home.
 4. When the individual meets the following criteria, he/she must be discharged from Intensive Crisis Support Services and the Crisis Response System service provider will complete a written discharge plan indicating at a minimum that:
 - a. The crisis has been resolved, and a plan has been developed that prevents future crises or allows current caregivers or staff to maintain safety should future crises arise AND
 - b. Family and/or provider have been trained and can implement all components of the plan AND
 - c. The individual has met the discharge criteria and the plan of discharge was developed with and reviewed with family, care-giver, and/or DD service provider OR
 - d. The individual exhibits medical conditions requiring more intensive medical care that cannot be provided through Intensive Crisis Supports.

E. Intensive In-Home Support Requirements

1. Intensive In-Home Support services include, but are not limited to the following:

- a. Implementation of behavioral intervention strategies provided under the recommendations of the DD Mobile Crisis Team, safety plans, or behavioral support plans already established for the individual; provision of one-to-one support, as necessary, to address the crisis; modeling of interventions with family and/or provider staff; assistance with simple environmental adaptations as necessary to maintain safety; and when necessary accompanying the individual to appointments related to the crisis response.
 - b. The provision of a staffing pattern up to 24 hours per day, 7 days per week, with the intensity of the Intensive In-Home Support services decreasing over 7 calendar days.
 - c. Maintenance of stakeholder's involvement in the response to the crisis, in order to restore the individual to pre-crisis supports and/or provider services.
 - d. Assurance of appropriate training to support crisis stabilization and the return of the individual to pre-crisis services and supports, to include:
 - i. Demonstration of interventions to the family/caregiver and/or existing DD service provider (if applicable) AND
 - ii. Implementation of these interventions by the family/caregiver and/or existing DD service provider (if applicable).
 - e. Provision of intensive case management services with the assistance of designated support coordinators or planning list administrators (if applicable), for assessment/evaluation for additional needs and supports, with follow-up to ensure implementation of recommended supports/services.
2. Documentation of Intensive In-Home Support services is to:
- a. Occur on a daily basis;
 - b. Include a description of the behavioral interventions utilized;
 - c. Indicate the training process and identity of the trained caregiver or staff that will support the individual upon termination of crisis supports.
3. As a time-limited response, Intensive In-Home Supports are not to exceed 7 calendar days. Extensions beyond 7 calendar days are the exception and are not typical.
- a. Exceptions to this timeframe are to be based on extraordinary circumstances assessed daily by the crisis service provider, and the support coordinator or planning list administrator if applicable.
 - b. Extensions beyond the 7calendar days are to be approved by the Regional Services Administrator for Developmental Disabilities (RSA-DD) for the applicable region. Extensions are only approved when discharge criteria noted in Section D 4a-4d have not been met as evident by observations, with assessment of outcomes related to clinical interventions documented on a daily basis.
Note: As soon as the need is indicated by the GCRSS-DD staff, the RSA-DD engages and reviews all necessary information for an individual's whose circumstances determine the need for an exception.

F. INTENSIVE OUT-OF-HOME SUPPORT REQUIREMENTS FOR CRISIS SUPPORT HOMES

The intent of Intensive Out-of-Home Supports is to stabilize the individual through nursing and behavioral supports, on a time-limited basis. Intensive Out-of-Home Supports are to be provided by Crisis Support

Homes, which are to serve no more than four adult individuals simultaneously. Individuals under the age of 18 years must not be served in a Crisis Support Home. There is currently no required licensure of Crisis Support Homes. However, each Crisis Support Home must receive Standards Compliance Review by DBHDD prior to operation.

F-1. CRISIS SUPPORT HOME PROTOCOL FOR OPERATIONS

Crisis System Response service providers must develop and maintain protocols for the Crisis Support Homes that include but are not be limited to:

- Criteria for determining when and if a referral to a Crisis Support Home is necessary
- Staffing plan to include the minimum staffing of a registered nurse, a licensed professional nurse, day, evening and night staff, a behavior specialist, and a psychologist
- Transportation plan to and from home(s)
- The availability of a licensed clinical social worker to assist crisis support home staff with case management and discharge planning services, to ensure that appropriate referrals and/or coordination of services are part of the transition back to the home environment.

In addition the protocols must meet the following:

1. As a time-limited response, Intensive Out-of-Home Supports are not to exceed a 7 calendar days. Extensions beyond 7 calendar days are the exception and are not typical.
 - a. Exceptions to this timeframe are to be based on extraordinary circumstances assessed daily by the crisis service provider and the support coordinator or planning list administrator if applicable.
 - b. Extensions beyond 7 calendar days are to be approved by the Developmental Disabilities Regional Services Administrator (RSA) for the applicable region. The following criteria must be met for consideration for an extension of the individual's length of stay:
 - i. Discharge criteria noted in Section D 4a-4d have not been met as evidenced by observations, with assessment of outcomes related to clinical interventions documented on a daily basis AND
 - ii. Environmental conditions (due to safety concerns) within the home preclude immediate discharge, AND/OR
 - iii. Extraordinary circumstances regarding the caregiver/provider that negate their ability to provide care for the individual upon discharge as determined by the DD RSA.
2. The development of a discharge plan is to be person-centered, beginning at intake and noting:
 - a. An evaluation of additional supports and services by the support coordinator for individuals with waiver services.
 - b. An evaluation of additional supports and services by the planning list administrator for individuals on the planning list.
 - c. Referral for intake and evaluation by the region I & E Team, to determine eligibility and most in need of services, for individuals not in waiver services.
 - d. Intensive Out-of-Home support staff have trained the personnel in post-crisis services placement and/or family members regarding all interventions utilized in the out-of-home crisis placement.

3. Upon discharge from the Crisis Support Homes, the individuals may:

- a. Return to his/her family home or provider placement;
 - b. Experience a permanent change in provider location. For individuals in waiver services, a permanent change in provider location will require an assessment evaluation as a result of an approved Individual Service Plan (ISP) addendum based upon the long term interests of the individual and in accordance with DBHDD policies.
4. Out-of-Home Support services and discharge planning case management are to be documented daily by appropriate personnel.
 5. Records of pre-service and annual training of Crisis Support Home staff, including names of persons trained, the training source, content, dates, length of training, and copies of certificates received and persons attending must be kept and be readily available.

F-2. CRISIS SUPPORT HOME MINIMUM FLOOR PLAN REQUIREMENTS

1. A residence must be constructed, arranged, and maintained so as to provide adequately for the health, safety, access, and well-being of the individual.
2. A Crisis Support Home must provide for common living space and private sleeping areas.
 - a. The living and sleeping areas for an individual must be within the same building.
 - b. Windows used for ventilation to the outside and exterior doors used for ventilation must be screened and in good repair.
 - c. Supportive devices must be installed as necessary to enable the individual to achieve a greater degree of mobility and safety from falling.
3. All Crisis Support Homes must provide an area that affords privacy for the individual and visitors. There must be common spaces, such as living and dining rooms, for use by the individual without restriction.
4. Common areas of the residence must be large enough to accommodate the individual without crowding. The areas must be comfortably furnished.
5. Upon request, the residence must provide a means of locked storage for the valuables or personal belongings of the individual.
6. The residence must provide laundering facilities on the premises for individual's personal laundry.
7. The following minimum standards for bedrooms must be met:
 - a. Bedrooms must have sufficient space to accommodate without crowding the individual, the individual's belongings, and the minimum furniture of a bed and dresser;
 - b. The individual's bedroom must have at least one window and a closet;
 - c. Bedrooms for individuals must be separated from halls, corridors, and other rooms by floor to ceiling walls. Hallways must not be used for sleeping;
 - d. The floor plan must be such that no person other than the occupant of that bedroom must pass through a bedroom in order to reach another room;
 - e. The bedroom occupied by the individual must have doors that can be closed. For bedrooms that have locks on doors, both the occupant and staff must be provided with keys to ensure easy entry. Double-cylinder locks (locks requiring a key on both sides) may not be used on the bedroom of an individual.

- f. A room must not be used as a bedroom where more than one half of the room height is below ground level. Bedrooms which are partially below ground level should have adequate natural light and ventilation and be provided with two useful means of egress; and
 - g. When an individual is discharged, the room and its contents must be adequately cleaned.
8. The following minimum standards apply to bathroom facilities:
- a. At least one functional toilet, lavatory, and bathing or showering facility must be provided for every four individuals residing in a Crisis Support Home;
 - b. At least one fully handicap accessible bathroom must be available;
 - c. Grab bars and non-skid surfacing or strips must be installed in all showers and bath areas;
 - d. Bathrooms and toilet facilities must have a window that can be opened or must have forced ventilation;
 - e. Toilets, bathtubs, and showers must provide for individual privacy;
 - f. Shower fixtures in bathrooms must be flush-mounted in the wall; and
 - g. All plumbing and bathroom fixtures must be maintained in good working order at all times and must present a clean and sanitary appearance.
9. All stairways and ramps must have sturdy handrails, securely fastened not less than 30 inches nor more than 34 inches above the center of the tread. Exterior stairways, decks, and porches must have handrails on the open sides unless the surface of the deck or porch is so close to ground level that it does not pose a significant risk of injury to the individual to fall from the deck or porch.
10. Floor coverings must be intact, safely secured, and free of any hazard that may cause tripping.
11. All areas including hallways and stairs must be lighted sufficiently.
12. The following exterior conditions must be maintained:
- a. Entrances and exits, sidewalks, and escape routes must be maintained free of any obstructions that would impede leaving the residence quickly in the case of fire or other emergency. All such entrances and exits, sidewalks, and escape routes must be kept free of any hazards such as ice, snow, or debris;
 - b. The yard area, if applicable, must be kept free of all hazards, nuisances, refuse, and litter; AND
 - c. The residence must have its house number displayed so as to be easily visible from the street.

F-3. CRISIS SUPPORT HOME FURNISHINGS AND FIXTURES

- 1. Furnishings of the individual in the living room, bedroom, and dining room, including furnishings provided by the individual, must be maintained in good condition, intact, and functional.
- 2. Furnishings and housekeeping standards must be such that a residence presents a clean and orderly appearance. The Crisis Support Home must provide the following bedroom furnishings based on safety:
 - a. An adequate closet or wardrobe;
 - b. Lighting fixtures sufficient for reading and other activities;
 - c. A bureau, dresser, or the equivalent;

- d. A shatter proof mirror appropriate for grooming;
 - e. A standard, non-portable bed measuring at least 36 inches wide and 72 inches long with comfortable springs and a clean mattress. The mattress must be not less than 5 inches thick or 4 inches of a synthetic construction.
3. The Crisis Support Home must provide to each individual clean towels and washcloths at least twice weekly and more often if soiled.
 4. The Crisis Support Home must provide bedding for each individual including two sheets, a pillow, a pillow case, and a minimum of one blanket and bedspread. The Crisis Support Home must maintain a linen supply for not less than twice the bed capacity.

F-4. CRISIS SUPPORT HOME PHYSICAL PLANT, HEALTH, AND SAFETY STANDARDS

1. Each Crisis Support Home must provide a safe and healthy environment for its individuals, and where subject to fire and safety standards promulgated by Office of the Safety Fire Commissioner, such Crisis Support Home must be in compliance with those standards.
2. Each Crisis Support Home must comply and remain in compliance with any and all local ordinances for fire safety in residences of that size and function. In the absence of or in addition to any such local ordinances, the following requirements must be met:
 - a. Wall-mounted electric outlets and lamps or light fixtures must be maintained in a safe and operational condition;
 - b. Cooking appliances must be suitably installed in accordance with approved safety practices;
 - c. Space heaters must not be used;
 - d. Fire screens and protective devices must be used with fireplaces, stoves, and heaters;
 - e. Sufficient AC powered smoke detectors, with battery backup, must be in place and, when activated, must initiate an alarm that is audible in the sleeping rooms. Strobe alarms must be used when required by the needs of individuals (e.g. for hearing impaired persons). NOTE: Strobe alarms should have the ability to be disarmed for individuals who have epilepsy/seizure disorders that are exacerbated by strobe lighting.
 - f. If natural gas or heating oil is used to heat the residence, or if a wood-burning fireplace is in the residence, the residence must be protected with carbon monoxide detectors;
 - g. Each residence must have at least one charged, 5 lb. multipurpose ABC fire extinguisher on each occupied floor and in the basement that must be readily accessible. These extinguishers must be checked annually by a fire safety technician and monthly by the staff of the Crisis Support Home to ensure they are charged and in operable condition; and Sufficient AC powered smoke detectors with battery backup must be in place and, when activated, must initiate an alarm that is audible in the sleeping rooms.
 - h. Exterior doors must be equipped with locks that do not require keys to open the door from the inside.
3. Water and sewage systems must meet applicable federal, state, and local standards and regulations.
4. Floors, walls, and ceilings must be kept clean and in good repair.

5. Kitchen and bathroom areas must be cleaned with disinfectant and maintained to ensure cleanliness and sanitation.
6. The storage and disposal of biomedical wastes and hazardous wastes must comply with applicable federal and state rules and standards.
7. The storage and disposal of garbage, trash, and waste must be accomplished in a manner that will not permit the transmission of disease, create a nuisance, or provide a breeding place for insects or rodents. Waste must be removed from the kitchen as necessary and from the premises at least weekly.
8. No animals must be kept at the residence;
9. Poisons, caustics, and other dangerous materials must be stored in clearly labeled and appropriate containers, safeguarded in an area away from medication storage areas and from food preparation and storage areas and secured as required by the capacity of the individuals.
10. The Crisis Support Home must be equipped and maintained so as to provide a sufficient amount of hot water for the use of the individuals. Heated water provided for use by individuals must not exceed 120 degrees Fahrenheit at the hot water fixture, unless a cooler temperature is required by the needs of the individual. A water temperature monitor or a scald valve must be installed where necessary to ensure the safety of the individuals.
11. There must be clearly accessible route(s) for emergencies throughout the residence.
12. The temperature throughout the residence must be maintained by a central heating system or its equivalent at ranges that are consistent with individual's health needs. No individual must be in any area of the residence that falls below 65 degrees or that exceeds 82 degrees Fahrenheit.
13. There must be a supply of first-aid materials available with a minimum of the following: bandages, antiseptic, gauze, tape, thermometer, and gloves.

F-5. CRISIS SUPPORT HOME SERVICES

1. Each Crisis Support Home must provide room, meals, and crisis services that are commensurate with the needs of the individuals. Services must be provided by appropriately qualified staff members.
2. Personal hygiene assistance must be given to those individuals who are unable to keep themselves neat and clean.
3. The Crisis Support Home administrator or his or her designee must teach each individual the techniques of "Standard Precautions," as appropriate to the individual's ability, or must support each individual in the performance of the techniques of "Standard Precautions," including washing his or her hands thoroughly after toileting, sneezing, or any other activity during which the individual's hands may become contaminated.
4. The routine of the residence must be such that an individual may spend the majority of his or her non-sleeping hours out of the bedroom if he or she so chooses.

5. The Crisis Support Home administrator or his or her designee must be available to any person within the Crisis Support Home, including each individual served.

F-6. CRISIS SUPPORT HOME RECORD MANAGEMENT

All records must be kept in accordance with requirements of the Department of Behavioral Health and Developmental Disabilities current Provider Manual, Part II, Section I, Community Standards for All Providers.

F-7. CRISIS SUPPORT HOME DOCUMENTATION OF SERVICES

Providers must document the following in the record of each individual based on the plan to support the individual as determined by the assessment team. The following must be on file for each individual:

1. Dates (beginning and ending) of service
2. Completed intake/evaluation documents (Medical and/or Behavioral Assessment)
3. Determined model of support
4. Discharge plan

F-8. CRISIS SUPPORT HOME INDIVIDUAL FILES AND INFORMATION

All individual files and information must be kept in accordance with requirements of the Department of Behavioral Health and Developmental Disabilities current Provider Manual, Part II, Section I, Community Standards for All Providers.

F-9. INDIVIDUAL RIGHTS IN A CRISIS SUPPORT HOME

All services delivered should be in accordance with Client's Rights Chapter 290- 4-9

F-10. ABUSE IN A CRISIS SUPPORT HOME

It is expressly prohibited to Mistreat, Abuse, Neglect, Exploit, and Seclude or Restrain any person(s) service in a Crisis Support Home. These include but are not limited to:

1. Physical Abuse- includes but is not limited to such actions as striking, pulling, pushing, twisting body parts, or inflicting any physical injury to an individual by any means. Physical abuse includes directing one individual to physically abuse another individual.
2. Sexual Abuse- includes but is not limited to sexual assault, rape, fondling, sexual exploitation or any sexual interaction.
3. Mental Abuse- includes but is not limited to any action, which creates mental anguish for the individual. These actions include but are not limited to discriminatory remarks, belittlement, derogatory name-calling, teasing, and unreasonable exclusion from conversation or activities and verbal abuse.
4. Neglect- includes but is not limited to the denial of meals, medication, habilitation and other necessities.
5. Exploitation- includes but is not limited to any illegal or improper action affecting a person or use of the person's resources for another person's profit or advantage.

6. Seclusion, is defined as placing an individual in a locked room, is prohibited. A locked room includes a room with any type of door locking device, such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door shut.
7. Physical restraints (i.e., mechanical restraints) - are not used as punishment, for staff convenience, or through a behavioral support plan or behavioral management intervention for purposes of restricting a participant's movement. Those devices which restrain movement, but are applied for protection of accidental injury (such as a helmet for protection of fall due to frequent, severe seizures but not for purposeful head banging or other self-injurious behavior) or required for medical treatment of the physical condition of the participant (such as protection for healing of an open wound) or for supportive or corrective needs of the participant (such as physical therapy devices) are not considered physical restraints.

Refer to the Department of Behavioral Health and Developmental Disabilities current Provider Manual, Part II, Section I, Standards for all Providers for additional details.

F-11. REPORTING AND INVESTIGATION OF DEATHS AND CRITICAL INCIDENTS IN A CRISIS SUPPORT HOME

Death and/or critical incidents of individuals in service must be reported to the Department of Behavioral Health and Developmental Disabilities according to the policy found in the Department of Behavioral Health and Developmental Disabilities current Provider Manual. This policy can be located at the website: <http://dbhdd.georgia.gov/portal/site/DBHDD> (click on *Provider Information*, and the *Provider Tool Kit* for the current *Provider Manual, Policy: Reporting and Investigation of Individual Deaths and Critical Incidents for Community*).

F-12. NUTRITION SERVICES IN A CRISIS SUPPORT HOME

1. A minimum of three regularly scheduled, well-balanced meals must be available seven days a week. Meals must be served in the early morning, at midday, and the evening, with the last meal taking place no earlier than 5:00 P.M. Meals must meet the general requirements for nutrition found in the recommended Daily Diet Allowances, Food and Nutrition Board, National Academy of Sciences or a diet established by a registered dietitian. Meals must be of sufficient and proper quantity, form, consistency, and temperature. Food for at least one nutritious snack must be available and offered mid-afternoon and evening. All food groups must be available within the residence and represented on the daily menu.
2. All foods, while being stored, prepared, or served, must be protected against contamination and be safe for human consumption in accordance with accepted standards for food safety.
3. Food received or used in a Crisis Support Home must be clean, wholesome, free from spoilage, adulteration, and mislabeling, and safe for human consumption.
4. A Crisis Support Home must have a properly equipped kitchen to prepare regularly scheduled, well-balanced meals unless it arranges for meals to be provided by a permitted food service establishment. In such case, a copy of required certification related-health, safety, sanitation is available.

5. A Crisis Support Home must maintain a three-day supply of non-perishable foods and water for emergency needs for all individuals receiving services in the Crisis Support Home and staff assigned.
6. A Crisis Support Home must arrange for and serve special diets as prescribed.
7. The Crisis Support Home shows evidence of individual choice and participation in the planning of meals, as appropriate.

F-13. MEDICATION MANAGEMENT IN A CRISIS SUPPORT HOME

All medication must be kept and administered in accordance with requirements of the Department of Behavioral Health and Developmental Disabilities current Provider Manual, Part II, Section I, Community Standards for All Providers.

F-14. STANDARDS COMPLIANCE REVIEW OF A CRISIS SUPPORT HOME

Each DD Crisis Support Home delivering out-of-home intensive supports must receive a Standards Compliance Review by DHBDD prior to operation. Each DD Crisis Support Home is subject to periodic review by Division and Regional staff and the Standards Compliance Unit. Outcomes of those reviews may include, but are not to be limited to a corrective action required of provider, or a moratorium on the use of the home for out-of-home intensive supports.

F-15. EMERGENCY EVACUATION PLAN FOR CRISIS SUPPORT HOME IN CASE OF NATURAL DISASTER

In the case of a natural disaster (i.e. tornado, flood, hurricane, etc) that requires emergency evacuation of the DD Crisis Home, individuals currently receiving in the home will be transported by the Crisis Provider to the nearest and safest DD Crisis Home. This home does not have to be located within the same Region of the original home.

G. Intensive Out-of-Home Support Requirements for Temporary and Immediate Support Homes

The intent of Intensive Out-of-Home Supports is to stabilize the individual through nursing and behavioral supports on a time-limited basis. Individuals between ages 10-17 years needing this level of care must be served in a Temporary and Immediate Support (TIS) Home. The TIS Home provider must be a Licensed Child Placing Agency. TIS Home supports will be available twenty-four hours a day, seven days a week. It is critical that children and youth remain in their family home environment and thus extraordinary circumstances must exist in order to place children and youth in this level of support.

G-1. TIS HOME PROTOCOL FOR OPERATION

TIS providers must develop and maintain protocols that include but are not be limited to:

- Criteria for determining when and if a referral to a TIS Home is necessary
- Staffing plan to include the minimum staffing of an RN, behavior specialist, TIS coordinator, TIS staff, and a psychiatrist.
- Transportation plan to and from home(s)

In addition, the protocols must meet the following:

1. As a time-limited response, Intensive Out-of-Home Supports are not to exceed 7 calendar days. Extensions beyond 7 calendar days are the exception and are not typical.
 - a. Exceptions to this timeframe are to be based on extraordinary circumstances assessed daily by the support coordinator or planning list administrator.
 - b. Extensions beyond 7 calendar days are to be approved by the Developmental Disabilities Regional Services Administrator (RSA) for the applicable region. The following criteria must be met for consideration for an extension of the individual's length of stay:
 - i. Discharge criteria noted in Section D 4a-4d have not been met as evidenced by observations, with assessment of outcomes related to clinical interventions documented on a daily basis AND
 - ii. Environmental conditions (due to safety concerns) within the home preclude immediate discharge, AND/OR
 - iii. Extraordinary circumstances regarding the care-giver/provider that negate their ability to provide care for the individual upon discharge as determined by the DD RSA.
2. The development of a discharge plan is to be person-centered, beginning at intake and noting:
 - a. An evaluation of additional supports and services by the support coordinator for individuals with waiver services.
 - b. An evaluation of additional supports and services by the planning list administrator for individuals on the planning list.
 - c. Referral for intake and evaluation by the Regional I & E Team, to determine eligibility and most in need of services, for individuals not in waiver services.
 - d. Intensive Out-of-Home support staff have trained the personnel in post-crisis services placement and/or family members regarding all interventions utilized in the out-of-home crisis placement.
 - e. Coordination with the family and/or DD service provider on a plan for return to school/educational activities.
3. Upon discharge from the TIS Home, the individual may:
 - a. Return to his/her family home or provider placement;
 - b. Experience a permanent change in provider location. For individuals in waiver services, a permanent change in provider location will require an assessment evaluation as a result of an approved Individual Service Plan (ISP) addendum based upon the long term interests of the individual and in accordance with DBHDD policies.
4. Out-of-Home Support services and discharge planning case management are to be documented daily by appropriate personnel.
5. Records of pre-service and annual training of TIS Home staff, including names of persons trained, the training source, content, dates, length of training, and copies of certificates received and persons attending must be kept and be readily available.
6. The applicable Regional Office is to be immediately notified of the child/youth's admission into the TIS home.

7. The TIS provider is to collaborate with to all applicable parties (Families/Caregivers, Support Coordination Agencies, Provider Agencies, and/or Regional Office I & E Teams) in order to establish a comprehensive discharge plan. A discharge plan may include “step downs” to a TIS host home model and then back to family or provider with scheduled maintenance respite in place. The TIS host home provider will be required to follow DBHDD and agency policies and procedures. Host Home provider will be required to follow plan of support determined by the assessment team. Additional support will be provided if authorized.

G-2. TIS HOME RECORD MANAGEMENT

All records must be kept in accordance with requirements of the Department of Behavioral Health and Developmental Disabilities current Provider Manual, Part II, Section I, Community Standards for All Providers.

G-3. TIS HOME DOCUMENTATION OF SERVICES

Providers must document the following in the record of each individual based on the plan to support the individual as determined by the assessment team. The following must be on file for each individual:

1. Dates (beginning and ending) of service
2. Completed intake/evaluation documents (Psychiatrist, Medical and/or Behavioral Assessment)
3. Determined model of support
4. Discharge plan

G-4. TIS HOME INDIVIDUAL FILES AND INFORMATION

All individual files and information must be kept in accordance with requirements of the Department of Behavioral Health and Developmental Disabilities current Provider Manual, Part II, Section I, Community Standards for All Providers.

G-5. INDIVIDUAL RIGHTS IN A TIS HOME

All services delivered should be in accordance with Client’s Rights Chapter 290- 4-9

G-6. ABUSE IN A TIS HOME

It is expressly prohibited to Mistreat, Abuse, Neglect, Exploit, and Seclude or Restrain any person(s) service in a Crisis Support Home. These include but are not limited to:

1. Physical Abuse- includes but is not limited to such actions as striking, pulling, pushing, twisting body parts, or inflicting any physical injury to an individual by any means. Physical abuse includes directing one individual to physically abuse another individual.
2. Sexual Abuse- includes but is not limited to sexual assault, rape, fondling, sexual exploitation or any sexual interaction.
3. Mental Abuse- includes but is not limited to any action, which creates mental anguish for the individual. These actions include but are not limited to discriminatory remarks, belittlement, derogatory name-calling, teasing, and unreasonable exclusion from conversation or activities and verbal abuse.
4. Neglect- includes but is not limited to the denial of meals, medication, habilitation and other necessities.

5. Exploitation- includes but is not limited to any illegal or improper action affecting a person or use of the person's resources for another person's profit or advantage.
6. Seclusion, is defined as placing an individual in a locked room, is prohibited. A locked room includes a room with any type of door locking device, such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door shut.
7. Physical restraints (i.e., mechanical restraints) – are not used as punishment, for staff convenience, or through a behavioral support plan or behavioral management intervention for purposes of restricting a participant's movement. Those devices which restrain movement, but are applied for protection of accidental injury (such as a helmet for protection of fall due to frequent, severe seizures but not for purposeful head banging or other self-injurious behavior) or required for medical treatment of the physical condition of the participant (such as protection for healing of an open wound) or for supportive or corrective needs of the participant (such as physical therapy devices) are not considered physical restraints.

Refer to the Department of Behavioral Health and Developmental Disabilities current Provider Manual, Part II, Section I, Standards for all Providers for additional details.

G-7. REPORTING AND INVESTIGATION OF DEATHS AND CRITICAL INCIDENTS IN A TIS HOME

Death and/or critical incidents of individuals in service must be reported to the Department of Behavioral Health and Developmental Disabilities according to current fiscal year Provider Manual Part VI Policies Reporting Consumer Deaths and Critical Incidents and Investigating Consumer Deaths and Critical Incidents.

G-8. NUTRITION SERVICES IN A TIS HOME

1. A minimum of three regularly scheduled, well-balanced meals must be available seven days a week. Meals must be served in the early morning, at midday, and the evening, with the last meal taking place no earlier than 5:00 P.M. Meals must meet the general requirements for nutrition found in the recommended Daily Diet Allowances, Food and Nutrition Board, National Academy of Sciences or a diet established by a registered dietitian. Meals must be of sufficient and proper quantity, form, consistency, and temperature. Food for at least one nutritious snack must be available and offered mid-afternoon and evening. All food groups must be available within the residence and represented on the daily menu.
2. All foods, while being stored, prepared, or served, must be protected against contamination and be safe for human consumption in accordance with accepted standards for food safety.
3. Food received or used in a TIS Home must be clean, wholesome, free from spoilage, adulteration, and mislabeling, and safe for human consumption.
4. A TIS Home must have a properly equipped kitchen to prepare regularly scheduled, well-balanced meals unless it arranges for meals to be provided by a permitted food service establishment. In such case, a copy of required certification related-health, safety, sanitation is available.

5. A TIS Home must maintain a three-day supply of non-perishable foods and water for emergency needs for all individuals receiving services in the Crisis Support Home and staff assigned.
6. A TIS Home must arrange for and serve special diets as prescribed.
7. The TIS Home shows evidence of individual choice and participation in the planning of meals, as appropriate.

G-9. MEDICATION MANAGEMENT IN A TIS HOME

All medication must be kept and administered in accordance with requirements of the Department of Behavioral Health and Developmental Disabilities current Provider Manual, Part II, Section I, Community Standards for All Providers.

H. Quality Assurance and Standard Compliance Requirements

In conjunction with DBHDD, the Providers of the DD Crisis Response System should develop performance indicators and outcome measures for each stage of the Georgia Crisis Response System. Once baseline data has been collected, DBHDD will develop specific performance indicators and outcome goals for the system. These indicators and outcomes will allow DBHDD to monitor the crisis response system and make quality improvement decisions based on data collected.

1. Providers of the DD Crisis System must develop a quality assurance system that will generate monthly reports to include, but not limited to, the following:
 - a. Reason for crisis call
 - b. Site of crisis (including DBHDD Region)
 - c. Demographic information of the individual in crisis (including Medicaid status)
 - d. Provider (include a category of none)
 - e. Family Involvement
 - f. Final outcome of crisis incident
 - g. Dispatch team response time
 - h. Services received (include a category of none, behavioral health services)
 - i. Waiver or planning list status (if yes on planning list, include level of planning list: if yes on waiver, indicate which waiver, including NOW, COMP, ICWP, SOURCE, CCSP, Unknown)
 - j. Support coordination agency, if applicable
 - k. Incidences of mobile crisis team dispatch to emergency rooms
 - l. Incidences of intensive in-home and out-of-home crisis supports
 - m. Number of days of use of intensive in-home and out-of-home crisis supports
 - n. Recidivism of individuals and providers in relation to utilization of Georgia Crisis Response System
 - o. Referrals by crisis service providers to Child Protection Services and Adult Protection Services
2. The Crisis Response System service provider must participate in data collection and generate monthly quality assurance reports for submission to DBHDD- Division of Developmental Disabilities, Outcomes and Quality Assurance Office.

I. STAFFING REQUIREMENTS

Qualifications and Standards of Crisis Response System provider professional staff:

1. Qualifications of Professional Social Worker (as defined for the purposes of the Georgia Crisis Response System must meet the following standards):
 - a. Clinical social work licensure (LCSW) issued by the State of Georgia that is current and unrestricted AND
 - b. Advanced skill in crisis intervention, conducting assessments and/or evaluations, and developing interventions using accepted standards of care AND
 - c. Knowledge of federal, state, and local programs that have been developed for people with developmental disabilities including eligibility criteria and how to access these services AND
 - d. Advocacy experience and knowledge of the Individuals with Disabilities Education Act (IDEA), and the Americans with Disabilities (ADA) Act and their legal mandates as they relate to special education programs and the rights of people with disabilities.
2. Professional Social Worker Standards:
 - a. Social workers must adhere to the values and ethics of the social work profession, utilizing the National Association of Social Workers (NASW) Code of Ethics as a guide to ethical decision making.
 - b. Social workers must adhere to clinical practice guidelines outlined in the NASW Standards for Clinical Social Work in Social Work Practice.
 - c. In accordance with the NASW Standard for Continuing Professional Education and the Georgia State Composite Board's licensure requirements for Continuing Education Units, clinical social workers should obtain any applicable certifications for crisis intervention curricula approved by DBHDD.
3. Qualifications of Registered Nurse (as defined for the purposes of the Georgia Crisis Response System must meet the following standards):
 - a. Must be a Registered Nurse with an unrestricted license to practice nursing in the state of Georgia AND
 - b. Have experience in caring for individuals with developmental disabilities who are in crisis.
4. Professional Registered Nurse Standards:
 - a. The Registered Nurse is committed to promoting health through assessment, nursing diagnosing, planning, intervention, evaluation and treatment of human responses when faced with a crisis. The Registered Nurse employs a purposeful use of self as its art and a wide range of nursing, psychosocial and neurobiological theories and research evidence as its science.
 - b. The Registered Nurse will adapt the American Nurses Association Code of Nursing standards and use these standards as comprehensive holistic assessment prior to engaging in any plan to resolve a crisis. The Registered Nurse will be directly involved in all aspect of crisis intervention by utilizing the nursing process.
5. Qualifications of Licensed Practical Nurse (as defined for the purposes of the Georgia Crisis Response System must meet the following standards):
 - a. Must be a Practical Nurse with an unrestricted license to practice nursing in the state of Georgia under the supervision of a Registered Nurse AND
 - b. Have experience in caring for individuals with developmental disabilities who are in crisis.

6. Professional of Licensed Practical Nurse Standards:
 - a. The Licensed Practical Nurse must accept the responsibilities as an accountable member of the health care team AND
 - b. Shall function within the limits of educational preparation and experience as related to assigned duties AND
 - c. Function with other members of the health care team in promoting and maintaining health, preventing diseases and disabilities in order to obtain optimal health, utilizing the nursing process under the supervision of the Registered Nurse.
7. Qualifications of Behavioral Specialist (as defined for the purposes of the Georgia Crisis Response System must meet the following standards):
 - a. Possess a minimum of a Masters degree in psychology, behavior analysis, education, social work or a related field AND
 - b. Possess specialized training and education in behavioral analysis and positive behavioral supports for people with developmental disabilities by provision of evidence of a minimum of thirty-five (35) hours of training and education in behavior analysis and behavioral supports for individuals with developmental disabilities, which may include college transcripts and/or copies of training certificates or evidence of national certification as a Board Certified Behavior Analyst through documentation of a certificate from the Behavior Analyst Certification Board AND
 - c. Have at least two years experience in behavioral supports evaluation and services for people with developmental disabilities.
8. Behavior Specialist Standards: Behavior Specialists are to adhere to the *Best Practice Standards for Behavioral Support Services*
9. Qualifications of Physician:
 - a. Graduate of medical or osteopathic college; AND
 - b. Licensed by the Georgia Composite Board of Medical Examiners

J. Definitions

1. Crisis Services: Occur through intensive on-site or off-site supports. This system will be an alternative to emergency room care, law enforcement involvement, and/or institutional placement. Crisis services are time-limited and present-focused in order to address the immediate crisis and develop appropriate links to alternate services.
2. Crisis Support Home: A home that serves up to four (4) individuals who are experiencing an emotional/behavioral change and/or distress that leads to a disruption of essential functions, which have not responded to Intensive-In-Home Support services.
3. Developmental Disability: An individual is determined to have developmental disability by a professional licensed to make this determination. The developmental disability is attributable to a significant intellectual disability, or any combination of a significant intellectual disability and physical impairments. The developmental disability manifests before the individual attains age 22 years and is likely to continue indefinitely.

4. Intensive Case Management: is a time-limited service that connects the individual in crisis to the necessary services and supports to ameliorate the crisis situation, coordinates with stakeholders to assure the development of a discharge plan from crisis support services, and ensures follow up on recommended supports/services.
5. Mobile Crisis Team: The mobile crisis team is composed of personnel with differing levels of expertise and training. Depending on the crisis, different team compositions may be dispatched. A minimum of three team members, including a behavior specialist, licensed clinical social worker, and a direct support staff, will respond to each mobile dispatch.
6. Safety Officer: An individual who provides support related to safety issues during the provision of GCRS-DD service. This individual is to have safety related training and dressed in a safety related uniform. A GCRS-DD safety officer must not carry any form of a weapon (such as a gun, any form of a “billy club”, baton”, hand cuffs, taser gun),
7. Temporary Intermediate Support (TIS) Home: A TIS Home is to serve no more than four children ages 10 thru 17 years of age, who are diagnosed with a developmental disability and are undergoing an acute crisis that presents a substantial risk of imminent harm to self or others. Placement in a TIS home is to only occur as a last result and after a clinical determination for this level of placement has occurred.

Part III

Community Service Standards Specific for Developmental Disabilities Services

SECTION II

Operational Standards for Host Home/Life-Sharing

Fiscal Year 2012

(Updated for October 1, 2011 Implementation)



**Georgia Department of Behavioral Health &
Developmental Disabilities**

October 2011

Department of Behavioral Health and Developmental Disabilities
Operational Standards for Host Home/Life-Sharing

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GENERAL PROVISIONS

Introduction

Host /Life-Sharing means living with and sharing life experiences with supportive persons who form a caring household. A Host Home /Life-Sharing residential setting is recognized as being both a close personal relationship and a place to live.

Host Home/Life-Sharing is based on the importance of enduring and permanent relationships as the foundation for learning life skills, developing self-esteem and learning to exist in interdependence with others. The Host Home/Life- Sharing experience provides an opportunity for each individual with developmental disability to grow and develop to his or her greatest potential and to participate in everyday community life. This is an important feature of a Host Home/Life-Sharing arrangement. Host Home/Life-Sharing also provides individualized attention based on the needs of the individual with developmental disabilities.

Life-Sharing is a process. A key to successful Life-Sharing is finding a family or person who is willing to share their lives with an individual with developmental disabilities. The matching process between people who want to Life-Share is critical to predicting future success of the relationship.

Purpose

The purpose of these Standards is for the protection, health, safety and well being of individuals with developmental disabilities, through the formation, implementation and enforcement of minimum requirements for Host Home/Life-Sharing as a residential service option.

Applicability

These Standards apply to Host Home /Life Sharing for adults with developmental disabilities.

These Standards contain the minimum requirements that are to be met to receive funding for individuals approved to receive community residential services by the Division of Developmental Disabilities (DD), of the Department of Behavioral Health and Developmental Disabilities (DBHDD).

These Standards apply to profit, nonprofit and publicly funded agencies approved as developmental disability residential providers offering Host Home/Life-Sharing service option.

The Department of Behavioral Health and Developmental Disabilities (DBHDD) is to enroll and approve each Community Residential Alternative (CRA) agency administering one or more Host Home /Life-sharing residential setting as part of the waiver provider enrollment process. The Support Coordination Agency or DBHDD designee for any individual choosing this residential option is to inspect the home using the Division of Developmental Disabilities approved Site Inspection tool prior to an individual with developmental disability living or receiving Host Home/Life-Sharing care in this setting.

Exemptions

These rules do not apply to the following facilities:

1. Private homes of persons providing care to a relative with developmental disability.

2. A community home licensed by Georgia Healthcare Facility Regulations (HFR) as a Community Living Arrangement.
3. Approved Foster Homes for Children operating under a Child Placement Agency licensed by Georgia Office of Residential Child Care.
4. A home operating under permit by the Georgia Healthcare Facility Regulations (HFR) as a Personal Care home exclusively serving people with mental illness, addictive diseases, or domiciliary care residents.
5. Residences in which a person lives with his or her family.
6. Boarding homes or rooming homes that provide personal services other than lodging and meals.
7. Facilities offering temporary or emergency shelter, such as those for the homeless or victims of family violence.
8. Respite homes
9. Emergency receiving, evaluation, and treatment facilities that provide medical and nursing services that are approved by the state and regulates under the more specific authorities.
10. Facilities providing residential services for federal, state or local correctional institutions under the jurisdiction for the criminal justice system.
11. Hospice that serve terminally ill persons.
12. Therapeutic substance abuse treatment facilities and residence that are not intended to be an individual's permanent residence.
13. Group residences organized by or for persons who choose to live independently and manage their own care and who share the cost of service including but not limited to attendant care, transportation, rent utilities and food preparation.
14. Charitable organizations providing shelter and other services without charging any fee to the resident and without billing other agencies for service provided.
15. A single person residence owned and operated by an agency.
16. Residences in which a person lives under his or her own lease or warranty deed, in which the agency providing services do not manage the person's residence and the resident, is not required to move when the agency providing services changes.
17. Apartments or other clustered residential arrangements where staff is available that are developed as permanent housing for adult with mental illness, in which an individual lives within his or her residential arrangement with immediate support of staff

Definitions

The following words and terms, when used in these Standards, have the following meanings, unless the content clearly indicates otherwise:

Agency - A legally constituted organization administering one or more Host Home /Life-Sharing residential settings.

Alternate care – Temporary Host Home/Life-Sharer care not to exceed 30 days for an individual in their Individual plan year.

Community Residential Alternative (CRA) – Services which are targeted for individuals who require intense levels of residential supports in small group setting of four or less, foster homes, or Host Homes and include range of interventions with particular focus on training and support in one or more of the following areas: eating, drinking, toileting, personal grooming and health care, dressing, communication, interpersonal relationships, mobility, home management and use of leisure time.

DBHDD – The Department of Behavioral Health and Developmental Disabilities

DCH – The Department of Community Health

Developmental Disability – A disability that is present in early life and prior to age 22 with related conditions similar to the limitations in everyday life functions present for someone with developmental disabilities.

Host Home– The private home of an individual or a family, whether owned or leased, in which residential supports are provided to one or two adult individuals, defined as 19 years of age and above with developmental disability. The home owner or lessee is not to be an employee of the same DBHDD approved provider agency, which provides the Host Home services. Individuals are not to be related to the occupant owner or lessee by blood or marriage. The occupant owner or lessee is not to be the guardian of any person served on their property nor the agent in such person’s advance directive for health care.

The term does not include a home if there are more than two individuals, including individuals receiving alternate care or respite care, living in the home at any one time, who are not family members, relatives or non-relatives of the family member. The total number of family members, relatives and non-relatives living in the home at any given time may not exceed six. This number does not include the individual(s) being served.

Individual – A person with developmental disability who resides, or receives residential care, in a Host Home/Life-Sharing residential setting and who is not a relative of the owner or the family members. The term does not include family members.

ISP – Individual Service Plan

Regional Office – Regional offices are the field operations offices of the Department of Behavioral Health and Developmental Disabilities.

Relative- A parent, child, stepparent, stepchild, grandparent, grandchild, brother, sister, half -brother, half-sister, aunt, uncle, niece or nephew.

GENERAL REQUIRMENTS

Waivers

A waiver of a specific section, subsection or paragraph of these subsections may be requested by writing to the Regional Office of Behavioral Health and Developmental Disabilities in accordance with Division Policy: *Request for Waiver of the Standards* at the website:

<http://dbhdd.georgia.gov/portal/site/DBHDD> (click on *Provider Information* and *Provider Tool Kit* for the current *Provider Manual*).

A waiver will be considered if all of the following criteria are met:

1. The waiver does not jeopardize the health, safety or well-being of any of the individuals in the home.
2. The waiver is based on the best interests and needs of the individuals.
3. Noncompliance with the guideline is of greater benefit to the individual than compliance with the Operational Procedures.
4. There is not an alternative method to meet the intent of the Operational Procedures.
5. There are special circumstances that make the home different from other homes complying with the Operational Procedures.
6. The waiver does not violate any other State regulation or statute.
7. There is only one provider per Host Home/ Life-Sharing environment.

Maximum capacity

No more than two (2) individuals with developmental disabilities served may live in the household.

Responsibility for Compliance

If the agency is the legal entity approved as a Developmental Disabilities Provider to provide Host Home/ Life-Sharing, the agency is responsible for compliance to the following:

1. Host Home/Life-sharing Standards located at the website: <http://dbhdd.georgia.gov/portal/site/DBHDD> (click on *Provider Information*, then the *Provider Tool Kit*).
2. *COMP Supports Waiver Program, Part II and Part III, and Part I Policies and Procedures for Medicaid PeachCare for Kids*, located at website: www.mmis.georgia.gov
3. The current *Provider Manual, Part II, Section I, Standards for all Providers* located at the website: <http://dbhdd.georgia.gov/portal/site/DBHDD> (click on *Provider Information*, then the *Provider Tool Kit*).

Self-Assessment of the Host Home/Life-Sharing Residential Setting

The agency is to complete a self-assessment of each Host Home site annually, to measure and record compliance with the Host Home/Life Sharing Standards.

To measure and record compliance, the agency is to utilize the Host Home/Life Sharing Standards, located at the website: <http://dbhdd.georgia.gov/portal/site/DBHDD> (click on *Provider Information*, then the *Provider Tool Kit*, for the current *Provider Manual, Part II, Section I, Standards for all Providers*).

A copy of the agency self-assessment results and a written summary of corrections made are to be kept in the Host Home/Life –Sharing residential setting for at least one (1) calendar year.

Home Study Requirements

The agency is to make a thorough evaluation of each prospective Host Home family (or current Host Home/Life-Sharing Residential Setting). The evaluation is to be documented in the study report, which is to be updated as changes in the required home study information occur, and include at least the following:

1. Full legal name of applicant, date of assessment, the family address and telephone number.
2. Description of the home and community, including, but are not limited to:
 - Type of home (i.e. ranch, 2 stories)
 - Rooms in the home (Include basement and attic)

- Number of steps to the front and back door if applicable
 - Handicap Accessibility Features if any
 - Sleeping arrangements for the potential placement(s)
 - Description of the neighborhood. List accessible community services and activities (Include access to hospitals/urgent care facilities, churches, schools, Physicians, YMCA etc.)
 - Public Transportation (Document distance from home to public transportation)
 - Physical Standards of the home, including:
 - a. Fire extinguishers (Note type, number and location)
 - b. Smoke and/or carbon monoxide detectors (Note functionality, number and location)
 - c. Is there a swimming pool? Is it secured by fence or gate?
 - d. Is there a locked box/space (note where medications will be locked and hazardous chemicals will be kept)
 - e. Do you have pets? Type and how many?
3. A description of family members/individuals living in the home, including:
- Date and Place of birth
 - Physical description
 - Family background and history
 - Current relationships with immediate and extended family members or other persons residing in the home
 - Educational background
 - Relationship to applicant(s)
4. A statement as to whether or not there are firearms kept in the home and if so, all firearms owned and in the home are unloaded, secured and locked in a cabinet with ammunition stored in a separate locked cabinet. If firearms are stored in an official gun cabinet, ammunition may also be stored in the same gun cabinet; however, the ammunition must be kept in a locked container or locked in a separate compartment of the gun cabinet.
5. Availability of Supervision:
- Describe the work schedule of all members of the household
 - Current relationship with extended family members
 - Support network in place for the Life-Sharing family
 - Willingness to cooperate with the DBHDD approved agency
6. Family Dynamics:
- Interest and Hobbies (include clubs, groups, associations etc.)
 - Personality of each member of the household
 - Interaction and relationship with neighbors
 - Examples of ways each person in household tend to interact with others in the home
 - Examples of ways each family member react to stress and coping strategies used
 - Family meal-time interaction (include what meals family eat together if applicable)
 - Family activities after work/school to bedtime
 - Description of a typical Saturday, Sunday, Holiday and vacations
 - Church or other religious relationship
 - Acceptance of an individual(s) of another culture/ethnicity. (Include response to various cultural issues i.e. religious practices, eating habits, holiday traditions)
 - Attitudes on potential placement(s) dating
 - Alcohol or drug use in the family (Include history and where alcohol is stored)
 - Anticipated adjustment of each Life-Sharing member to a potential placement

7. Experience and Expectations:
 - The motivation for Life-Sharing including but not limited to attitudes towards an individual with developmental disability
 - Document the following:
 - a. Whether or not the potential Life-Sharing family worked for another provider (in or out of state)
 - b. Whether or not the potential Life-Sharing family ever been denied
 - c. Whether or not the potential Life-Sharing family been investigated for any serious reportable incident
 - Knowledge of developmental disabilities, attitudes and skills
 - Methods of discipline used by applicant if applicable
 - Discuss training and compliance requirements (Include Host Home/ Life-Sharing Operating Procedures, DBHDD Provider Manual, DCH Waiver Manual and Agency Policy and Procedures)
 - Attitudes towards family involvement of the potential placement
 - Description of experience with working with individuals with MRDD, if applicable
8. A description of the type of individual desired by the prospective Life- Sharer
9. A general health examination of each member living in the prospective Host Home/Life-Sharing residential setting
10. Screening for tuberculosis and communicable disease for each member living in the prospective Host Home/Life-Sharing residential setting
11. Criminal Records Check/Clearance
12. Who will be transporting the individual(s) and how would transportation be provided
13. A minimum of three (3) character references;

At least one reference is to be from an extended family member not residing with the prospective Host Home/Life-Sharing family,

And

If any member of the potential Host Home/ Life-Sharing family has either served previously as a provider for another agency, and/or been employed within the past five (5) years in a job involving the care of individuals with DD, at least one reference must be from the former agency or employer. In addition, documentation must be provided if any member of the potential Host Home/Life-Sharing family has been terminated as a provider/agency and any adverse actions taken by DBHDD or another state entity.

14. Proof of homeowner's, renter's insurance or personal property insurance
Note: Insurance must be kept current.
15. Proof of potential Life-Sharer's home ownership (ex. mortgage statement) or current lease
16. Signed statement from the potential Life-Sharer (s) indicating the receipt and review of the Host Home/ Life-Sharing Standards and the Policy: *Enrolling, Matching and Monitoring Host Homes for Community Providers Serving Individuals with DD.*
17. The home study is to be completed, signed and dated by a designated employee of the agency or professional under contract with the agency and reviewed, signed and dated by the Agency Director or Developmental Disabilities Professional (DDP).

18. Documentation of any recommendation regarding approval as a prospective Life-Sharer, including description of identified training or resources needed, and that the prospective Life sharers possess the capacity to provide room, board and watchful oversight
19. Notification of Approval. Prospective Host Home/Life-Sharer(s) will be notified in writing as to whether or not their have been approved by the agency

Inspection of Homes

The agency will complete a site inspection of each home the agency has approved to operate.

All inspections and investigations by DBHDD may be unannounced and without prior notice. The Host Home/Life-Sharing provider or any adult living in the home (excluding the individual(s) served) must be present during any inspection of the home. The inspector must have access and authority to examine quality of care and services delivery, the individual's records, physical premises, including the condition of the home, grounds and equipment, food, water supply, sanitation, maintenance, housekeeping practices and any other areas necessary to determine compliance with these Standards.

The inspector has the authority to interview the host home provider, any adults living in the home, the individual and the individual's family. Interviews with the individual will be confidential and conducted privately unless otherwise specified by the individual.

M.A.N.E.

It is expressly prohibited to Mistreat, Abuse, Neglect or Exploit any person(s) receiving host/life sharing service. Mistreatment, abuse, neglect and exploitation is defined as, but not limited to:

Physical Abuse- includes but is not limited to such actions as striking, pulling, pushing, twisting body parts, or inflicting any physical injury to an individual by any means. Physical abuse includes directing one individual to physically abuse another individual.

Sexual Abuse- includes but is not limited to sexual assault, rape, fondling, sexual exploitation or any sexual interaction.

Mental Abuse- includes but is not limited to any action, which creates mental anguish for the individual. These actions include but are not limited to discriminatory remarks, belittlement, derogatory name calling, teasing, unreasonable exclusion from conversation or activities and verbal abuse.

Neglect- includes but is not limited to the denial of meals, medication, habilitation and other necessities.

Exploitation- includes but is not limited to any illegal or improper action affecting a person or use of the person's resources for another person's profit or advantage.

Reporting and Investigation of Deaths and Critical Incidents

Death and/or critical incidents of individuals in service will be reported to the Department of Behavioral Health and Developmental Disabilities according to the policy found in the Department of Behavioral Health and Developmental Disabilities current Provider Manual, at the website: <http://dbhdd.georgia.gov/portal/site/DBHDD> (click on *Provider Information*, and the *Provider Tool Kit* for the current *Provider Manual, Policy: Reporting and Investigation of Individual Deaths and Critical Incidents for Community Services*).

Criminal History Check/Clearance

National Crime Information Center criminal records check (NCIC) and Georgia Crime Information Center (GCIC) state criminal history record check/clearance documentation is required for all Host Home contractors and any adults living temporary or permanently, who have direct care, treatment, or custodial responsibilities for participants served by the agency.

The requirements apply to any person seventeen (17) years of age or older who moves into the home and any person who reaches the age of eighteen (18) years, after the individual lives in the home.

Any person who is a visitor in the home is not required to have a criminal records check/clearance but must not have unsupervised contact with the individual(s) receiving services.

Only Cogent/GAPS or DHS-DFCS Offices will be used to obtain GCIC/NCIC fingerprint results. For more information regarding GAPS enrollment, registration, print and locations go to Cogent's website www.ga.cogentid.com

Criminal history record check/clearance is to have been completed no more than one (1) year prior to an individual living or receiving alternate care in the home.

A copy of the final criminal history reports is to be kept in the provider agency record. The agency must have a policy and procedure for ongoing criminal history monitoring. *Refer to the Provider Manual, Part II, Section I, Standards for all Providers* at the website. <http://dbhdd.georgia.gov/portal/site/DBHDD> (click on *Provider Information* and *Provider Tool Kit* for the current *Provider Manual*).

Individuals that are served are excluded from criminal background check/clearance.

Character References

A minimum of three (3) character references are required.

At least one reference is to be from an extended family member not residing with the prospective Host Home/ Life-Sharing family; and if the prospective Host Home/Life-Sharing family has either served previously as a provider for another agency, and/or been employed within the past five (5) years in a job involving the care of individuals with MRDD, at least one (1) reference must be from the former agency or employer.

Individual Funds and Property

The provider agency is to have a written policy that establishes procedures for the protection and adequate accounting of individual funds and property, and for advising the individual concerning the use of the funds and property.

The policy may not prohibit or interfere with the individual's right to manage her or his own finances.

An individual's personal funds include but are not limited to savings/checking account and other investment accounts, earned income and the remaining portion from SSI payment for day-to-day living expenses.

An individual's funds and property are to be used for the individual's benefit.

An up-to-date financial and property record is to be kept for each individual. This record is to include the following:

1. Personal possessions and funds received by or deposited with the family or agency.
2. Disbursements made to and for the individual.

If the agency or Host Home/Life-Sharing family assumes the responsibility for an individual's financial resources, the following is to be maintained for each individual:

1. A separate record of financial resources including the dates and amounts of deposits and withdrawals.
2. For a withdrawal when the individual is given the money directly, the record will indicate that the funds were given directly to the individual.
3. Documentation, by the actual receipt or expense record, of each single purchase made on behalf of the individual carried out by the family member or agency staff.

There may not be commingling of the individual's personal funds with agency or household funds.

There may not be borrowing of the individual's personal funds by family members or agency staff.

Driver License and other Access to Transportation

For providers transporting individuals in their personal vehicles, at least one adult member of the Host Home/Life-Sharing household will have a valid Georgia Driver's License and access to a properly operating vehicle covered under Georgia Vehicle Insurance requirements.

A *Driving History Report (MVR)* is required for any member of the household responsible for transporting the individual. There must be no more than two chargeable accidents, moving violations or DUI's in a three (3) year period, within the last five (5) years of the seven (7) year Motor Vehicle (MVR) period.

Providers residing near public transportation and who are currently using this mode of transportation are required to submit documentation verifying that the home has access to public transportation within a one-fourth (1/4) mile walking distance from the Host Home/Life-Sharing residence.

ENROLLING HOST HOMES

Current and New DBHDD providers must meet the following requirements prior to enrolling a Host Home as a CRA service option:

1. DBHDD provider must be a provider of DD Community Residential Alternative (CRA) services

AND

2. DBHDD provider must be in business for twelve (12) months delivering Developmental Disabilities (DD) Community Residential Alternative services

AND

3. DBHDD providers cannot enroll any Host Home/Life-Sharing residence until the CRA service/site in the initial provider application have successfully achieved full accreditation and/or complete compliance with the Standards Compliance Review, for a minimum of six (6) months. Provisional status of any type will not be accepted.

DBHDD provider agencies are required to make a thorough evaluation of each prospective Host Home family/individual, and document this evaluation in a Host Home study report. This will be completed

and/or updated as changes in the required home study information occur or when there is a vacancy to be filled.

Note:

1. **Only one (1) DBHDD approved CRA provider agency may enroll and provide CRA services at any Host Home site.**
2. **Host Home providers cannot be the owner of a Personal Care Home (PCH) or Community Living Arrangement (CLA), either of which provide services to COMP waiver participants.**

Based on the Host Home study report and any supporting documents, the DBHDD provider agency will notify the potential Host Home provider in writing as to whether or not the Host Home provider has been deemed appropriate to work with their organization.

Each Host Home must have a site specific Medicaid Provider (CRA) number assigned by the Department of Community Health (DCH) before placement of any person into that particular Host Home.

DBHDD provider agencies must submit the Host Home study, all supporting documentation, and Host Home provider's evidence of required competency-based training, along with the DBHDD and DCH application for a site specific number to DBHDD Office of Provider Network Management for review.

Supporting documents for the Host Home study include the following:

1. A general health examination of each member living in the potential Host Home
2. Evidence of screening for tuberculosis and communicable disease for each member living in the potential Host Home
3. National Criminal records check/clearance
4. A minimum of three (3) character references
5. Proof of homeowner's, renters insurance or personal property insurance
6. Statement as to whether or not there are firearms in the home
7. Documentation of home ownership (ex. current mortgage statement) or renter's lease. Document(s) must be in the name of the potential Host Home provider.
8. The home study will be completed, signed and dated by a designated employee of the agency or professional under contract with the agency and reviewed, signed and dated by the Agency Director or Developmental Disabilities Professional (DDP).
9. Signed statement from potential Host Home provider indicating the receipt and review of the Host Home/ Life-Sharing Standards.

The adult family member who will have primary responsibility to the individual and for providing services to the individual will have at least the following training *prior* to the DBHDD provider agency submission of an application for a site specific Medicaid provider number:

1. Person-Centered Values, Principles And Approaches
2. Human Rights and Responsibilities
3. Recognizing and Reporting Critical Incident
4. Individual Service Plan
5. Confidentiality Of Individual Information, Both Written And Spoken
6. Fire Safety
7. Emergency and Disaster Plans and Procedures
8. Techniques Of Standard Precautions
9. Basic Cardiac Life Support (BCLS)
10. First Aid and Safety
11. Medication Administration and Management/Supervision Of Self-Medication
12. Agency Policy And Procedures

The DBHDD provider agency must submit evidence of the type of training, content, dates, length of training, and/or copies of certificates. A signed attestation between the agency and the potential host home provider, which indicates the receipt of trainings, must also be submitted.

Host Home applications must not be submitted for any location that is currently licensed as a PCH or CLA. Licensed PCH or CLA providers must relinquish their license prior to making application to become a Host Home. A Host Home study must be submitted, along with documentation of the surrender of the perspective license and the required trainings (by evidence of training certificate or signed attestation indicating receipt of training), to DBHDD Office of Provider Network Management.

PROCEDURE FOR MATCHING INDIVIDUAL AND HOST HOME PROVIDER

When an individual is identified for potential placement in a Host Home, provider agencies must forward a summary of the Host Home study report to Support Coordination or the Planning List Administrator. A summary of the Host Home study may include, but is not limited to: the address and access to local services; the current living arrangement; names and ages of the family/individuals residing in the home; family/individuals' previous work history, education and religious affiliation, membership or participation in community organizations; the DBHDD provider recommendations.

DBHDD provider agencies will discuss the prospective placement with the Host Home family/individual, and prepare the family/individual for the placement of a particular person with developmental disabilities by anticipating the adjustments and problems that may arise during placement, and providing any specialized training and support.

The Host Home study report must be reviewed by all stakeholders involved in placement planning to ensure an appropriate match between the individual and the Host Home provider.

Submission Of Information To The Division Of Developmental Disabilities

The DBHDD provider agency must submit specified information to the Division of Developmental Disabilities pertaining to administrative cost and payment to the Host Home /Life-Sharing Provider

The requirements for administrative costs of the CRA provider agency and the agency's payment to the Host Home/Life-Sharing provider are as follows:

1. The budget and payment to the Host Home/Life-Sharing provider for each individual in each Host Home/Life-Sharing services enrolled by the DBHDD provider agency must support the amount of payment to the Host Home/Life-Sharing provider that allows for the provision of the CRA services specified in the ISP of the individual, and ensures the health and safety of the individual in the Host Home/Life-Sharing arrangement.
2. The budget and agreed payment of the Host Home/Life-Sharing provider must be submitted to the Division of DD prior to any individual moving into a Host Home/Life-Sharing residential setting, whenever there is an enhancement or decrease in the individual's residential allocation, and on an annual basis (by June 30). Host Home/Life-Sharing providers of individuals with exceptional rates receive a higher payment based on enhanced services provided by the Host Home/Life-Sharing provider.
3. Each individual's budget submitted to the Division of DD must include, but is not limited to the individual's name and Medicaid number, address and contact information of the Host Home/Life-Sharing.

Provider agencies must comply with Division of Developmental Disabilities Policy: *Management/Supervision/Safeguarding of Possessions, Valuables, Personal Funds and Day-To-Day Living Expenses in Developmental Disabilities Residential Services* in the current Provider Manual at the website <http://dbhdd.georgia.gov/portal/site/DBHDD/> (click Provider Information and Provider Tool Kit).

1. The CRA Provider is to make available to individuals, who reside in agency operated Host Homes /Life-Sharing residence a day-to-day living expenses agreement upon admission, annually, or as needed. The day-to-day living expenses agreement is reviewed at the annual ISP. The day-to-day living expenses agreement includes a statement of all associated housing and food costs; and any estimated medical, dental, and clothing fees or charges assessed to the individual, to the extent that those funds are available. Any changes in charges for day-to-day living expenses are provided to the individual served and the agency operated Host Home/Life-Sharing Provider, in writing, 60 days prior to changes in charges. Copies of each day-to-day living expenses agreement are maintained in the record of the person served.
2. Day-to-day living expenses agreement must be signed by the CRA Provider agency and Host Home/Life Sharing Provider and submitted to the Division of Developmental Disabilities annually (by June 30th) or whenever there is a change of the Host Home/Life-Sharing Provider serving the individual, or prior to any individual moving into the home.
3. Day-to-day living agreements are to be mailed to:
Division of Developmental Disabilities
Attn: Sherry Newton, Administrative Operational Manager
2 Peachtree Street, Suite 22-413
Atlanta, GA 30303

PROCEDURE FOR MONITORING HOST HOMES

DBHDD provider agencies will ensure compliance with the Host Home/ Life-Sharing Standards, DCH COMP Waiver and current Fiscal Year (FY) DBHDD Provider Manual.

DBHDD provider agency will complete an initial Site Inspection of each Host Home/Life-sharing residential setting the agency has approved to operate. The Support Coordinator or DBHDD Regional Office designee will conduct a follow-up site inspection.

Support Coordinator and/or the Planning List Administrator will conduct home visits, at least on a monthly basis, to monitor the person's progress in the specific Host Home/Life-Sharing setting, and to ensure that Host Home/Life-Sharing services is delivering the supports in accordance with the individual's ISP.

DBHDD provider agency will conduct home visits at least monthly, in order to verify that the Host Home is delivering care, room and watchful oversight in a safe and healthy environment. The DBHDD provider agency is to evaluate and document the following during each visit:

1. Available services, supports, care and treatment. This includes, but is not limited to the service needs addressed in the ISP.
2. Human and Civil Rights are maintained.
3. Oversight of Self-Administering of Medication Administration (if applicable) or that the administering of medication follows federal and state laws, rules and regulations.
4. Person Centered Focus is Evident in Documentation.
5. Information and documentation management is protected, secure, organized and confidential.
6. The host home environment demonstrates respect for the individual(s) served and is appropriate to the supports provided. This includes, but is not limited to, the physical environment, review of disaster and fire safety plan, required training, community inclusion, personal funds, and vehicle transportation requirement.

This evaluation is to be shared with the Host Home family/individual and made available for review by the Support Coordinator or DBHDD staff as evidenced by the signature of the Host Home family/individual and the DBHDD provider agency. A copy of each monthly visit and written summary of corrections are to be kept in the Host Home.

The DBHDD provider agency will complete an annual summary of each monthly home visit. The summary is to include, but is not limited to all items identified in the above sections 1-6. A copy of the annual summary and a written summary of corrections are to be kept in the home for each fiscal year (FY).

DBHDD Regional Offices and designated staff from the Division of DD are to provide technical assistance to DBHDD provider agencies enrolling host homes, as needed.

The Division of DD will conduct quarterly Quality Assurance reviews of provider agencies some of which will be contracting host homes. Reviews may include, but are not limited to, Support Coordinator ratings of 3's and 4's, external quality reviews, and critical incidents. Based on these reviews, the Division of DD will recommend and/or implement the following, which includes, but is not limited to, provision of technical assistance to the provider and/or host home, the movement of the individuals from the host home, full standards compliance review, and/or moratorium on the enrollment of host homes for a specific DBHDD provider agency.

TERMINATION OF CONTRACT BETWEEN THE HOST HOME AND CRA PROVIDER AGENCY

When a Host Home provider no longer wants to provide services to the individual and/or wants to end its subcontract with the DBHDD provider agency, they must give at least thirty (30) days written notice to:

1. The individual(s) served
2. The DBHDD provider agency under contract

When a Host Home provider initiates termination and end its subcontract with the provider agency, the following applies:

1. The Host Home provider must relinquish CRA service provision for the individual(s) supported to the contracted DBHDD provider agency and assist the DBHDD provider agency with the movement of the individual(s).
2. The Host Home provider must not serve the same individuals they previously served when contracting with another DBHDD provider agency.

The Host Home provider will be expected to continue working for thirty (30) days unless otherwise determined by the DBHDD provider agency or DBHDD.

If an emergency occurs and services must be terminated immediately, the Host Home provider must give immediate notice to all parties listed above.

The DBHDD provider must submit both DBHDD and DCH Change of Information forms to DBHDD Office of Provider Network Management to deactivate the Host Home provider number.

TRANSFERENCE OF A HOST HOME(S)

The DBHDD provider agency and Host Home provider must cooperate as requested by DBHDD to effectuate the smooth and reasonable transition of the care and services for individuals as directed by DBHDD. This includes, but is not limited to, the transfer of the individual records, personal belongings, and funds of all individuals as directed by DBHDD.

DBHDD reserves the right under all Host Home agreements to transfer a Host Home to another DBHDD provider agency on the following grounds:

1. DBHDD termination of the contract/letter of agreement, or agreement with the DBHDD provider agency.
2. DBHDD provider agency termination of the contract/letter of agreement.

3. **The Individual or Family/Representative's termination of the relationship with an identified contracting provider agency, (which requires the termination of the site specific Medicaid Provider Number by the contracting provider agency).**

In either case above, the Host Home provider must be in agreement to contract with another DBHDD provider agency if they want to serve the same individual(s).

Prior approval for the transfer of the Host Home to an alternative DBHDD provider agency must be given by the designated DBHDD, Regional Coordinator.

CONVERSION OF A HOST HOME/S

The DBHDD does not allow for a conversion from a Personal Care Home (PCH) or Community Living Arrangement (CLA) to a Host Home except under the following conditions:

1. The home is under a subcontracting relationship.
2. The home is occupied by the owner.
3. The home occupancy must be two or less, for individuals with developmental disabilities.
4. The licensed must be in the name of the proposed Host Home provider.

The provider must complete the *Request for Conversion Form (Appendix A)*.

Upon preliminary approval of the Request for Conversion Packet and before a final approval as a Host Home, the provider must:

1. Surrender the PCH or CLA license to the Department of Community Health (DCH), Division of Healthcare Facility Regulation (HFR), and
2. Submit a copy of the Letter of Surrender from HFR to the Provider Network Management

INDIVIDUAL RIGHTS

Informing and Encouraging Exercise of Rights

Each individual, or the individual's parent, guardian or advocate (if appropriate) is to be informed of the individual's rights upon admission and annually thereafter. Individuals are to receive this information through their primary form of communication.

A statement signed and dated by the individual, or the individual's parent, guardian or advocate if appropriate, acknowledging receipt of the information on individual rights upon admission and annually thereafter, will be kept.

Each individual is to be encouraged to exercise his or her individual rights.

Rights

An individual may not be deprived of rights.

Rights of the Individual

1. An individual may not be neglected, abused, mistreated or subjected to corporal punishment.
2. An individual may not be required to participate in research projects.

3. An individual has the right to manage his or her personal financial affairs.
4. An individual has the right to participate in program planning that affects him or her.
5. An individual has the right to privacy in bedrooms, bathrooms and during personal care.
6. An individual has the right to receive, purchase, have and use personal property.
7. An individual has the right to receive scheduled and unscheduled visitors, communicate, associate and meet privately with their family and persons of the individual's choice.
8. An individual has the right to reasonable access to a telephone and the opportunity to receive and make private calls, with assistance when necessary.
9. An individual has the right to unrestricted mail privileges.
10. An individual who is of voting age will be informed of the right to vote and will be assisted to register and vote in elections.
11. An individual has the right to practice the religion or faith of the individual's choice.
12. An individual has the right to be free from excessive medication.
13. An individual may not be required to work at the home except for the typical upkeep of the individual's bedroom and in the upkeep of family areas and yard. For example: Repair of a clogged drain, seeding of lawns, etc., would not be considered typical upkeep.

Civil Rights

An individual may not be discriminated against because of race, color, religious creed, disability, handicap, ancestry, national origin, age or sex.

Civil Rights policies and procedures are to be developed and implemented in accordance to all State and Federal legislation. Civil rights policies and procedures are to include the following:

1. Nondiscrimination in the provision of services, admissions, placement, referrals and communication with non-English speaking and nonverbal individuals.
2. Physical accessibility and accommodation for individuals with physical disabilities.
3. The opportunity to lodge civil rights complaints.
4. Informing individuals of their rights to register civil rights complaints.

STAFFING

Staffing Qualifications and Responsibilities

Provider agencies rendering Community Residential Alternative Services (CRA) must have staffing that meets the following requirements, in addition to any applicable licensure requirements:

1. A designated agency director who must:
 - Have either a bachelor's degree in a human service field (such as social work, psychology, education, nursing, or closely related field) or business management and two years of

experience in service delivery to persons with developmental disabilities, with at least one year in a supervisory capacity; or

- Have an associate degree in nursing, education or a related field and four (4) years of experience in service delivery to persons with developmental disabilities, with at least one year in supervisory capacity

Duties of the Agency Director include, but are not limited to:

- Overseeing the day-to-day operation of the agency;
 - Managing the use of agency funds;
 - Ensuring the development and updating of required policies of the agency;
 - Managing the employment of staff and professional contracts for the agency;
 - Designating another agency staff member to oversee the agency, in his or her absence.
2. At least one agency employee or professional under contract with the agency, who must:
- Have the responsibility for overseeing the delivery of Community Residential Alternative Services to participants.
3. At least one agency employee or professional under contract with the agency who must:
- Be a Developmental Disability Professional (DDP) (for definition, see the COMP Manual at the website: www.mmis.georgia.gov)

Duties of the DDP include, but are not limited to:

- Overseeing the services and supports provided to participants;
- Supervising the formulation of the participant's plan for delivery of Community Residential Alternative Services;
- Conducting functional assessments; and
- Supervising high intensity services.

Note: The same individual may serve as both the agency director and the Developmental Disability Professional.

4. Direct Care Staff, must:

- Be 18 years or older
;
- If transporting an individual served or family, have a valid Class C license as defined by the Georgia Department of Driver's Services and no major or multiple traffic violations if transporting participants (s);
- Be provided with a basic orientation prior to direct contact with individuals and show competence in:

- a. The purpose and scope of CRA services, including related Host Home/Life-Sharing Standards;
- b. Confidentiality of individual information, both written and spoken;
- c. Rights and responsibilities of individuals;
- d. Requirements for recognizing and reporting suspected abuse, neglect, or exploitation of any individual:
 - i. To BHDD
 - ii. Within the organization
 - iii. To appropriate regulatory or licensing agencies; and
 - iv. To law enforcement agencies

5. For any additional requirements refer to:

- *COMP Supports Waiver Program, Part II and Part III, and Part I Policies and Procedures for Medicaid PeachCare for Kids*, located at website: www.mmis.georgia.gov

And

- The current *Provider Manual, Part II, Section I, Community Standards for all Providers*, at the website: <http://dbhdd.georgia.gov/portal/site/DBHDD/> (click Provider Information and Provider Tool Kit).

Direct Care Staffing

The adult family member in the Host Home/Life-Sharing is responsible for the 24- hour care of the individual (s) served.

Exceptional Rate Requests for direct care staffing must document a clear demonstration of enhanced intensity and type of service beyond what a Host Home/ Life-Sharing family could provide with training.

Direct care staffing may also be utilized to provide *intermittent* support to the Host/Life-Sharing family. This type of staffing should be within the maximum Community Residential Alternative (CRA) rate and would not qualify for an Exceptional Rate.

Supervision

An individual (receiving services) may not be left unsupervised with a person who is not 18 years of age or older, unless the absence of direct supervision is consistent with the individual's assessment, and is part of the Individual Service Plan (ISP) aimed at achieving self sufficiency.

An individual may not be left unsupervised solely for the convenience of the Host Home/Life-Sharing family.

The agency will provide a 24- hour, 7- day per week emergency after hours on call contact, and response systems for all Host/Life-Sharing Homes and the individuals receiving services.

TRAINING

Pre Service/Annual Training

Prior to the DBHDD provider agency's submission of an application for a site specific Medicaid provider number, the adult family member who will have primary responsibility to the individual and for providing services to the individual is to have at least the following training:

1. Person-Centered Values, Principles And Approaches

2. Human Rights and Responsibilities
3. Recognizing and Reporting Critical Incidents
4. Individual Service Plan
5. Confidentiality Of Individual Information, Both Written And Spoken
6. Fire Safety
7. Emergency and Disaster Plans And Procedures
8. Techniques Of Standard Precautions
9. Basis Cardiac Life Support (BCLS)
10. First Aid and Safety
11. Medication Administration and Management/Supervision Of Self-Medication
12. Agency Policies And Procedures

Prior to direct contact with the individual, the adult family member who will have the primary responsibility to the individual and for providing services to the individual is to receive at least the following training:

1. The Purpose, Scope Of Services, Supports, Care And Treatment Offered, Including Related Policies And Procedures
2. Holistic Care Of The Individual
3. Promoting Positive, Appropriate And Responsive Relationships With Persons Served And Their Families
4. Medical, Physical, Behavioral And Social Needs, As Well As Characteristics Of Persons Served
5. The Utilization Of Positive Communication, Positive Behavioral Supports And Crisis Intervention Techniques
6. Ethics, Cultural Preference And Awareness
7. Service, Support, Care and Treatment Specific Appropriate To the Care of Person Served

All trainings specified above must also be provided to the Host Home/Life-Sharing adult family member on an annual basis.

Record of Training

Records of pre-service and annual training, including name of person trained, the training source, content, dates, length of training, and copies of certificates received and persons attending will be kept and be readily available.

PHYSICAL HOME SAFETY

All living quarters will be maintained and not threaten the health or safety of occupants.

Special Accommodations

A home serving an individual with a physical disability, blindness, a visual impairment, deafness or a hearing impairment will have accommodations to ensure the safety and reasonable accessibility for entrance to, movement within and exit from the home based upon each individual's needs.

Adaptive equipment will be provided if needed for the individual to move about and function in the home (i.e. wheelchairs, walkers, low shelves, cabinets, countertops, special doorbells and telephone devices for individuals who have a hearing impairment, and tactile guides for individuals who have visual impairment).

Poisons

Poisonous materials will be kept locked or made inaccessible to individuals if all individuals living in the home are unable to safely use or avoid poisonous materials

Poisonous materials may also be kept unlocked and accessible to individuals if all individuals living in the home are able to safely use or avoid poisonous materials.

Documentation of each individual's ability to safely use or avoid poisonous materials will be in each individual's ISP.

Poisonous materials will be stored in their original, labeled containers.

Poisonous materials will be kept separate from food, food preparation surfaces and dining surfaces.

Heat Sources

Heat sources, such as hot water pipes, fixed space heaters, hot water heaters, radiators, wood and coal burning stoves and fireplaces, exceeding 120°F that are accessible to individuals, will be equipped with protective guards or insulation to prevent individuals from coming in contact with the heat source.

Heat sources do not require guards or insulation if all individuals living in the home understand the danger of heat sources. and have the ability to sense and move away from the heat source quickly. Documentation of each individual's understanding and ability will be in each individual's ISP.

Sanitation

Clean conditions will be maintained in all areas of the home.

There may not be evidence of infestation of insects or rodents in the home. Chemicals used in the control program must be selected, stored and used safely. The chemical must be selected on the basis of the pest involved and used only in the manner prescribed by the manufacturer.

Trash will be removed from the premises on a routine basis.

Ventilation

Living areas, dining areas, individual bedrooms, kitchens and bathrooms will be ventilated by at least one operable window or by mechanical ventilation. Exceptions are home theater rooms.

Lighting

Rooms, hallways, interior stairways, outside steps, outside doorways, porches, ramps and fire escapes, that are used by individuals will be lighted to assure safety and to avoid accidents.

Surfaces

Floors, walls, ceilings and other surfaces will be free of hazards, as determined by the needs of the individual resident.

Running Water

A home will have hot and cold running water under pressure.

Hot water temperatures in bathtubs and showers that are accessible to individuals must be within 10- 120 degree Fahrenheit.

Water and sewage systems will meet federal, state, and local standards and regulations.

Heating and Air Conditioning Systems

Heating and Air Conditioning Systems will be operational and maintained to provide adequate heat and air conditioning throughout the home.

Telephone

A home will have an operable telephone that is easily accessible. The individual must have adequate privacy while using the telephone.

Emergency Telephone Numbers

The telephone must be immediately available in case of emergency. Telephone numbers of the nearest hospital, police department, fire department, ambulance and poison control center will be readily accessible in the home.

Screens, Windows and Doors

Windows, including windows in doors, will be securely screened when windows or doors are open.

Screens, windows and doors will be in good repair.

Handrails

An interior stairway exceeding two steps that is accessible to individuals, ramp and outside steps exceeding two steps, will have a well-secured handrail.

First Aid Materials

Each home will have antiseptic, an assortment of adhesive bandages, sterile gauze pads, tweezers, tape, and scissors.

Exterior Conditions

An outside walkway that is used by individuals will be free from ice, snow, obstructions and other hazards.

The yard and outside of the home will be well maintained and free from unsafe conditions.

Individual Bedrooms

An individual's bedroom may not be located in basements, attics, stairway, hall or any room commonly used for other than bedroom purposes.

A bedroom will have at least one exterior window that permits a view of the outside.

Bedroom windows will have clean and/or operable drapes, curtains, shades, blinds or shutters.

Bedrooms will have doors at all entrances for privacy.

In bedrooms, each individual will have the following:

A bed of size appropriate to the needs of the individual. Cots and portable beds are not permitted. Bunk beds are not permitted for individuals 18 years of age or older.

A clean, comfortable mattress and solid foundation.

Clean bedding, including a pillow, linens and blankets appropriate for the season.

1. A chest of drawers.
2. Closet or wardrobe space with clothing racks and shelves accessible.

An individual may not share a bedroom with anyone of an opposite sex in the home.

Bathrooms

There will be at least one toilet and one bathtub or shower in the home.

Privacy will be provided for toilets, showers and bathtubs by partitions or doors.

At least one bathroom area will have a sink, wall mirror, soap, toilet paper, individual clean paper or cloth towels and trash receptacle.

A clean washcloth, bath towel and operable toothbrush will be provided for each individual.

Kitchens

Each home will have a kitchen area with a clean and operable refrigerator, sink, cooking equipment and cabinets for storage.

Utensils used for eating, drinking and preparation of food or drink will be washed and rinsed after each use.

Laundry

Individual bed linens, towels, washcloths and clothing will be kept clean.

Swimming Pools

An in-ground swimming pool will be fenced with a gate that is locked when the pool is not in use.

An aboveground swimming pool will be made inaccessible to individuals when the pool is not in use.

Firearms

All firearms owned and in the home are unloaded, secured and locked in a cabinet with ammunition stored in a separate locked cabinet. If firearms are stored in an official gun cabinet, ammunition may also be stored in the same official gun cabinet. **However, the ammunition must be kept in a locked container or locked in a separate compartment of the gun cabinet.**

Yard

The yard surrounding the home must be safe and maintained.

FIRE SAFETY

Unobstructed Stairways, Halls, Doorways and Exits

Stairways, halls, doorways and exits from rooms and from the home will be unobstructed.

No interior locks, keyed locks or dead bolts in the Host Home/Life-Sharing residence will prohibit free access to exit from the home.

Flammable and Combustible Materials

Flammable and combustible supplies and equipment will be utilized safely and stored away from heat sources.

Furnaces

Furnaces filters will be cleaned or replaced at least annually. Written documentation of the cleaning or changing of filters will be kept.

Portable Space Heaters

Portable space heaters defined as heaters that are not permanently mounted or installed, may not be used while individuals are in the Host Home.

Wood and Coal Burning Stoves

The use of wood and coal burning stoves is permitted only if the stove is inspected and approved for safe installation by a licensed and/or bonded contractor specialized in this area. Written documentation of the inspection and approval is to be kept.

Wood and coal burning stoves, including chimneys and flues, will be cleaned at least every year. Written documentation of the cleaning will be kept.

If natural gas or heating oil is used to heat the residence, or if a wood-burning fireplace is in the residence, the residence will be protected with sufficient carbon monoxide detectors listed by Underwriters Laboratories, Inc. Information on Underwriters Laboratories, Inc. may be found at <http://www.ul.com/consumers/monoxide.html>

Fireplaces

Fireplaces will be securely screened and/or equipped with protective guards while in use.

Smoking

Smoking is a fire hazard. The Host Home/Life Sharing residence may choose to allow or not allow smoking. If the Host Home/Life-Sharing chooses to allow smoking it must reduce the risk of fire by:

1. Prohibiting smoking in any area where flammable liquid, gases or oxidizers are in use or stored;
2. Prohibiting residents from smoking in bed; **and**

3. Prohibiting unsupervised smoking of individuals unless unsupervised smoking is documented in the ISP.

Smoke Detectors

Each Host Home will be protected with sufficient smoke detectors listed by Underwriters Laboratories, Inc., which when activated will initiate an alarm, that is audible in sleeping rooms. Information on Underwriters Laboratories, Inc. may be found at http://www.ul.com/fallsafety/smoke_alarms.html

An operable smoke detector must also be located in the attic. (An area with pull down steps is considered an attic.)

Each smoke detector will be tested each month to determine if the detector is operable.

Fire Extinguishers

There must be at least one operable fire five pound (5lb.) multipurpose ABC fire extinguisher on each floor; including basements. All fire extinguishers must be located in accessible locations.

All fire extinguishers must be examined monthly to determine that:

1. Fire extinguishers are accessible and in a designated location;
2. Seals or tamper indicator are not broken;
3. The extinguishers have not been physically damaged; and
4. The extinguishers do not have any obvious defects.

Disaster/Severe Weather Emergency and Fire Drills

The agency will have that support the Host Home /Life-Sharing residential setting's emergency notification and preparedness processes. This includes, but is not limited to a three-day supply of non-perishable foods and water for emergency needs and supplies for an emergency preparedness kit for the household.

For information on creating an emergency preparedness kit visit the following website:
<http://www.gema.ga.gov> or <http://ready.ga.gov>

A written disaster/severe weather and fire safety plan will be developed for each household. The plan will be reviewed and updated annually or as needed. The plan will include general fire safety, evacuation procedures, responsibilities during drills or actual events, the designated meeting place outside the home, the use of fire extinguishers, notification of local fire and emergency response teams and if applicable, smoking safety procedures if an individual of household member smokes. A written record of the training will be kept readily available.

Fire drills will be conducted every month at alternate times. At least two drills per calendar year will be during sleeping hours. All fire drills will be documented and kept readily available.

The plan should also address medical emergencies, natural disasters (i.e. tornado), power failures, loss of heat or air conditioning, continuity in critical medical care needs of individuals supported, and notification of individuals' natural supports as soon as the situation renders this possible. Components of the plan will be maintained, tested, inspected, drilled and reviewed for risk reduction on a quarterly basis. Disaster and severe weather emergency drills are conducted at least once per quarter at various times throughout the year, including one drill during typical sleep hours of the household.

PROGRAM

Implementation of Individual Service Plan

The Host Home/Life-Sharing family will cooperatively participate with the individual's support team in the development and implementation of the individual's service plan.

The Host Home/Life-Sharing dynamics is enduring, offering dependability, consistency, trustworthiness and security. The Host Home/Life-Sharing family joins together in celebration of anniversaries, birthdays and in simple day-to-day interactions, joys and accomplishments. They also mourn together in their losses at times of illness and death. The Host Home/Life-Sharing family should encompass extended families and promote the individual's maturing relationship with his or her own natural birth family.

The Host Home /Life-Sharing individual(s) should be active participants in their community. Community integration could be facilitated by the contracting family's own friends, civic interests, neighbors, recreational and hobby activities, and religious affiliations. This expands and includes the individual's family, friends and special interests.

Record Management

All records will be kept in accordance with requirements of the Department of Behavioral Health and Developmental Disabilities current Provider Manual found at the website:

<http://dbhdd.georgia.gov/portal/site/DBHDD/> (click Provider Information and Provider Tool Kit).

A copy of the Individual Service Plan will be in the Host Home/ Life-Sharing residence along with case notes per direction in the Individual Service Plan along with DCH documentation requirements.

Providers must document the following in the record of each participant receiving Community Residential Alternative Services:

1. Specific activity, training, or assistance provided;
2. Date and the beginning and ending time when the service was provided;
3. Location where the service was delivered;
4. Verification of service delivery, including first and last name and title (if applicable) of the person providing the service and his or her signature;
5. Progress towards moving the participant towards independence by meeting the participant's ISP, which includes person-centered goals, desired outcomes in the participant's actions plan, and the amount/type of assistance/support in the Current Service Summary and the Health and Safety sections of the ISP.

Each Host Home/Life-Sharing residence provider is to retain a copy of the home study, including any updates, annual self-assessment of the home and required monthly meeting/quality assurance minutes for review by the state.

HEALTH

Individual Health Care Examinations

The individual served will have a health care examination within 12 months prior to living in the Host/Life-Sharing Home and annually thereafter.

The health exam will be completed and documented on the Annual Health Form found in the Provider Manual found at the website: <http://dbhdd.georgia.gov/portal/site/DBHDD/> (click on Provider information and the Provider Manual for the current year).

Refusal of Health Care

If an individual refuses routine health care examinations or treatment, the refusal and continued attempts to train the individual about the needs of health care will be documented in the individual's record.

If an individual has a serious medical condition, reasonable efforts will be made to obtain consent from the individual or substitute consent in accordance with applicable law.

Host Home / Life-Sharing Family Health Care Examinations

Family members and persons living in the Host Home / Life-Sharing residence will have a health care examination within 12 months prior to any individual in service living in the home and annually thereafter.

The health care examination documentation will be completed, signed and dated by a licensed physician, certified nurse practitioner or licensed physician assistant.

The general health care examination will include:

1. A general health care examination
2. Tuberculin skin testing by Mantoux method with negative results every 2 years for family members 1 year of age or older; or, if a tuberculin skin test is positive, an initial chest X-ray with results noted. Tuberculin skin testing may be completed and certified in writing by a registered nurse or licensed practical nurse instead of a licensed physician.
3. A signed statement that the person is free of communicable diseases or specific precautions to be taken if the person has a communicable disease.
4. Information of medical problems, which might interfere with the health of the individuals.

Communicable Diseases

If an individual or family member has a serious communicable disease (relating to specific identified reportable diseases, infections and conditions) and /or medical problems which might interfere with the health, safety or well-being of the individual(s), specific instructions and precautions to be taken for the protection of the individuals will be specified in writing by a licensed physician. If specific instructions/precautions are not ensured, then the individual will not be appropriate for placement in the identified Host Home/Life-Sharing residential setting.

The physician's written instructions and precautions will be followed.

MEDICATIONS

Storage of Medications

Prescriptions and nonprescription medications of individuals will be kept in their original containers, except for medications of individuals who self-administer medications and keep their medications in personal daily or weekly dispensing containers.

Prescription and potentially toxic nonprescription medications stored in a refrigerator will be kept in a separate locked container or made inaccessible to the individuals, unless it is documented in each individual's assessment that each individual in the home can safely use or avoid toxic materials.

Prescriptions and nonprescription medications of individuals will be locked and stored under proper conditions of sanitation, temperature, moisture and light.

Discontinued prescription medications of individuals will be disposed of in a safe manner. Documentation of the date and manner disposed will be recorded.

Labeling of Medications

The original container for prescription medication of individuals will be labeled with a pharmaceutical label that includes the individual's name, the name of the medication, the date the prescription was issued, the prescribed dose and the name of the prescribing physician.

Medication Training

Host Home /Life-Sharing Family members who assist with or supervise self-medication for individual(s) will receive training about the administration, side effects and contraindications of the specific medication in accordance with state laws and regulations

NUTRITION

Protection of Food

Food received or used in the home will be clean, wholesome, free from spoilage, adulteration, and misbranding, and safe for human consumption.

All foods, while being stored, prepared, or served, will be protected against contamination and be safe for human consumption in accordance with accepted standards for food safety.

Three Meals a Day

At least three meals a day will be available to the individuals and in accordance with any specific dietary needs identified in the individual's Individual Service Plan.

Quantity of Food

The quantity of food served for each individual will meet minimum daily requirements as recommended by the United States Department of Agriculture, unless otherwise recommended in writing by a licensed physician.

Food Groups

At least one meal each day will contain at least one item from the dairy, protein, fruits and vegetables and grain food groups, unless otherwise recommended in writing by a licensed physician for individuals.

BEHAVIOR MANAGEMENT GUIDELINES

Positive Behavior Supports are intended to provide guidelines for managing challenging behavior(s) of individuals with Developmental Disabilities residing in Host Home.

Policies developed within Host Home regarding positive behavior supports are expected to comply with guidelines set forth in the Guidelines for Supporting Adults with Challenging Behaviors in Community Settings applicable to all providers under contract or Letter of Agreement (LOA) with the Department of Behavioral Health and Developmental Disabilities.

These guidelines are available at the website: <http://dbhdd.georgia.gov/portal/site/DBHDD/> (click on Provider Information, then Provider Tool Kit)

Documentation of annual policy review for appropriate update and revisions will be readily available to all reviewers.

Behavior Support Plans should be incorporated in the Individual Service Plan (ISP) and every attempt will be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restrictive procedures.

Plans should be developed by appropriately qualified individuals with expertise in behavioral supports evaluation and services for people with developmental disabilities. The individual, Host Home/Life-Sharing family and other vested stakeholders will be involved in the development of the behavior support plan.

Replacement behavior acquisition training and/or family education training on Positive Behavior Supports are required to show the effectiveness of the plan.

Written documentation of person/staff trained will be kept and readily available. This documentation must include the date and signature of the trainer evidencing that the individual has competently completed the training.

Seclusion and Mechanical Restraint

Seclusion, defined as placing an individual in a locked room, is prohibited. A locked room includes a room with any type of door locking device, such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door shut.

Physical restraints (i.e. mechanical restraints) **are not** used as punishment, for staff convenience, or through a behavioral support plan or behavioral management intervention for purposes of restricting a participant's movement. Those devices which restrain movement, but are applied for protection of accidental injury (such as a helmet for protection of fall due to frequent, severe seizures but not for purposeful head banging or other self-injurious behavior) or required for medical treatment of the physical condition of the participant (such as protection for healing of an open wound) or for supportive or corrective needs of the participant (such as physical therapy devices) are not considered physical restraints.

ALTERNATE CARE

Provision for Host Home/Life-Sharing Setting

Alternate care must be offered to the Host Home/Life-Sharing family through other Host Homes managed by the **SAME** agency. Alternate care is to be offered to each Host Home/Life-Sharing family annually, not to exceed 30 units of CRA services.

The alternate care Host Home/Life-Sharing setting will meet all and the Standards for Host Home/Life-Sharing. Each CRA agency administering one or more Host Home/Life-Sharing residential settings must have, at minimum, of one (1) vacancy available at all times for alternate care.

Only one (1) Alternate Care home may be used and identified for each individual accessing this provision.

The ISP must identify the following:

1. The need for Alternate Care.
2. The Alternate Care home physical location and contact information. The Alternate Care home must be site specific.
3. The allotted number of days for the use of the Alternate Care home (not to exceed 30 units of CRA services annually).

If Alternate Care provisions are utilized, the individual's Prior Authorization (PA) must indicate:

1. The primary Host Home/Life-Sharing site
2. The amount of CRA units
3. Alternate Care site and
4. The amount of CRA units

For example, there might be 294 units at Host Home site, and 30 units at Alternate Care Site. In cases where the maximum of 30 units of Alternate Care will not be utilized, a PA change is required to add the units back to the main Host Home/Life Sharing site.

The annual maximum number of units for CRA services per year must **NOT** be exceeded.

VACATION

Vacation billing must not exceed thirty (30) days in a calendar year for individual (s) choosing to go on a vacation with the Host Home/Life- Sharing family.

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES (DBHDD)

REQUEST for CONVERSION FORM

DBHDD will allow for conversion from a licensed Personal Care Home (PCH) or licensed Community Living Arrangement (CLA) to a Host Home only under the following four conditions:

- (1) The home is under a subcontracting relationship **AND**
- (2) The Home is occupied by the owner **AND**
- (3) The current occupancy must be two or less **AND**
- (4) The license must be in the name of the proposed Host Home provider.

Instructions: The approved provider, who is requesting to convert from a CLA or PCH to a Host Home/Life-Sharing site, must complete the [REQUEST FOR CONVERSION FORM](#)

REQUIRED INFORMATION FOR COMPLETION OF THE REQUEST FOR CONVERSION FORM

1. **Type of Change: Check either PCH or CLA, whichever is applicable to your current site.**
2. **Current Provider Identification**
 - a. Provider's complete full name or business name as it is currently on file with DBHDD.
 - b. Provider's complete address that is currently on file with DBHDD:
3. **Licensed Home Information**
 - a. Provide the name or location name. (Note: For any name change, the provider must submit a certified copy of the legal document(s) showing the old and new names.)
 - b. **Mailing Address/Location Address Information**
 - Mailing Address: Check "Mailing Address" if the provider would like correspondence sent to an address other than the mailing address that is currently on file. A Post Office Box **is** acceptable as the mailing address.
 - Location Address: Check "Location Address" if the provider is making a change in the physical address of the service site. A Post Office Box **is not** acceptable as the physical location address. A change in physical address must be communicated to the Regional Office and a site visit performed for the services. (Note: For any name change, the provider must submit a certified copy of the legal document(s) showing the old and new names.)
 - c. **Telephone Number and FAX Number:** Include the "Telephone Number" of the home. If applicable, include the "Fax Number."
 - d. **E-Mail Address:** Include the "E-Mail Address" of the approved provider.
 - e. **Medicaid Provider Number:** Include the "Site Specific Medicaid Provider Number."
 - f. **Number of Individuals currently residing in the home:** Indicate the "number" of individuals residing in the home.
4. **Attestation Statements (Required)**

Sign and date this form attesting to the accuracy of the requested changes. An authorized representative of the agency must sign this form to confirm the requested change(s).
5. **Regional Office Response**

Return this form with any necessary attachments to: **Provider Enrollment Unit
Office of Provider Network Management
Department of Behavioral Health and Developmental Disabilities
2 Peachtree Street, 23rd Floor
Atlanta, Georgia 30303
Fax: 404-463-6678**

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES (DBHDD)**REQUEST for CONVERSION FORM**

**THIS FORM IS TO BE COMPLETED BY APPROVED DBHDD PROVIDERS REQUESTING
A CHANGE FROM A LICENSED HOME TO A HOST HOME/LIFE-SHARING SITE.**

1. Type Of Change:	FROM: <input type="checkbox"/> Community Living Arrangement (CLA) <input type="checkbox"/> Person Care Home (PCH)	TO: <input type="checkbox"/> Host Home/ Life- Sharing
2. Current Provider Information:		
<ul style="list-style-type: none"> ▪ Agency Name (Provide the name <u>or</u> location name): _____ ▪ Name Change: ____ Yes ____ No ▪ Required: Report the complete date on which any name change is effective: ____/____/____ (For any name change submit a certified copy of the legal document(s) showing the old and new names.) 		
3. Licensed Home Information:		
a. CLA or PCH Name:		
Address:		
City:	State:	Zip:
b. _____ Mailing Address _____ Location Address <ul style="list-style-type: none"> ▪ Address Change: ____ Yes ____ No ▪ Required: Report the complete date on which any address change is effective: ____/____/____ (For any change of address, submit a certified copy of the legal document(s) showing the old and new names.) 		
c. Telephone Number of the Home (_____) _____ Fax (if applicable): (_____) _____	d. E-mail Address: _____	
e. Medicaid Provider Number: _____	f. Number of Individuals currently residing in the home: _____	

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES (DBHDD)

REQUEST for CONVERSION FORM

4. Attestation Statements	
<u>Provider CEO/Director</u>	
I certify that I have examined the above information and that it is true, accurate, and complete. I understand that any misrepresentation or concealment of material information may subject me to liability under civil and criminal law.	
Provider CEO/Director's Name (Print):	
Provider CEO/Director's Signature:	Date:
<u>Subcontractor Attestation Statement</u>	
I acknowledge that I am currently in a subcontracting relationship with licensed home noted above section #2. I am aware of and/or have requested the change of the above licensed home to a host home.	
Subcontractor's Name (Print):	
Subcontractor's Signature:	Date:
5. Regional Office Response	
I have reviewed this request and I support the change.	
Regional Services Administrator-DD or Regional Coordinator's Name (Print):	
Regional Services Administrator-DD or Regional Coordinator Signature:	Date:

Part III

**Community Service Standards Specific for
Developmental Disabilities Services**

SECTION III

***Operational Standards for
Family Support Services***

Fiscal Year 2012



**Georgia Department of Behavioral Health &
Developmental Disabilities**

October 2011

Department of Behavioral Health and Developmental Disabilities
Operational Standards for Family Support Services

I. Introduction

The Family Support Operating Procedures provide the guidelines for Family Support programs under contract with the Department of Behavioral Health Developmental Disabilities (DBHDD), Division of Developmental Disabilities (DD), regarding the provision and purchase of Family Support services and goods.

A. Purpose

Family Support services are aimed to:

1. Keep families together until the individual with a disability chooses to live independently,
2. Enhance a family's ability to meet the many needs of the family member with a disability,
3. Improve the quality of supports to families while minimizing the need and cost of out-of-home placement to allow families to participate in recreational and social activities and
4. Make a positive difference in the life of the person with a disability as well as the lives of all family members.

While the family is the principal target of Family Support Services, a family's eligibility for services is determined by the presence of a member with a developmental disability.

B. Definitions

Contractor - The provider/agency responsible for administration and provision of Family Support authorized goods and services, in adherence to the Letter of Agreement with Department of Behavioral Health and Developmental Disabilities Division of Developmental Disabilities and the *Family Support Operating Procedures*.

Developmental Disability – A developmental disability means a diagnosis of an intellectual disability prior to age 18 years or a severe, chronic disability, other than mental illness, that is manifested during the developmental period before the age of 22 years, such as cerebral palsy, epilepsy, autism, or other neurological impairments of intellectual functioning or adaptive functioning.

Family - A group of persons living together as a unit, in which there is at least one individual diagnosed with a developmental disability, with his or her family. Family is inclusive of birth or adoptive parents, members of the extended family, a full guardian, legal custodian or a person acting in place of a parent or family member and living as a family unit.

Family Support - An array of goods and services aimed at providing families with individualized support services and/or goods needed to continue the care of a family member with developmental disabilities residing in the family home. Family Support Services is not a crisis program. These services are provided to families with the goal of preventing crises that can result in the need for out-of-home placements or higher intensity services.

Individual Family Support Plan (IFSP) - The Individual Family Support Plan (IFSP) is a person centered, written participation agreement, signed by the individual and/or family, a representative of the contracted Family Support agency, and the designated Family Support Coordinator.

Institutionalization - A restrictive environment (such as an Intermediate Care Unit or hospital), which offers specialized care or incarceration.

II. Eligibility Determination for Family Support Services

The two (2) eligibility criteria that must be met for the receipt of Family Support Services are a diagnosis of developmental disability by an individual residing in a family unit and financial need.

A. Criteria: Diagnosis of Developmental Disability

A family that has a member with a developmental disability will be determined eligible for services by a Contractor of Family Support Services evaluation process utilizing the following criteria:

1. The individual identified is three (3) years or older with a developmental disability.
2. The eligible individual with a developmental disability has the desire to or have continued home care or the family with a member who is eligible, wishes to return to or continue home care of the individual, but requires support and /or assistance to do so.
3. The authorized services and goods for which the individual or family is eligible, is sufficient to support and/or assist in the individual's return to home care or the continuation of care in the home setting.

The Individualized Family Support Application form is to be attached to documentation indicating developmental disability status (See Appendix I)

The contractor of Family Support services will submit to the Region the approved documentation (Individualized Family Support Application, with documents identifying the developmental disability determination) for the recipient of Family Support. The Region will acknowledge the receipt of the documentation, determine the final approval (if applicable) and monitor the service delivery (see Appendix II).

Note: Children who are 0 to 3 years of age may be served if *Early Intervention: Babies Can't Wait* funding has been exhausted in the region where the family resides.

B. Criteria: Financial Need

Authorized goods and services are to be provided on a "sliding fee" basis. The fee schedule is to be set by the Family Support Provider/Agency and approved by the Regional Office.

Documentation of family income and resources will be obtained in order to determine if funds will be allocated. The family is eligible only if the member with a developmental disability is residing in the home or if Family Support funds are to be used to prepare the home and family for the return of the member with a developmental disability from an alternate placement of care.

An eligible family referred and deemed eligible will be served by Family Support within the limits of the funding available. Prioritizing eligible families will be the responsibility of the contracted Family Support Provider, utilizing the required inter-disciplinary team and family assessment process with consideration of the following factors:

1. The degree of the family's financial ability to obtain services;
2. The degree of critical need to support the family's functioning and well-being;
3. The status of the family's plan to accept the member with a developmental disability back into the home from out-of-home placement (if applicable).

Referrals to a Family Support Service Provider/Agency for funding purposes may be accepted from a variety of sources (such as public and private providers, disability specific, generic and other program recipients, as well as self-referrals). The Regional DBHDD I & E team are responsible for designating a point of receipt for all Family Support referrals.

The Family Support Service Provider/Agency must approve or disapprove each family's application within thirty (30) days after receipt of the application.

III. Individualized Service Plans

The goal of Family Support is to sustain and enhance the quality of family/home life so that the individual with developmental disabilities can remain within a nurturing family in his/her home. Support and service provision may be directed to the person with the developmental disability or his/her family members. The task is to determine what authorized goods and services need to be provided to assure that this goal is accomplished. Documentation of the need for goods and services is to be made considering the following components:

1. The comprehensive needs of the individual with a developmental disability,
2. The needs of the family as primary caregiver and
3. The community supports necessary to meet the identified needs.

A. Documentation of the Need for Goods and Services

When the family is determined in need of authorized goods and services, and Family Support funds are to be utilized, the written service plan is to document the following components:

1. A person-centered description of the individual, the family and its support network, the physical environment, and current services. (**Note:** A plan that has been in place prior to the implementation of this document is to be updated to include at a minimum “what is important to” and “what is important for” the individual with a developmental disability);
2. A description of the needs of the family, based on the assessment described above;
3. A written statement of the goods and services that are projected for Family Support funding, with an estimated duration of need and annual cost.
4. A written agreement (See Appendix III- *Family Support Agreement*) signed by the individual or parent(s) and by a representative of the administering Family Support Provider/Agency, which describes how Family Support funds are to be utilized on the family's behalf.

Note: All Funding Sources And Services Available Through Existing Programs Must Be Documented As Not Available Prior To Utilization Of Family Support Funds.

B. Plan Review

Any plan which includes the special provisions of Family Support funds is to be reviewed, consistent with time lines required for that plan, but no less than once every six (6) months following the initial plan development date and more often if determined needed. Parameters for the review process are as follows:

1. For each plan that includes the use of Family Support funds, the need for review or changes in the plan may be made by the Family Support /Agency or by the family. Families should be informed at the time of the initial assessment of the planned review cycle and of their right to participate and request changes.
2. If changes are made in the family's service plan, the reason for the changes is to be included in the record.
3. A parent or individual and a representative of the administering Family Support Service Provider/Agency must sign the amended agreement, with the understanding that the agency retains the flexibility to each referred family on an “as needed basis.”

IV. Authorized Goods and Services

The following is a listing of goods and services which may be purchased with Family Support funds either by contracted provider or directly from a family depending on funding allocations. All goods and services purchased with Family Support funding must be provided in accordance with the Family Support Operating Procedures (*Provider Manual, Current Fiscal Year, Part I: Section II, DD Individual Eligibility, Service Definitions and Service Guidelines For Developmental Disability Services*, located at dbhdd.georgia.gov Provider Information, in the Provider Tool Kit).

A. Respite Care - A service designed to relieve a family/care giver of physical or emotional stresses associated with the care of the member with a developmental disability by the provision of temporary care of the member with a developmental disability in or out of the home. This service may also include care of other young children who are members of the family, when necessary for the primary care giver(s) to devote exclusive time to attend to the care and well being of the member with a developmental disability.

Each contracted Family Support Service /Agency is to maintain a “List of Approved Respite Providers.” Prior to receiving any Family Support funding, respite care providers must be on a Family Support Provider /Agency’s “List of Approved Respite Providers.” For additional requirements regarding respite provider requirements and this registry, see the Administration/Records section in these Family Support Operating Procedures.

B. Community Living Support - An array of services to assist an individual with the developmental disability to perform activities of daily living. These services include the following:

1. Assistance with, and/or training in activities of daily living, such as bathing, dressing, grooming, feeding, toileting, transferring and other similar tasks;
2. Accompanying individuals and facilitating their participation in visits for medical care, therapies, personal shopping, recreation and other community activities. (This category includes staff to serve as interpreters and communicators, as well as the transportation costs to provide such services.)
3. Training and assisting in household cares, such as meal preparation, clothes laundering, bed-making, housekeeping, shopping, simple home repair, yard care and other similar tasks;
4. Assisting with therapeutic exercises, supervising self-administration of medication and performing other services essential to health care at home and
5. Training and support in the areas of social, emotion, physical and special; intellectual development. This category includes mobility training, as well as programming, intervention and/or consultation to reduce inappropriate or maladaptive behaviors.

C. Community Access - An array of services that support an individual with a developmental disability in being involved in their community, based on his/her needs, wants and preferences. The goal of services is to help the person learn or improve their skills in personal care, being independent, socializing with others, adjusting to community life, using resources in their community, and becoming independent outside his/her home or family home. The purpose of these services is to increase the individual's skills and contacts in community living.

D. Dental Services - The full array of services designed to care for the teeth, oral cavity and maxillofacial area, provided by or under the direct supervision of a licensed dentist; in-patient or outpatient.

B. Medical Care - Services provided by or under the direct supervision of a licensed physician or by other licensed or certified health care professionals, when recommended by a licensed physician. The array of Medical Care services are inclusive of diagnosis/evaluation, service provision and consultation with other medical/health care providers or non-medical service providers, as recommended by a licensed physician. Services may be inpatient or outpatient.

C. Specialized Clothing - Services that include the assessment of need, design, construction, fitting and cost of an article of clothing, which is necessitated by the handicapping condition of the individual with the developmental disability.

D. Specialized Diagnostic Services - Specific investigative procedures determined as needed by the family and inter-disciplinary team and are necessary to complete the assessment of needs of the individual with disabilities and/or family. Such specific

investigative procedures assessed as needed are not provided by the interdisciplinary team.

- E. Recreation/Leisure Activities** - Activities and or goods designed to support the participation of the individual with a developmental disability in recreational/leisure activities in the home and/or community.
- F. Environmental Modifications** - Changes, additions or repairs to the personal home of the family/caregiver that are designed to increase their ability to enhance the development/functioning, health or well being of the individual with a developmental disability. These modifications changes, additions or repairs are not structurally permanent.
- G. Specialized Equipment** - Adaptive and therapeutic devices specifically prescribed to meet the habilitative needs of the individual with a developmental disability or devices and equipment needed by the family to better provide for the specific needs of the family member with a developmental disability.
- H. Therapeutic Services** - A direct intervention service provided by a specifically trained therapist aimed at reducing or eliminating physical manifestations of a developmental disability or in improving/acquiring specific skills precluded by the developmental disability. An assessment/evaluation is required for the provision of these services. Therapeutic services are inclusive of audiology, physical therapy, occupational therapy and speech therapy.
- I. Counseling** - Services utilizing a varied number of specific psycho-social approaches, clinical or non-clinical, for the individual with a developmental disability and/or his/her family. These services are aimed at assisting the individual with a developmental disability in coping with life circumstances.
- J. Parent/Family Training** - Information and training for parents/family members to enhance understanding and to better address the needs of the family member who has a developmental disability. Training may be provided as a one-time experience or on-going experience. This training may be delivered in or out of the home setting.
- K. Specialized Nutrition** - An array of services that include assessment, planning, counseling, supervision and provision of specific dietary, nutritional and feeding needs of the individual with a developmental disability. These services are to be provided by a nutritionist qualified by state standards.
- L. Supplies** - Any number of items that may require frequent usage due to the individual's developmental disability. These supplies may not be specialized or specific to the needs of the individual with the developmental disability, but maybe necessary to the on-going operation or maintenance of specialized devices or any number of items that are needed by the family, to better provide for the disability specific needs of the family member with the developmental disability. The need for

such supplies must be clearly documented in the Individual Family Support Plan (IFSP).

- M. Behavioral Consultation and Support** - Professional services which train and support the family in avoiding and/or responding appropriately to behaviors which may create barriers to the individual a developmental disability ability to remain in the home and community; and/or direct individual services intended to address problematic behaviors.
- N. Financial and Life Planning Assistance** - Professional services which assist the family in planning for future services and/or financial needs of the family member with a developmental disability.
- O. Exceptional Disability Related Living Costs** - This service is to be utilized to pay living expenses that are higher than normal due to the nature of the person's developmental disability or to cover unexpected emergency costs. For example, a person who is heat sensitive may require air conditioning during the summer months. The family support budget may include extra costs to cover the higher electrical bills during the summer months so as not to stress the family's household budget. This might also cover higher electrical bills caused by the individual with a developmental disability being on special monitoring machines.

Exceptional Disability Related Living Costs may be approved on a one time, emergency basis, or for ongoing needs. When approved on an ongoing basis, the contracted Family Support Provider must document continued need at least every six (6) months.

- P. Homemaker Services** – Light household work or tasks provided in the home, which are:
1. Necessitated by the lack of a family member capable of performing such tasks or
 2. By the incapacity or absence of the family member who normally performs the tasks and
 3. Are not available through an existing program such as the Community Care Waiver.
- Q. Transportation** – Travel and travel related costs (including subsistence costs) associated with the receipt of a service identified in the plan, and documented by the provider to be necessary to meet the needs of the family.
- R. Other Services:** Any other service not listed above, which, in the opinion of the family and inter-disciplinary team, is necessary to meet the needs of an eligible individual/family, for which a written request is submitted to and approved by DBHDD-Regional Coordinator or the Regional Services Administrator for Developmental Disabilities.

V. Provider /Agency: Contractor Responsibilities

A. Administration

The Contractor retains ultimate responsibility for appropriate administration and for all documentation. This is inclusive of eligibility determination and development of the Individual Family Support Plan. Coordination with all relevant and involved agencies is also the responsibility of the Contractor.

B. Family Support Coordination

A single point of entry for contact with the Family Support Provider/Agency must be established and publicized within the service area so that families will be provided adequate information at the time of their inquiry.

The Contractor will appoint a staff person(s) to act as Coordinator(s) for Family Support. The person(s) appointed may perform administrative tasks and function as a service coordinator for participating families. The administrative and service coordinator duties may be shared among more than one staff person.

As representatives of an organization contracted with the DBHDD Division of Developmental Disabilities, coordinators and staff persons are to practice cultural diversity competency evident by the articulation of an understanding of the social, cultural, religious and other needs, and differences unique to the individuals and families seeking Family Supports, adhering to Family Support Operating Guidelines (*Provider Manual, Current Fiscal Year, Part I: Section II, DD Individual Eligibility, Service Definitions and Service Guidelines For Developmental Disability Services*, located at dbhdd.georgia.gov Provider Information, in the Provider Tool Kit).

C. Reporting

The Contractor will submit reports, which may be required by the Regional Office. These reports may include an annual report that provides a statistical summary of expenditure, client data and a narrative summary of achievements of Family Support. Monthly reporting and other requirements of the contract between the Family Support Provider / Agency and the State of Georgia, Department of Behavioral Health and Developmental Disabilities must be met.

D. Records

The Contractor is responsible for maintaining all financial records including service vouchers/purchase orders that are relevant to service provision per each applicant and recipient of Family Support. Records are to be maintained in an easily accessible place for monitoring/auditing purposes.

The Contactor is responsible for maintaining an updated “List of Approved Respite Providers”.

E. Grievances/Appeal Process

The Contractor is responsible for insuring that an individual/family is notified in writing of the reasons for denial, discontinued or reduced benefits. The Contractor established client appeal procedures are to be made available in writing to the participating families upon application for services. The Regional Services Administrator for Developmental Disabilities (RSA-DD) is to be made aware for the Contractor’s grievances/appeal processes.

Individualized Family Support Application

Section I: Demographic Information

Applicant Name: _____ Date of Application: _____

Medicaid #: _____ Date of Birth: _____

Gender (Male or Female): _____ Social Security Number: _____

Family/Caregiver Name _____

Phone #: Day: _____ Evening: _____ Other: _____

Address: _____ City: _____

State: _____ Zip Code: _____ County: _____

Race/Ethnicity: () American Indian or Alaska Native () Asian or Pacific Islander

() Black or African American (Not Hispanic) () Hispanic or Latino () White (Not Hispanic)

() Multi-Racial/Ethnic Group () Other

Section II: Diagnostic Information

Developmental Disability Diagnosis: _____

Age at Time of Diagnosis: _____

Supporting Documentation Verifying Disability (Check the Documentation That Applies and Attach a Copy of the Documentation to This Application):

___ DD I&E Assessment

___ Adaptive Behavior Score

___ Psychological Evaluation

___ Functional Limitations

___ School IEP

___ Medical Verification

___ IQ Score

___ Social Security Disability Determination

___ Other: _____

Section III: Financial Information

1. The degree of the family's financial ability to obtain services: _____

Individualized Family Support Application

2. The degree of critical need to support the family’s functioning and well-being; _____

3. The status of the family’s plan to accept the member with a developmental disability back into the home from out-of-home placement (if applicable). _____

Section IV: Current Service Information

1. Is this person currently enrolled in a Medicaid waiver program: () Yes () No

2. If “Yes”, please check the appropriate Medicaid waiver program: () NOW () COMP

() ICWP () SOURCE () CCSP () GAP () Katie Beckett () GIA

3. List the Medicaid waiver services that are currently received:

4. Have these resources been exhausted? () Yes () No

5. Do you want this person to continue living in your home? () Yes () No

6. Are you looking for out of home placement? () Yes () No

7. If “Yes”, what type of out of home placement? _____

Section V: Agreement Section

I hereby confirm that the information given at the time of application is true to the best of my knowledge.

Responsible Party Signature: _____

Responsible Party Printed Name: _____

Relationship: _____ Date: _____

Individualized Family Support Application

Section VI:

For Agency/Provider Office Use Only

Date Application Received: _____

Disposition for Family Support:

() Eligible For Family Support Services (Forward Application and Supporting Documents to the Regional RSA-DD)

() Ineligible For Family Support Services

Provider Agency - Name: _____

Provider Staff - Name: _____

Title: _____ Contact Number: _____

E-Mail Address: _____

Provider Staff - Signature: _____ Date: _____

Section VII:

For Regional Office Use Only

Date Application Reviewed: _____

Disposition for Family Support:

Eligible Status confirmed: () Yes

() No - State the reason: _____

Regional Staff's Name: _____ **Title:** _____

Regional Staff's Signature: _____ **Date:** _____

Provider:

Date of Notification:

Individualized Family Support Application

For Office Use Only:

Provider

Regional Office

Comments:

Appendix II

Guidelines for Approval of the Family Support Referral by the Regional Office

An individual/family applies for Family Support at a Family Support Provider based on support needed to continue the care of a family member with developmental disabilities residing in the family home. The steps for approval include:

1. An Individualized Family Support Application is submitted to the Regional Office (see Appendix I).
2. The assigned Regional Office staff reviews the application. Areas of review:
 - Section I (Individual's Information).
 - Section II (Developmental Disability Diagnosis Status) and the attached Supporting Documentation Verifying Disability
 - Section III Financial Information
 - Section IV (Current Services Summary)
 - The Family Support Agreement (See Appendix III)
3. The assigned Regional Office staff acknowledges receipt and review of the document by e-mail to the provider staff, within ten (10) working days (See Appendix I)

FAMILY SUPPORT AGREEMENT

_____ (“Applicant”) has submitted an application on behalf of the family of _____ (“Individual”) for Family Support services.

The _____ (“Provider”), a Family Support Provider / Agency contracting with DBHDD Region _____, has agreed to provide certain services.

This is an agreement between Applicant, on behalf of Individual and his/her family (as defined in the Family Support Guidelines) and the Provider/Agency regarding Family Support Services. The family is eligible only if the member with a developmental disability is residing in the home, or if the Family Support funds are to be used to prepare the home and the family for the return of the member with a developmental disability from an alternate care placement.

Applicant agrees as follows:

- The Applicant understands and acknowledges that Family Support services are provided only in the event that such services are not available or cannot be funded through other programs (including but not limited to Medicaid, Medicare, charitable organizations, etc.)
- The Applicant has provided complete and accurate information to Provider / Agency regarding Applicant’s and Individual’s efforts to obtain services through other programs, and regarding Applicant’s and Individual’s financial and other resources and needs. The Applicant represents that no other resources are available for the services the Applicant has requested as Family Support.
- The Applicant represents that all money received through Family Support services will be used solely for the purpose(s) documented on the Applicant’s Individual Family Support Plan. The Applicant understands and acknowledges that Family Support funds cannot be advanced to the Applicant or to any provider of services under any circumstances.
- The Applicant understands and acknowledges that he/she must present receipts or other documentation to verify any expenses for which he/she requests payment or reimbursement. Any misrepresentations of expenses or other attempt to misappropriate these funds is strictly prohibited and is subject to legal action.

FAMILY SUPPORT AGREEMENT

- The Applicant understands and acknowledges that any misrepresentation of Applicant's/ Individual's needs, resources, efforts to obtain services elsewhere, expenses incurred as part of the Family Service Plan and any attempt to misappropriate Family Support funds will result in immediate discontinuation of services, and the Applicant will be responsible to pay back any funds received based on such misrepresentation(s) or misappropriation(s).
- Applicant understands and acknowledges that any individual providing respite services as part of Family Support must be on a region maintained "List of Approved Respite Providers" prior to providing any respite services. (They cannot be reimbursed for any services provided prior to being approved.)
- Applicant understands and acknowledges that Family Support services are neither an entitlement nor a grant, and are provided as services to assist in maintaining a cohesive family unit and to assist the Individual to live at home in the community. The continued need for Family Support services will be re-evaluated no less than every six (6) months.
- The Applicant agrees to use the Family Support services in compliance with all applicable guidelines (Attached hereto as Annex B).
- The Provider agrees as follows:
 1. Provider will develop an Individual Family Support Plan (IFSP) for Applicant and Individual. Provider will develop the IFSP in consultation with Applicant and to the extent possible, with the Individual.
 2. Provider will set fees for Family Support goods and services on a "sliding fee" basis in consideration of Applicant's resources, and in compliance with any applicable DBHDD fiscal rules and regulations.
 3. Provider will designate a Family Support Coordinator as a single point of contact to work with Applicant and Individual in obtaining Family Support.
 4. Provider will review the IFSP every six (6) months, and at such time as there has been a significant change in Applicant's/ Individual's resources or needs.
 5. Provider will inform Applicant in writing of Applicant's rights to participate in the IFSP and IFSP reviews, and to appeal a denial, discontinuance, or reduction in benefits.
- Both parties agree as follows:
 1. The Provider and Applicant will sign both copies of this agreement and return one signed copy to the appropriate BDHDD Regional Office. A copy will be kept on file by the Provider for State Review, as needed.
 2. This Agreement contains the entire agreement of the parties and there are no other promises or conditions in any other agreement whether oral or written. This Agreement supersedes any prior written or oral agreements between the parties.
 3. This Agreement may not be amended or modified except in writing signed by both parties.

FAMILY SUPPORT AGREEMENT

- 4. The failure of either party to enforce any provision of this Agreement shall not be construed as a waiver or limitation of that party's right to subsequently enforce and compel strict compliance with every provision of this Agreement.
- 5. This Agreement is a required part of the Individual Family Support Plan; no Family Support funds may be expended prior to both parties' signing this Agreement.
- 6. This agreement will terminate upon written notice of either party.

Individual's Printed Name and Date of _____

Birth:

Printed Name of Applicant: _____

Relationship to : _____

Signature of Applicant: _____

Date of Applicant's Signature: Month: _____ Date: _____ Year: _____

Applicant's Complete Address: _____

Applicant's Contact Telephone/Cell _____ / _____

Number(s):

Name of Provider / Agency: _____

Printed Name of Provider / Agency _____

Official:

Title of Provider / Agency Official: _____

Provider / Agency Official Signature: _____

Date of Official's Signature: Month: _____ Date: _____ Year: _____

Provider / Agency's Complete Address: _____

Provider / Agency's

Contact Telephone/Cell Number(s): _____ / _____

PART IV

Community Service Standards Specific for Behavioral Health Services

**Provider Manual for
Community Mental Health,
Developmental Disabilities and
Addictive Diseases
Providers**

Fiscal Year 2012

(Section I and IV Updated for October 1, 2011 Implementation)



**Georgia Department of Behavioral Health &
Developmental Disabilities**

October 2011

Part IV

Community Service Standards Specific for Behavioral Health Services

SECTION I

Operational and Clinical Standards for Assertive Community Treatment (ACT) Teams

Fiscal Year 2012

(Updated for October 1, 2011 Implementation)



**Georgia Department of Behavioral Health &
Developmental Disabilities**

October 2011

**Georgia's
Program Operations Manual
For Assertive
Community Treatment
(ACT) Teams**



Georgia Department of Behavioral Health & Developmental Disabilities
Frank E. Shelp, M.D., M.P.H., Commissioner
Division of Mental Health
Two Peachtree Street NW, 23.415, Atlanta, Georgia 30303-3142~404-657-2273~FAX
404-463-7149

This manual is available on the Georgia Department of Behavioral Health and Developmental Disabilities website:

www.dbhdd.ga.gov

Assertive Community Treatment is identified by the Substance Abuse and Mental Health Services Administration as an evidence based practice that consistently demonstrates positive outcomes and is considered by experts as a recommended treatment option for individuals with serious and persistent mental illness.

Georgia's Program Operations for ACT Teams

ACT Program Operations:

The Georgia's Program Operations Manual for ACT Teams serves to guide ACT program start-up and implementation by clearly defining what is the expected minimum program requirements for each state ACT agency. A successful ACT program model implementation is demonstrated by improvements in consumer outcomes which are accomplished by close adherence to the evidence based practice of ACT operations (Herinchx et al., 1997; McHugo et al.,1999).

The DBHDD is invested in keeping you informed on the efforts for improving the quality of care and services provided to this particular adult population. We are committed to a clearly articulated philosophy (assertive outreach, integrated mental health and substance abuse treatment, stage-wise interventions, comprehensive services, and a long-term perspective) consistent with the ACT model.

There are 13 sections of the ACT Program Operations Manual. At the beginning of each section, the overall purpose and rationale for that section is explained and an explanation regarding program components will be discussed.

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I. Introduction

ACT is an Evidence Based Practice that is consumer-centered, recovery-oriented, and a highly intensive community based service for individuals who have severe and persistent mental illness.

Core Customer:

- The individual's mental illness has significantly impaired his or her functioning in the community.
- The individual has been unsuccessfully treated in the traditional mental health service system because of his/her high level of mental health acuity.
- The use of the traditional clinic based services for the individual in the past or present have usually been greater than 8 hours of service per month.
- The recipient may have experienced chronic homelessness and/or criminal justice involvement; and may have had multiple or extended stays in state psychiatric/public hospitals.

ACT provides access to a variety of interventions twenty-four (24) hours, seven days a week. The service utilizes a multidisciplinary mental health team from the fields of psychiatry, nursing, psychology, social work, substance abuse, and vocational rehabilitation; additionally, a Certified Peer Specialist is an active member of the ACT Team providing assistance with the development of natural supports, promoting socialization, and the strengthening of community living skills (DBHDD, 2011)

The ACT Team works as one organizational unit providing community based interventions that are rehabilitative, intensive, integrated, and stage specific. Services emphasize social inclusiveness through relationship building and the active involvement in assisting individuals to achieve a stable and structured life style. The service providers must develop programmatic goals that clearly articulate the use of best/evidence-based practices for ACT recipients using co-occurring and trauma-informed service delivery and support. Practitioners of this service are expected to maintain knowledge and skills according to the current research trends in best/evidence-based practices. ACT is a unique treatment model in which the majority of mental health services are directly provided internally by the ACT program in the recipient's natural environment. ACT services are individually tailored with each consumer to address his/her preferences and identified goals, which are the basis of the Individualized Recovery Plan (DBHDD, 2011).

The Essential Characteristics of Assertive Community Treatment Programs

- ACT is identified for individuals who have been diagnosed with a severe and persistent mental illness in which the mental illness has interrupted his or her ability to live in the community successfully. Due to the person's mental health conditions, he or she is a higher user of acute psychiatric hospitals and/or emergency/crisis services and/or incarcerations (Allness & Knoedler, 2003; Phillips et al., 2001).
- The process of recovery is embraced because each person with mental illness is believed to have the ability to live a healthy and productive life when proper guidance, skills, and supports are provided.
- The consumer group is often over-represented among the homeless and in jails and correctional facilities, and has been unfairly thought to resist or avoid involvement in treatment. However this is not the case, the use of traditional mental health services has not been beneficial for the person (Lamberti, Weisman, & Faden, 2004).
- ACT services are delivered by utilizing a multidisciplinary mental health team from the fields of psychiatry, nursing, psychology, social work, substance abuse, and vocational rehabilitation. The team is directed by a team leader who is an integrated part of the multidisciplinary team providing face to face and community based services to ACT individuals (Allness & Knoedler, 2003).
- ACT support staff will work in shifts to cover 24 hours per day, seven days a week to provide intensive services. It is recommended that the ACT Team provide for some individuals at least 5 face-to-face contacts per week based on the persons mental health acuity. The ACT model addresses having frequent but shorter length of contacts with participants. According to NAMI (Allness & Knoedler, 2003) the average length of services per consumer per week is 2 or more hours.
- Multiple contacts may be as frequent as two to three times per day, seven days per week, and are based on consumer need and a mutually agreed upon plan between the consumer and ACT staff. Many, if not all, staff share responsibility for addressing the needs of all consumers requiring frequent contact. The expected total number of contacts per consumer per month is 12 face to face contacts (Sherman & Ryan, 1998; DBHDD 2011).
- ACT services are individually tailored by addressing the preferences and identified goals of each consumer. Services and Supports are individually tailored emphasizing social inclusiveness through relationship building and the active involvement in assisting individuals to achieve a stable and structured life style. The approach with each consumer emphasizes relationship-building and active consumer involvement to make improvements in functioning, to better manage

symptoms, to achieve individual goals, and to maintain optimism (Allness & Knoedler, 2003).

- Georgia's Assertive Community Treatment programs will include a comprehensive and integrated set of medical and psychosocial services provided in non-office settings 80% of the time by a mobile multidisciplinary team. The ACT team will provide any number of elements necessary for a person's recovery (Teague, Bond, & Drake, 1998; SAMSHA).
- It is expected that 90% or more of the consumers have face to face contact with more than one staff member in a 2 week period (Teague, Bond, & Drake, 1998; SAMSHA; DBHDD 2011).
- ACT consumers will receive an array of services in order to meet individualized treatment goals. Individuals with SPMI (Serious Persistent Mental Illness) have a wide range of needs, such as developing a capacity for independent living; obtain employment or a meaningful activity, improving the quality of their family and social relationships, and managing anxiety and other negative moods (Allness & Knoedler, 2003).
- ACT services are delivered in an ongoing rather than time-limited framework to aid the process of recovery and ensure continuity of caregiver. Serious mental illnesses are episodic disorders and many consumers benefit from the availability of a longer-term treatment/service approach and continuity of care. This allows consumers opportunities to re-compensate, consolidate gains, sometimes slip back, and then take the next steps forward until they achieve recovery (McHugo et al., 1999; Herinckx et al., 1997).
- The ACT team will be involved in 95% or more of the hospital admissions and hospital discharges. The ACT team will be fully engaged in hospitalizations and discharges by collaborating with hospital personnel. The consumers ACT treatment plan should address the suggestions made by hospital personnel (DBHDD, 2011; SAMHSA).
- It is expected that individuals receiving ACT will achieve housing stability and have a decrease in the debilitating effects from the mental illness. Also, the individual will be assisted by the ACT team in social integration and functioning in order to increase community tenure. The individual will be assisted in defining what is his or her self-defined recovery plan should be (Allness & Knoedler, 2003; SAMSHA).

- The ACT team is expected to work with collateral contacts at least 2 to 4 times a month with or without the consumer present to provide support and skill training as necessary to assist the consumer in his or her recovery (i.e., family, landlord, employers, support systems, probation officers). If the consumer is not an engaged participant in this contact, the service shall not be billed (DBHDD, FY'11; (McHugo et al., 1999; Teague et al., 1998; SAMSHA).

There is an expectation that ACT consumers will experience a decrease in frequency and/or duration of hospitalizations, crisis services, and/or incarcerations (Lamberti, Weisman, & Faden, 2004; Herinckx, et al., 1997). The agency will be monitored by the State ACT Coordinator from DBHDD by submitting a monthly outcomes report on the number of individuals hospitalized and/or incarcerated and the number of consumers who received competitive employment and/or housing. If the agency appears to have a pattern of consumers being hospitalized and/or incarcerated, the agency will receive technical assistance in order to coordinate an action plan (DBHDD, 2011). Also, the ACT agency will receive an ACT Fidelity Review minimally once a year to evaluate if the ACT agency is operating at Full Fidelity.

- There will be an external review organization will conduct audits utilizing a authorization process that verifies there is a proper match between consumer need and the services provided. This involves identification of over-utilization *and* under-utilization of services through careful analysis of consumer functional and behavioral status, resources, and participation in the recovery process. It also ensures the services provided as defined in the DBHDD Provider Manual address consumers' therapeutic needs as demonstrated by provider documentation in the areas of assessment, individual recovery and resiliency plans, and progress notes.

II. Intake Process, Admission, and Discharge Criteria

Intake Process

Georgia's ACT teams are expected to take the initiative to develop collaborative intake processes with their relevant community and institutional referral sources to determine an individual's eligibility for admission and to effectively prioritize and engage new consumers. Georgia ACT teams must have clearly written admission criteria that are consistent with the DBHDD guidelines. According to best practices, the ACT program is expected to respond to any referral resource within a 72 hours period..

During initial program implementation, each state ACT team will stagger consumer admission's to gradually build up to full capacity. Even though Fidelity to the Dartmouth Assertive Community Treatment Scale states that the ACT Agency is not to admit no more than 6 consumers a month, the state of Georgia expects the ACT agency to admit more than 6 consumers a month until the agency has 40 consumers enrolled. The ACT agency is expected to have 40 consumers by July 1, 2011. After 40 consumers are admitted in to ACT, the tapering of admissions will be no more than 6 per month in order

to meet full fidelity requirements. This admission expectation is based on the necessity to maintain a stable service environment for existing consumers, while meeting the needs of newly admitted consumers who are usually in need of higher intensity of services from the team. Each team will gradually build up capacity to serve 100-120 consumers to meet full fidelity requirements (SAMSHA; Teague et al., 1998).

Admission Criteria

Admission decisions are based on considerations that are included in the Provider Manual for Community Mental Health, Developmental Disabilities, and Addictive Diseases Providers for the Department of BHDD. The admission criteria. (2011) defines 5 domains that a consumer must meet to qualify for ACT. The ACT model has demonstrated effectiveness for “consumers in greatest need” (Taube, Morlock, Burns, & Santos, 1990). DBHDD defines targeted ACT consumers as:

1. Individuals with severe and persistent mental illness that seriously impairs the ability to live in the community. **Priority** is given to people recently discharged from an institutional setting with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder) or bipolar disorder, because these illnesses more often cause long-term psychiatric disability; **AND**
2. Individuals with significant functional impairments as demonstrated by the **inability to consistently engage in at least three of the following:**
 - a. Maintaining personal hygiene;
 - b. Meeting nutritional needs;
 - c. Caring for personal business affairs;
 - d. Obtaining medical, legal, and housing services;
 - e. Recognizing and avoiding common dangers or hazards to self and possessions;
 - f. Persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others such as friends, family, or other relatives;
 - g. Employment at a self-sustaining level or inability to consistently carry out homemaker roles (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks and responsibilities)
 - h. Maintaining a safe living situation (e.g. evicted from housing, or recent loss of housing, or imminent risk of loss of housing) **AND**
3. Past (within 180 days of admission) or current response to other community-based intensive behavioral health treatment has shown minimal effectiveness (i.e. Psychosocial Rehabilitation, CSI, etc). Admission documentation must include evidence of this criterion; **AND**
4. Individuals with **two or more of the following problems** that are indicators of continuous high-service needs (i.e., greater than 8 hours of service per month):
 - a. High use of acute psychiatric hospitals or crisis/emergency services including mobile, in-clinic or crisis residential (e.g., 3 or more admission per year) or

- extended hospital stay (60 days within the past year) or psychiatric emergency services.
 - b. Persistent, recurrent, severe, or major symptoms that place the individual at risk for harm to self or others (e.g. command hallucinations, suicidal ideation or gestures, homicidal ideation or gestures, self harm).
 - c. Coexisting substance use disorder of significant duration (e.g., greater than 6 months) or co-diagnosis of substance abuse (ASAM Levels I, II.1, II.5, III.3, III.5).
 - d. High risk for or a recent history of criminal justice involvement because of mental illness (e.g., arrest and incarceration).
 - e. Chronically homeless defined as a) continuously homeless for one full year; OR b) having at least four (4) episodes of homelessness within the past three (3) years.
 - f. Residing in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available [NOTE: Medicaid may not be billed for services provided while in an inpatient facility-see Community Transition Planning service],
 - g. Inability to participate in traditional clinic-based services; **AND**
4. A lower level of service/support has been tried or considered and found inappropriate at this time.

Continued Stay/Discharge/Transitioning Criteria

ACT provides services that are delivered in a continuous rather than time limited framework for persons with longer-term episodic disorders. This time-unlimited structure allows the ACT team to address relapse possibilities that might occur for the consumer when he or she is beginning the transition process to less intensive practices. The ACT team will be provided up to a 4 week period to transition the consumer, however, even if a consumer and the ACT team recognize current treatment accomplishments, the consumer may begin to show signs of decompensation during this transitioning period. The transition period can be a scary time for the consumer but this is normal. If the consumer appears to need a continued stay for another authorization period, the ACT team may request if consumer meets continuing stay criteria in the provider manual. The ACT team will incorporate discharge/transition planning with activities that prepare the consumer for a greater sense of self reliance, when the consumer perceives self to be ready.

Consumers should not be forced out of the program prematurely. In appropriate circumstances, consumers may transition to less intensive services, but arrangements must be made to maintain contact with the consumer until the transfer is complete. All too often consumers are not discharged for reasons of recovery or goal achievement but are dropped due to conflicts with staff or because the complexity of the problems and issues require too much staff time.

In circumstances when a consumer wants to “fire” the ACT team, it is important that the ACT team be willing to listen and to accommodate the consumer’s preferences regarding services. If the consumer still requests discharge, their request must be honored.

The consumer should be given all necessary help to arrange alternative services and given priority for readmission to current ACT provider or another ACT provider if they so choose.

The discharge and transitioning criteria as described for Best Practices and/or from the Provider Manual for Community Mental Health, Developmental Disabilities, and Addictive Diseases Providers for DBHDD:

1. Individual no longer meets admission criteria (DBHDD, 2011);

OR

2. Individual has substantially met individually established goals for discharge. Program staff will arrange for transfer to a less intensive service and maintain contact with the consumer until transfer is complete (DBHDD, 2011);

OR

3. Individual has successfully demonstrated an ability to function in all major role areas (i.e., work, social, self-care) without ongoing assistance from the program, and without significant relapse when services are withdrawn (over approximately a two-year period) (Allness & Knoedler, 2003);

OR

4. Individual has moved or will move outside the geographic area of ACT’s geographical responsibility. The ACT team shall partner with the consumer to arrange for transfer of mental health service responsibility to an ACT program or another provider. The ACT team shall maintain contact with the consumer until this service transfer is implemented (Allness & Knoedler, 2003);

OR

5. Individual has declined or refused services and request discharge and not in imminent danger of harm to self or others (DBHDD 2011);

OR

6. Individual requires services not available in this level of care (DBHDD, 2011).

Note: During discharge/ transition, the ACT Team will provide at least 3 face-to-face contacts per week for most individuals on an ongoing basis. All individuals participating

in ACT transitioning must receive a minimum of 4 face-to-face contacts per month. The Team must see each individual at least once a month for symptom assessment and medication management. A transition plan must be adequately documented in the Individualized Recovery Plan and clinical record (DBHDD, 2011).

The ACT team can provide these transitioning services for up to 4 weeks:

- Psychosocial Rehabilitation
- Community Support
- Behavioral Health Assessment
- Service Plan Development
- Diagnostic Assessment
- Physician Assessment (specific to engagement only)
- Individual Counseling (engagement only)

Documentation of Discharge/Transitioning shall include:

- The reasons for discharge as stated by both the consumer and the ACT team.
- The consumer's discharge bridging services in which he or she will be engaged
- A written final evaluation summary of the consumer's progress toward the goals set forth in the treatment plan.
- Discharge diagnosis (s) both medical and psychiatric
- Living arrangement
- Summary of consumer's progress for all areas of his or her life
- Written description of how the consumer defines how he or she has met recovery goals
- A plan developed in conjunction with the consumer for follow-up treatment after discharge.
- The signature of the consumer, the team leader, and the psychiatrist.

III. Service Intensity and Capacity Frequency of Client Contact

ACT Teams must be designed to deliver services in various environments, such as homes, schools, homeless shelters, and street locations. The provider should keep in mind that individuals may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. their place of employment or school). Staff who drive a vehicle that is clearly marked as a state or agency vehicle need to remember that a breach of confidentiality may occur if the ACT staff member does not have consent to meet consumer in an agency marked vehicle. Staff should be sensitive to and respectful of individuals' privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with an individual during their work time, mutually agree upon a meeting place nearby that is the least conspicuous from the individual's point of view).

- The service delivery by ACT teams must consider confidentiality. An ACT staff member will address with the consumer the privacy and confidentiality issues regarding his/her treatment in the community. ACT staff members need to remember that wearing visible name tags, wearing stethoscope in to consumers building or desired location, driving agency car/van, wearing nursing scrubs, and any other identifiable items does impede on consumers rights for confidentiality.
- At least 80% of all service units must involve face-to-face contact with consumers. Eighty percent (80%) or more of face-to-face service units must be provided outside of the program office locations that are comfortable and convenient for consumers (including the individual's home, based on individual need and preference and clinical appropriateness) (Teague et al., 1998; SAMSHA).
- Some individuals may need at least 5 face-to-face contacts per week because of his or her mental health acuity. Some consumers may not need 5 contacts in a week. But, all individuals participating in ACT must receive a minimum of 12 face-to-face contacts per month. Also, it is expected that 90% or more of consumers have face to face contact with more than one staff member in a 2 week period (DBHDD, 2011; Teague et al., 1998; SAMSHA).
- In addition to a minimum of 12 face to face contacts a month, one of those 12 contacts a month must be for symptom assessment and management of medications (McGrew et al., 1994; Teague et al., 1998; DBHDD, 2011).

Frequency of Collateral Contacts

The ACT team is expected to work with collateral contacts (i.e., family, landlord, employers, support network, probation officers) at least 2 to 4 times a month with or without the consumer present to provide support and skill training is necessary to assist the identified resource and/or consumer in establishing needed supports/services. These formal and informal support persons and the ACT team can work together to meet the wide range of needs the consumer may have, such as developing a capacity for independent living, obtaining employment or some other meaningful activity, improving the quality of their family and social relationships, and managing anxiety and other negative moods.

All identified partners must have a release of confidentiality signed by the consumer. The services provided to the collateral contacts are not billable when the consumer is not engaged in the interaction. (ACT Teams must have a release of confidentiality signed by the consumer for each collateral contact.)

Staff Coverage

- ACT teams maintain a small consumer-to-clinician ratio, of no more than 10 consumers per staff member. This does not include the psychiatrist, program assistant/s, transportation staff, or administrative personnel. Staff-to-consumer ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be served.
- Staff-to-client ratios may also need to be adjusted in settings where safety is an issue and staff must pair up to work in a particular setting. However, the overall staff-to-client ratio should be no less than 1 FTE for every 10 consumers.
- Services must be available by ACT Team staff skilled in crisis intervention 24 hours a day, 7 days a week with emergency response coverage, including psychiatric services (SAMSHA; DBHDD, 2011).
- Answering device, services, referring or forwarding lines to the Georgia Crisis and Access Line do not meet the expectation of “emergency response.” Crisis services are available to ACT consumers and provided by ACT staff (SAMSHA; DBHDD, 2011).
- The team must be able to rapidly respond to early signs of relapse and de-compensation and must have the capability of providing multiple contacts daily to individuals in acute need. Best practice recommends that a limited geographic area be served by each ACT team so that ACT team members can typically respond to a potential crisis within 30 minutes.

The ACT team shall be available to provide treatment, rehabilitation, and support activities seven days per week, 24 hours a day. It is important for the ACT agency to consider achieving regularly operating and scheduling of staff to work two eight-hour shifts with a minimum of two staff on the second shift (afternoon/evening), thus providing services at least 12 hours per day /weekdays. When the agency reaches 100 consumers, the depth of staff working morning/afternoon and evening shifts will assist in continuity of care for the consumer. The ACT agency should schedule ACT staff for on-call duty to provide crisis and other services the hours when staff members are not working assigned shifts. Additionally, the availability of the ACT psychiatrist during 24 hours is not always feasible so an alternative psychiatric back-up should be arranged.

Continuity of Care

ACT teams shall establish mechanisms to provide continuity of care and ensure collaboration with other service-providers (e.g., to facilitate transition to other services, in-patient admissions when necessary, and access to other community and institutional services). Of particular concern is access to crisis stabilization and crisis residential care.

The major premise of ACT is that consumers are capable of playing a vital role in the management of their illnesses and in making progress towards achieving their goals. Providers accept the responsibility of getting information to the consumers so that they can become more effective participants in their treatment process. All consumers receiving ACT services are offered choices and the team will abide by the consumers preferences when offering and providing services.

Note: ACT recipients who also receive a DBHDD Residential Service may not receive ACT-provided skills training which is a part of the “residential” service is. The ACT provider shall be in close coordination with the Residential provider such that there is no duplication of services supports/efforts (DBHDD, 2011).

IV. Staff Requirements

ACT Staffing Plan per 100 Consumers

Position	FTE	Minimum Dedicated Hours per week	**Required Agency Employees	Consumer Capacity
Team Leader	1.0	40	X	
Psychiatrist	.4	16		
RN	1.0	40	X	
SA Practitioner	1.0			.50 if >50 Dually Diagnosed Consumers
Licensed or Associate-Licensed Clinician under supervision	1.0	40	X	
CPS	1.0			.50 with > 50 consumers
Vocational Specialist	1.0			.50 with > 50 consumers
Para Professional	1.0			
Other	2.5			
Total	10			100

*At least 2/3 (i.e. 7 of 10) staff must be Agency Employees (not “contracted:/1099).

The following practitioners can provide Assertive Community Treatment:

- Practitioner Level 1: Physician/Psychiatrist
- Practitioner Level 2: Psychologist, APRN, PA
- Practitioner Level 3: LCSW, LPC, LMFT, RN
- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT’s Supervisee/trainee with at least a Bachelor’s degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-I, CAC-II,

CADC, CCADC, GCADC (II, III); PP, CPRP, CPS, or Addiction Counselor Trainees with Master's or Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (addictions counselors may only perform counseling functions related to treatment of addictive diseases).

- Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above.

Assertive Community Treatment Team Members Composition must include:

- ***Team Leader:*** (1 FT Employee required) A fulltime Team Leader who is the clinical and administrative supervisor of the team and also functions as a practicing clinician on the team; this individual must have at least 2 years of documented experience working with adults with a SPMI and following qualifications to be an “independently licensed practitioner:” It is expected that the practicing ACT Team Leader provides services in the community at least 50% of the time. The Team Leader must be a FT employee and dedicated to only the ACT team (DBHDD, 2011; SAMSHA). The Team Leader must be a FT employee and dedicated to only the ACT team. and can be licensed as one of the following:
 - Physician
 - Psychologist
 - Physician's Assistant
 - APRN
 - RN with a 4-year BSN
 - LCSW
 - LPC
 - LMFT
- ***Psychiatrist*** :(.40 FTE required) A full or part time Psychiatrist who provides clinical and crisis services to All ACT team consumers, works with the team leader to monitor each individual's clinical and medical status and response to treatment, and directs psychopharmacologic and medical treatment. The psychiatrist to ACT consumer ratio must not be greater than 1:100 and the psychiatrist must provide a minimum of 16 hours per week of direct support to the ACT team/ACT consumers. Effective 7/1/11, the psychiatrist must participate at least one time/week in the ACT team meetings (DBHDD, 2011; SAMSHA).
- ***Registered Nurse:*** One Fulltime Employee Registered Nurse who provides nursing services in the community and on location for all ACT team consumers and works with the team to monitor each individual's physical health, clinical status and response to treatment. The nurse is responsible for conducting psychiatric assessments, assessing physical health, providing a range of medical treatment, education to consumers on adherence to treatment and prevention of medical issues, nutrition, and providing a range of rehabilitation and support

services. The nurse is expected to be dedicated to the ACT Team, participate in overall treatment goals, and plans in collaboration with consumer and ACT team. The nurse is to be included with the on-call staff rotation providing crisis intervention. The ACT team nurse is expected to consult with community agencies and families for coordination of care. At least one ACT RN must be dedicated to a single ACT team. "Dedicated" means that the RN works with only one team at least 40 hours/week and is a full-time employee of the agency (not a subcontractor/1099 employee) (DBHDD, 2011; SAMSHA).

- *Certified Peer Specialist*: One FTE who is fully integrated into the team and promotes consumer self-determination and decision-making and provides essential expertise and consultation to the entire team to promote a culture in which each consumer's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation and community self-help activities. The CPS will conduct a Wellness and Recovery Action Plan with each consumer on an ongoing basis. Each Certified Peer Specialist has the ability to serve as an advocate, life coach, or mentor; develop community support; assist in the development of rehabilitation goals; facilitate resolution of issues; or provide education on the importance of maintaining personal wellness and recovery.

The CPS is expected to complete a Wellness Recovery Action Plan (WRAP) with each consumer. The WRAP is an on going collaboration between the consumer and the CPS. The WRAP is considered to be the CPS comprehensive assessment tool.

Key elements of WRAP consist of:

- Wellness Toolbox
- Daily Maintenance Plan
- Identify Triggers and an Action Plan
- Identify Early Warning Signs and an Action Plan
- Identify When Things Are Breaking Down and an Action Plan
- Crisis Plan
- Post Crisis Plan

The WRAP is designed and managed by the consumer and the CPS. The goal of developing a WRAP is to empower the consumer in acknowledging he or she has personal strengths and recovery is possible. The WRAP guides the consumer in exploring behaviors and supports that have been or would be useful in decreasing and preventing intrusive or troubling feelings and behaviors. The ACT team will assist the consumer with increasing personal empowerment, improving quality of life, and assisting the consumer in achieving his/her own life goals and dreams (Copeland; 2009).

- *Substance Abuse Specialist*: (1/2 FTE minimum) A 1/2 to fulltime equivalent substance abuse practitioner who holds a CACI (or an equally recognized SA certification equivalent or higher) and assesses the need for and provides and/or accesses substance abuse treatment and supports for team consumers. If any

single team serves 50 or more individuals with a co-occurring SA issue, then there must be 1 FTE on the team. The ACT team provides most of the substance abuse treatment services for consumers with serious mental illness and co-existing substance abuse disorders. The most effective assessment and treatment approaches employ an integrated treatment model in which mental health and substance abuse treatment are provided simultaneously. The Substance Abuse Specialist must be knowledgeable regarding evidence based practices for dually diagnosed individuals. The use of Motivational Interviewing, Stage-wise treatments, and Integrated Dual Diagnosed Treatment are all interventions that can be implemented. The Substance Abuse Specialist is expected to see each dually diagnosed consumer 1 time a week and to ensure that 50% of the total dually diagnosed consumers receive one monthly dual diagnosis treatment based group (SAMSHA; DBHDD, 2011).

- *Vocational Specialist:* (1/2 to 1 FTE) One of these staff must be a Vocational Specialist. A Vocational Specialist is a person with a minimum of one year verifiable vocational rehabilitation experience. This person may be a ½ FTE if the team serves less than 50 individuals (DBHDD, 2011; SAMSHA; Allness & Knoedler, 2003).

Vocational Specialists primarily participate in core principles of Individual Placement and Support (IPS) and can refer/connect ACT consumers to Supported Employment Services. The vocational specialist's roles are:

- To integrate Supported Employment in to the ACT Treatment Plan once consumer has a desire to work..
- To interact with the Supported Employment Specialist and coordinate services together and develop a Memorandum of Understanding (MOU) between the ACT provider and the Supportive Employment provider if these are different services provided by a different agency.
- To focus on community jobs that pay at least minimum wage and is of interest to the consumer. The vocational specialist provides outreach, education, and support to employers who may be interested in hiring people with mental illness.
- To maintain continuous follow-along supports for the consumer even after employment and as long as the consumer desires assistance from the vocational specialist
- To assists consumers to develop a vocational or employment plan that leads to entry into the labor market. Vocational plans should be developed after an assessment of aptitudes, abilities and interests.
- To provide support to ensure that consumers can keep their jobs or remain in their chosen educational programs. The support needed may involve education or problem solving for consumers, employers and co-workers. Supports can also involve coordination and advocacy to ensure consumers have access to necessary community supports, such as income, housing, medical benefits and counseling.

(SAMSHA; Allness & Knoedler, 2003)

- *A second licensed or licensed associate team member:* (1 FT employee) A full-time practitioner licensed to provide psychotherapy/counseling under the practice acts or a person with an associate license who is supervised by a fully licensed clinician, and provides individual and group support to team consumers (this position is in addition to the Team Leader). An associate licensed professional **Can Not** be a team lead.
- *Para-Professional:* (2 FTEs) Two paraprofessional mental health workers who provide rehabilitation and support services under the supervision of a Licensed Clinician. For example:
 - (1/2 to 1 FTE) One of these staff must be a Vocational Specialist. A Vocational Specialist is a person with a minimum of one year verifiable vocational rehabilitation experience. This person may be a ½ FTE if the team serves less than 50 individuals.
 - (1 to 1 ½) FTE Other Paraprofessional
- *Program/Administrative Assistant:* The program/administrative assistant (minimum one FTE) is responsible for organizing, coordinating, and monitoring all non-clinical operations of ACT, including: managing medical records; operating and coordinating the management information system; maintaining accounting and budget records for consumer and program expenditures; and providing receptionist activities, including triaging calls and coordinating communication between the team and consumers. This position is recommended based on best practices but **not a requirement** (Allness & Knoedler, 2003).
- *Primary Practitioner:* **This is not an added position** but a title given to a consumer's primary ACT staff member who leads and coordinates the activities of the Individual Treatment Team (ITT) (review Allness & Knoedler, 2003 for explanation about ITT) and is the ITT member who has primary responsibility for establishing and maintaining a therapeutic relationship with a consumer on a continuing basis, whether the consumer is in the hospital, in the community, or involved with other agencies. In addition, he or she is the responsible team member to be knowledgeable about the consumer's life, circumstances, and goals and desires. The primary practitioner develops and collaborates with the consumer to write the person-centered treatment plan, ensures that changes are made as the consumer's needs change, and advocates for the consumer. The primary practitioner works with other community resources to coordinate activities and to integrate other agencies or service activities into the overall service plan with the consumer. The primary practitioner provides individual supportive therapy and provides primary support and education to the family and/or support system and other significant people. The primary practitioner shares these service activities with other members of the ITT who are responsible

to perform them when the primary practitioner is not working (Allness & Knoedler, 2003).

Staff Supervision

The team leader shall assume responsibility for supervising and directing all staff activities. This supervision and direction shall consist of:

- Individual, side-by-side sessions in which the supervisor accompanies an individual staff member to meet with consumers in regularly scheduled or crisis meetings to assess staff performance, give feedback, and model alternative treatment/service approaches.
- Participation with team members in daily organizational staff meetings and regularly scheduled treatment/ planning meetings to review and assess staff performance and provide staff direction regarding individual cases.
- Regular meetings with individual staff to review their work with consumers, assess clinical performance, and give feedback.
- Regular reviews, critiques, and feedback of staff documentation (i.e., progress notes, assessments, treatment/service plans, treatment/service plan reviews).
- Written documentation of all clinical supervision provided to ACT team staff.

Staff Training Requirements

The DBHDD requires ACT Providers and ACT Teams to receive technical assistance from the central office on ACT implementation, the organizational structure of ACT, team roles, and achieving full fidelity. Also, the central office may develop separate and mandated training through the term of the contract.

Paraprofessional Required Training

Georgia's Department of Behavioral Health and Developmental Disabilities (DBHDD) has specified a minimum standard training requirement for staff who are not licensed/certified practitioners and/or do not have one of a number of recognized credentials but who provide reimbursable services for an approved provider agency. Provider employees who are not licensed professionals or holders of an approved credential are hereafter referred to as paraprofessionals. Individuals who are credentialed as Georgia Certified Alcohol and Drug Counselors (GCADC, II or III) or Registered

Alcohol and Drug Technicians (I, II or III) are exempt from the paraprofessional training requirement and do not have to take the courses/tests.

The Minimum Standard Training Requirement is the minimum standard necessary for paraprofessionals to provide state funded or Medicaid reimbursable services.

Organizations may choose to require more training to fulfill their organization's specific needs.

Essential Learning, LLC (EL) has been used to provide online, 24/7 access to course content for paraprofessionals. The EL courses provide usable information necessary to fulfill requirements for delivering DBHDD behavioral health services and supports, while also providing paraprofessionals with access to information that will help them be more effective on the job. For general information about EL, please visit www.essentiallearning.com.

Minimum Standard Training Requirement for Paraprofessionals

- Corporate Compliance
- Cultural Competence
- Documentation
- First Aid/CPR
- Mental Illness – Addictive Disorders
- Pharmacology & Medication Self-Admin
- Professional Relationships
- Recovery Principles
- Safety/ Crisis De-escalation
- Explanation of Services
- Service Coordination
- Suicide Risk Assessment

The Minimum Standard Training Requirement for Paraprofessionals is designed to include subject matter that may be satisfied using Essential Learning online courses in addition to courses provided at the organization level. Proof of course completion via a certificate, generated either online by Essential Learning or by the “live” course provider, is necessary to receive credit toward meeting the standard training requirement.

V. Staff Meetings and Planning Service

The ACT team shall conduct Treatment Team Meetings, Individual Treatment Team Meeting, Treatment Planning Meeting, and a Treatment Planning Review Meeting at regularly scheduled times per a schedule established by the team leader. These meetings will be conducted in accordance with the following procedures:

- Treatment Team Meetings (referred to as the Daily Organization/Morning Meeting in the NAMI start-up manual) is a **daily** staff meeting held at regularly scheduled times under the direction of the team leader or an appointed designee. The meetings are conducted at least 4 times a week to meet Full Fidelity. However, the DBHDD service guidelines require at least a minimum of 3 meetings a week. Each consumer is discussed briefly in order to review the service contacts which occurred the previous day and the status of the consumer. The meetings will review the service contacts which are scheduled to be completed during the current day and revise as needed based on consumer needs. The daily staff assignment discussed to carry out the day's service activities. Also, the meeting will be used to revise treatment plans and plan for emergency and crisis situations as needed. The daily log and the daily staff assignment schedule are used during the meeting to facilitate completion of these tasks. All consumers within ACT receive care from a multidisciplinary team and providers of ancillary services who work collaboratively on the mental health team. Collaboration suggests that team members regularly communicate about the consumer's progress and are not merely component parts.

It is expected that all ACT programs coordinate all elements of treatment and rehabilitation to ensure that everyone is working toward the same goals in a collaborative manner (Allness & Knoedler, 2003).

- Daily Staff Assignment Schedule is a **daily timeline** summarizing all consumer treatment and service contacts. Based on the consumers individualized needs will depend on which team member will be doing face to face. This daily staff schedule itinerary for all consumer's activities for that day, what will be conducted by specific team members, where colleagues are, and how to reach them if issues or situations arise. Because consumers needs often change, the daily staff schedule addresses personalized care which is not based on a team member seeing the same consumer each week at the same time. For example, the day prior, a consumer admitted to the CPS that she is using substances. In the next day morning meeting, the daily schedule would incorporate the CAC to begin treatment with the consumer.
- Individual Treatment Team (ITT) is a group of three to five ACT staff members who are comprised of both clinical and rehabilitation skills and expertise. According to best practices, the team is organized **at least thirty days after admission**. The ITT members are assigned by the team leader and the psychiatrist to work collaboratively with a consumer and his/her family and/or natural supports in the community. The ITT team is considered the primary team at that time based on the consumer's needs and goals. For example, the consumer verbalized during the comprehensive assessment that he desires to obtain employment, wants to address his substance abuse, and feels ashamed about his mental illness. The primary ITT would consist of vocational specialist, substance abuse specialist, and the certified peer specialist. All teams must include the primary practitioner, psychiatrist, and at least one clinical or rehabilitation staff

person who shares case coordination and service provision tasks for each consumer.

The ITT has continuous responsibility to be knowledgeable about the consumer's life, circumstances, goals and desires. The team will collaborate with the consumer to develop and write the treatment plan; to offer options and choices in the treatment plan; to ensure that immediate changes are made as a consumer's needs change; and to advocate for the consumer. The ITT is responsible to provide much of the consumer's treatment, rehabilitation, and support services. ITT members are assigned to take separate service roles with the consumer as specified by the consumer and the ITT in the treatment plan. Please review NAMI Start-up Manual by Allness and Knoedler (2003) for further discussion about ITT.

- *Treatment Planning Meeting* a regularly scheduled meeting conducted under the supervision of the team leader and the psychiatrist. The purpose of this meetings is for the entire ACT staff and the consumer and his/her family/natural supports, to thoroughly prepare for their working together. The meeting is conducted **after the Comprehensive Assessment is completed** and the team will meet together to present and integrate the information collected through the assessment in order to learn as much as possible about the consumer's life, his/her experience with mental illness, and the type and effectiveness of the past treatment they have received. The presentations and discussions at this meeting make it possible for all staff to be familiar with each consumer and his/her goals and aspirations and for each consumer to become familiar with each ITT staff person.
- *Treatment Plan Review* a thorough, written summary describing the consumer's and the ITT's evaluation of the consumer's progress/goal attainment, the effectiveness of the interventions, and satisfaction with services since the last person-centered treatment plan. DBHDD requires treatment plan review to occur at **least every 3 months (or as needed)** treatment plan review be conducted and revised as indicated. The Treatment Plan Review is utilized to capture the consumer's progress toward goals for problems that they are currently being treated for. The review is performed periodically during treatment and addresses the justification for continued stay at the current level of care or justification for a transfer to different level of care.

ACT Meeting Grid

Type of Meeting	Tasks/Description/Purpose	Who is Present	How often
<p>Treatment Team Meeting Usually conducted in the morning</p>	<ul style="list-style-type: none"> ▪ Discussion on every csr; even if briefly . ▪ Lasts 1 hour ▪ Meeting covers: medical, medication, SA, crisis or relapse signs for SA/MH issues, supports, upcoming appointments, progress, needs, & vocational. ▪ Daily Staff Assignments ▪ Daily Log ▪ Weekly csr schedules and schedule changes: Based on csr needs which the team member might need to see csr that day. ▪ Building team cohesiveness, brain storming, and supporting each other. 	<ul style="list-style-type: none"> ▪ The Entire Team and Psychiatrist at least once a week 	<ul style="list-style-type: none"> ▪ Minimal 3 times a week ▪ DACTS gives an agency a score of a 5 when the Tx team meets 4 to 5 times a week.
<p>Treatment Planning Meeting</p>	<ul style="list-style-type: none"> ▪ Discuss comprehensive assessment. ▪ Orient csr ACT services. ▪ Review what consumer wants out of treatment. ▪ Introduce csr to his/her ITT members. ▪ Answer csr questions. ▪ Make recommendations for the treatment plan. ▪ Discuss resources, barriers, goals, needs, and deficiencies. 	<ul style="list-style-type: none"> ▪ Newly enrolled Consumer ▪ The entire team and Psychiatrist 	<p>Upon completion of comprehensive assessment and prior to the ITT meeting</p>

Individual Treatment Team (ITT) Meeting	<ul style="list-style-type: none"> ▪ Discussion on identified consumers. ▪ Explore how ITT team will reach recovery goals and treatment needs. ▪ Devise Treatment Plan ▪ Write a progress note with who attended the meeting, outcome of the meeting, and who is on the csr ITT Team. 	3-5 people who best fit the consumers needs	<p>Meeting occurs after the comprehensive assessment is completed and the Treatment Planning Meeting has already occurred.</p> <p>Meet as needed</p> <p>ITT team may change every 3 months depending on consumers needs.</p> <p>Prior to Discharge and transitioning consumer</p> <p>Team may need to meet with csr if issues arise.</p>
Treatment Plan Review	<ul style="list-style-type: none"> ▪ Update treatment plan – the Primary Case Manager will update treatment plan in this meeting. ▪ A written summary describing the consumer’s and the ITT’s evaluation of the consumer’s progress/goal attainment, the effectiveness of the interventions, and satisfaction with services since the last person-centered treatment plan was written. 	<ul style="list-style-type: none"> ▪ Entire Team ▪ psychiatrist ▪ Consumer 	Quarterly and at reauthorization; on going.

Non-attendance exception can be decided and documented by the Team Leader.

Documentation of Meetings

The ACT team must have documentation (e.g., notebook, binder, file, etc.) which contains all staffing interactions (which shall become a document for audit purposes, and by which claims/encounters can be revoked-even though there are no funds attached). In addition to the requirements in Section G.2 in the DBHDD Provider Manual, a log of staff meetings is required to document staff meetings as outlined in Section A.2 of the DBHDD Provider Manual.

The ACT program should develop a *Daily log* which is a notebook or a cardex used by the ACT team which is maintained on a **daily basis** during the first meetings of the day to provide a roster of individuals served and for each individual served there is a brief documentation of any treatment or service contacts that have occurred during the day and the behavioral description of the individuals clinical status. Team members who do not attend the morning meeting can review the daily log. The log is a good source of communication between the morning shift and the evening shift. It is similar to a brief shift report in hospital settings (Allness & Knoedler, 2003).

VI. Client-Centered Assessment and Individualized Recovery Treatment Planning

The consumer and the ACT team work together to formulate and prioritize consumers issues, set goals, research approaches and interventions, and establish the individualized recovery treatment plan (IRP). Because eligible individuals may be difficult to engage, the initial recovery treatment plan for an individual may be more generic at the onset of treatment/support. It is expected that the treatment plan be individualized and recovery-oriented after the team becomes engaged with the individual and comes to know the individual. The allowance for “generic” content of the IRP shall not extend beyond one initial authorization period.

The Individualized Recovery plan are individually tailored so that the treatment/rehabilitation/support approaches and interventions achieve optimum symptom reduction, help fulfill the personal needs and aspirations of the consumer, take into account the cultural beliefs and realities of the individual, and improve all the aspects of psychosocial functioning that are important to the consumer.

Initial Assessment

An initial assessment and treatment plan shall be completed on the day of the consumer’s admission to ACT by the team lead and the psychiatrist. The initial assessment evaluates the consumer’s appropriateness for ACT, documents his or her initial diagnosis, reviews

the immediate needs for the consumer, informs the consumer about ACT, and develops a generic individualized recovery plan/service plan.

ACT Comprehensive Assessment

- *ACT Comprehensive Assessment* is the organized process of gathering and analyzing current and past information with each consumer and the family and/or support system and other significant people in the individual's social network. The multidisciplinary team is to gather data pertaining to their specialty on the ACT team. For example, the substance abuse section will be completed by the Certified Addictions Counselor. According to best practices and the DACTS model, the comprehensive assessment is used to establish immediate and longer-term service needs with each consumer and to set goals and develop the first individualized treatment plan. Because of the complexity of the mental illness and the need to build trust with the served individual, the comprehensive mental health, addiction, and functional assessments may take up to 60 days. When a person identifies and allows his/her natural supports to be partners in his or her recovery that the supports will be fully involved in the assessment activities. The ACT team documentation will demonstrate this participation and in accordance with confidentiality. Please review NAMI Start-up Manual by Allness and Knoedler (2003) for copy of a comprehensive assessment.

The ACT Comprehensive Assessment will cover the following areas (Allness & Knoedler, 2003)

- Reasons for admission
- History of present illness
- Treatment goals and individual strengths
- Evaluation of mental and functional status; along with a proper diagnosis
- Prior treatment and rehabilitating services used and the outcomes of these services
- Physical health
- Use of alcohol or drugs and SA treatment
- Education and employment
- Assets, limitations, preferences for future education and employment
- Social development and functioning
- Social skills and legal involvement
- Activities of daily living skills
- Family structure and relationships
- Recommendations for initial plan
- Recommendations for treatment plan goals and individual strengths/weaknesses

Goals of the comprehensive assessment

- To reconstruct and evaluate what the individual has been through in his or her life while living with a mental illness
- To form a therapeutic alliance with each ACT consumer
- Working with the individual on his or her own terms by not rushing to complete the comprehensive assessment but to view the assessment as an ongoing practice
- To help the individual identify personal needs and aspirations and instilling hope for recovery
- To understand the individual on various individual and social levels in order to develop an individualized treatment plan
- For nurse and psychiatrist to have evaluate medical needs and interventions that are to be addressed in treatment

Additional Requirements: A psychiatric and social functioning timeline

- *Psychiatric and Social Functioning TimeLine* is a form which assists the team staff to organize chronological information about significant events in the consumer's life. The timeline can reveal how ones mental illness impacts a person from living productively in the community. The timeline can reveal developmental milestones that weren't reached because of the persons' mental illness. The timeline will also provide a treatment history of possible anniversary dates or triggers that lead to hospitalization. This format allows staff systematically to analyze and evaluate the information with the consumer, to formulate hypotheses for treatment, and to determine appropriate treatment and rehabilitation approaches and interventions with the consumer. One person on the team is responsible for gathering the data and completing the form.. The individual chosen to complete the timeline will be working in the ACT office gathering data. Please review the NAMI Start-up Manual by Allness & Knoedler (2003) for a copy of a timeline.

Individualized Recovery Treatment Planning

The Individualized Treatment Plan shall be developed through a client-centered approach in collaboration with the consumer and the family or substitute decision maker. The consumer's participation in the development of the treatment plan shall be documented. Together the ACT team and the consumer shall assess the consumer's needs, strengths, and preferences, and develop an individualized treatment service plan. The Individual Treatment Team members are responsible to ensure that the consumer is actively involved in the development of treatment recovery goals. With the consent of the

consumer, the ACT team shall also involve pertinent agencies and members of the consumer's social network in the formulation of treatment/service plan.

The treatment/service plan shall:

- Identify individual issues/problems
- Set specific measurable short-term and mid-term goals for each issue/problem.
- Establish the specific approaches and interventions necessary for the consumer to meet his or her goals, improve his or her capacity to function as independently as possible in the community, and achieve the maximum level of recovery possible (i.e., a meaningful, satisfying, and productive life).
- Document in the plan who will carry out the approaches and interventions.

Possible components of the treatment/service plan may include:

- Symptom management
- Physical health issues
- Substance abuse (if indicated)
- Education and employment
- Social development and functioning
- Activities of daily living
- Family structure and relationship
- Psychiatric illness or symptom reduction
- Housing
- Daily structure and employment
- Family and social relationships
- Co-occurring illnesses (if indicated)

VII. Required Services

The ACT multidisciplinary team will individually plan and deliver services that are targeted to help consumers address the complex interaction between symptoms and psychosocial functioning in order for the consumer to achieve personal goals.

Best Practices and Full Fidelity for ACT include the following services:

- Service coordination
- Crisis assessment and intervention
- Symptom assessment and management
- Cognitive-Behavioral Therapy, Motivational Interviewing
- Self-management skills
- Medication prescription, administration, monitoring and documentation;
- Substance abuse treatment
- Work/education-related services
- Activities of daily living services and family supports

- Social, interpersonal relationship and leisure-time activity services
- Support services or direct assistance to ensure that consumers obtain the basic necessities of daily life

It is important that members of the ACT team reflect the cultural diversity of the local population that the team serves.

Crisis Assessment and Intervention

A crisis is a period of disequilibrium and decreased functioning. A crisis is not the event but the individual's perception of and response to situation. Consumers' acute responses include helplessness, confusion, anxiety, shock, and anger (Golan, 1978) and crisis supports are considered to be nonlinear interventions. Nonlinear crisis support interventions holds the belief that emotional disorder does not reside within the person; rather, psychological and emotional issues often relate to the disordered environments and relationships in which the consumer lives and engages. ACT is a "hospital without walls" and the ACT team is expected to be available 24 hours a day/7 days a week. One goal of ACT is to prevent hospitalization. Each ACT consumer should have a WRAP to assist him or her in recognizing signs and triggers that might inhibit a crisis episode.

The ACT team should have conversations upon admission and through on going dialogue with the consumer regarding preventive measures for not being hospitalizations/incarcerated before the consumer has de-compensated to the point of needing inpatient care or jail. Examples of preventive measure include medication compliance, teaching skills to consumer that he or she can use when being triggered or is feeling stressed, having a list of names and numbers of contacts consumer may call, and/or exploring items that may be of comfort for the consumer which can provide a sense of safety/security.

The beginning stage of a crisis:

- Engagement with consumer
- Define and assess the crisis situation
- Explore meaning and importance of the upsetting situation
- Identify the emotional and behavioral responses and perceptions of consumer
- Break down the crisis in to smaller manageable parts to help identify steps leading up to consumer feeling helpless
- Review current behavioral reactions
- Review how situation could have been dealt with differently by providing hope, reviewing strengths, and choices

The second phase of crisis intervention consists of an Action Plan:

- Design an action plan
- Review barriers to action plan
- Write down past resilience behaviors

- Identify triggers
- Identify signs leading up to crisis

The last stage of a crisis intervention consists of:

- Review the action taken and evaluate success
- Guidance about handling future crisis situations
- Process feelings around ending the crisis-therapeutic relationship
- If crisis intervention did not deescalate thoughts, feelings, or behaviors then hospitalization may be necessary

Co-Occurring Disorder Services

If a consumer has a co-occurring disorder, the Substance Abuse Specialist will provide at least one weekly session addressing co-occurring issues with the use of stage-wise interventions. Evidence based practices shows positive results for individuals with co-occurring disorders which includes Integrated Dual Diagnosis Treatment, Motivational Interviewing, and Cognitive Behavioral Therapy,

The ACT team shall provide a stage-based integrated treatment model that is non-confrontational, considers interactions of mental illness and substance abuse, and has client-determined goals. When promoting behavior change for a consumer, the change is based on incremental growth. In order for lasting change to occur, an individual must be educated, prepared, motivated, and supported. The stage-wise interventions are suggestions to provide individually adapted health and behavioral changes tailored to the individual's specific interests, preferences, and readiness to change. Evidence Based Practice stage-wise interventions teach participants the behavioral skills needed to incorporate healthier habits into their lifestyle. The interventions provide leverage constructs from established behavioral change models.

Consumers in the early stages of readiness to change (pre-contemplation or engagement stage) receive content that is designed to raise their awareness about the benefits of change. As their state of readiness evolves, the interventions adapt according to the consumers goals and confidence level. The interventions are built around weekly themes that encourage sustainable and incremental changes. The goal is to promote action by providing resources, education, and support. Motivational Interviewing incorporates stages of change that are identifiable by the person's statements and behaviors.

Harm Reduction needs to be addressed with the dually diagnosed consumer. Harm reduction is not a model but a set of practical strategies that reduce negative consequences of substance use by incorporating a spectrum of strategies for safer use and to manage ones use to possible abstinence. Harm reduction strategies meet substance users where they are in his or her life.

Harm reduction is based on four principles

- While absolute abstinence may be preferable for many or most substance abusers, very few will achieve it, and even that small group will take time to do so and may relapse periodically
- Ordinary medical treatment readily accepts and practices ameliorative therapies, which preserve health and well-being even when people fail to observe all recommended health behaviors
- Therapists should present accurate information to clients and may even express their own beliefs, but they cannot make judgments for clients
- There are many shades of improvement in every kind of therapy—this improvement may be all that people are capable of and should be encouraged and nurtured.

(Denning, Little, & Glickman, 2004)

Examples of Harm Reduction Techniques

- Remind consumer not to repeat the previous dosage if he/she has stopped using drugs/alcohol for a while in order to prevent overdose or blackouts through lowered tolerance
- Encourage the consumer to take their first dose later in the day to encourage control and gradual reduction (avoid or reduce the early morning dose)
- Reflect on previous episodes of treatment and relapses as well as why
- Analyze the causes underlying one's previous criminal behavior, triad connection, and its possible consequences
- Explore costs and benefits of crime

Work Related Services

Work related services are integrated in to the ACT model to guide consumers to find and maintain competitive employment. Employment, even if part-time, will create social inclusion for the consumer, enhance self esteem, and provide a structured life style. Every individual with a mental illness diagnosis has the right to access opportunities to have employment.

An ACT consumer can receive services with a Supported Employment agency and ACT simultaneously. A collaborative relationship between the supported employment agency and the ACT vocational specialist will be established. Both professionals will provide different components of treatment and services but both professionals work toward achieving the same goal of assisting the consumer in obtaining competitive employment and building upon skill set. A MOU will need to be developed between the supported

employment case manager and the ACT vocational specialist if these are separate agencies providing the services.

A few reasons why working is good for someone's mental health

- Allows one to feel “ I'm doing something useful”
- Allows one to be busy and fulfills the time
- Allows creativity and to make money
- Allows one to do a variety of tasks
- Allows meeting new people
- Allows new experiences
- Allows one to learn about responsibility
- Allows opportunities to make friends
- Allows one to contribute to the community

Activities of Daily Living and Wellness Recovery

Activities of daily living services support consumers with enhancing and maintaining housing which is safe and affordable. The ACT team will teach/assist (but not complete for) consumers in procuring necessities in order to maintain and live independently. The ACT team will teach activities of daily living skills such as performing household activities, cooking, grocery shopping, and laundry, developing healthy eating habits, carrying out personal hygiene and grooming tasks, developing or improving money-management skills; using available transportation, and to effectively use a personal physician or other medical professional. Also, the ACT team will educate consumers on wellness topics such as nutrition, exercise, diabetes and diabetes prevention, heart disease, relaxation and stress management, and smoking cessation.

Social/Interpersonal Relationship and Leisure-Time Skill Training

The ACT team will assist consumers in the improvement of their social/interpersonal relationships and their use of leisure-time as needed. These activities may include improving communication skills, developing assertiveness, developing social skills, increasing social experiences, family reunification, and planning appropriate use of leisure time and relating to landlords, neighbors, and others effectively. When ACT recipients are also receiving a DBHDD Residential Service, the consumer may not receive ACT-provided skills training which is a part of the “residential” service. The ACT provider shall be in close coordination with the Residential provider such that there is no duplication of services supports/efforts. A formal MOU is needed to structure and clearly define what services the ACT team will provide and what services the Residential Provider will provide.

Peer Support Services

DBHDD promotes client-centered practices with the use of Certified Peer Specialists. The peer support specialists serve to validate consumers' experiences and to guide and encourage consumers to take responsibility for and actively participate in their own recovery. In addition, services help consumers identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce self-imposed stigma.

Because of life experience with mental illness and mental health services, the certified peer specialist provides expertise that professional training cannot replicate. The Certified Peer Specialists are fully integrated ACT team members who provide highly individualized services in the community and promote consumer self-determination and decision-making. Peer specialists also provide essential expertise and consultation to the entire team to promote a culture in which each consumer's point of view and preferences are recognized, understood, and respected.

Peer Support services include:

- Self-disclosing and sharing of life experience to serve as a mentor and a role model;
- Assisting consumers to recognize the need for and developing a coping mechanisms to deal with symptoms and social stigma;
- Educating staff within the team regarding the consumer perspective on the mental health system and assisting the team to maintain a client centered approach that maximizes consumer participation and empowerment;
- Advocating for development of consumer initiatives within the community and identifying opportunities for consumer empowerment; and
- Introducing and referring consumers to consumer self-help programs and advocacy organizations that promote recovery; and
- Developing a WRAP with consumer

Support Services

To ensure that consumers have access to the basic necessities of daily life, the ACT team will assist consumers in using transportation, making medical and dental appointments, provide benefits counseling (e.g. Income Assistance, assistance in filing Social Security/Disability); assisting with finding affordable housing; and assistance in locating and referring to other community resources.

Family-Centered Services

ACT teams are expected to include consumer's family members or others who the consumer considers to be of significance to participate in the consumer's recovery process. Some services utilize active inclusion of significant others in the consumer's recovery are:

- To discuss strengths and experiences of the consumer
- How the consumers' mental illness impacted his or her support system
- To promote reduction in stress and increase coping skills
- To structure problem solving approach
- To improve communication skills
- To build support systems and plans
- To provide family psychoeducation
- To address family unification

Groups

Research indicates that better outcomes are achieved when group treatment is integrated as a curriculum based treatment for individuals with severe and persistent mental illness. Research suggests that modifications in maladaptive behavior occur most effectively when stages of treatment are taken into account (Kanas, 2000).

- Clarification for groups: (up to 8 units/week) A group may be offered to no more than 10 ACT participants at one time and must be directed by no fewer than 2 staff in order to be billed as a Group. This group contains no less than 3 consumers and no more than 10 consumers. This may be offered for no more than 2 hours in any given week. Only ACT consumers are permitted to attend these group services. The group practitioner levels are 1-5 when a curriculum-based therapeutic group is offered such as Dialectical Behavioral Therapy skills building, Motivational Interviewing, Cognitive Behavioral groups (DBHDD, 2011). Acceptable group practitioners are those on the ACT team who meet the practitioner levels as follows:
 - Practitioner Level 1: Physician/Psychiatrist
 - Practitioner Level 2: Psychologist, CNS-PMH
 - Practitioner Level 3: LCSW, LPC, LMFT, RN
 - Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC,

CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, and counseling, psychology, or criminology (may only perform these functions related to treatment of addictive diseases).

- Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases)
- Substance abuse groups are expected to be offered 1 time a month to at least 50% of the total dually diagnosed consumers in ACT (SAMSHA; DBHDD, 2011). This group has to be treatment oriented and curriculum based. An ACT team can refer a consumer to another program that offers a treatment oriented and curriculum based group. Must attend same group (SAMSHA; DBHDD, 2011).

Examples of Self Help Groups that are not billable include

- Double Trouble
- NA/AA Anonymous

Note: If an ACT organization provides these self help groups, the interactions that may occur between a consumer and an ACT team member is not billable.

ACT is a comprehensive team intervention and most additional services are excluded, with the exceptions of

- Peer Supports,
- Residential Supports,
- Community Transition Planning (to be utilized as a person is transitioning to/from an inpatient setting, jail, or CSP)
- Group Training/Counseling (within parameters listed in Section A), and
- Supported Employment

And those services which are identified as a part of the transition plan (see page 13 of this document)

VIII. Client Record

The ACT team shall maintain a treatment record for each consumer. The treatment record is confidential, complete, accurate, and contains up-to-date information relevant to the consumer's care and treatment. The record shall accurately document assessments, treatment plans, and the nature and extent of services provided, such as a person unfamiliar with the ACT team can easily identify the consumer's treatment needs and services received. The team leader and the program assistant shall be responsible for the maintenance and security of the consumer treatment records. The consumer records are

located at the ACT team headquarters and, for confidentiality and security, are to be kept in a locked file. For purposes of confidentiality, disclosure of treatment records by the ACT team is subject to all the provisions of applicable state and federal laws. Consumers shall be informed by staff of their right to review their record and the process involved to request to do so. Each consumer's clinical record shall be available for review and may be copied by authorized personnel (DBHDD, 2011).

Detailed expectation for documentation are set forth in the Provider Manual for Community Mental Health, Developmental Disabilities, and Addictive Diseases Providers for the Department of BHDD. *Documentation Guidelines for Behavioral Health Providers*.

IX. Client Rights and Complaint Resolution Procedures

ACT teams' policies and procedures ensure the protection of consumer rights and must be consistent with provincial legislation and Provider Manual for Community Mental Health, Developmental Disabilities, and Addictive Diseases Providers for the Department of BHDD, and the Medicaid Part I Program and Policy Manual, which include a mechanism to readdress complaints. All team members must fully understand a consumer's right:

- To have his or her capable decisions about autonomy and self determination
- To be respected; to make decisions that may not be in his or her best interests; and to give or refuse consent to services or treatment, where the consumer is capable with respect to such decisions.
- Where the consumer is not capable, all team members must respect the need to comply with legislation and professional operations that govern consent to treatment and services for incapable persons.
- These principles are intrinsic to the basic tenets of consumer-centered care. The team must facilitate the fair and efficient resolution of complaints.
- Nondiscrimination
- Control of own money
- Voice or file grievances or complaints
- Confidentiality

XI: ACT Fidelity Review: Program Evaluation

- *What is an ACT Fidelity Review* The ACT Fidelity Scale is the Dartmouth Assertive Community Scale (DACTS) developed by Teague, Bond, and Drake (1998). The DACTS contains 28 program specific items to measure the adequacy of implementation of ACT programs. Each item is scored a likert scale from 1-5 with 5 meaning Fully Implemented. The scale items fall in to three categories: human resources (structure and composition); organizational boundaries; and nature of services.

- ACT Fidelity monitoring ascertains a measurement of the Team's current practice based upon clinical record reviews, staff interviews, and interviews with consumers; along with administrative documents. The fidelity score and composite report can assist you in practice improvement areas and assist in providing technical assistance to your professional employees.
- The ACT Fidelity Scale has been developed to measure the adequacy of ACT program implementation. A team of 2 to 3 representatives will conduct the Fidelity Reviews and will convene to review results. If the team feels a need for further clarification, you will be asked to submit additional documents to ensure the most accurate results as possible. It is important for the ratings to be made objectively, based on fidelity evidence.
- At the end of the review, a brief summary of findings will be verbally shared with the program, highlighting significant ratings with an emphasis on the strengths of the program.
- You will receive an ACT Fidelity Monitoring Report which includes a fidelity score and explanation. The report will be informative, factual, and constructive.
- The ACT Fidelity Review is conducted at least once a year. The DBHDD Evidence Based Program Specialist will contact the agency to schedule a Fidelity review.
- To review ACT Fidelity Tool Kit, please visit www.samsha.gov.
- *The Description of the 3 Categories of the DACTS*
 - **Human resources section:**
The Human Resources Domain measures the number and mix of Professional's comprising the ACT team and the extent to which the team uses a multi-disciplinary approach to service delivery.
 - **Organization boundaries section :**
The Organizational Boundaries Domain examines the structure and operations of the ACT team and the extent to which the team coordinates with other organizations involved in delivery of services to ACT recipients.
 - **Nature of services :**
The Nature of Services Domain evaluates how the ACT team delivers services to ACT recipients

Note: A fidelity review will not be conducted on an ACT agency if the agency has not been billing for services at least 6 months. Also, if an ACT agency does not have the proper staffing as stated in the Provider Manual for Community Mental Health, Developmental Disabilities, and Addictive Diseases Providers for the Department of BHDD, which reflects the DACTS full fidelity recommendations, the agency will not receive a fidelity score because the agency is considered not meeting minimal staffing requirements to provide ACT services.

The fidelity assessment is administered by individuals who have experience and training in interviewing, data collection, and auditing. The evaluators have an understanding of the nature of ACT. It is expected that the ACT agency receive a 90% to 100% for the implementation of ACT services in order to be considered meeting full fidelity to the model.

XII. Community Advisory Bodies

Each ACT program is encouraged to establish a local community advisory body that would support and guide the ACT team implementation and operation. This body may support other mental health services as well as ACT teams. This body performs a key role in promoting high quality and recovery-oriented services for ACT clients.

The advisory members are chosen for their specific knowledge about the ACT model, their general knowledge of mental health and addiction services, their links with relevant community resources, and their ability to represent the interests of consumers and the ACT community program. Members selected should include both mental health consumers and the community stakeholders. Membership on the advisory body should be culturally aware and competent, and reflect the diversity of the local population.

Possible Committee Members

- State, county, and local mental health administrators
- Consumers and family members
- Corrections
- Vocational rehabilitation
- Housing and Medicaid representatives
- NAMI

The community advisory body should have written terms of reference for incorporating the requirements outlined in this section. The main responsibilities of the advisory body are to

- Promote fidelity to the ACT Program Operations.
- Problem-solve and advocate to reduce system barriers to ACT implementation.
- Provide the program with advice on timely resolutions to emerging issues.

- Represent the interests of consumers and their families about services received from the ACT team.
- Develop and maintain good communication with the community.
- Promote partnerships, awareness and understanding of the program's target population.
- Review and make recommendations on the ACT agency's annual operating plan and budget, identify any opportunities to increase cost-effectiveness by collaborating with other agencies, and bringing to the Board's attention any significant deviations from the plan and budget during the year.

ACT Coalition

ACT teams are a key community resource to help manage consumers in the community who are most at risk of re-hospitalization. ACT can also serve as a bridge to the community for many of our consumers who have had repeated and prolonged hospitalizations.

In order to improve the utilization of ACT services, DBHDD hosts monthly meetings including ACT providers and key members of the DBHDD as well as other speakers. The meetings include information which is directly relevant to providing treatment for ACT consumers and for maintaining full fidelity to the model.

It is therefore very important that you or a decision maker in your agency attend at least 80% of the meetings. Do not send representatives who are not administratively responsible for management level decisions. We welcome staff from your team but require a key management team member to develop strategies related to ACT services.

Letters will be mailed to agencies that are not meeting the Department of Behavioral Health and Developmental Disabilities expectations for the 80% attendance to the ACT Coalition Meetings. According to the Commissioner's letter dated in July 2010, the expectation is to see you or a key administrative person at the ACT Coalition Meetings the 2nd Thursday of the month at 1pm.

The ACT provider will need to maintain a current ACT team list serve in order to receive emails about ACT related items and invites to the ACT Coalition. Please email the agency's primary contact for ACT and the CEO's email to XXXXXX.

The Benefits of the ACT Coalition Meetings

A collaborative and objective arrangement that allows ACT providers an opportunity to pool resources and combine efforts in order to effect change in serving mentally ill adults.

- Technical assistance trainings to help ACT provider evolve their program
- An opportunity to network with other agencies
- An opportunity to find support from fellow peers

- To share resources
- To learn about changes in policies and procedures
- To learn from quest speakers

XII: Outcomes

Outcomes show the benefits and changes for individuals during or after participating in the ACT program activities. The outcomes can be both positive and negative over time. With the use of outcome data, the patterns of the program and consumers become visible depending on the program's overall organizational structure and consumer characteristics.

The DBHDD expects all ACT providers to bestow quality services with the emphasis of reaching full fidelity to the ACT Model. If the ACT agency is modeling full fidelity, the outcome data will display a decline in recurrent acute episodes of the illness, an increase in the consumer's quality of life, an increase of consumer involvement in social and employment roles and activities, and a decline of homelessness, hospitalizations, and incarcerations.

Outcomes are considered a program evaluation tool that provides the viewer a snap shot of the program implementation to the ACT model. Each ACT program shall evaluate: 1) consumer outcomes; 2) consumer and family satisfaction with the services; and 3) fidelity to the ACT model. Program evaluation will be used by the ACT team, the Regional Offices, an External Review Organization, the state ACT Coordinator of DBHDD, and the community advisory board in order to evaluate program effectiveness and to establish program improvement and performance goals. Each ACT agency is expected to submit outcome data to the state ACT Coordinator once a month. Please review outcome form on pages 43-44.

XIII. Recovery

Recovery is more than the elimination of symptoms from an otherwise unchanged life. It is about regaining wholeness, connection to the community, and a purpose-filled life. Pat Deegan (1987) wrote:

“Recovery does not refer to an end product or result. It does not mean that one is "cured" nor does not mean that one is simply stabilized or maintained in the community. Recovery often involves a transformation of the self wherein one both accepts ones limitation and discovers a new world of possibility. This is the paradox of recovery i.e., that in accepting what we cannot do or be, we begin to discover who we can be and what we can do. Thus, recovery is a process. It is a way of life. It is an attitude and a way of approaching the day's challenges. It is not a perfectly linear process. Like the sea rose, recovery has its seasons, its time of downward growth into the darkness to secure new roots and then the times of breaking out into the sunlight. But most of all recovery is a slow, deliberate process that occurs by poking through one little grain of sand at a time”.

DBHDD expects all ACT agency's to Create a Recovery Supportive Environment where consumers are involved in all aspects of their own treatment, where people define their own recovery, staff acknowledge that consumers are fellow human beings and not a diagnosis, and self-determination, critical thinking, and independence are valued.

ACT Monthly Programmatic Report –ANNEX C

Please Submit the ACT Monthly Programmatic Report by the 10th of each month to the State ACT Coordinator at XXXXXXXX. This report must reflect the *actual* number of consumers benefiting from ACT Services each Monthly.

Provider Name: _____ Geographic Area: _____
Month and Year of Service: _____

A. ACT TEAM CENSUS Monthly

1. ACT Team Consumer Census End of LAST MONTH. _____
2. Number ACT Team Consumer Enrollments this Month. _____
3. Number ACT Team Consumer Discharges this Month (12.a + b + c + d + e). _____
4. ACT Team Consumer Census End of THIS MONTH (11.a + b + c + d + e + f). _____

B. OUTCOME DATA (For Consumers Receiving ACT Services this Month) Monthly

5. Number Admissions to Psychiatric Hospitals, CSPs, Inpatient Detox, this Month. _____
6. Number Days Utilized in Psychiatric Hospitals, CSPs, Inpatient Detox, this Month. _____
7. Number of ACT Consumer Contacts with Police/Criminal Justice this Month. _____
8. Number of Days Spent in Jail or Prison this Month. _____
9. Number of ACT Consumers Competitively Employed this Month. _____

- 10. Number of ACT Consumers w/an Episode of Homelessness this Month. _____

- 11. ACT Team Consumers by Living Arrangement this Month:
 - a. Congregate Care (Personal Care Home, Group Home) _____

 - b. With Family or Friends (no rental agreement) _____

 - c. Supervised Apartment (rental agreement, on-site support) _____

 - d. Independent Apartment (rental agreement, no on-site support) _____

 - e. Homeless or Shelter _____

 - f. Other _____

C. DISCHARGE DATA
Monthly

- 12. Number ACT Consumer Discharges By Discharge Criteria this Month:
 - a. Graduated, Stepped Down to Lesser Intensive Services _____

 - b. Graduated, No Need for Further Services _____

 - c. Drop Out, Refused Service, Unable to Locate, Unplanned Move _____

 - d. Admitted to Institution (Hospital, Prison, Nursing Facility) _____

 - e. Deceased _____

Provider Program Manager

DBHDD ACT Coordinator

Date Submitted

Data Received

Evidence Based Practices in ACT- Appendix B

EBP Embedded in ACT:

- Illness Management and Recovery
- Integrative Dual Diagnosis Treatment
- Collaboration with families/Psycho-education
- Motivational Interviewing Techniques
- Supported Employment
- Permanent Supported Housing
- Psycho-educational Multifamily Groups

Specific evidence-based practices that are within the ACT model can be provided by the ACT team :

- Cognitive Behavioral Therapy for Social Skills Training
- Evidence-based pharmacological treatment using practice guidelines (algorithms) and a collaborative approach with ACT consumers;
- Double Trouble to Recovery (non-billable because self help group)
- Pathways to Housing First Model
- Dialectical Behavioral Therapy
- Trauma Affect Regulation: Guide for Education and Therapy
- Seeking Safety
- Program to Encourage Active, Rewarding Lives for Seniors
- IPS
- Trauma Recovery Empowerment Model

Note: Please review www.SAMHSA.gov for descriptions of all these evidence based practices.

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Part IV

Community Service Standards Specific for Behavioral Health Services

SECTION II

Crisis Stabilization Standards for Adults

Fiscal Year 2012

Due to a change in Georgia State law these standards will be replaced by rules and regulations for Crisis Stabilization Units early in the fiscal year. Providers will be notified when the rules and regulations are accepted. Until then, the standards in this section are in effect.



**Georgia Department of Behavioral Health &
Developmental Disabilities**

October 2011

**DEPARTMENT OF BEHAVIORAL HEALTH AND
DEVELOPMENTAL DISABILITIES¹⁰**

**CORE REQUIREMENTS FOR ADULT CRISIS STABILIZATION PROGRAMS
Operated by COMMUNITY SERVICE BOARDS**

Effective July 1, 2001

Crisis Stabilization Program standards for adults are incorporated by reference into those found in the State of Georgia, Department of Behavioral Health and Developmental Disabilities document entitled “Standards for All Providers”.¹⁰

The CSP standards document has been footnoted to indicate modifications and additions to the standards since their inception. Crisis Stabilization Program standards that arose from issues resulting from the Certificate of Need concern addressed in the “Letter of Agreement” between the Department of Community Health and DHR Division of MHDDAD, signed on the 28th day of February, 2001 by George P. A. Newby, representing DCH and by Jerry Lovrien, representing DHR, have not been modified and may be modified only pursuant to agreement between DHR and DCH.

SSr 11.1. DESCRIPTION OF THE PROGRAM

SSr 11.1(a). Crisis Stabilization Program is a medically monitored short-term residential service operated by the Community Service Board⁴ for the purpose of providing psychiatric stabilization and detoxification services. The crisis stabilization program must be designated by the Department as both an emergency receiving facility and an evaluating facility.

Interpretive guideline 1: The department may designate any private facility or such portion of a certified community mental health and substance abuse program which complies with the standards for a CSP within the State of Georgia at the request of or with the consent of the governing officers of such facility. Rules of DHR MHMRSA ERETF 290-4-1-.02(a). Et. Seq.

Interpretive guideline 2: As defined in the Rules of DHR MHMRSA ERETF 290-4-1-.01(b), the term “Crisis Stabilization Program (“CSP”) means a short term residential program operated as a part of a comprehensive community mental health and substance abuse program [operated by a Community Service Board or by a Department of Behavioral Health and Developmental Disabilities (DBHDD) state hospital facility]^{4/10} for the purpose of providing psychiatric stabilization or detoxification services, which complies with applicable Community Service Standards contained within the *Provider Manual for Community Mental Health*,

⁴ CSP’s may be state operated effective FY04

¹⁰ Updated FY10

Developmental Disabilities and Addictive Diseases for The Department of Behavioral Health and Developmental Disabilities Providers..

Interpretive guideline 3: Crisis stabilization programs are state supported residential services provided as a part of a Community Service Board⁴ and designed to serve as a first line alternative to hospitalization in state hospitals, offering psychiatric stabilization and detoxification services on a short term basis.

Interpretive guideline 4: The target population served in the CSP is adults (age 18 or older) with severe and persistent mental illness, persons with substance related disorders and persons with co-occurring mental health and substance use needs.

Interpretive guideline 5: Emancipated minors and juveniles who are age 17 may be served within these programs when their need for stabilization can be met by the CSP, when they do not need specialized child and adolescent services, and when their life circumstances demonstrate they are more appropriately served in an adult environment. Such admissions must be approved by the Medical Director.

Interpretive guideline 6: Residential detoxification services offered within the CSP **shall not exceed** services described in Level III.7 of the *American Society for Addiction Medicine Patient Placement Criteria* (ASAM), Second Edition, April 2001.

Interpretive guideline 7: NOTE: Twenty-four hour residential services offering detoxification ONLY shall be licensed by the Healthcare Facility Regulation Division under the “Rules of Department of Human Resources Chapter 290-4-2: Drug Abuse Treatment and Education Programs”. These CSP standards shall not apply.

Interpretive guideline 8: **Psychiatric stabilization services** offered within the CSP **shall not exceed** services described in Level Six of the *Level of Care Utilization System for Psychiatric and Addiction Services, Adult Version 2000* (LOCUS), published by the American Association of Community Psychiatrists, August 2006 (most recent version).¹⁰

Interpretive guideline 9²: The term “emergency receiving facility” means a facility designated by the department to receive patients under emergency conditions as provided in Part 1 of Article 3 of Chapter 3 or of Chapter 7 of Title 37. Rules of DHR MHM RSA ERETF 290-4-1-.01(d).

Interpretive guideline 10²: The term “evaluating facility” means a facility designated by the department to receive patients for evaluation as provided in Part 2 of Article 3 or of Chapter 7 of Title 37. Rules of DHR MHM RSA ERETF 290-4-1-.01(e).

¹⁰ Updated citation added FY08

² Added to CSP Standards FY02

¹⁰ Updated FY2010

Interpretive guideline 11²: Designation reviews will be conducted for physical plant, safety and food service according to the specifications outlined in the Rules for Drug Abuse Treatment & Education Programs, Chapter 290-4-2, section .11 “Physical Plant and Safety” and section .12 “Food Service”.

Interpretive guideline 12⁶: CSP’s that are newly constructed or CSP’s undergoing physical plant modifications after June 30, 2005 shall address safety issues to minimize the opportunity for self-harm of an individual such as, but not limited to the following:

- Shower fixtures in bathrooms shall be flush-mounted in the wall
- Headers supporting bathroom stalls shall be flush-mounted to the ceiling
- There shall be two avenues of visual access into the seclusion and restraint room, one of which shall be through a shatterproof window in the locked door. The room shall have a minimum fifty (50) square feet in area and the door to the room can be opened from the outside.¹⁰
- Blind spots on the unit and in the seclusion and restraint room shall be addressed through use of convex mirrors allowing for visual access. A room used for seclusion or restraint must:
 - i. Allow staff full view of the resident in all areas of the room;
 - ii. Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets
- Video cameras are not a permitted alternative to direct observation of an individual in the seclusion or restraint room.
- Doors to bedrooms shall be hung on hinges that swing both in to the room and out from the room⁷ Note that if a building is being *modified* and it is not possible for the door to swing both ways, the door should be mounted to open away from the room.
- Facility must have a satisfactory food service permit score, if applicable. Facility may utilize meal preparation services from an affiliated or contracted entity with a current food service permit. A copy of the current food service permit must be on file in the facility. Should the facility elect to have meals prepared off-site, the facility will have a modified kitchen that includes a microwave, a refrigerator, and clean-up facilities.¹⁰
- Facility must maintain a daily temperature log for freezer and refrigerator.¹⁰
- Foods, drinks and condiments shall be dated when opened.¹⁰
- Facility must have a sufficient designated area to accommodate meal service. This area may double as a group or activity area.¹⁰
- Facility maintains a temperature between 65 and 82 degrees F that ensures the comfort and safety of all clients.¹⁰
- Facility is free of offensive odor and noise.¹⁰
- Ramps are built according to specifications of Section 504 of the Rehabilitation Act of 1973.¹⁰
- The facility enforces a nonsmoking policy, but may provide a designated smoking area. If smoking is permitted, the facility designates and confines smoking to the designated smoking area.¹⁰

¹⁰ Added to CSP standards FY10

⁶ Added to CSP Standards FY06

⁷ Added to CSP Standards FY07

- Outdoor client area must be secured for safety and privacy.¹⁰
- Pre-admission waiting area, including restroom, must meet all safety requirements applicable to designated client areas.¹⁰
- Multi client bedrooms shall have a minimum of 60 sq ft per client and a private room shall not be less than 100 sq ft.¹⁰
- Beds must be either weighted or secured to the floor.¹⁰
- Prohibited bed types include but not limited to beds with springs, cranks, rails or wheels. The use of hospital beds is discouraged and rollaway, cots, double deck, stacked; hide-a-bed and studio couches are not to be used in lieu of standard beds.¹⁰
- Facility lighting shall be sufficient enough for reading and other activities.¹⁰
- Gender specific restrooms shall have adequate ventilation and have an adequate number of sinks, toilets and showers to accommodate the population served.¹⁰
- Exposed plumbing pipes shall be covered to prevent client access.¹⁰
- Rods/curtains utilized for privacy shall be designed not to sustain more than 30 pounds.¹⁰
- Water temperature for consumer usage must be maintained between 110-120 degrees. For those facilities providing onsite food service, a separate water heater is designated for usage.¹⁰
- Facility windows and mirrors must be either temper glass, plastic or shatterproof.¹⁰

Interpretive guideline 13: Facilities are accessible to and usable by physically disabled individuals and must meet the minimum requirements of Section 504 of the Rehabilitation Act of 1973. Centers install required alterations or modifications in accordance with the 1984 Law of Georgia regarding Access to and Use of Public Facilities by Physically Handicapped Persons: O.C.G.A. Section 30-3-1 et. Seq.

SSr 11.1(b). The Crisis Stabilization Program shall describe its capacity to serve voluntary and involuntary clients.

Interpretive guideline 1^{6.1}: The program description of the CSP clearly describes their service mission including its capacity to carry out the emergency receiving and evaluating functions of the CSP.

Interpretive guideline 2: The CSP clearly outlines their voluntary and involuntary admission criteria and there is evidence of documented practice of the established admission criteria.¹⁰

SSr 11.1(c). The Crisis Stabilization Program is NOT a designated treatment facility as defined by O.C.G.A. 37-3 and 37-7.

Interpretive guideline 1: The term ‘treatment facility’ means a facility designated by the department to receive patients for treatment as provided in Part 3 of Article 3 of Chapter 3 of Title 37. Rules of DHR MHMRSA ERETF 290-4-1-.01(f).

^{6.1} Modified FY06

Interpretive guideline 2: The program description of the CSP clearly states that it is not a designated treatment facility or service.

SSr 11.1(d). The Crisis Stabilization Program shall not use the word “inpatient” anywhere for any purpose to describe the services offered within the CSP.

Interpretive guideline 1: The program description and all other documents within the CSB and CSP shall describe the services offered within the CSP as *residential* services.

SSr 11.1(e). The Crisis Stabilization Program shall not hold itself out as a hospital or bill as a hospital for inpatient service.

Interpretive guideline 1: There is no evidence that the CSP is holding itself out as a hospital or that it is billing for hospital or inpatient services.

SSr 11.1(f).² The CSP shall not operate in a manner or offer any service that brings them within the purview of Georgia’s Certificate of Need (CON) Program as defined by the CON Statute and Rules (O.C.G.A. 31-6-1 et. seq. and O.C.R.R. 272-2-1 et. seq.).

Interpretive guideline 1: There is no evidence that the CSP is operating in a manner or offering any service which brings them within the purview of Georgia’s Certificate of Need (CON) Program.

SSr 11.2 CERTIFICATION OF THE CRISIS STABILIZATION PROGRAM

SSr 11.2. The Crisis Stabilization Program shall be surveyed for compliance with State standards.

Interpretive guideline 1: Any Crisis Stabilization Program (CSP), to be eligible for designation, shall be a part of a comprehensive community mental health and substance abuse program and shall be in compliance with: 1) Standards for All Providers found in the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases for the Department of Behavioral Health and Developmental Disabilities*¹⁰ and 2) the Department of Human Resources Grants to Counties Policy Manual. Rules of DHR MHM RSA ERETF 290-4-1-.02(d).

Interpretive guideline 2⁶: Any state Crisis Stabilization Program (CSP), to be eligible for designation, shall be operated by an accredited and licensed (if applicable) healthcare authority and shall be in compliance with: 1) Standards for All Providers found in the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases for the Department of Behavioral Health and Developmental Disabilities*¹⁰ and 2) the Department of Human Resources Grants to Counties Policy Manual. Rules of DHR MHM RSA ERETF 290-4-1-.02(d).

² Added to CSP Standards FY02

SSr 11.3. LINKAGES FOR CARE OF COMPLEX CARE NEEDS

SSr 11.3. The Crisis Stabilization Program shall have operating agreements with private and public inpatient hospitals and treatment facilities.

Interpretive guideline 1: Crisis Stabilization Programs shall have documented operating agreements and referral mechanisms for psychiatric, addictive disorder and physical health care needs that are beyond the scope of the Crisis Stabilization Program and that require inpatient treatment. Operating agreements shall delineate the type and level of service to be provided by the private or public inpatient hospital or treatment facility. Operating agreements must be updated **at a minimum every five years** as evidenced by date and signatures.¹¹

Interpretive guideline 2: The following shall be clearly stated within the body of the operating agreements between the CSP and designated treatment facilities(s):

The purpose of clinical services provided by the CSP is psychiatric stabilization or detoxification. When it becomes evident 48 hours into the ‘evaluation’ legal status that a client is not stabilizing and may not stabilize quickly, arrangements shall be made to transfer the client to a designated treatment facility at that point. The transfer of the client shall take place no later than 72 hours into the ‘evaluation’ legal status, unless there has been a different time limit established in a written agreement with a hospital. The client may be transferred to the treatment facility on the existing 1014 or 2014 legal status. For the purposes of calculating the 48 or 72 hours, Saturdays, Sundays or holidays will not apply.

Interpretive guideline 3: The private facility or the CSP shall utilize available resources in the community to provide psychological tests and social work services if such services are needed for the patients and do not exist within the facility. Rules of DHR MHMRSA ERETF 290-4-1-.04(4).

SSr 11.4. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

SSr 11.4. The Crisis Stabilization Program will operate within the guidelines of EMTALA with respect to stabilization and transfer of clients.

Interpretive guideline 1: The Crisis Stabilization Programs are not hospitals nor do they receive Medicare monies. However, the CSP’s will operate within the guidelines of EMTALA with respect to the stabilization and transfer of clients to and from hospitals.

SSr 11.5. LENGTH OF STAY

SSr.11.5^{2.1}. The average length of stay shall not exceed five (5) days excluding Saturdays, Sundays and Holidays.

¹¹ Requirement for updated agreements added FY08

^{2.1} Modified FY02

Interpretive guideline 1: For any one episode of care, an individual person may not remain in a CSP beyond 10 days, excluding Saturdays, Sundays and Holidays, with the exception described in Interpretive Guideline 2 below.

Interpretive guideline 2^{4.1}: A CSP must designate transitional beds separate from crisis residential beds. Clients occupying transitional beds may remain in the CSP beyond 10 days excluding Saturdays, Sundays and Holidays **only if they are in services and activities on a daily basis that indicate the individual is actively engaged in transitioning to the community**^{6.1}. Length of stay in a transitional bed may not exceed 30 calendar days including crisis days. Transitioning activities may include, but are not limited to, participation in day services; meetings with the client/family; and/or active participation in services with the intent toward discharge.¹⁰ The CSP must record the date of transfer to the transitional bed(s) and the length of stay in transitional beds for each episode of transitional care. Transitional bed designation should be made using these parameters:

- a) A CSP with up to 29 beds may designate one or two beds as transition beds. The total bed count for crisis beds and transition beds shall not exceed 29.
- b) A CSP with up to 39⁴ beds may designate up to three beds as transition beds. The total bed count shall not exceed 39.
- c) A CSP with 40⁴ or more beds may designate up to four additional beds as transition beds.

Interpretive guideline 4²: CSP's shall report census and length of stay data as required to the Department of Behavioral Health and Developmental Disabilities for both regular and transitional CSP beds.^{10.1}

SSr 11.6. ADVERTISING OF SERVICES

SSr.11.6. The Crisis Stabilization Program shall not advertise services offered within the CSP.

Interpretive guideline 1: The Community Service Board may inform and educate the public about services offered by the CSP, but shall not advertise any of the CSP services or hold itself out in any manner as providing inpatient or hospital service.

SSr 11.7. BILLING AND REVENUE SOURCE

SSr 11.7(a).^{2.1} The primary revenue source shall be public funds.

^{10.1} Updated FY10

¹⁰ Added to CSP Standards FY10

^{6.1} Modified FY06

⁴ Added to CSP Standards FY04

^{4.1} Modified FY04

² Added to CSP Standards FY02

^{2.1} Modified FY02

Interpretive guideline 1: Review of revenue budget for the CSP will show that no less than 95% of the funding is public, including State Grant in aid and Medicaid. Note: Medicaid may be billed only if the program has 16 or fewer beds.

SSr 11.7(b). Clients are billed on a sliding fee scale basis according to their ability to pay.

Interpretive guideline 1: Review of billing practices shall demonstrate that clients have been billed on a sliding fee scale basis.

SSr 11.8. PHYSICIAN OVERSIGHT

SSr 11.8(a). All services offered within the Crisis Stabilization Program shall be provided under the direction of a physician.

Interpretive guidelines 1: “Physician” means any person who is licensed to practice in this State under the provisions of Article 2 of chapter 34 of Title 43, or who is employed as a physician by the United States Veterans Administration or other federal agency. Rules of DHR MHMRSA ERETF 290-4-1-.01(g).

Interpretive guideline 2: The active medical staff of the CSP shall include a physician who has completed at least one year of approved psychiatric residency and consultation by a psychiatrist shall be available. Rules of DHR MHMRSA ERETF 290-4-1-.04(2)

Interpretive guideline 3: In the event that the physician providing coverage is not a psychiatrist, arrangements shall be in place for psychiatric consultation.

Interpretive guideline 4: There is documented evidence of Physician oversight for the dispensing of sample medications.¹⁰

SSr 11.8(b) A physician shall conduct assessments of new clients address client care issues and write orders as required.

Interpretive guideline 1: A physician is NOT required to be on site 24 hours a day, however the physician must report to the Charge Nurse daily. A physician must be available by pager 24 hours a day and must respond to staff calls immediately, not to exceed one hour. The physician must personally report to the CSP within one hour at the request of the charge nurse.

Interpretive guideline 2: CSP’s must have capacity to admit and discharge seven days a week.

Interpretive guideline 3: A physician must assess each new client within 24 hours of admission.

Interpretive guideline 4: Documentation by the physician shall include, at a minimum the initial evaluation of the client, resulting diagnoses and care orders, the response to care and

services provided, a rationale for medications ordered or prescribed, and assessment of the client at the time of discharge.

*Interpretive guideline 5*¹⁰: Searches of individuals shall be ordered by the physician. There is to be no mandatory removal of clothing or standing orders for strip searches. Strip searches are to be performed for cause and the rationale clearly documented in the person's record.

Interpretive guideline 6^{10.1}: Levels of observation shall be ordered by the physician and will be based on physician assessment. When the levels of observation are changed, there is documented justification to support the ordered level change by the physician.

SSr 11.8(c). The functions performed by physician's assistants, nurse practitioners and clinical nurse specialists are within the scope allowed by state law and professional practice acts.

Interpretive guideline 1: The CSP utilizing physician's assistants, nurse practitioners and clinical nurse specialists can demonstrate verbally and through documentation their implementation of agreements and protocols required by state law and professional practice acts. Renewal of Georgia Board of Nursing authorization as a nurse practitioner will coincide with the renewal of the registered professional nurse license.

SSr 11.9. REGISTERED NURSE OVERSIGHT

SSr 11.9(a). The Crisis Stabilization Program shall have a position classified as a lead nurse or higher that serves as the nursing administrator.

Interpretive guideline 1: The Registered Nurse designated as nursing administrator is a full-time employee of the programs whose job responsibilities include, but are not limited to, the clinical supervision of the nursing staff, implementation of physician's orders and oversight of the clinical functions of the unit.

SSr 11.9(b). The Crisis Stabilization Program shall have a Registered Nurse present within the facility at all times.

Interpretive guideline 1: A Registered Nurse must be in the CSP facility at all times.

Interpretive guideline 2: A Registered Nurse must be the Charge Nurse at all times.

Interpretive guideline 3: There must be one Registered Nurse within the CSP facility for every 30 CSP facility beds.

¹⁰ Added to the standards FY10

^{10.1} Added to the standards FY10

Interpretive guideline 4: CSPs that employ sanctioned nurses must assure that their assigned duties comply with the requirements stated by the Georgia Board of Nursing/Georgia Board of Examiners of Licensed Practical Nurses in their consent orders.¹⁰

SSr 11.10. STAFF TO CLIENT RATIOS

SSr 11.10. Staff to client ratios shall be established based on the stabilization needs of clients being served.

Interpretive guideline 1: The ratio of direct care staff to clients should not be less than 1:8 (including the Registered Charge Nurse). Assigned levels of observation shall be utilized as guidelines for establishing staffing ratios greater than 1:8.¹⁰

Interpretive guideline 2: There shall always be at least two staff present within the CSP including the Charge Nurse.

Interpretive guideline 3: The utilization of licensed practical nurses shall be considered to provide technical support to the Registered Nurse.

Interpretive guideline 4: The functions performed by registered nurses and licensed practical nurses are within the scope allowed by State Law and professional practice acts.

SSr 11.11. USE OF SECLUSION OR RESTRAINT

SSr 11.11(a). A Crisis Stabilization Program may only use restraint and seclusion as a safety intervention of last resort.

Interpretive guideline 1: In all cases, the law regarding seclusion and restraint found in 42 CFR 482.13 (revised October 1, 2006)¹², O.C.G.A. 37-3 and 37-7 as well as the rules found in Rules of Department of Human Resources, Mental Health, Mental Retardation and Substance Abuse Chapter 290-4-6 Patients' Rights shall apply.

Interpretive guideline 2: All forms of restraint and seclusion shall be used solely for the purposes of providing effective treatment and protecting the safety of the patient and other persons and shall not be used as punishment [or] for the convenience of staff. Restraint in any form or seclusion should only be used when no less restrictive methods of controlling behavior which would reasonably insure the safety of the patient and other persons are feasible. Rules of DHR MHMRSA PR290-4-6-.02 (1)(c)1.

Interpretive guideline 3^{5.1}: Seclusion or restraint may be used when less restrictive interventions have been determined to be ineffective. All interventions utilized prior to the seclusion or restraint episode must be descriptively documented in the sequence used and identified as to the staff member conducting the intervention.

¹² Added to CSP Standards FY08

^{5.1} Modified FY05

Interpretive guideline 4^{5.1}: CSP's must have a written policy and procedure about the use of seclusion and restraint. Evidence of annual training and competency in the proper and safe use of seclusion and restraint including techniques and alternative methods for handling behavior, symptoms and situations that traditionally have been treated through the use of restraints or seclusion must be available within staff personnel files for all staff who have direct contact with clients.

Interpretive guideline 5: The body of the admission assessment shall contain an assessment of past trauma or abuse. The person shall also be asked how they would prefer to be approached should they become dangerous to themselves or to others. Findings from these queries shall direct the decision making process for determining behavioral interventions.

Interpretive guideline 6: In all cases, the rules regarding *Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs* found at 42 CFR Part 441 Subpart D and the *Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21* found in 42 CFR Part 483 Subpart G shall apply.¹⁰

SSr 11.11(b).^{5.1} A physician or other licensed practitioner permitted by the State shall give an order for the seclusion or restraint episode within one hour of the implementation of seclusion or restraint intervention.

Interpretive guideline 1^{5.1}: The physician or Clinical Nurse Specialist (CNS) must be notified immediately of the seclusion or restraint episode. An order must be given that approves the use of the seclusion or restraint intervention, that defines specific time limits for the episode (not to exceed four (4) hours), and that states the behavioral indicators which signal the end of the episode. The restraint or seclusion episode shall be ended at the earliest possible time.

Interpretive guideline 2⁵: The treating physician must be consulted within one hour if the restraint or seclusion is ordered by a licensed practitioner permitted by the State who is not a physician.

SSr 11.11(c).⁸ A physician or other licensed practitioner permitted by the State must see and evaluate the need for restraint or seclusion within one (1) hour after the initiation of this intervention.

Interpretive guideline 1⁸: The physician or CNS must personally examine the client by the end of the first hour of the seclusion or restraint episode. The findings of the examination of the client shall be documented in the client record.

^{5.1} Modified FY05

⁵ Added to CSP Standards FY05

⁸ Modified FY08

Interpretive guideline 2: If the client is released from seclusion or restraint prior to the end of the first hour *and* prior to the personal examination of the physician or CNS, the rationale for release of the client *and* the fact that the client was not personally seen by a physician or CNS shall be fully documented within the client record.

Interpretive guideline 3^{5.1}: After the order expires, a new determination for continued seclusion or restraint may be made ONLY after the client is PERSONALLY examined by a physician or CNS and may be ordered for an additional specific time episode not to exceed four (4) hours.

Interpretive guideline 4: After any seclusion or restraint episode, there must be a determination by the treating physician or Medical Director as to whether transfer to a treatment facility for a higher level of care is indicated. The treating physician or Medical Director's determination for a higher level of care (ASAM 3.7 or LOCUS 6 or greater) must be documented within the progress notes. Justification for maintaining the client at the CSP for additional care must be documented in the physician progress note.

SSr 11.11(d). During the seclusion or restraint episode, the person must be continuously monitored and a documentation entry to that effect be made every 15 minutes.

Interpretive guideline 1: A staff member must be assigned to be present immediately outside the seclusion door when a client is secluded.

Interpretive guideline 2: A staff member must be assigned to be present at all times within the room and the door to the room left open when a client is restrained.

Interpretive guideline 3: A client placed in physical restraints shall be checked at least every 15 minutes by staff members trained in the use of restraints, and a written record of these checks and all other activities shall be made.

Interpretive guideline 4: While in restraints each client should be spoken to, checked for indications of obvious physical distress, be offered liquids and an opportunity to meet his need to urinate and defecate as needed or at least every 2 hours unless the person is asleep or his condition does not permit. The restraints sites should be checked every hour for evidence of swelling or abrasion. Each hour a restraint should be removed from each limb for five minutes and then reapplied if his condition permits. A client in restraints should receive all meals available to other client except as otherwise ordered by a physician based upon the person's health needs and his condition to take meals while in restraints. In all situations, the client must receive nutrition at regular meal intervals unless refused by the client. Restraints are to be discontinued when they are no longer needed to prevent the client from hurting self or others and their medical needs allow removal.

Interpretive guideline 5: During any seclusion/restraint episode, there is documented nursing staff oversight.¹⁰

^{5.1} Modified FY05

Interpretive guideline 6: Video monitoring does not meet the requirement of personal monitoring of the client while in seclusion or restraints. Where video monitoring does “co-exist” with 1:1 monitoring, the privacy of the video monitored image is secured from other clients, visitors and non-direct care staff. ¹⁰

SSr 11.11(e). Staff shall conduct a debriefing with the client after release from seclusion or restraint.

Interpretive guideline 1: The client shall have an opportunity to talk to an appropriate staff member authorized by the facility (preferably a staff member who was not involved in the incident), as soon as appropriate after release from seclusion or restraint.

Interpretive guideline 2: The following are potential issues to explore with the client:

- What the client remembers happening prior to their becoming angry, destructive or self injurious?
- Whether the client remembers sensory changes prior to being placed in seclusion or restraints?
- What thoughts the client has about why the client was placed in seclusion or restraint?
- How the client felt while in seclusion or restraint?
- How the client felt after being released from seclusion or restraint?
- Was there something the client did that was helpful in gaining personal control?
- Was there something the staff did that was helpful in the client gaining personal control?
- What changes could be made to assist the client in future instances when the client might lose control?

Interpretive guideline 3: The client responses shall be documented with pertinent intervention information incorporated within the client plan of care.

SSr 11.11(f). The staff members involved in the seclusion or restraint episode shall receive a debriefing after the episode.

Interpretive guideline 1: The staff members involved in the seclusion or restraint episode shall be interviewed immediately after the episode to determine the following information. The identified leader of the episode shall conduct the critique of the seclusion or restraint episode.

- What physical cues were present that indicated escalation of client behaviors?
- What interventions were conducted, by what staff member and in what order as the events unfolded leading up to seclusion or restraint?
- What was the client response to each intervention conducted?
- Could alternate interventions result in a different outcome other than seclusion or restraint?
- What did the staff involved do well?

- What could staff do differently in the future that might avoid reaching the point of a seclusion or restraint?
- What recommendations shall be documented within the client plan of care for use in future situations?

Interpretive guideline 2: Staff must document in the client’s record that debriefing took place and must include:

- a. The names of staff who were present for the debriefing;
- b. The names of staff who were excused from the debriefing;
- c. Any changes to the client’s treatment plan that resulted from the debriefing.

Interpretive guideline 3: Staff involved in an emergency safety intervention that resulted in an injury to a client or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

SSr 11.12 ORGANIZATIONAL RISK AND COMPLIANCE⁶

SSr 11.12 The CSP has a well-defined approach for assessing its performance, for anticipating, identifying, correcting and solving problems, and for improving quality of care related to use of safety interventions of last resort.

Interpretive guideline 1: The CSP maintains a record of each emergency safety situation, the interventions used, and their outcomes.

Interpretive guideline 2: Staff involved in an emergency safety intervention that results in an injury to a client or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

Interpretive guideline 3: Data regarding the use of safety interventions of last resort will be aggregated and reported quarterly to the CSP management and risk management authority of the managing Community Service Board or State Hospital facility. The report shall include issues that have been addressed pursuant to review of the data, or that no action is required based on aggregate information.

SSr 11.13 PHARMACY SERVICES

SSr 11.13 All pharmacy operations or services within the CSP must be licensed and under the direct supervision of a Registered Pharmacist or provided by contract with a licensed pharmacy operated by a Registered Pharmacist.

Interpretive guideline 1: Pharmacy services must be provided under the license and supervision of a Registered Pharmacist who is operating under a ‘retail’ or ‘hospital’ license.

⁶ Added to CSP Standards FY06

Interpretive guideline 2: Any request for exemptions for requirements regarding a pharmacy license must be submitted in writing to the Georgia State Board of Pharmacy.

Interpretive guideline 3: CSP must ensure access to Pharmacy services for prescription medications within eight (8) hours of the Physician's order¹⁰

SSr 11.14. MEDICATION ADMINISTRATION

SSr 11.14 in all cases, the rules regarding medications found in Rules of Department of Human Resources, Mental Health, Mental Retardation and Substance Abuse Chapter 290-4-9 Clients' Rights shall apply.

Interpretive guideline 1: Medications shall be used solely for the purposes of providing effective treatment and protecting the safety of the client and other persons and shall not be used as punishment or for the convenience of staff.

Interpretive guideline 2⁶: The CSP shall follow policies and procedures found in the Division of MHDDAD Policy 2:100, *Informed Consent and Involuntary Administration of Psychotropic Medication*, concerning the use of psychotropic medications and the use of involuntary medications.^{6/10}

Interpretive guideline 3: The CSP shall follow management protocols for controlled substances, floor stock medications, and physician's sample medications. These accountability medication management techniques must include: inventories, counting, signing out each dose or sample to an individual, and witnessed / documented disposal.¹⁰

SSr 11.15. PROVISION OF INDIVIDUALIZED CARE

SSr 11.15. Educational and program offerings within the CSP include services to meet the individual stabilization needs of each client including co-occurring mental health and substance use needs.

Interpretive guideline 1: Educational and program offerings include offerings that address issues both common and distinct to the person in psychiatric distress and to the person requiring detox from substances.

Interpretive guideline 2: The client clinical record will demonstrate individualized interventions based on the care needs of each person served as evidenced within the body of assessments, documentation of the progression of care and documented discharge linkages.

Interpretive guideline 3: Staff training records shall show evidence of annual training and competency in caring for the person with co-occurring mental health and substance use issues.

⁶ Added to CSP Standards FY06

¹⁰ Updated FY10

SSr.11.16 REPORTING OF SERIOUS OCCURRENCES⁶

SSr.11.16. The CSP must report each serious occurrence.

Interpretive guideline 1: Critical incidents shall be reported as specified in DBHDD Policy for *Reporting of Consumer Deaths and Critical Incidents*.¹⁰

SSr. 11.17 REPORTING OF CLIENT DATA TO THE DEPARTMENT OF BHDD^{7/10}

SSr.11.17. The crisis stabilization program shall report data to the Department of BHDD as directed by provider agreement.¹⁰

Interpretive guideline 1: Encounter data shall be reported to the Department of BHDD in the format directed by the operational guidelines provided by the Department of BHDD to the parent organization (Community Service Board or State Hospital Facility)¹⁰.

Interpretive guideline 2: Encounter data shall include but may not be limited to:

- a. Client name
- b. Date of admission
- c. Date of discharge
- d. Legal status
- e. Admitting diagnosis
- f. Referred to

SSr. 11.18. DESIGNATION AS A CRISIS STABILIZATION PROGRAM

SSr 11.18. The designation must be approved and may be withdrawn by the department. Designation is not transferable.

Interpretive guideline 1: Designation as a crisis stabilization program must be approved and may be withdrawn by the Department of BHDD. Designation is non-transferable.

Interpretive guideline 2: Each designation or provisional designation shall be returned to the department in the following cases. This includes but may not be limited to:

- Change in location
- Program closure
- Department of BHDD finding of failure to comply with CSP standards¹⁰
- Loss of accreditation.

⁶ Added to CSP Standards FY06

⁷ Added to CSP Standards FY07

¹⁰ Updated FY10

Part IV

Community Service Standards Specific for Behavioral Health Services

SECTION III

Crisis Stabilization Standards For Children and Youth

Fiscal Year 2012

Due to a change in Georgia State law these standards will be replaced by rules and regulations for Crisis Stabilization Units early in the fiscal year. Providers will be notified when the rules and regulations are accepted. Until then, the standards in this section are in effect.



**Georgia Department of Behavioral Health &
Developmental Disabilities**

October 2011

**DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL
DISABILITIES**

**CORE REQUIREMENTS FOR CRISIS STABILIZATION PROGRAMS
FOR CHILDREN AND YOUTH**

Effective July 1, 2005

The following requirements for Crisis Stabilization Programs for Children and Youth have been built from the Core Requirements for Crisis Stabilization Programs serving adults that were implemented in July of 2001, and have been modified to address issues around children and youth.

The CSP standards document has been footnoted to indicate modifications and additions to the standards since their inception. Crisis Stabilization Program standards that arose from issues resulting from the Certificate of Need concern addressed in the “Letter of Agreement” between the Department of Community Health and DHR Division of MHDDAD, signed on the 28th day of February, 2001 by George P. A. Newby, representing DCH and by Jerry Lovrien, representing DHR, have not been modified and may be modified only pursuant to agreement between DHR and DCH.

Crisis Stabilization Program standards for children and youth are incorporated by reference into those found in the State of Georgia Department of Behavioral Health and Developmental Disabilities document entitled “Standards for All Providers”.¹⁰

SSr 11.1. DESCRIPTION OF THE PROGRAM

SSr 11.1(a). The Crisis Stabilization Program for children and youth is a medically monitored short-term residential service operated by the Community Service Board⁴ for the purpose of providing psychiatric or behavioral stabilization for children and youth who are seriously emotionally disturbed and/or detoxification services for youth. The crisis stabilization program must be designated by the Department as both an emergency receiving facility and an evaluating facility.

Interpretive guideline 1: The department may designate any private facility or such portion of a certified community mental health and substance abuse program which complies with the standards for a CSP within the State of Georgia at the request of or with the consent of the governing officers of such facility. Rules of DHR MHMRSA ERETF 290-4-1-.02(a). Et. Seq.

Interpretive guideline 2: As defined in the Rules of DHR MHMRSA ERETF 290-4-1-.01(b), the term “Crisis Stabilization Program (“CSP”) means a short term residential program operated as a part of a comprehensive community mental health and substance abuse program

¹⁰ Updated FY10

⁴ CSP’s may be state operated effective FY04

[operated by a Community Service Board or by a Department Behavioral Health and Developmental Disabilities (DBHDD) state hospital facility]^{4/10} for the purpose of providing psychiatric stabilization or detoxification services, which complies with applicable community service standards contained within the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases for the Department of Behavioral Health and Developmental Disabilities*.¹⁰

Interpretive guideline 3: Crisis stabilization programs are state authorized residential services provided as a part of a Community Service Board⁴ and designed to serve as a first line alternative to hospitalization in state hospitals, offering psychiatric or behavioral stabilization and detoxification services on a short term basis. CSP's for children and youth are not designed to provide 'study and report' services or to be available for court ordered placement for the purpose of temporary placement only.

Interpretive guideline 4: The target population served in the CSP is children and youth ages 5-17 requiring psychiatric or behavioral stabilization and youth ages 13-17 with substance related disorders or with co-occurring mental health and substance use needs.

Interpretive guideline 5: Youth through age 21 may be served at a Crisis Stabilization Program for Children and Youth *provided* it is indicated clinically and is based on the youth's maturational age. The Medical Director must approve such admissions.

Interpretive guideline 6: Residential detoxification services offered within the CSP **shall not exceed** services described in Level III.7 of the Adolescent Criteria section of the *American Society for Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders* (ASAM PPC-2R), Second Edition, April 2001.

Interpretive guideline 7: NOTE: Twenty-four hour residential services offering detoxification ONLY shall be licensed by the Healthcare Facility Regulation Division under the "Rules of Department of Human Resources Chapter 290-4-2: Drug Abuse Treatment and Education Programs." These CSP standards shall not apply.

Interpretive guideline 8: **Psychiatric stabilization services** offered within the CSP **shall not exceed** services described in Level Six of the *Child and Adolescent Level of Care Utilization System for Psychiatric and Addiction Services*, Version 1.5 (CALOCUS), published by the American Association of Community Psychiatrists, August 2006 (most recent version).⁷

Interpretive guideline 9²: The term "emergency receiving facility" means a facility designated by the department to receive patients under emergency conditions as provided in Part 1 of Article 3 of Chapter 3 or of Chapter 7 of Title 37. Rules of DHR MHMRSA ERET 290-4-1-.01(d).

¹⁰ Updated FY10

⁴ CSP's may be state operated effective FY04

⁷ Updated citation added FY08

² Added to CSP Standards FY02

Interpretive guideline 10²: The term “evaluating facility” means a facility designated by the department to receive patients for evaluation as provided in Part 2 of Article 3 or of Chapter 7 of Title 37. Rules of DHR MHMRSA ERETF 290-4-1-.01(e).

Interpretive guideline 11²: Certification reviews will be conducted for physical plant, safety and food service according to the specifications outlined in the Rules for Drug Abuse Treatment & Education Programs, Chapter 290-4-2, section .11 “Physical Plant and Safety” and section .12 “Food Service”.

Interpretive guideline 12⁶: CSP’s that are newly constructed or CSP’s undergoing physical plant modifications after June 30, 2005 shall address safety issues to minimize the opportunity for self-harm of an individual such as, but not limited to the following:

- a. Shower fixtures in bathrooms shall be flush-mounted in the wall
- b. Headers supporting bathroom stalls shall be flush-mounted to the ceiling
- c. There shall be two avenues of visual access into the seclusion and restraint room, one of which shall be through a shatterproof window in the door. The room shall be a minimum fifty (50) square feet in area and the door should be opened from the outside.¹⁰
- d. Blind spots on the unit shall be addressed through use of convex mirrors allowing for visual access. A room used for seclusion or restraint must:
 - i. Allow staff full view of the resident in all areas of the room;
 - ii. Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets
- e. Video cameras are not a permitted alternative to direct observation of an individual in the seclusion or restraint room
- f. Doors to bedrooms shall be hung on hinges that swing both in to the room and out from the room. ⁷Note that if a building is being *modified* and it is not possible for the door to swing both ways, the door should be mounted to open away from the room.
- g. Facility must have a satisfactory food service permit score, if applicable. Facility may utilize meal preparation services from an affiliated or contracted entity with a current food service permit. A copy of the current food service permit must be on file in the facility. Should the facility elect to have meals prepared off-site, the facility will have a modified kitchen that includes a microwave, a refrigerator, and clean-up facilities.¹⁰
- h. Facility must maintain a daily temperature log for freezer and refrigerator.¹⁰
- i. Foods, drinks and condiments shall be dated when opened.¹⁰
- j. Facility must have a sufficient designated area to accommodate meal service. This area may double as a group or activity area.¹⁰
- k. Facility maintains a temperature between 65 and 82 degrees F that ensures the comfort and safety of all clients.¹⁰
- l. Facility is free of offensive odor and noise.¹⁰

¹⁰ Added to CSP standards FY10

⁶ Added to CSP Standards FY06

⁷ Added to CSP Standards FY07

- m. Ramps are built according to specifications of Section 504 of the Rehabilitation Act of 1973.¹⁰
- n. Outdoor client area must be secured for safety and privacy.¹⁰
- o. Preadmission waiting area, including restroom where exist, must meet all safety requirements applicable to designated client areas.¹⁰
- p. Multi client bedrooms shall have a minimum of 60sq ft per client and a private room shall not be less than 100 sq ft.¹⁰
- q. Beds must be either weighted or secured to the floor.¹⁰
- r. Prohibited bed types include but not limited to beds with springs, cranks, rails and wheels. The use of hospital beds is discouraged and rollaway, cots, double deck, stacked; hide-a-bed and studio couches are not to be used in lieu of standard beds.¹⁰
- s. Furniture should be appropriately sized to fit population served and preferably weighted.¹⁰
- t. Electronics and/or game equipment needs to be locked/secured when not in use.¹⁰
- u. Facility lighting shall be sufficient enough for reading and other activities.¹⁰
- v. Gender specific restrooms shall have adequate ventilation and have an adequate number of sinks, toilets and showers to accommodate the population served.¹⁰
- w. Exposed plumbing pipes shall be covered to prevent client access.¹⁰
- x. Rods/curtains utilized for privacy shall be designed not to sustain more than 30 pounds.¹⁰
- y. Water temperature for consumer usage must be maintained between 110 – 120 degrees F. For those facilities providing onsite food service, a separate water heater is designated for usage.¹⁰
- z. Facility windows and mirrors must be either temper glass, plastic or shatterproof.¹⁰

Interpretive guideline 13: Facilities are accessible to and usable by physically disabled individuals and must meet the minimum requirements of Section 504 of the Rehabilitation Act of 1973. Centers install required alterations or modifications in accordance with the 1984 Law of Georgia regarding Access to and Use of Public Facilities by Physically Handicapped Persons: O.C.G.A. Section 30-3-1 et. Seq.

SSr 11.1(b). The Crisis Stabilization Program shall describe its capacity to serve voluntary and involuntary residents.

Interpretive guideline 1: The term ‘treatment facility’ means a facility designated by the department to receive patients for treatment as provided in Part 3 of Article 3 of Chapter 3 of Title 37. Rules of DHR MHMRSA ERETF 290-4-1-.01(f).

Interpretive guideline 2: The CSP clearly outlines their voluntary and involuntary admission criteria and there is evidence of documented usage of the established admission criteria. ¹⁰

SSr 11.1(c). The Crisis Stabilization Program is NOT a designated treatment facility as defined by O.C.G.A. 37-3 and 37-7.

Interpretive guideline 1: The term ‘treatment facility’ means a facility designated by the department to receive patients for treatment as provided in Part 3 of Article 3 of Chapter 3 of Title 37. Rules of DHR MHMRSA ERETF 290-4-1-.01(f).

Interpretive guideline 2: The program description of the CSP clearly states that it is not a designated treatment facility as provided in Part 3 of Article 3 of Chapter 3 of Title 37.

SSr 11.1(d). The Crisis Stabilization Program shall not use the word “inpatient” anywhere for any purpose to describe the services offered within the CSP.

Interpretive guideline 1: The program description and all other documents within the CSB and CSP shall describe the services offered within the CSP as *residential* services.

SSr 11.1(e). The Crisis Stabilization Program shall not hold itself out as a hospital or bill as a hospital for inpatient services.

Interpretive guideline 1: There is no evidence that the CSP is holding itself out as a hospital or that it is billing for hospital or inpatient services.

SSr 11.1(f).² The CSP shall not operate in a manner or offer any service that brings it within the purview of Georgia’s Certificate of Need (CON) Program as defined by the CON Statue and Rules (O.C.G.A. 31-6-1 et. seq. and O.C.R.R. 272-2-1 et. seq.).

Interpretive guideline 1: There is no evidence that the CSP is operating in a manner or offering any service that brings them within the purview of Georgia’s Certificate of Need (CON) Program.

SSr 11.2 CERTIFICATION OF THE CRISIS STABILIZATION PROGRAM

SSr 11.2. The Crisis Stabilization Program shall be surveyed for compliance with State standards.

Interpretive guideline 1: Any Crisis Stabilization Program (CSP), to be eligible for designation, shall be a part of a comprehensive community mental health and substance abuse program and shall be in compliance with: 1) Standards for All Providers found in the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases for the Department of Behavioral Health and Developmental Disabilities*¹⁰ and 2) the Department of Human Resources Grants to Counties Policy Manual. Rules of DHR MHMRSA ERETF 290-4-1-.02(d).

Interpretive guideline 2⁶: Any state operated Crisis Stabilization Program (CSP), to be eligible for designation, shall be operated by an accredited and licensed (if applicable) healthcare authority and shall be in compliance with: 1) Standards for All Providers found in the *Provider*

² Added to CSP Standards FY02

⁶ Added to CSP Standards FY06

SSr 11.3. LINKAGES FOR COMPLEX CARE NEEDS

SSr 11.3. The Crisis Stabilization Program shall have operating agreements with private and public inpatient hospitals and treatment facilities.

Interpretive guideline 1: Crisis Stabilization Programs shall have documented operating agreements and referral mechanisms for psychiatric, addictive disorder and physical health care needs that are beyond the scope of the Crisis Stabilization Program and that require inpatient treatment. Operating agreements shall delineate the type and level of service to be provided by the private or public inpatient hospital or treatment facility.

Interpretive guideline 2: The following shall be clearly stated within the body of the operating agreements between the CSP and designated treatment facilities(s):

“The purpose of clinical services provided by the CSP is psychiatric or behavioral stabilization for children and youth who are severely emotionally disturbed and detoxification for youth ages 13-17 with substance related disorders or co-occurring mental health and substance use needs.” When it becomes evident 48 hours into the “evaluation” legal status that a client is not stabilizing and may not stabilize quickly, arrangements shall be made to transfer the client to a designated treatment facility at that point. The transfer of the client shall take place no later than 72 hours into the “evaluation” legal status, unless there has been a different time limit established in a written agreement with a hospital. The client may be transferred to the treatment facility on the existing 1014 or 2014 legal status. For the purposes of calculating the 48 or 72 hours, Saturdays, Sundays, or holidays will not apply.

Interpretive guideline 3: The CSP shall have an agreement that makes available medical pediatric services for children and youth.

Interpretive guideline 4: The private facility or the CSP shall utilize available resources in the community to provide psychological tests and social work services if such services are needed for the patients and do not exist within the facility. Rules of DHR MHMRSA ERETF 290-4-1-.04(4).

SSr 11.4. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

SSr 11.4. The Crisis Stabilization Program will operate within the guidelines of EMTALA with respect to stabilization and transfer of residents.

Interpretive guideline 1: The Crisis Stabilization Programs are not hospitals nor do they receive Medicare monies. However, the CSP’s will operate within the guidelines of EMTALA with respect to the stabilization and transfer of residents to and from hospitals.

SSr 11.5. LENGTH OF STAY

SSr.11.5^{2.1}. The average length of stay shall not exceed nine (9) days excluding Saturdays, Sundays and Holidays.

Interpretive guideline 1: For any one episode of care, an individual child or youth may not remain in a CSP beyond 14 days, excluding Saturdays, Sundays and Holidays, with the exception described in Interpretive Guideline 2 below.

Interpretive guideline 2^{4.1}: A CSP must designate transitional beds separate from crisis residential beds. Residents occupying transitional beds may remain in the CSP beyond 14 days excluding Saturdays, Sundays and Holidays **only if they are in services and activities on a daily basis that indicate the resident is actively engaged in transitioning to the community.** Length of stay in a transitional bed including crisis days may not exceed 29 calendar days. Transitioning activities may include, but are not limited to, participation in day services, meetings with client/family, continuing school classes, and/or active participation in services with the intent toward discharge.¹⁰ The CSP must record the date of transfer to the transitional bed(s) and the length of stay in transitional beds for each episode of transitional care. Transitional bed designation should be made using these parameters:

- a. A CSP with up to 29 beds may designate one or two beds as transition beds. The total bed count for crisis beds and transition beds shall not exceed 29.
- b. A CSP with up to 39⁴ beds may designate up to three beds as transition beds. The total bed count shall not exceed 39.
- c. A CSP with 40⁴ or more beds may designate up to four additional beds as transition beds.

Interpretive guideline 3: It is the intent of the Department of BHDD that children or youth shall return to their natural environment as quickly as possible.^{10.1} Therefore the TOTAL LENGTH OF STAY in a CSP for any one episode of care that includes a stay in both a crisis residential bed and a transitional bed **shall not exceed 29 calendar days.**

Interpretive guideline 4²: CSP's shall report census and length of stay data as required to the Department of BHDD for both regular and transitional CSP beds.^{10.1}

SSr 11.6. ADVERTISING OF SERVICES

SSr.11.6. The Crisis Stabilization Program shall not advertise services offered within the CSP.

^{2.1} Modified FY02

^{4.1} Modified FY04

¹⁰ Added to CSP Standards FY10

⁴ Added to CSP Standards FY04

^{10.1} Updated FY10

² Added to CSP Standards FY02

Interpretive guideline 1: The Community Service Board may inform and educate the public about services offered by the CSP, but shall not advertise any of the CSP services or hold itself out in any manner as providing inpatient or hospital service.

SSr 11.7. BILLING AND REVENUE SOURCE

SSr 11.7(a).^{2.1} The primary revenue source shall be public funds.

Interpretive guideline 1: Review of revenue budget for the CSP will show that no less than 95% of the funding is public, including State Grant in Aid and Medicaid. Note: Medicaid may be billed only if the program has 16 or fewer beds.

SSr 11.7(b). Legal guardians are billed on a sliding fee scale basis according to their ability to pay. Fees for children and youth served under the Department of Family and Children’s Services or under the Department of Juvenile Justice shall be set by mutual agreement by the Departments.

Interpretive guideline 1: Review of billing practices shall demonstrate that residents’ legal guardians have been billed on a sliding fee scale basis.

Interpretive guideline 2: Review of billing practices shall demonstrate that fees billed for children and youth served under the Department of Family and Children’s Services or under the Department of Juvenile Justice are billed according to agreements set by the Departments.

SSr 11.8. PHYSICIAN OVERSIGHT

SSr 11.8(a). All services offered within the Crisis Stabilization Program shall be provided under the direction of a physician.

Interpretive guidelines 1: “Physician” means any person who is licensed to practice in this State under the provisions of Article 2 of chapter 34 of Title 43, or who is employed as a physician by the United States Veterans Administration or other federal agency. Rules of DHR MHMRSA ERETF 290-4-1-.01(g).

Interpretive guideline 2: The active medical staff of the CSP shall include a physician who has completed at least one year of approved psychiatric residency and consultation by a psychiatrist shall be available. Rules of DHR MHMRSA ERETF 290-4-1-.04(2)

Interpretive guideline 3: It is preferred that the CSP is under the direction of a psychiatrist with training or experience in working with children and youth.

Interpretive guideline 4: In the event that the physician providing coverage is not a psychiatrist, arrangements shall be in place for psychiatric consultation.

^{2.1} Modified FY02

Interpretive guideline 5: There is documented evidence of Physician oversight for the dispensing of sample medications.

SSr 11.8(b) A physician shall conduct assessments of new residents, address resident care issues and write orders as required.

Interpretive guideline 1: A physician is NOT required to be on site 24 hours a day, however the physician must report to the Charge Nurse daily. A physician must be available by pager 24 hours a day and must respond to staff calls immediately, not to exceed one hour. The physician must personally report to the CSP within one hour at the request of the charge nurse.

Interpretive guideline 2: CSP's must have capacity to admit and discharge seven days a week, 24 hours per day.

Interpretive guideline 3: A physician must assess each new resident within 24 hours of admission.

Interpretive guideline 4: Documentation by the physician shall include, at a minimum, the initial evaluation of the resident, resulting diagnoses and care orders, the response to care and services provided, a rationale for medications ordered or prescribed, and assessment of the resident at the time of discharge.

Interpretive guideline 5¹⁰: Searches of individuals shall be ordered by the physician. There is to be no mandatory removal of clothing or standing orders for strip searches. Strip searches are to be performed for cause and the rationale clearly documented in the person's record.

Interpretive guideline 6^{10.1}: Levels of observation shall be ordered by the physician and based on physician assessment. When the levels of observation are changed, there is documented justification to support the ordered level change by the physician.

SSr 11.8(c). The functions performed by physician's assistants, nurse practitioners and clinical nurse specialists are within the scope allowed by state law and professional practice acts.

Interpretive guideline 1: The CSP utilizing physician's assistants, nurse practitioners and clinical nurse specialists can demonstrate verbally and through documentation their implementation of agreements and protocols required by state law and professional practice acts. Renewal of Georgia Board of Nursing authorization as a nurse practitioner will coincide with the renewal of the registered professional nurse license.

SSr 11.9. REGISTERED NURSE OVERSIGHT

¹⁰ Added to the standards FY10

^{10.1} Added to the standards FY10

SSr 11.9(a). The Crisis Stabilization Program shall have a position classified as a lead nurse or higher that serves as the nursing administrator.

Interpretive guideline 1: The Registered Nurse designated as nursing administrator is a full-time employee of the programs whose job responsibilities include, but are not limited to, the clinical supervision of the nursing staff, implementation of physician's orders and oversight of the clinical functions of the unit.

Interpretive guideline 2: It is preferred that the designated Registered Nurse administrator has training or experience with children and youth.

SSr 11.9(b). The Crisis Stabilization Program shall have a Registered Nurse present within the facility at all times.

Interpretive guideline 1: A Registered Nurse must be in the CSP facility at all times.

Interpretive guideline 2: A Registered Nurse must be the Charge Nurse at all times.

Interpretive guideline 3: There must be one Registered Nurse within the CSP facility for every 30 CSP facility beds.

Interpretive guideline 4: CSPs that employ sanctioned nurses must assure that their assigned duties comply with the requirements stated by the Georgia Board of Nursing/Georgia Board of Examiners of Licensed Practical Nurses in their consent orders.¹⁰

SSr 11.10. STAFF TO CLIENTS RATIOS

SSr 11.10. Staff to clients' ratios shall be established based on the stabilization needs of residents being served.

Interpretive guideline 1: The ratio of direct care staff to clients should not be less than one to four (1:4), including the Registered Charge Nurse. Assigned levels of observation shall be utilized as guidelines for establishing staffing ratios greater than 1:4.

Interpretive guideline 2: There shall always be at least three staff present within the CSP including the Charge Nurse.

Interpretive guideline 3: The utilization of licensed practical nurses shall be considered to provide technical support to the Registered Nurse.

Interpretive guideline 4: The functions performed by registered nurses and licensed practical nurses are within the scope allowed by State Law and professional practice acts.

SSr 11.11 USE OF TIME OUT

SSr 11.11(a) If “time out” or “time away” is used as a less restrictive intervention prior to using an emergency safety intervention, the “time out” or “time away” shall be used according to these guidelines.

Interpretive guideline 1: Time out may be utilized in these ways:

- a. Away from the area of activity or from other clients’, such as in the client’s room (exclusionary)
- b. In the area of activity or other clients’ (inclusionary)
- c. Only private rooms can be utilized as a “time-out” or “time away” area.¹⁰

Interpretive guideline 2: A client in time out must never be physically prevented from leaving the time out area.

Interpretive guideline 3: A designated seclusion or restraint room shall not be used for time out.

Interpretive guideline 4: Staff must monitor the client while he or she is in time out.

SSr 11.12. USE OF SECLUSION OR RESTRAINT

SSr 11.12(a). A Crisis Stabilization Program for children and youth may only use restraint and seclusion as an emergency safety intervention of last resort.

Interpretive guideline 1: In all cases, the law regarding seclusion and restraint found in O.C.G.A. 37-3 and 37-7 as well as the rules and definitions found in Rules of Department of Human Resources, Mental Health, Mental Retardation and Substance Abuse Chapter 290-4-6 Patients’ Rights shall apply.

Interpretive guideline 2: In all cases, the rules regarding *Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs* found at 42 CFR Part 441 Subpart D and the *Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21* found in 42 CFR Part 483 Subpart G shall apply.

Interpretive guideline 3: Restraint and seclusion may not be used simultaneously.

Interpretive guideline 4: All physical restraints and seclusion shall be used solely for the purpose of providing an immediate response to an emergency safety situation

- a. Restraint or seclusion must not result in harm or injury to the resident.
- b. Restraint or seclusion must be used only to ensure the safety of the resident or others during an emergency safety situation.
- c. Restraint or seclusion must be used only until the emergency safety situation has ceased and the resident’s safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired.

- d. Restraint or seclusion shall not be used as punishment, coercion, discipline, retaliation or for the convenience of staff.

Interpretive guideline 5: Seclusion or restraint may only be used when less restrictive interventions have been determined to be ineffective.

Interpretive guideline 6: All documentation related to the safety intervention of last resort must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:

- a. Each order for restraint or seclusion.
- b. The time the emergency safety intervention actually began and ended..
- c. The time and results of the 1-hour assessment conducted by the physician or clinically qualified registered nurse.
- d. The emergency safety situation that required the client to be restrained or put in seclusion.
- e. The names of staff involved in the emergency safety intervention.
- f. All interventions utilized prior to the seclusion or restraint episode must be descriptively documented in the sequence used and identified as to the staff member conducting the intervention.

Interpretive guideline 7: CSP's must have a written policy and procedure about the use of seclusion and restraint. Evidence of annual training and competency in the proper and safe use of seclusion and restraint including techniques and alternative methods for handling behavior, symptoms and situations that traditionally have been treated through the use of restraints or seclusion must be available within staff personnel files for all staff who have direct contact with clients. Policy, procedures and training documentation evidence must include:

- a. Techniques to identify staff and client's behaviors, events and environmental factors that may trigger emergency safety situations.
- b. The use of nonphysical intervention skills, such as de-escalation, mediation, conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations.
- c. The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in clients who are restrained or who are in seclusion.
- d. Evidence of exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.
- e. Evidence that staff is trained and demonstrate competency before participating in an emergency safety intervention.
- f. Evidence that staff have demonstrated their competencies related to seclusion and restraint on a semiannual basis.
- g. Evidence of current certification in the use of cardiopulmonary resuscitation.
- h. Evidence that staff have demonstrated their competency in cardiopulmonary resuscitation on an annual basis.

Interpretive guideline 8: The CSP must document in the staff personnel records that the training and demonstration of competency were successfully completed.

- a. Documentation must include the date training was completed and the name of persons certifying the completion of training

SSr11.12. (b). Notification of the CSP policy on seclusion or restraint must be given.

Interpretive guideline 1: The CSP must inform both the incoming client and the client's parent(s) or legal guardian(s) of the CSP's policy regarding the use of restraint or seclusion during an emergency safety situation of last resort.

Interpretive guideline 2: The CSP must communicate its restraint and seclusion policy in a language that the client or his or her parent(s) or legal guardian(s) understands (including American Sign Language) and when necessary, the CSP must provide interpreters or translators.

Interpretive guideline 3: The CSP must obtain an acknowledgment, in writing, from the client, the parent(s) or legal guardian(s) that he or she has been informed of the CSP's policy on the use of restraint or seclusion during an emergency safety situation. This acknowledgment must be filed in the client's record.

Interpretive guideline 4: The CSP must provide a copy of the facility policy to the client and to the client's parent(s) or legal guardian(s).

SSr.11.12(c). Each resident shall be assessed for a history of past trauma or abuse.

Interpretive guideline 1: The body of the admission assessment shall contain an assessment of past trauma or abuse. The client and his or her parent or legal guardian shall also be asked how he or she would prefer to be approached should he or she become dangerous to themselves or to others. Findings from these queries shall inform the decision making process about the plan of care.

Interpretive guideline 2: Emergency safety interventions must be performed in a manner that is safe, proportionate and appropriate to the severity of the behavior, and the client's chronological and developmental age, size, gender, physical, medical and psychiatric condition and personal history (including any history of physical or sexual abuse).

SSr 11.12(d).^{5.1} A physician or other licensed practitioner permitted by the State shall give an order for the seclusion or restraint episode as soon as possible within the first fifteen minutes of the implementation of seclusion or restraint intervention.

Interpretive guideline 1: Orders for restraint or seclusion must be by a physician or other licensed practitioner permitted by the State and CSP.

^{5.1} Modified FY05

Interpretive guideline 2^{5.1}: The physician or Clinical Nurse Specialist (CNS) must be notified immediately of the seclusion or restraint episode. The physician or CNS must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.

Interpretive guideline 3: If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other staff licensed to receive orders, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends.

- a. If the treating physician is not available to order the use of restraint or seclusion, the physician's verbal order must be obtained.
- b. The physician ordering the restraint or seclusion must verify the verbal order in a signed written form in the client's record as soon as possible.
 - i. If the physician or CNS giving the order is not the client's treating physician, the physician or CNS must consult with the treating physician as soon as possible and inform the treating physician of the emergency safety situation;
 - ii. Staff must document in the client's record the date and time the treating physician was consulted.

Interpretive guideline 4: Each order for restraint or seclusion must:

- a. Be limited to no longer than the duration of the emergency safety situation.
- b. Specify the time limits for the restraint or seclusion episode. Under no circumstances shall an order exceed :
 - i. Four (4) hours for clients ages 17 and above;
 - ii. Two (2) hours for clients ages 9 to 17;
 - iii. One (1) hour for clients under age 9.
- c. Specify the behavioral indicators that signal the end of the episode.
- d. State that the restraint or seclusion episode shall be ended at the earliest possible time.

Interpretive guideline 5: If the emergency safety situation continues beyond the time limit of the physician's order for the use of restraint or seclusion, a registered nurse must immediately contact the ordering physician in order to receive further instructions.

Interpretive guideline 6: After any seclusion or restraint episode, there must be a determination by the treating physician or Medical Director as to whether transfer to a treatment facility for a higher level of care is indicated. The treating physician or Medical Director's determination for a higher level of care (ASAM 3.7 or CALOCUS 6 or greater) must be documented within the progress notes. Justification for maintaining the client at the CSP for additional care must be documented in the physician progress note.

Interpretive guideline 7: Each order for restraint or seclusion must include:

- a. The name of the ordering physician or CNS;
- b. The date and time the order was obtained;

^{5.1} Modified FY05

- c. The emergency safety intervention ordered;
- d. The length of time for which the physician authorized its use;
- e. The behavioral indicators that signal the end of the episode.

The restraint or seclusion episode shall be ended at the earliest possible time.

Interpretive guideline 8: Orders for restraint or seclusion may not be written as a standing order or as an as-needed basis.

SSr 11.12(e).^{6.1} A physician or clinically qualified registered nurse must personally examine the client within one (1) hour of the initiation of the emergency safety intervention and immediately upon the end of the seclusion or restraint episode.

Interpretive guideline 1^{5.1}: The physician or clinically qualified registered nurse must personally examine the client within one hour of the initiation of the emergency safety intervention and immediately upon the end of the seclusion or restraint episode. The findings of the examination of the resident shall be documented in the resident record and must include the resident's physical and psychological well being, including but not limited to:

- a. The client's physical and psychological status.
- b. The client's behavior.
- c. The appropriateness of the intervention measures.
- d. Any complications resulting from the intervention.

Interpretive guideline 2: If the client is released from seclusion or restraint prior to the end of the first hour *and* prior to the personal examination of the physician or clinically qualified registered nurse, the rationale for release of the client and the fact that the client was not personally seen by a physician shall be fully documented within the client record.

Interpretive guideline 3^{5.1}: After the order expires, a new determination for continued seclusion or restraint may be made ONLY after the client is PERSONALLY examined by a physician or a clinically qualified registered nurse and may be ordered by a physician or CNS for an additional specific time episode not to exceed:

- a. Four (4) hours for clients ages 17 and above;
- b. Two (2) hours for clients ages 9 to 17;
- c. One (1) hour for clients under age 9.

SSr 11.12(f). During the seclusion or restraint episode, clinical staff trained in the use of emergency safety interventions must be physically present, continuously monitoring the physical and psychological well-being of the client and the safe use of restraint or seclusion, and shall document findings and care given every 15 minutes.

^{6.1} Modified FY06

Interpretive guideline 1: A staff member must be assigned to be present immediately outside the seclusion door and must continuously visually monitoring the client when seclusion is utilized.

Interpretive guideline 2: A staff member must be assigned to be present at all times within the room and the door to the room left open when a client is restrained.

Interpretive guideline 3: A client placed in physical restraints must be checked at least every 15 minutes by staff members trained in the use of restraints, and a written record of these checks and all other activities shall be made.

Interpretive guideline 4: While in restraints each client should be spoken to, checked for indications of obvious physical and psychological distress, be offered liquids and an opportunity to meet his need to urinate and defecate as needed or at least every 2 hours unless the client is asleep or their condition does not permit. The restraints sites should be checked every hour for evidence of swelling or abrasion. Each hour a restraint should be removed from each limb for five minutes and then reapplied if their condition permits. A client in restraints should receive all meals available to other clients except as otherwise ordered by a physician based upon the client's health needs and as their condition to take meals while in restraints. In all situations, the client must receive nutrition at regular meal intervals unless refused by the client. Restraints are to be discontinued when they are no longer needed to prevent a client from hurting their self or others and their medical needs allow removal.

Interpretive guideline 5: Video monitoring does not meet the requirement of personal monitoring of the resident while in seclusion or restraints. Where video monitoring does "co-exist" with 1:1 monitoring, the privacy of the video monitored image is secured from other clients, visitors and non-direct care staff.¹⁰

Interpretive guideline 6: During any seclusion/restraint episode, there is documented nursing staff oversight.¹⁰

Interpretive guideline 7: The physician must be available to staff for consultation at least by telephone throughout the period of the emergency safety intervention.

SS 11.12(g). Notification of the use of seclusion or restraint shall be given to the parent(s) or legal guardian(s).

Interpretive guideline 1: The CSP must secure the privacy and notify the parent(s) or legal guardian(s) of the client who has been restrained or placed in seclusion within one hour after the initiation of each emergency safety intervention. There must be documentation of notification or the attempt to notify parent(s) or legal guardian(s) of the client who has been restrained or placed in seclusion within one hour.

Interpretive guideline 2: The CSP must document in the resident's record that the parent(s) or legal guardian(s) has been notified of the emergency safety intervention including the date and time of notification and the name of the staff person providing the notification.

SSr 11.12(h). Staff shall conduct a debriefing with the resident within 24 hours after release from seclusion or restraint.

Interpretive guideline 1: The client shall have an opportunity to talk to staff members within 24 hours after release from seclusion or restraint. This discussion must include staff involved in the intervention except when the presence of a particular staff person may jeopardize the well being of the resident. The discussion may include supervisory and administrative staff if appropriate.

Interpretive guideline 2: The following are potential issues to explore with the resident:

- a. Circumstances resulting in the use of seclusion or restraint, including:
 - i. What the client remembers happening prior to becoming angry, destructive or self injurious.
 - ii. Whether the client remembers sensory changes prior to being placed in seclusion or restraints.
 - iii. What thoughts the client has about why the resident was placed in seclusion or restraint.
 - iv. How the client felt while in seclusion or restraint.
 - v. How the client felt after being released from seclusion or restraint.
- b. The outcome of the interventions used, including any injuries that may have resulted from the use of seclusion or restraint.
- c. Strategies to be used by the staff, the client or others that could prevent the future use of restraint and seclusion.
 - i. Alternative techniques might have prevented the use of seclusion or restraint.
- d. Procedures, if any, that staff should implement to prevent any recurrence of the use of restraint or seclusion.
- e. Strategies that were helpful to the client in gaining personal control:
 - i. Was there something the client did that was helpful in gaining personal control?
 - ii. Was there something the staff did that was helpful in the client gaining personal control?

Interpretive guideline 3: Staff must document in the client's record that debriefing took place and must include:

- a. The names of staff that was present for the debriefing.
- b. The names of staff that were excused from the debriefing.
- c. Any changes to the client's treatment plan that result from the debriefing.

SSr 11.12(i). The staff members involved in the seclusion or restraint episode shall receive a debriefing after the episode.

Interpretive guideline 1: Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention and appropriate supervisory and administrative staff must conduct a debriefing session that includes, at a minimum, a review and discussion of:

- a. The emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention, such as:
 - i. What physical cues were present that indicated escalation of client's behaviors?
- b. Review of techniques used and alternative techniques that might have prevented the use of the restraint or seclusion:
 - i. What interventions were conducted, by what staff member and in what order as the events unfolded leading up to seclusion or restraint?
 - ii. What was the client response to each intervention conducted?
 - iii. Could alternate interventions result in a different outcome other than seclusion or restraint?
- c. What did the staff involved do well?
- d. What could staff do differently in the future that might avoid reaching the point of a seclusion or restraint?
- e. What recommendations shall be documented within the client plan of care for use in future situations?

Interpretive guideline 2: Staff must document in the client's record that debriefing took place and must include:

- a. The names of staff who were present for the debriefing;
- b. The names of staff who were excused from the debriefing; client's
- c. Any changes to the treatment plan as a result from the debriefing.

Interpretive guideline 3: Staff involved in an emergency safety intervention that resulted in an injury to a client or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

SSr 11.13 MEDICAL TREATMENT FOR INJURIES RESULTING FROM A SAFETY INTERVENTION

SSr 11.13 The CSP shall insure that medical treatment is immediately obtained from qualified medical personnel for a resident injured as a result of an emergency safety intervention.

Interpretive guideline 1: Staff must immediately obtain medical treatment from qualified medical personnel for a client injured as a result of an emergency safety intervention.

Interpretive guideline 2: Staff must document in the client's record, all injuries that occur as a result of an emergency safety intervention, including injuries to staff from that intervention.

SSr 11.14 ORGANIZATIONAL RISK AND COMPLIANCE

SSr 11.14 The CSP has a well-defined approach for assessing its performance, for anticipating, identifying, correcting and solving problems, and for improving quality of care related to use of safety interventions of last resort.

Interpretive guideline 1: The CSP maintains a record of each emergency safety situation, the interventions used, and their outcomes.

Interpretive guideline 2: Staff involved in an emergency safety intervention that results in an injury to a client or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

Interpretive guideline 3: Data regarding the use of safety interventions of last resort will be aggregated and reported quarterly to the CSP management and risk management authority of the managing Community Service Board or State Hospital facility. The report shall include issues that have been addressed pursuant to review of the data, or that no action is required based on aggregate information.

Interpretive guideline 4: Each CSP with a current Medicaid provider agreement must provide to the State Medicaid agency, at the time it executes a provider agreement with the Medicaid agency, in writing, that the CSP is in compliance with CMS's standards governing the use of restraint and seclusion. The CSP director must sign this attestation.

SSr 11.15 PHARMACY SERVICES

SSr 11.15 All pharmacy operations or services within the CSP must be licensed and under the direct supervision of a Registered Pharmacist or provided by contract with a licensed pharmacy operated by a Registered Pharmacist.

Interpretive guideline 1: Pharmacy services must be provided under the license and supervision of a Registered Pharmacist who is operating under a 'retail' or 'hospital' license.

Interpretive guideline 2: Any request for exemptions for requirements regarding a pharmacy license must be submitted in writing to the Georgia State Board of Pharmacy.

Interpretive guideline 3: CSP must ensure access to Pharmacy services for prescription medications within eight (8) hours of the Physician's order.¹⁰

SSr 11.16. MEDICATION ADMINISTRATION

SSr 11.16 In all cases, the rules regarding medications found in Rules of Department of Human Resources, Mental Health, Mental Retardation and Substance Abuse Chapter 290-4-9 Residents' Rights shall apply.

Interpretive guideline 1: Medications shall be used solely for the purposes of providing effective treatment and protecting the safety of the client and other persons and shall not be used as punishment, coercion, discipline, retaliation or for the convenience of staff.

Interpretive guideline 2⁶: The CSP shall follow policies and procedures found in the Division of MHDDAD Policy 2:100, *Informed Consent and Involuntary Administration of Psychotropic Medication*, concerning the use of psychotropic medications and the use of involuntary medications.^{6/10}

Interpretive guideline 3: The CSP shall follow management protocols for controlled substances, floor stock medications, and physician's sample medications. These accountability medication management techniques must include: inventories, counting, signing out each dose or sample to an individual, and witnessed / documented disposal.¹⁰

SSr 11.17 INDIVIDUALIZED CARE

SSr 11.17. Educational and program offerings within the CSP include services to meet the individual stabilization needs of each resident including psychiatric or behavioral stabilization for children and youth who are seriously emotionally disturbed and detoxification services for youth. Educational and program offerings shall also include attention to the child or youth's academic development.

Interpretive guideline 1: Educational and program offerings include offerings that address issues both common and distinct to the child or youth needing psychiatric or behavioral stabilization and for the youth needing detoxification services.

Interpretive guideline 2: Each child or adolescent shall be assessed to determine his or her academic development. The CSP shall utilize educational integration services has a mechanism to support and enhance the child or adolescent's academic development.

- a. Educational specialists or teachers will be available to provide instruction and support services such as tutoring;
- b. Individualized planning and linkage shall occur with child or youth's community school.

Interpretive guideline 3: Educational, program and academic offerings are age appropriate and presented in a way easily understood by the resident.

Interpretive guideline 4: The client's clinical record will demonstrate individualized interventions based on the care needs of each person served as evidenced within the body of assessments, documentation of the progression of care and documented discharge linkages.

⁶ Added FY06

¹⁰ Updated FY10

Interpretive guideline 5: A record of academic assessment, offerings and the child or youth's response to those offerings shall be maintained in a separate record that shall be filed with the clinical record at discharge.

Interpretive guideline 6: Staff training records shall show evidence of annual training and competency in caring for children or youth needing psychiatric or behavioral stabilization and for the youth needing detoxification services.

SSr.11.18 REPORTING OF SERIOUS OCCURRENCES

SSr.11.18. The CSP must report each serious occurrence.

Interpretive guideline 1: Serious occurrences shall be reported as specified in DBHDD Policy for *Reporting of Consumer Deaths and Critical Incidents*.¹⁰

Interpretive guideline 2: The CSP must report any serious occurrence to the State Medicaid agency. Serious occurrences that must be reported include:

- a. Client's death
- b. Client's suicide attempt
- c. Serious injury to a client manifesting itself as any serious impairment of the physical condition of the resident as determined by qualified medical personnel including, but not limited to:
 - i. Burns
 - ii. Lacerations
 - iii. Bone fractures
 - iv. Substantial hematoma
 - v. Injuries to internal organs, whether self-inflicted or by someone else

Interpretive guideline 3: The CSP shall notify the parent(s) or legal guardian(s) as soon as possible and in no case later than 24 hours after a serious occurrence.

Interpretive guideline 4: A description of the serious occurrence must be recorded in the client's record, including:

- a. Medical treatment sought, outcome of treatment, and follow-up required;
- b. That the serious occurrence was reported, including
 - i. The names of the parent(s) legal guardian(s) to whom it was reported
 - ii. The name of the agencies to which it was reported, including the name of the person at the agency who received the report.
 1. The State Medicaid Agency (if the CSP is enrolled as a Medicaid provider)
 2. The Department of BHDD¹⁰

Interpretive guideline 5: In addition to the agencies listed above, if the CSP is

¹⁰ Updated FY10

¹⁰ Updated FY10

enrolled as a Medicaid provider, ALL DEATHS of any client must be reported to the Regional Office for the Centers for Medicare and Medicaid (CMS) by no later than the close of the next business day after the resident's death.

- a. The method of reporting and corresponding documentation noted within this standard shall apply.
- b. Staff must document in the client's record that the death was reported to the CMS regional office.

Interpretive guideline 6: A copy of the incident and accident report shall be kept by the CSP.

SSr. 11.19 REPORTING OF CLIENT DATA TO THE DEPARTMENT OF BHDD^{7/10}

SSr.11.19. The crisis stabilization program shall report data to the Department of BHDD as directed by provider agreement.¹⁰

Interpretive guideline 1: Encounter data shall be reported to the Department of BHDD in the format directed by the operational guidelines provided by the Department of BHDD to the parent organization (Community Service Board or State Hospital Facility).¹⁰

Interpretive guideline 2: Encounter data shall include but may not be limited to:

- a. Client name
- b. Date of admission
- c. Date of discharge
- d. Legal status
- e. Admitting diagnosis
- f. Referred to

SSr. 11.20 DESIGNATION AS A CRISIS STABILIZATION PROGRAM

SSr 11.20. The designation must be approved and may be withdrawn by the department. Designation is not transferable.

Interpretive guideline 1: Designation as a crisis stabilization program must be approved and may be withdrawn by the Department of BHDD. Designation is non-transferable.

Interpretive guideline 2: Each designation or provisional designation shall be returned to the department in the following cases. This includes but may not be limited to:

- Change in location
- Program closure
- DBHDD finding of failure to comply with CSP standards
- Loss of accreditation

⁷ Added to CSP Standards FY07
FY08 State Protection & Advocacy program references are removed from text

Part IV

**Community Service Standards Specific for
Behavioral Health Services**

SECTION IV

***Documentation Guidelines for
Behavioral Health Providers***

Fiscal Year 2012

(Updated for October 1, 2011 Implementation)



**Georgia Department of Behavioral Health &
Developmental Disabilities**

October 2011

Introduction

The purpose of documentation of consumer services is to provide a written, legal record of the course of treatment and the delivery of services. Ideally, documentation provides the following:

- Evidence that the consumer's needs have been assessed, eligibility established and needs prioritized;
- Medical necessity of the service is supported;
- Appropriate outcomes are identified and discharge criteria established;
- Appropriate treatment is planned;
- Appropriate interventions and services are selected;
- Evidence of consumer participation, consent and response to treatment are present;
- Evidence of monitoring of service provision and progress towards desired outcomes are monitored;
- Evidence of reassessment(s) occurring on an ongoing and as needed basis;
- Evidence that services and treatment plans are amended and changes are implemented to facilitate progress when needed; and
- Clear evidence that the services billed are the services provided.

Core Components of Documentation

There are three core components of consumer related documentation. These include **assessment and reassessment**; **treatment and care planning** (individualized service/recovery plan); and **progress notes**. These core components are independent and yet must be inter-related in order to create a sound medical record. The required elements for all Behavioral Health services are detailed below. The documentation guidelines outlined herein do not supersede service-specific requirements. This Provider Manual may list additional requirements and standards which are service-specific; when there is a conflict, providers should defer to those requirements which are most stringent.

Assessment

Comprehensive assessment and reassessment documentation includes all components of the current ERO authorization, a biopsychosocial assessment, a medical screening, an integrated/interpretive summary, and a verified diagnosis. A verified diagnosis is defined as a behavioral health diagnosis provided by a licensed psychologist, a physician, or a Physician Assistant or APRN¹ working in conjunction with a physician with an approved job description or protocol. At a minimum, all diagnoses must be verified annually by a licensed psychologist, medical doctor, APRN, or Physician Assistant following a face-to-face evaluation of the consumer (internal or external to the agency).² For any diagnoses

¹ APRNs include Clinical Nurse Specialists (CNS) and Nurse Practitioners (NP).

² This will be monitored by the ERO audit tool effective January 1, 2010.

that are valid for less than one year, an assessment must be completed more often as indicated in the current DSM. If this requirement is not met due to consumer refusal or choice, documentation in the record should reflect this.

For all verified diagnoses assigned or annually verified following **August 1, 2010**: Documentation of diagnosis/diagnoses must clearly indicate the diagnosis or diagnoses and include a summary of findings to include any supporting documentation. The documentation must clearly indicate the diagnosing practitioner, his/her credential/s, date of diagnosis, and be signed by the practitioner. On all medical record documentation, the practitioner's printed name must be the name listed on his or her practitioner's license³. This requirement is applicable to diagnoses provided both internal and external to the agency.

As defined in Part I, Section I of this Provider Manual, "Eligibility, Service Definitions and Requirements", a diagnostic impression is sufficient for brief or stabilization services. Diagnostic impressions may be provided by those professionals or paraprofessionals who are permitted to provide the Behavioral Health Assessment service.

A comprehensive assessment must include:

- Justification of elements which support diagnosis;
- Summary of central themes of presenting symptoms/needs and precipitating factors;
- Consumer strengths;
- Prior treatment and rehabilitation services used and outcomes of these services;
- Interrelationship of history and assessments;
- Preferences for treatment, consumer choice and hopes for recovery;
- An assessment for co-occurring disorders;
- Barriers impacting prospects for stabilization and recovery;
- Current issues placing the client most at risk;
- How needs are to be prioritized and addressed;
- What interventions are needed, when, how quickly, in what services and settings, length of stay, and with what provider(s); and
- The step-down services.

Treatment and Care Planning

Treatment and care planning documentation is included in the consumer's Individualized Recovery/Resiliency Plan (IRP). The IRP should be reviewed frequently and evolve to best meet the consumer's needs. This plan sets forth the course of care by integrating the information gathered from the current assessment, status, functioning, and

³ It is acceptable that the initials can be used for first and middle names. The last name must be spelled out and each of these must correlate with the names on the license. This is an effort to ensure that a connection can be made between the printed/stamped name on the chart entry and a license.

past treatment history into a clinically sound plan of care. The following components are required:

Order/Recommendation for Course of Treatment⁴

All services must be recommended (“ordered”) by a physician or other appropriately licensed practitioner. The recommendation/order for a course of treatment must specify each service (**by official Group Name**) to be provided and shall be reviewed and signed by the appropriately licensed practitioner(s) on or before the initial date of service **AND** on or before the effective date of each reauthorization of service(s). If the provider utilizes service packages (i.e. Intensive Outpatient) to order services, each service included in the service package must be individually named (**by official Group Name**) in the recommendation/order. All recommendations/orders expire at the time of the expiration of the current authorization.

- There are two formats that may be used for writing a recommendation/order:
 1. An individualized recovery/resiliency plan (IRP) which fulfills the required components **A-E** listed below, can be used as a recommendation/order for the applicable authorization period for services indicated within the plan.
 2. A stand-alone recommendation/order in the client record which fulfills required components **A-E** listed below.
- **Required Components** of the recommendation/order include:
 - A. Consumer name,
 - B. All services recommended as a course of treatment/ordered as indicated by Group Name as listed in the current DBHDD Provider Manual,
 - C. Signature and credentials⁵ of appropriately licensed practitioner(s),
 - D. Printed or stamped name and credentials of appropriately licensed practitioner(s), and
 - E. Date of signature(s).
- The appropriately licensed practitioner(s) authorized to recommend/order specific services may be found within each service definition.
- Should the recommendation for course of treatment (order) cross multiple pages in a paper record, the provider is responsible for ensuring that it is clear that the additional pages are a continuation of the order. For example, in a 2 page order, page 2 must contain the name of the consumer, a page number, and indication that the signature of the practitioner indicates authorization for services as noted on page 1.

⁴ Note that the following requirements apply only to recommendation/orders for **services** as defined in the MH and AD Service Definitions and Guidelines (FY 09 Provider Manual, Part I, Section I). Standards regarding orders for medication and procedures can be found in the Standards for All Providers (FY 09 Provider Manual, Part II, Section II).

⁵ See Appendix 1 for additional information regarding credentials.

- Recommendation for course of treatment (“orders”) may be made verbally. This Provider Manual may list additional requirements and standards which are service-specific; *when there is a conflict, providers should defer to the more stringent requirements and standards.* Required components of the verbal recommendation/order include:
 - The organization must have policies and procedures which govern procedures for verbal orders;
 - Recommendations/Orders must be documented in the medical record and include:
 - A. Consumer name,
 - B. All services recommended as a course of treatment/ordered as indicated by official Group Name as listed in the current DBHDD Provider Manual,
 - C. Printed or stamped name and credentials of appropriately licensed practitioner(s) recommending service, and
 - D. Date of verbal order(s); and
 - E. Printed or stamped name, credentials, original signature, and date signed by the staff member receiving the verbal order. Organization’s policy must specify which staff can accept verbal orders for services.
 - Verbal orders must be authenticated by the ordering practitioner’s signature within seven (7) calendar days of the issuance of orders. This may be an original signature or faxed signed order.
 - Faxed orders signed by the ordering practitioner are acceptable and a preferred alternative to verbal orders. The fax must be dated upon receipt, contain Required Components A-E.

Individualized Treatment (Recovery/Resiliency) Planning must:

- Identify and prioritize the needs of the consumer;
- Document by consumer signature and/or, when applicable, guardian signature that the consumer is an active participant in the planning and process of care (to the degree to which that is possible). Subsequent changes to the plan must also document consumer or guardian signature via dated initials.
- State goals which will honor achievement of stated hopes, choice, preferences, and desired outcomes of the consumer and/or family;
- Assure goals/objectives are:
 - related to assessment/reassessment;
 - designed to ameliorate, rectify, correct, reduce or make symptoms manageable; and
 - indicative of desired changes in levels of functioning and quality of life to objectively measure progress.
- Define goals/objectives that are individualized, specific and measurable with achievable timeframes;
- Detail interventions which will assist in achieving the outcomes noted in the goals/objectives;

- Identify and select services and interventions of the right duration, intensity and frequency to best accomplish these objectives;
- Assure there is a goal/objective that is consistent with the service intent;
- Identify frequency and duration of services which are set to achieve optimal results with resource sensitive expenditures.

Discharge/Transition Plan which:

- Documents transition planning at onset of service delivery;
- Defines discharge criteria which objectively measures progress by aligning with documented goals/objectives, desired changes in levels of functioning, and quality of life;
- Defines specific step-down service/activity/supports to meet individualized needs; and
- Is measurable and includes anticipated step-down/transition date.

Within 30 days from the date of discharge, the Discharge Summary must:

- Document the reason for ending services;
- Indicate the outcome of the goals and objectives made during the service provision period;
- Strengths, needs, abilities, and preferences of the individual;
- Define specific to step-down service/activity/supports where consumer was referred; and
- Living situation at discharge.

Progress Note

Progress Note documentation includes the actual implementation and outcome(s) of the designated services in a consumer's IRP. The progress note is an integral part of the consumer's written legal record. The purpose of the progress note documentation is to accurately describe the delivery of services and the impact of the services to the consumer.

Progress note documentation requires prospective and current providers to develop and implement protocols by which they design, execute and monitor the documentation in a consistent, systematic, agency wide manner on an ongoing basis. While the Department of BHDD has not prescribed a specific format for progress notes, there are clear standards related to the **content, components, required characteristics, and format of progress note documentation.**

The Department of BHDD has provided the information in this section to communicate **requirements** for progress note documentation and to offer guidance for implementation of the standards related to the purpose, components, characteristics, content, context and quality of progress note documentation.

It is the recommendation of Department of BHDD that current and prospective providers of Medicaid Community Mental Health Services and State Funded Services utilize the

information in structuring their internal standards, protocols, practices, performance, monitoring and training activities.

The **content in progress note documentation** must provide all the necessary supporting evidence to justify the need for the services based on medical necessity criteria and support all requirements for billing and adjudication of the service claims. For this reason, progress notes for all billed services (e.g. face-to-face, telemedicine, collateral, etc) should include observations of the consumer's symptoms, behaviors, affect, level of functioning and reassessment for risk when indicated as well as information regarding the exact nature, duration, frequency and purpose of the service, intervention and/or modality. Review of sequential progress notes should provide a snapshot of the consumer over a specified time frame.

Required components of progress note documentation:

- **Linkage** - Clear link between assessment and/or reassessment, Individualized Recovery/Resiliency Plan and intervention(s) provided.
- **Consumer profile** – Description of the current status of the consumer to include consumer statements, shared information and quotes; observations and description of consumer affect; behaviors; symptoms; and level of functioning.
- **Justification** – Documentation of the need for services based on admission criteria and measurable criteria for medical necessity. This documentation should also reflect justification for payment of services provided and utilization of resources as it relates to the service definition and the needs/desires of the consumer.
- **Specific services/intervention/modality provided** – Specific detail of all provided activity(ies) or modality(ies) including date, time, frequency, duration, location and when appropriate, methodology.
- **Purpose or goal of the services/intervention/modality**- Clarification of the reasons the consumer is participating in the above services, activities, and modalities and the demonstrated value of services.
- **Consumer response to intervention(s)** – Identification of how and in what manner the service, activity, and modality have impacted the consumer; what was the effect; and how was this evidenced.
- **Monitoring** - Evidence that selected interventions and modalities are occurring and monitored for expected and desired outcomes.
- **Consumer's progress** – Identification of the consumer's progress (or lack of progress) toward specific goals/objectives as well as the overall progress towards wellness.
- **Next steps** – Targeted next steps in services and activities to support stability
- **Reassessment and Adjustment to plan** – Review and acknowledgement as to whether there is a need to modify, amend or update the individualized service/recovery plan and if so, how.

Required characteristics of progress note documentation⁶:

- **Presence of note** – For any claim or encounter submitted to DBHDD (including Medicaid Rehabilitation Option), a note must be present justifying that specific intervention. In addition, other ancillary or non-billable services which are related to the well-being of the individual served must be included in the consumer’s official medical record.
- **Service billed** – All progress notes must contain the corresponding HIPAA code which must include any designated modifier. When documenting practitioner modifiers, the modifier must indicate the reimbursement level, which may differ from the practitioner level in certain cases. For example, if a RN provides CSI, the RN would include the modifier U4 to indicate the practitioner level even though an RN is generally a level 2 Practitioner.
- **Timeliness** – All activities/services provided are documented (written and filed) within the current consumer record within a pre-established time frame set by agency policy not to exceed 7 calendar days. Best practice standards require progress notes to be written within 24 hours of the clinical or therapeutic activity.
- **Legibility** – All documentation that is handwritten must be readable, decipherable and easily discernable to the all readers.
- **Conciseness and clarity** – Clear language, grammar, syntax, and sentence structure is used to describe the activity and related information.
- **Security and confidentiality** – All documentation is managed in such a manner to ensure consumer confidentiality and security while providing access and availability as appropriate.
- **Activities dated** - Documentation specifies the date/time of service.
- **Dated entries** – All progress note entries are dated to reflect the date of signature of the individual providing the service (this date may differ from the actual date of service). Dates written to indicate the date of a signature should only be dated by the signer. In electronic records, the date of entry should reflect the date that the secure electronic signature was entered. Back-dating and post-dating are not permitted.
- **Duration of activities** – Documentation of the duration must be noted for all services to include the number of units, times, and dates. For those services in which the unit/rate is based on time (not per contact/encounter), documentation must include time-in and time-out for all services. This requirement applies for both face-to-face and collateral contacts. Residential services are excluded from the daily notation of time-in/time-out and must follow the specific guidelines outlined in each specific residential code. Further instruction related to Psychosocial Rehabilitation and Peer Supports services can be found in the respective Service Guidelines.
- **Rounding of Units** – Rounding of units is permitted when a service meeting the service definition is provided in less time than the unit increment requirement. Each provider must have an internal policy regarding rounding of units. **Effective January 1, 2011**: Regarding “rounding” of units, a unit may be billed for a service when an activity meets the service definition of the service billed but does not meet the full time/unit requirement. In order to bill a unit of service, at least 50% of the time

⁶ Any electronic records process shall meet all requirements set forth in this document.

required per unit must be provided and documented by the “time-in, time-out” documentation. For example, a provider may bill a single 15 minute unit for a service greater or equal to 8 minutes and less than 23 minutes. If the duration of the service is greater than or equal to 23 minutes and less than 38 minutes, then 2 units may be billed. Providers must document rounding practices in internal policy.

- **Location of intervention** – For those services which may be billed as either in or out-of clinic, progress notes shall reflect the location as either in-clinic or out-of-clinic (unless otherwise noted in Service Guideline). If the intervention is in-clinic, no further specificity is required. If an intervention is “out-of-clinic”, the note must reflect the specific location of the intervention; this indication should be specific enough that it can be generally understood where the service occurred (for example: “...at the individual’s home,” “...at the grocery store”, etc.). Documenting that the service occurred “in the community” is not sufficient to describe the location.
- **Participation in intervention** – Progress notes shall reflect all the participants in the treatment and/or support intervention (consumer, family, other natural supports, multi-disciplinary team members, etc.)
- **Signature, Printed staff name, qualifications and/or title**⁷ – The writer of the documentation is designated by name and credentials/qualifications and when required, degree and title. If an individual is a licensed practitioner, the printed name must be the name listed on his or her practitioner’s license on all medical record documentation⁸. An original signature is required. The printed name and qualifications and/or title may be recorded using a stamp or typed onto the document. Automated or electronic documentation must include a secure electronic signature⁹.
- **Black or Blue ink** – Currently, the State of Georgia requires that any handwritten documentation must be in black or blue ink.
- **Recorded changes** – Any corrections or alternations made to existing documentation must be clearly visible. No “white-out” or unreadable cross-outs are allowed. A single line is used to strike an entry and that strike must be initialed and dated. Any changes to the electronic record must include visible “edits” to include the date and the author of the edit. Additionally, if a document contains a Secure Electronic Signature, it must be linked to data in such a manner that if the data is changed the electronic signature is invalidated.
- **Consistency** – Documentation should follow a consistent, uniform format. Should the progress note cross multiple pages in a paper record, the provider is responsible for ensuring that it is clear that the additional pages are a continuation of the progress note. For example, in a 2 page note, page 2 must contain the name of the consumer, date of

⁷ See Appendix 1 for additional information regarding credentials.

⁸ It is acceptable that the initials can be used for first and middle names. The last name must be spelled out and each of these must correlate with the names on the license. This is an effort to ensure that a connection can be made between the printed/stamped name on the chart entry and a license.

⁹ As defined in PART I POLICIES AND PROCEDURES FOR MEDICAID/PEACHCARE FOR KIDS, a Secure Electronic Signature means an electronic or digital signature, symbol, or process associated with a document which is created, transmitted, received, or stored by electronic means which (1) requires the application of a security procedure; (2) capable of verification/authentication; (3) adopted by a party with the intent to be bound or to authenticate a record; (4) signed under penalty of perjury; (5) unique to the person using it; (6) under the sole control of the person using it; and (7) linked to data in such a manner that if the data is changed the electronic signature is invalidated.

service, a page number, and indication that the signature of the practitioner or paraprofessional is related to the progress note on page 1.

- **Diversions and non-billable activities –**

- Providers may not bill for multiple services which are direct interventions with the consumer during the same time period. If multiple services are determined to have been billed at the same or overlapping time period, billing for those services are subject to recoupment. Allowable exceptions include a consumer receiving a service during the same time period or overlapping time period as:

- A service provided without client present as indicated with the modifier "HS", or
- A collateral contact service as indicated by the modifier "UK".

For example, a provider may bill Individual Counseling with the consumer while, simultaneously, CSI is being billed for a collateral contact. This is only allowable when at least one of the services do not require that the consumer be present and the progress note documents such.

- Non-billable activities are those activities or administrative work that does not fall within the Service Definition. For example, confirming appointments, observation/monitoring, tutoring, transportation, completing paperwork, and other administrative duties not explicitly allowed within the Service Guidelines are non-billable activities. Billing for non-billable activities is subject to recoupment.
- Billing for services that do not fall within the respective Service Definition is subject to recoupment.
- Diversions activities are activities/time during which a therapeutic intervention tied to a goal on the individual's treatment plan is not occurring. Diversions activities which are billed are subject to recoupment. An exception to this includes activities billed as Structured Activity Supports which fall within the service definition.

Formats for progress note documentation:

The Department of BHDD does not require providers to utilize a specific format for progress notes. However, providers are expected to follow best practices and select a format or create a prescribed narrative that can be used consistently throughout their agency. Information regarding best practices for progress note documentation including expanded acronym definition, specific content and examples are available through accrediting bodies, professional organizations, and other resources.

Specific details regarding actual practice should be described in provider's policies, procedures, training manuals and/or documentation instruction sheets.

There are numerous acceptable formats for best practice of progress note documentation. Among many others, these formats may include the **SOAP, PIR, GIO, GIRP, BIRP, OSRP, DAP and TREATS**. The acronyms definitions of these formats stand for:

- **S-O-A-P:** *Subjective, Objective, Assessment and Plan*

- **P-I-R:** Problem(s)-Intervention(s)-Response(s)
- **G-I-O:** Goal(s), Intervention(s), Objective(s)
- **G-I-R-P:** Goal(s), Intervention(s), Response(s), Plan
- **B-I-R-P:** Behavior(s), Intervention(s), Response(s), Plan
- **O-S-R-P:** Objective(s), Strategy(ies), Response(s), Plan
- **D-A-P:** Data, Assessment, Plan
- **T-R-E-A-T-S:** Traits, Response, Events, Assessment, Treatment Strategies

While these formats differ slightly in identifying acronyms or “labels,” they share similar structure, common data elements and required content. All formats require a clear match or link between the progress note, assessment and service and planning data. In addition, formats lay out specific standards for capturing detailed information related to the consumer’s current status, specific service, intervention, activity and/or modality provided; the consumer response and progress; and what should be the next steps in the planning process.

For more information on progress note development, see BHDD’s “Progress Note Development Checklist” online at www.apsero.com

Documentation of Standard Training Requirement for Paraprofessionals

Providers must comply with the Standard Training Requirement for Paraprofessionals. Documentation of compliance must be available for each paraprofessional. For the Essential Learning (online) component, demonstration of fulfilling this requirement includes printing the certificates and/or the Learners’ transcripts and keeping them in personnel files. Providers must also have documentation available to demonstrate completion of the training provided by the organization. In addition, **effective January 1, 2011**, an orientation agenda/checklist/spreadsheet with the name of the employee, date, topic of training, and number of hours must be available for audit purposes. The date of hire must also be available for review. For additional details regarding the Standard Training Requirement, refer to the Standards for All Providers within this Provider Manual.

Documentation of Supervision for Individuals Working Towards Licensure

Psychologist/LCSW/LPC/LMFT’s supervisee/trainee is defined as:

An individual with a minimum of a Bachelor’s degree and one or more of the following:

1. Registered toward attaining an associate or full licensure;
2. In pursuit of a Master’s degree that would qualify the student to ultimately qualify as a licensed practitioner(Psychologist, LCSW, LMFT,LPC, LMSW, LAMFT, LAPC);
3. Not registered, but is acquiring documented supervision toward full licensure in accordance with O.C.G.A. 43-10A-3

See Service Guideline for information regarding practitioners authorized to provide specific services.

These individuals must be under supervision of a licensed Psychologist/LCSW, LPC, or LMFT in accordance with the GA Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists or enrolled in a practicum with an accredited educational Master's degree program which provides supervision as a part of a curriculum which is the foundation toward licensure.

Effective for all services provided on or after August 1, 2009, students and individuals who meet the definition of a Supervisee/Trainee above will not require a co-signature on progress notes unless required by the rules of the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists.

In accordance with the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists, interns and trainees must work under direction and documented clinical supervision of a licensed professional. Effective for all services provided on or after August 1, 2009, agencies will be required to present documentation of supervision of Supervisee/Trainees upon request by DBHDD or the DBHDD's ERO. Supervision must be completed monthly; documentation of supervision for previous month must be in employee file by the 10th day of the following month. For example, January supervision must be recorded by February 10th.

As of the print date of this Provider Manual, documentation of supervision is described by O.C.G.A. 43-10A-3 as, "a contemporaneous record of the date, duration, type (individual, paired, or group), and a brief summary of the pertinent activity for each supervision session". More information can be found online at <http://sos.georgia.gov/plb/counselors/>. Documentation of supervision as defined by O.C.G.A. 43-10A-3 must be present and current in personnel record.

In addition, for Supervisee/Trainees who are either:

1. In pursuit of a Master's degree that would qualify the student to ultimately qualify as a licensed practitioner (Psychologist, LCSW, LMFT, LPC, LMSW, LAMFT, LAPC), or
2. Not registered toward attaining licensure, but is acquiring documented supervision toward full licensure in accordance with O.C.G.A. 43-10A-3,

The agency will be required to present an attestation signed by both the supervisor and supervisee/trainee which either:

1. Confirms enrollment in a practicum with an accredited educational Master's degree program which provides supervision as a part of a curriculum which is the foundation toward licensure, or
2. Confirms that supervision is being provided towards licensure in accordance with O.C.G.A. 43-10A-3.

Documentation of Supervisee/Trainees who are receiving on-site supervision in addition to the supervision that they are receiving off-site towards their licensure must include:

1. A copy of the documentation showing supervision towards licensure, and
2. Documentation in compliance with the above-stated requirements.

For example, if a Supervisee/Trainee is working at Agency “A” as a supervisee-trainee and receiving supervision towards their licensure outside of Agency “A”, the a copy of the documentation showing supervision towards licensure must be held at Agency “A”.

This Provider Manual may list additional requirements and standards which are service-specific; when there is a conflict, providers should defer to those requirements which are most stringent.

Documentation of Supervision of Addiction Counselor Trainees

Addiction Counselor Trainees may provide certain services under Practitioner Level 5. See Service Guideline for information regarding practitioners authorized to provide specific services. The definition of Addiction Counselor Trainee is “an individual who is actively seeking certification¹⁰ as a CADC, CCADC, CAC II or MAC and is receiving appropriate Clinical Supervision”. The Addiction Counselor Trainee Supervision Form (Appendix 2) and supporting documentation indicating compliance with the below requirements must be provided for all services provided by an Addiction Counselor Trainee on or after August 1, 2009. The following outlines the definition of supervision and requirements of clinical supervision:

- Supervision means the direct clinical review, for the purpose of training or teaching, by a supervisor of a specialty practitioner's interaction with a client. It may include, without being limited to, the review of case presentations, audio tapes, video tapes, and direct observation in order to promote the development of the practitioner's clinical skills.
- Monthly Staff Supervision form must be present and current in personnel record. Supervision must be completed monthly; supervision form for previous month must be in employee file by the 10th day of the following month. For example, January supervision must be recorded by February 10th.
- Evidence must be available to show that supervising staff meet qualifications:
 - The following credentials are acceptable for Clinical Supervision: CCS; CADC; CCADC; CAC II; MAC **or** LPC/ LCSW/LMFT who have a minimum of 5 hours of Co-Occurring or Addiction specific Continuing Education hours per year; certification of attendance/completion must be on file.
- The Addiction Counselor Trainee must have a certification test date that is within 3 years of hire as an Addiction Counselor Trainee, and;
- The Addiction Counselor Trainee may not have more than 3 years of cumulative experience practicing under supervision for the purpose of addiction certification, per GA Rule 43-10A, and;
- Addiction Counselor Trainees must have a minimum of 4 hours of documented supervision monthly – this will consist of individual and group supervision.

¹⁰ Persons actively seeking certification are defined as: Persons who are training to be addiction counselors but only when such persons are: employed by an agency or facility that is licensed to provide addiction counseling; supervised and directed by a supervisor who meets the qualifications established by the certifying body; actively seeking certification, i.e. receiving supervision & direction, receiving required educational experience, completion of required work experience. (Georgia Rule 43-10A)

This Provider Manual may list additional requirements and standards which are service-specific; when there is a conflict, providers should defer to those requirements which are most stringent.

The DBHDD has added specificity regarding the supervision of these practitioners due to the volume of practice provided by LCSW/LPC/LMFT's supervisee/trainees and Addiction Counselor Trainees. Psychologists in training should adhere to the supervision requirements outlined in the Official Code of Georgia.

Appendix 1

The below chart provides abbreviations for credentials recognized in the Practitioner Level system. These approved abbreviations must be on the signature lines in documentation where credentials are required (i.e. orders for services, progress notes, etc). For those staff members (PP, CPS, S/T, etc) whose practitioner level is affected by a degree, the degree initials should also be included. For example, if a Paraprofessional is working with a Bachelor of Arts degree, he or she would include “PP, BA” as his or her credentials.

Professional Title	ABBREVIATION FOR SIGNATURE LINE
Physician	M.D., D.O., etc.
Psychiatrist	M.D., etc.
Physician Assistant	PA
Advanced Practice Registered Nurse, Clinical Nurse Specialist/Psychiatric-Mental Health and Nurse Practitioner	APRN or CNS-PMH or NP
Licensed Pharmacist	LPh
Registered Nurse	RN
Licensed Practical Nurse	LPN
Licensed Dietician	LD
Qualified Medication Aide	QMA
Psychologist	PhD or PsyD
Licensed Clinical Social Worker	LCSW
Licensed Professional Counselor	LPC
Licensed Marriage and Family Therapist	LMFT
Licensed Master’s Social Worker	LMSW
Licensed Associate Professional Counselor	LAPC
Licensed Associate Marriage and Family Therapist	LAMFT
Psychologist/LCSW/LPC/LMFT’s supervisee/trainee	S/T
Certified Clinical Alcohol and Drug Counselor	CCADC
Georgia Certified Alcohol and Drug Counselor, Level III	GCADCIII
Master Addiction Counselor (MAC), National Board of Certified Counselors	MAC-NBCC
Master Addiction Counselor (MAC), National Association of Alcohol and Drug Counselors,	MAC-NAADC
Certified Alcohol and Drug Counselor	CADC
Georgia Certified Alcohol and Drug Counselor II	GCADC-II
Certified Addiction Counselor, Level II	CAC-II
Certified Addiction Counselor, Level I (CAC-I)	CAC-I
Registered Alcohol and Drug Technician I, II, III	RADT-I, RADT-II, RADT-III
Addiction Counselor Trainees	ACT
Certified Psychiatric Rehabilitation Practitioner (CPRP)	CPRP
Certified Peer Specialist (CPS)	CPS
Paraprofessional (PP)	PP
Vocational Rehabilitation Specialist	PP/VS

ADDICTION COUNSELOR TRAINEE SUPERVISION FORM

Individual

Group

SECTION A. EMPLOYEE INFORMATION

Name:	Month of Supervision:
Hire Date as an Addiction Counselor Trainee:	Projected Certification Test Date: (Eligible to test w/in 2 years of hire date)

SECTION B.

Check Domain discussed during Supervision and briefly describe (see TAP 21 description):

- Clinical Evaluation (total monthly hours completed: ____) (accumulative hours completed: ____)
- Treatment Planning (total monthly hours completed: ____) (accumulative hours completed: ____)
- Referral (total monthly hours completed: ____) (accumulative hours completed: ____)
- Service Coordination (total monthly hours completed: ____) (accumulative hours completed: ____)
- Counseling (total monthly hours completed: ____) (accumulative hours completed: ____)
- Client, Family and Community Education (total monthly hours completed: ____) (accumulative hours completed: ____)
- Documentation (total monthly hours completed: ____) (accumulative hours completed: ____)
- Professional and Ethical Responsibilities (total monthly hours completed: ____) (accumulative hours completed: ____)

Short Term Goals/Action Required: (define expectations – timelines – areas needing improvement)

Training Needs: (progress toward certification, licensure and/or other areas of professional growth)

Training Hours Completed: _____

Next Scheduled Supervision: _____

SECTION C. SIGNATURES

Supervisor’s Signature and credentials ¹¹ :	Date:
Employee Signature:	Date:

¹¹ The following credentials are acceptable for Clinical Supervision and are required to provide proof of credential: CCS; CADC; CCADC; CAC II; MAC or LPC/ LCSW/LMFT who have a minimum of 5 hours of Co-Occurring or Addiction specific Continuing Education hours per year, certification of attendance/completion must be on file.

PART V

Block Grant Funding Requirements

Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers

Fiscal Year 2012

*(Updated the Substance Abuse, Prevention, and Treatment Block Grant
and the Safe and Drug Free Schools and Communities Block Grant
for October 1, 2011 Implementation)*



**Georgia Department of Behavioral Health &
Developmental Disabilities**

October 2011

Part V

BLOCK GRANT FUNDING REQUIREMENTS

- **Mental Health Block Grant**
- **Substance Abuse, Prevention and Treatment Block Grant**
- **Safe and Drug Free Schools and Communities Block Grant**
- **Special Requirements for Programs serving Children and Adolescents**
- **PATH Summary**
- **Title XX Social Services Block Grant for DD Services**
 - **Reporting Form**



**Georgia Department of Behavioral Health &
Developmental Disabilities**

October 2011

MENTAL HEALTH BLOCK GRANT

(Note: The information contained here is for emphasis and is not inclusive of all requirements for which the Contractor has to comply. For a complete list of all requirements please obtain a full copy of Public Law 102-321, Section 1912 and following applicable code sections at www.mentalhealth.samhsa.gov)

The Contractor in accepting and expending Block Grant funds recognizes the following services for Adult and Child Adolescent Mental Health are the only services eligible to be funded with Mental Health Block Grant dollars for 2010. The Contractor recognizes the services specified below will be provided in accordance with the applicable standards as specified in this Provider Manual.

A. Adult

1. Outpatient services (screening and assessment to determine appropriateness of services or state hospital admissions; physician or nursing assessment; individual, group and/or family counseling, and training; medication administration, monitoring and training; service coordination).
2. 24-hour-a-day emergency care services (crisis intervention services).
3. Intensive community intervention and support or psychosocial rehabilitation services.
4. Consumer directed programs (consumer peer supports).
5. Residential services
6. Supported Employment.
7. Assertive Community Treatment (ACT).

B. Child and Adolescent

1. Outpatient services (screening and assessment, counseling and training, medication administration, medication monitoring).
2. Wraparound/Family support/Respite.
3. Crisis intervention services including Crisis Stabilization Programs and mobile crisis.
4. Intensive In-home Therapy services.

C. Exclusions: Mental Health Block Grant funds may not be expended for:

1. Provision of inpatient services.
2. Cash payments to recipients of services.
3. The purchase or improvement of land; purchase, construction or permanent improvement (other than minor remodeling) of any building or other facility or the purchase of major medical equipment.
4. To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds.
5. Provision of financial assistance to any entity other than a public or nonprofit private entity.**

****Federal block grant funds may be expended in procurement or acquisition relationships with for-profit entities. Contracts must be developed that identify specific deliverables to be purchased with the funds.**

SUBSTANCE ABUSE, PREVENTION AND TREATMENT BLOCK GRANT

Federal Substance Abuse Prevention and Treatment Block Grant Funds provide for allotments each year to States for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse. The Block Grant funds may be expended to provide for a wide range of activities to prevent and treat substance abuse and may be expended to deal with the abuse of alcohol, the use or abuse of illicit drugs, and the abuse of licit drugs. The requirements for the expenditure of these funds are summarized below. The complete description of these requirements known as 45 CFR 96 – Rules and Regulations, may be found on the Substance Abuse Mental Health Services Administration (SAMHSA) web site at www.samhsa.gov/centers/csat/csat.html. Click on the index listing for 45 CFR 96 – Rules and Regulations. The document is 57 pages in length.

I. GENERAL PROVIDER ASSURANCES

- A. That an assessment of each consumer's need be conducted and documented;
- B. That a policy and procedure be implemented to prevent inappropriate disclosure of patient records covered by Federal confidentiality regulations for substance abuse.
- C. That prevention activities and treatment services be coordinated with the provision of other appropriate services;
- D. That continuing education of employees providing prevention activities or SA treatment services is required;
- E. That grant dollars not be used to supplant State and local funding of alcohol and other drug prevention and treatment programs;
- F. That grant dollars not be used to cover expenses that are eligible for payment or reimbursement through other sources.
- G. Compliance with restrictions on the expenditure of grant funds, including:
 - 1. Inpatient hospital services, except as provided under specific exceptions;
 - 2. Cash payments to intended recipients services;
 - 3. The purchase or improvement of land, a building or other facility, or the purchase of major medical equipment, except under specific circumstances
 - 4. The satisfaction of any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds;
 - 5. Financial assistance to any entity other than a public or nonprofit private entity*; or
 - 6. To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, except under certain circumstances.
- H. That independent peer review in accordance with the Regional Office's requirements be carried out to assess the quality, appropriateness, and efficacy of treatment services;

- I. Compliance with all applicable Federal laws and regulations, including those relating to audits, lobbying, drug-free workplace, non-discrimination, and disclosure of certain information and events.

*Federal block grant funds may be expended in procurement or acquisition relationships with for-profit entities. Contracts must be developed that identify specific deliverables to be purchased with the funds.

II. PROVIDER ASSURANCES WITH REGARD TO PRIMARY PREVENTION PROGRAMS

- A. Use of SAPTBG prevention funds is limited to primary substance abuse prevention activities that are:
 1. Provided in a variety of settings;
 2. Provided to individuals not in need of substance abuse treatment;
 3. Targeted to the general population or sub-populations who are at high risk for substance abuse;
 4. Provided directly or through one or more public or nonprofit private entities.
- B. Activities funded with grant funds must be part of a comprehensive plan that includes services and programs under six CSAP strategies:
 1. **Information dissemination** to promote awareness of the nature and extent of alcohol, tobacco and drug use, abuse and addiction; its effects on individuals, families and communities, and 1.dissemination is characterized by one-way communication from the source to the audience, with limited interaction between the two.
 2. **Education** to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g. of media messages) and systematic judgment abilities. Education is characterized by two-way communication, involving interaction between the educator/facilitator and the participant.
 3. **Alternatives** to activities involving alcohol, tobacco and other substance use for at risk populations and sub-populations.
 4. **Identification and Referral** of adults, children and adolescents engaged in the illegal/age inappropriate use of tobacco or alcohol, and/or first use of illicit drugs, in order to assess if their behavior can be reversed through education.
(Note: Activities intended to assess treatment needs are not included within this strategy.)
 5. **A Community-Based Process** to build prevention and treatment capacity at the local level, including, interagency collaboration, coalition building and networking.
 6. **Environmental Strategies** to affect community standards that will result in a reduction of the incidence of the use of alcohol, tobacco and other substances. Strategies include legal and regulatory initiatives, as well as service and action oriented initiatives.
- C. In order to meet the requirements of both the Substance Abuse Prevention and Treatment Block Grant, providers are required to enter service/program data into the Georgia electronic Prevention Minimum Dataset System (MDS) on a consistent basis. The deadline

for data entry is 45 days from the service date. The MDS will also limit data entry on a quarterly basis. The MDS Users Manual, New User Request forms, and entry into the system can be found at [www. georgiamds.uga.edu](http://www.georgiamds.uga.edu)

III. PROVIDER ASSURANCES WITH REGARD TO PROGRAMS FOR WOMEN

- A. Providers shall give preference to admission to services as follows:
 - 1. Pregnant injecting drug users;
 - 2. Pregnant substance abusers;
 - 3. Injecting drug users; and
 - 4. All others

- B. The provider shall publicize the availability of services and the preference extended to pregnant women through its outreach programs, ongoing public service announcements (radio/television), regular advertisements in local/regional print media, posters placed in targeted areas, and frequent notification of availability of such treatment distributed to the network of community based organizations, health care providers, and social service agencies.

- C. Programs will treat the family as a unit and admit both women and their children into treatment services, if appropriate. Programs must provide, or arrange for the provision of, the following services to pregnant women and women with dependent children, including women who are attempting to regain custody of their children:
 - 1. Primary medical care for women, including referral for prenatal care and, while the women are receiving services, childcare;
 - 2. Primary pediatric care, including immunization, for their children;
 - 3. Gender specific substance abuse treatment and other therapeutic interventions for women, which may address issues of relationships, sexual and physical abuse, parenting, and child care;
 - 4. Therapeutic interventions for children in custody of women in treatment which may address developmental needs, sexual and physical abuse and neglect; and
 - 5. Sufficient case management and transportation to ensure access to services.

- D. In the event that the provider has insufficient capacity to serve any pregnant woman seeking treatment, the provider will refer the woman to the Regional Office.

IV. PROVIDER ASSURANCES WITH REGARD TO PROGRAMS FOR INTRAVENOUS DRUG USERS

- A. Providers receiving grant dollars for treatment services for intravenous drug abusers must encourage the participation of such individuals through outreach models prescribed by the Regional Office, or if no such models are prescribed, through a strategy that reasonably can be expected to be an effective. Outreach efforts shall include:
 - 1. Selecting, training and supervising outreach workers;
 - 2. Contacting, communicating and following-up with substance abusers, their associates, and neighborhood residents, within the constraints of Federal and State confidentiality requirements, including 42 C.F.R. Part 2;

3. Promoting awareness among substance abusers about the relationship between intravenous drug abuse and communicable diseases such as HIV, and recommending steps to prevent disease transmission; and
 4. Encouraging entry into treatment
- B. Each individual who requests and is eligible for service must be admitted to a treatment program not later than:
1. Fourteen days after making the request for admission to a program; or
 2. One hundred and twenty days after the date of such request, if:
 - a. No such program has the capacity to admit the individual on the date of such request, and
 - b. Interim services, including referral for prenatal care, are made available to the individual not later than 48 hours after such request.
- C. The provider shall establish a system for reporting unmet demand for treatment services to the Regional Office. This waiting list shall use a unique patient identifier for each injecting drug abuser seeking treatment, including those receiving interim services while awaiting admission to such treatment. The reporting system shall ensure that individuals who cannot be placed in comprehensive treatment within 14 days receive ongoing contact and appropriate interim services while awaiting admission.
- D. Providers receiving grant funding for the treatment of intravenous substance abusers must, upon reaching 90 percent of service capacity, notify the Regional Office within seven days.

V. PROVIDER ASSURANCES WITH REGARD TO TUBERCULOSIS

- A. The provider will implement infection control procedures that are designed to prevent the transmission of tuberculosis.
- B. The provider shall routinely make available tuberculosis services to each individual receiving or seeking treatment services, either directly or through arrangements with other public or nonprofit private entities, including:
 1. Counseling
 2. Diagnostic Testing
 3. Therapy
- C. All individuals identified with active tuberculosis shall be reported to the appropriate State official as required by law.

VI. PROVIDER ASSURANCES WITH REGARD TO HIV (Human Immunodeficiency Virus)

- A. Providers shall participate in any HIV project as required by the Regional Office.
- B. The provider shall routinely make available Early Intervention Services to each individual receiving or seeking treatment services, either directly or through arrangements with other public or nonprofit private entities, provided that such services are not required as a condition of receiving treatment services for substance abuse, and are undertaken

voluntarily and with the informed consent of the individual. Early Intervention Services must include:

1. Counseling for HIV/AIDS
2. Diagnostic testing
3. Therapy

SAFE AND DRUG-FREE SCHOOLS AND COMMUNITIES BLOCK GRANT

The Safe and Drug Free Schools and Communities Block Grant (SDFSC) is authorized by the Title IV of the Federal *Improving America's School Act of 1994* and is administered by the U.S. Department of Education.

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) administers that portion of the State's total SDFSC grant allocated directly to the Governor for drug and violence prevention programs.

Applicants eligible for funding through the Governor's SDFSC allocation include parent groups, community action and job training agencies, and community-based organizations and consortia.

I. GENERAL PROVIDER ASSURANCES

A. Providers of prevention programs shall give priority to activities for:

1. children and youth who are not normally served by state or local educational agencies; or
2. populations that need special services or additional resources (youth in juvenile facilities, runaway or homeless children and youth, pregnant and parenting teenagers, and school dropouts.)

B. Compliance with the Department of Education's *Principles of Effectiveness* ;

1. Be based on an assessment of objective data regarding the incidence of violence and illegal drug use in the elementary schools and secondary schools and communities to be served, including an objective analysis of the current conditions and consequences regarding violence and illegal drug use, including delinquency and serious discipline problems, among students who attend such schools (including private school students who participate in the drug and violence prevention program) that is based on ongoing local assessment or evaluation activities.
2. Be based on an established set of performance measures aimed at ensuring that the elementary schools and secondary schools and communities to be served by the program have a safe, orderly, and drug-free learning environment.
3. Be based on scientifically based research that provides evidence that the program to be used will reduce violence and illegal drug use.
4. Be based on an analysis of the data reasonably available at the time, of the prevalence of risk factors, including high or increasing rates of reported cases of child abuse and domestic violence; protective factors, buffers, assets; or other variables in schools and communities in the State identified through scientifically based research.
5. Include meaningful and ongoing consultation with and input from parents in the development of the application and administration of the program or activity.

- C. Providers are required to enter service/program data into the Georgia electronic Prevention Minimum Dataset System (MDS) on a consistent basis. The deadline for data entry is 45 days from the service date. The MDS will also limit data entry on a quarterly basis. The MDS Users Manual, New User Request forms, and entry into the system can be found at www.georgiamds.uga.edu
- D. Compliance with other guidelines and requirements of the Office of Prevention Services and Programs.

II. AUTHORIZED ACTIVITIES AND SERVICES

- A. Disseminating information about drug and violence prevention;
- B. Training parents, law enforcement officials, judicial officials, social service and health providers, and community leaders and drug and violence prevention, health education, early intervention, pupil services, or rehabilitation referral;
- C. Developing and implementing comprehensive, community-based drug and violence prevention programs that link community resources with schools and integrate services involving education, vocational and job skills training and placement, law enforcement, health, mental health, community service, mentoring, and other appropriate services;
- D. Planning and implementing drug and violence prevention activities that coordinate the efforts of State agencies with efforts of the State educational agency and its local educational agencies;
- E. Activities to protect students traveling to and from school;
- F. Before-and-after school recreational, instructional, cultural, and artistic programs that encourage drug-and violence-free lifestyles;
- G. Activities that promote the awareness of and sensitivity to alternatives to violence through courses of study that include related issues of intolerance and hatred in society;
- H. Developing and implementing activities to prevent and reduce violence associated with prejudice and intolerance;
- I. Developing and implementing activities to prevent illegal gang activity;
- J. Coordinating and conducting community-wide violence and safety assessments and surveys;
- K. Service-learning projects that encourage drug-and violence-free lifestyles; and
- L. Evaluating programs and activities assisted under this section.

SPECIAL REQUIREMENTS FOR PROGRAMS SERVING CHILDREN AND ADOLESCENTS

The Contractor agrees to comply with Public Law 103-227, also known as the Pro-Children Act of 1994, which requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by the Contractor and used routinely or regularly for the provision of health care, day care, early childhood development services, education or library services to children under the age of 18. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the Contractor.

It is expected that all services provided to children and adolescents will be delivered within the state of Georgia unless approved by the Regional Director/Regional Coordinator.

**SUBJECT: Projects for Assistance in Transition from Homelessness
PATH**

REFERENCES: 45CFR 92.22 and Sections 521-535 of the Public Health Service Act

I. PURPOSE

The Projects for Assistance in Transition from Homelessness (PATH) program provides funds to each State to support services to individuals with serious mental illness, as well as individuals with serious mental illness and substance use disorders, *who are homeless or at risk of becoming homeless*.

II. ELIGIBILITY

An adult 18 years of age or older who is-

- homeless or imminent risk of becoming homeless; and
- unwilling or unable to seek services on their own and services must go to them; and
- suspected of having a serious mental illness; and
- not in the custody/guardianship of the State of Georgia; and
- not enrolled in DMHDDAD MICP system as receiving similar or duplicate services.

III. DEFINITIONS

- A. Homelessness- An individual who lacks fixed, regular, and adequate nighttime residence; or whose primary nighttime residence is a shelter designed to provide temporary living accommodations; or an institution that provides temporary residences for persons intended to be institutionalized; or a place not designed for human beings to live.
- B. Imminent Risk of Becoming Homeless-Persons who are about to be evicted from or lose a housing arrangement and have no resources or supports, or are about to be discharged from a psychiatric or substance abuse treatment facility without any resources or supports for housing.

IV. SERVICE SPECIFICATIONS

Those service specifications eligible for PATH funding include the following:

- 1) **Outreach Services:** Face-to-face interaction with literally homeless people in streets, shelters, under bridges, and other non-traditional settings, offering support while assisting with immediate and basic needs, and referral to appropriate resources.
- 2) **Screening, Diagnostic and Treatment Services:** A continuum of physician assessment services ranging from brief eligibility screening to comprehensive clinical assessment and treatment.
- 3) **Case Management Services:** Assist in accessing needed services, coordinate the delivery of services, and follow-up and monitor progress.

- 4) **Supportive and Supervisory Services in Residential Settings:** Within a residential setting, provide support to restore and develop skills in functional areas that interfere with the ability to maintain housing, participate in educational activities, regain or maintain employment, develop or maintain social relationships, and manage resources.
- 5) **Housing Services:** Specialized services designed to increase access to and maintenance of stable housing.
- 6) **Staff Training:** Training of individuals who work in shelters, mental health clinics, substance abuse programs, and other sites where homeless individuals require service;

V. RESTRICTION ON USE OF FUNDS

A Provider receiving PATH funds must agree to the following:

- 1) Not more than 4% of the payments will be expended for administrative expenses regarding payments;
- 2) Not more than 20% of the payments will be expended for housing services;
- 3) Payments will not be expended-
 - a. To support emergency shelters or construction of housing facilities;
 - b. For inpatient psychiatric treatment costs or inpatient substance abuse treatment costs;
 - c. To make cash payments to intended recipients of mental health or substance abuse services.

VI. PROVIDER REPORTING REQUIREMENTS

A Provider receiving PATH funds must:

- 1) Submit a description of the intended use and proposed budget prior to receiving PATH funds. Such description provides information relating to the programs and activities to be supported and services to be provided, including information relating to coordinating such programs and activities with any similar programs and activities of public and private entities; and such description will be revised throughout the year as may be necessary to reflect substantial changes in the programs and activities assisted by the State.
- 2) Submit a completed annual report per CMHS guidelines which includes the following items-
 - a. The types of services being offered by PATH provider;
 - b. The number of characteristics of the persons receiving services from PATH provider; and
 - c. The contribution of PATH funds toward the support of services provided to persons who are homeless and have serious mental illnesses.
- 3) Submit a monthly performance report describing the actual monthly service provision performance and housing coordination expenditures.

VII. PROGRAM EVALUATIONS

- 1) The Georgia PATH Contact will conduct a one-day site visit for all PATH sites annually. A site visit consists of the following:
 - a. Interview with PATH funded staff and administrator

- b. Accompany PATH staff on outreach to at least one homeless service site;
 - c. Review a minimum of three (3) PATH case records
- 2) The Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA) shall evaluate at least once every 3 years the expenditures of grants by eligible entities in order to ensure that expenditures are consistent with the provisions of the Public Health Service Act, and shall include in such evaluation recommendations regarding changes needed in program design or operations.

VIII. ADDITIONAL INFORMATION SOURCES

Secure a copy of the Public Health Service Act on the PATH website at www.pathprogram.samhsa.gov under Program Information.

TITLE XX SOCIAL SERVICES BLOCK GRANT

Congress passed Public Law 93-647, or Title XX of the Social Security Act (SSA), in 1974 to make federal funds available for states to provide social services which address the needs of each individual state. Social Services Block Grant (SSBG) funds are used to provide a variety of services to Georgia's citizens, including vulnerable children and adults who need protection, persons with mental retardation, and the elderly.

The Department of Human Resources prepares an annual report to inform the Secretary of the U.S. Department of Health and Human Services and the people of Georgia of the intended use of the funds the State is to receive under provision of the Act. This annual report is called the Report on the Intended Use of Title XX Social Services Block Grant Funds. The following description of services to persons with mental retardation (I) and the statements on limitations/assurances on the use of the grants (II) are taken from the Report on Intended Use.

I. SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Services for persons with developmental disabilities are services or activities to maximize the potential of persons with disabilities, help alleviate the effects of disabilities, and to enable persons served to live in the least restrictive environment possible. Component services or activities may include personal and family counseling, respite care, family support, recreation, transportation aid to assist with independent functioning in the community and training in mobility, communication skills, the use of special aides and appliances and self-sufficiency skills. Residential and medical services are not included in the array of SSBG services for persons with developmental disabilities in Georgia.

II. LIMITATION/ASSURANCES ON USE OF GRANTS

The Georgia Department of Human Resources gives assurance that Title XX Social Services Block Grant funds will **NOT** be used:

- 1) for the purchase or improvement of land, or the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility, or
- 2) to provide cash payments for costs of subsistence or to provide room and board (other than cost of subsistence during rehabilitation, room and board provided for a short term as an integral but subordinate part of a social service, or temporary emergency shelter provided as a protective service); or
- 3) for payment of the wages of any individual as a social service (other than payment of wages of welfare recipients employed in the provision of day care services); or
- 4) for the provision of medical care; or
- 5) for social services provided in and by employees of any hospital, skilled nursing facility, or prison, or to any individual living in such institution. The only exceptions to this limitation are services to an alcoholic or drug dependent individual or rehabilitation services; or
- 6) for the provision of any educational service which the state makes generally available to its residents without cost and without regard to their income; or

- 7) to provide child care services unless such services meet applicable standards of State and local law; or
- 8) for the provision of cash payments as a service.

III. APPLICATION FOR SERVICE

Each individual or family unit shall have the right to apply for Social Services Block Grant Services without delays in the application process. Application for services may be made by the applicant or by a relative, friend, neighbor or legal guardian acting responsibly on behalf of the person needing the service. The application should be made to Regional Office's designated point of entry.

IV. ELIGIBILITY

All recipients of Social Services Block Grant (SSBG) funded services must be physically located in the State of Georgia.

- **Non-School Aged Adults** - SSBG funded services may be provided to non-school aged adults with a documented programmatic need and a current diagnosis of mental retardation/developmental disability.
- **School Aged Individuals** - School-aged individuals may be provided non-education-related services with a documented programmatic need and a current diagnosis of mental retardation/developmental disability.
- **Pre School Aged Individuals** - SSBG funded services may be provided to pre-school aged individuals with a documented programmatic need and a current diagnosis of mental retardation/developmental disability.

V. BEGINNING THE SERVICES

Once eligibility is determined, the service must be provided with reasonable promptness. Reasonable promptness is defined as within fifteen (15) calendar days. If the service is temporarily unavailable, the individual should be placed on a Planning List.

VI. PLANNING LIST (Waiting Lists)

Planning Lists will be maintained in accordance with Division Policy.

VII. SERVICES TO PERSONS RESIDING IN INSTITUTIONS

In most instances, services to persons residing in institutions are the responsibility of staff of the facility. Accordingly, Social Services Block Grant funds may not be used for the provision of social services that are the inherent responsibility of the institution. Those facilities which are Intermediate Care Facilities or Skilled Nursing Facilities and which receive funding under Title XVIII (Medicare) and/or Title XIX (Medicaid) are required either to provide social services or arrange for them with qualified outside resources. In these facilities and in any other where an investigation indicates that social services are an inherent responsibility of the institution, Social Service Block Grant Services to eligible persons are limited to assisting an

individual and/or family to seek admission to the institution, and/or supporting or augmenting the discharge plan of the facility for the individual. If social services are not an inherent responsibility of the institution, Social Services Block Grant services may be delivered to eligible persons.

IX. DOCUMENTATION OF SERVICE PROVISION

- Contractors are responsible for the documentation of service delivery in compliance with the terms of the provider contract.
- Reporting of Services - Services delivered must be reported in compliance with the terms of the provider contract.

X. NOTIFICATION OF THE CONSUMER OF SERVICE TERMINATION

- A.** Notification to the consumer must follow a decision by the agency to terminate services. Form 5536, included below, shall be used.

(Note: Even though space is available on this Form, the Form should not be used to notify a consumer of eligibility for service. Form 5536 should only be used to notify a client of termination of service.)

In cases of termination of service, services must continue through the ten- (10) day notice period and the notification process must be (1) adequate and (2) timely.

1. **Adequate notice** is defined as a written communication (Form 5536) that includes a statement of the specific action the agency intends to take, the reason for the intended action, explanation of the individual's right to request a fair hearing and the circumstances under which services are continued if a hearing is requested.
2. **Timely notice** is defined as the notice being mailed or hand delivered to the consumer at least ten (10) calendar days before the date the action is to become effective. No action shall be taken to terminate services during the ten- (10) day notice period. If the consumer does not request a hearing before the expiration of the tenth (10th) day, the services shall be terminated after the tenth day has passed.

- B. Waiver of Timely Notice** - The following are situations in which timely notice (10 calendar days) is not required but adequate (written) notice shall be given not later than the effective date of action:

1. The agency received a clearly written statement signed by consumer that he/she no longer wishes to receive services.
2. The whereabouts of the consumer are unknown and mail to him/her has been returned by the Post Office indicating no forwarding address. Returned mail should be filed in the service record.

3. The consumer moves to another State and the move is documented by the agency.
4. The consumer was informed in writing, at the time the services began, that the service would automatically terminate at the end of a specified period.
5. A change in either Federal/State law or policy requires automatic service adjustments for categories of service recipients.

XI. CONSUMER GRIEVANCES

Providers shall make a grievance and appeal process available to aggrieved consumers in compliance with Federal regulations governing the Social Service Block Grant, and policy and procedure promulgated by the Division and the State of Georgia.

**Georgia Department of Human Resources
NOTIFICATION FORM FOR TITLE XX SOCIAL SERVICES**

Agency Name: _____
DATE: _____
CASE ID: _____

Your application for social services has been given careful consideration. The following determination has been made

- I. A. INITIAL DETERMINATION: You have been determined eligible/ ineligible for the following Title xxx Social Services:

Reason (if ineligible)

- B. REDETERMINATION: You have been determined eligible/ineligible for the following Title xx Social Services effective _____.
The following Title xx Social Services have been/will be terminated:

Reason if (ineligible)

- I. You are still eligible for these Title xx Social Services:

However, if the following services will be:

- A. Reduced effective:
Reason:

- B. Terminated effective:
Reason: _____

III. LIMITED ELIGIBILITY

You have been determined eligible for the following Title xx services _____

You have been determined ineligible for the following Title xx services _____

If for any reason you disagree with this decision you may request a hearing. You may request a hearing orally or in contacting this agency within 10 days of the date given at the top of this form. This agency will be glad to furnish the form (s); help you in filing your appeal and in any way possible to prepare for the hearing.

The hearing will be held in your county by a hearing officer. You may be represented at the hearing by legal counsel or other spokesperson. If you would like an attorney, contact this agency which can provide information about legal services that may be available in your community at no cost to you.

Form 5536 (Rev. 05-00)

Signature of Agency Representative

**Georgia Department of Human Resources
Title XX Administration**

PART VI

General Policies and Procedures

Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers

Fiscal Year 2012

(Policies 02-601, 02-704, 02-803, and 01-107 Updated and
23-100, 23-101, 23-102 Added
For October 1, 2011 Implementation)



**Georgia Department of Behavioral Health &
Developmental Disabilities**

October 1, 2011

DBHDD

Some of the policies provided in this section have not yet been updated to reflect our name/structure change. Incorporation of the DBHDD name/structure and policy number for the following policies will continue as policies are reviewed and updated.

General Policies and Procedures

▶ = Policies added or changed for October 1, 2011 update

PART VI - General Policies and Procedures

- **Policy:** Accreditation and Standards Compliance Requirements for Providers of Behavioral Health Services
- **Policy:** Accreditation and Standards Compliance Requirements for Providers of Developmental Disabilities Services
- **Policy:** Bowel Management for Individuals Diagnosed with Developmental Disabilities
- ▶ **Policy: Community Integration in Residential Service Options and Supervised Apartment Living Arrangements for Individuals with Developmental Disabilities**
- **Policy:** Complaints and Grievances Regarding Community Services
- **Policy:** Criminal History Records Check for Contractors
- **Policy:** Criteria for Admission to DBHDD Hospitals for Persons with Mental Illness
- **Policy:** Denial and Appeal Process for Psychiatric Residential Treatment Facility (PRTF) Level of Care for Children and Adolescents with a Mental Health Diagnosis
- **Policy:** Emergency Preparedness and Disaster Response – Basic Requirements for DBHDD Hospitals and Community Providers
- ▶ **Policy: Process for Enrolling, Matching and Monitoring Host Homes/Life-Sharing Sites for DBHDD Developmental Disabilities Community Service Providers**
- **Policy:** External Entities Audit Standards
- **Legal Summary:** Georgia Open Meetings Act and Open Records Act
- **Policy:** Guiding Principles Regarding Co-Occurring Disorders (Mental Health and Addictive Diseases)
- **Policy:** Guiding Principles Regarding Serving those with Co-Occurring Behavioral Health Disorders and Developmental Disabilities
- ▶ **Policy: Health Risk Screening Tool (HRST)**
- **Policy:** Human Rights Council for Developmental Disabilities Services
- **Policy:** Independent Peer Review for Addictive Diseases Providers
- **Policy:** Informed Consent for Psychotropic Medication Treatment of Child and Adolescent Populations
- **Policy:** Language Access for Limited English Proficient (LEP) and Sensory Impaired (SI) Customers
- **Policy:** Management of Personal Needs Spending Accounts for Consumers (Applicable to Behavioral Health Services Only)
- **Policy:** Management/Supervision/Safeguarding of Possessions, Valuables, Personal Funds and Day- To-Day Living Expenses in Developmental Disabilities Residential Services
- **Policy:** Medical Evaluation Guidelines & Exclusion Criteria for Admission to State Hospitals and Crisis Stabilization Programs
- ▶ **Policy: Payment by Individuals for Community Behavioral Health Services**
- **Policy:** Planning List for Developmental Disabilities Services for Individuals Living in the Community
- **Policy:** Prevention of Choking for Individuals with Developmental Disabilities
- **Policy:** Professional Licensing Requirements and the Reporting of Practice Act Violations
- **Policy:** Protection of Human Subjects

- ▶ **Policy: Confidentiality and HIPAA**
- ▶ **Policy: Notice of Privacy Practices**
- ▶ **Policy: Reporting and Notification of Breaches**
 - Protocol 3.200-01 - Individual Rights Regarding Protected Health Information
 - Protocol 3.200-02 - Privacy Rule Administration - Complaints
 - Protocol 3.200-06 - Sanctions
 - Protocol 3.200-08 - Business Associates
- **Policy:** Recruitment and Application to become a Provider of Developmental Disabilities Services
- **Policy:** Regions of Responsibility Determination
- **Policy:** Reporting and Investigation of Individual Deaths and Critical Incidents for Community Services
 - Attachment A - Definitions
 - Attachment B - Death Report Form
 - Attachment C - Critical Incident Report Form (CIR)
 - Attachment c.1 - Critical Incident Report Form (CIR) (Supplemental)
 - Attachment D - Reporting to Other Agencies
 - Attachment E - Investigative Report Format
 - Attachment e.1 - Investigative Report
 - Attachment F - Request for Extension
 - Attachment G - Corrective Action Plan
- **Policy:** Requirement to Ensure that Families Complete the Application Process for Medicaid and PeachCare for Kids
- **Policy:** Request for Waivers of the Standards for DBHDD Services
- **Policy:** State Funded Respite for Individuals with Developmental Disabilities
- **Policy:** Verification of Lawful Presence in United States for Individuals Seeking MHDDAD Services

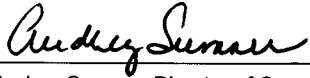


Chapter: Behavioral Health Community Services
Subject: Accreditation and Standards Compliance Requirements for Providers of Behavioral Health Services

Applicability:
All Providers of Behavioral Health Services as defined in this policy.

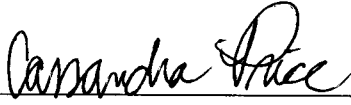
Effective Date: July 1, 2010
Scheduled Review Date: July 2011

References:
Official Code of Georgia Annotated 37-2, 37-3, 37-4 and 37-7 37-2-11(a); 37-6-7(a,b) and 37-7-2(a)

Approved:
 6/10/10

Attachments:
None

Audrey Sumner, Director of Community Services Date
Division of Mental Health

 6/10/10
Cassandra Price, Executive Director Date
Division of Addictive Diseases

 6/14/10
Frank E. Shelp, M.D., M.P.H., Commissioner Date

Accreditation and Standards Compliance Requirements for Providers of Behavioral Health Services

I. POLICY

The Department of Behavioral Health and Developmental Disabilities (DBHDD) ensures the safety of consumers and staff and promotes high quality Behavioral Health (BH) services by establishing requirements related to Accreditation and Standards Compliance of providers. DBHDD requires that all BH providers meet standards which ensure that the organization has the administrative capacity to do business with DBHDD and the structure to provide necessary services and supports for individuals with mental illness and addictive diseases. Providers of Behavioral Health Services must meet DBHDD Standards for All Providers and must be accredited.

Any organization who has made application to DBHDD to become a BH provider prior to February 1, 2010 and is approved based upon the content of that application must be accredited within 18 months after the date the organization was approved by DBHDD Provider Network Management.

Any organization making application to become a BH provider after February 1, 2010 must be accredited at the time of application.

II. DEFINITIONS

Accreditation - A review process conducted by a nationally recognized and approved

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accrediting body utilizing their professionally recognized standards.

Approved Accrediting Bodies – The national accrediting organizations approved and recognized by DBHDD for BH services are the following:

- Commission on Accreditation of Rehabilitation Facilities (CARF)
- The Joint Commission (TJC)
- The Council on Quality and Leadership (CQL)
- Council on Accreditation of Services for Families and Children (COA)

Behavioral Health (BH) – Refers to both mental health and addictive diseases

Effective Date – The begin date of a contractual agreement with DBHDD to provide services

License – All applicable licenses and permits

Provider – For the purposes of this policy, the term provider includes organizations that provide consumer services that are financially supported in whole or in part by funds authorized through DBHDD.

Standards Compliance Review - A review process conducted by DBHDD of a provider; this review determines whether the provider is meeting the Standards Required for All Providers.

Standards for All Providers - Requirements of DBHDD that are applicable to all providers regardless of the type of services provided. These Standards are contained in the Provider Manual, which is updated and released annually. Accreditation does not relieve the provider of the obligation to comply with these Standards.

III. PROCEDURES

A. Requirements for Accreditation for BH Providers

Per the Medicaid State Plan Amendment for Medicaid BH programs, accreditation is required for BH providers who participate in Medicaid BH programs. DBHDD also requires other BH providers to be accredited whether or not they are participating in Medicaid BH programs.

The application process serves as the initial review of the applicant’s compliance with DBHDD requirements. The provider must submit proof of accreditation including the most recent survey report in the application to DBHDD.

Accreditation is granted by the accrediting body for one or more service types. The provider is responsible for ensuring that all service types that the organization provides are properly accredited. The provider is expected to obtain accreditation for the specific

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service type that the provider is offering to consumers. For a new service type to be added, the provider must:

- Apply to DBHDD Provider Network Management (PNM) to add a service, AND
- Be approved by PNM for that service, AND
- Be in compliance with their accrediting agency requirements for adding the new service type.

The provider must be accredited for the new service type at the time of their next accreditation survey. If the provider’s next accreditation survey is not due for longer than 12 months from the time that the additional type of service is approved by PNM, DBHDD may require:

- a special review of the new service by Provider Compliance Unit OR
- a special review of the new type of service by the accrediting body.

B. Requests for Waivers

There may be circumstances when a provider has a need to request a waiver of the time frames specified in this policy.

In order to request a waiver of the time frames specified in this policy, the provider submits a letter to the Regional Office. The letter includes:

- The rationale for the request, AND
- A specified period of time not to exceed 90 days, during which time the provider will seek and successfully achieve accreditation, AND
- Supporting documentation; such as a confirmation letter from the accrediting agency.

In lieu of granting the requested waiver, DBHDD may elect to take action against the provider including termination.

C. Maintenance of Accreditation

It is expected that all providers maintain appropriate accreditation throughout the Contract/Provider Agreement/LOA period. If an accredited provider loses accreditation, fails to reapply for accreditation or comes under an accreditation-related corrective action plan, that provider must notify DBHDD within 30 days; this notification is done in writing via a letter sent to:

- DBHDD Regional Office,
- DBHDD PNM, Suite 23-247, 2 Peachtree Street, Atlanta GA 30303, AND
- DBHDD Contracts Section, Suite 23-173, 2 Peachtree Street, Atlanta GA 30303

In addition to compliance notification outlined below, copies of the confirmation of the agency’s renewal of accreditation must also be sent to the same three DBHDD offices.

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Providers must immediately notify the Regional Office when corrective action related to accreditation is required; the provider must submit a copy of the accrediting agency's correspondence regarding the corrective action. The provider under corrective action must successfully correct their deficiencies and provide a copy of the corrective action plan to the Regional Office at the time the corrective action plan is submitted to the accrediting agency. A copy of response from the accrediting agency must be provided to the Regional Office immediately upon receipt of the response.

Failure to comply with this policy regarding accreditation may result in one or more of the following adverse action(s):

- The Provider may be recommended for Prepayment Review as managed by the Department of Community Health (DCH);
- Suspension of referrals through the Georgia Crisis and Access Line;
- Suspension of new consumers being allowed to access services through the provider agency;
- Suspension, Probation, or Termination of the Provider Agreement, Letter of Agreement, or Contract;
- Recommendation to DCH of Suspension or Termination of the provider number for the services in accordance with Part I, Policies and Procedures for Medicaid/PeachCare for Kids Manual, Chapter 400; AND/OR
- Any other recommended course of action DBHDD may determine is appropriate.

D. Emergency Circumstances

In situations where emergency circumstances result in urgent need to approve a non-accredited provider to provide BH services, the DBHDD Commissioner may waive some or all of the requirements in this policy regarding accreditation.



Chapter: Developmental Disabilities Community Services
Subject: Accreditation and Standards Compliance Requirements for Providers of Developmental Disabilities Services

Applicability: All DD providers as defined in this policy.

Effective Date: October 1, 2010
Scheduled Review Date: October 2011

References: Official Code of Georgia Annotated 37-4-3(a)

Approved: Beverly D. Rollins, M.P.A., Executive Director
Division of Developmental Disabilities

Attachments: None

6/23/10
Date

Frank E. Shelp, M.D., M.P.H., Commissioner

6/28/10
Date

Accreditation and Standards Compliance Requirements for Providers of Developmental Disabilities Services

I. POLICY

The Department of Behavioral Health and Developmental Disabilities (DBHDD) promotes high quality Developmental Disabilities (DD) services by establishing requirements related to Accreditation and Standards Compliance for providers of Developmental Disabilities Services to ensure the rights, health and safety of individuals served in the community. DBHDD requires that all providers meet Standards Compliance requirements regardless of accreditation status to ensure that the organization has the administrative capacity to do business with DBHDD and the structure to provide necessary services and supports for individuals with Developmental Disabilities.

Providers authorized by DBHDD to receive an amount less than \$250,000 per year for services must complete the Standards Compliance process conducted by the Provider Compliance Unit for DBHDD.

Providers authorized by DHBDD to receive an amount of \$250,000 or more per year for services must be accredited by an approved accrediting body.

There are some DD services that are not required to be accredited or to complete Standards Compliance. These include:

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- Support Coordination
- Specialized Services which include Specialized Medical Equipment, Specialized Medical Supplies, Environmental Accessibility Adaptation, and Vehicle Adaptation when one or more of these specialized services are the only service(s) being delivered by the organization.

II. DEFINITIONS

Accreditation - A review process conducted by a nationally recognized and approved accrediting body utilizing their professionally recognized standards. For the purposes of this policy, an organization must be accredited for the specific services and sites in Georgia.

Approved Accrediting Bodies – The national accrediting organizations approved and recognized by DBHDD are the following:

- Commission on Accreditation of Rehabilitation Facilities (CARF)
- The Joint Commission (TJC)
- The Council on Quality and Leadership (CQL)
- Council on Accreditation of Services for Families and Children (COA)
- Accreditation Council for Healthcare (ACHC) - for DD Nursing Services Only

License - All applicable licenses and permits to operate.

Provider – For the purposes of this policy, the term provider includes organizations that provide services that are financially supported in whole or in part by funds authorized through DBHDD.

Standards Compliance - The provider is in compliance with all requirements set forth in the *DBHDD Standards For All Providers*.

Standards Compliance Review - A review process conducted by the Provider Compliance Unit of DBHDD of a provider to determine standards compliance.

Standards For All Providers –Standards or requirements of DBHDD that are applicable to all providers regardless of the type of services provided. The standards are contained in the DBHDD Provider Manual, which is updated annually. Accreditation does not relieve the provider of the obligation to comply with these standards compliance requirements.

Moratorium – The period of time during which a provider is not permitted to do any of the following:

- admit any additional individuals;
- add additional services; or
- add additional locations/sites.

III. PROCEDURES

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A. STANDARDS COMPLIANCE FOR DD PROVIDERS AUTHORIZED TO RECEIVE LESS THAN \$250,000

1. Standards Compliance review conducted by DBHDD

The Provider Compliance Unit of DBHDD conducts reviews regarding Standards Compliance in accordance with the following processes:

- a) The Provider Compliance Unit contacts the organization within six months following approval to be a provider to schedule an initial review regarding Standards Compliance. If the organization is not serving any individuals, the Provider Compliance Unit postpones conducting the review until they are notified that the organization is serving one or more individuals.
- b) The Regional Coordinator, the Division of DD, as well as various other state office staff, are notified when the review is scheduled and provided the results of that review.
- c) The Standards Compliance review is conducted as follows:
 - i. An initial letter is sent to the provider informing them of the dates, time, and what information/documents will be reviewed.
 - ii. The report regarding the review is emailed to the provider within twenty-one (21) calendar days.
 - iii. If Standards are identified during the review as not met, within thirty (30) calendar days from the date of the emailed report, the provider must submit corrective action(s) plan (CAP) with supporting documents. The CAP is submitted via email and in hard copy. The CAP is reviewed by Provider Compliance Unit and feedback is given to the Provider so that the Provider can implement the proper changes needed to meet the Standards.
 - iv. If any of the "critical" function areas of the Standards are identified in the report as not being met, a moratorium is put in place.
 - v. Within fortyfive (45) calendar days of CAP submission, a visit is made by the Provider Compliance Unit to review the corrective action(s) taken by the provider.
- d) If the provider is found to be in compliance with the DBHDD Standards For All Providers, the organization receives a Certificate of Standards Compliance for a period not to exceed two years; after two years a new Standards Compliance review is required. DD providers must maintain a current certificate of compliance to provide services.
- e) If a provider does not meet the *DBHDD Standards For All Providers* at the end of the corrective action period, the following action may take place:

The provider may request a waiver of standards compliance to DBHDD through the Regional Coordinator requesting additional time to make the corrections .The Regional Coordinator may make the recommendation of a waiver of Standards Compliance for a period from one (1) day up to sixty (60) calendar days, subject to

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the approval of the Executive Director of the Division of Developmental Disabilities, during which time the provider has a final opportunity to correct remaining issue(s) that are out of compliance. At the end of the approved waiver period, the Provider Compliance Unit will review those issues that were out of compliance. The provider must be found fully in compliance at the completion of the waiver period or DBHDD, through the Regional Coordinator, terminates the DBHDD relationship with the provider.

2. Additional expectations related to demonstrating Standards Compliance:

- a) Standards Compliance must be maintained for all approved services.
- b) Providers must maintain standards compliance for a period of six months for the services they are initially authorized to provide, and be in business a minimum of 12 months before additional services may be added.
- c) If new services are approved, they will be included in the subsequent review of Standards Compliance.
- d) Providers terminated due to failure to comply with the review regarding Standards Compliance may not make application to become a provider for a period of one (1) year.
- e) At any time, the Department of Behavioral Health and Developmental Disabilities may request a Special Review for Standards Compliance to assess a provider's compliance with the *DBHDD Standards For All Providers*.
- f) If a provider (a) does not request a waiver; or (b) is denied a waiver; or (c) fails to be in compliance with the *DBHDD Standards For All Providers* at the end of an approved waiver period, DBHDD, through the Regional Coordinator, terminates the DBHDD relationship with the provider and may recommend loss of the Medicaid provider number.

B. ACCREDITATION FOR DD PROVIDERS WITH ANNUAL REVENUE PROJECTED TO BE GREATER THAN \$250,000

1. General expectations regarding Accreditation:

- a) It is the responsibility of the Provider to select an accrediting agency from the list approved by DBHDD and submit an Application for accreditation. This must occur within 30 days after the Provider has crossed the threshold of contracting or receiving funding through authorization from DBHDD in an amount more than \$250,000 per year.
- b) The Provider is responsible for paying accreditation fees and providing to Regional Coordinator a copy of the Accrediting body's letter confirming the date of the survey.

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- c) The Provider must be accredited within 12 months of application for accreditation.
- d) The provider must submit to Regional Coordinator results of accrediting body visit within seven (7) working days of receipt.
- e) The provider is responsible for ensuring that all services that the organization provides are properly accredited. The organization is expected to obtain accreditation for the specific services offered by the provider.
- f) If a new category of service is added, the provider must notify DBHDD and the accrediting agency and must be accredited for the new category of service as of the time of their next accreditation survey.
- g) If the provider's next accreditation review is not due for longer than 12 months from the time that the additional services are initiated by the provider, DBHDD may require:
 - a special review of the new services by Provider Compliance Unit OR
 - that the provider verify compliance with their accrediting body's requirements related to accrediting new services.

2. Maintenance of Accreditation and Requests for Waiver:

If an accredited provider loses accreditation, fails to reapply for accreditation, or come under a corrective action requirement with the Accrediting body, the provider must notify DBHDD within 7 days; this notification is done in writing via a letter sent to:

- DBHDD Regional Office
- DBHDD, Division of DD Provider Development Section, Suite 22-427, 2 Peachtree Street, Atlanta, GA 30303
- DBHDD Provider Network Management, Suite 23-247, 2 Peachtree Street, Atlanta GA 30303, AND
- DBHDD Contracts Section, Suite 23-173,.2 Peachtree Street, Atlanta GA 30303

Actions related to each of the following situations:

- a) Loss of accreditation:
Loss of accreditation results in termination of DBHDD relationship with the provider.
- b) Failure to reapply:
Failure to reapply will result in actions being taken against the provider. The provider will be given thirty (30) days during which they must make application to the accrediting agency and must submit written proof of application and payment to the regional office prior to the end of the thirty (30) days. Failure to meet this time frame results in termination of DBHDD relationship with the provider.

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Chapter: Developmental Disabilities Community Services
Subject: Bowel Management for Individuals Diagnosed with Developmental Disabilities

Applicability:
Developmental Disabilities Residential Services Providers

References:
none

Attachments:
none

Original Effective Date: July 1, 2010
Scheduled Review Date: July 2011
Approved:

Beverly D. Rollins
Beverly D. Rollins, M.P.A., Executive Director,
Division of Developmental Disabilities

6/28/10
Date

Frank E. Shelp
Frank E. Shelp, M.D., M.P.H., Commissioner

6/28/10
Date

BOWEL MANAGEMENT FOR INDIVIDUALS DIAGNOSED WITH DEVELOPMENTAL DISABILITIES

PURPOSE

The purpose of this policy is to implement safeguards to ensure the health and safety of persons with developmental disabilities receiving services under the auspices of the Division of Developmental Disabilities (DD), Department of Behavioral Health and Developmental Disabilities (DBHDD). Bowel management is important for individuals determined to be at risk for developing constipation, impaction, and/or bowel obstruction. Poor diet, inadequate fluid intake, environmental factors, prolonged inactivity, use of certain prescription medications, and diseases affecting the bowel are just some of the contributing factors that place individuals at risk for medical complications and possibly death. Developing and implementing a bowel management program which assesses and monitors individuals' needs is vital to promoting and ensuring the individuals' physical health and safety.

POLICY STATEMENT

It is a policy of the Department of Behavioral Health and Developmental Disabilities (DBHDD) that providers of developmental disabilities residential services ensure the health and safety of individuals receiving services under the auspices of the Division of Developmental Disabilities (DD). Trained residential staff will identify, in a timely manner, those individuals who are at risk for developing bowel complications secondary to their diagnoses. It is the goal of DBHDD to ensure that every provider of DD residential services has established protocols for monitoring bowel function and responding to changes as needed.

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DEFINITIONS

- **Bowel obstruction:** For the purposes of this policy, a bowel obstruction is the partial or full blockage in either the small intestine or large intestine that inhibits stool from passing.
- **Constipation:** For the purposes of this policy, constipation is an acute or chronic condition in which bowel movements consist of unusually hard, dry stools which are painful or difficult to pass. It often involves vigorous straining and/or a person sensing they have not completely emptied their bowels. Although bowel habits vary, an adult who has not had a bowel movement in three days or a child who has not had a bowel movement in four days is considered constipated.
- **Normal bowel function:** For the purposes of this policy, a normal bowel function is characterized by a minimum of three stools per week and no more than three per day.
- **Licensed Healthcare Professional:** For the purposes of this policy, a licensed health care professional refers to either a Registered Nurse (RN) or Licensed Practical Nurse (LPN).
- **Provider:** For the purposes of this policy, the term provider includes organizations that provide developmental disabilities residential services that are financially supported in whole or in part by funds authorized through DBHDD. The words organization or agency are synonymous with the term provider.

PROCEDURES

1. Causes of Constipation, Impaction, and Bowel Obstruction

It is the expectation that the residential provider provide training to residential staff in initial orientation and at least annually thereafter regarding the causes of constipation, impaction, and bowel obstruction. These causes include but are not limited to the following:

Diet:

- Insufficient fiber or bulk in diet
- Inadequate fluid intake

Altered bowel habits:

- Repeatedly ignoring defecation reflex
- Excessive use of laxatives and/or enemas

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Prolonged immobility and/or inadequate exercise:

- Spinal cord injury
- Bed rest

Medications:

- Opioids
- Anticholinergic preparations
- Antipsychotics
- Antidepressants
- Calcium and aluminum-based antacids
- Diuretics
- Vitamin supplements (e.g., iron and calcium)
- Sleeping medications
- General anesthesia

Bowel disorders:

- Irritable colon, diverticulitis or tumor

Neuromuscular disorders:

- Neurological lesions
- Cerebral palsy
- Paraplegia
- Spinal cord injury or compression
- Cerebrovascular accident with slight paralysis of motor function
- Weak abdominal muscles

Depression

Environmental factors:

- Strange or hurried environment
- Excess heat leading to dehydration
- Change in bathroom habits (e.g., use of a bedpan)
- Lack of privacy

Other Factors:

- Chronic illness
- Anorexia
- Immobility

2. Symptoms of Constipation, Impaction, and Bowel Obstruction

Staff are also educated about the signs and symptoms of constipation, impaction, and bowel obstruction.

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Below is a list of indicators for bowel problems:

- Hard, small dry stools
- Stomach pain or discomfort
- A bowel pattern that differs from the individual's normal pattern
- Hemorrhoids
- Spending a lot of time sitting on the toilet
- Straining and/or grunting on the toilet
- Bloated stomach that feels hard to the touch
- Feeling of rectal fullness
- Indigestion
- Increased gas, either flatus or burping
- Nausea
- Seizure activity
- Other – back pain, headache, decreased appetite

Staff must immediately report any noted changes to the individual's nurse or physician if the individual appears gravely ill, produces vomit that smells like a bowel movement, vomits what appears like coffee grounds or dark jelly, has a very hard, protruding abdomen, or reports severe abdominal pain.

3. Assessment of Constipation, Impaction, and/or Bowel Obstruction

The Health Risk Screening Tool (HRST) is initiated upon arrival to a residential setting and is continually updated based on observations of significant changes in the individual's health status.

For individuals determined to be at risk for developing constipation and/or bowel obstruction the HRST assessment is updated and the licensed healthcare professional recommends a physical examination that includes, but is not limited to: a thorough history of the individual's bowel pattern, dietary intake, laxative and/or suppository dependency, and activity level. Information gathered is documented in the individual's medical record.

If risk factors or symptoms of constipation and/or bowel obstruction have been identified by any staff member, the staff member making the observation is responsible for documenting the observation in the bowel tracking record and immediately notifying the designated licensed healthcare professional. Collateral reports made to staff by family members and other contact sources (e.g., service providers) are also reported promptly. Upon notification of risk factors or signs/symptoms of constipation and/or bowel obstruction, the licensed healthcare professional consults with the individual's primary physician for treatment options. Treatment interventions are documented in the individuals' medical record.

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4. Bowel Tracking & Management

Providers of residential services are required to have established protocol for monitoring bowel function for individuals with a history of constipation, impaction, and/or bowel obstruction.

An accurate recording of each individual's bowel status must be maintained during each shift. This also entails communicating with family members and service providers (e.g., day programs) to ensure accuracy. Communication is done in a manner that is sensitive to the rights and dignity of the person served.

Bowel movements are tracked by staff and noted on the bowel tracking record during each shift. Each day, agency staff should ascertain whether individuals have had a bowel movement. This information must be documented in the individual's bowel tracking record in order to learn what the individual's normal routine is to monitor for the onset of problems. Providers of residential services are responsible for developing their own bowel tracking record; at a minimum, this record must be designed to document the following information:

- Number of bowel movements per day
- List of the individual's medications that increase the risk of constipation, impaction, and/or bowel obstruction
- Abdominal pain reported by the individual
- Consistency of bowel movement
- Treatment intervention(s)

Familiarity with the individuals' routines and adeptness at detecting non-verbal cues of pain or discomfort are especially important for staff assisting those who may have difficulty communicating their needs.

Trained staff members who assist with the self-administration of medications are responsible for the daily review of the bowel tracking record to determine if the criteria are met for intervention as ordered by the person's primary physician.

The agency Developmental Disabilities Professional (DDP) trained in assessing the effectiveness of intervention or a licensed healthcare professional checks the bowel tracking record a minimum of once per week to assess the effectiveness of the intervention and health status of the person. The DDP or licensed healthcare professional consults with the individual's primary physician or other medical staff providing coverage if changes in the effectiveness of the individual's treatment intervention(s) and/or the individual's health status are noted.



Chapter: Developmental Disabilities Community Services
Subject: Community Integration in Residential Service Options and Supervised Apartment Living Arrangements for Individuals with Developmental Disabilities

Applicability: Developmental Disabilities
Community Providers, State Office, Regional Office,
Support Coordination Agencies

Original Effective Date: July 1, 2010
Revised Effective Date: October 1, 2011
Scheduled Review Date: October 2013

References:

none

Approved:

Attachments:

none

Beverly D. Rollins 8/19/11

Beverly D. Rollins, M.P.A., Executive Director Date
Division of Developmental Disabilities

J. Bryce McLaughlin 8/21/11

J. Bryce McLaughlin, M.D., Date
Assistant Commissioner of Programs

Frank E. Shelp 8/22/11

Frank E. Shelp, M.D., M.P.H., Commissioner Date

POLICY

Community integration in residential service options and supervised apartment living arrangement for individuals with Developmental Disabilities is defined by the Department of Behavioral Health and Developmental Disabilities (DBHDD) to reflect federal and state standards and to promote community integration.

DEFINITIONS

Residential Service Options includes Personal Care Homes (PCH), Community Living Arrangements (CLA) and Host Homes.

Most Integrated Setting- A setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.

Personal Care Home is a licensed residence that provides or arranges for the provision of housing, food service, and one or more personal services for two or more adults with developmental disabilities, who are not related to the owner or administrator by blood or marriage. (Personal services include but are not limited to individual assistance with and supervision of self-administered medications and essential activities or daily living such as eating, bathing, grooming, dressing, and toileting.)

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Community Living Arrangement is a licensed residence, whether operated for profit or not, that undertakes through its ownership or management to provide or arrange for the provision of daily personal services, supports, care, or treatment for two or more adults with developmental disabilities, who are not related to the owner or administrator by blood or marriage and whose residential services are financially supported, in whole or in part, by funds designated through the DBHDD.

Host Home is the (unlicensed) private home of an individual or a family, whether owned or leased, in which residential supports are provided to one or two adults with developmental disabilities. The home owner or lessee must not be an employee of the same DBHDD approved provider agency which provides the host/life sharing home services. Individuals should not be related to the occupant owner or lessee by blood or marriage. The occupant owner or lessee must not be the guardian of any person served on their property nor the agent in such person’s advance directive for health care.

Supervised Living Arrangement provides community living support services to individuals with developmental disabilities in which the individual can experience living in community with supervision. It is a living arrangement where individuals live in an apartment unit. Individuals are involved in activities that will lead them to greater independence and more control of their lives.

STANDARDS FOR INTEGRATED SETTINGS

For the purposes of this policy, the following standards are set by DBHDD for integrated settings.

Residential Service Options and apartment living arrangements:

- Are integrated and inclusive environments within established residential neighborhoods,
- Are ordinarily considered to be a single family unit,
- Have personal space and privacy for persons supported,
- Are understood to be the “home” of the persons supported or served, **AND**
- Campus type settings that cluster group or host homes in the same community **are strictly prohibited** (e.g. establishing a Community Access Facility on a residential site (property)).

Integration into the larger natural community is evident, as evidenced by the following:

- Inclusion and community integration is supported and evident;
- Individuals have responsibilities in the community, such as employment, volunteer activities, church and civic membership and participation;
- The organization has community partnerships that demonstrate input and involvement by:

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- Advocates; and
- The person served;
- Families;
- Business and community representatives
- The organization coordinates with community organizations to develop and expand its array of services, support, care and treatment as a basis for:
 - Continuity in cooperative service delivery
 - Provider Networking
 - Referrals
 - Sub-contracts and
 - Joint planning efforts

CAPACITY

The Comprehensive Supports Waiver (COMP), by existing policy, does not allow residential facilities, such as Personal Care Homes and Community Living Arrangements to serve more than four (4) individuals in this residential setting. Exceptions require the approval of the DBHDD Regional Coordinator and are reviewed by the Division of Developmental Disabilities. All exceptions to the existing policy are based on justifications, such as assuring safety, privacy, community integration and participation.

There is no exception to the capacity limit of two (2) for Host Homes.

Supervised apartment living arrangements include:

- Scattered arrangements - Individuals and others with disabilities reside in apartments scattered/geographically dispersed throughout the community. Up to 49% of all individuals residing in apartments located in one building can be individuals with disabilities including individuals supervised by one agency.
- Cluster arrangements - Individuals and others with disabilities reside in apartments located in one building. Up to 49% of all individuals residing in apartments located in one building can be individuals with disabilities including individuals supervised by one agency.

The following standards are followed regarding supervised apartment living:

- The staff is excluded from any determination of the percentage documented above.
- Individuals renting/leasing in private residences must meet all standards for integrated settings.
- All homes/apartments must comply with all state and local zoning regulations.
- The Standards for Integrated Settings as specified in this policy pertain to supervised apartment living.



Chapter: Constituent Services and Complaints

Subject: COMPLAINTS AND GRIEVANCES REGARDING COMMUNITY SERVICES

Applicability:

Department of Behavioral Health & Developmental Disabilities State and Regional Offices, Service Providers, and State-Operated Community Services

Original Effective Date: July 1, 2002

Revision #2 Effective Date: June 1, 2011

Scheduled Review Date: June 1, 2013

Approved:

References:

Official Code of Georgia Annotated (O.C.G.A.) § 37-2-5.2(a)(9); § 37-2-11.2; § 30-5-1 et seq.

The procedures established by this policy shall not supplant the complaint procedures governing complaints alleging violation(s) of a patient's rights under the Rules and Regulations for Patient's Rights, Chapter 290-4-6 or a client's rights under the Rules and Regulations for Client's Rights, Chapter 290-4-9.

Consuelo L. Campbell 7/10/11
Date

Consuelo L. Campbell, Director

Office of External Affairs

Lavin Gartland 5/11/11
Date

Lavin Gartland,
Assistant Commissioner of Public Affairs

Frank E. Shelp 5/11/11
Date

Frank E. Shelp, M.D., M.P.H., Commissioner

Attachments:

None

COMPLAINTS AND GRIEVANCES REGARDING COMMUNITY SERVICES

POLICY

The Department of Behavioral Health and Developmental Disabilities (DBHDD) ensures that consumers, representatives, guardians, associations, agencies, contractors, sub-contractors, or those who seek to become involved with the delivery or receipt of services may file complaints and grievances. All complaints and grievances are accepted, reviewed, and investigated; in addition, a response is provided promptly to the individual(s) who submitted the complaint or grievance in accordance with the procedures in this policy. No person is retaliated against or denied services for making a complaint or grievance. Complaints involving allegation of abuse, neglect, or other reportable incidents are managed in accordance with DBHDD policies regarding reporting of incidents, and are not subject to the procedures included in this Complaints and Grievance policy.

DEFINITIONS

Complaint - Complaints are allegations made by consumers, representatives, guardians, associations, or agencies concerning the delivery or receipt of disability services which may violate rules and policy, or adversely affect a consumer's health and well-being.

Grievance – A grievance is a problem, perceived by the consumer to involve unfair treatment or violation of client/patient rights and privileges accorded by law, DBHDD policy, or established practice.

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Provider or Service Provider – For the purposes of this policy, the terms provider or service provider refer to organizations or individuals that provide consumer services that are financially supported in whole or in part by funds authorized through DBHDD.

Regional Office – A unit of DBHDD which serves as the entity for the administration of disability services in a region.

GENERAL PROCEDURES

- A. Complaints and grievances may be filed against the Department of Behavioral Health & Developmental Disabilities (DBHDD) State Office, Regional Offices, service providers having a contract or letter of agreement with the DBHDD, and state-operated community service providers. DBHDD recognizes that complaints are dealt with at all levels throughout the system.
- B. DBHDD State Office, Regional Offices, and providers each designate staff to receive, process, investigate, follow-up and report complaints and grievances.
- C. Within the DBHDD State Office, the Office of External Affairs (OEA) is the designated entity for the management of complaints and grievances, and follows a standard process for managing complaints and grievances. Complaints and grievances should be handled as close to the point where the problem is initiated. OEA is especially focused on complaints and grievances that occur frequently, that relate to high risk situations, and/or that may reflect some type of larger systemic problem.
- D. Complaints and grievances must:
- Be taken, whether received via telephone, in person, in writing, by referral, fax, email;
 - Be documented, either by the complainant or by the person taking the complaint or grievance;
 - Identify the provider, where applicable;
 - State the nature of the complaint or grievance;
 - Identify the person(s) involved (if possible), and/or the name and contact information of the person (if possible) filing the complaint or grievance; and
 - Be kept on file for 5 years.
- OEA can provide tools for documentation of this information upon request.
- E. Staff encourage individuals who have a complaint or grievance regarding a provider to initiate their complaint/grievance process according to the provider's internal policy.

A party may file an initial complaint or grievance to the DBHDD State Office. In such event, the following steps are taken:

1. The complaint/grievance is sent to DBHDD Office of External Affairs (OEA)

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Phone: 404-657-5964

Fax: 770-408-5439

Email: DBHDDconstituentservices@dhr.state.ga.us

2. OEA sends out an email to the applicable Regional Coordinator (RC), Regional Services Administrator (RSA), their Administrative Assistant; and other state staff when appropriate.
3. The complaint/grievance is assigned by the RC, RSA, or State Office staff to the appropriate staff member for follow-up and resolution in accordance with this policy;
4. Staff performs follow up and provides the RC, RSA, or State Office staff with a summary or their initial response to the complainant, which is then communicated to OEA within two (2) business days; and
5. Regional or State Office staff notifies OEA, within five (5) business days of receiving the complaint or grievance, of the finding(s) and the recommendation(s) for resolving the complaint or grievance.
6. The Regional, State Office, or OEA contacts the complainant to follow up with the findings and recommendation for resolving the complaint or grievance.

F. Reporting complaints and grievances to Legal Services

During conversation with the complainant, the Regional Office, when possible, determines if the matter under complaint or grievance is the subject of pending or current litigation. If the complaint or grievance may be or is the subject of current litigation, the Regional Office immediately contacts the DBHDD Office of Legal Services for guidance.

PROCEDURES SPECIFIC TO COMPLAINTS AND GRIEVANCES AGAINST SERVICE PROVIDERS

- A. Individuals being served or other stakeholders may register complaints or grievances with service providers.
- B. The Regional Office follows specific steps in addressing complaints and grievances made directly to the Regional Office regarding providers or services. Upon receipt of a complaint or grievance, the Regional Office first determines whether the complaint or grievance will be processed by the Regional Office or whether the complaint or grievance must be referred to another agency or entity. If the complaint or grievance involves legislators or media then the Regional Office notifies the Office of External Affairs (OEA).
 1. **Step 1 - Complaints requiring referral outside the Regional Office:** If the complaint or grievance will not be processed by the Regional Office, the Regional Office staff notifies the complainant, by telephone or in writing, within five (5) business days of receipt of the complaint or grievance, explaining the reason(s) the Regional Office cannot properly address the

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complaint or grievance. For example, complaints or grievances involving client rights should be first referred to the Client's Rights Subcommittee for the provider serving the complainant. Whenever possible, staff of the Regional Office provide sufficient information to the complainant for referral to the appropriate entity for relief.

2. **Step 2 - Complaints involving providers:** The Regional Office determines whether the complainant has filed the complaint or grievance first with the provider, and if any resolution was suggested by the provider.

- a. If the complainant has filed the complaint or grievance with the provider, but:
 - The complainant is dissatisfied with the provider's suggested resolution; **or**
 - The complainant does not want to or refuses to communicate with the provider; **or**
 - The provider has not taken any action regarding the complaint or grievance,

Then the Regional Office reviews and attempts to resolve the complaint or grievance. If complaint or grievance is of a client's rights nature, Regional Office requests that the provider immediately transmit to the Regional Office a copy of the provider's decision, together with a copy of the Client's Rights Subcommittee' recommendation and other documents utilized in the review. If the complaint relates to reportable incidents in accordance to DBHDD policies, then those policies are followed.

- b. If the complainant has not filed the complaint or grievance with the provider, the Regional Office:
 - Advises the person that it is generally best to address their complaint or grievance to the provider, unless circumstances warrant otherwise and offers the complainant the option of either addressing it themselves or having the Regional Office staff forward the complaint/grievance to the provider.
 - If necessary, records the complaint or grievance and forwards it to the provider.
 - Informs the complainant that the complaint or grievance has been forwarded to the provider and that the provider will contact the complainant to resolve the matter.
 - Follows up with the provider within five (5) business days of the referral to verify that the complaint or grievance has been or is in the process of being resolved. The Regional Office is not prohibited from reducing the time period for this follow up.

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- c. When following up on a referral of the complaint or grievance to the provider, the Regional Office may find that the following pertains:
- No process for resolution has commenced. The Regional Office then records the reason(s) why no process has begun and conducts a review of the complaint or grievance as described below; or
 - The provider has begun to review the complaint or grievance and is working toward a resolution, the Regional Office records that information and requests that the provider forward to the Regional Office notice of resolution of the complaint or grievance. The Regional Office does not need to take additional action unless the circumstances demand further inquiry or action.
3. **Step 3 - Regional Office Review/Investigation:** The Regional Office conducts and completes a review of the complaint or grievance within five (5) business days of receipt of the complaint or grievance or within five (5) business days of the date it is determined the provider has not begun a resolution process.
- a. Review elements: The Regional Office’s review/investigation provides, at a minimum, that:
- Informal resolution, where appropriate, is utilized;
 - Investigative methods deemed most suitable to determine the facts are utilized. Such methods may include, but are not limited to, personal interviews, telephone calls, and/or review of documents and correspondence. The reviewer/investigator has access to all documents and records and personnel relevant to the investigation. In addition, the Regional Office may request the assistance of other offices in DBHDD;
 - Confidential information is protected against unauthorized disclosure;
 - Conflicts of interest are avoided and where discovered, immediately corrected; and
 - Whenever appropriate or necessary, a signed release of information is obtained.
- b. Extensions: The Regional Coordinator may grant an extension of this time frame upon request and upon a showing of good cause, such as the complexity of the issue(s) or if fact gathering warrants additional time. If the Regional Coordinator approves an extension, the Regional Office notifies the complainant of the extension and indicates the approximate time frame within which the review will be concluded. Where applicable, a copy of the notice of extension is also forwarded to the provider. If an extension exceeds twenty (20) business days from the date of receipt of the complaint or grievance, the complainant receives an update from the Regional Office.

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4. **Step 4 - Findings/Resolution:** The notification of findings/resolution of any complaint or grievance related to client rights includes an explanation of the appeal process. A copy of the findings and recommendations is kept on file along with the complaint or grievance and a copy must be forwarded to the provider, if applicable.

If complaint or grievance is of a client's rights nature, the Regional Office sends a copy of the complaint and recommendations to the complainant and the Office of External Affairs (OEA).

5. **Step 5 - Appeal:** When a complainant is dissatisfied with the resolution proposed by the Regional Office, the complainant may request that the Regional Office forward a copy of the complaint or grievance, all relevant material, and all proposed resolution(s) to DBHDD OEA. A complainant is not precluded from filing an appeal directly to the DBHDD Commissioner or OEA, in which case the Commissioner or designee contacts the Regional Office to request copies of all material(s) relevant to the complaint or grievance. If possible, the Commissioner or designee completes the review of the complaint or grievance within ten (10) business days of receipt of the appeal and all relevant materials. The Commissioner or designee provides a resolution for the complainant that is final. A copy of the final resolution is forwarded to the Regional Office and, if applicable, to the provider. The Regional Office and where applicable, the provider, must maintain on file a copy of the final resolution of all complaints and grievances for no less than six (6) years.

C. In addition to an appeal, a party may file an initial complaint or grievance to the DBHDD State Office. The DBHDD website <http://dbhdd.georgia.gov> includes information about how to do so. In such event, the following steps are taken:

1. The complaint/grievance is sent to DBHDD OEA upon receipt or notification;
2. OEA sends out an email to the applicable Regional Coordinator (RC), Regional Services Administrator (RSA), the DBHDD office or division, their Administrative Assistant; and other state staff when appropriate.
3. The complaint/grievance is assigned to the appropriate staff for follow-up and resolution;
4. Staff performs follow up and provides an initial response to the RC and RSA, which is then communicated to OEA within two (2) business days; and
5. Regional Office notifies OEA, within five (5) business days of receiving the complaint or grievance, of the finding(s) and the recommendation(s) for resolving the complaint or grievance.
6. The Regional office or constituent services contacts the complainant to follow up with the findings and recommendation for resolving the complaint

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or grievance.

- D. Upon request, providers submit to the Regional Office a copy of the provider's policies and procedures for receiving, considering, and resolving client complaints and grievances.
- E. Each provider's policies and procedures address, at a minimum, the following:
1. Instructions on how a complaint or grievance may be filed with the provider.
 2. A description of the review/investigation process for resolving the complaint or grievance, including reasonable applicable time frames and extensions, if permitted, for review by and response from the provider.
 3. A description of the Client's Rights complaint and grievance process.
 4. Directions for the complainant to appeal to the Regional Office if a satisfactory resolution is not reached at the provider level.
 5. Directions for the complainant to appeal to the DBHDD if an unsatisfactory decision is made by the Regional Office.
 6. Information that is displayed prominently at each service location: name, title, location, hours of availability, and telephone number (a 1-800 number is preferred for multi-county locations) of the designated person whose responsibility it is to accept and oversee the process of any complaint or grievance on behalf of the provider.
 7. Maintenance of copies of all complaints and grievances received and reviewed by the provider and complaints and grievances reviewed by the Regional Office, copies of appeals made to the DBHDD Commissioner or OEA, notices of extension of the time to conduct and complete a complaint or grievance review/investigation, and copies of all "final" rulings or resolutions.
 8. Method to ensure that each individual served by the provider receives information explaining the provider's complaint and grievance procedure, including appeals, in a manner that is understandable to the person served.
 9. Method to ensure that each individual receives information explaining his/her rights and the client rights complaint and grievance procedure, including appeals, in a manner that is understandable to the person.
 10. Assurance that the filing of a complaint or grievance will not result in retaliation or barriers to service.
 11. Requirement that all provider staff receive training regarding the provider's complaint and grievance policy and procedure, including the duty to assist individuals in reporting complaints and grievances.
 12. Description of how complaint and grievance information is utilized for continuous quality improvement.

Provider policies and procedures address and include the following expectations:

- Complaints and grievances are to be handled in best interest of the complainant.
- The handling of complaints and grievances is done in a manner that demonstrates flexibility, responsiveness and timeliness.

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- Resolution of complaints and grievances is done in collaboration with the complainant and/or representative.
- The provider exhausts all possible options and choices to reach a mutually satisfactory resolution.
- All appropriate parties are informed about resolution of the complaint and/or grievance.
- The provider demonstrates good customer service skills while working to resolve complaints and grievances.

F. Reporting of complaints and grievances

1. Providers maintain information about complaints and grievances including but not limited to the following information:
 - Types and dates of all complaints and grievances;
 - Originator of complaints and grievances;
 - Complaints and grievances new in the current quarter and those unresolved from previous quarters;
 - Of resolved complaints and grievances, the numbers of substantiated and unsubstantiated complaints and grievances;
 - Days to resolution for each complaint or grievance;
 - Disability and program involved; and
 - Identified systems issues and corrective measures taken, if any.

2. OEA maintains information about complaints and grievances including the following:
 - Number of complaints and grievances;
 - Types of complaints and grievances;
 - Originators of complaints and grievances;
 - Days to resolution for complaint or grievance;
 - Disabilities and programs involved;

G. Reporting complaints and grievances to Legal Services:

During conversation with the complainant, the Regional Office, when possible, determines if the matter under complaint or grievance is the subject of pending or current litigation. If the complaint or grievance may be or is the subject of current litigation, the Regional Office immediately contacts the DBHDD Office of Legal Services for guidance.

HOSPITAL COMPLAINTS AND GRIEVANCES

Complaints and grievances regarding DBHDD Hospitals are handled in accordance with hospital specific policies and procedures.



Chapter: Administrative Issues Related to Behavioral Health & Developmental Disabilities Service Delivery

Subject: Criminal History Records Checks for Contractors

Applicability:

All Contractors as defined in this policy

Original Effective Date: July 1, 2010

Revision 1 Effective Date: March 1, 2011

Scheduled Review Date: March 2012

Approved:

References:

DBHDD Policy 22-504;
O.C.G.A. § 31-7-350, et seq. and § 35-3-30 et seq.;
O.C.G.A 37-1-28;
Criminal Code of Georgia (O.C.G.A. Title 16);
Code of Federal Regulations 42, IV, § 483.420 (d) (1) (iii);
Title 28 CFR 50.12(b);
Rules of the Georgia Crime Information Center (GCIC) Council

Beverly D. Rollins 2/24/11

Beverly D. Rollins, M.P.A. Date
Executive Director, Division of Developmental Disabilities

Cassandra Price 2/23/11

Cassandra Price, GCADC-II, MBA Date
Executive Director, Division of Addictive Diseases

Attachments:

Attachment A: Applicant Disqualification Notice
Attachment B: Applicant Request for Disposition Information

J. Bryce McLaughlin 2/24/11

J. Bryce McLaughlin, M.D. Date
Executive Director, Division of Mental Health

Frank E. Shelp 3/1/2011

Frank E. Shelp, M.D., M.P.H., Commissioner Date

CRIMINAL HISTORY RECORDS CHECKS FOR CONTRACTORS

POLICY

The Department of Behavioral Health and Developmental Disabilities (DBHDD) is concerned about the health and safety of all individuals and the safeguarding of state property. It is the policy of DBHDD that all reasonable efforts are made to provide safe and secure environments for individuals receiving services, staff, and any other work-related contacts. Based on this objective, a criminal history record check, which is fingerprint based, is completed on any individual who is under contract to provide services for DBHDD, to include employees of Contractors and anyone with whom a Contractor contracts to perform direct care, treatment, custodial responsibilities, or any combination thereof, for individuals receiving services.

DEFINITIONS

Individual receiving services – For the purposes of this policy, the term *individual receiving services* is used to refer to any person who receives or participates in mental health, addictive diseases, and/or developmental disabilities services that are financially supported in whole or in part by funds authorized by DBHDD. Previously, the term consumer was used to refer to these individuals receiving services.

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Contractor – For the purposes of this policy, the term Contractor includes all organizations that provide mental health, addictive diseases, and/or developmental disability services that are financially supported in whole or in part by funds authorized through DBHDD.

Employee – For the purposes of this policy, the term employee refers to any individual who is performing services on behalf of a Contractor, including direct care, treatment, custodial responsibilities, or any combination thereof, for individuals receiving services.

PROCEDURES

A. General Provisions

1. All individuals who contract with DBHDD or their employees, who have direct care, treatment, custodial responsibilities, or any combination thereof, for individuals receiving services must undergo a fingerprint based criminal history record check.
2. The Contractor Hiring Authority (hereinafter referred to as the Contractor) is responsible for ensuring that a criminal history record check is completed on each employee, and that the results are reviewed by the DBHDD Office of Incident Management and Investigations/Criminal Records Section, in accordance with this policy.

B. Crimes that Restrict Employment as a Contractor or Contractor Employee

Individuals who have been convicted of a crime listed in this section, or any other offense committed outside the State of Georgia that would have been considered one of these crimes if committed in Georgia, are not eligible to perform services for DBHDD on behalf of the contractor as indicated below.

1. There is a Mandatory disqualification from providing services for DBHDD for a minimum of five (5) years from the date of conviction, a plea of *nolo contendere*, or release from incarceration or probation, whichever is later, for the following crimes.
 - Murder or Felony Murder
 - Attempted Murder
 - Kidnapping
 - Rape
 - Robbery/Armed Robbery
 - Aggravated Assault

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- Aggravated Battery
 - Cruelty to Children
 - Sexual Offenses
 - Arson
 - Theft by Taking (O.C.G.A. §16-8-2), by Deception (O.C.G.A. § 16-8-3) or by Conversion (O.C.G.A. §16-8-4)
 - Forgery (in the first or second degree)
2. DBHDD Contractors or their employees are permanently ineligible to provide services for DBHDD if they have ever been convicted of abuse, neglect, or maltreatment of a child, an individual receiving services, or a patient.
 3. Contractors or their employees may be ineligible to provide services for DBHDD, if the criminal history record indicates any of the following that have direct relevancy to the responsibilities or duties of the position.
 - 3.1 Any other Conviction or Pattern of Convictions
 - 3.2 A Pattern of Recent Arrests
 - 3.3 A Significant Recent Arrest (Disqualification until charge is resolved)

C. Criminal Drug Offenses

Contractors or their employees that have been convicted of a criminal drug offense will be ineligible to provide services for DBHDD as follows:

1. Disqualification to provide services in any position for a period of two (2) years from the date of conviction for the first offense.
2. Disqualification to provide services in any position for a period of five (5) years from the most recent conviction for the second or subsequent offense.
 - NOTE: For purposes of this disqualification, “conviction” does not include treatment under Georgia First Offender Act, or a plea of *nolo contendere*.

D. Release of Criminal History Record Information

1. FBI Regulations do not allow for the release of Criminal History Record Information to Contractors or their employees, and require that DBHDD make suitability determinations for DBHDD Contractors and their employees. Contract Agencies will only be notified of the eligibility of the applicant to provide services to DBHDD.

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E. Fingerprinting of Contractor and Contractor Employees

1. DBHDD Contractors and Contractor employees that provide services for DBHDD must submit to a fingerprint based criminal background check. Applicants must be notified in writing prior to fingerprinting that they are being subjected to an FBI Criminal History Records Check, and they have the right to challenge the contents of their Criminal History Record Information, should they chose to do so.
2. Fingerprinting must be conducted prior to employment where possible, or within ten (10) business days of the employee's start date.
3. Specifically trained DBHDD personnel review the Criminal History Record Information and provide a determination as to the suitability of the individual to provide services for DBHDD by contractor or on behalf of the contractor, within seven (7) business days of the receipt of the criminal record information.
4. Contractors who require fingerprinting must register their agency with the State Approved Vendor authorized to capture and submit fingerprint images for comparison with the Georgia and Federal Criminal Record Databases. To obtain information on how to register with the State Approved Vendor, go to the following website and follow the prompts:
 - www.ga.cogentid.com
 - Under General Information click the link "How to get an ORI or OAC Number" and follow the instructions provided.
5. Contractors are responsible for the proper registration of their employees. Contractors cannot use the GBI Issued OAC Number to register applicants for other agencies. DBHDD assumes no liability for registration errors that create additional costs for reprinting. Contractors must provide the applicant's Name, Address, Telephone Number and Applicant's Email (if the applicant's email is available).
6. Contractors or their designee are responsible for contacting the DBHDD Criminal Records Section for accurate registration information if they are not sure of the proper procedure to register an applicant/employee that will provide services for DBHDD. Obtain information on the proper registration of applicants for DBHDD through the following manner:
 - www.dbhdd.georgia.gov and select Provider Information and then select the link to "Background Policy and Cogent Information"
 - www.ga.cogentid.com and click on the link to the Department of Behavioral Health and Developmental Disabilities. Then select the link to

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Provider Information and click on the link “Background Policy and Cogent Information”.

- Contact the Criminal Records Section at (404) 232-1541 or via email at DBHDD-CRS@dhr.state.ga.us

7. DBHDD Criminal Records Section can not process inaccurate or invalid official documents or criminal records.
8. Within three (3) business days of the receipt of the incorrect information, *such as invalid court documents or criminal record requests*, Criminal Records Section staff notifies the Contractor of the issue and the corrective action that must be taken in order to properly review the criminal record.
9. Unless otherwise agreed, the cost of applicant/employee fingerprinting is paid by the Contractor.

F. Notice from the Office of Incident Management and Investigations/ Criminal Records Section

1. The Criminal Records Section advises the Applicant in writing of any findings or issues that need further documentation in order to make a suitability determination.
 - When registering Applicants in the Cogent system, the Contractor must provide the Applicant’s Name, Correct Mailing Address, Telephone Number and Email address (If email address is available).
2. If the written determination from the Criminal Records Section indicates the applicant has No Criminal History, then no further action by the Contractor is necessary.
3. If the determination from the Criminal Records Section indicates the applicant’s criminal history information disclosed a conviction or other charge that prohibits employment as listed under **Section B** of this policy, the Applicant will be notified he/she has fifteen (15) days to challenge the contents of their criminal history record information before making the final notification of disqualification to the Contracting Agency. (See **Attachment A**)
 - ***Attachment A is for example only. Criminal Records Section Staff will provide the completed form when appropriate.***
4. If the applicant’s/employee’s Criminal History Record Information is not complete, such as a missing disposition, etc. the Criminal Records Section shall notify the Applicant in writing of the issues, and appropriate actions to take, *such as*

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obtaining official court documents that indicate how a charge was disposed, so that a proper determination can be made. (See **Attachment B**)

- ***Attachment B is for example only. Criminal Records Section Staff will provide the completed form when appropriate***
5. Anyone who refuses to provide requested ***Certified Copies of Court Documents***, or discuss the pending issues, shall be ineligible to provide services for DBHDD, on behalf of the Contractor. Applicants will have forty-five (45) days to provide requested information. Upon expiration of the (45) days, and the Criminal Records Section has not received the requested documents, the applicant will be deem ineligible to provide services to DBHDD and the file will be closed. The Contract Agency will be notified at that time of the applicant’s status.
 6. DBHDD does not provide copies of Result Letters after sixty (60) days of the initial letter. If a new Result Letter is needed, the contractor will be required to have the applicants/employees reprinted in order to obtain a new Result Letter.

Note: Depending on the complexity of the applicant’s Criminal History Record Information, the Criminal Records Section has seven (7) business days from the time the record is received in the Criminal Records Section, to process the applicant’s/employee’s criminal record and generate a Result Letter to the requesting agency.

G. Rejected Fingerprint Images

1. There are times when an applicant’s/employee’s fingerprint images are rejected by either the Georgia or Federal Integrated Automated Fingerprint Identification System (IAFIS). When rejections occur, the Contractor is notified within two (2) business days of the receipt of the rejection, regarding the reason the fingerprints were rejected, and the corrective action that must be taken, such as a reprinting of the applicant’s/employee’s fingerprints. Below is information concerning rejected fingerprint images:
 - Cogent Systems provides Rejection Notices, those notices will be sent to the Contract Agency by DBHDD Criminal Records Section Staff
 - Rejections can occur because of improper registration, bad fingerprint images, or improperly trained operators.
 - Rejections because of Registration Errors will require the contractor to have to re-register the applicant/employee and pay again.
 - Rejected Fingerprint Image Reprints must be completed at the site where the original fingerprints were taken within 90 Days of the original fingerprinting in order to avoid additional fees.

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H. Notification of Employment Decision

The Contract Agency will only be notified that the applicant is either Eligible or Ineligible to provide services to DBHDD. Once the notification is made, no other action is required by the Contract Agency.



Georgia Department of Behavioral Health & Developmental Disabilities
Frank E. Shelp, M.D., M.P.H., Commissioner

Incident Management & Investigations- Criminal Records Section
Two Peachtree Street NW, Suite 24-462, Atlanta, Georgia 30303-3142 ~ 404-232-1541

DATE:

TO:

FROM: DBHDD Office of Incident Management and Investigations
Criminal Records Section

RE: Suitability Determination

This is notification that GBI and FBI Fingerprint Based Criminal History Checks have been completed, at your request. In accordance with DBHDD Policy 04-104, the results of the checks indicate a conviction(s) that makes you ineligible to provide services to DBHDD, at this time. Below are the specific contents of the Criminal History Record that prompted this notification.

Conviction Information:

Agency	Charge	Conviction Date

You have the right to challenge the contents of your Criminal History Record. If you chose to do so, you have **fifteen (15) days** from the date of this letter to notify our office in writing that the information is incorrect. If we do not hear from you in writing, we will notify the hiring agency that you are ineligible to provide services to DBHDD, at that time. The agency will not be provided the reason for this decision, only of your eligibility status.

If you choose to challenge the above listed conviction(s), you will be provided instructions upon contacting our office.

You can Fax your notification to (404) 657-2187 or via email to DBHDD-CRS@dhr.state.ga.us.

In your challenge request, please specify why you believe this information is incorrect.

If you have any questions, please contact our office at (404) 232-1541 or (404) 463-8115



Georgia Department of Behavioral Health & Developmental Disabilities
Frank E. Shelp, M.D., M.P.H., Commissioner

Incident Management & Investigations-Criminal Records Section
Two Peachtree Street NW, Suite 24-462, Atlanta, Georgia 30303-3142 ~ 404-232-1541

DATE:

TO: Applicant Name
Address
City, State, Zip

FROM: DBHDD Office of Incident Management and Investigations
Criminal Records Section

RE: Need for Final Disposition Information

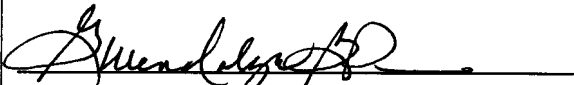
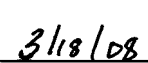
Below you will find a list of incomplete charge information that was listed on your Criminal History Record Information. Please contact the Court of Record to obtain final disposition information for the Charges indicated below. DBHDD only accepts Certified Court Documents for review. Please provide these documents to our office within forty-five (45) days of the date of this letter. After forty-five (45) days, if we do not hear from you concerning these issues, your file will be closed to further review. If you need more time to obtain these documents, please notify us prior to the forty-five (45) day expiration.

Date	Agency	Charge	Status
			Need Disposition

DBHDD will not issue a final clearance to your employer/provider to provide services until we receive these documents and we can make a full determination of suitability. You have the right to challenge the validity of the contents of your Criminal History Record Information. If this is necessary, please contact either the Georgia or Federal Bureau of Investigation to obtain a copy of your Criminal History Record Information.

If you need further assistance, or have questions, please contact our office at (404) 232-1541, (404) 463-1885 or via email to DBHDD-CRS@dhr.state.ga.us

Return Documents to the address listed in the heading above, or FAX to (404) 657-2187

Georgia Department of Human Resources Division of Mental Health, Developmental Disabilities & Addictive Diseases	DHR Online Directive Information System (ODIS) Directive # 6805-201 <div style="text-align: right;">Page 1 of 2</div>
DHR ODIS Policy: Provision of Care, Treatment, and Services for Consumers in Division of MHDDAD Hospitals Subject: Criteria for Admission to DHR DMHDDAD Hospitals for Persons with Mental Illness	
Applicability: All DMHDDAD Hospitals	Effective Date: April 15, 2008 Scheduled Review Date: April 2010 Approved:
References: Official Code of Georgia Annotated (OCGA) Sec. 37-3-1 (9.1)-(12) (definitions), 37-3-43, and 37-3-64.	 Gwendolyn B. Skinner, Director, Division of MHDDAD
Attachment: A – Assessment by Admitting Physician	<div style="text-align: center;">  <hr/> Date Signed </div>

CRITERIA FOR ADMISSION TO DHR DMHDDAD HOSPITALS FOR PERSONS WITH MENTAL ILLNESS

POLICY

Admission of persons with mental illness is based upon the needs and the best interests of the individual. Decisions concerning the admission of persons with mental illness are based on independent medical judgment by physicians at the admitting facilities. Hospitalization is appropriate only when it is the least restrictive level of care available to meet the individual's needs.

Criteria for Mental Health Admissions of Adults to DMHDDAD Hospitals

1. The consumer has mental illness consisting of a disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life. (Traumatic brain injury does not qualify as a mental illness.) **AND**
2. Hospitalization is the least restrictive level of care available for the individual **AND**
3. One of the following:
 - The consumer presents a substantial risk of harm to himself/herself or others, as manifested by recent overt acts or recent expressed threats of violence which present a probability of physical injury to himself/herself or others **OR**
 - The consumer is so unable to care for his/her own physical health and safety as to create an imminently life-endangering crisis.

These criteria are applicable for both involuntary and voluntary civil admissions.

Every attempt is made to meet the needs of individuals presenting with primary substance use disorders by serving these individuals in the community. They are carefully evaluated to determine whether there is the presence of a mood or thought disorder that warrants admission to the Division of MHDDAD hospital.

DIVISION OF MHDDAD	SUBJECT: Criteria for Admission to DHR DMHDDAD Hospitals for Persons with Mental Illness	ODIS Directive # 6805-201
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The needs of individuals with organic brain diseases and neurological diseases of the brain are carefully evaluated to determine whether there is the presence of a mood or thought disorder that warrants admission to the Division of MHDDAD hospital.

If the consumer does not meet the criteria for admission he/she is referred to appropriate services in the community.

Every effort is made to expedite the assessment and admission decision process.

Upon arrival at the Division of MHDDAD hospital Emergency Receiving Facility, the individual is evaluated by a physician who determines whether the individual's symptoms meet the criteria for admission and whether hospitalization is the least restrictive environment for the individual.

The admitting physician documents the rationale for the decision. (See Attachment A – Assessment by Admitting Physician).

The BHL **Georgia Access and Crisis Line (GCAL)** is utilized as a resource for making referrals to hospitals and community providers. The number for GCAL is **1-800-715-4225**.

See the Policy #6801-101 **Legal Status of Persons Admitted to DMHDDAD Hospital** for additional details regarding involuntary and voluntary civil admissions.

Attachment A - Assessment by Admitting Physician

Please note that hospitals are to utilize their existing [Assessment by Admitting Physician](#) form to document as indicated in the policy.



Chapter: Behavioral Health Community Services
Subject: Denial and Appeals Process for Psychiatric Residential Treatment Facility (PRTF) Level of Care for Children and Adolescents with a Mental Health Diagnosis

Table with 2 columns: Policy details (Applicability, References, Attachments) and Approval/Implementation details (Effective Date, Full Implementation Date, Scheduled Review Date, Approved signatures).

DENIAL AND APPEAL PROCESS FOR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) LEVEL OF CARE FOR CHILDREN AND ADOLESCENTS WITH A MENTAL HEALTH DIAGNOSIS

POLICY

The Department of Behavioral Health and Developmental Disabilities (DBHDD) manages processes (including denial and appeal processes) related to Psychiatric Residential Treatment Facility (PRTF) level of services in a consistent manner that complies with applicable federal law and regulations.

- 1. DBHDD will provide a fair hearing to a Medicaid recipient whose application for PRTF level of services is denied or is not acted upon in a reasonably prompt manner.
2. DBHDD informs Medicaid applicants and recipients of the right to request a hearing, the method to obtain a hearing, and the ability to be represented by an attorney or other representative.
3. DBHDD provides a Medicaid beneficiary who requests a fair hearing the right to: review his/her case file; review all documents to be used by the state at the hearing; call witnesses, establish the facts of the case without interference from the state; and confront and cross-examine adverse witnesses.
4. DBHDD maintains that the member or legal custodian/guardian will be responsible for paying for all PRTF level of services rendered after the date that the External Review Organization (ERO) determines that the youth no longer will meet criteria unless the Office of Administrative Hearings makes a ruling to overturn that determination.

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PROCEDURES

I. Initial Authorization

1. PRTF Level of Care referral application packet is completed and sent to DBHDD's ERO by the member's Core Provider, CSP, or State Hospital.
2. The DBHDD ERO completes a clinical review of the packet within five (5) business days of the complete packet being received to determine if the member meets DBHDD PRTF Level of Care Criteria. The determination is made by the ERO's Clinical Team, which is lead by a physician.
 - If the Clinical Team determines that there is sufficient clinical information to support PRTF Level of Care, a PRTF Referral Summary is generated indicating that the member meets Admission Criteria. The ERO sends the Referral Summary to the DBHDD State Office, DBHDD Regional Office via the Regional Program Specialist, and Referring Party. For the purposes of this policy, the DBHDD Regional Office responsible for an individual's PRTF Level of Care processes is defined in the DBHDD policy regarding region of responsibility determination. No further action is needed since the member was not denied PRTF service.
 - If the Clinical Team determines that there is insufficient clinical information to support PRTF Level of Care, Step 3 (below) is initiated.
3. The ERO physician or designated clinician contacts the referring agency's clinician to clarify and/or acquire further information. The ERO physician makes a final determination regarding whether the member meets PRTF Level of Care Criteria.
 - If the clinical information does support approval, a PRTF Referral Summary is generated indicating that the member meets Admission Criteria and includes the information the ERO physician acquired during their review with the referring provider. The ERO sends the Referral Summary to the DBHDD State Office, DBHDD Regional Office via the Regional Program Specialist, and Referring Party. No further action is needed since the member was not denied PRTF service.
 - If the clinical information does not support approval, a PRTF Referral Summary is generated indicating that the member does not meet Admission Criteria and includes the ERO's rationale. **Attachment A – Denial of Admission to PRTF Level of Care Letter**, informing the member the right to a fair hearing, is also generated. The letter includes the rationale for the member not meeting Admission Criteria. The ERO sends the Referral Summary and the copy of the Denial Letter (**Attachment A**) to the DBHDD State Office, DBHDD General Counsel, DBHDD Regional Office via the Regional Program Specialist, and Referring Party. Step 4 (below) is initiated.

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4. The ERO sends a copy of the Denial Letter (**Attachment A**) to the member's address on file in the MMIS System via USPS Certified Mail with Return Receipt sent to DBHDD State Office. The return address on the letter will be:

Attn: PRTF Review
 DBHDD, Division of Mental Health
 2 Peachtree Street, N.W., Suite 23-436
 Atlanta, GA 30303-3171

If the member is an adult, the letter will only be addressed to the member. If the member is a minor or an adult with a legal guardian, the letter will be addressed to the member, care of their legal custodian/guardian.

5. The ERO sends a copy of the signed Denial Letter (**Attachment A**) via email to the DBHDD State Office, DBHDD General Counsel, DBHDD Regional Office via the Regional Program Specialist, and the PRTF provider.
6. DBHDD State Office, C&A Services receives the Return Receipt of USPS Certified Mail (Step 7 initiated) or returned mail from USPS noting that it was undeliverable (Step 6A initiated).

If the letter is returned as undeliverable, DBHDD C&A will submit to DBHDD General Counsel the PRTF Admission Criteria, ERO Referral Summary, Denial Letter (**Attachment A**), undelivered letter (with envelope), and documentation from the Parental Agreement Form and/or 297A Medicaid Form regarding member's responsibility to keep residential address accurate. No further action is necessary and the Denial Process does not proceed to Step 7 (below).

7. DBHDD records the date that the Certified Mail was received by the member's address. If the member or legal guardian/custodian wants a hearing, they must request a hearing by returning the Denial Letter (**Attachment A**) with the appropriate box checked and the legal authority's signature. The request must be sent back to DBHDD and be postmarked within 15 days of the date the letter was confirmed as being received on USPS' Return Receipt.
 - a. If the noted response requesting a fair hearing is not received by DBHDD, with a postmark within 15 days of the Certified Mail being received, from the member or their legal custodian/guardian, no further action is needed since the member and/or legal custodian/guardian did not request a fair hearing.
 - i. If the request for a fair hearing is received but postmarked after the 15 days of the Certified Mail being received, DBHDD sends a letter to member or their legal custodian/guardian indicating that their request for a hearing was denied based on not submitting the request within the timeframe. Step 7 a. ii. (below) is initiated.
 - ii. DBHDD C&A will submit to DBHDD General Counsel the PRTF Admission Criteria, ERO Referral Summary, Denial Letter (**Attachment A**), copy of Return Receipt of

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USPS Certified Mail, request from member or legal custodian/guardian for a fair hearing, envelope showing postmark, and copy of the letter sent to member in Step 7. a. i.

- b. If a response requesting a fair hearing is received and is postmarked from the member or their legal custodian/guardian within 15 days of the Certified Mail being received, Steps 8 and 9 (below) are initiated concurrently.
8. If a hearing is requested, DBHDD State Office and the Regional Office convene to determine the reason for appeal.
 - a. If it is determined that the reason for appeal is related to medical necessity, DBHDD State Office submits a copy of the PRTF Referral Summary and Denial Letter (**Attachment A**) to DBHDD's Medical Director or designee for a tertiary in-house clinical review. This review will not interrupt, hinder, or stop Step 9 from being initiated.
 - b. If it is determined that the reason for appeal is related to matters unrelated to medical necessity, DBHDD Medical Director or designee will not complete a review. This lack of review will not interrupt, hinder, or stop Step 9 from being initiated.
 - i. If there is suspicion of neglect or child abandonment, DBHDD will address the issue in accordance to state law.
 9. DBHDD State Office, C&A Services notifies DBHDD General Counsel and DBHDD ERO of a request for fair hearing. DBHDD State Office, C&A Services provides DBHDD General Counsel with copies of the PRTF Level of Care Criteria, ERO Referral Summary, Denial Letter (**Attachment A**), copy of Return Receipt of USPS Certified Mail, and request from member or their custodian/guardian for a fair hearing.
 10. DBHDD General Counsel requests a hearing from The Office of State Administrative Hearings.
 11. The Office of State Administrative Hearings receives request for an administrative hearing. The Office of State Administrative Hearings schedules a hearing date, time, and location and informs DBHDD General Counsel and the member of the hearing.
 12. DBHDD General Counsel informs DBHDD C&A Services and the ERO of the hearing date, time, and location.
 13. DBHDD case preparation occurs for hearing.
 14. On the date of hearing DBHDD General Counsel and the member, or their legal custodian/guardian, with their desired representation meet before The Office of State Administrative Hearings.

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- a. If the member or their legal custodian/guardian withdraws the request for a hearing, no further action is necessary and PRTF Level of Care is denied.
- b. If the member and/or legal custodian/guardian fail to show at the hearing, no further action is necessary and PRTF Level of Care is denied unless otherwise directed by The Office of State Administrative Hearings.
 - i. If the hearing is rescheduled, Step 14 will be re-initiated.
 - ii. If the hearing is dismissed, no further action is needed and PRTF Level of Care is denied.
- c. If the ruling is upheld, no further action is necessary and PRTF Level of Care is denied. Member has the option to initiate Step 15 (below).
- d. If the ruling is overturned, PRTF Level of Care is approved. DBHDD has the option to initiate Step 15 (below).
 - i. If DBHDD does not initiate Step 15, DBHDD will await court documentation from the Office of State Administrative Hearings and provide a copy to the ERO and Referring Provider to permit authorization of member into a PRTF.

15. DBHDD or Member appeals the ruling of the Office of State Administrative Hearings to the Commissioner at the Department of Community Health. If DBHDD or the member disagrees with the ruling, they have the option to initiate Step 16 (below).

16. DBHDD and Member go to Superior Court for a final determination.

II. Continued Stay Review – PRTF

Upon admission to a PRTF, the member or their legal custodian/guardian signs the Parental Agreement Form. A section in this form indicates that discharge is determined by the treatment team at the PRTF, which includes the member and any legal custodian/guardian. It also indicates that Medical Necessity is required for any member to stay at a PRTF, which is determined by DBHDD’s ERO. (The PRTF submits a Continuing Stay Review to DBHDD’s ERO to determine if the member still meets PRTF Level of Care Criteria.) The Parental Agreement Form indicates that it is the responsibility of the member or legal custodian/guardian to maintain their mailing address in accordance with the Medicaid Rights & Responsibilities in the 297A. The Parental Agreement Form also states that DBHDD will offer the right to a fair hearing when DBHDD’s ERO determines that the member no longer meets PRTF Level of Care Criteria and denies the member services at the PRTF. If the ERO never indicates that the member no longer meets PRTF Level of Care Criteria, hearings will not be offered. This commonly occurs when the member or their legal custodian/guardian voluntarily discharges the member, with or without the support of the rest of the clinical team, before DBHDD’s ERO indicates that the member does not meet PRTF Level of Care Criteria.

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The member or legal custodian/guardian will be responsible for paying for all PRTF services rendered after the date that the ERO determines that the youth no longer will meet criteria unless The Office of Administrative Hearings makes a ruling to overturn that determination.

1. The DBHDD ERO completes a clinical review of the Continuing Stay Review to determine if the member meets PRTF Level of Care Criteria.
 - a. If the ERO determines that there is sufficient clinical information to continue to support PRTF Level of Care, either before or after completing Review I procedures, the ERO authorizes the Continuing Stay for up to 30 days. No further action is needed since the member was not denied PRTF service.
 - b. If the ERO determines that there is sufficient clinical information to continue to support PRTF Level of Care, either before or after completing Review I procedures, but indicates a date that the member will no longer meet criteria, Step 2 (below) is initiated.
 - c. If the ERO determines that there is insufficient clinical information to support PRTF Level of Care after completing Review I procedures, the Continuing Stay is placed on Review II status. Step 2 (below) is initiated.
2. The ERO physician or designated clinician contacts the PRTF agency to clarify and/or acquire further clinical information. The ERO physician makes a final determination regarding whether the member meets PRTF Level of Care Criteria.
 - a. If the clinical information does support approval, the ERO authorizes the Continuing Stay Review for up to 30 days. No further action is needed since the member was not denied PRTF service.
 - b. If the clinical information does not support approval, the Continuing Stay Review is denied and a date is given to the PRTF indicating the date that the youth will no longer meet criteria. Step 3 (below) is initiated.
3. **Attachment B - Continuing Stay Denial Letter** is generated by the ERO indicating that the member will not meet PRTF Level of Care Criteria as of the date noted in Step 2 Item B and includes the ERO's rationale. The Continuing Stay Denial Letter (**Attachment B**) also includes that the member has the right to a fair hearing.
4. The ERO sends the original Continuing Stay Denial Letter (**Attachment B**) to the member's address on file in the MMIS System via USPS Certified Mail with Return Receipt sent to DBHDD State Office. The return address on the letter will be:

Attn: PRTF Review
DBHDD, Division of Mental Health
2 Peachtree Street, N.W., Suite 23-436
Atlanta, GA 30303-3171

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- a. If the member is an adult, the Continuing Stay Denial Letter (**Attachment B**) will only be addressed to the member.
 - i. If the member is still at the PRTF, the ERO will send an additional Continuing Stay Denial Letter (**Attachment B**) to the member at the PRTF address in conjunction with the mailing noted above. This letter will also be sent via USPS Certified Mail with Return Receipt sent to DBHDD State Office.
 - b. If the member is a minor or an adult with a legal guardian, the Continuing Stay Denial Letter (**Attachment B**) will be addressed to the member, care of their legal custodian/guardian at the legal custodian/guardian's address noted in MMIS.
5. The ERO sends a copy of the signed Continuing Stay Denial Letter (**Attachment B**) via email to the DBHDD State Office, DBHDD General Counsel, DBHDD Regional Office via the Regional Program Specialist, and the PRTF provider.
 6. Concurrent to completing Steps 4 and 5 (above), the ERO will end the PRTF Authorization for services effective the date they determined that the youth no longer will meet criteria from Step 2 Item B.
 7. DBHDD State Office, C&A Services receives the Return Receipt of USPS Certified Mail (Step 8 is initiated) or returned mail from USPS noting that the Continuing Stay Denial Letter (**Attachment B**) was undeliverable (Step 7A is initiated).
 - a. If the letter is / letters are returned as undeliverable, DBHDD C&A will submit to DBHDD General Counsel the PRTF Admission Criteria, Continuing Stay Denial Letter (**Attachment B**), undelivered letter(s) [with envelope(s)], and documentation from the Parental Agreement Form and/or 297A Medicaid Form regarding member's responsibility to keep residential address accurate. No further action is necessary and the Denial Process does not proceed to Step 8 (below).
 8. DBHDD records the date that the Certified Mail was received by the member's address. If the member or legal guardian/custodian wants a hearing, they must request a hearing by returning the Continuing Stay Denial Letter (**Attachment B**) with the appropriate box checked and the legal authority's signature. The request must be sent back to DBHDD and be postmarked within 15 days of the date the letter was confirmed as being received on USPS' Return Receipt.
 - a. If the noted response requesting a fair hearing is not received by DBHDD, with a postmark within 15 days of the Certified Mail being received from the member or their legal custodian/guardian, no further action is needed since the member and/or legal custodian/guardian did not request a fair hearing.
 - i. If the request for a fair hearing is received but postmarked after the 15 days of the Certified Mail being received, DBHDD sends a letter to member or their legal

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- custodian/guardian indicating that their request for a hearing was denied based on not submitting the request within the timeframe. Step 8 a. ii. (below) is initiated.
- ii. DBHDD C&A will submit to DBHDD General Counsel the PRTF Admission Criteria, PRTF Continuing Stay Review, Continuing Stay Denial Letter (**Attachment B**), copy of Return Receipt of USPS Certified Mail, request from member or legal custodian/guardian for a fair hearing, envelope showing postmark, and copy of the letter sent to the member in Step 8. a. i.
 - b. If a response requesting a fair hearing is received and is postmarked from the member or their legal custodian/guardian within 15 days of the Certified Mail being received, Steps 10 and 11 (below) are initiated concurrently.
9. If a hearing is requested, DBHDD State and Regional Office convenes to determine the reason for appeal.
 - a. If it is determined that the reason for appeal is related to medical necessity, DBHDD State Office submits a copy of the PRTF Continuing Stay Denial summary and Continuing Stay Denial Letter (**Attachment B**) to the DBHDD Medical Director or designee for a tertiary in-house clinical review. This review will not interrupt, hinder, or stop Step 11 from being initiated.
 - b. If it is determined that the reason for appeal is related to matters unrelated to medical necessity, DBHDD Medical Director or designee will not complete a review. This lack of review will not interrupt, hinder, or stop Step 11 from being initiated.
 - i. If there is suspicion of neglect or child abandonment, DBHDD will address the issue in accordance to state law.
 10. DBHDD State Office, C&A Services notifies DBHDD General Counsel and DBHDD ERO of a request for fair hearing. DBHDD State Office, C&A Services provides DBHDD General Counsel with copies of the PRTF Level of Care Criteria, PRTF Continuing Stay Review, Continuing Stay Denial Letter (**Attachment B**), copy of Return Receipt of USPS Certified Mail, and request from member or their custodian/guardian for a fair hearing.
 11. DBHDD General Counsel requests a hearing from The Office of State Administrative Hearings.
 12. The Office of State Administrative Hearings receives request for an administrative hearing. The Office of State Administrative Hearings schedules a hearing date, time, and location and informs DBHDD General Counsel and the member of the hearing.
 13. DBHDD General Counsel informs DBHDD C&A Services and the ERO of the hearing date, time, and location.
 14. DBHDD case preparation occurs for hearing.

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15. On the date of hearing, DBHDD General Counsel and the member, or their legal custodian/guardian, with their desired representation meets before The Office of State Administrative Hearings.
 - a. If the member or their legal custodian/guardian withdraws the request for a hearing, no further action is necessary and PRTF Level of Care is denied.
 - b. If the member and/or legal custodian/guardian fail to show at the hearing, no further action is necessary and PRTF Level of Care is denied unless otherwise directed by The Office of State Administrative Hearings.
 - i. If the hearing is rescheduled, Step 14 will be re-initiated.
 - ii. If the hearing is dismissed, no further action is needed and PRTF Level of Care is denied.
 - c. If the ruling is upheld, no further action is necessary and PRTF Level of Care is denied. Member has the option to initiate Step 16 (below).
 - d. If the ruling is overturned, PRTF Level of Care is approved.
 - i. If DBHDD does not initiate Step 16, DBHDD will await court documentation from the Office of State Administrative Hearings to provide a copy to the ERO and Referring PRTF Provider to retro-authorize the member from the end date noted in Step 6 (above) to an end Authorization date of 30 days after the date of the hearing determination.
16. DBHDD or Member appeals the ruling of the Office of State Administrative Hearings to the Commissioner at the Department of Community Health. If DBHDD or the member disagrees with the ruling, they have the option to initiate Step 17 (below).
17. DBHDD and Member go to Superior Court for a final determination.

III. Continued Stay Review – CBAY

1. The Care Management Entity submits a Continuing Stay Review authorization 45 – 60 days before the end of the youth’s authorization period.
2. The DBHDD ERO completes a clinical review of the Continuing Stay Review to determine if the member meets PRTF Level of Care Criteria.
 - a. If the ERO determines that there is sufficient clinical information to continue to support PRTF Level of Care, either before or after completing Review I procedures, the ERO authorizes the Continuing Stay for up to 30 days. No further action is needed since the member was not denied PRTF service.

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- b. If the ERO determines that there is sufficient clinical information to continue to support PRTF Level of Care, either before or after completing Review I procedures, but indicates a date that the member will no longer meet criteria, Step 2 (below) is initiated.
 - c. If the ERO determines that there is insufficient clinical information to support PRTF Level of Care after completing Review I procedures, the Continuing Stay is placed on Review II status. Step 2 (below) is initiated.
3. The ERO physician or designated clinician contacts the Care Management Entity (CME) to clarify and/or acquire further clinical information. The ERO physician makes a final determination regarding whether the member meets PRTF Level of Care Criteria.
 - a. If the clinical information does support approval, the ERO authorizes the Continuing Stay Review for another 365 day authorization. No further action is needed since the member was not denied PRTF service.
 - b. If the clinical information does not support approval, the Continuing Stay Review is denied and the CME is told to begin transitioning the youth out of CBAY at their initial authorization date. Step 4 (below) is initiated.
4. The Continuing Stay Denial Letter (**Attachment B**) is generated by the ERO indicating that the member will not meet PRTF Level of Care Criteria as of the date noted in Step 3 Item B and includes the ERO's rationale. The letter also includes that the member has the right to a fair hearing.
5. The ERO sends the original Continuing Stay Denial Letter (**Attachment B**) to the member's address on file in the MMIS System via USPS Certified Mail with Return Receipt sent to DBHDD State Office. The return address on the letter will be:

Attn: PRTF Review
DBHDD, Division of Mental Health
2 Peachtree Street, N.W., Suite 23-436
Atlanta, GA 30303-3171
6. The ERO sends a copy of the signed Continuing Stay Denial Letter (**Attachment B**) via email to the DBHDD State Office, DBHDD General Counsel, DBHDD Regional Office via the Regional Program Specialist, and the CME.
7. Concurrent to completing Steps 5 and 6 (above), the ERO will end the PRTF Authorization for services effective the date they determined that the youth no longer will meet criteria from Step 3 Item B.
8. DBHDD State Office, C&A Services receives the Return Receipt of USPS Certified Mail (Step 9 is initiated) or returned mail from USPS noting that it was undeliverable (Step 8A is initiated).

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- a. If the letter is / letters are returned as undeliverable, DBHDD C&A will submit to DBHDD General Counsel the PRTF Admission Criteria, Continuing Stay Denial Letter (**Attachment B**), undelivered letter(s) [with envelope(s)], and 297A Medicaid Form regarding member's responsibility to keep residential address accurate. No further action is necessary and the Denial Process does not proceed to Step 9 (below).
9. DBHDD records the date that the Certified Mail was received by the member's address. If the member or legal guardian/custodian wants a hearing, they must request a hearing by returning the Continuing Stay Denial Letter (**Attachment B**) with the appropriate box checked and the legal authority's signature. The request must be sent back to DBHDD and be postmarked within 15 days of the date the letter was confirmed as being received on USPS' Return Receipt.
 - a. If the noted response requesting a fair hearing is not received by DBHDD, with a postmark within 15 days of the Certified Mail being received from the member or their legal custodian/guardian, no further action is needed since the member and/or legal custodian/guardian did not request a fair hearing.
 - i. If the request for a fair hearing is received but postmarked after the 15 days of the Certified Mail being received, DBHDD sends a letter to member or their legal custodian/guardian indicating that their request for a hearing was denied based on not submitting the request within the timeframe. Step 9 a. ii. (below) is initiated
 - ii. DBHDD C&A will submit to DBHDD General Counsel the PRTF Admission Criteria, CBAY Continuing Stay Review, Continuing Stay Denial Letter (**Attachment B**), copy of Return Receipt of USPS Certified Mail, request from member or legal custodian/guardian for a fair hearing, envelope showing postmark, and copy of the letter sent to the member in Step 9. a. i.
 - b. If a response requesting a fair hearing is received and is postmarked from the member or their legal custodian/guardian within 15 days of the Certified Mail being received, Steps 10 and 11 (below) are initiated concurrently.
 10. If a hearing is requested, DBHDD State and Regional Office convenes to determine the reason for appeal.
 - a. If it is determined that the reason for appeal is related to medical necessity, DBHDD State Office submits a copy of the CBAY Continuing Stay Denial summary and Continuing Stay Denial Letter (**Attachment B**) to the DBHDD Medical Director or designee for a tertiary in-house clinical review. This review will not interrupt, hinder, or stop Step 11 from being initiated.
 - b. If it is determined that the reason for appeal is related to matters unrelated to medical necessity, DBHDD Medical Director or designee will not complete a review. This lack of review will not interrupt, hinder, or stop Step 11 from being initiated.

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- i. If there is suspicion of neglect or child abandonment, DBHDD will address the issue in accordance to state law.
11. DBHDD State Office, C&A Services notifies DBHDD General Counsel and DBHDD ERO of a request for fair hearing. DBHDD State Office, C&A Services provides DBHDD General Counsel with copies of the PRTF Level of Care Criteria, CBAY Continuing Stay Review, Continuing Stay Denial Letter (**Attachment B**), copy of Return Receipt of USPS Certified Mail, and request from member or their custodian/guardian for a fair hearing.
 12. DBHDD General Counsel requests a hearing from The Office of State Administrative Hearings.
 13. The Office of State Administrative Hearings receives request for an administrative hearing. The Office of State Administrative Hearings schedules a hearing date, time, and location and informs DBHDD General Counsel and the member of the hearing.
 14. DBHDD General Counsel informs DBHDD C&A Services and the ERO of the hearing date, time, and location.
 15. DBHDD case preparation occurs for hearing.
 16. On the date of hearing, DBHDD General Counsel and the member, or their legal custodian/guardian, with their desired representation meets before The Office of State Administrative Hearings.
 - a. If the member or their legal custodian/guardian withdraws the request for a hearing, no further action is necessary and PRTF Level of Care is denied.
 - b. If the member and/or legal custodian/guardian fail to show at the hearing, no further action is necessary and PRTF Level of Care is denied unless otherwise directed by The Office of State Administrative Hearings.
 - i. If the hearing is rescheduled, Step 14 will be re- initiated.
 - ii. If the hearing is dismissed, no further action is needed and PRTF Level of Care is denied.
 - c. If the ruling is upheld, no further action is necessary and PRTF Level of Care is denied. Member has the option to initiate Step 17 (below).
 - d. If the ruling is overturned, PRTF Level of Care is approved.
 - i. If DBHDD does not initiate Step 17, DBHDD will await court documentation from the Office of State Administrative Hearings to provide a copy to the ERO and Referring PRTF Provider to retro-authorize the member from the end date noted in Step 8 (above) to an end Authorization date of 365 days after the date of the hearing determination.

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17. DBHDD or Member appeals the ruling of the Office of State Administrative Hearings to the Commissioner at the Department of Community Health. If DBHDD or the member disagrees with the ruling, they have the option to initiate Step 18 (below).

18. DBHDD and Member go to Superior Court for a final determination.

IV. Denial, Reduction or Termination of Services Process for CBAY

1. Completed Action Plan packet is completed and sent to DBHDD's CBAY Staff at CBAYNotifications@dhr.state.ga.us by the member's Care Management Entity (CME).
2. The DBHDD CBAY Staff completes a clinical and waiver review of the packet within five (5) business days of the complete packet being received to determine if the waiver rules and regulations are being followed, as well as if clinical needs of youth are being met appropriately. The determination is made by the CBAY Staff's C & A Specialist and Waiver Coordinator.
 - a. If the CBAY Team determines that there is sufficient information to support the approval of the action plan and safety plan and requests for CBAY services, approvals are given and a feedback form is sent to the CME Supervisor via email by the Waiver Coordinator.
 - b. If the CBAY Team determines that there is insufficient information to support the approval of the action plan and requests for CBAY services during the five (5) days, follow up phone calls and emails are made with the CME Care Coordinator and Supervisor to obtain more information. All information gathering is documented.
 - i. If the Clinical Team determines there is sufficient information to support the approval of CBAY services, the CBAY team approval CBAY services and the action plan and the feedback form is sent to the CME Supervisor via email by the Waiver Coordinator.
 - ii. If the Clinical Team determines that there is still insufficient information to support the initial approval of CBAY services, denials, termination or reductions of services notices are created and emailed, along with the feedback form and submitted to the CME Supervisor via email by the Waiver Coordinator. (go to step 3)
3. The CME has five (5) days to take **Attachment C - Notice of Denial, Termination or Reduction** to the family and explain it to the family. They are responsible for explaining the rights of the family to the family and having the family sign the notice.
 - a. If the family agrees to the denial, reduction, or termination of service, the CME will witness the document and scan a copy and submit it back to the state office within 10 days.
 - b. If the family disagrees with the denial, reduction or termination of service, the CME will witness the document. The legal guardian/custodian must mail the original Notice of

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Denial, Termination or Reduction (**Attachment C**) back to the state office within 10 days to request a hearing.

4. DBHDD State Office, C&A Services receives the original Notice of Denial, Termination or Reduction (**Attachment C**).
5. DBHDD records the date that the original Notice of Denial, Termination or Reduction (**Attachment C**) was signed by the member or legal custodian/guardian. If the member or legal guardian/custodian wants a hearing, they must request a hearing by returning the notice with the appropriate box checked and the legal authority's signature. The request must be sent back to DBHDD and be postmarked within 15 days of the email noted in Step 2.b.ii.
 - a. If the noted response requesting a fair hearing is not received by DBHDD, with a postmark within 15 days of the email noted in Step 2.b.ii. from the member or their legal custodian/guardian no further action is needed since the member and/or legal custodian/guardian did not request a fair hearing.
 - i. If the request for a fair hearing is received but postmarked after the 15 days of the email noted in Step 2.b.ii, DBHDD sends a letter to member or their legal custodian/guardian indicating that their request for a hearing was denied based on not submitting the request within the timeframe. Step 5.a.ii (below) is initiated.
 - ii. DBHDD C&A will submit to DBHDD General Counsel the PRTF Admission Criteria, CBAY File, Notice of Denial, Termination or Reduction (**Attachment C**), copy of Sent Email, request from member or their custodian/guardian for a fair hearing, envelope showing postmark, and copy of the letter sent to the member in Step 5.a.i.
 - b. If a response requesting a fair hearing is received and is postmarked from the member or their legal custodian/guardian within 15 days of the email noted in Step 2.b.ii, Steps 6 and 7 (below) are initiated concurrently.
6. If a hearing is requested, DBHDD CBAY Office convenes to determine the reason for appeal.
 - a. If it is determined that the reason for appeal is related to medical necessity, DBHDD State Office submits a copy of the CBAY file, Notice of Denial, Termination or Reduction (**Attachment C**) to the DBHDD Medical Director or designee for a tertiary in-house clinical review. This review will not interrupt, hinder, or stop Step 7 from being initiated.
 - b. If it is determined that the reason for appeal is related to matters unrelated to medical necessity, DBHDD Medical Director or designee will not complete a review. This lack of review will not interrupt, hinder, or stop Step 7 from being initiated.

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- i. If there is suspicion of neglect or child abandonment, DBHDD will address the issue in accordance to state law.

7. DBHDD State Office, C & A Services notifies DBHDD General Counsel and DBHDD CBAY of a request for fair hearing. DBHDD State Office, C&A Services provides DBHDD General Counsel with copies of the CBAY File, Notice of Denial, Termination or Reduction (**Attachment C**), copy of Scanned letter, and request from member or their custodian/guardian for a fair hearing.

8. DBHDD General Counsel requests a hearing from The Office of State Administrative Hearings.

9. The Office of State Administrative Hearings receives request for an administrative hearing. The Office of State Administrative Hearings schedules a hearing date, time, and location and informs DBHDD General Counsel and the member of the hearing.

10. DBHDD General Counsel informs DBHDD C&A Services and the CBAY Staff of the hearing date, time, and location.

11. DBHDD case preparation occurs for hearing.

12. On the date of hearing DBHDD General Counsel and the member, or their legal custodian/guardian, with their desired representation meet before The Office of State Administrative Hearings.
 - a. If the member or their legal custodian/guardian withdraws the request for hearing, no further action is necessary and requested CBAY Services noted in Step 1 are denied.

 - b. If the member and/or legal custodian/guardian fail to show at the hearing, no further action is necessary and CBAY Services denied unless otherwise directed by The Office of State Administrative Hearings.
 - i. If the hearing is rescheduled, Step 12 will be re- initiated.
 - ii. If the hearing is dismissed, no further action is needed and requested CBAY Services noted in Step 1 are denied.

 - c. If the ruling is upheld, no further action is necessary and requested CBAY Services noted in Step 1 are denied. Member has the option to initiate Step 13 (below).

 - d. If the ruling is overturned, requested CBAY Services are approved.
 - i. If DBHDD does not initiate Step 13, DBHDD will await court documentation from the Office of State Administrative Hearings and provide a copy to the CBAY Staff and CME to permit authorization of member of requested CBAY Services noted in Step 1.

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13. DBHDD or Member appeals the ruling of the Office of State Administrative Hearings to the Commissioner at the Department of Community Health. If DBHDD or the member disagrees with the ruling, they have the option to initiate Step 14 (below).

14. DBHDD and Member go to Superior Court for a final determination.

VIA CERTIFIED MAIL

Name
c/o Legal Custodian
Street Address
City, State, Zip

Re: Eligibility

Dear Name:

Based on the information provided, it has been determined that you are not eligible to receive Psychiatric Residential Treatment Facility (PRTF) Level of Care services via the PRTF institution or the Community Based Alternatives for Youth (CBAY) Waiver. This determination is based on the information provided and gathered via your submitting provider. Your request for this level of care has been denied for the following reason: *Insert first paragraph of Denial Reason from Denial Summary*. If you would like additional information, please contact the submitting provider.

You have the right to a fair hearing on the denial of your eligibility for Psychiatric Residential Treatment Facility (PRTF) Level of Care services via the PRTF institution or the Community Based Alternatives for Youth (CBAY) Waiver. You may obtain a hearing by checking the box below and returning this document to the address listed below within 15 days of receiving this letter. If no response is received within the time limits discussed, you waive your right to a fair hearing. You may represent yourself at the hearing or use legal counsel, a relative, a friend or other spokesperson. The Office of State Administrative Hearings will notify you of your hearing date, time and location.

Check here if you are requesting a fair hearing

Signature (Parent or Legal Guardian)

Date

Comments: _____

Return to: **Attn: PRTF Review**
DBHDD, Division of Mental Health
Office of C & A Mental Health Services
2 Peachtree Street, N.W., Suite 23-436
Atlanta, GA 30303-3171

Please feel free to call with any questions that you may have.

Sincerely,

Reviewing Psychiatrist
APS Healthcare, Georgia External Review Organization

Cc: **Regional Program Specialist**
Child and Adolescent Mental Health Director
PRTF Program Director
CBAY Project Director
DBHDD General Counsel
Referring Provider

VIA CERTIFIED MAIL

Name
c/o Legal Custodian
Street Address
City, State, Zip

Re: Eligibility

Dear Name:

Based on the information provided, it has been determined that you are not eligible to receive continued Psychiatric Residential Treatment Facility (PRTF) Level of Care services via the PRTF institution or the Community Based Alternatives for Youth (CBAY) Waiver. This determination is based on the information provided and gathered via your submitting provider. Your request for continuing this level of care has been denied for the following reason: *Insert first paragraph of Denial Reason from Denial Summary*. If you would like additional information, please contact the submitting provider.

You have the right to a fair hearing on the denial of your eligibility for Psychiatric Residential Treatment Facility (PRTF) Level of Care services via the PRTF institution or the Community Based Alternatives for Youth (CBAY) Waiver. You may obtain a hearing by checking the box below and returning this document to the address listed below within 15 days of receiving this letter. If no response is received within the time limits discussed, you waive your right to a fair hearing. You may represent yourself at the hearing or use legal counsel, a relative, a friend or other spokesperson. The Office of State Administrative Hearings will notify you of your hearing date, time and location. As a reminder, per our policy, the member or legal custodian/guardian will be responsible for paying for all PRTF/CBAY services rendered after the date that the ERO determines that the youth no longer will meet criteria unless The Office of Administrative Hearings makes a ruling to overturn that determination.

Check here if you are requesting a fair hearing

Signature (Parent or Legal Guardian)

Date

Comments: _____

Return to: **Attn: PRTF Review**
DBHDD, Division of Mental Health
Office of C & A Mental Health Services
2 Peachtree Street, N.W., Suite 23-436
Atlanta, GA 30303-3171

Please feel free to call with any questions that you may have.

Sincerely,

Reviewing Psychiatrist
APS Healthcare, Georgia External Review Organization

Cc: **Regional Program Specialist**
Child and Adolescent Mental Health Director
PRTF/CBAY Program Director
DBHDD General Counsel
Referring Provider



Georgia Department of Behavioral Health & Developmental Disabilities
Frank E. Shelp, M.D., M.P.H., Commissioner

Division of Mental Health, Office of Community Mental Health
Two Peachtree Street, NW, Suite 23.415, Atlanta, Georgia 30303-3142

VIA EMAIL THROUGH CARE MANAGEMENT ENTITY

Name
c/o Legal Custodian
Street Address
City, State, Zip

Re: Service Authorization Request

Dear Name:

Your participation in the CBAY program has been given careful consideration. In accordance with the Code of Federal Regulations, _____, the following determination has been made:

A. You have been **DENIED** the following services because :

- Family Support and Training _____
- Respite _____
- Wraparound-Unskilled _____
- Supported Employment _____
- Transportation _____
- Community Transition _____
- Financial Support _____
- Customized Goods and Services _____
- Consultative Clinical and Therapeutic _____
- Community Guide _____

B. You have been determined to require **FEWER** of these services because:

- Family Support and Training _____
- Respite _____
- Wraparound-Unskilled _____
- Supported Employment _____
- Transportation _____
- Community Transition _____
- Financial Support _____



Georgia Department of Behavioral Health & Developmental Disabilities

Frank E. Shelp, M.D., M.P.H., Commissioner

Division of Mental Health, Office of Community Mental Health

Two Peachtree Street, NW, Suite 23.415, Atlanta, Georgia 30303-3142

- Customized Goods and Services _____
- Consultative Clinical and Therapeutic _____
- Community Guide _____

C. You have been determined to have the following services **TERMINATED** because:

- Family Support and Training _____
- Respite _____
- Wraparound-Unskilled _____
- Supported Employment _____
- Transportation _____
- Community Transition _____
- Financial Support _____
- Customized Goods and Services _____
- Consultative Clinical and Therapeutic _____
- Community Guide _____

Please check below if you agree to the determination made above. **If for any reason, you think the proper consideration has not been given to your situation, or if you disagree with this decision, you have the right to a hearing conducted by the Office of State Administrative Hearings.** You may obtain a hearing by checking the box below and returning this document to the address listed below within 15 days of receiving this letter. If no response is received within the time limits discussed, you waive your right to a fair hearing. You may represent yourself at the hearing or use legal counsel, a relative, a friend or other spokesperson. The office of State Administrative Hearings will notify you of your hearing date, time and location.

- Check here if you agree with the determination above Check here if you are requesting a fair hearing

Signature (Parent or Legal Guardian, if applicable)

Date

Comments: _____



Georgia Department of Behavioral Health & Developmental Disabilities

Frank E. Shelp, M.D., M.P.H., Commissioner

Division of Mental Health, Office of Community Mental Health

Two Peachtree Street, NW, Suite 23.415, Atlanta, Georgia 30303-3142

Witness/Title

Date

Return to: **Attn: CBAY Review**
DBHDD, Division of Mental Health
Office of C & A Mental Health Services
2 Peachtree Street, N.W., Suite 23-436
Atlanta, GA 30303-3171

If you have any questions, please contact your care coordinator.

Sincerely,

CBAY Waiver Coordinator

Date

Cc: DCH Program Manager
Child and Adolescent Mental Health Director
CBAY Project Director
DBHDD General Counsel



Chapter: Administrative Issues Related to Behavioral Health & Developmental Disabilities Service Delivery
Subject: Emergency Preparedness and Disaster Response – Basic Requirements for DBHDD Hospitals and Community Providers

Applicability:
• State Hospitals
• Community Providers

Original Effective Date: January 16, 1994
Revision #1 Effective Date: June 1, 2010
Scheduled Review Date: June 2011

Approved:

References:
Official Code of Georgia Annotated Chapter 37-1-20;
Rules of Georgia Department of Human Resources Public Health Chapter 290-5-45 Disaster Preparedness Plans, Georgia Emergency Operations Plan, Emergency Support Function 8, Section III.D Crisis Counseling, The Joint Commission

Audrey Sumner 4/29/10
Audrey Sumner, Director
Community Mental Health

Beverly D. Rollins 4/28/10
Beverly D. Rollins, M.P.A.,
Executive Director
Division of Developmental Disabilities

Cassandra Price 5/6/10
Cassandra Price, GCADC-II, MBA,
Executive Director
Division of Addictive Diseases

Attachments:
Attachment A - Georgia Mental Health Disaster Response Crisis Counseling Program Grant Funding Opportunities (Sample)

Frank E. Shelp 5/12/10
Frank E. Shelp, M.D., M.F.H., Commissioner

EMERGENCY PREPAREDNESS AND DISASTER RESPONSE – BASIC REQUIREMENTS FOR DBHDD HOSPITALS AND COMMUNITY PROVIDERS

POLICY

The DBHDD providers and Hospitals provide for the safety and care of consumers in the preparation for and response to emergency and disaster situations. In addition, under the Georgia Emergency Operations Plan (GEOP), Emergency Support Function (ESF) 8, Section III.D Crisis Counseling DBHDD designated providers provide mental health services to the general population during times of disaster and emergency.

DEFINITIONS

Emergency - an unexpected situation or sudden occurrence of a serious and urgent nature that demands immediate attention, which impedes or prohibits the continuation of normal activities.

Disaster - an occurrence causing widespread destruction and distress. Severe weather conditions such as ice storms, snow accumulations, storms or torrential rains,

DBHDD	SUBJECT: Emergency Preparedness and Disaster Response – Basic Requirements for DBHDD Hospitals and Community Providers	Policy: 04-102
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depending upon severity may be classified as either emergencies or disasters. Hurricanes, tornadoes, floods, droughts and earthquakes are usually classified as disasters.

Preparedness – activities that occur prior to an emergency or disaster to support and enhance response. Planning, training, exercising, and coordinating with other agencies, community awareness and education are among such activities.

Response – activities that address the immediate and short-term effects of an emergency or disaster. These activities help reduce casualties and damage and speed recovery. Response includes coordination and direction, communications and warning, evacuation and emergency support function responsibilities (crisis counseling).

Large providers – for the purpose of this policy, this term refers to agencies that contract with DBHDD for more than \$250,000 a year and DBHDD Hospitals

Small providers – for the purpose of this policy, this term refers to agencies that contract with DBHDD for less that \$250,000 a year

Local resources – Large providers’ personnel and supplies

PROCEDURES

1. Planning for Safety and Care of Consumers: Responsibilities for Large and Small Providers

Large providers and State Hospitals meet the standards for emergency and disaster preparedness established by the national accreditation or certification they are required to maintain (for example: The Joint Commission and/or the Commission on Accreditation of Rehabilitation Facilities).

Small providers meet the requirements for emergency and disaster preparedness established by DBHDD and found in the Provider Manual under Standards for all Providers in order to receive provider certification.

Assisted living facilities, personal care homes, and nursing homes meet the standards of the Rules of Georgia Department of Human Resources Public Health Chapter 290-5-45 Disaster Preparedness Plans in order to receive a license and/or certification from the Department of Community Health (DCH) Healthcare Facility Regulation Division.

State of Georgia Behavioral Health Emergency Preparedness Planning Kits, located on the DBHDD web site at <http://dbhdd.georgia.gov/portal/site/DBHDD/> under Disaster Mental Health, may serve as a guide for the development of emergency plans. The kits contain instructions and worksheets that assist facilities with the following:

DBHDD	SUBJECT: Emergency Preparedness and Disaster Response – Basic Requirements for DBHDD Hospitals and Community Providers	Policy: 04-102
		Page 3 of 4

- Hazard Vulnerability Analysis
- Continuity of Operations Planning
- Surge Capacity Planning
- Personnel Planning for Continuity of Operations and Surge Capacity
- Other Response Capabilities (including Financial Resiliency)
- Planning for Support of the Community Response

2. Responding to Disaster Mental Health Needs in the Community: Responsibilities of Large Providers

A. Background information regarding the Georgia Emergency Operations Plan

The Georgia Emergency Operations Plan (GEOP), Emergency Support Function 8, Section III.D Crisis Counseling states that DBHDD will manage crisis counseling and mental health assistance in coordination with the American Red Cross (ARC), local religious organizations and private agencies and organizations. In the case of an airline accident, federal law designates the ARC as the coordinator of crisis counseling and mental health services. In this case, DBHDD coordinates with the ARC and renders assistance as requested. The GEOP is located on the Georgia Emergency Management Agency web site at <http://www.gema.state.ga.us>

B. Preparation

In addition to using the State of Georgia Behavioral Health Emergency Preparedness Planning Kits (located on the DBHDD web site at <http://dbhdd.georgia.gov/portal/site/DBHDD/> under Disaster Mental Health) to plan for the for the safety and care of consumers, large providers are encouraged to use the Planning for Support of the Community Response section of the kits to develop plans that assist in providing mental health services to the general population during times of disaster and emergency.

Each quarter, the DBHDD State Office Emergency Preparedness Coordinator requests from large providers an update of the provider’s emergency contact information for use in the event of an emergency or disaster. This contact information includes office, home, cell/blackberry and/or pager numbers. This information will be made available to the Regional Coordinators, Regional Hospital Administrators and DBHDD State Office. Corresponding information for Regional Coordinators and Hospital Administrators will be made available to large providers.

Large providers will participate in community emergency and disaster planning by attending planning meetings and participating in drills and exercises with community partners (e.g. county emergency management agencies and Public Health Districts).

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Employees of large providers are encouraged to attend training in Georgia Disaster Mental Health Field Response and/or American Red Cross Disaster Mental Health. The number of staff trained will be determined by the planning needs of each provider. These staff members also participate in the National Incident Management System training that is available on-line at the Federal Emergency Management Agency (FEMA) web site <http://www.fema.gov> under Training.

C. Response

Response to an event takes place on the local level.

Large providers will deploy local resources as available upon the request of a local authority (e.g. county emergency management agency) and/or the Regional Office.

If an event becomes too large for the local resources to handle, a request for additional resources is made by the large provider to the Regional Office that serves the area where the event occurred.

D. Federal Emergency Management Agency (FEMA) Crisis Counseling Assistance and Training Program (CCP)

In the case of a Presidentially declared disaster, the Regional Office contacts large providers who serve the counties included in the Presidential declaration.

Large providers serving the counties included in the Presidential declaration conduct a needs assessment and provide feedback to the Regional Office as to whether or not they feel they will be able to meet the disaster-related mental health needs of the community. **See Attachment A – Georgia Mental Health Disaster Response Crisis Counseling Program Grant Funding Opportunities (Sample).**

If the needs assessment determines that the large provider can not meet the disaster-related mental health needs of the community, a Federal Emergency Management Agency (FEMA) Crisis Counseling Assistance and Training Program (CCP) implemented. Information about the FEMA CCP is available on the Substance Abuse and Mental Health Services Administration Disaster Technical Assistance Center web site at <http://mentalhealth.samhsa.gov/dtac> under FEMA Crisis Counseling Program.

E. Reimbursement

Large providers maintain separate records of all expenses associated with disaster response. Details of managing reimbursement are coordinated by the State Office at the time of the emergency or disaster.

**Georgia Mental Health Disaster Response
Crisis Counseling Program Grant Funding Opportunities
Georgia Disaster:
FEMA-XXXX-DR, Georgia**

Presidential Declaration Effective Date:
Declaration Expanded:
Incident Type:
Date(s) of Incident Period:
Presidentially Declared Counties:
Counties Declared Eligible for Individual
Assistance that Qualify for crisis counseling:

FEMA Immediate Services Program (ISP) Grant	Grant request is due within 14 calendar days of Presidential Declaration
Immediate Response Period:	Date of Incident to submission of ISP grant application (up to 14 days)
ISP	Up to 60-day grant beginning with Disaster Declaration date, based on needs assessment
ISP Extension	An ISP Extension may be requested to allow for federal review of a RSP grant
CMHS Regular Services Program (RSP) Grant	Grant request is due within 60 calendar days of Disaster Declaration, and provides funding for up to nine months, based on needs assessment

When a Presidentially declared disaster occurs involving Georgia, the Georgia Emergency Management Agency (GEMA) initiates emergency disaster response. GEMA receives funding through the Federal Emergency Management Agency (FEMA) to cover certain disaster recovery expenses. The Robert T. Stafford Disaster Relief and Emergency Services Act makes funding available immediately for disaster recovery, including a mental health response. GEMA submits allowable actual expenditures for reimbursement, based on state agency involvement and related requests for reimbursement. This same Act recognizes the need for a mental health response in disasters and provides Federal assistance through a crisis counseling program (CCP) grant opportunity. The Act recognizes that there may be limited mental health resources to adequately respond to the disaster and offers funding assistance for mental health disaster response. A State or Federally-recognized Indian Tribe may apply for a crisis counseling grant to assist those counties in Georgia that are declared eligible for Individual Assistance through the Presidential declaration. When a Presidentially declared disaster occurs, the Mental Health Preparedness Planner will coordinate mental health response activities through GEMA and the Regional Offices. The Mental Health Preparedness Planner will work with the Regional Offices to ensure that crisis counseling and outreach response is initiated and perform an assessment of mental health capacity and needs in the local area(s) to ensure an appropriate mental health response as well as to assess the need for an Immediate Services Program (ISP) CCP grant. The Regional Offices will coordinate the response with local provider(s). During the immediate response period which is the two weeks following the disaster incident, crisis counseling and outreach should be provided if deemed appropriate and providers should document expenditures, the nature of response activity and related numbers of person served (individual persons are not identified in response records). At the same time, a needs assessment will be conducted and a determination will be made as to whether the state should apply for a CCP grant. If so, the Mental Health Preparedness

Planner, in conjunction with local input, will develop an application which is due within 14 days of the disaster declaration. This is a lot of activity in a very short period of time, but it is also an important opportunity to provide for adequate funding for the disaster mental health response. The ISP covers the first 60 days, and possibly an additional month or so of service. To the extent further time is needed for an appropriate mental health response, State's may apply for a Regular Services Program (RSP) that could extend through the anniversary of the disaster. The ISP and RSP are two entirely separate grants that are funded by separate federal agencies thereby requiring a separate application and related budget for each. The Department of Behavioral Health and Developmental Disabilities (DBHDD) will coordinate development of the grant application(s), however, a lot of input is needed from the local areas. FEMA and SAMHSA require detailed budget requests supported by detailed narratives.

The ISP CCP is funded by FEMA under the authority of the Robert T. Stafford Disaster Relief and Emergency Services Act which authorizes FEMA to fund emergency mental health assistance and training activities immediately in disaster declared areas. On behalf of FEMA and through interagency agreement, the Center for Mental Health Services (CMHS) provides grant technical assistance, program guidance and oversight. Funding for an ISP grant is drawn down by the mental health agency through the Georgia Emergency Management Agency. For RSP grants, FEMA transfers funds to CMHS, so it is drawn down by the mental health agency through CMHS, SAMHSA through a Notice of Grant Award (NOGA). Therefore, the ISP and RSP are administered as two entirely separate grants. There are no state or local match requirements for the grants, but it is expected that in-kind resources will be made available to support the grant. Examples could include office space, equipment, telephone line, payroll function, meeting rooms, etc.

A crisis counseling grant is intended to provide outreach and referral services and short-term intervention counseling for mental health problems caused or aggravated by the disaster in instances where expenses for such cannot be met by insurance or other programs. An ISP grant, a 60-day program which begins on the date of the disaster declaration, may be requested for specific areas based on a needs assessment to cover the two reimbursable components of a CCP:

1. **Immediate Response Period:** Costs incurred to carry out outreach and crisis counseling services funded by the CCP may be reimbursed from the Date of Incident (DOI) through the date the ISP is applied for. **To the extent the state applies for an ISP grant, immediate disaster response costs may be covered through this grant in counties even though they may not pursue an ISP for their area.** For example, two counties may be hit very hard and will require an ISP and perhaps a RSP to meet crisis counseling needs. To the extent that the state applies for an ISP to cover these two counties, other disaster declared counties are eligible to recoup documented and allowable immediate response period costs. **A provider who incurs costs to provide crisis counseling response in the immediate response period may seek grant reimbursement for that period although their area may not choose to participate in the additional ISP period.** For grant application purposes, a broad estimate of expenses is needed. However, the grant award for this period is based on actual expenditures.
2. **Immediate Services Program Period:** Covers costs incurred to carry out outreach, crisis counseling, assessment and services to groups funded by the CCP through the remainder of the 60-day period. To the extent the state applies for a RSP grant, an ISP grant extension request may be required to allow time for federal approval of the RSP grant.

During the ISP grant period, the state and local agencies update the needs assessment and make a determination as to whether a RSP grant will be requested. A RSP grant, generally for 9-months or leading up to the disaster anniversary, may be requested for specific areas based on a needs assessment to continue outreach and crisis counseling services to help deal with mental health problems caused or aggravated by the disaster. The RSP grant application is due within 60 days of the disaster declaration. By way of an ISP grant extension if needed, the RSP grant immediately follows the ISP grant, without a break in service period.

Following a disaster event an immediate mental health response is expected. Additionally, an assessment of needs must be undertaken by the State and local mental health agencies. State and local resources must be considered first in order to meet the needs assessed. To the extent that existing resources cannot meet expected needs, the State may apply for an Immediate Services Program to provide crisis counseling services for those areas deemed eligible for Individual Assistance. Requested funds must supplement, not supplant, existing state or local resources. In the CCP, most programs rely heavily on newly hired staff or hourly staff with some involvement of existing State and local staff. On-going service needs generally preclude extensive use of existing staff in the CCP. Separate budgets for the immediate response period, ISP and RSP must be detailed and justified for each provider and costs should be consistent with the needs assessment. The State oversees the development of the grant applications and insures consistency among providers or areas.

Services Funded (excerpts from <http://www.mentalhealth.samhsa.gov>)

Disaster mental health interventions include outreach and education for disaster survivors, their families, local government, rescuers, disaster services workers, business owners, religious groups and other special populations. The CCP is primarily geared toward assisting individuals in coping with the extraordinary stress caused by the disaster. Programs are strongly encouraged to coordinate with other public and private agencies responding to the disaster to ensure that needs are met with the most effective use of existing resources. The CCP does not support long-term, formal mental health services such as medications, office-based therapy, diagnostic services, psychiatric treatment or substance abuse treatment. Services that are supported are short-term interventions with individuals and groups experiencing psychological reactions to a major disaster and its aftermath. Outreach is the primary method for delivering crisis counseling services to disaster survivors. It consists primarily of face-to-face contact with survivors in their natural environments in order to provide disaster-related crisis counseling services.

The following descriptions characterize services most frequently funded by the CCP:

- **Individual Crisis Counseling Services** assist disaster survivors in understanding their current situation and reactions, reviewing their options, addressing their emotional support and linking with other individuals and agencies that may be able to assist them. During individual services, crisis counselors are active listeners who provide emotional support.
- **Group Crisis Counseling Services** involves providing/facilitating support groups, meeting with citizens, working in classrooms with affected students, working with affected teachers and administrators after school, discussing disaster-related issues with families, assisting people in understanding their current situation and reactions, reviewing their options, addressing their emotional support and linking with other individuals and agencies who may provide assistance. Groups may be facilitated by a mental health professional, a paraprofessional or the group members themselves.

- **Education Services** include the distribution or presentation of information on the project or crisis counseling-related topics. Educational information may be provided through brochures, flyers posted in public areas, mailings and training to human service personnel such as the clergy or teachers. The media is often a partner in providing information through Public Service Announcements, newspaper articles and advertisements. Educational information may also be provided to groups of people. The key difference between group education services and group crisis counseling services is that project staff present psycho-educational information to groups rather than facilitate the sharing of experiences between members of the group.
- **Referrals** are a key component of the CCP. In most disasters, the majority of survivors have needs that can be met by short-term, relatively informal interventions. However, in some circumstances, some disaster survivors may need long-term, more formal mental health services that are beyond the scope of the CCP. Survivors requiring longer-term, more formal mental health treatment should be referred to an appropriate agency or licensed mental health professional. Some disaster recovery needs may be more physical, structural or economical in nature and addressing these issues is outside the scope of the CCP. In these instances, CCP staff perform a key role in referring survivors to specific disaster services available through FEMA Tele-registration, the American Red Cross, the Salvation Army, Interfaith Disaster Recovery Services and Unmet Need Committees.

CCP Reimbursable Cost Guidelines

Cost Type	Nature of Cost	Allowable Costs
Labor		Crisis counselors or outreach workers to provide direct services to disaster-impacted persons; their managers or supervisors and administrative or fiscal support staff equivalent time, given the additional considerations below. Agency/provider established fringe benefits rates should be followed, which may be different for hourly or temporary employment. Be mindful of compliance with FLSA requirements.
	Salaried staff	Only overtime labor costs are eligible for emergency mental health and outreach work. Applicable fringe benefits are allowable, and must be identified separately. An organization's pre-disaster policy on overtime work performed by salaried staff will determine whether or not overtime is reimbursable.
	Temporary staff, labor or hourly rate, hired or assigned to disaster response	Regular and overtime labor costs for temporary staff hired or assigned to perform disaster-related mental health and outreach work, including identified fringe benefits.
	Part-time labor/staff	Excess regular and overtime costs for part-time employees (only for hours worked over their normal work schedule), including identified fringe benefits – which may vary from permanent labor benefit costs
	Contract labor	Contract labor to perform disaster-related mental health and outreach work
Travel		Necessary mileage and related per diem required in response to disaster-related mental health and

		outreach work, in accordance with established agency reimbursement policies. No out-of-state travel is allowable.
Equipment	Rented/leased or purchased	Equipment used in response to disaster-related mental health work, amount claimed may be based on an internally-developed equipment usage rate depending on actual usage and may require deduction of salvage value
Materials and supplies	Inventory or Purchased	<ul style="list-style-type: none"> ○ Organizations using an existing inventory of materials and supplies to assist in the mental health disaster response may be reimbursed for the reasonable cost of replenishing the inventory. ○ Purchased materials and supplies used to assist in the mental health disaster response ○ Can include copy paper, printer or copy cartridges, and basic office supplies associated with mental health and outreach response. Can also include supplies e.g. caps or shirts used to identify or associate with program. Budget can be estimated, reimbursement requests must be itemized. ○ Unallowable costs include food and beverages, medications, disaster kits, stuffed animals, toys, etc.
Telephone		Can include telephone line charges, cell phones or pagers to help assure staff safety for CCP staff/equivalent, and conference call fees for CCP communications.
Media Advertising		<ul style="list-style-type: none"> ○ Development and production of brochures, flyers, posters, television or radio spots to provide information about the CCP. ○ Advertisements to recruit staff, publicize services available to disaster survivors, or educate the public concerning typical reactions to the disaster.
Postage		Postage or other delivery costs, such as overnight.
Miscellaneous		Other justifiable direct charged miscellaneous costs associated with the mental health and outreach response. Costs must be itemized.
Data collection		Costs associated with program activity data collection, evaluation and reporting, using the CCP toolkit, collecting and entering data into an Access database, and evaluating outreach and program activity and reach.
Hotline		24/7 mental health crisis response access line costs
Indirect Costs		Not allowable

PROVIDER INFORMATION

County(s) Services Provided in: _____

Provider Name: _____ EIN: _____

Provider Address: _____

Primary Contact Person Name: _____

Primary Contact Person Telephone No: _____

E-Mail Address: _____

SAMPLE

Provider Level Budget Request

Provider Agency:	Immediate Response Period				Immediate Services Program					Total	
	Declaration - ISP Applic., 1st 14 days				Date of declaration up to 60 days						
Budget Category	No. Rate	No. Hours	Type Pos.	Total Req. for Reimb	No. Rate	No. Hours	No. Pos.	Total for Wks	Total Grant Request	In-Kind	Program Cost
Personnel											
(Identify pos. by salaried, temporary, hourly, contracted)											
Fringe Benefit Rate Temp/Hrly											
Fringe Benefit Rate Salaried											
Total Personnel											
Consult/contracts/fees											
List each											
Office Space											
Supplies											
Office Supplies											
Computer Supplies											
Telephones											
Cellphones											
Pagers											
Postage, freight, delivery											
Fingerprint charges											
Background investigation chg.											
Other - describe											
Total Supplies											
Travel											
Mileage											
Lodging											
Per Diem											
Training											
Trainer Fee											
Trainer Travel											
Meeting Room Fee											
Audio Visual Fee											
Media, advertising, printing											
Describe each											
Hotline											
Data Entry and Evaluation											
Data Consultation											
Total Grant											



Chapter: Developmental Disabilities Community Services
Subject: Process for Enrolling, Matching, and Monitoring Host Homes/Life-Sharing Sites for DBHDD Developmental Disabilities Community Service Providers

Applicability: DD Provider Agencies with a contract or letter of agreement with DBHDD.

Original Effective Date: July 1, 2010
Revision #2 Effective Date: October 1, 2011
Scheduled Review Date: October 2013

References:

Approved:

Attachments:

None

Signatures and dates of Beverly D. Rollins, Bryce McLaurin, and Frank E. Shelp.

POLICY

DBHDD provides guidance to community providers in the process of enrolling, matching and monitoring of Host Home/Life-Sharing sites.

DEFINITIONS

Host Home/Life-Sharing refers to a private residence in a residential area in which the occupant owner or lessee provides Community Residential Alternative services to one or two persons with developmental disabilities who are not related to the occupant owner or lessee by blood or marriage.

Community Residential Alternative (CRA) - Services which are targeted for individuals who require intense levels of residential supports in small group setting of four or less, foster homes, or host home/life-sharing sites, and include a range of interventions with particular focus on training and support in one or more of the following areas: eating and

DBHDD	SUBJECT: Process for Enrolling, Matching, and Monitoring Host Home/Life-Sharing Sites for DBHDD Developmental Disabilities Community Service Providers	Policy: 02-704
		Page 2 of 8

drinking, toileting, personal grooming and health care, dressing, communication, interpersonal relationship, mobility, home management, and use of leisure time.

Provider Agency- For the purposes of this policy, the term provider agency include organizations that provide developmental disabilities CRA services that are financially supported in whole or in part by funds authorized through DBHDD.

PROCEDURES

A. ENROLLING HOST HOMES/LIFE-SHARING SITES

1. Current and New DBHDD providers must meet the following requirements prior to enrolling Host Home/Life-Sharing sites as a CRA service option:
 - DBHDD provider must be a provider of DD Community Residential Alternative (CRA) services **AND**
 - DBHDD provider must be in business for twelve (12) months delivering Developmental Disabilities (DD) Community Residential Alternative services **AND**
 - DBHDD providers cannot enroll any Host Home/Life-Sharing site until the CRA service/site in the initial provider application have successfully achieved full accreditation and/or complete compliance with the Standards Compliance Review, for a minimum of six (6) months. Provisional status of any type will not be accepted.
2. DBHDD provider agencies are required to make a thorough evaluation of each prospective Host Home/Life-Sharing family/individual and document this evaluation in a Host Home/Life-Sharing study report. This is completed and/or updated as changes in the required home study information occur or when there is a vacancy to be filled.

Note:

- **Only one (1) DBHDD approved CRA provider agency may enroll and provide CRA services at any Host Home/Life-Sharing site.**
 - **Host Home/Life-Sharing providers cannot be the owner of a Personal Care Home (PCH) or Community Living Arrangement (CLA).**
3. Based on the Host Home/Life-Sharing study report and any supporting documents, the DBHDD provider agency notifies the potential Host Home/Life-Sharing provider in writing as to whether or not the Host Home/Life-Sharing provider has been deemed appropriate to work with their organization.

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		Page 3 of 8

4. Each Host Home/Life-Sharing site must have a site specific Medicaid Provider (CRA) number assigned by the Department of Community Health (DCH) before placement of any person into that particular Host Home/Life-Sharing site.
5. DBHDD provider agencies must submit the Host Home/Life-Sharing study, all supporting documentation, and Host Home/Life-Sharing provider's evidence of required competency-based training, along with the DBHDD and DCH application for a site specific number to DBHDD Office of Provider Network Management for review.

Supporting documents for the Host Home/Life-Sharing study include the following:

- A general health examination of each member living in the potential Host Home/Life-Sharing site
- Evidence of screening for tuberculosis and communicable disease for each member living in the potential Host Home/Life-Sharing site
- Criminal records check/clearance
- A minimum of three (3) character references
- Proof of homeowner's, renters insurance or personal property insurance
- Statement as to whether or not there are firearms in the home
- Documentation of home ownership (ex. current mortgage statement) or renter's lease. Document(s) must be in the name of the potential Host Home/Life-Sharing provider.
- The home study is completed, signed and dated by a designated employee of the agency or professional under contract with the agency and reviewed, signed and dated by the Agency Director or Developmental Disabilities Professional (DDP).
- Signed statement from potential Host Home/Life-Sharing provider indicating the receipt and review of the Operational Standards for Host Home/Life-Sharing and the Policy for Enrolling, Matching and Monitoring Host Home/Life-Sharing sites for DBHDD Developmental Disabilities Community Providers.

The adult family member who has primary responsibility to the individual and for providing services to the individual has at least the following training *prior* to the DBHDD provider agency making application for a site specific Medicaid provider number:

- Person centered values, principles and approaches
- Human Rights and responsibilities
- Recognizing and Reporting Critical Incident
- Individual Service Plan
- Confidentiality of individual information, both written and spoken
- Fire Safety
- Emergency and disaster plans and procedures
- Techniques of standard precautions
- Basic cardiac life support (BCLS)
- First aid and safety
- Medication Administration and Management/Supervision of Self-Medication

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The DBHDD provider agency must submit evidence of the type of training, content, dates, length of training, and/or copies of certificates. A signed attestation between the agency and the potential host home provider, which indicates the receipt of trainings, must also be submitted.

(See current DBHDD Provider Manual, in the Section titled *Operational Standards for Host Home/Life-Sharing* for additional information).

6. Host Home/Life-Sharing applications must not be submitted for any location that is currently licensed as a PCH or CLA. Licensed PCH or CLA providers must relinquish their license prior to making application to become a Host Home/Life-Sharing site. A Host Home/Life-Sharing study must be submitted, along with documentation of the surrender of the perspective license and the required trainings (by evidence of training certificate or signed attestation indicating receipt of training), to DBHDD Office of Provider Network Management.

B. MATCHING INDIVIDUAL AND HOST HOME/LIFE-SHARING PROVIDER

1. When an individual is identified for potential placement in a Host Home/Life-Sharing site, provider agencies must forward a summary of the Host Home/Life-Sharing study report to Support Coordination or the Planning List Administrator. A summary of the Host Home/Life-Sharing study may include, but is not limited to: Address and access to local services, current living arrangement, names and ages of the family/individuals residing in the home, previous work history, education and religious affiliation, membership or participation in community organizations, DBHDD provider recommendations etc.
2. The Host Home/Life-Sharing study report is reviewed by all stakeholders during the transition planning and/or Individual Service Plan (ISP) meeting to ensure an appropriate match between the individual and the Host Home/Life-Sharing provider.
3. DBHDD provider agencies discuss the prospective placement with the Host Home family/individual and shall prepare the family/individual for the placement of a particular person with developmental disabilities by anticipating the adjustments and problems that may arise during placement and provide any specialized training and support.

C. SUBMISSION OF ADMINISTRATIVE COST & PAYMENT INFORMATION TO THE DIVISION OF DD

The DBHDD provider agency must submit specified information to the Division of Developmental Disabilities (Division of DD) pertaining to **administrative cost and payment to the Host Home /Life-Sharing Provider**

The requirements for administrative costs of the CRA provider agency and the agency's payment to the Host Home/Life-Sharing provider are as follows:

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- The budget and payment to the Host Home/Life-Sharing provider for each individual in each Host Home/Life-Sharing services enrolled by the DBHDD provider agency must support the amount of payment to the Host Home/Life-Sharing provider that allows for the provision of the CRA services specified in the ISP of the individual, and ensures the health and safety of the individual in the Host Home/Life-Sharing arrangement.
- The budget and agreed payment of the Host Home/Life-Sharing provider must be submitted to the Division of DD prior to any individual moving into a Host Home/Life-Sharing residential setting, whenever there is an enhancement or decrease in the individual's residential allocation, and on an annual basis (by June 30). Host Home/Life-Sharing providers of individuals with exceptional rates receive a higher payment based on enhanced services provided by the Host Home/Life-Sharing provider.
- Each individual's budget submitted to the Division of DD must include, but is not limited to the individual's name and Medicaid number, address and contact information of the Host Home/Life-Sharing.

Provider agencies must comply with DBHDD Policy:

Management/Supervision/Safeguarding of Possessions, Valuables, Personal Funds and Day-To-Day Living Expenses in Developmental Disabilities Residential Services in the current Provider Manual at the website

<http://dbhdd.georgia.gov/portal/site/DBHDD/> (click Provider Information and Provider Tool Kit).

D. MONITORING HOST HOMES/LIFE-SHARING SITES

1. DBHDD provider agencies ensure compliance with the Host Home/Life-Sharing Policy and Operational Standards, DCH COMP Waiver, and current Fiscal Year (FY) DBHDD Provider Manual.
2. DBHDD provider agency completes an initial Site Inspection of each Host Home/Life-Sharing residential setting the agency has approved to operate. The Support Coordinator or DBHDD Regional Office designee conducts a follow-up site inspection.
3. Support Coordinator and/or the Planning List Administrator conducts home visits, at least on a monthly basis, to monitor the person's progress in the specific Host Home/Life-Sharing site, and to ensure that the Host Home/Life-Sharing provider is delivering the supports in accordance with the individual's ISP.
4. DBHDD provider agency conducts home visits at least monthly, in order to verify that the Host Home/Life-Sharing site is delivering care, room and watchful oversight in a safe and healthy environment. The DBHDD provider agency should evaluate and document the following during each visit:
 - Available services, supports, care and treatment. This includes, but is not limited to the service needs addressed in the ISP.

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- Human and Civil Rights are maintained.
- Oversight of Self-Administering of Medication Administration (if applicable) or that the administering of medication follows federal and state laws, rules and regulations.
- Person Centered Focus is Evident in Documentation.
- Information and documentation management is protected, secure, organized and confidential.
- The host home/life-sharing environment demonstrates respect for the individual(s) served and is appropriate to the supports provided. This includes, but is not limited to, the physical environment, review of disaster and fire safety plan, required training, community inclusion, personal funds, and vehicle transportation requirement.

(See current DBHDD Provider Manual in the Section titled *Standards for All Providers* for additional information).

This evaluation is shared with the Host Home/Life-Sharing family/individual and made available for review by the Support Coordinator or DBHDD staff as evidenced by the signature of the Host Home/Life-Sharing family/individual and the DBHDD provider agency. A copy of each monthly visit and written summary of correction made is kept in the Host Home/Life-Sharing site.

5. The DBHDD provider agency completes a self-assessment of the Host Home/Life-Sharing site on an annual basis. The annual assessment should include, but is not limited to, items identified in #4 above. A copy of the agency's self-assessment results and a written summary of corrections made are kept in the home for at least one (1) calendar year.
6. DBHDD Regional Offices and designated staff from the Division of DD provide technical assistance to DBHDD provider agencies enrolling Host Home/Life-Sharing sites.
7. The Division of DD conducts quarterly Quality Assurance reviews of provider agencies contracting Host Home/Life-Sharing sites. Reviews may include, but are not limited to, Support Coordinator ratings of 3's and 4's. Based on these reviews, the Division of DD will recommend and/or implement the following, which includes, but is not limited to, the movement of the individuals from the Host Home/Life-Sharing sites, full standards compliance review, and/or moratorium on the enrollment of Host Home/Life-Sharing sites for a specific DBHDD provider agency.

E. TERMINATION OF CONTRACT BETWEEN THE HOST HOME/LIFE-SHARING SITE AND CRA PROVIDER AGENCY

DBHDD	SUBJECT: Process for Enrolling, Matching, and Monitoring Host Home/Life-Sharing Sites for DBHDD Developmental Disabilities Community Service Providers	Policy: 02-704
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1. When a Host Home/Life-Sharing provider no longer wants to provide services to the individual and/or wants to end its subcontract with the DBHDD provider agency, they must give at least thirty (30) days written notice to:
 - The individual(s) served
 - The DBHDD provider agency under contract

2. When a Host Home/Life-Sharing provider initiates termination and ends its subcontract with the provider agency, the following applies:
 - The Host Home/Life-Sharing provider must relinquish CRA service provision for the individual(s) supported to the contracted DBHDD provider agency and assist the DBHDD provider agency with the movement of the individual(s).
 - The Host Home/Life-Sharing provider must not serve the same individuals they previously served when contracting with another DBHDD provider agency.

3. The Host Home/Life-Sharing provider is expected to continue working for thirty (30) days unless otherwise determined by the DBHDD provider agency or DBHDD.

4. If an emergency occurs and services must be terminated immediately, the Host Home/Life-Sharing provider must give immediate notice to all parties listed in the section above.

5. The DBHDD provider must submit both DBHDD and DCH Change of Information forms to DBHDD Office of Provider Network Management to deactivate the Host Home/Life-Sharing provider number.

F. TRANSFERRANCE OF HOST HOME/LIFE-SHARING SITES

The DBHDD provider agency and Host Home/Life-Sharing provider cooperate as requested by DBHDD to effectuate the smooth and reasonable transition of the care and services for individuals as directed by DBHDD. This includes, but is not limited to, the transfer of the individual records, personal belongings, and funds of all individuals as directed by DBHDD.

DBHDD reserves the right under all Host Home/Life-Sharing agreements to transfer a Host Home/Life-Sharing site to another DBHDD provider agency on the following grounds:


- DBHDD termination of the contract/letter of agreement, or agreement with the DBHDD provider agency.
- DBHDD provider agency termination of the contract/letter of agreement.
- The Individual or Family/Representative's termination of the relationship with an identified contracting provider agency, (which requires the termination of the site specific Medicaid Provider Number by the contracting provider agency).

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In either case above, the Host Home/Life-Sharing provider must be in agreement to contract with another DBHDD provider agency if they want to serve the same individual(s).

Prior approval for the transfer of the Host Home/Life-Sharing site to an alternative DBHDD provider agency must be given by the designated DBHDD, Regional Coordinator.

LEGAL REFERENCES O.C.G.A. 37-1-20(18) and (19)

	Department of Human Resources Online Directives Information System	Index: Revised: Review:	PRO1244 02/01/2005 02/01/2011
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SUBJECT: External Entities Audit Standards

PROCEDURE

Entities that contract with the Department must meet certain financial reporting requirements. These requirements are defined in: the Single Audit Act Amendment of 1996; OMB Circular A-133; Contract Provisions; DHR Policy; and [Title 50, Chapter 20, Sections 1](#) through [8](#) of the Official Code of Georgia Annotated. The requirements vary according to the dollar amount expended by the entity during its accounting year. The Office of Audits and the DHR Programmatic Division have certain responsibilities that are delineated below. Several words and phrases are used in these procedures that may have meaning that is special to these procedures. These words and phrases are defined below.

The address for the DHR Office of Audits is:

DHR Office of Audits
Two Peachtree Street, NW
Suite 26.425
Atlanta, Georgia 30303-3142

The address for the State Department of Audits is:

State Department of Audits and Accounts
Professional Practices Division - Suite 214
254 Washington Street SW
Atlanta, Georgia 30334-8400

1. Definitions

Budget Category: A numbering system used for budget and accounting purposes that corresponds to a specific program name. Numbers reduce chances of confusion with similar program names.

Contractor's Fiscal Year: The 12-month accounting period established by the entity as its business year, which is on file with the U.S. Internal Revenue Service as the basis for filing required tax and Tax Exempt Status Returns.

Entity: An organization receiving funds from DHR exclusive of DHR field offices.

Expense Category: A numbering system corresponding to a list of specific services within a Budget Category, where the amount of funds used to pay for the service are recorded for accounting purposes.

Independent Auditor:

- A Certified Public Accountant (CPA); or
- A Registered Public Accountant (RPA) licensed on or before December 31, 1970; or
- A government Auditor located outside the staff or line management function of the unit under audit.

To be independent, the auditor's relationships with the auditee is of such an "arm's length" nature so as to preclude any **appearance** of bias, or any obligation to or interest in the auditee, its management or its owners. Relationships or combinations of relationships with the auditee must not create any conflict of interest that impairs the auditor's integrity and objectivity with respect to the audit engagement. It is inappropriate in some circumstances for auditors to perform both audit and non-audit services for the same client.

Major Program: A federally funded program determined by the auditor to be a major program in accordance with OMB circular A-133, Section_.520 or a program defined as a major program by a federal agency or pass-through entity in accordance with Section_.215(c).

Nonprofit Organization: Any corporation, trust, association, cooperative, or other organization that is operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest; is not organized primarily for profit; and uses its net proceeds to maintain, improve, or expand its operations.

Program: A grouping of activities and resources to accomplish a mission with specific goals and objectives. Some programs have names, some have numbers, and some have both. Usually programs are budgeted by number for ease of tracking and to reduce potential confusion. Budget categories can and are considered to be programs. Federal programs are considered to be those activities that are or can be assigned a single number in the Catalog of Federal Domestic Assistance (CFDA). When no CFDA number is assigned, all federal awards from the same agency made for the same purpose are to be combined and considered one program. Throughout this procedure, the term "program" refers either to a named activity or an activity that is numbered.

Public Entity: Includes, but is not limited to: state and local governments and their instrumentalities; authorities; county Boards of Health; Community Service Boards; and District Attorneys (judicial circuits) operating Child Support Enforcement programs through contracts with DHR.

Schedule of State Awards Expended: A schedule arranged by state program name and contract number that reflects revenues, expenditures, or expenses and amounts owed to and due from each state organization. Amounts listed for each program should include federal funds that pass through state organizations to the entity.

2. Requirements Prior to Contract

Prior to executing a contract between the DHR and a non-profit organization, the organization furnishes a previous year's audit. If the entity has been in existence for less than a year, then they furnish unaudited financial statements. If no audit or unaudited financial statements are on record with DHR, the following procedure is followed:

- The contracting division or Office of DHR requests such audit or financial statements as part of its negotiation or solicitation process.
- The entity furnishes an audit report (or unaudited financial statements, if appropriate) to the DHR Office of Financial Services, Contract Section, as a part of its contract package.

-When it is received, the financial information is forwarded to the Office of Audits for a compliance review. The Division of Mental Health, Mental Retardation, and Substance Abuses' Regional Boards submit requested financial audits and statements directly to the Office of Audits for compliance review.

-The Office of Audits reviews the information and determines compliance with [O.C.G.A. Section 50-20-1](#) through [50-20-8](#), as amended, 1998 Legislative Session.

-The Office of Audits notifies the Contracts Section of the Office of Financial Services or the Regional Board of the results of its review. For instances of non-compliance with requirements, the omitted items are specified.

3. Requirements of Contractors

The financial reporting requirements vary depending on the amount of state and/or federal funds expended by the entity during its fiscal year.

3.1. Entities expending \$500,000 or more in federal funds

All entities expending \$500,000 or more in federal funds during their fiscal year comply with: the provisions of the Single Audit Act Amendments of 1996 and their implementing regulation - OMB Circular A-133; with contract provisions; and with DHR Policy. Non-profit organizations also comply with the provisions of the O.C.G.A. Annotated, Section 50-20-1 through 50-20-8, as amended, 1998 Legislative Session. Audits of nonprofit organizations also include a "Schedule of State Awards Expended."

These entities obtain a single entity-wide audit of their financial records performed by an independent auditor. The audit covers all financial activities for the fiscal year and is conducted in accordance with Generally Accepted Government Auditing Standards issued by the Comptroller General of the United States.

Audits for public entities include, for those contracts that were completed during the audit period, a "Statement of Revenues and Expenditures Compared to Budget," presented by program name or contract name and number. This statement is presented by contract name and number for the entire contract period. Audits of public entities also include a "Schedule of State Awards Expended."

The entity files two copies of the independent auditor's report with the Director, DHR Office of Audits, within 180 days after the end of the organization's fiscal year. Additionally, private nonprofit organizations submit one copy of the report to the State Department of Audits and Accounts within the same time period. If an extension of the time period is desired, the State Department of Audits (for private nonprofit entities) or the DHR Office of Audits (for public entities) may waive the requirement for completion if a request is made that shows good cause. The waiver is for an additional period of not more than 90 days, and no such waiver is granted for more than two successive years to the same entity. A plan of corrective action for all deficiencies disclosed in the audit report is submitted with the audit report.

3.2. Entities expending \$100,000 or more in state funds

All entities expending \$100,000 or more in state funds during their fiscal year comply with contract provisions and DHR policy. Nonprofit organizations also comply with the provisions of the O.C.G.A. Annotated, Section 50-20-1 through 50-20-8, as amended, 1998 Legislative Session. Audits of nonprofit organizations also include a "Schedule of State Awards Expended."

These entities obtain an entity-wide audit of their financial records performed by an independent auditor. The audit is conducted in accordance with Generally Accepted Auditing Standards issued by the American Institute of Certified Public Accountants and the financial statements are prepared in accordance with generally accepted accounting principles. Audits for public entities include, for those contracts that were completed during the audit period, a "Statement of Revenues and Expenditures Compared to Budget," presented by program name or contract name and number. This statement is presented by contract name and number for the entire contract period. Audits of public entities also include a "Schedule of State Awards Expended."

The entity files two copies of the independent auditor's report with the Director, DHR Office of Audits, within 180 days after the end of the organization's fiscal year. Additionally, private nonprofit organizations submit one copy of the report to the State Department of Audits and Accounts within the same time period. If an extension of the time period is desired, the State Department of Audits (for private nonprofit entities) or the DHR Office of Audits (for public entities) may waive the requirement for completion if a request is made that shows good cause. The waiver is for an additional period of not more than 90 days, and no such waiver is granted for more than two successive years to the same entity. A plan of corrective action for all deficiencies disclosed in the audit report is submitted with the audit report.

3.3. Entities expending between \$25,000 and \$100,000 in state funds

All entities expending at least \$25,000 but less than \$100,000 in state funds during their fiscal year comply with contract provisions and DHR policy by submitting audited or unaudited financial statements. Nonprofit organizations are also required to comply with the provisions of the O.C.G.A. Annotated, Section 50-20-1- through 50-20-8, as amended, 1998 Legislative Session. Audits or financial statements of nonprofit organizations also include a "Schedule of State Awards Expended."

Financial statements that have been audited include the auditor's report on the financial statements. Audits for public entities include, for those contracts that were completed during the audit period, a "Statement of Revenues and Expenditures Compared to Budget," presented by program name or contract name and number. This statement is presented by contract name and number for the entire contract period. Audits or financial statements of public entities also include a "Schedule of State Awards Expended."

Financial statements that have not been audited include a statement from the president or other responsible official of the organization which states that:

- The financial statements are presented in accordance with generally accepted accounting principles and, if not, the basis used for their presentation;
- The financial statements are prepared on a basis consistent with that of the preceding year, and if not, the respects in which they differ from the preceding year;
- The financial statements of public entities include for those contracts that were completed during the audit period, a "Statement of Revenues and Expenditures Compared to Budget," presented by program name or contract name and number. This statement is presented by contract name and number for the entire contract period. The financial statements of public entities also include a "Schedule of State Awards Expended."

The entity files two copies of the audit or financial statements with the Director, DHR Office of Audits, within 180 days after the end of the organization's fiscal year. Additionally, private nonprofit organizations submit one copy of the report to the State Department of Audits and Accounts within the same time period. If an extension of the time period is desired, the State Department of Audits (for private nonprofit entities) or the DHR Office of Audits (for public entities) may waive the requirement for completion if a request is made that shows good cause. The waiver is for an additional period of not more than 90 days, and no such waiver is granted for more than two successive years to the same entity. A plan of corrective action for all deficiencies disclosed in the audit report is submitted with the audit report.

4. Role of the DHR Office of Audits

The DHR office of Audits:

- Requests the required audit or financial statements, management reports, memoranda and internal documents from those entities that have failed to provide them;
- Reviews the audit reports for financial settlement amounts, questioned costs, and findings and recommendations;
- Communicates the dollar amounts of financial settlements to the DHR Office of Financial Services for settlement;
- Requests corrective action plans to preclude recurrence of findings from those entities that have failed to provide them;
- Forwards one copy of the audit report or financial statements to the programmatic Division(s) or Office(s); and
- Notifies the appropriate DHR programmatic Division(s) or Offices(s) of those entities which have not complied with the filing requirements of this policy as well as the DHR Office of Financial Services that will impose the appropriate sanctions.

5. Role of the Programmatic Division(s) or Office(s)

The programmatic Division(s) or Office(s):

- Insures that appropriate programmatic corrective actions are implemented when required by an audit report;
- Reviews audits for compliance with programmatic performance goals;
- Enforces corrective action on repeat findings; and
- Approves or disapproves budget and spending variances.

A. History

Replaces Department of Human Resources Administrative Policy and Procedures Manual, Part V. A. 4., "Auditing/Reporting/Sanctions for Nonprofit Organizations Required by the Governor's Executive Order Dated May 27, 1997", effective July 1, 1997, and Part V. A. 5., "Standards for Audits Purchased by DHR Agencies and Local Entities as Required by the Single Audit Act Amendments of 1996", effective July 1, 1997.

B. Proponency

Office of Audits

[BACK TO POL 1244](#)



I Legal References

O.C.G.A. § 50-14-1, et seq. and O.C.G.A. § 50-18-70, et seq.

The Open Records and Open Meetings Acts are often referred to as Georgia's "Sunshine Laws." Recent legislation adopted by the Georgia General Assembly has expanded significantly the laws governing the conduct of meetings by governmental and certain private entities and streamlined the public's access to records maintained by these entities. It is incumbent on all those conducting business on behalf of the state to become familiar with these laws, and to see that they are complied with strictly and fully. Below is an overview of these laws.

II Open Meetings

The Open Meetings Act applies to the governing body of an "agency" or its committees in the conduct of its business. The law allows citizens an opportunity to monitor local officials and certain private concerns under contract for state funded services to insure fairness and openness in the conduct of its affairs. An "agency", according to the statute, can take many forms and typically includes all state departments, agencies, boards and commissions, and authorities and those entities' counterparts at the county, municipal and local level. Of particular significance is the recent adoption of legislation that includes certain nonprofit organizations among those that now must comply with the Open Meetings Act. However, the nonprofit organization must receive a direct allocation of tax funds from a governing authority in excess of 33 ⅓ of its total allocation in order for the requirements of the Act to apply.

A. Meetings Covered by Act

According to O.C.G.A. § 50-14-1(a)(2), a meeting that must be open is one in which there is a gathering of a quorum of members of an agency at a designated time and place, pursuant to notice, during which any public matter, official business or policy is discussed or presented. This applies equally to any standing or special committees within the organization as well. If there is not a quorum of either the agency or a committee, then the law does not apply. There are also several exceptions to the Act:

1. The Act authorizes "an agency with statewide jurisdiction" to conduct business meetings via teleconference, but this would not be applicable to most agencies under the act.
2. The gathering of a quorum of a board or committee to inspect a facility within its jurisdiction.
3. Meeting with the board or committee of another agency as long as conducted outside the agencies' jurisdiction and where no final action is taken.



4. Meetings of the medical or administrative staff, advisory committees that may not act on behalf of the board, social gatherings where business is not discussed or action taken.
- B. Examples of matters excluded from the Act
1. Staff meetings held for investigative purposes as required by law
 2. Real estate acquisitions
 3. Personnel matters
 4. Commercially valuable plans, proposals
 5. Peer review
 6. Attorney – Client privilege
 7. Meetings when discussing any records that are exempt from public inspection or disclosure pursuant to law.

Because of the legislative intent that the business of the various agencies be open to all, and with few exceptions, meetings closed to the public must be done in strict compliance with the law. **If in doubt as to the legality of closing a meeting, legal counsel should be consulted.**

- C. Procedural Requirements
1. Notice – Time, place and dates of meetings must be made known to the public at least 24 hours in advance. Generally, the posting of the time and date at the place where meetings are regularly held is sufficient. However, where meeting locales move about, other means, such as placing a notice in the areas' legal organ, may be required. The statute covers most contingencies regarding notice and should be consulted if in doubt.
 2. Agenda – Any time within two weeks of the scheduled meeting, an agenda must be made available to the public outlining all matters expected to come up at the meeting. The agenda shall be posted at the meeting sight and made available upon request by third parties. An item not listed on the agenda, however, may still be considered and acted upon.
 3. Records – After an open meeting has concluded, a summary of the matters acted upon and the members present must be prepared and made available for public inspection within two business days of the meeting. Minutes of the meeting, however, must eventually be prepared and ready for



distribution no later than immediately following the next regular meeting of the board or committee. These minutes must contain, at a minimum, names of the members present, a description of every motion or proposal made and a record of all votes. Minutes of closed or “executive sessions” need not be kept as long proper procedures have been followed.

4. Closed meetings – Whenever a meeting is closed to the public, the proper procedure must be carefully followed. A motion to close the meeting must be made, members must vote, and the reasons for the closure stated and recorded. The record used to memorialize a closed meeting is an affidavit, filed by the presiding officer, and stating that provision of the law which allows for the session to be closed to the public. Minutes of the closed session may or may not be maintained but if so, filed separately from the public portion and need not be distributed publicly.

D. Penalties

Any official action taken during a meeting not in compliance with this statute is not binding. Any such challenge to the conduct of a meeting and the resulting action taken must be commenced within 90 days of the contested action. Any person who knowingly and willfully participates in a meeting in violation of the Open Meetings Act is guilty of a misdemeanor and may be fined in an amount up to \$500.00. However, any person that knowingly and willfully files a false affidavit pursuant to the closed meeting procedure, is guilty of false swearing, and may be fined up to \$1,000 or imprisonment from 1 to 5 years.

III Open Records

O.C.G.A .§50-18-70 (a) defines “public records” as all documents, papers, letters, maps, books, tapes, photographs computer based or generated information, etc., maintained or received in the course of business of a public office or agency. More recently, “public records” also include records maintained by a private person or entity on behalf of a public office or agency. This means, for example, that records in the sole possession of private entities or individuals relating to work on or behalf of any state agency are subject to the Open Records Act.

A. Right to Access and to Make Copies

All public records, except those excluded by law, must be open for personal inspection and copying by any citizen at a reasonable time and



place. The person making the request does not have to demonstrate a personal or special interest in the record(s) requested.

1. Responding to requests – Typically, a request for records goes to the agencies' custodian of records or an agency designee. Upon receipt of a request, it must first be determined if the records requested are accessible under the act. If so, the record must be available for inspection and copying by the requestor within three business days of the request. If the information requested comes within the ambit of the Act, but is not available within the three days, the agency must notify the requestor of the documents unavailability and provide a timetable for eventual inspection and copying.
2. Costs - The costs for copying may not exceed .25¢ per page. DHR's current copy charge is ~~.25¢~~ per page. Also, an agency may charge for retrieval and other administrative costs. An hourly charge for administrative costs may not exceed the salary of the lowest paid full-time employee capable of performing the task. Information maintained by computer is accessible.

B. When public disclosure not required (O.C.G.A. § 50-18-72)

Public disclosure shall not be required for the following records

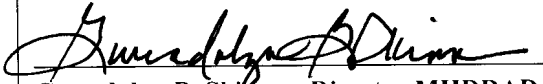
1. Records specifically required by the federal government to be kept confidential.
2. Medical or veterinary records and similar files.
3. Records prepared for law enforcement purposes to the extent such records may contain confidential identifying information, the disclosure of which may jeopardize the safety of an individual or investigation.
4. Records of law enforcement, prosecution or other regulatory agencies compiled in the course of an investigation.
 - 4.1 Individual Georgia Uniform Motor Vehicle Reports (numerous exceptions).
5. Records of a confidential nature regarding a public official appointment or hiring or investigative information regarding same.
6. Real estate appraisals made for a state or local agency.



7. Records that would reveal the identity of one under consideration for appointment to an agency head (information may be released under certain conditions).
8. Certain records related to staff services of members of the General Assembly.
9. Records donated for historical purposes where the owner places restrictions to access.
10. Records maintained by the Department of Natural Resources (DNR) designating certain locations to be of historic value (to avoid possible harm to the property).
11. Records maintained by DNR identifying rare plants, animals, etc. to avoid possible harm or destruction.
 - 11.1 An individual's social security number and insurance or medical information in personnel records may be redacted from such records.
12. Public records that would disclose an "electronic signature".
13. Records that would reveal the home address phone number, social security number or medical information of, among others, law enforcement employees, judges, correctional employees and prosecutors.

Furthermore, the Open Records Act shall not apply to trade secrets, proprietary information, Attorney-Client privilege, confidential tax matters, computer software and programs, personnel records (narrowly construed, see 11.1 above) and records relating to pending administrative proceedings. **This list of exceptions and non-applicability of the Act to certain records cannot substitute for a through reading of the Act itself and consultation with legal counsel when in doubt about the Act's applicability to a request for documents.**

- C. Penalty (O.C.G.A. § 50-18-74 (a))
Any person knowingly and willfully violating the provisions of this article by failing or refusing to provide access to records not subject to exemption...or failing to provide access to such records within the time limits set forth...shall be guilty of a misdemeanor and upon conviction shall be punished by a fine not to exceed \$100.00.

Georgia Department of Human Resources Division of Mental Health, Developmental Disabilities and Addictive Diseases	DMHDDAD POLICY NO: 6203-101 DHR ODIS No. 6203-101 Page 1 of 2
Applicability: <ul style="list-style-type: none"> • All MHDDAD 	REFERENCE: Not applicable
SUBJECT: DHR DMHDDAD Guiding Principles Regarding Co-Occurring Disorders	Effective date: March 1, 2008 Scheduled Review Date: March 1, 2010 APPROVED:
Attachments: None	 Gwendolyn B. Skinner, Director MHDDAD

DHR DMHDDAD GUIDING PRINCIPLES REGARDING CO-OCCURRING DISORDERS

Purpose

Research has shown that for individuals with both psychiatric symptoms and addiction issues, mental health and substance abuse treatment provided together, in tandem, is far more effective than either of these provided separately or in the absence of the other. The design, delivery, and evaluation of Georgia's behavioral health system must be fully responsive to adults and adolescents with co-occurring mental health and substance abuse disorders.

Policy Statement


The publically funded behavioral healthcare system in Georgia aspires to be highly responsive to the multiple and complex needs of persons and families experiencing co-occurring mental health and addictive diseases disorders, in all levels of care, across all system providers, throughout all phases of the recovery process.

Guiding Principles

- It is the expectation (not the exception) that people in our behavioral healthcare system experience co-occurring disorders.
- When psychiatric and substance abuse disorders co-exist, both are considered "primary".
- Adults with co-occurring mental health and substance abuse disorders have the potential to achieve recovery in both domains of mental health and substance abuse. Youth and their families with serious emotional disturbances and substance use have the ability to improve functioning and develop increased resiliency.
- Services must be available and accessible without regard to which program/service arena (mental health or addictive diseases) the person first entered our behavioral health system.
- Integrated treatment and support (screening, assessment, planning, and treatment) must be accomplished by preserving and capitalizing on the values, philosophies, and core technologies of both the mental health and addiction treatment fields.
- Integrated treatment is a means of coordinating interventions aimed at both substance use and mental health symptoms. Integrated services must appear seamless to the individual participating in services. It is preferable if the interventions are done by one clinician, but when necessary it can be accomplished by two or more clinicians working together within one program or a network of services.

DIVISION OF MHDDAD	SUBJECT: DHR DMHDDAD Guiding Principles Regarding Co-Occurring Disorders	DMHDDAD POLICY NO: 6203-101 DHR ODIS NO: 6203-101
		Page 2 of 2

- Effective intervention programs incorporate, either implicitly or explicitly, the concept of stages of treatment. Services must be available and accessible to an individual regardless of level of motivation, stage of change, and phase of the recovery process.
- Effective co-occurring services are those that engage individuals and their support systems by providing assertive outreach.
- Effective co-occurring services take a long-term, community-based perspective that includes rehabilitation activities to prevent relapse and enhance gains made in treatment.
- Recovery support (including self-help, mutual support, peer-delivered and peer-run services) and family education and support are important components of a co-occurring enhanced system of behavioral healthcare.
- Services for individuals with co-occurring mental health and substance abuse disorders are provided in a culturally competent manner.
- The Georgia behavioral health system offers training on best practices, evidence-based techniques and protocols, striving to identify and support new, emerging or promising practices.
- The service system strives to improve services, system infrastructure, and opportunities for workforce development, in order to support integrated services for co-occurring disorders.

Georgia Department of Human Resources Division of Mental Health, Developmental Disabilities & Addictive Diseases	DHR Online Directive Information System (ODIS) Directive # 6203-102 <div style="text-align: right;">Page 1 of 3</div>
DHR ODIS Policy: Array of Community Behavioral Health Services Subject: DHR DMHDDAD Guiding Principles Regarding Serving those with Co-Occurring Behavioral Health Disorders and Developmental Disabilities	
Applicability: All DMHDDAD	Effective Date: October 1, 2008 Scheduled Review Date: October 2010 Approved:
References: Not Applicable	 <hr/> Gwendolyn B. Skinner, Director Division of MHDDAD
Attachments: Attachment A – Best Practices for Mental Health Assessment of Persons with Developmental Disabilities	

DHR DMHDDAD GUIDING PRINCIPLES REGARDING SERVING THOSE WITH CO-OCCURRING BEHAVIORAL HEALTH DISORDERS AND DEVELOPMENTAL DISABILITIES

Purpose

The design, delivery, and evaluation of Georgia's MHDDAD system must be fully responsive to adults and youth with co-occurring behavioral health disorders and developmental disabilities (DD). People with intellectual disabilities and/or other developmental disabilities experience the full range of psychiatric disorders at rates higher than the general population. Based on national estimates a minimum of 7% - 20% of individuals with developmental disabilities will experience concurrent mental illness. Behavioral health disorders are misdiagnosed, under-diagnosed, or undiagnosed in this population. Children and adults with multiple disabilities often require services simultaneously delivered by different service providers and systems. Complex needs require organizations to work collaboratively to develop and coordinate services and supports in the community.

Policy Statement

The publicly funded MHDDAD system in Georgia aspires to be highly responsive to the multiple and complex needs of persons and families experiencing co-occurring behavioral health disorders and developmental disabilities, in all levels of care, across all system providers, throughout all phases of services.

Definition

Behavioral Health Disorders – For the purpose of this policy, the term Behavioral Health Disorder is used to describe a health condition in which an individual is diagnosed with serious mental illness, or is dually diagnosed with serious mental illness and addictive disease.

Guiding Principles and Expectations

- Individuals with developmental disabilities can benefit from mental health services.

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- If a person has a diagnosis that qualifies for mental health services, the presence of any other diagnosis, including intellectual disability, does not exclude that individual from receiving mental health services. Intellectual level in and of itself does not qualify or disqualify a person if a particular diagnosis is adequate to justify the need for mental health services.
- Coordinated treatment and support should be the standard for individuals with more than one disability who are served by the MHDDAD system.
- When an individual has needs which can not be appropriately met by a single disability service, it is incumbent upon those in the MHDDAD system to make sure that other needed disability services are identified and accessed.
- Concurrent enrollment in developmental disability services does not prohibit access to mental health services.
- Concurrent enrollment in behavioral health services does not prohibit access to developmental disability services.
- The individual must meet the criteria for the specific service(s) being provided. This requires clinically defining the person's needs, wishes, and their ability (with reasonable accommodations) to benefit from the specific service(s).
- The issue of "which came first?" is not relevant. Phrases such as "primary diagnosis" should not be used in determining service delivery to persons with mental illness and developmental disabilities.
- Providers of behavioral health services may not exclude individuals from receiving their services based on the fact that an individual has a developmental disability. Providers of DD services may not exclude individuals from receiving DD services simply based on the fact that the individual has a behavioral health diagnosis or is prescribed psychotropic medications.
- Proper Assessment is essential in order to address the needs of individuals who have a developmental disability and a behavioral health need. For guidance regarding assessment, see ***Attachment A – Best Practices for Mental Health Assessment of Persons with Developmental Disabilities***.

While endorsing these guiding principles and expectations regarding co-occurring behavioral health disorders and developmental disabilities, the Division of Mental Health, Developmental Disabilities & Addictive Diseases also recognizes the difficult balance involved in addressing the needs of individuals given current constraints related to:

- Funding,
- Workforce development challenges, and
- The gap between current practice and state of the art evidence-based practices.

Therefore, the Division has identified best practices standards that Georgia aspires to achieve as our MHDDAD system improves services and supports provided for those with co-occurring behavioral health disorders and developmental disabilities. These best practice standards include the following:

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- Individuals with developmental disabilities are afforded access to a behavior support plan in order to address challenging behaviors, reduce the risk of over-medicating, and achieve a meaningful life in the community.
- Individuals with developmental disabilities receive mental health services from staff that are specifically trained and experienced in working with developmental disabilities. Staff working in developmental disability settings who serve individuals with co-occurring behavioral health disorders are knowledgeable about behavioral health. Integrated treatment approaches are recommended.
- Providers at the local level are strongly encouraged to develop collaborative agreements with providers of the other disability services.
- Multi-dimensional assessment and treatment approaches include consideration of biological, psychological, social, and developmental factors.

Best practices for Mental Health Assessment of Persons with Developmental Disabilities

<p style="text-align: center;">Diagnostic Manual – Intellectual Disability: <i>A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability</i> (www.thenadd.org)</p>	<p style="text-align: center;">Ohio Department of Mental Health – Report and Recommendations: <i>Clinical Best Practices for Serving People with Developmental Disabilities and Mental Illness</i> (http://www.mh.state.oh.us/medicaldiv/documents/mimr02282002.pdf)</p>	<p style="text-align: center;">Summary</p>
<p>Multiple sources of information or adaptations to the assessment procedures are needed to assist in the evaluation process. Use information from family and direct support professionals, acquire historical information from third-party sources in addition to self reports, and maintain an open and skeptical attitude with constant reevaluation of the working diagnosis. "Clinical uncertainty" is a priority in providing good care to individuals with intellectual disorders.</p>	<p>Assessment should be comprehensive, thorough, and interdisciplinary. The greater the number of informed individuals contributing their observations, the more complete the picture of the individual.</p>	<p>Gather historical and current information from multiple sources and settings. Maintain "constant skepticism" .</p>
<p>Because clinicians customarily talk rapidly and use complex language in long sentences, clinicians can put individuals with intellectual disabilities at a disadvantage during the interview. Clinicians can make the following adjustments:</p> <ul style="list-style-type: none"> • Use simple words • Short sentences • Ask one question at a time • Wait for an answer before asking the next question • Check back to confirm that they understood the questions • Avoid asking leading questions • Limit yes or no questions <p>These adaptations take extra time and organizational factors may limit time available for screening and examinations.</p>	<p>Diagnostic assessment with this population requires more time than is typically allotted because the clinical interview with the individual alone is not diagnostic.</p>	<p>Increase interview time allotment, allowing as much time as necessary to conduct an accurate assessment/evaluation.</p>
<p>Evaluation must be done in the context of the developmental delay and intellectual impairment.</p>	<p>Accurate diagnosis and effective care and treatment require knowledge of the context in which a person has experienced the world and also how they relate in their current environment.</p>	<p>Factor in the individual's limitations. An individual's level of functioning will dramatically affect the assessment interview.</p>
<p>The clinician should consider the presenting problem as part of a constellation of changes in the individual's functioning.</p>	<p>The assessment is to be holistic and include the individuals emotional, psychological, physical, social and other (e.g. educational, vocational, etc.) state at present, and is not just to catalog problem areas</p>	<p>Assessment takes into consideration all aspects of the individual's situation and life experiences.</p>
<p>Psychosocial stressors might be the cause of behavioral or emotional reactions that are mistaken for serious mental disorders .</p>	<p>Immediate circumstances may exist that need to be addressed simultaneously to the assessment. Examples are behaviors that threaten safety or placements.</p>	<p>Assessment takes in to account the psychosocial stressors of the individual, their family, and support professionals prior to the onset of the complaint/presenting problem.</p>

Best practices for Mental Health Assessment of Persons with Developmental Disabilities

<p style="text-align: center;">Diagnostic Manual – Intellectual Disability: <i>A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability</i> (www.thenadd.org)</p>	<p style="text-align: center;">Ohio Department of Mental Health – Report and Recommendations: <i>Clinical Best Practices for Serving People with Developmental Disabilities and Mental Illness</i> (http://www.mh.state.oh.us/medicaldiv/documents/mimr02282002.pdf)</p>	<p style="text-align: center;">Summary</p>
<p>Medical problems are often the source of the chief complaint for the mental health interview for an individual with intellectual disability, in contrast to the typical interview for intellectually normal individuals (who can understand that they have a medical condition that could be associated with a mental disorder, such as chronic pain leading to Depressive Disorder). . . . It is therefore, extremely important that the clinician consider medical or physical causes, make every effort to get complete information, and conduct a baseline medical assessment.</p>	<p>A thorough physical examination is a critical part of the assessment and additional psycho-neurological assessments may be necessary. Symptoms associated with mental illness also could be caused by a medical problem or medications. Eliminate the possibility that the symptoms have medical cause prior to looking for mental illness.</p>	<p style="text-align: center;">Accurate and comprehensive medical history information and complete physical examination is necessary for proper assessment/evaluation.</p>
<p>Continued monitoring and re-evaluation is required to note progress and identify changing needs.</p>	<p>The assessment and diagnosis is ongoing and must continue after an initial evaluation is completed. The assessment must be concurrent with treatment.</p>	<p style="text-align: center;">Continuous re-assessment of the diagnosis and monitoring of the individual's progress is essential.</p>
<p>If the individual has not had a cognitive assessment within a reasonable number of years, a new assessment will be helpful to the diagnostic formulation. . . . Formal psychological tests can be helpful when the diagnosis is uncertain Instrumentation refers to the use of rating scales that either are administered to a third party or are encompassed in a self report instrument administered to the individual.</p>	<p>Several psychological screening/assessment instruments may also be helpful as part of the diagnostic assessment process.</p>	<p style="text-align: center;">If appropriate, administer standardized psychological assessments, testing, and instrumentation.</p>
	<p>Clinicians conducting assessments must recognize that various mental illnesses can manifest differently across the levels of intellectual disability.</p>	<p style="text-align: center;">People with intellectual disabilities are a diverse group and it can not be assumed that a single diagnosis or treatment is appropriate for the entire population.</p>
	<p>Clinicians doing diagnostic, assessment, and treatment planning need specialized education, supervision, and training in the MH aspects of DD and need to be available to provide technical assistance on an ongoing basis to people providing services to the individual.</p>	<p style="text-align: center;">Proper training and supervision of clinicians and support professionals is essential.</p>
	<p>Risk assessment may be necessary, in addition to diagnostic assessment. . . . Risk assessment and crisis planning should occur simultaneously with diagnostic assessment and treatment....as a collaborative effort with the individual's treatment team.</p>	<p style="text-align: center;">Include risk assessment and crisis planning in the assessment/evaluation.</p>

Best practices for Mental Health Assessment of Persons with Developmental Disabilities

Diagnostic Manual – Intellectual Disability: <i>A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability</i> (www.thenadd.org)	Ohio Department of Mental Health – Report and Recommendations: <i>Clinical Best Practices for Serving People with Developmental Disabilities and Mental Illness</i> (http://www.mh.state.oh.us/medicaldiv/documents/mimr02282002.pdf)	Summary
	Agencies should not just “make do” with what they have. Get suggestions, technical assistance, and direction to needed resources.	Seek and utilize technical assistance and outside resources.
	In vivo observation must occur at home, work, school, hospital, etc.	When possible, observe the individual in the environment in which the behavior is taking place.
	This comprehensive assessment process must include the review of clinical records, in vivo behavioral observation, and interviews with multiple informants who know the individual and his/her level of functioning	Assessment/Evaluation of the individuals is thorough, ongoing, comprehensive, and interdisciplinary.

References:

Hurley, A. D., Levitas, A., Lecavalier, L., & Pary, R.J. (2007). Assessment and Diagnostic Procedures. In Fletcher, R., Loschen, E., Stavrakaki, C., & First, M. (Eds.) *Diagnostic Manual - Intellectual Disability: A textbook of Diagnosis of Mental Disorders in Person with Intellectual Disability* (pp. 11 - 31). New York: National Association of the Dually Diagnosed Press.

Ohio Department of Mental Health - Ohio Department of Mental Retardation and Developmental Disabilities Advisory Committee. (2002). *Report and Recommendations: Clinical Best Practices for Serving People with Developmental Disabilities and Mental Illness* (http://www.mh.state.oh.us/medicaldiv/documents/mimr02282002.pdf)



Chapter: Developmental Disabilities Community Services
Subject: Health Risk Screening Tool (HRST)

Applicability:
All Intake & Evaluation staff, Community Developmental Disability Providers, Support Coordinators, and Planning List Administrators

References: None

Attachments:
Appendix I: Graphic Example of a HRST Scoring Summary
Appendix II: Addressing the HRST Training Recommendations in the ISP

The Health Risk Screening Tool is located online at <https://gadd.hrstonline.com>

Original Effective Date: March 1, 2011
Revision #2 Effective Date: October 1, 2011
Scheduled Review Date: October 2013

Approved:
Beverly D. Rollins 8/19/11
Beverly D. Rollins, M.P.A., Executive Director Date
Division of Developmental Disabilities

J. Bryce McLain 8/21/11
J. Bryce McLain, M.D., Date
Assistant Commissioner of Programs

Frank E. Shelp 8/22/11
Frank E. Shelp, M.D., M.P.H., Commissioner Date

POLICY

The Health Risk Screening Tool (HRST) is used to determine an individual's vulnerability in terms of potential health risks and supports early identification of individuals with deteriorating health. This web-based (online) tool screens for health risks associated with a wide variety of disabilities, including developmental disabilities. HRST measures health risk **not** disability. The greatest vulnerability to risk is exhibited or experienced among those individuals whose services are periodic, while less intense for someone who needs daily nursing care.

The completion of the HRST meets health and safety requirements, enabling the monitoring of health needs, allowing early identification of health issues, and supporting the prevention of complications and preventable deaths. The HRST assigns point scores to rating items. The total points result in a health care level with an associated degree of health risk. The health care levels are 1 through 6, with level 1 being the lowest risk for health concerns, and level 6 being the highest risk for poor health.

DEFINITIONS

Intake and Evaluation: A team located in each regional field office that provides screening to determine if individuals with developmental disabilities are eligible for services. Identified Intake and Evaluation (I & E) staff also execute tasks, which support ongoing assessment of individuals currently receiving services (i.e. the completion of the HRST tool).

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PROCEDURES

A. COMPLETION OF THE HRST

The Health Risk Screening Tool (HRST) is an online instrument that is completed by the following HRST trained persons:

1. Intake and Evaluation (I & E) Staff

- Completes the initial HRST for individuals when they are approved for services.
- Completes the initial HRST for individuals who choose to participant direct (self-direct) their services. (Pertaining to Participant Direction, see the NOW Manual (Current Year), Part II, Chapter 1200, Section: Participant Direction).

2. Community Developmental Disabilities Provider - Completes the HRST for individuals receiving provider services. All providers are required to have qualified staff that have completed the required HRST training and have been certified to administer the HRST.

- Residential providers are always the lead provider to complete the HRST when an individual receives services from multiple providers.
- If the person does not receive residential services, the designated provider will be identified in the annual Individual Service Plan (ISP). This will usually be the provider or entity providing the greatest quantity of service.

3. State Operated Hospital Staff - Completes the Initial HRST for each person transitioning from State Operated Hospital services to community services.

B. TRAINING REQUIREMENTS FOR THE COMPLETION OF THE HRST

1. All staff members responsible for the completion of the HRST must complete training prior to using this online screening tool. Completion of the HRST is not allowed without the training.
2. The training for Direct Support Staff is now available online as a HRST Online Rater's Training module (<http://learn.hrsonline.com/gadd>). Providers may also utilize this electronic training process by submitting an emailed request to custserv@hrsonline.com.
3. Nurses and managers are required to complete quarterly online training and attend a two-day training session with the HRST Staff. For additional information access <http://learn.hrsonline.com/gadd>.
4. Provider must attend web based trainings, which are held every four (4) months. DBHDD will disseminate notifications regarding the dates/times of the scheduled webinars

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C. TIME-LINE FOR HRST COMPLETION

The time-line for the completion of the HRST is identified as follows:

1. **Initially** the HRST must be completed for each person approved to receive community developmental disability services.
2. **Annually** the HRST must be updated by the Provider, or designated entity in the person’s Individual Service plan (ISP). **The HRST must be completed or updated at least 90-120 days prior to the ISP expiration date.**
 - **If the HRST is not updated 90 days before the ISP, the Support Coordinator will score the site visit with a “3” rating.** (Refer to the Monitoring Report Guidelines for the Case Management Information System (CIS) at <https://cis.columbusorg.com>)
 - The Support Coordinator must contact the Regional I & E Manager regarding a score of “3” or higher.
 - The I & E Office must contact the provider and require that the HRST be updated within three (3) business days.
3. When a person chooses to “**participant direct**” all of his/her services, an update HRST is completed by the Regional I & E team **annually** for re-certification.
4. **Ongoing updates** of the HRST are completed by the provider or designated entity in the person’s ISP when a person experiences significant changes in health, functional or behavioral status. Examples include but are not limited to:
 - **Any time there is a change in medication. Whenever there is a change, addition or discontinuation of any medication, the HRST must be updated. This includes all types and forms of medication administered to the individual.**
 - All Hospitalizations
 - All Emergency Room Visits
 - Any significant changes in behavior
 - An increased in the frequency of complaints from the person regarding how they are feeling or acting

Note: When providers are updating the HRST and there are significant changes which increase the HRST score to a **level “3” or above**, the Support Coordination agency is to be contacted immediately. **Scores “3” and “4” indicate health and or safety issues, which are to be addressed immediately** (see Appendix 1: Graphic Example of a HRST Scoring Summary).

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D. HRST PROCEDURES

1. The Provider, or designated person identified in the ISP, is to complete the HRST online at <http://www.hrstonline.com>. The web address (URL) for HRST Support is <http://support.hrstonline.com/support/>
2. All providers are to complete a HRST data tracking log that is maintained on site. When the Support Coordinator visits the individual with developmental disabilities, the tracking log is to be reviewed:
 - Providers may use the tracking log presented at the HRST training or develop their own data tracking log.
 - Only those items that are an issue for an individual are tracked.
 - The tracking log is updated monthly.
 - Support Coordinators review the tracking log during visits.
3. Once the HRST is completed online and linked to the ISP by the Support Coordinator, the scores from the HRST will automatically populate in the individual's ISP contained in the DBHDD Division of DD web-based system.
4. Providers are to inform the Support Coordinator of any changes in the HRST level within 24 hours.
5. The Provider and Support Coordinator are to arrive at the ISP meeting prepared to discuss training recommendations. If the provider's nurse cannot be at the ISP meeting, the provider must discuss training recommendations with the nurse before the meeting. The provider is to identify areas of new or ongoing training that will be completed within thirty (30) days of the start of the ISP meeting.
6. The Provider and Support Coordinator review training recommendations at the ISP meeting: The Team determines which training recommendations will be addressed. The information is recorded in the designated section of the Health and Safety pages of ISPs to help mitigate those identified risks.
7. Reports are made available from the HRST website to trend health related issues across the system and by provider.
8. With an individual's consent, his/her HRST information is available for downloading and printing, to be taken to a health care appointment for use in the ongoing review of the individual's health history.
9. **If a person's HRST level results is a score of 3 or higher**, the HRST must be reviewed and signed off on by the Provider's Registered Nurse Reviewer. The nurse is to ensure that the information is accurate.

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10. **Individuals with a HRST level score of 3 or higher** are considered higher risk, thus requiring increased monitoring/supervision by the agency nurse.

E. I & E NURSING RESPONSIBILITIES REGARDING HRST SCORE LEVEL OF THREE (3) OR HIGHER

1. If the person receives a rating of a level “3” or higher before the next annual certification, the provider and/or the support coordinator must complete and forward request to the Regional I & E Nurse for technical assistance.
2. The I & E Nurse must provide technical assistance to the provider, that includes a contact with the Developmental Disabilities (DD) provider, nurse or manager.
3. The I&E Nurse is to determine the next step, which may include a mandate that the provider renders additional staff training and/or seek additional medical support for the individual. **Note:** The provider is to document all services rendered in a report that is uploaded at <http://www.hrsonline.com>.
4. The I&E Nurse must share all information with the Support Coordinator. The I & E Nurse provides follow-up as necessary until all recommendations are implemented, informing the Support Coordinator of all actions and outcomes.

F. SUPPORT COORDINATION RESPONSIBILITIES

1. If the Support Coordinator is visiting an individual and notices issues, he /she must notify the provider that the individual needs to be re-rated.
2. The Support Coordinator is to be kept informed and up-to-date on any changes.
3. Red Flags for the Support Coordinator to be aware of are as follows:
 - Falls and injuries, which are to be noted in monthly reports. Incident reports are to be checked for completion by the Support Coordinator. **Note: There is a very strong correlation between type and frequency of injuries and quality of care. High ratings in this area require an intense review of facility management practices.**
 - Changes in the health level ratings and the correlation of data.
 - Drug use and the increase in administered medications.
 - Hospitalizations and Emergency Room visits.

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G. HRST RECOMMENDATIONS: SUPPORT COORDINATORS AND ISP TEAM FOLLOW-UP RESPONSIBILITIES

The scores of the HRST automatically pre-populate in the ISP template. Training recommendations that will be addressed within the first thirty (30) days of the ISP start date, are listed in the ISP Health and Safety Review Section.

Note: This section is based on the team’s discussion of the HRST recommendations; it is not simply a “copy/paste” of the HRST recommendations.

1. The Support Coordinator and ISP team are to access a copy of the Evaluation and Service Requirement Report that addresses needs for each section of the HRST.
2. The ISP Team reviews the training recommendations and prioritizes the training needs (see Appendix II: Addressing the HRST Training Recommendations in the ISP).
3. The monitoring report, which addresses training needs and the HRST tracking form are to be consistently updated by the Support Coordinator.
4. The Support Coordinator monitors training during the visits to the home setting to ensure that the training is completed.
5. The Support Coordinator monitors and ensures that the training is documented in the individual’s record. If the training is not completed, the Support Coordinator must indicate this on the monitoring report.

(Refer to the *Monitoring Report Guidelines for the Case Management Information System (CIS)* at <https://cis.columbusorg.com>)

H. INTAKE AND EVALUATION: COMPLETION OF THE HRST FOR PARTICIPANT DIRECTION

1. Intake & Evaluation (I & E) Registered Nurse (RN) is required to complete the HRST for any individual receiving **Participant Direction services only**. If a person is receiving another service from a traditional provider along with **Participant Direction**, the traditional provider is responsible for completion.
2. Because the I&E RN is designated to complete “ **The Participant Direction Only**” HRST, she/he completes the following:
 - Prior approved certification to administer the HRST from the HRST web trainings
 - The clinical two-day trainings
3. In preparation for completion of the HRST, the I&E RN is to obtain the Participant Direction’s information 90 days before the person’s date of birth.

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4. Sixty (60) days before the individual’s date of birth, the I&E RN is to complete the HRST and uploaded the document in the HRST online system (<http://www.hrstonline.com>).
5. The I&E RN is required to meet face-to-face with family members, caretaker/legal guardian and Support Coordinator to discuss data collection from the point of the last HRST. The discussion is to utilize one (1) year worth of data.

The Exception to the Rule: If changes are not reported during the RN’s initial conversation with the family and the HRST remains within the levels of “1” or “2”, the RN can use his/her clinical judgment to complete the HRST without having face-to-face encounters. It is important that this option be discussed and explained to the family and Support Coordinator.

Note: When the RN is updating the HRST and there are significant changes, which increase the HRST score to a level “3” or above, the Support Coordination agency is to be contacted immediately. Scores “3” and “4” indicate health and or safety issues: They are to be addressed immediately.

6. The RN is to complete the HRST in the Case Management System (CIS). Refer to the Case Management Information System (CIS) at <https://cis.columbusorg.com> .

I. HRST USER ID AND PASSWORD PROTECTION

Each Provider must have a designated person or persons who are trained to enter data in to the HRST online system.

1. The **User ID and Password** must be protected and used only by the HRST trained individual to whom it has been assigned. Data entry under another person’s User ID, constitutes falsification of data when entered into the HRST online system. A Provider can be held liable in the event of an individual with developmental disabilities being compromised due to falsification of data.
2. Each Provider must have a documentation/technology policy that includes the procedure to ensure protection of staff’s User ID and password information. **This policy must include the following statement: “User IDs and Passwords can only be used by the authorized individuals assigned to those IDs and Passwords.”**

J. QUALITY ASSURANCE

1. Each DBHDD Region is responsible for executing a **monthly review** of at least five percent (5%) of all HRST(s) administered by Providers throughout the region.

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2. Each Provider is responsible for executing a **monthly review** of at least five percent (5%) of all HRST(s) administered by designated staff.

K. MEETING SESSIONS

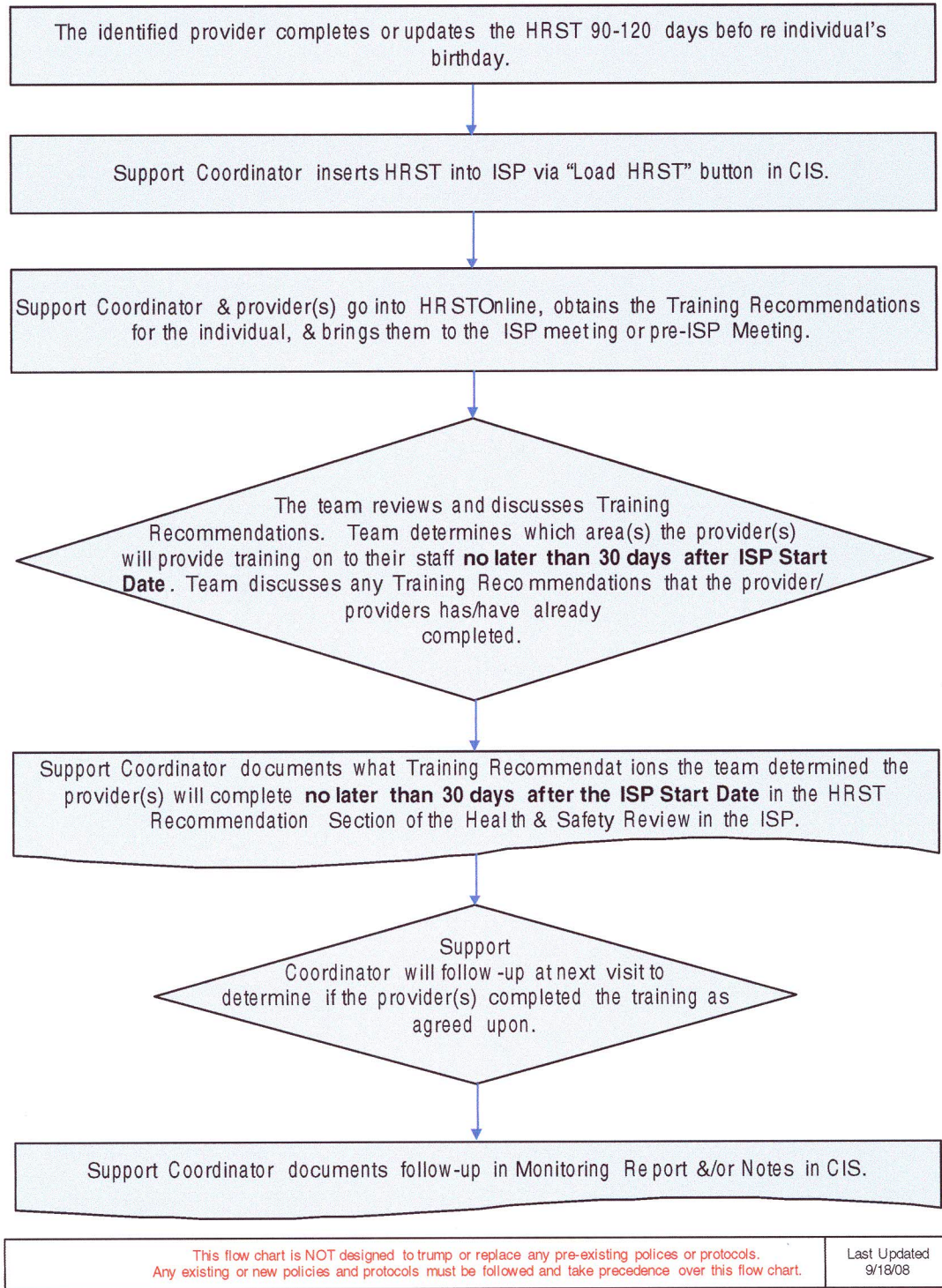
All Providers are required to be available anytime a HRST related meeting is held; **including online web conference meetings.**

An EXAMPLE of the HRST Web-Based Scoring Summary

Scoring Summary		Service Requirements	Training Requirements
			[Printable Page]
Scoring Summary		Alice M. Bradley	
last updated: 04/05/07			
Total Score: 42	Total 4 Ratings: 1	"Q" Scored?: No	Healthcare Level: 4 (RN review required)
1. Functional Status Category			
Rating Area	Score	Explanation	Notes/Comments
A. Eating	3	<p>Requires constant physical assistance and mealtime intervention to eat safely</p> <p>Unable to obtain adequate calories and fluids without assistance. May have difficulty breathing/swallowing while eating or conditions that impairs ability to eat safely. Interventions are required (specific positioning support, eating devices, presentation techniques, modifications in food/fluid consistency). May have enteral (feeding) tube, but maintains some level of oral eating.</p> <p align="right">rated: 04/05/07</p>	<ul style="list-style-type: none"> Staff gives her 1 Tbsp. of food per day with no coughing or respiratory consequences
B. Ambulation	3	<p>Requires assistance to change positions or shift weight in wheelchair</p> <p>Has limited use of limbs. May need assistance to propel wheelchair.</p>	<ul style="list-style-type: none"> Wheelchair has several adaptations which are required for providing mechanical support
C. Transfer	4	<p>Needs lifting equipment/procedures to safely transfer</p> <p>May need range of specially designed positions. May require specialized equipment due to severe spasticity, history of bone fragility, potential for injury due to size, or due to degree of physical deformity.</p> <p align="right">rated: 04/05/07</p>	<ul style="list-style-type: none"> Is currently moved using a 2 person transfer, but due to her weight, she should be transferred with lifting equipment to protect the safety of herself and the staff working with her
D. Toileting	3	<p>Incontinent of bowel or bladder</p> <p>Inability to recognize elimination (loss of sensation, physical inability to manage toileting needs). May require scheduled toileting or use of incontinent briefs.</p> <p align="right">rated: 04/05/07</p>	<ul style="list-style-type: none"> Wears diapers and is checked every 2 hours
E. Clinical Impact on ADL's	0	<p>None. No clinical restrictions</p> <p align="right">rated: 04/05/07</p>	
Category:	13	-	

This is one of the reports that is generated by the HRST, showing the scores, pertinent data, and any notes entered by the rater.

Addressing the HRST Training Recommendations in the ISP





Chapter: Developmental Disabilities Community Services
Subject: Human Rights Council for Developmental Disabilities Services

Applicability: Providers of Developmental Disabilities Services

Effective Date: July 1, 2010
Scheduled Review Date: July 2011
Approved:

References:

- DBHDD Rules and Regulations:
Client Rights
Patient Rights
DBHDD Policies and Procedures

Beverly D. Rollins 6/24/10
Beverly D. Rollins, M.P.A.
Executive Director
Division of Developmental Disabilities

Attachments:

None

Frank E. Shelp 6/24/10
Frank E. Shelp, M.D., M.P.H.
Commissioner

HUMAN RIGHTS COUNCIL FOR DEVELOPMENTAL DISABILITIES SERVICES

I. PURPOSE

The purpose of this policy is to ensure the protection of health and human rights of persons with developmental disabilities served through the Division of Developmental Disabilities (DD), Department of Behavioral Health and Developmental Disabilities (DBHDD).

The Human Rights Council, as an advisory and review body, shall determine whether the human rights of an individual receiving developmental disability (DD) services are protected by reviewing the following concerns/issues:

- allegations of or suspected individual rights violations;
behavioral support plans referred by a Behavioral Program Review Committee (BPRC) which are designed to reduce challenging behaviors;
individual support plans related to individuals being prescribed five (5) or more psychotropic drugs; and
all requests for participation of individuals receiving DD services in experimental research to ensure adherence to the practices of DBHDD.

Service providers must follow all DBHDD policies, standards and guidelines related to health and human rights, including but not limited to:

- rights suspension
restrictive procedures
psychotropic medication
allegations of mistreatment
abuse
neglect

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- exploitation
- experimental research

The Human Rights Council policy exists to ensure practices of DBHDD service providers follow DBHDD Rules & Regulations, DBHDD Policies & Procedures, and Provider Standards regarding the following topics:

DBHDD Rules and Regulations related to:

- Client Rights
- Patient Rights

DBHDD Policies and Procedures related to:

- Informed consent for psychotropic medication
- Protection of human subjects
- Complaints and grievances
- HIPAA privacy rules
- DBHDD Provider Manual Community Service Standards

II. POLICY STATEMENT

It is a policy of the Department of Behavioral Health and Developmental Disabilities, Division of Developmental Disabilities (DD) to ensure that an individual with developmental disabilities, their representatives/guardians, or agencies involved with the delivery of that individual's services may file and have reviewed human rights issues through a Regional Human Rights Council (HRC). Each Region will have a minimum of two councils. Human Rights Councils meet as often as necessary, but at least quarterly, with findings/resolutions provided in writing.

III. DEFINITIONS

- A. **Behavioral Program Review Committee (BPRC)** – A committee comprised of regional or agency personnel who have the highest level of expertise in applied behavioral analysis (ABA) behavioral supports services within a region or for one or more provider agencies. The primary function is to evaluate the technical adequacy of all behavioral supports interventions and to make recommendations for improvement.
- B. **Behavior Plan Subcommittee (BPS)** - A subcommittee of the HRC that reviews all Behavior Support Plans after the plans have been reviewed by the Behavior Program Review Committee (BPRC). The Behavior Plan Subcommittee reviews the plan to make sure it is not in violation of the individual's Human Rights, and then the plan is returned to the Behavior Program Review Committee for final authorization.
- C. **Challenging Behaviors** – Behaviors that are defined as problematic or maladaptive by others noticing the behavior or by the person displaying the behavior. What is determined a challenging behavior can vary depending on what is accepted by the individual, community or by society.

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- D. **Human Rights Coordinator** - DBHDD employee responsible for ensuring the provision of technical assistance, guidance, and training for the Human Rights Committee (HRC).
- E. **Human Rights Council (HRC)** – An advisory and review body comprised of local community members who provide independent oversight as a regional intermediary structure in matters related to the health and rights of citizens with developmental disabilities who reside in the state of Georgia. ***No spouse, sibling, child, contractor, employee, board member of a provider and/or employee of DBHDD shall serve as a member of the HRC.***
- F. **Interdisciplinary Team (IDT)** – The people who create/write an individual’s Individual Service Plan (ISP) to include but not limited to: Individual receiving support, Parent/Guardian, Support Coordinator, Direct Support Worker, Provider, Advocate, Therapist, Clinicians, Physicians, and Friends.
- G. **Individual with Developmental Disability** – Person in the community who is eligible for developmental disability services either through a DD waiver or state funded services.
- H. **Provider** – For the purposes of this policy, the term “provider” or “service provider” includes organizations that provide DD services that are financially supported in whole or in part by funds authorized through DBHDD.
- I. **Provider Support Staff** – Provider staff responsible for implementing recommendations from the HRC
- J. **Psychotropic Medication** - Those medications categorized as antipsychotic, anti-manic, antidepressant, anti-anxiety, and anti-obsessive drugs as well as other medications employed as treatment of psychiatric disorders. This does not include medications typically prescribed for extra-pyramidal side effects.
- K. **Regional Office** – An office of the Department of Behavioral Health and Developmental Disabilities, created pursuant to The Official Code of Georgia Annotated (O.C.G.A.); such office shall serve as the entity for the administration of behavioral health, addictive disease, and developmental disability services in a region.

IV. PROCEDURES

The broad role of the HRC is to assist individuals with developmental disabilities to promote their health and human rights by addressing concerns of possible rights violations or restrictions.

Service providers must follow all health and human rights related policy and guidelines including, but not limited to, the rights suspension, restrictive procedures, psychotropic medication, allegations of mistreatment, abuse, neglect, or exploitation, and experimental research. No person shall be retaliated against or be denied services for presenting an issue to a regional HRC.

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Any person who considers filing with the HRC is encouraged to resolve the matter informally by discussing it first with the staff members or other persons involved or Service Provider's Clients' Rights staff as specified in the Service Provider's Program's Quality Improvement Plan.

The individual receiving DD services is not required to use the procedures established by this Policy or Client's Rights Rules and Regulations in lieu of other available remedies, including the right to directly submit a written complaint to the Regional Director, or Deputy Director of the Division of Developmental Disabilities (the Division), or Governor's Advisory Council as provided in O.C.G.A. Chapter 37-2-4.

In addition, the HRC provides recommendations concerning overall health and human rights related practices. The Division Office, Regional Offices, support coordinators, providers and/or persons with developmental disabilities, representatives, guardians, individuals, associations, or agencies involved with the delivery or receipt of disability services shall refer cases for review to the HRC in the manner prescribed in these procedures.

The Division's Human Rights Coordinator is responsible for ensuring the provision of technical assistance, guidance, and training for the Human Rights Committee (HRC). The Human Rights Coordinator maintains the following information:

- current HRC membership lists
- current calendar year's regularly scheduled meetings, and
- copies of meeting minutes.

The coordinator must be made aware of all emergency HRC meetings via e-mail. Information flow between the Human Rights Councils and applicable parties outside of the HRC may be coordinated by the Human Rights Coordinator to ensure timely receipt of information by the HRC.

Human Rights Council Membership:

Each HRC is comprised of an odd number of members of no less than seven (7) persons and no more than nine (9) persons. One or more community volunteers from each category of the following categories listed below may serve on an HRC however, representatives from the first four categories are required:

- a. Medical Professional (one of the following required)
 1. Physician
 2. Registered Nurse (RN)
- b. Pharmacist (required)
- c. Self Advocate (required)
- d. Parent and /or Guardian (required)
- e. Law Professional/Enforcement (one of the following required)

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1. Lawyer (Relevant field to DD services)
 2. Law Officer
 3. Paralegal
- f. Business leader or Faith Community leader
- g. Educator active in the classroom and/ or administration
1. School Teacher (Relevant field to DD services)
 2. College Professor (Relevant field to DD services)
- h. Advocacy Professional
1. Paid ARC staff member
 2. Paid DD advocacy organization staff member

There may be no more than two individuals from any one category on the HRC at any time to provide a balance of perspectives. Should an HRC need expert consultation that a member of the HRC is not qualified to provide, the Human Rights Coordinator must be contacted immediately. The Human Rights Coordinator will then inform the appropriate state level official and aid in obtaining expertise.

Each HRC also has a Behavior Plan Subcommittee (BPS) comprised of a minimum of three persons to maximum of five persons (must be an odd number) to review the Behavioral Support Plans. The BPS is comprised of members on the HRC, one of which must be from the following categories: Self Advocate, Parent or Guardian, or Advocacy Professional.

Additional Human Rights Council Membership Requirements

- a. No contractor, employee or Board of Directors member of a Provider, Support Coordinator or employee of DBHDD may be a voting member. The Division of Developmental Disabilities staff will ensure orientation and training regarding duties and responsibilities to the members of the HRC.
- b. Members serve a maximum of three consecutive (3) years. Initially members should be appointed to staggered terms to ensure continuity across years.
- c. HRC members, agency administrators, family members, Division or Regional staff and persons receiving services may nominate members for the HRC. Prospective members complete an application and submit resume and/or a brief statement describing their qualifications and/or interest in serving on the council. All HRC members are unpaid. If funds are available self advocates/parent or guardian members may receive a stipend for travel.
- d. All decisions of the HRC and the BPS are made by a quorum. A quorum is comprised of one half of the HRC membership plus one additional member. Final decisions are reached through majority vote of the quorum. A vote may be cast via telephone/conference call if so needed.

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- e. HRC members review nominations and vote to select by a quorum those members they feel are most qualified and committed to serve. The HRC Chair and Secretary make the final decision regarding the nominated candidate. If the nomination is accepted, the HRC Chair extends a formal invitation to the candidate and if accepted, the new member is oriented in regards to the HRC responsibilities. This orientation is coordinated with the Human Rights Coordinator to ensure that new members receive all required training.
- f. Former provider staff or former support coordinators may be nominated to serve after they have been disassociated from DBHDD service provider or support coordinator agency for a period of two (2) years and only if they have left the agency in good standing. No current employee or Board Member/ Director of DBHDD, DBHDD contractor, a DBHDD provider or a support coordination agency may be an HRC member. A HRC member must immediately forfeit their seat on the HRC upon the acceptance of an offer of employment with DBHDD or its affiliates.

Responsibilities of Human Rights Council Members

1. The HRC shall elect a Chairperson and Secretary. The Chairperson and Secretary shall serve a one (1) year term. The Chair's responsibilities shall include facilitating the scheduled HRC meetings.
2. Members must analyze the HRC packets prior to the review date, attend quarterly meetings, and make themselves available for rare emergency meetings. If an individual does not actively participate in the activities of the HRC by missing more than two (2) consecutive meetings, quarterly council meetings and emergency meetings, the Chairperson or Human Rights Coordinator notifies the member that their appointment is under review and may be rescinded.
3. The HRC shall convene a minimum of once per quarter up to once per month as designated by the HRC Chairperson and as determined by a council quorum. The standard for active membership is not to miss 2 consecutive meetings, quarterly council meetings and/or emergency meetings.
4. In the event that an emergency meeting is needed, the Chairperson may schedule a HRC meeting with 7 business days notice to committee members.
5. In the event that a consultant serves on the HRC, they shall not vote on issues that may present a conflict of interest, nor shall they vote on situations in which they have provided consultation.
6. In the event that an HRC member is guardian for an individual presented to HRC for review, he/she shall not be a voting member during such case.
7. Regional Office, service provider, support coordinator employees or contractors may serve as participants upon invitation and as a resource to the HRC, but not as voting members of the HRC.

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8. Each HRC member is required to sign a statement which obligates him/her to maintain the confidentiality of the individuals, programs, providers and other matters discussed or read about in course of carrying out HRC duties.
9. The current HRC membership list, current calendar year's regularly scheduled meeting schedule, and copy of meeting minutes must be kept current with the Division of Developmental Disabilities, Human Rights Coordinator. The Human Rights Coordinator must be made aware of all emergency meetings via e-mail.

Training and Guiding Principles for Human Rights Council

1. The Division of Developmental Disabilities is responsible for ensuring adequate training and guidance to the HRC members.
2. The Division's Human Rights Coordinator is responsible for ensuring the provision of direct training from appropriate DBHDD staff and/ or contractors and ensuring adequate guidance to HRC members.
3. Prior to voting on HRC issues, all HRC members must receive training on:
 - human and civil rights for persons with intellectual and developmental disabilities
 - the roles and responsibilities of the HRC human rights
 - use of psychotropic drugs in the treatment of persons with developmental disabilities
 - protections and safeguards when experimental research is proposed
 - confidentiality, including HIPAA compliance
 - statutory and regulatory requirements,
 - agency policies and procedures, and
 - behavioral support plan review for all HRC members

Council Review Duties and Decision Making

The Human Rights Council, as an advisory and review body, shall determine whether an individual receiving DD services human rights persons' human rights are protected by reviewing concerns/issues submitted by persons with developmental disabilities, representatives, guardians, individuals, associations, or agencies involved with the delivery or receipt of disability services regarding health and human rights issues.

A. Issues Submitted to the HRC

1. All rights complaints shall be filed with the service provider per Client's Rights Rules and Regulations. The HRC first verify that the complaint has been filed with the Client's Rights Subcommittee or its equivalent. In accordance with DBHDD complaint and grievance policy.
2. The provider support staff is to submit to the HRC members any information discovered in investigation of the complaint seven (7) working days before the scheduled HRC meeting. Information shall

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include, but not be limited to: copy of the complaint, if applicable, resolution from the provider's investigation of complaint (see below); personal interview notes, and documents for review, correspondence and proper release of information.

3. The investigation of complaint, as outlined in Clients' Rights, 290-4-9-.04, should include contact information for the Interdisciplinary Team (IDT).
4. Each service provider shall prepare the necessary documents meeting the required criteria as identified by Client's Rights Rules and Regulations, of any issues needing HRC review.
5. Council members will review materials submitted for HRC review and determine if it does or does not meet the HRC standards for approval for issues specific to rights suspension, restrictive procedures, psychotropic medication, allegations of mistreatment, abuse, neglect, or exploitation, and experimental research.
6. From time to time, HRCs may request additional information from parties involved with specific issues submitted to the HRC. When such a request is made, the Human Rights Coordinator will expect a response to the request within seven (7) working days. If requested information is not received within that time, the Human Rights Coordinator will make the determination if there is sufficient information to continue the review and may contact the party responsible concerning the delay in receipt of information.

B. Issues Submitted to the Human Rights Council by the Division of Developmental Disabilities

The Division of Developmental Disabilities may submit a human rights incident to the HRC. The Division of Developmental Disabilities shall submit pertinent information related to the complaint filed including but not limited to applicable data reports, documents for review, correspondence and proper release of information.

Council members review materials submitted for HRC review and determine if it does or does not meet the HRC standards for approval for issues specific to rights suspension, restrictive procedures, medication or other practices used for modifying behavior, allegations of mistreatment, abuse, neglect, or exploitation, and/or experimental research.

C. Review of Behavioral Support Plans

The Human Rights Council shall delegate to its Behavior Plan Subcommittee (BPS) the review of plans that are designed to reduce challenging behaviors.

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1. The Behavior Program Review Committee (BPRC) submits to the HRC, all behavior support plans at least seven (7) working days before the scheduled HRC meeting.
2. The HRC delegates responsibility for review of behavior support plans to the BPS, who determines if each behavior support plan does or does not meet its standards for approval for issues specific to rights suspension, restrictive procedures, psychotropic medication, allegations of mistreatment, abuse, neglect, or exploitation, and/or experimental research. The BPS review plans within 30 days of submission.
3. The BPS submits its findings to the Chairperson of the HRC. The Chairperson and Human Rights Coordinator signs off on all approved behavior support plans. The Human Rights Coordinator returns all plans to the BPRC as “approved” or “needs revision” with suggested revisions included.

D. Psychotropic Drug Use

The Human Rights Council must also review all of the following actions: (a) medication initiation and/or changes involving the use of five or more psychotropic drugs and (b) requests for individuals receiving DD services to participate in experimental research.

1. HRC are to review all initiation of and changes in use of five or more psychotropic medications.
2. When possible, the review should occur prior to the implementation of such procedures.
3. The provider support staff shall submit to the HRC all relevant documentation, such as a current behavioral support plan, regarding initiation of and/or changes in the use of five or more psychotropic medication; this documentation is submitted seven (7) working days before the scheduled HRC meeting.
4. In the event that a physician is not available for specific review of the medication documentation, the Human Rights Coordinator shall assist in finding a physician from another region to consult with the HRC for the purposes of this medication-related review.

E. Experimental Research and the Protection of Human Subjects

In the event that the HRC is made aware of complaints regarding Experimental Research and the Protection of Human Subjects, the HRC will immediately notify the applicable regulatory bodies as detailed in the Institutional Review Board (IRB) policies applicable for DBHDD. The Department of Behavioral Health and Developmental Disabilities (DBHDD) utilizes the Department of Community Health (DCH) Institutional Review Board (IRB) to ensure protection of human subjects. Policies and procedures regarding the protection of human subjects and operation of

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the IRB are developed and maintained by DCH. Therefore, the DCH Protection of Human Subjects policy and procedures constitute the DBHDD directive on this topic.

F. Referred Cases Found not to Directly Impact Human Rights

If the case does not fall into the purview of HRC standards for review, the HRC will document its resolution in writing and give notice to the party who submitted the complaint / issue and include information for appeal the process to the Division of Developmental Disabilities, Human Rights Coordinator.

G. Case Review and Final Recommendations

1. All HRC activities shall remain confidential in order to ensure the following:
 - that internal quality improvement investigations and monitoring activities are completed fully and in an in-depth manner;
 - to encourage candid evaluations;
 - and that adequate corrective action is taken in all cases, review actions are taken and documentation is completed in furtherance of Clients Rights Rules and Regulations.

2. Any recommendations made by the HRC are communicated to the Human Rights Coordinator, Provider Director and the complainant by the HRC in writing within five (5) business days following the HRC meeting.

3. The recommendations of the HRC shall be recorded on a case specific information form that shall be signed by the eligible council members present for that review at the time of case hearing. Dissenting opinion(s) will be documented on the same form. Within ten (10) workdays' copies of the form shall be disseminated to the individual (s) involved, Provider, Regional Office, the Division of Developmental Disabilities Human Rights Coordinator, and Support Coordination Agency. The original report of the recommendations shall be kept in the HRC records at the provider agency and copies shall be distributed to the HRC Coordinator.

4. Recommendations include a timeframe for HRC ongoing review to be set at the discretion of the council in intervals of week(s), month(s), or annually.

5. The Regional HRC Chair person shall designate a council member to be responsible for providing support to the council chairperson. This support is to include the following:
 - a. Scheduling of meetings

 - b. Notification of council members, Division of Developmental Disabilities staff, Regional Office staff, the service provider staff, and support coordination agency of meeting dates and times

 - c. Recording and dissemination of meeting minutes including recommendations of the HRC on the Minute/Data Collection Form. Follow-up to HRC recommendations will be noted.

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H. Appeals Process

When an individual with developmental disabilities, their representatives/guardians, or agencies involved with the delivery of that individual's services is dissatisfied with a resolution proposed by the HRC, an appeal may be filed with the DBHDD Division of Developmental Disabilities Executive Director or designee. In such situations, the Division Executive Director or designee will contact the HRC to request copies of all materials relevant to the complaint or grievance. The Division Executive Director or designee's review of the appeal shall be completed within 10 business days of receipt of the appeal and all relevant materials. The Division Executive Director or designee provides a final resolution for the Human Rights issue. A copy of the resolution shall be forwarded to all applicable parties and a copy of the final resolution shall remain on file with the Human Rights Coordinator.

V. General Provisions

No person shall be subject to any form of discipline or reprisal solely because he or she has sought a remedy through or participated in the procedures established by Client's Rights Rules and Regulations and this policy.


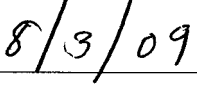

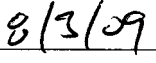
Obstruction of the investigation or disposition of a complaint by any person shall be reported. Staff members are subject to adverse action for engaging in such obstruction, in accordance with personnel policies of DBHDD or the personnel policies of the provider agency.

Time limits designated in this policy and those of the Client's Rights Rules and Regulations may be extended at each step by the HRC chairperson for good cause.

To successfully implement this policy's procedures regarding review of psychotropic drug use for individuals who are receiving five or more psychotropics prior to this plan's implementation, the HRC will utilize a tiered approach that begins with review of individuals at higher risk (as reflected by the fact that they are prescribed a larger number of medications).

VI. Notification of Rights

In accordance to the Client's Rights Rules and Regulations, each Provider shall display a notice in a prominent place of the availability and accessibility of these regulations at each appropriate service site.

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Chapter: Behavioral Health Community Services Subject: Independent Peer Review for Addictive Diseases Providers	
Applicability: Community Addictive Diseases Providers	Effective Date: August 25, 2009 Scheduled Review Date: August 2011 Approved:
References: Federal Substance Abuse Prevention and Treatment Block Grant, Goal #15	 <hr/> Onaje Salim, LPC, Director Division of Addictive Diseases
Attachments: Attachment A – Independent Peer Review Form Attachment B – Bill for Services Rendered Template – Notification Letter Template	<div style="text-align: center;">  <hr/> Date </div> <div style="text-align: center;">  <hr/> Frank Shelp, M.D., M.P.H., Commissioner </div> <div style="text-align: center;">  <hr/> Date </div>

INDEPENDENT PEER REVIEW FOR ADDICTIVE DISEASES PROVIDERS

POLICY

The purpose of the Independent Peer Review is to improve the effectiveness of Georgia’s substance abuse services. This is accomplished by using professional peers to review the clinical and administrative practices of programs by identifying innovations and best clinical practices. As staff members from different programs meet, observe, and review program practices, a natural sharing of information takes place. The opportunity for professionals from different programs to discuss best practices is the most advantageous aspect of the peer review process. This information is summarized in a yearly report created by the Division of Addictive Diseases.

DEFINITIONS

For the purposes of this policy, “**Quality**” is defined as the provision of treatment services within the constraints of technology resources, and patient/consumer circumstances that meet accepted standards and practices which improve patient/consumer health and safety status in the context of recovery. “**Appropriateness**” is defined as the provision of treatment services consistent with the patient/consumer identified clinical needs and level of functioning.

SELECTION OF COMMUNITY ADDICTIVE DISEASES PROVIDERS AND PEER REVIEWERS FOR THE INDEPENDENT PEER REVIEW

The Federal Substance Abuse Prevention and Treatment Block Grant Regulations require the State to provide independent peer review. These regulations require that five percent (5%) of all programs receiving funding be reviewed annually by professional peers to assess the quality and appropriateness of their treatment services. The Division of Addictive Diseases selects a treatment modality to be reviewed and randomly chooses a representative sample of programs of community addictive disease providers delivering the determined level of care within a specific region of the state. Programs chosen for review are selected from a comprehensive list generated by DBHDD and certified by the Director of Provider Network Management.

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Independent peer reviewers are identified and selected by the Division of Addictive Diseases to carry out the peer review process. The Division of Addictive Diseases Director contracts a consultant to coordinate the efforts of independent peer reviewers who are informally contracted by the Division of Addictive Diseases to examine: admission criteria/intake process, assessment; treatment planning, including appropriate referral; documentation of treatment services provided; discharge and continuing care planning; and indications of treatment outcomes. The regulations require that independent peer reviewers cannot review their own programs or programs for which they have administrative oversight and the review must be separate from any funding decisions and not part of any licensing/certification process.

QUALIFICATIONS OF A PEER REVIEWER

Peer reviewers are individuals with expertise in the field of alcohol and drug abuse treatment and knowledgeable of the various disciplines utilized by the program being reviewed. Peer reviewers are knowledgeable about the modality being reviewed and its underlying theoretical approach to addiction and must be sensitive to the cultural and environmental issues that may influence the quality of the services provided.

GENERAL INFORMATION ABOUT INDEPENDENT PEER REVIEWS

Independent Peer Reviewers use a number of methods to gather information on programs and the services they provide. Methods used are:

- Tours of the facility
- Interviews with agency staff performing various functions in the modality reviewing
- Review of clinical forms used in the clinical records
- Observation of admission/intake processes
- Review of consumer satisfaction surveys or interview consumers
- Review of open and closed consumer records

A clinical review of the program is required by the Federal regulations. The clinical review is broken into six sections. Sections 7-10 include consumer satisfaction surveys, and an administrative review:

- | | |
|------------------|---|
| Section 1 | Determine if the admission/intake process respects the dignity of the consumers. |
| Section 2 | Determine if the assessment process identifies the need for care, the appropriate level of care and forms the basis for a treatment plan. |
| Section 3 | Determine if the treatment plan provides a flexible guide for helping consumers get better. |
| Section 4 | Determine if the documentation demonstrates the delivery of appropriate treatment services to meet the consumer's needs in a timely manner. |
| Section 5 | Determine if the discharge plan supports the consumer's recovery. |
| Section 6 | Determine the program's policies, procedures and practices regarding treatment outcome. |
| Section 7 | Determine consumer satisfaction with the program. |

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- Section 8** Administrative Review.
- Section 9** Reviewer’s summary of Peer Review Process.
- Section 10** Provider’s Assessment of the Independent Peer Review Process.

PROCEDURES

Prior to the commencement of the review, a notification letter (**see Notification Letter Template**) is sent to the peer reviewer to confirm their participation in the review process and establish due dates. Applicable documentation, materials, and/or information relevant to the review are also submitted to the reviewer as soon as possible. The Director of the Division of Addictive Diseases and/or consultant is responsible for discussing the expectations of the review and preparing the peer reviewers for proper completion of the review.

Each peer reviewer completes the following:

1. Contact the program to be reviewed to:
 - a. Discuss the review agenda and arrange a mutually convenient date. Once the date has been set, the reviewer informs the Division of Addictive Diseases and the program being reviewed in writing the date the review is scheduled.
 - b. Ask the program being reviewed if there are any specific areas they would like to focus on during the review.
 - c. Coordinate with the program being reviewed to have available documentation that is needed for the review process. Some of this material may be provided to the reviewer prior to the review date. This material may include:
 - Agency and or Program brochure,
 - Sample case record format to facilitate chart review,
 - Schedule of program activities,
 - Program mission statement,
 - Program objectives and philosophy,
 - Criteria for consumer admission, movement through treatment phases and completion.

2. The review begins with an introduction during which:
 - a. The reviewer explains the purpose of the review and how it will be conducted and asks, again, if there are any areas they would like to focus on during the review.
 - b. The program being reviewed provides the reviewer with a general overview of the program’s operations including types of services, staffing and census.
 - c. If possible, the initial meeting includes any staff member who will participate in the review process.

3. A tour of the facility following the introductory session is recommended.

4. The reviewer begins the review process by following the guidelines set forth in **Attachment A – Independent Peer Review Form**. The form provides methodologies on how to gather information, focus issues questions, and guidance in completing the form.

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5. Within one week after the site review, the reviewer provides a draft summary report of the findings to the program reviewed.
6. The program may respond, verbally or in writing, to the reviewer to determine the information included in the final summary report.
7. Within 30 calendar days of the program review, the reviewer completes the final summary report and sends it to the person/division listed below along with the **Bill for Services Rendered Form (Attachment B)**, an invoice, and a copy of the Independent Peer Review Form for approval and signature by the Director of the Division of Addictive Diseases.

Onaje Salim, Director
Division of Addictive Diseases
2 Peachtree Street, NW, Suite 22.273
Atlanta, GA 30303

INDEPENDENT PEER REVIEW FORM

NAME OF PROGRAM REVIEWED: _____

DATE OF REVIEW: _____

MODALITY REVIEWED: _____

NAME AND TITLE OF REVIEWER: _____

NUMBER OF RECORDS REVIEWED: _____ **OPEN** _____ **CLOSED** _____

=====
Methodology section contains suggestions on how to gather information for each objective. The Focus Issues section contains questions that should be used. The reviewer is encouraged to be as detailed as possible in order to highlight the innovative and best practices activities of the program being reviewed.
=====

SECTION 1: DETERMINE IF THE ADMISSION/INTAKE PROCESS RESPECTS THE DIGNITY OF THE CLIENT.

Methodology: Interview intake personnel, observe the general admission area, review documentation of the process, and interview clients if available.

Focus Issues:

- a. Does the staff present themselves to clients in a warm, informative, and non-threatening manner?
YES NO
- b. Are admissions timely? **YES NO**
- c. What is the approximate length of time between contact and admission appointments?
- d. How is the client made to feel comfortable?
- e. How is the client informed of his/her rights and confidentiality regulations?
- f. Reviewer's documentation: _____

SECTION 2: DETERMINE IF THE ASSESSMENT PROCESS IDENTIFIES THE NEED FOR CARE, THE APPROPRIATE LEVEL OF CARE AND FORMS THE BASIS FOR A TREATMENT PLAN.

METHODOLOGY: Review charts and interview clinicians.

FOCUS ISSUES:

- a. Does the assessment indicate the admission was appropriate to the admission criteria? **YES NO**
- b. What is the approximate length on time between the assessment and admission in the program?
- c. Does the assessment support the diagnostic impression? **YES NO**
- d. Does the assessment identify and address areas of dysfunction? **YES NO**
- e. Is the level of care appropriate? **YES NO**
- f. Assessment was conducted within a reasonable time frame from the time of initial contact? **YES NO**
- g. Reviewer's documentation: _____

SECTION 3: DETERMINE IF THE TREATMENT PLAN PROVIDES A FLEXIBLE GUIDE FOR HELPING CLIENTS GET BETTER.

METHODOLOGY: Review charts, interview clinicians and clients.

FOCUS ISSUES:

- a. Does the treatment plan address problems noted in the psychosocial assessment? **YES NO**
- b. Does documentation of treatment plan updates/revisions reflect a joint effort between the clinician and client? **YES NO**
- c. Are the treatment goals achievable based on the client's abilities and program resources? **YES NO**
- d. How does the client participate in the treatment planning process?
- e. Reviewer's documentation: _____

SECTION 4: DETERMINE IF THE DOCUMENTATION DEMONSTRATES THE DELIVERY OF APPROPRIATE TREATMENT SERVICES TO MEET THE CLIENT'S NEEDS IN A TIMELY MANNER.

METHODOLOGY: Review charts and interview clinicians.

FOCUS ISSUES:

- a. Do progress notes tie in to the treatment plan? **YES NO**
- b. Does the chart document the level of client functioning in response to the treatment and justify the level of services offered? **YES NO**
- c. Is treatment rendered and documented on a timely basis? **YES NO**
- d. Reviewer's documentation: _____

SECTION 5: DETERMINE IF THE DISCHARGE PLAN SUPPORTS THE CLIENT'S RECOVERY

METHODOLOGY: Review charts and interview clinicians.

FOCUS ISSUES:

- a. Is the discharge plan consistent with the documented history? **YES NO**
- b. Is the plan consistent with the client's level of functioning and resources? **YES NO**
- c. Did the client participate in the development of the plan? **YES NO**
- d. Is the continued care of the client addressed in the plan and does it meet the client's needs? **YES NO**

e. Reviewer's documentation: _____

SECTION 6: DETERMINE THE PROGRAM'S POLICIES, PROCEDURES AND PRACTICES REGARDING TREATMENT OUTCOME

METHODOLOGY: Interview administrators and other staff, review documentation of process, and review sample discharge summaries/aftercare plans.

FOCUS ISSUES:

- a. What if any, documentation is collected by the program regarding treatment outcomes at discharge?
- b. How is the information utilized by program improvement?
- c. Reviewer's documentation: _____

SECTION 7: CLIENT SATIFICATION SURVEY

METHODOLOGY: Interview clients and/or review client satisfaction surveys or others means used to measure client satisfaction if available.

FOCUS ISSUES:

- a. How does the program assess client satisfaction? If the program does not use a survey, one is supplied for the reviewer to use to interview clients.

- b. Does the client feel the program serves his/her needs? **YES NO**
- c. Is the client informed of the procedures to be used for filing complaints, both internal and external? **YES NO**

e. Reviewer's documentation: _____

SECTION 8: ADMINSTRATIVE REVIEW

SUGGESTED AREAS OF DISCUSSION:

- | | | |
|---------------------|--------------------|----------------------------------|
| Quality Assurance | Utilization Review | Program Activity Scheduling |
| Staffing Patterns | Internal Controls | Customer Satisfaction |
| Program Development | Outcome Measures | Employment Environment |
| Computer Technology | Marketing | Data Flow Admin/Billing/Clinical |

- a. Is the administrative area system efficient and effective? **YES NO**
- b. Does the selected system support the clinical goals? **YES NO**
- c. Is the programs current practices based on research/evidence based practices? **YES NO**

If yes, please identify the practices _____

- d. What mechanism for information flow, in the areas of treatment and research information, exist in the program?

e. Reviewer's Documentation: _____

SECTION 9: REVIEWER'S SUMMARY OF THE PEER REVIEW PROCESS

INNOVATIVE APPROACHES: _____

SUGGESTIONS SHARED: _____

**SECTION 10: Providers assessment of the independent peer review process.
(To be completed by provider being reviewed.)**

a. What part(s) of the Peer Review Process did you find most helpful/useful?

b. What part(s) of the Peer Review Process did you find the least helpful/useful?

c. What additional areas would you include as a part of the review?_____

d. What changes to the review would you recommend?_____

Section Ratings

Rate the program in each section by circling the appropriate answer.

Section 1: Determine if the Admission/intake process respects the dignity of the client.

Excellent Good Fair Poor

Section 2: Determine if the Assessment process identifies the need for care, the appropriate level of care and forms the basis for a treatment plan.

Excellent Good Fair Poor

Section 3: Determine if the treatment plan provides a flexible guide for helping clients get better.

Excellent Good Fair Poor

Section 4: Determine if the documentation demonstrates the delivery of appropriate treatment services to meet the client’s needs in a timely manner.

Excellent Good Fair Poor

Section 5: Determine if the discharge plan supports the client’s recovery.

Excellent Good Fair Poor

Section 6: Determine the program’s policies, procedures and practices regarding treatment outcome.

Excellent Good Fair Poor

Section 7: Client satisfaction.

Excellent Good Fair Poor

=====

Independent Peer Review Form Signatures

PEER REVIEWER SIGNATURE

Printed Name

Date

DBHDD DIRECTOR OF ADDICTIVE DISEASES SIGNATURE

Printed Name

Date

CLIENT SATISFACTION SURVEY

**Modality reviewed: Adult IOP Adult Crisis Residential Adult Residential Rehabilitation
Special Women's Program Adolescent OP/IOP Adolescent Residential**

Please circle your answers.

HOW SATISFIED ARE YOU:

1. With the staff who served you?

1	2	3	4	5
Not at all satisfied	Not satisfied	OK	Satisfied	Very Satisfied

2. With how staff keep things about you and your life confidential?

1	2	3	4	5
Not at all satisfied	Not satisfied	OK	Satisfied	Very Satisfied

3. That the agency staff respected your ethnic and cultural background?

1	2	3	4	5
Not at all satisfied	Not satisfied	OK	Satisfied	Very Satisfied

4. With the services you received?

1	2	3	4	5
Not at all satisfied	Not satisfied	OK	Satisfied	Very Satisfied

5. That services are provided in a timely manner?

1	2	3	4	5
Not at all satisfied	Not satisfied	OK	Satisfied	Very Satisfied

6. That your treatment plan helped you get better?

1	2	3	4	5
Not at all satisfied	Not satisfied	OK	Satisfied	Very Satisfied

7. With how the staff treated you?

1	2	3	4	5
Not at all satisfied	Not satisfied	OK	Satisfied	Very Satisfied

8. What did you like best about the services you received?

9. How could the services you received be improved?

10. If you have any other comments, please write them below and/or on the back of this sheet.

Office of Addictive Diseases Peer Review Process Overview

Step 1:

Division of Addictive Diseases obtain a master list of providers

The Division of Addictive Diseases selects a treatment modality to be reviewed, i.e., crisis stabilization, core service provider, adolescent residential, adult residential, etc.

A representative sample list of programs to be reviewed by region is generated by the end of the fiscal year.

Step 2:

Contact reviewers and programs

30 days after the end of the fiscal year, the Director of the Division of Addictive Diseases or consultant sends letter(s) to peer reviewers and programs confirming their participation and supplying any needed information or documentation regarding the completion of the Addictive Diseases Peer Review Process.

Step 3:

Notification Letter sent to reviewers

60 days after the end of the fiscal year, the Office of Addictive Diseases Director or consultant sends a notification letter with due dates for the process to be completed. (Letters can get delayed in mail, etc. so it is best practice that any letter is followed up quickly with email and/or telephone call. The purpose of an email or telephone follow up is to confirm that the letter has been received and to determine if questions need to be answered, etc.)

Step 4:

Data Collection

Analyze Reports

Write Annual Report



Georgia Department of Human Resources

Bill for Services Rendered - Effective January 1, 2006

Section 1 Approving authority should complete all fields with bold headings in this section.

Vendor Name				Vendor ID		Location	
Invoice Date	Invoice #	Invoice Amt	Pay Terms	Description			
Speedchart (Project Code)		Amount		Account		Fund	
						10100	
Department (Organization Code)		OPB Sub Program			Class		
					312		
Pay by (Mark One)	Check	EFT	Handling Code		Pay Date		Accounting Template
			FP				ACCTSPAY1

Section 2 Payee or approving authority should complete all items in this section.

Professional Title			Degree Held		
Make payment to:	Name of Payee				
	Address line 1				
	Address line 2				
	City		State		Zip Code

Section 3 Payee should complete all items in this section.

I hereby certify the validity of this statement of my services, hours and expenses and that :			
Check one	<input type="checkbox"/>	I am not a full time salaried employee of any state agency.	<i>Remember: Page 2 must be completed to assure payment.</i>
	<input type="checkbox"/>	I am a salaried employee of a state agency. In accordance with the provisions of OCGA 45-10-24 & 45-10-25 & DHR Policy 1203, the necessary authorization for services has been obtained.	Agency name
Payee Signature			Date

I approve the foregoing request and authorize payment. In addition, I certify that all provisions of OCGA 45-10-24 & 45-10-25 are met if applicable.	
Approval Signature	Date
_____	_____
Print or type name of approver	Phone
_____	_____

Processed by OFS Staff Member

Date

Voucher #



DHR Bill for Services Rendered

In accordance with appropriate authorization, I have served as a part-time professional consultant to the Georgia Department of Human Resources for the time shown below:

Sec. 4 Services / Hours

Monthly Retainer (if applicable)

Date(s) of Service	Place of Service	Description of Service / Purpose of Travel	Number of Hours
Explain any expenses that are unusual or exceed established limits; Explain telephone & telegraph charges.			Total

Sec. 5 Expenses

Date	A. Transportation (Complete only those items for which you are claiming reimbursement)					B. Meals & Lodging (Entries should not exceed maximum rates & must include city where meals were taken)					C. Telephone & Telegraph Explain Above	D. Registration Attach Receipt	
	Month Day	Time Departure	Origin - Points Visited Destination	State Use Milage Personal Vehicle	Common Carrier, Parking or Tolls Attach Receipt	Taxi, Limousine or Portorage	Brkfst	Lunch	Dinner	Total Meals			Lodging Attach Receipt
		Return					Amnt	Amnt	Amnt				
Subtotals			-	\$ -	\$ -				\$ -	\$ -	\$ -	\$ -	
TOTALS			A. Transportation		\$ -	B. Meals & Lodging					C.	D.	
Total Reimbursement Claimed (A + B + C + D)										\$ -			

Date:

Dear _____,

I would like to thank you for participating as a peer reviewer in the Independent Peer Review process this year.

I have contacted _____ at _____ and he/she is willing to have his/her program reviewed as apart of the peer review process. He/She will be your contact to setup the peer review process. He/She can be contacted at (____)____-____.

I have enclosed a copy of the **Independent Peer Review Form** you will use during your site visit. I have also enclosed the **Independent Peer Review for Addictive Diseases Providers Policy** which outlines reviewer qualifications and the procedures used when conducting the peer review. Please read the policy and follow the instructions outlined in the procedures. The program you will be visiting will have a copy of the policy and will be able to follow along with you as you explain how the review process will be conducted.

The peer review process must be completed by _____.

You will receive in the mail a peer review "**Bill for Services Rendered**" from the Department of Behavioral Health and Developmental Disabilities. **Please complete and sign the Bill for Services Rendered form and return it to our office as soon as possible. You cannot conduct the peer review before the form is signed and returned to this office. Payment cannot be made if we don't receive a signed form prior to the start of your review.** I do not want anyone to conduct a review and not be able to get paid.

Once you have signed the Bill for Services Rendered form and mailed it back to our office, please contact the program to be reviewed and set a tentative date for the review. Please notify me as soon as possible by e-mail or by letter to let me know the date(s) of the review.

I have enclosed the Bill for Services Rendered form. Once the peer review process has been completed, a copy of the **Independent Peer Review Form**, along with an invoice, should be sent to:

ATTENTION: Name
Office/Section
Address and Suite/Unit
City, State, Zip

Remember, all peer reviews must be completed prior to _____ (date).

Thank you for your help. If you have any questions I can be reached at (____) ____-____.

Sincerely,

Name
Office/Section



Chapter: Behavioral Health Community Services
Subject: Informed Consent for Psychotropic Medication Treatment For Child and Adolescent Population

Applicability: All DBHDD Child and Adolescent Providers

Original Effective Date: October 1, 2010

Scheduled Review Date: October 2011

References: None

Approved:

Attachments:

Attachment A – Psychotropic Medication Utilization Parameters for Severely Emotionally Disturbed (SED) Children and Adolescents

Audrey Sumner 8/5/10
Audrey Sumner, LCSW
Director of Community Mental Health
Division of Mental Health

Attachment B – Informed Consent for Psychotropic Medication Treatment for Children and Adolescents

Cassandra Price 8/5/10
Cassandra Price, GCADC-II, MBA,
Executive Director
Division of Addictive Diseases

Frank E. Shelp 8/6/10
Frank E. Shelp, M.D., M.P.H., Commissioner

INFORMED CONSENT FOR PSYCHOTROPIC MEDICATION TREATMENT FOR CHILD AND ADOLESCENT POPULATION

POLICY

The Division of Child and Adolescent Mental Health within the Department of Behavioral Health and Developmental Disabilities recognizes an individual's right to exercise informed consent to treatment prior to the administration of psychotropic medication and throughout the course of treatment with such medication. The Division seeks to assure that each individual receiving psychotropic medication as a part of his/her treatment is aware of the benefits, side effects which may occur while taking this medication and the available treatment alternatives, including no medication. The process of Informed Consent helps to encourage and support the discussion of questions and concerns regarding the use of psychotropic medication with a youth and his or her parent/legal guardian and should be actively encouraged. This process is best supported by open, verbal communications, must include medication education and information, administration and dosage information, and must be documented in the medical record. All medications must be used solely for the purposes of providing effective treatment and protecting the safety of the consumer and other persons and not as punishment or for caregiver, staff or parental convenience. Assessment of safety determines whether involuntary administration of medication is necessary. Informed consent for medications should always be documented in a consistent manner and located in the youth's medical record in a designated location for easy accessibility. Crisis Stabilization Programs shall continue to follow policies and procedures in the Informed Consent and Involuntary Administration of Psychotropic Medication in Hospitals, concerning the use of psychotropic medication in involuntary situations.

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Targeted Population(s)

This policy is applicable to all child and adolescent consumers who are enrolled in mental health and/or co-occurring services contracted by the Department of Behavioral Health and Developmental Disabilities, and who are prescribed psychotropic medications as part of their treatment plan.

INTRODUCTION

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), has established this policy for obtaining Informed Consent for all DBHDD enrolled child and adolescent consumers who are prescribed psychotropic medications. A medical practitioner (licensed physician, certified physician assistants, or advanced practice nurse pursuant to the written protocol with the physician that meets the statutory criteria) shall obtain informed consent from the youth's parent or legal guardian, and shall obtain assent from the youth.

A youth's parent/legal guardian shall give the Informed Consent by signing and dating an acknowledgement that the youth/parent/legal guardian has received the information, and the parent/legal guardian gives consent to the proposed treatment. If the parent/legal guardian *is unavailable* to sign informed consent documentation, verbal informed consent may be obtained and documented as provided further in this policy. Please refer to **Attachment A - Psychotropic Medication Utilization Parameters for Severely Emotionally Disturbed (SED) Children and Adolescents** for recommended utilization parameters and guidelines for the use of psychotropic medication in the treatment of youth who are served by DBHDD Child and Adolescent Providers. These are the expected parameters for all DBHDD providers serving this target population.

DEFINITIONS

Provider – For the purposes of this policy, the term “provider” includes organizations that provide consumer services that are financially supported in whole or in part by funds authorized through DBHDD.

PROCEDURES

- A. Informed consent shall be obtained from the parent/legal guardian for each psychotropic medication prescribed. The individual medical record must contain documentation of each informed consent.
- B. For providers under contract with DBHDD to provide services, DBHDD has developed the **Informed Consent for Psychotropic Medication Treatment for Children and Adolescents** form (**Attachment B**). All DBHDD providers are required to use this form or alternative forms/electronic medical records with the same content or allow prescribers to document informed consent in their Progress Notes. However, all essential elements must be captured in the informed consent documentation, wherever it is located.

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DBHDD form “Informed Consent for Psychotropic Medication Treatment for Children and Adolescents” (**Attachment B**) includes the following essential elements of informed consent:

1.)

- Consumer name and date of birth
- Printed name of each medication
- The diagnosis and target symptoms for the medication being prescribed;
- The FDA status (black box warning, indicated/off-label)
- How the Informed Consent was obtained
- Signature/initials of parent/legal guardian showing consent or refusal to consent for each psychotropic medication prescribed
- Printed name and signature of medical practitioner

By obtaining signature on the Informed Consent, the practitioner is stating that he/she has discussed the following information with the parent/legal guardian for each medication listed on the Informed Consent:

2.)

- The side effects and potential side effects upon discontinuing as well as the benefits of taking the medication and the intended outcome of treatment;
- Possible medication and treatment alternatives to the proposed medication treatment, including the option of not taking psychotropic medication;
- The potential side effects and results associated with not taking the recommended medication;
- The possibility that psychotropic medication dosages may need to be adjusted over time and in consultation with the medical practitioner;
- Where possible, the practitioner has discussed the above statements with the child at a level and in a manner which the child can understand. The practitioner should attempt to obtain the child’s assent when possible.
- The parent’s/legal guardian’s right and the provider’s responsibility to openly discuss any medication questions and/or concerns and to allow the consumer to actively participate in the treatment planning process regarding the use of psychotropic medication;
- A parent’s/legal guardian’s right to withdraw the Informed Consent for Psychotropic Medications at any time in the treatment process. The provider should, in advance, have reviewed and documented the potential side effects associated with discontinuance of psychotropic medication.

C. Medical practitioners are encouraged to use open-ended questions to assess whether or not the youth/parent/legal guardian understands the issues of informed consent. Information provided in the process of obtaining informed consent must always be communicated in a manner that the youth/parent/legal guardian can understand and comprehend. This should include verbal communication in the youth/parent/legal guardian’s primary language. If necessary, translation services must be obtained.

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- D.** For providers who dispense from their own pharmacy, written information must be provided to the youth/parent/or legal guardian for each new medication prescribed. Such handouts should generally use simple, understandable language. It is recommended that the information in these materials include:
- Name of the medication (generic and brand name);
 - What is the common use of the medication;
 - What drugs or foods may interact with this medication;
 - Important side effects to be aware of;
 - What to do if a dose of medication is missed;
 - How to take the medication as well as how the medication should be stored;
 - Any other specific information pertaining to the medication prescribed.
- E.** When the medical practitioner is unable to obtain signature on the informed consent by the parent/legal guardian, the provider must discuss verbally the essential elements, as described in section B., 1.) and 2.) above, related to the informed consent process to the parent/legal guardian. Telephonic/verbal Informed Consent must be obtained by the medical practitioner and one additional staff of the provider agency. The medical practitioner should document on the informed consent form or “Unable to sign; Verbal consent given” in the blank for the person’s/legal guardian’s signature. The additional staff person must sign in the blank for witness. Written consent must be obtained within 90 days.
- F.** In the event that medication is administered to a youth when the youth is uncooperative and consent has been obtained from the parent/legal guardian, providers must ensure they are following the standards regarding restrictive interventions, as stated in the *Georgia DBHDD Provider Manual, Part II, Community Service Standards, Section I, Standards for All Providers, Section E. Human and Civil Rights are Maintained*
- G.** Dosage changes for the exact medication *do not* require a new Informed Consent.
- H.** Changes in medication within the same class *do* require a new Informed Consent.
- I.** When obtaining Informed Consent for two or more medications that are being initiated at the same time, one signature at the bottom of the form, with initials and date for each respective medication, can provide for Informed Consent, provided that each medication is listed separately on the Informed Consent and the parent/legal guardian initials are obtained for each.
- J.** A renewal of the informed consent process and signatures must be completed every 12 months even in the event there are no changes that occur to the psychotropic medication treatment plan.
- K.** Unless the youth is maintained under formal legal guardianship upon reaching the age of 18, a new psychotropic medication informed consent must be obtained from the youth as a legally responsible adult.

DBHDD	SUBJECT: Informed Consent for Psychotropic Medication Treatment For Child and Adolescent Population	Policy: 01-104
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- L. If a child or youth has been removed from the home by CPS (Child Protective Services), and is in the custody of CPS/State of Georgia, the person who is providing informed consent is the Department of Human Services (DHS) through the Division of Family and Children Services (DFCS). If the provider is unable to obtain signature on the informed consent, the provider must thoroughly document efforts taken to obtain the informed consent on more than one occasion, and place those in the medical record of the child/youth. If necessary, this consent may be obtained verbally through the process provided in paragraph E. above.
- M. In the event of a psychiatric emergency (defined as imminent risk of harm to self of others) that warrants emergency psychotropic medication treatment, an attempt to obtain the Informed Consent, at least verbally, must be made. If an Informed Consent cannot be obtained by the parent/legal guardian, the medical practitioner must complete the documentation on the Informed Consent and should provide a written explanation of the emergency situation in the person's medical record, including the rationale for the emergency use of medication treatment. The medical practitioner will document on the Informed Consent form "Emergency Medication Treatment" in the blank for the parent's/legal guardian's signature. For continued use of a medication that was prescribed as a result of an emergency situation, informed consent must be obtained within 72 hours.
- N. If the child/adolescent has discontinued the medications for a period of 90 days, a new informed consent must be completed. The discussion with the parent/legal guardian in this situation should include a review of the potential side effects of a discontinuance of psychotropic medications and a consideration of the current willingness and desire of the youth to follow the current treatment plan should be made.
- O. If a person is seen at the *same* provider agency under contract with DBHDD, but by a *different* medical practitioner to prescribe the *same* medications that the previous medical practitioner prescribed, a new informed consent form is *not* required.
- P. If the youth's care is enrolled with a *new* agency under contract with DBHDD, a *new* informed consent for medication treatment must be obtained. The new prescriber must verify that the parent/legal guardian continues to consent to treatment with the medication(s) and the prescriber has addressed any current questions or concerns.

Psychotropic Medication Utilization Parameters for Severely Emotionally Disturbed (SED) Children and Adolescents

Developed by:



DBHDD

Georgia Department of
Behavioral Health and Developmental Disabilities

Psychotropic Medication Utilization Parameters for SED Children and Adolescents

Introduction and General Principles

The use of psychotropic medications by children and adolescents is an issue confronting parents, other caregivers, and health care professionals across the United States. Prescription of these medications has become more widespread in recent years, and in many cases children are prescribed psychotropics by their primary care physicians without concomitant psychiatric consultation. Severely emotionally disturbed (SED) youth, particularly those in state care, have multiple needs, including those related to emotional or psychological stress. SED youth typically have experienced abusive, neglectful, or chaotic care taking environments. Establishment of rapport is often difficult, and these youth often present complicated diagnostic and treatment planning issues. SED youth may reside in areas of the state where child psychiatrists are not readily available. Similarly, caregivers and health providers may be faced with critical situations that require immediate decisions about the care to be delivered. For these and other reasons, a need exists for treatment parameters regarding the appropriate use of psychotropic medications.

Because of the complex issues involved in the lives of SED youth, it is important that a comprehensive evaluation be performed before beginning treatment for a mental or behavioral disorder. Except in the case of an emergency, a child should receive a thorough health history, psychosocial assessment, mental status exam, and physical exam before the prescribing of psychotropic medication. Psychological testing may be particularly useful in clarifying a diagnosis and informing appropriate treatment. The physical assessment should be performed by a physician or another healthcare professional qualified to perform such an assessment. The mental health assessment should be performed by an appropriately qualified mental health professional with experience in providing care to youth. The youth's symptoms and functioning should be assessed across multiple domains, and the assessment should be developmentally appropriate and culturally sensitive. It is very important that information about the child's history and current functioning be made available to the treating physician in a timely manner, either through an adult who is well-informed about the youth or through a comprehensive medical record.

The role of nonpharmacological interventions should be considered before beginning a psychotropic medication, except in urgent situations not limited to suicidal ideation, psychosis, self injurious behavior, and physical aggression that is acutely dangerous to others, or severe impulsivity endangering the youth or others. Given the unusual stress and change in environmental circumstances associated with SED youth, counseling or psychotherapy should generally begin before or concurrent with prescription of a psychotropic medication. Patient and caregiver education about the mental disorder, treatment options (nonpharmacological and pharmacological), treatment expectations, and potential side effects provided through informed consent by the prescribing practitioner should occur before and during the prescription of psychotropic medications.

It is recognized that many psychotropic medications do not have Food and Drug Administration (FDA) approved labeling for use in children. The FDA has a statutory mandate to determine whether pharmaceutical company sponsored research indicates that a medication is safe and effective for those indications in which it has been studied by the manufacturer. The FDA also assures that information in the approved product labeling is accurate, and limits the manufacturer's marketing to the information contained in the approved labeling. ***The FDA does not regulate physician and other health provider practice. In fact, the FDA has stated that it does "not limit the manner in which a practitioner may prescribe an approved drug."*** Studies and expert clinical experience often support the use of a medication for an "off-label" use. Physicians should utilize the available evidence, expert opinion, their own clinical experience, and exercise their clinical judgment in prescribing what they feel is best for each individual youth. "Off-label" medication use should be clearly explained to the youth and his/her parent or legal guardian when obtaining informed consent. The practitioner always documents the rationale for choosing to prescribe off label medication in the medical record of the consumer.

General principles regarding the use of psychotropic medications in SED children include:

- A DSM-IV psychiatric diagnosis should be made before the prescribing of psychotropic medications.
- Assessment of the youth's living situation/caregiver specifically for likelihood of adherence to the prescribed medication regimen.
- Clearly defined target symptoms for the use of psychotropic medications should be identified and documented in the medical record and on the informed consent paperwork at the time of, or before beginning, treatment with a psychotropic medication. These target symptoms should be assessed at each clinic visit with the youth and caregiver. Whenever possible, recognized clinical rating scales (clinician, youth, or caregiver assessed, as appropriate) or other measures should be used to quantify the response of the youth's target symptoms to treatment and the progress made toward treatment goals.
- In making a decision regarding whether to prescribe a psychotropic medication for a specific child, the clinician should carefully consider potential side effects, including those that are uncommon but potentially severe. The clinician should take into account information from the youth's medical history that may support or contraindicate the use of medication with potentially severe side effects. An appropriate risk-benefit analysis should be performed by the prescribing physician, and discussed with the patient and his/her parent or legal guardian, before beginning pharmacotherapy.
- Except in the case of emergency, defined as imminent risk of harm to self or others, informed consent should be obtained from the appropriate party(ies) before beginning psychotropic medication. Informed consent to treatment with psychotropic medication entails informing the appropriate party(ies) of the diagnosis, expected benefits and risks of treatment, including common side effects, discussion of laboratory findings, and uncommon but potentially severe adverse effects. Alternative treatments, the risks associated with no treatment, and the overall potential benefit to risk ratio of treatment should also be discussed.
- In the event that a youth is uncooperative and does not assent to the use of psychotropic medication in the treatment process, it is important that the medical practitioner consider means by which the youth can be further engaged in the treatment process. This situation presents an opportunity for the medical practitioner to recognize that the assent of the youth will likely lead to a more positive clinical outcome, and that the medical practitioner and youth/family share decision making as well as responsibility for positive treatment outcomes.
- Throughout the time psychotropic medication is administered, the presence or absence of medication side effects should be documented in the youth's medical record at each visit. Clinicians should ask the youth and the caregiver what side effects the youth is experiencing.
- Appropriate monitoring of indices such as BMI, growth charts, blood pressure, abnormal involuntary movements (use of AIMS) and laboratory findings should be documented.

- Treatment with one psychotropic medication (monotherapy) for a given disorder or specific target symptoms should usually be attempted before additional medications are prescribed (polypharmacy). The clinician should document the rationale for deciding to use polypharmacy.
- Doses should usually be started low and titrated carefully as needed;
- Only one medication should be changed at a time, unless a clinically appropriate reason to do otherwise is documented in the medical record. (Note: starting a new medication and beginning the dose taper of a current medication is considered one medication change);
- The frequency of clinician follow-up with the patient should be appropriate for the severity of the youth's condition and adequate to monitor response to treatment, including: symptoms, behavior, function, and potential medication side effects. Titration to the minimum effective dose should be an active goal of any pharmacologic intervention.
- In depressed youth, the potential for emergent suicidality should be carefully evaluated and monitored, and the clinician should inform the caregiver of this potential and ask the caregiver to report any symptoms.
- If the prescribing clinician is not a child psychiatrist, referral to or consultation with a child psychiatrist, or a general psychiatrist with significant experience in treating children, should occur if the child's clinical status has not experienced meaningful improvement within a timeframe that is appropriate for the child's clinical response and the medication regimen being used.
- Before adding additional psychotropic medications to a regimen, the child should be assessed for adequate medication adherence, accuracy of the diagnosis, the occurrence of comorbid disorders (including substance abuse and general medical disorders), and the influence of psychosocial stressors.
- If a medication is being used in a child for a primary target symptom of aggression associated with a DSM-IV nonpsychotic diagnosis (e.g., conduct disorder, oppositional defiant disorder, intermittent explosive disorder), and the behavior disturbance has been in remission for six months, then serious consideration should be given to slow tapering and discontinuation of the medication. If the medication is continued in this situation, the necessity for continued treatment should be evaluated and the rationale documented at a minimum of every six months.
- The clinician should clearly document care provided in the child's medical record, including history, mental status assessment, physical findings (when relevant), impressions, adequate laboratory monitoring specific to the drug(s) prescribed at intervals required specific to the prescribed drug and potential known risks, medication response, presence or absence of side effects, treatment plan, and intended use of prescribed medications. The rationale for any decision to prescribe in a manner that is not standard practice should be documented clearly in the youth's medical record.

Criteria That May Indicate Further Review of a Child's Clinical Status

The following situations indicate a need for further review of a patient's case. These parameters do not necessarily indicate that treatment is inappropriate, but they do indicate a need for further review and documentation of findings and relevant clinical decisions. For a child being prescribed a psychotropic medication, any of the following suggests the need for additional review of a patient's clinical status:

- 1) Absence of a thorough assessment of DSM-IV diagnosis in the child's medical record.
- 2) Four (4) or more psychotropic medications prescribed concomitantly, either within or across medication groups.
- 3) Prescribing of:
 - a) Two (2) or more concomitant antidepressants within the same class
 - b) Two (2) or more concomitant antipsychotic medications
 - c) Two (2) or more concomitant stimulant medications *
 - d) Three (3) or more concomitant mood stabilizer medications

*Concomitant prescription of the same stimulant medication in an extended release and immediate-release formulation is regarded as one (1) stimulant medication.

- 4) The prescribed psychotropic medication is not consistent with appropriate care for the patient's diagnosed mental disorder or with documented target symptoms usually associated with a therapeutic response to the medication prescribed.
- 5) Psychotropic polypharmacy for a given mental disorder is prescribed before an adequate trial of psychotropic monotherapy. For the purpose of this document, polypharmacy is defined as the use of two or more medications for the same indication (i.e., specific mental disorder or target symptoms).
- 6) The psychotropic medication dose exceeds FDA maximum dosage guidelines.
- 7) Psychotropic medications are prescribed for children of very young age, including children receiving the following medications:
 - Antidepressants: Less than six (6) years of age
 - Antipsychotics: Less than six (6) years of age
 - Psychostimulants: Less than five (5) years of age
 - Polypharmacy: Less than six (6) years of age
- 8) Prescribing by a primary care provider for a diagnosis **other** than the following (unless recommended by a psychiatrist consultant):
 - Attention Deficit Hyperactive Disorder (ADHD)
 - Non Co-Occurring anxiety disorders
 - Non Co-Occurring depression

Usual recommended maximum doses of common psychotropic medications

These tables are intended to reflect usual maximum doses of commonly used psychotropic medications. These doses represent usual daily maximum doses, and are intended to serve as a guide for clinicians. The tables are not intended to serve as a substitute for sound clinical judgment in the care of individual patients, and individual patient circumstances may dictate the need for the use of higher doses in specific patients. In these cases, careful documentation of the rationale for the higher dose should occur, and careful monitoring of response to treatment should be observed and documented.

Not all medications prescribed by clinicians for psychiatric diagnoses in children and adolescents are included below. However, in general, medications not listed do not have adequate efficacy and safety information available to support a usual maximum dose recommendations for youth.

Antidepressants/Anxiolytics	Usual Maximum Dose per Day ⁽¹⁾	
	Children Age 6-11	Adolescents Age 12-17
Citalopram	40 mg	60 mg
Escitalopram	20 mg	20 mg
Fluvoxamine ⁽³⁾	200 mg	200 mg
Fluoxetine ^(2, 3)	20 mg	40 mg
Paroxetine ⁽⁴⁾	(-)	40 mg
Sertraline ⁽³⁾	200 mg	200 mg
Venlafaxine	3 mg/kg/d	225 mg

(1) In general, doses should be started low and titrated slowly while monitoring the patient for improvement in depressive symptoms, potential side effects, or emergent suicidality

(2) Has FDA approved labeling for treatment of depression in children.

(3) Has FDA approved labeling for treatment of anxiety disorders in children.

(4) Paroxetine is not recommended for use in preadolescents

Antipsychotics	Usual Maximum Dose per Day	
	Children Age 6-11	Adolescents Age 12-17
Aripiprazole	15 mg	30 mg
Clozapine	300 mg	600 mg
Haloperidol	5 mg	10 mg
Olanzapine	12.5 mg	20 mg
Perphenazine	No data	32 mg
Quetiapine	300 mg	600 mg
Risperidone	4 mg	6 mg
Ziprasidone	No data	180 mg

ADHD Medications**Usual Maximum Dose per Day*****Children Age 6-11* *Adolescents Age 12-17***

Amphetamine (Mixed amphetamine salts or dextroamphetamine)	40 mg	40 mg
Atomoxetine	1.8 mg/kg/d	100 mg
Bupropion	6 mg/kg/d	450 mg
Clonidine	0.4 mg	0.4 mg
Dexmethylphenidate	20 mg	20 mg
Guanfacine	4 mg	4 mg
Imipramine	5 mg/kg/day	300 mg
Methylphenidate	60 mg	60 mg
	(72 mg with Concerta [®] only)	
Methylphenidate patch	82.5 mg patch (30 mg dose delivered)	
Nortriptyline	3 mg/kg/day	150 mg

Mood Stabilizers**Usual Maximum Dose per Day*****Children Age 6-11* *Adolescents Age 12-17***

Carbamazepine ⁽¹⁾	7 mg/kg/day	(Max Cs: 12 mcg/mL)
Lamotrigine	15mg/kg/d (200 mg)	300 mg
Lithium ⁽¹⁾	30 mg/kg/day	(Max Cs: 1.2 mEq/L)
Valproic acid ⁽¹⁾ (Divalproex)	20 mg/kg/day	(Max Cs: 125 mcg/ml)

(1) Maximum daily dose typically determined by drug serum concentration (Cs) and individual patient tolerability.



Provider Agency _____

Consumer Name **DOB**

**State of Georgia, Department of Behavioral Health and Developmental Disabilities
 Informed Consent for Psychotropic Medication Treatment for Children and Adolescents**

I have discussed the following information with my youth's behavioral health medical practitioner for each medication listed below:

- The diagnosis and target symptoms for the medication recommended
- The possible benefits/intended outcome of treatment, and as applicable, all available procedures involved in the proposed treatment
- The possible risks and side effects
- The possible alternatives
- The possible results of not taking the recommended medication
- The possibility that the medication dose may need to be adjusted over time, in consultation with my youth's behavioral health medical practitioner
- My right to actively participate in the treatment by discussing medication concerns or questions with the behavioral health medical practitioner
- My right to revoke consent for medication at any time unless the use of medications is court ordered.

Medication	Diagnosis	Symptoms Targeted with Medication*	Medication Status	How Discussed	Parent/Guardian Initials & Date**	Physician or Designee Initials & Date
			<input type="checkbox"/> Off Label <input type="checkbox"/> Black Box Warning	<input type="checkbox"/> In Person <input type="checkbox"/> Telephone <input type="checkbox"/> Tele-Medicine	Initials: _____ Date: _____	Initials: _____ Date: _____ Time: _____
			<input type="checkbox"/> Off Label <input type="checkbox"/> Black Box Warning	<input type="checkbox"/> In Person <input type="checkbox"/> Telephone <input type="checkbox"/> Tele-Medicine	Initials: _____ Date: _____	Initials: _____ Date: _____ Time: _____
			<input type="checkbox"/> Off Label <input type="checkbox"/> Black Box Warning	<input type="checkbox"/> In Person <input type="checkbox"/> Telephone <input type="checkbox"/> Tele-Medicine	Initials: _____ Date: _____	Initials: _____ Date: _____ Time: _____
			<input type="checkbox"/> Off Label <input type="checkbox"/> Black Box Warning	<input type="checkbox"/> In Person <input type="checkbox"/> Telephone <input type="checkbox"/> Tele-Medicine	Initials: _____ Date: _____	Initials: _____ Date: _____ Time: _____

I understand the medication(s) listed above are necessary and potentially helpful for my child's mental illness.

Off-label medication use (not FDA approved) and black box warnings have been clearly explained to me by the prescribing physician or his/her designee.

 Parent/Legal Guardian Printed Name Signature Initials Physician or Designee Printed Name Signature Initials


 Witness Name Signature

*Target symptoms refer to specific symptoms associated with a diagnosis, such as tearfulness, hallucinations, impulsivity

** Ensure informed consent form with original signature is located in consumer's file. If consent is obtained by telephone or electronically, individual must sign and date within 90 days.

IREVOKE MY CONSENT: By signing below I am communicating that I hereby revoke the informed consent and am aware of the potential risks including the potential for involuntary administration of medication if it is considered necessary to maintain my safety or the safety of others:

 Parent/Legal Guardian Printed Name Signature Date Staff/Witness Printed Name Signature Date

	Department of Human Resources Online Directives Information System	Index: Revised: Review:	POL1701 3/26/07 3/1/11
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SUBJECT: Language Access for Limited English Proficient (LEP) and Sensory Impaired (SI) customers

POLICY

The policy of the Georgia Department of Human Resources (DHR) is to provide meaningful language access to limited English proficient and/or sensory impaired customers to all programs and activities conducted or supported by the department.

A. Authority

- [Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000 et.seq.](#)
- [Americans with Disabilities Act \(ADA\) of 1990, Title II](#)
- [Rehabilitation Act of 1973 \(Sec. 504\)](#)

B. References

DHR Limited English Proficiency and Sensory Impaired Procedures (released August 25, 2006)

C. Applicability

This policy applies to all Divisions and Offices of DHR for programs, services and activities.

D. Definitions

Language – Refers to the method by which an individual communicates with another and includes languages other than English and generally accepted means of communication used by customers with sensory impairments.

Limited English Proficient – Refers to Persons who do not speak English as their native/primary language and who have a limited ability to read, speak, write or understand English.

Meaningful Access – Meaningful access to programs and services is the standard of access required of federally funded entities to comply with Title VI language access requirements. LEP/SI customers must be given the opportunity to benefit from all available resources, services, and activities to the same extent as non-LEP/SI customers.

Sensory Impaired - Refers to Individuals who are deaf, deafened and hearing impaired, visually impaired, blind, or deaf and blind.

E. Responsibilities

Rev. 2/07

The Director of the Policy Planning and Compliance Group, Office of the Commissioner, is responsible for issuing and updating, as appropriate, procedures to implement this policy.

F. History

This revision replaces Policy 1701 which was effective August 25, 2006.

G. Evaluation

The LEP/SI service delivery is evaluated using feedback from randomly selected customers receiving services from DHR, staff securing services for customers and language services contractors providing services to DHR customers. The LEP/SI Program Office uses the feedback to enhance programmatic operations and service delivery.


H. Authentication

B.J. Walker

Commissioner

3/29/07

Date

	Department of Human Services Online Directives Information System	Index: Revised: Review:	PRO1701 6/30/2010 6/01/2012
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SUBJECT: Language Access for Limited English Proficient (LEP) and Sensory Impaired (SI) Customers

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<u>SECTION V</u>	Translation of Documents
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SECTION VII

Attachments - [click here for All ATTACHMENTS](#)

**[The following attachments can be found on the DHS ODIS website:
http://www.odis.dhr.state.ga.us/1000_adm/1700_Accessibility/Accessibility%20Index.htm](http://www.odis.dhr.state.ga.us/1000_adm/1700_Accessibility/Accessibility%20Index.htm)**

[1 - Definitions](#)

[2 – LEP/SI Policy](#)

[3 - Organizational Commitment](#)

LEP/SI Program Responsibilities

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Community Advisory Council Responsibilities

[4 - Local Language Access Plan Template](#)

[5 - Notice of Free Interpretation Services Wall Poster](#)

[6 - “I SPEAK” card](#)

[7 – Georgia Relay Services – How to Guide](#)

[8 - Tips for Using an Interpreter to Improve Service Delivery](#)

[Suggested Guidelines for Sign Language Interpreters](#)

[9 - Waiver of Rights Form](#)

[10 - Intake and Tracking Form and Instructions](#)

[11 - 1 Policy/Notice of Non-Discrimination in Services – General](#)

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[11 – 2.1 Policy/Notice of Non-Discrimination in Services – DFCS English](#)

[11 – 2.2 Policy/Notice of Non-Discrimination in Services – DFCS Spanish](#)

[12 - 1 LEP/SI Discrimination Complaint Form – General](#)

(English & Spanish)

[12 - 2 LEP/SI & Title VI Discrimination Complaint Form – DFCS](#)

(English & Spanish)

[13 - LEP/SI Employee Feedback Form & Instructions](#)

[14 - LEP/SI Contractor Feedback Form & Instructions](#)

[15 - LEP/SI Customer Feedback Form & Instructions](#)

[16 – Selection and Evaluation Criteria for Interpreter and Interpreter](#)

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[17 - Code of Professional Conduct](#)

[18 - Code of Ethics](#)

[19 - Translation Request Form](#)

[20 - Request for a Quote Form](#)

[21 - LEP/SI Service Delivery Checklist](#)

Purpose

The Georgia Department of Human Resources (DHR or the Department) is committed to ensuring that limited English proficient (LEP) and sensory impaired (SI) customers have meaningful language access to all programs and activities conducted or supported by the Department. Those services include programs and assistance provided directly by the Department, its Divisions and Offices (Division of Aging Services, Division of Family and Children Services, Division of Mental Health, Developmental Disabilities and Addictive Diseases, Division of Public Health, Office of Child Support Enforcement, Office of Regulatory Services, Office of Investigative Services). For a comprehensive listing of services by Division and Office, the Department maintains a website at <http://www.georgia.gov/portal/site/DHR/>. Refer to [Attachment 1](#) for a list of definitions of words and terms used throughout these procedures.

DHR offers communication assistance by securing and utilizing interpreters, translators and other necessary communicative resources when serving LEP and SI customers. In all situations, language and other communication assistance is administered in accordance with the DHR's Language Access for Limited English Proficient and Sensory Impaired Customers Policy #1701 and is included as [Attachment 2](#).

The United States Department of Health and Human Services, Office For Civil Rights (HHS/OCR) approved the initial DHR State LEP/SI Plan in July, 2002. The plan has been integrated into the DHR Language Access for Limited English Proficient and Sensory Impaired Customers Policy and Procedures #1701 Policy and Procedures and establishes the policy and procedures for implementing a statewide strategy to determine service needs and to identify and develop the necessary resources and methods for service delivery to LEP/SI customers.

The responsibility for implementing DHR Language Access for Limited English Proficient and Sensory Impaired Customers Policy #1701 Policy and Procedures is shared between the Department as a whole through the joint effort of the Policy Planning and Compliance Group (PPCG), Limited English Proficient/Sensory Impaired Program (LEP/SI) and the various DHR County Offices, Regional Offices, Health Districts and State Office Programs that provide direct benefits and services to LEP/SI customers. For a description of DHR's organizational commitment, including the staff structure and teams, to ensure meaningful language access to programs and services for LEP/SI customers, see [Attachment 3](#).

Legal Authority

Limited English Proficient (LEP)

[Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d.et. seq.](#) prohibits recipients of Federal financial assistance from discriminating on the basis of race, color, or national origin. Specifically Section 601 of Title VI states: “No person in the United States shall on the ground of race, color or national origin, be excluded from participation in, be denied benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance”.

Regulations implementing Title VI provide in part at 45 C.F.R. Section 80.3 (b):

- “(1). A recipient under any program to which this part applies may not, directly or through contractual or other arrangements, on ground of race, color, or national origin:
- (i). Deny an individual any service, financial aid, or other benefit provided under the program;
 - (ii). Provide any service, financial aid, or other benefit to an individual which is different, or is provided in a different manner, from that provided to others under the program; ...
- (2). A recipient, in determining the types of services, financial aid, or other benefits, or facilities which will be provided under any such program, or the class of individuals to whom, or the situations in which, such services, financial aid, other benefits, or facilities will be provided... may not, directly or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race, color, or national origin.”

Sensory Impairment (SI)

- [Section 504 of the Rehabilitation Act of 1973](#)

- [Title II of the Americans with Disabilities Act of 1990 \(ADA\)](#)

Section 504 and the ADA prohibit covered entities from discriminating against persons with disabilities in the provision of benefits and services or the conduct of programs or activities on the basis of their disability.

Section 504 applies to programs or activities that receive Federal financial assistance. Title II of the ADA covers all of the services, programs, and activities conducted by public entities (state and local governments, departments, agencies, etc.) including licensing.

Section 504 and the ADA protect qualified individuals with disabilities from discrimination on the basis of their disability. An individual with a disability is a person who has a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such impairment. Major life activities means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, breathing, learning and working.

SECTION II Needs Assessment

Language assistance for customers who are limited English proficient and/or sensory impaired may be needed at the following customer contact points:

- Program Intake
- Assessments (eligibility, diagnostic)
- Service Plan Development
- Discharge Planning
- Caseworker and Care Coordinator Contacts
- Home Visits
- Field Contacts
- Telephone Contacts
- Appointments with custodial and non-custodial parents
- Court hearings involving child support

DHR Divisions and Offices that provide social services to customers at the local level develop local Language Access Plans to ensure that service delivery is consistent with the needs of the

LEP/SI population in the service area. (Local level is defined by each DHR Division and Office based on programmatic operations). A sample Language Access Plan template is included as [Attachment 4](#). An electronic copy of the completed local Language Access Plan is submitted to the LEP/SI Office

at lepsi@dhr.state.ga.us.

DHR Divisions and Offices complete an annual review of its Language Access Plans as well as a self-assessment of needs and resources at the county level for LEP/SI customers that is administered by the LEP/SI Office. The LEP/SI Office administers a random telephone assessment of all customer contact points twice each fiscal year to determine if LEP/SI customers are able to communicate via telephone with targeted DHR Divisions/Offices.

SECTION III Staff Orientation and Training

Employees are informed of DHR's Policy of Non-Discrimination during new employee orientation. Also, the DHR Language Access for Limited English Proficient (LEP) and Sensory Impaired (SI) Customers Policy and Procedures are located accessible in DHR's ODIS and the Employee INTRANET. The DHR website (Language Access portal) includes resources to aid staff in the delivery of services to LEP/SI customers. A comprehensive multi-approach training plan, i.e., Train-the-Trainer, classroom, web-based and self-paced, which is designed to reach employees who are likely to have direct contact with LEP/SI customers, is under development. This training will include all of the DHR notices, forms, and resources available for assisting LEP/SI customers. During the interim, the LEP/SI Program staff is providing training as requested by Divisions and Offices.

SECTION IV Service Delivery to LEP/SI Customers

The Four-factor Analysis is used to determine the level of services provided at the local level. This Analysis includes a look at:

- the number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee/recipient,
- the frequency with which LEP individuals come in contact with the program,
- the nature and importance of the program, activity, or service provided by the program to people's lives, and
- the resources available to the grantee/recipient and costs.

Providing Notice to LEP/SI Customers

A Notice of Free Interpretation Services Wall Poster ([Attachment 5](#)) is located in DHR's waiting rooms and intake and reception areas. This poster informs the public of DHR's Language Access policy to provide free interpretation services (in the major languages spoken in Georgia, Sign Language and Braille). Wall posters are available through the LEP/SI Office.

Identifying LEP/SI Customers

When services are delivered to LEP/SI customers, whether by Departmental employees or contract vendors,

Languages spoken by LEP/ SI customers are identified at all customer contact points through the use of either bi-lingual staff when available, the "I SPEAK" card ([Attachment 6](#)) or through a telephone interpretation service. Note that the "I SPEAK" card is also available on the DHR Website at <http://lepsi.dhr.georgia.gov/>.

- Staff takes immediate steps to identify the language spoken by the customer, ensuring that unreasonable delays do not occur, so that the appropriate communication resource is secured. The LEP/SI customer is informed by the bi-lingual staff or an interpreter of their right to free interpreter services and how/when services will be provided (i.e. staff, contract interpreter, telephone interpreter, services provided immediately or an appointment is scheduled).
- Services for LEP/SI customers are provided at all times using the same standards as for English speaking customers.

Providing Language Assistance

Interpreters and/or assistive technology and adaptive equipment are used in the following situations when:

- Requested by a customer.
- Requested by a service provider of a LEP/SI customer.
- Necessary to establish or maintain a customer's eligibility for DHR programs or services.
- Interpreter services are necessary to access public meetings sponsored by DHR or those under contract to DHR.
- Necessary for the customer to access any service funded directly or indirectly by DHR.

Guide for Providing Meaningful Language Access to LEP/SI Customers

1	Identify customers who do not speak English as their primary language and have a limited ability to read, speak, write or understand English (LEP) or are either deaf, deafened and hearing impaired, blind, visually impaired or deaf/blind (SI).
2	If LEP customer, use either bi-lingual staff, the “I SPEAK” Language Identification Card (Attachment 6), or telephone interpretation service to determine language spoken. Note that telephone interpretation services can identify the language spoken and provide interpretation for the LEP customer on the telephone via 3-way calling.
3	<p>If SI customer, communication with the <u>deaf and hearing impaired</u> is generally through sign language, video recording transmitter, a TeleTYpewriter (TTY) or a Telecommunications Device for the Deaf (TDD). Use of TTY/TDD services may be accessed through the Georgia Relay Service, 24 hours a day, 7 days a week by dialing: 711 or 1-800-255-0135 (for hearing callers) or 1-800-255-0056 (for text telephones). See Attachment 7 for a description of how to use the Relay Service. This service may be used for incoming and outgoing calls.</p> <p>If SI customer, communication with the <u>visually impaired</u> is generally through voice, Braille, large print and cassette audiotapes.</p>
4	Determine how communication with the customer will occur (i.e. bi-lingual employee interpreter, contract interpreter from the DHR List of Language Contractors maintained by the LEP/SI Office, Telephone Interpreter Service, or Other Services). Attachment 8 includes Tips for Using an Interpreter to Improve Service Delivery and Suggested Guidelines for Sign Language Interpreters.
5	<p>Secure the language assistance resource needed to communicate with the LEP/SI customer. Please inform the customer of their right to FREE interpreter services. (DHR provides interpreter/translation services FREE to LEP/SI customers. Under NO condition will DHR require a LEP/SI customer to provide their own interpreter/translator. When free interpreter services are declined, the Waiver of Rights to Free Interpreter Services (Attachment 9) is signed by the customer and interpreter providing services for the customer).</p> <p>Place signed Waiver in customer file/record and provide a copy to the customer. (DHR will provide either an on-site or telephone interpreter to observe communication when interpreter services are not provided by DHR. Documentation is placed in the customer’s file regarding the appropriateness or non-appropriateness (i.e., proficiency in English, understanding of terminology, sufficient knowledge of program, confidentiality is not breached, information is not compromised) of the non-DHR provided interpreter. If there are questions or concerns about the appropriateness of an interpreter providing services for a customer, DHR shall request the assistance of a DHR provided interpreter. The LEP/SI customer may revoke the Waiver at any time and request the services of a free Interpreter).</p>
6	Schedule an appointment within 2 business days for non-emergency cases. Service to the LEP/SI customer is consistent with service delivery to English speaking customers.
7	Create customer file/record. Complete LEP/SI Intake and Tracking Form (Attachment 10) or local reporting document/system. Information from the Intake and Tracking form is used for reporting and includes type of service provided (specific SI or language for LEP), number of times service is provided, resources provided, cost of services and if Waiver form was signed).
8	Confirm that the Policy/Notice of Non-Discrimination in Services (Attachment 11- 1, 11-2 DFCS) sign is posted and that copies of the Discrimination Complaint Form (Attachment 12-1, 12-2 DFCS) are available at the front desk for the customer in the appropriate language.
9	Record all services provided on the LEP/SI Intake and Tracking Form or local reporting document/system. File completed LEP/SI Intake and Tracking Form in customer file/record and a copy in the central LEP/SI file. (NOTE: Central LEP/SI files are maintained for tracking and reporting purposes.)
10	Complete Employee Feedback Form (Attachment 13) if the services of a Contractor were utilized and mail, FAX or e-mail to the LEP/SI Office. Feedback forms are also provided to the Contractor (Attachment 14) and to randomly selected LEP/SI customers (Attachment 15). Process invoice for payment of contractor for services upon receipt.

NOTE: When utilizing the services of a language contractor, staff must be present for on-site and telephone interpretation services. Staff persons are required to be present either via speaker telephone or 3-way conference when language contractors (interpreters) contacts customers via telephone. When DHR services are provided through a 3-way conference call, the staff person must use an agency phone (LAN line or cell phone) to set up the call.

DHR Master List of Language Contractors

The LEP/SI office recruits and maintains a Master List of Language Contractors to provide language assistance services to DHR offices on an “as needed” basis. These contractors have terms and conditions that have been agreed upon, thus Divisions and Offices are not required to enter into negotiations prior to or during service delivery. All contractors meet standards established by the Department (see [Attachment 16](#) for the Selection and Evaluation Criteria for Interpreters and Interpreter Services) and are required to adhere to a Code of Professional Conduct ([Attachment 17](#)) and Code of Ethics ([Attachment 18](#)). The Master List of Language Contractors is updated on an ongoing basis to ensure accuracy and is available on the DHR Language Access SharePoint site which is accessible by the Language Access Coordinators, located in local offices, and the Language Access Team members (at least one state level representative for each Division/Office). Divisions/Offices may also contact the LEP/SI office for the Master List of Language Contractors. DHR Divisions/Offices may recommend contractors to the LEP/SI Office for consideration to determine if there is a need for the language and if the potential contractor meets the standards established by the Department.

Departmental Employees/ Pay Supplements

Based on the language needs of a Division or Office, an employee of the Department may be placed on the list of DHR Bi/Multi-lingual employees by demonstrating proficiency in English and the language for which they will interpret. Proficiency is evidenced by achieving a passing score on a standard Interpreters’ Skills examination administered by a language testing service or completion of an interpreter training program that includes receiving a passing score on an Interpreter’s oral examination. With supervisory approval, employees are eligible to receive a 5% or 10% pay supplement for providing language services (e.g., 5% - one language, 10% - two or more language).

Supervisors who wish to have employees tested may contact the Language Access Coordinator (LAC) for copies of testing information which is located on the Language Access SharePoint Site. Also, supervisors may contact the LEP/SI Office for testing information.

Cultural competency training for staff providing services to LEP/SI customers is being incorporated into the overall DHR LEP/SI training.

SECTION V Translation of Documents

The Policy Planning and Compliance Group (PPCG) LEP/SI Office coordinates the translation of documents, forms and brochures such as applications, consent forms, letters containing information regarding participation in a program, notices pertaining to the reduction, denial or termination of services or benefits and notices advising LEP/SI customers of the availability of free language assistance. The translation process is described as follows:

- When translations are needed, the Translation Request Form ([Attachment 19](#)) is completed by DHR Divisions/Offices and submitted to the LEP/SI Office. The LEP/SI Office identifies appropriate certified/qualified translators or translation service providers capable of producing camera ready, formatted documents suitable for printing or publishing to the DHR website and forwards the Request for a Quote ([Attachment 20](#)) to at least 3 vendors. Unless there is a compelling reason, the lowest bidder is selected.
- Translators and translation services ensures that the translated text reflects a sound conceptual understanding of the source material; hence, translators will secure a verifiable and independent, certified or qualified translator to proof read the final document. All proofreaders will meet the criteria established for primary translators.
- Translators and translation services take into consideration the foreign language and English literacy levels of the intended audience when translating DHR materials.
- Translators and translation services return all source documents and related files to the Department with the finished product.
- Documents containing occupation-specific terminology (such as medical and legal) will be translated by individuals who are qualified or certified to translate in those specific fields.

SECTION VI Monitoring and Complaint Resolution Process

Monitoring

The PPCG LEP/SI staff monitors services to LEP and SI customers in collaboration with monitoring activities conducted by each Division or Office. Three methods are used to monitor: (1) LEP/SI staff accompanies staff from DHR's Divisions and Offices as they conduct regular, on-site monitoring activities, (2) an annual assessment of service delivery, including telephone surveys and (3) responding to customer complaints. When feasible, the LEP/SI staff collaborates with Divisions/Offices when conducting customer satisfaction surveys.

The following criteria are used when monitoring LEP/SI service delivery:

- Compliance with the LEP/SI Service Delivery Checklist ([Attachment 21](#)).
- Total number of LEP/SI customers receiving service.
- Total number of instances, by language category, services are provided.
- Total number of hours, by language category, services is made available.
- Competence of the interpreter used (Bi-lingual employee, DHR Listing, qualified/certified/licensed vs. unqualified/non-certified or unlicensed).
- Timeliness of service.
- Frequency of Waiver of Rights to Free Interpreter Services usage.
- Corrective action taken, if needed.

Complaint Resolution Process

Managing complaints of discrimination by LEP and SI customers is accomplished in accordance with existing Departmental policies and procedures. In addition, complaints related to access to services by LEP and SI customers are forwarded to the LEP/SI office. Complaints may be submitted in any format; however, the preferred format is to complete the LEP/SI Discrimination Complaint Form ([Attachment 12-1](#), [12-2 DFCS](#)). The LEP/SI staff shares the complaint with the LEP/SI Complaint Resolution Team (CRT) within 2 business days after receipt. The CRT consists of the LEP/SI staff, the Language Access Team (LAT) member from the affected Division/Office and two additional LAT members. The CRT will work together to investigate and respond to the complaint. Complaints will be responded to in 5 business days.

SECTION VII

Attachments

[1 - Definitions](#)

[2 – LEP/SI Policy](#)

[3 - Organizational Commitment](#)

LEP/SI Program Responsibilities

Language Access Team (LAT) Responsibilities

Language Access Coordinators (LAC) Responsibilities

Complaint Resolution Team Responsibilities

Community Advisory Council Responsibilities

[4 - Local Language Access Plan Template](#)

[5 - Notice of Free Interpretation Services Wall Poster](#)

[6 - “I SPEAK” card](#)

[7 – Georgia Relay Services – How to Guide](#)

[8 - Tips for Using an Interpreter to Improve Service Delivery](#)

[Suggested Guidelines for Sign Language Interpreters](#)

[9 - Waiver of Rights Form](#)

[10 - Intake and Tracking Form and Instructions](#)

[11 - 1 Policy/Notice of Non-Discrimination in Services – General](#)

(English & Spanish)

[11 - 2 Policy/Notice of Non-Discrimination in Services – DFCS](#)

(English & Spanish)

[12 - 1 LEP/SI Discrimination Complaint Form – General](#)

(English & Spanish)

[12 - 2 LEP/SI & Title VI Discrimination Complaint Form – DFCS](#)

(English & Spanish)

[13 - LEP/SI Employee Feedback Form & Instructions](#)

[14 - LEP/SI Contractor Feedback Form & Instructions](#)

[15 - LEP/SI Customer Feedback Form & Instructions](#)

[16 – Selection and Evaluation Criteria for Interpreter and Interpreter](#)

[Services](#)

[17 - Code of Professional Conduct](#)

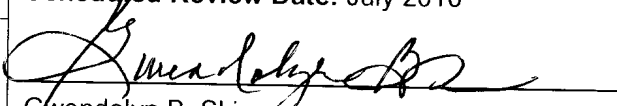
[18 - Code of Ethics](#)

[19 - Translation Request Form](#)

[20 - Request for a Quote Form](#)

[21 - LEP/SI Service Delivery Checklist](#)

Applicable to Behavioral Health Services Only

<p>Georgia Department of Human Resources Division of Mental Health, Developmental Disabilities & Addictive Diseases</p>	<p>DHR Online Directive Information System (ODIS) Directive # 6001-601 Page 1 of 3</p>
<p>ODIS Policy: Maintenance of Safety for Division of MHDDAD Consumers and Staff Subject: Management of Personal Needs Spending Accounts for MHDDAD Consumers in the Community</p>	
<p>Applicability:</p> <ul style="list-style-type: none"> • Providers of Community MHDDAD Services • State Operated Community Services 	<p>Effective Date: July 1, 2008 Revised: November 14, 2008 Revised Effective Date: November 21, 2008 Scheduled Review Date: July 2010</p>
<p>References: DHR Rules and Regulations 290-9-37-.18; 290-9-37-.19; 290-5-35-.18; 290-4-9</p>	 Gwendolyn B. Skinner Director, Division of MHDDAD
<p>Attachments: none</p>	<p>11/19/08 Date</p>

MANAGEMENT OF PERSONAL NEEDS SPENDING ACCOUNTS FOR MHDDAD CONSUMERS IN THE COMMUNITY

POLICY

It is the policy of DMHDDAD that personal funds of all consumers are to be used and accounted for according to Federal and State laws and these guidelines. Individuals served in residential services contribute to the cost of room and board expenses based on the amount of their benefits (SSI or SSDI, Veteran's and Railroad Retirement benefits) less an amount for Personal Needs Spending. If the individual's benefit exceeds the amount of the room and board costs, benefits may be used for other consumer personal expenses. Provider organizations serving persons with disabilities (also referred to here as Contractors) ensure that these Personal Needs Spending Accounts are properly managed.

PROCEDURES

Consumer Personal Needs Spending Accounts

The Personal Spending Needs amount is set each year by the Division of MHDDAD. In most cases, Contractors become the payee of residential consumers' checks and maintain consumers' personal needs funds. The Contractor keeps all records pertaining to personal needs accounts (including bank statements and bank books) and at least one set of such records is maintained at the consumer's place of residence.

Residents have the right to manage their own funds. Consumers' ability to manage their funds is documented in their respective individual services plan. In instances where a residential services consumer or his/her representative continues as payee and manages his/her own funds, the consumer or his/her representative is responsible for forwarding benefit funds less the established Personal Spending amount to the Contractor.

Management and Protection of Consumer Funds

In the event the provider organization has to assume responsibility for the safeguarding or management of any consumer valuables or finances, the following requirements are

Applicable to Behavioral Health Services Only

DIVISION: MHDDAD	SUBJECT: Management of Personal Needs Spending Accounts for MHDDAD Consumers in the Community	ODIS Policy # 6001-601
		Page 2 of 3

considered minimal and must be fulfilled by the provider organization:


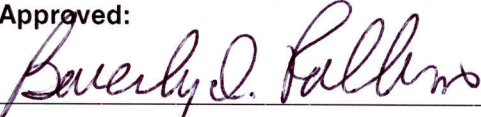
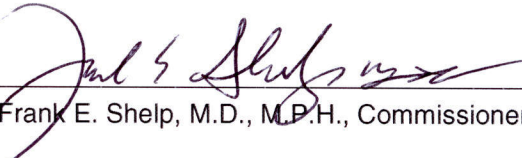
- I. The organization must have written and implemented policies and procedures for safeguarding consumer possessions, valuables, and finances. All policies and procedures are in compliance with the guidelines of the Social Security Administration and any other laws or regulations of the federal and state governments. The policies provide for the following:
 - A. A strict prohibition, punishable by termination, for any employee, agent or representative of the organization to be listed or designated, either directly or indirectly, as a beneficiary, payee or other recipient of any funds of the consumer, including but not limited to, any insurance, burial or trust benefits;
 - B. A procedure in accordance with the guidelines listed below to ensure the timely deposit and accounting of all consumer funds (e.g., trusts, work-related income, Social Security, disability benefits, gifts, etc.) in an account in the individual name of each consumer receiving any such funds;
 1. Funds may not be pooled or co-mingled in any organizational account or other combined accounts, or with other individuals' funds.
 2. Funds not needed for ordinary use by the consumer on a daily basis are deposited in an account insured by agencies of or corporations chartered by the state or federal government and in a form, which clearly indicates that the organization has only a fiduciary interest in the funds.
 3. Funds received from a resident or on his/her behalf may be deposited in an interest-bearing account; provided, however, that any interest earned on such account shall accrue to the consumer.
 4. To the extent that certain funds are properly due the organization for services, goods or donations, funds must first be deposited to the individual consumer account and then subsequently disbursed in accordance with these requirements and the written policies of the organization.
 - C. A requirement that consumer funds may only be disbursed upon request or authorization of the consumer and/or his/her family, if appropriate, and, in the case where the organization serves as the designee to receive and disburse funds on behalf of the consumer, upon signature or written authorization of two independent staff members or organizational representatives.
 - D. A procedure or set of procedures to assure that at least two people, other than those having authorization to receive and disburse funds on behalf of any consumer, independently reconcile consumer bank and/or account records on a monthly basis.
 - E. A procedure for establishing and maintaining a written record of all financial arrangements and transactions involving the resident's funds. This record is made available to the resident, his/her family or guardian, the Regional Office,

Applicable to Behavioral Health Services Only

DIVISION: MHDDAD	SUBJECT: Management of Personal Needs Spending Accounts for MHDDAD Consumers in the Community	ODIS Policy # 6001-601
		Page 3 of 3

and any other legally authorized representative for inspection and copying upon request.

- F. A method for providing to each consumer on at least a quarterly basis a written statement showing the current balance of any account(s) and an itemized listing of all transactions occurring during that quarter; and
 - G. A procedure or set of procedures to account for and inventory consumer possessions to include insurance and other benefits policies (exclusive of consumer funds) on a semi-annual basis to assure clothing, personal effects, memorabilia, and other items of personal value are protected and, as appropriate, remain in the consumers possession during the course of his/her time receiving care and/or services from the organization.
- II. The organization that has assumed responsibility for safeguarding and/or managing consumer possessions or finances ensures that monitoring and reporting on the use of personal funds are incorporated into the organization's Quality Improvement Program. Individual financial records are subject to audits by the Social Security Administration and by DHR.
- III. In the case of any breach of these procedures or any loss, theft or misappropriation of consumer possessions or funds, the organization must immediately comply with all requirements of the Division's policies regarding incident reporting and investigation, documenting the occurrence(s) and any redress which has occurred. The provider organization bears full liability to replace, either through insurance, bond, surety or cash, any funds illegally or inappropriately taken from a consumer by any employee, agent or representative of the organization.

 Georgia Department of Behavioral Health & Developmental Disabilities DBHDD	Policy # 02-702 Replaces DBHDD Policy #6001-601 for DD Providers Only Page 1 of 7
Chapter: Developmental Disabilities Community Services Subject: Management/Supervision/Safeguarding of Possessions, Valuables, Personal Funds and Day-To-Day Living Expenses in Developmental Disabilities Residential Services	
Applicability: DD Residential Providers	Original Effective Date: July 1, 2010
References: Social Security Representative Payment Program	Revision #1 Effective Date: January 1, 2011 Scheduled Review Date: January 2012
Attachments: Attachment A – Money Management Tool Attachment B - Personal Spending Account Record	Approved:  12/1/10 Beverly D. Rollins, M.P.A., Executive Director, Date Division of Developmental Disabilities  12/1/10 Frank E. Shelp, M.D., M.P.H., Commissioner Date

MANAGEMENT/SUPERVISION/SAFEGUARDING OF POSSESSIONS, VALUABLES, PERSONAL FUNDS, AND DAY-TO-DAY LIVING EXPENSES IN DEVELOPMENTAL DISABILITIES RESIDENTIAL SERVICES

POLICY STATEMENT

It is the policy of the Department of Behavioral Health and Developmental Disabilities (DBHDD) that personal funds of all individuals served in Developmental Disabilities (DD) Community Residential Alternative (CRA) services be used and accounted for according to federal and state guidelines. All individuals served in CRA services contribute to their day-to-day living expenses. CRA providers must maintain a current personal spending policy which is consistent with this DBHDD policy, the current DBHDD Provider Manual, and any other applicable state or federal requirements. All DD residential providers must follow the requirements for management/supervision/safeguarding individual possessions, valuables, and funds specified in this DBHDD policy and maintain a current policy consistent with these requirements.

DEFINITIONS

Benefits – The amount of unearned income received by a person, which includes but is not limited to: Social Security Disability Insurance (SSDI), Social Security Disability Insurance for Disabled Adult Children (SSDAC), Supplemental Security Income (SSI), Veterans, or Retirement benefits.

Community Living Arrangement (CLA) – A licensed residence, whether operated for profit or not, that undertakes through its ownership or management to provide or arrange for the provision of daily personal services, supports, care, or treatment for two or more adults with developmental disabilities, who are not related to the owner or

DBHDD	SUBJECT: Management/Supervision/Safeguarding of Possessions, Valuables, Personal Funds and Day-To-Day Living Expenses in Developmental Disabilities Residential Services	Policy: 02-702
		Page 2 of 7

administrator by blood or marriage and whose residential services are financially supported, in whole or in part, by funds designated through the DBHDD.

Community Living Support (CLS) – Services which are individually tailored supports that assist with the acquisition, retention, or improvement in skills related to an individual’s continued residence in his or her own or family home.

Community Residential Alternative (CRA) – Services which are targeted for individuals who require intense levels of residential supports in small group settings of four or less, foster homes, or host homes and include a range of interventions with a particular focus on training and support in one or more of the following areas: eating and drinking, toileting, personal grooming and health care, dressing, communication, interpersonal relationships, mobility, home management, and use of leisure time.

Day-to-Day Living Expenses - Determined costs of the individuals needs for day-to-day living who are served by an organization as a representative payee. These day-to-day living expenses may include housing, food, medical and dental expenses, personal items, and clothing.

DD Residential Services – Any out of family home placement funded by DBHDD where the provider is a provider of DD Community Residential Alternative Services and the person served is authorized to receive DD residential services. Residential services include DD services provided in any out of home placement, such as in personal care homes, community living arrangements, and host homes, and pertain particularly to any situation in which day-to-day living payment exists. DD residential services also include individuals who receive Community Living Support Services in their own home.

Earned Income – Compensation from participation in a business, including wages, salary, tips, commissions and bonuses.

Family Home – A family home is defined as a home where a person lives with family members and where services funded by DBHDD are provided in that home.

Host Home – The (unlicensed) private home of an individual or a family, whether owned or leased, in which residential supports are provided to one or two adults with developmental disabilities, and in which the following requirements are met: (1) The home owner or lessee shall not be an employee of the same DBHDD approved provider agency which provides the host/life sharing home services; (2) Individuals should not be related to the occupant owner or lessee by blood or marriage; and (3) The occupant owner or lessee shall not be the guardian of any person served on their property nor the agent in such person’s advance directive for health care.

Personal Care Homes (PCH)– A licensed residence that provides or arranges for the provision of housing, food service, and one or more personal services for two or more adults with developmental disabilities, who are not related to the owner or administrator

DBHDD	SUBJECT: Management/Supervision/Safeguarding of Possessions, Valuables, Personal Funds and Day-To-Day Living Expenses in Developmental Disabilities Residential Services	Policy: 02-702
		Page 3 of 7

by blood or marriage. (Personal services include but are not limited to individual assistance with and supervision of self-administered medications and essential activities or daily living such as eating, bathing, grooming, dressing, and toileting.)

Personal Funds – Money available for the individual to spend on personal needs as defined by the Social Security guidelines, comprised of those funds he or she has available after deducting costs associated with day-to-day living expenses.

Provider – For the purposes of this policy, the term provider includes organizations that provide developmental disabilities residential services that are financially supported in whole or in part by funds authorized through DBHDD. In this policy, the word organization is also used to refer to a provider.

Representative Payee (also referred to as “Payee”) – An individual or organization that is authorized by the Social Security Administration to receive monthly benefits on behalf of an individual served and uses the benefits to pay for current needs, including: Housing and utilities; Food; Medical and dental expenses; Personal care items; Clothing; and Rehabilitation expenses.

Unearned Income – Is defined by SSA, for SSI as all income that is NOT earned income from a job or business.

PROCEDURES

A. Management/Supervision/Safeguarding of Funds, Possessions, and Valuables of Individuals Served by the Residential Provider Organization

The organization must have written and implemented policies and procedures for management/ supervision and safeguarding the funds, possessions, and valuables, of individuals served by the organization. All policies and procedures must be in compliance with this policy, provider specific internal policies, guidelines of the Social Security Administration associated with the management and protection of the funds of individuals served, and any other laws or regulations of the federal and state governments. The policies must provide for the following:

- I. A procedure (or set of procedures) to inventory an individual’s possessions and valuables. Possessions include:
 - insurance and other benefits policies (exclusive of the funds of the individual served)
 - clothing,
 - furnishings,
 - electronics,
 - personal effects,
 - memorabilia,
 - and any other items individually valued at \$20.00 (twenty dollars) or more

DBHDD	SUBJECT: Management/Supervision/Safeguarding of Possessions, Valuables, Personal Funds and Day-To-Day Living Expenses in Developmental Disabilities Residential Services	Policy: 02-702
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Inventory of an individual's possessions and valuables is done at admission and updated as needed (items added or deleted) or on a semi-annual basis, at a minimum, to assure that inventory items are protected and, as appropriate, remain in the individual's possession during the course of his/her time receiving care from the organization.

- II. Individuals have the right to manage their own funds. However, the residential provider organization is responsible for the management/supervision of any individual valuables or funds. This responsibility is applicable regardless of the payee status of the provider, unless the representative payee is family, guardian, friend, or anyone not involved in direct provision of residential services. When this occurs, the residential provider continues to be responsible for designating an area for the safeguarding of an individual's valuables and all personal spending money, unless the individual served has requested to manage and safeguard their own valuables and funds independent of the provider.

- III. The individuals' ability to manage their funds is documented in their respective Individual Service Plan. Additionally, upon admission, each individual's capacity for money management is assessed. This is documented in Attachment A - Money Management Tool.

- IV. When the person served is unable to manage valuables and/or funds and there is no other person in the life of the individual who is able to assist in the management of the individual's valuables and/or funds, the residential provider must be able to demonstrate a documented effort to secure an independent party to manage those valuables and/or funds. The effort to secure an independent party will be documented in the ISP annually.

- V. The organization demonstrates special care to assure that the funds of individuals served by the organization are not mismanaged or exploited. Procedures define the checks and balances established to ensure agency accountability. The agency is able to demonstrate evidence of working toward the goal of participative management of the personal funds of the individuals served by the agency.

- VI. A strict prohibition, punishable by termination, for any employee, agent or person representing the organization to be listed or designated, either directly or indirectly, as a beneficiary, payee or other recipient of any funds of the individual, including but not limited to, any insurance, burial or trust benefits.

- VII. Personal funds are readily accessible for use by the individuals served by the organization. A mechanism is in place, at least on a quarterly basis to assure that the individual and/or representative is aware of monies that are in his or her personal account. A statement of funds received and spent is provided to the individual and/or representative when requested.

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- VIII. The monies of individuals served by the organization are not co-mingled into a collective account without permission from the Social Security Administration. Collective accounts must show that the funds belong to the beneficiaries and not the payee; the account is separate from the organization's operating account; and any interest earned is credited to the beneficiaries. The Social Security Administration requires clear and current records showing the amount of each beneficiary's share; and proper procedures must be followed for documenting credits, debits, and allocation of interest.
- IX. To the extent that certain funds are properly due the organization for services, goods or donations, funds must first be deposited to the personal account of the individual served by the organization and then subsequently disbursed in accordance with this policy, Social Security guidelines and the written policies of the organization.
- X. A procedure or set of procedures to assure that at least two people, other than those having authorization to receive and disburse funds on behalf of any individual, independently reconcile the bank and/or account records of any individual served by the organization on a monthly basis.
- XI. When providers are selected and become the payee of individuals' checks, they must maintain records of each individual's personal funds and all other records pertaining to personal needs accounts (including bank statements and bank books). Documentation of personal spending is accounted for on the Division of DD approved Personal Spending Account Record (Attachment B), or a payee created document that contains all of the same elements as Attachment B. Only the current month's Personal Spending Account Record must be kept at the individual's place of residence, for immediate inspection, as applicable. All previous month's Personal Spending Account Records may be kept off site at the agency business office, but is to be available to the person served, his or her family, the Support Coordinators, the Regional Office, and any other legally authorized representative for inspection and copying upon request, or within one to two business days of request.
- XII. Providers who are the representative payee for individuals with developmental disabilities are monitored for compliance by SSA and must adhere to Social Security Guidelines for Organizational Representative Payees, which includes, but is not limited to, the following:
- Determining the individual's current needs for day-to-day living (e.g., food, clothing, housing, medical and dental expenses and personal items) and using his or her payments to meet those needs;
 - Keeping written records for at least two years of all payments from the Social Security Administration (SSA), bank statements and cancelled checks, receipts or cancelled checks for rent, utilities, and major purchases;
 - Reporting to SSA changes in the individual's entitlement or in circumstances impacting performance as a payee;

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- Completing all required annual and any other periodic reporting;
- Meeting the above listed and all other requirements as specified at the following website:

<http://www.socialsecurity.gov/payee/NewGuide/toc.htm>

In the case of any breach of these procedures or any loss, theft or misappropriation of individuals' possessions or funds, the organization must immediately comply with all requirements of DBHDD policies regarding incident reporting and investigation, documenting the occurrence(s) and any redress which has occurred. The provider organization bears full liability to replace, either through insurance, bond, surety or cash, any funds illegally or inappropriately taken from an individual served by the organization or by any employee, agent, or person representing the organization.

B. Day-to-Day Living Expenses

The provider organization acting as a representative payee must determine the individuals served current needs for day-to-day living and use his/her payments to meet those needs. For the purposes of this policy, these day-to-day living expenses may include:

Housing - Housing may be calculated by a residence specific cost or the average cost of similar homes in a geographic area. The charge to the individual for housing, as approved by social security, must be equitably distributed among all individuals supported in the home.

Food – Payee assures that individual’s preferences and dietary needs are honored.

Medical and Dental Expenses – Medical and Dental Expenses are an allowable and expected use of the individual’s Social Security and/or SSI benefits. The payee assures that the individual’s medical and dental expenses not covered by Medicare, Medicaid, and/or private insurance are paid by the individual’s social security and SSI benefits to the extent that those funds are available.

Personal Items and Clothing– items specified in Social Security guidelines on personal items and clothing.

C. Personal Funds

At minimum (regardless of day-to-day living expenses) each individual in DD residential services is to receive \$65.00 monthly for personal needs and spending.

After the day-to-day living needs are met, the payee may also use the benefits for personal comfort items, recreation, and miscellaneous expenses. If a person has unearned or earned income greater than the determined day-to-day living expenses all remaining funds will be available to the person served as personal needs funds. These funds may be saved by the payee in a checking or savings account (preferably interest bearing), U.S. savings bonds, or other appropriate investment(s).

DBHDD	SUBJECT: Management/Supervision/Safeguarding of Possessions, Valuables, Personal Funds and Day-To-Day Living Expenses in Developmental Disabilities Residential Services	Policy: 02-702
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D. Day-to-Day Living Expenses Agreement

The CRA Provider provides individuals who reside in agency operated (or sub-contracted) CLA, PCH, and/or Host Homes with a day-to-day living expenses agreement upon admission, annually, or as needed. The day-to-day living expenses agreement is reviewed at the annual ISP. The day-to-day living expenses agreement includes a statement of all associated housing and food costs (per the above definition in Section B); and any estimated medical, dental, and clothing fees or charges assessed to the individual, to the extent that those funds are available. Any changes in charges for day-to-day living expenses are provided to the individual served and the agency operated (or sub-contracted) CLA, PCH, and/or Host Home Provider, in writing, 60 days prior to changes in charges. Copies of each day-to-day living expenses agreement are maintained in the record of the person served.

Day-to-day living expenses agreement must be signed by the CRA Provider agency and/or the agency operated (or sub-contracted) CLA, PCH, and/or Host Home Provider and submitted to the Division of Developmental Disabilities annually (by June 30th) or whenever there is a change of CLA, PCH and/or Host Home Provider serving the individual. Contracts are to be mailed to:

Division of Developmental Disabilities
Attn: Sherry Newton, Administrative Operational Manager
2 Peachtree Street, Suite 22-413
Atlanta, GA 30303

The organization as representative payee must be aware of the beneficiary's current and reasonably foreseeable needs and ensure these needs are met to the extent possible based on the available funds. **Current needs are never sacrificed** to pay other expenses, past debt, or used as a means to accumulate conserved funds.

**DBHDD, DIVISION OF DEVELOPMENTAL DISABILITIES
MONEY MANAGEMENT TOOL**

NAME:

DATE:

STAFF ADMINISTERING TEST:

SKILL	Independent	Assistance Needed	Full Supervision	ISP Goal Needed Y/N	Implementation Strategy to Meet ISP Goal
1. Aware of and understands all financial sources and amounts.					
2. Aware of and understands rent, board and other bills.					
3. Budgets enough money to pay all bills.					
4. Creates daily budget.					
5. Creates weekly budget.					
6. Follows daily or weekly budget.					
7. Keeps money safely in wallet or room.					
8. Saves money for miscellaneous items, trips, etc.					
9. Deposits into / withdraws money from bank account independently.					
10. Writes out checks or money orders independently.					

OVERALL ASSESSMENT:

UPDATED AS OF 12/10/10

Personal Spending Account Record

Page ____ of ____

NAME:	ID Number:
Location:	Month/Year:

Balance Brought Forward ►

Date	Detailed Description of Transaction (Describe what the money was spent for or source of deposit)	Amount of Deposit	Amount of Expenditure	Receipt Yes/No	Balance	Staff or Individual Initials	Date Reconciled	Staff Initials

** Managers will audit once a month

Individual Signature (if appropriate)

Staff Signature and Title

Staff Signature and Title

Staff Signature and Title

Staff Signature and Title

Staff Signature and Title

Staff Signature and Title

Staff Signature and Title

Staff Signature and Title



Chapter: Hospital Operations
Subject: Medical Evaluation Guidelines and Exclusion Criteria for Admission to State Hospitals and Crisis Stabilization Programs

(Replaces title "Medical Evaluation Guidelines and Exclusion Criteria for Admission to DHR DMHDDAD Hospitals")

Applicability:
All State Hospitals
All Crisis Stabilization Programs

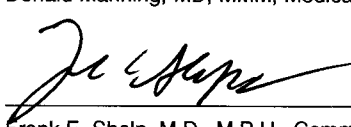
References: 42 U.S.C § 1395dd, 42 C.F.R § 489.24, Official Code of Georgia Annotated (O.C.G.A) 37-3-2, O.C.G.A 37-3-3

Attachments:
Attachment A – Medical Evaluation Guidelines and Exclusion Criteria for Persons Referred for Admission to State Hospitals and Crisis Stabilization Programs

Revision #4 Effective Date: September 1, 2010
Scheduled Review Date: September 2011

Approved:
 8.30.10
Gregory C. Hoyt, Director Date
Hospital System

 8.30.10
Donald Manning, MD, MMM, Medical Director Date

 8/31/10
Frank E. Shelp, M.D., M.P.H., Commissioner Date

MEDICAL EVALUATION GUIDELINES AND EXCLUSION CRITERIA FOR ADMISSION TO STATE HOSPITALS AND CRISIS STABILIZATION PROGRAMS

POLICY

The Department of Behavioral Health and Developmental Disabilities (DBHDD) ensures the safety of those admitted to a State Psychiatric Hospital (State Hospital) or Crisis Stabilization Program (CSP) by requiring appropriate medical screening of individuals prior to the person being transported to the State Hospital or CSP. Individuals who require medical services that cannot be provided by a State Hospital or CSP are screened and referred to appropriate medical providers. This policy pertains to all CSPs, whether state operated or operated by other organizations under contract with the Division of MHDDAD.

DBHDD seeks to provide psychiatric stabilization and detoxification services in the safest environment possible within all hospital or crisis stabilization services operated by or under contract with the Division of MHDDAD. To that end, the "Medical Evaluation Guidelines and Exclusionary Criteria" contained in this policy are designed to clarify healthcare issues that, if present, must be medically assessed and stabilized prior to referring any individual for care at a State Hospital or CSP operated by or under contract with the Division of MHDDAD.

If the referral source believes that the individual does not have healthcare issues present that must be medically assessed and stabilized prior to admission at the State Hospital or CSP, the referral source may contact medical personnel at the State

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Hospital or CSP by phone to discuss the individual. If it is then determined by the medical personnel at the State Hospital or CSP that the individual does not appear to have healthcare issues noted in the *Medical Evaluation Guidelines and Exclusionary Criteria*, the individual may proceed directly to the State Hospital or CSP for evaluation of need for psychiatric stabilization or detoxification services.

DEFINITIONS

Medical Clearance – An assessment conducted by a physician, Advance Practice Nurse, or Physician’s Assistant involving physical examination and laboratory evaluation, when indicated, in order to determine whether a person being considered for referral to a State Hospital or CSP requires medical services which cannot be provided by that State Hospital or CSP.

PROCEDURES

The DBHDD Medical Executive Committee defines the medical evaluation guidelines for use by State Hospitals and CSPs, as well as medical exclusion criteria. See **Attachment A - Medical Evaluation Guidelines & Exclusion Criteria for Persons Referred for Admission to State Hospitals and Crisis Stabilization Programs.**

Healthcare providers referring an individual for admission to a State Hospital or CSP are expected to conduct an assessment of any medical or substance abuse problems the person may have and include this information in the referral to the State Hospital or CSP, in addition to information about the behavioral health issues which in the view of the healthcare provider necessitates the admission.

Following review of the referral information, the State Hospital or CSP physician takes one of the following actions:

- accepts the individual for transportation to the State Hospital or CSP for evaluation,
- denies the referral due to medical condition, **or**
- requests additional information.

If medical information about the patient is inadequate in accordance with the Medical Evaluation Guidelines contained in this policy, the State Hospital or CSP physician may request additional evaluations within the capability of the referring provider. If the referring provider is unable to conduct sufficient evaluation to determine that the individual is medically clear and the physician has clinical reasons to suspect the presence of a significant medical problem, the referral source may be asked to refer the patient to a medical hospital for medical clearance.

Medical clearance may be waived by the State Hospital or CSP admitting physician when clinically appropriate or when medical clearance is not available.

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The Medical Evaluation Guidelines are not intended to replace good clinical judgment. In specific cases, more information or lab work may be requested or specific labs may be omitted, depending on presenting problems and other medical conditions.

The physicians are encouraged to always engage in a physician-to-physician discussion of the issues, especially when there is a difference of opinion between the State Hospital or CSP physician and the physician at a medical hospital. In cases where the referring physician believes the State Hospital or CSP physician is requesting inappropriate labs or evaluations or denying acceptance inappropriately, the referring physician may request to discuss the case with the State Hospital or CSP Clinical Director (or designee) at any time through any Admissions staff member. At all times it is the DBHDD policy that transfers are compliant with the Emergency Medical Treatment and Active Labor Act (EMTALA).

If, following the individual's arrival at the State Hospital or CSP and evaluation by the physician, it is determined that referring information was inaccurate and the State Hospital or CSP cannot safely meet the individual's medical needs, the individual may be sent back to the referring hospital. In such circumstance, any individuals who did not go to a medical hospital prior to arrival at the State Hospital or CSP would be sent to the nearest medical hospital.

Department of Behavioral Health and Developmental Disabilities
MEDICAL EVALUATION GUIDELINES AND EXCLUSION CRITERIA
For persons referred for admission to State Hospitals and Crisis Stabilization Programs
Updated 8-26-10 – Effective 9-1-10

A. EXCLUSION CRITERIA

1. Burns (severe) requiring acute care or physical therapy
2. Cardiac disease, unstable, including
 - a. Bradycardia below 60/minute, symptomatic, persistent
 - b. Tachycardia above 120/minute, symptomatic, persistent
3. Delirium
4. Dementia
5. Fracture, open or closed, and unstable
6. GI bleed, active
7. Infectious disease requiring isolation and/or treatment by IV antibiotic
8. Intravenous fluids or IV antibiotics
9. Joint dislocations, acute, until reduced
10. Laceration or draining wound, open, requiring packing changes
11. Medical devices used that cannot be secured
12. Oxygen dependent
13. Overdose, acute, unstable
14. TB, active
15. Traumatic Brain Injury
16. Tubes or drains, chest or abdominal, including ostomies (unless the patient provides their own ostomy care)
17. For Crisis Stabilization Programs only: Durable medical equipment that is not readily available

B. MEDICAL EVALUATION GUIDELINES for CRISIS STABILIZATION PROGRAMS and DBHDD HOSPITALS

1. **ALL patients presenting at the ER**
 - a. CBC
 - b. UA
 - c. UDS
 - d. Vital signs acceptable range: >90/60; <160/100
2. **Psychiatric. New onset psychosis or altered sensorium**
 - a. Normal neurological examination
 - b. Rule out medical etiologies
 - c. Age 49 or less: labs as indicated in item #1 above plus metabolic panel to include Electrolytes, Creatinine, BUN and Glucose
 - d. Age 50 and older: also consider CT or MRI of brain; EKG
3. **Psychiatric. Disorders of thought or mood not covered in item 2 above**
 - a. Rule out delirium
 - b. Rule out medical etiologies
 - c. Age 49 or less: labs as indicated in item 1 above
 - d. Age 50 and older: metabolic panel to include Electrolytes, Creatinine, BUN and Glucose

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4. **Alcohol Abuse, Dependency or Intoxication**
 - a. CIWA assessment¹ or equivalent clinical evaluation of withdrawal symptoms including but not limited to:
 1. Blood alcohol >300 (individual programs may vary)
 2. Tremor
 3. Diaphoresis
 4. Myalgia
 - b. Metabolic panel to include Electrolytes, Creatinine, BUN and Glucose
 - c. LFT
 - d. May request labs such as amylase or lipase to rule out other medical etiologies
 - e. May request CT of brain if subdural is suspected
 - f. CIWA-Ar guidelines:
 1. Score of 9–24: individual should be considered for residential detoxification
 2. Score higher than 24: individual should be considered for general hospitalization
 3. Score lower than 9: individual should be considered for ambulatory or social detoxification
5. **Acetaminophen overdose.** Follow Washington Manual guidelines. Repeat levels until below risk for possible hepatotoxicity. Patients on Mucomyst must complete entire course of treatment prior to transfer.
 - a. Initial level >120 at 4 hrs
 - b. .60 at 8 hrs
 - c. .30 at 12 hours
 - d. Repeat after 4 hour interval
6. **Other overdoses requiring medical intervention-** Patients must be observed for up to 24 hours prior to transfer.
7. **AIDS**
 - a. Labs as indicated in # 1 above
 - b. Metabolic panel to include Electrolytes, Creatinine, BUN and Glucose and additional tests as indicated, such as CT of brain if pathology suspected
 - c. End stage AIDS patients should not be referred for psychiatric care in crisis stabilization programs or DBHDD hospitals.
8. **Anemia**
 - a. Hgb <8 requires work up and correction prior to transfer
 - b. Chronic anemia with known cause, with hemodynamic stability and no acute symptoms, should be discussed with physician prior to transfer
9. **Diabetes Mellitus**
 - a. Accucheck less than 250---no additional work up, unless other associated conditions or issues require any other labs
 - b. Accucheck more than 250 --- add metabolic panel to include Electrolytes, Creatinine, BUN and Glucose
 - c. Blood sugar must be stabilized consistently below 250 mg % for a 2-hour period before approval and within one hour of transfer

¹ CIWA is attached to this document.

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10. **Febrile patients**
 - a. T>101.5, labs as indicated in #1 above and metabolic panel to include Electrolytes, Creatinine, BUN and Glucose
 - b. Chest X-ray if indicated
 - c. Fever of unknown origin: additional labs per physician-to-physician consultation.
11. **HIV+**
 - a. Normal vital signs and no acute complaints: nothing further than labs indicated in #1 above
12. **Hypokalemia**
 - a. Below 3.0, determine etiology
 - b. EKG to rule out arrhythmias
 - c. Levels below 3.0 must be treated and level repeated with appropriate response to treatment verified prior to transfer.
13. **Hyponatremia**
 - a. Below 125 must be normalized prior to acceptance
14. **Hypertension**
 - a. If asymptomatic and BP below 140/90, no additional labs
 - b. BP >160/100 must be evaluated and treated with follow up BP's <160/100 prior to transfer
15. **Hypotension**
 - a. BP <90/60 and/or symptomatic, must be stabilized for at least one hour prior to transfer.
16. **MRSA**
 - a. Physician to physician communication is expected, with Infectious Diseases consult if needed
 - b. Sensitive to Vancomycin on blood/wound discharge culture should have documented intravenous treatment with Vancomycin for ten days before switching to oral for referral for transfer
 - c. MRSA sensitive to other antibiotics may be transferred earlier and may not need intravenous treatment with Vancomycin.
17. **Pregnancy**
 - a. Assessment of current physical status of mother and child
18. **WBC**
 - a. >15,000 or <3000, specific etiology must be identified and treatment begun prior to acceptance.
19. **Mechanical assistance or wheelchair**
 - a. Patients able to move or transfer independently with mechanical assistance or wheelchair may be accepted
20. **Patient refusal to cooperate with lab testing**
 - a. Decision regarding acceptance must be made on the basis of the information available
21. **Patients who have a history of requiring more than seven (7) days to achieve stabilization are not appropriate for Crisis Stabilization Programs.**
22. **Patients who are actively violent are not appropriate for Crisis Stabilization Programs.**

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Doctor-to-doctor communication is requested to ensure continuity of care, and is required in cases of differences of opinion. **Doctor-to-doctor communication** is required when there is any unstable medical condition.

In cases where the referring physician believes the receiving physician is requesting inappropriate labs or evaluations or denying acceptance inappropriately, the referring physician may request to discuss the case with the agency Medical Director (or designee) at any time.

These guidelines are intended to provide consistency for referrals into crisis stabilization programs and DBHDD hospitals in Georgia. **However** the ultimate decision to admit or not admit is that of the receiving physician.

Alcohol Detoxification

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA – Ar)

Many qualification instruments have been developed for monitoring alcohol withdrawal (Guthrie, 1989; Sullivan et al., 1989; Sellers & Naranjo, 1983). No single instrument is significantly superior to others. What is clear is that there are significant clinical advantages to quantifying the alcohol withdrawal syndrome. Quantification is key to preventing excess morbidity and mortality in a group of patients who are at risk for alcohol withdrawal. Such instruments help clinical personnel recognize the process of withdrawal before it progresses to more advanced stages, such as *delirium tremens*. By intervening with appropriate pharmacotherapy in those patients who require it, while sparing the majority of patients whose syndromes do not progress to that point, the clinician can prevent over and under treatment of the alcohol withdrawal syndrome. Finally, quantifying and monitoring the withdrawal process can modify the treatment regimen modified as needed.

The best known and most extensively studied scale is the Clinical Institute Withdrawal Assessment – Alcohol (CIWA – A) and a shortened version, the CIWA – A revised (CIWA – Ar). This scale has well-documented reliability, reproducibility and validity, based on comparison to ratings by expert clinicians (Knott, et al., 1981; Wiehl, et al., 1994; Sullivan, et al., 1989). From 30 signs and symptoms, the scale has been carefully refined to a list of 10 signs and symptoms in the CIWA – Ar (Wiehl, et al., 1994). It is thus easy to use and has been shown to be feasible to use in a variety of clinical settings, including detoxification units (Naranjo, et al., 1983; Hoey, et al., 1994), psychiatry units (Heinala, et al., 1990), and general medical/surgical wards (Young, et al., 1987; Katta, 1991). The CIWA – Ar has added usefulness because high scores, in addition to indicating severe withdrawal, are also predictive of the development of seizures and delirium (Naranjo, et al., 1983; Young, et al., 1987).

Copied from: ASAM Patient Placement Criteria, Second Edition - Revised

CLINICAL PRACTICE GUIDELINES: ALCOHOL DETOXIFICATION

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA - Ar)

What it Measures: The CIWA – Ar can measure 10 symptoms. Scores of less than 8 to 10 indicate minimal to mild withdrawal. Scores of 8 to 15 indicate moderate withdrawal (marked autonomic arousal); and scores of 15 or more indicate severe withdrawal. The assessment requires 2 minutes to perform (Sullivan, et al, 1989).

CIWA – Ar categories, with the range of scores in each category, are as follows:

Agitation	(0 – 7)
Anxiety	(0 – 7)
Auditory Disturbances	(0 – 7)
Clouding of Sensorium	(0 – 4)
Headache	(0 – 7)
Nausea/Vomiting	(0 – 7)
Paroxysmal Sweats	(0 – 7)
Tactile Disturbances	(0 – 7)
Tremor	(0 – 7)
Visual Disturbances	(0 – 7)

A study of the revised version of the CIWA predicted that those with a score of >15 were at increased risk for severe alcohol withdrawal (RR 3.72; 95% confidence interval 2.82 – 4.85) the higher the score the greater the risk. Some patients (6.4%) still suffered complications, despite low scores, if left untreated (Foy, et al., 1988).

EXAMPLE - ALCOHOL DETOXIFICATION PROTOCOL The following is an example of a protocol developed around the use of the CIWA – Ar in an alcohol detoxification program:

1. CIWA to be completed on admission and q 8 hours for a period of 24 hours.
2. Determine and record blood alcohol concentration (BAC) by breathalyzer on admission.
3. Vital signs: pulse rate and BP q 4 hours. **Call physician if patient has HR > 110mmHg, DBP > 120 mmHg, or SBP > 180 mmHg.**
4. Obtain serum glucose, HFP (hepatic function profile), CMEP (comprehensive metabolic panel, CBC w/DIFF and urine for drug screen.
5. Give Thiamine 100 mg IM now, and then Thiamine 100 mg PO bid times 3 days.
6. If CIWA score is > 0 but ≤ 8 and vital signs are stable, no medication is required. Repeat vital signs q 4 hours and the CIWA q 8 hours. (May repeat CIWA and vital signs as needed.)
7. If CIWA is > 8 but < 15, give Lorazepam (Ativan) 2 mg PO/IM and repeat vital signs q 2 hours and the CIWA q 4 hours.
8. If CIWA is ≥15 or DBP > 110 mmHg, give Lorazepam (Ativan) 2 mg PO/IM q 1 hour until patient has a CIWA of < 15 or DBP < 110 mmHg (CIWA and vital signs checked q 1 hour until patient's CIWA is < 15 and DBP < 110 mmHg.) When CIWA

CBHA – NETWORK PROVIDER MANUAL

is between 8 and 15, give Lorazepam (Ativan) 2 mg PO/IM and resume vital signs q 2 hours and the CIWA q 4 hours.

9. **CALL MD IF PATIENT REQUIRES ≥ 6 mg OF LORAZEPAM (ATIVAN) IN THREE HOURS.**
10. May awaken patient to complete CIWA and vital signs.
11. When CIWA is ≤ 8 for 3 consecutive 8-hour increments, d/c CIWA protocol.

Addiction Research Foundation
Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA – Ar)

Patient: _____ Pulse or heart rate, take for 1 minute: _____
 Date: _____ Time: _____ Blood Pressure: _____

<p>Nausea and Vomiting: Ask, "Do you feel sick to your stomach? Have you vomited?" Observation:</p> <p>0 No nausea and no vomiting 1 Mild nausea and no vomiting 2 3 4 Intermittent nausea with dry heaves 5 6 7 Constant nausea, frequent dry heaves and vomiting.</p>	<p>Tactile Disturbance: Ask, "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling under your skin?" Observation:</p> <p>0 None 1 Very mild itching, pins and needles, burning or numbness 2 Mild itching, pins and needles, burning or numbness 3 Moderate itching, pins and needles, burning or numbness 4 Moderate severe hallucinations 5 Severe hallucinations 6 Extremely severe hallucinations 7 Continuous hallucinations</p>
<p>Tremor: Arms extended and fingers spread apart. Observation:</p> <p>0 No tremor 1 Not visible but can be felt fingertip to fingertip 2 3 4 Moderate, with patient's arm extended 5 6 7 Severe, even with arms not extended</p>	<p>Auditory Disturbances: Ask, "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation:</p> <p>0 Not present 1 Very mild harshness or ability to frighten 2 Mild harshness or ability to frighten 3 Moderate harshness or ability to frighten 4 Moderately severe hallucinations 5 Severe hallucinations 6 Extremely severe hallucinations 7 Continuous hallucinations</p>
<p>Paroxysmal Sweats: Observation:</p> <p>0 No sweat visible 1 2 3 4 Beads of sweat obvious on forehead 5 6 7 Drenching sweats</p>	<p>Visual Disturbances: Ask, "Does the light appear to be too bright? Is the color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation:</p> <p>0 Not present 1 Very mild sensitivity 2 Mild sensitivity 3 Moderate sensitivity 4 Moderately severe hallucinations 5 Severe hallucinations 6 Extremely severe hallucinations 7 Continuous hallucinations</p>

**Addiction Research Foundation
Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA – Ar)**

Patient: _____	Pulse or heart rate, take for 1 minute: _____
Date: _____	Time: _____ Blood Pressure: _____

<p>Anxiety: Ask, "Do you feel nervous?" Observation:</p> <p>0 No anxiety, at ease 1 Mildly anxious 2 3 4 Moderately anxious, or guarded, so anxiety is inferred 5 6 7 Equivalent to acute panic states, as seen in severe delirium or acute schizophrenic reactions</p>	<p>Headache, Fullness in Head: Ask, "Does your head feel different? Does it feel like there is a band around your head?" Do not rate dizziness or lightheadedness. Otherwise, rate severity.</p> <p>0 Not present 1 Very mild 2 Mild 3 Moderate 4 Moderately severe 5 Severe 6 Very severe 7 Extremely severe</p>
<p>Agitation: Observation</p> <p>0 Normal activity 1 Somewhat more than normal activity 2 3 4 Moderately fidgety and restless 5 6 7 Paces back and forth during most of the interview, or constantly thrashes about</p>	<p>Orientation and Clouding of Sensorium: Ask, "What day is this? Where are you? Who am I?" Observation:</p> <p>0 Oriented and can do serial additions 1 Cannot do serial additions or is uncertain about date 2 Disoriented for date by no more than 2 calendar days 3 Disoriented for date by more than 2 calendar days 4 Disoriented for place and/or person</p>

<p>Total CIWA – Ar Score _____ (maximum possible score = 67)</p> <p>Rater's Initials _____</p>	<p>Patients scoring less than 10 do not usually need additional medication for withdrawal.</p>
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Note: The CIWA – Ar is not copyrighted and may be used freely. Source: Sullivan JT, Sykora K, Schneiderman J, Naranjo CA & Sellers EM (1989) Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA – Ar) *British Journal of Addiction* 84:1353 – 1357



Chapter: Behavioral Health Community Services

Subject: Payment by Individuals for Community Behavioral Health Services: Ability to pay for Services, Sliding Fee Scale, Third Party Coverage, Collection of Fees, Refusal to Pay, Management of Accounts Receivable

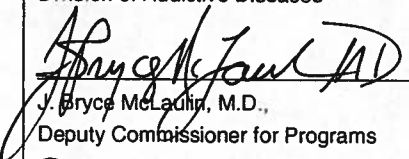
Applicability:
Community Providers of Mental Health and Addictive Diseases Services

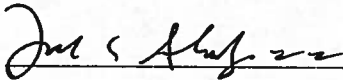
Original Effective Date: July 1, 2007
Last Reviewed Date: September 1, 2011
Last Revised Date: September 1, 2011
Full Implementation Date: October 1, 2011
Next Review Date: September 2013

Attachments:
Attachment A: Application for Financial Assistance for Community Behavioral Health Services
Attachment B: Behavioral Health Sliding Fee Scale for Community Based Services

Approved:

 8/19/11
Cassandra Price, Executive Director Date
Division of Addictive Diseases

 8/21/11
J. Bryce McLachlin, M.D., Date
Deputy Commissioner for Programs

 8/22/11
Frank E. Shelp, M.D., M.P.H., Commissioner Date

POLICY

DBHDD ensures prudent use of resources to support Community Behavioral Health Services through the following requirements:

- State funds paid to organizations are a benefit for those individuals who meet the functional, diagnostic and financial eligibility criteria established by DBHDD.
- DBHDD establishes the payment amount that those individuals who are eligible for services under DBHDD eligibility criteria are required to pay.
- DBHDD is the payor of last resort.
- Organizations must vigorously pursue payment for services from all payor sources so that public resources can be maximized to meet the needs of citizens that have been determined to be unable to pay or who can not pay the full maximum rate for services.
- Individuals who present as dangerous to themselves or others, in crisis, or at risk of inpatient care must be served regardless of ability to pay status or their payment history with the organization. State funds will cover the full rate until such time as the crisis is resolved.
- Organizations must responsibly manage their accounts receivables within the parameters of this policy.
- The Organization's response to an Individual's refusal to pay must consider Individual's ability to understand the expectations and consequences related to non-payment.
- The state's payment along with the individual's co-payment must be considered full compensation for the services provided to an eligible individual served by the organization.

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- All use of DBHDD funds to pay for services is subject to requirements specified in the Provider Manual and in contractual agreements with DBHDD.

APPLICABILITY

This policy applies to organizations under contract, letter of agreement, memorandum of understanding or service agreement with the Department to provide community based Mental Health and Addictive Diseases services. This policy governs services provided to individuals who meet DBHDD established eligibility criteria requirements for mental health and/or addictive diseases services. For any service for which DBHDD has promulgated service-specific directives regarding payment processes, this policy does not override those directives; one example of such a service is Psychiatric Residential Treatment Facilities (PRTF).

DEFINITIONS

The following definitions are used only for the purposes of this policy:

Ability to pay: An individual is determined to have an ability to pay using their adjusted income and applying that to the income levels found on the DBHDD sliding fee scale. Individuals whose adjusted income is at or below the poverty level for their family size in accordance with Health and Human Services Poverty Guidelines are determined not to have an ability to pay for services and therefore are not required to pay a fee. For individuals and families above the poverty guidelines, ability to pay is based on their adjusted income, family size and the percentage of the full charge payment as indicated on the division's sliding fee scale.

Adjusted Monthly Income: The total monthly income minus the total allowable deductions is the Adjusted Monthly Income. The allowable deductions are defined on the **Application for Financial Assistance for Community Mental Health and Addictive Diseases Services (Attachment A)** form that must be used to identify the percentage of the rate to charge an individual who has been determined to have an ability to pay for services.

Crisis: An individual is determined to be in crisis when:

- a. The individual is experiencing a behavioral or psychiatric crisis which could potentially endanger the safety of either the individual or others; or
- b. The individual is experiencing hallucinations, delusions, disorientation, generalized confusion or unusual or dangerous behaviors, or
- c. The individual is experiencing a substance withdrawal crisis.

Department: The Department of Behavioral Health and Developmental Disabilities (DBHDD)

DBHDD Funds: Funds which flow to organizations under contract, letter of agreement, memorandum of understanding or service agreement with the Department to provide community based Mental Health and Addictive Diseases services.

Eligible Individual: An individual who meets the published eligibility for DBHDD funded or authorized services. For mental health and addictive diseases services this is currently the Core Customer. A person who is mandated to services or who is under court/correctional supervision is

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evaluated in the same manner as all others and their ability to pay is determined in keeping with this policy.

Family: A family is an inter-reliant unit of people. For the purposes of determining the number of family members living in a family unit to establish ability to pay, one uses the same logic applied in determining a dependent when completing a federal tax return. If a person is determined to need the financial support of the inter-reliant unit to live and could meet the test to be claimed as a dependent on someone’s tax return, then they are a part of that person’s family and should be included when determining the family size. Adult children living at home but not claimed as a dependent on the family’s tax return must be considered a family of one.

Individual: For the purposes of this policy, the term “individual” is utilized to refer to persons served by DBHDD-funded services; it replaces the previous terms “consumer” and “client”.

Maximum Charge/Fee: The highest amount an organization may charge for a service provided to an individual.

Organization: Any legally recognized entity that has a contract, a letter of agreement, a memorandum of understanding, a provider agreement or that is approved by DBHDD for the provision of community based mental health or addictive diseases services. This includes DBHDD hospitals who serve as the administrators of state operated community services.

Poverty: The poverty income level is determined using Health and Human Services Poverty Guidelines for the 48 Contiguous States and the District of Columbia.

Provider: For the purposes of this policy, the term 'Provider' means organizations or persons approved to serve individuals with mental illness and/or addictive diseases, wherein those services are financially supported in whole or in part by funds authorized through DBHDD.

Service Rates: The rates that organizations may charge for the covered services that are provided. These rates are contained in the DBHDD Provider Manual.

Sliding Fee Scale: A scale set by DBHDD for use statewide that determines the percentage of the full charge for a service that an individual will be charged based on their adjusted income and family size.

Third Party Coverage: Any health insurance, Medicaid benefit, or Medicare benefits that can be used to pay for services.

PROCEDURES

A. THIRD PARTY COVERAGE

Providers are required to obtain and document verification with the third party payor the following information:

- Coverage
- Benefits
- Authorization for covered services

DBHDD funds may not be used in place of eligible third party payments including Medicaid,

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Medicare and other private health insurance plans; this includes co-payments, co-insurance, and/or deductibles.

Where applicable, services must be delivered in accordance with the third party payor's policies. The organization will bill the individual's third party coverage and the individual for services in accordance with that health plan's protocol for beneficiary billing.

If the individual has third party insurance coverage that includes BH services, the provider is not enrolled in that insurance company's panel, the provider has the following options:

- The provider can enroll in the panel.
- The provider can refer the family to someone who is on the panel. OR
- The individual can pay full fee for services.

If the third party insurance authorizes a service but requires credentialed staff that provider does not utilize to provide the approved service, then DBHDD funds may not be used in lieu of utilizing third party insurance. The provider has the following options:

- The individual can pay full fee for services
- The provider can offer a credentialed practitioner to meet the third party insurance requirement. OR
- The individual may be referred to a credentialed practitioner outside their organization.

Providers are expected to negotiate with private health insurance plans when benefits exclude or limit recommended services. For certain "DBHDD bundled services", this negotiation may result in unbundling of "DBHDD bundled services" and billing the third party payor for the services authorized by the third party payor. In this circumstance, the provider may not use DBHDD funding for components of "DBHDD bundled services" for which the third party has refused to pay.

When an individual has a third party payor, an Explanation of Benefits (EOB) and necessary documentation are required for all services being provided and may be audited by DBHDD. In addition, documentation of any negotiation that has taken place with the third party payor is maintained.

When the third party payor covers a particular authorized service, but coverage limits have been exceeded, DBHDD funding may be used for the service not covered by the third party payor.

The Mental Health Parity and Addiction Equity Act (2008) sets forth the requirements for insurance to cover behavioral health services. However, if an individual's insurance does not include behavioral health services, then they may qualify for DBHDD funded services.

B. ABILITY TO PAY FOR SERVICES

The individual's income determines the amount of assistance received from DBHDD funds.

The **Application for Financial Assistance for Community Mental Health and Addictive Diseases Form (Attachment A)** must be used to gather information about the individual's income, taking into account financial obligations in order to determine adjusted monthly income.

The organization must attempt to verify the information contained on the application including but not limited to asking for tax returns, pay check stubs, verification of benefits from DFCS. The information gathered is used to determine the individual's adjusted monthly income. The adjusted

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monthly income is used to determine a person's ability to pay.

No fee is assessed to a person who has been determined to not have the ability to pay for services. If an individual has been determined to not have the ability to pay for service, their services are covered fully by DBHDD funds. The following criteria define such situations:

- a. When an Individual whose adjusted income is at or below the poverty level for their family size in accordance with Health and Human Services Poverty Guidelines.
- b. When an individual is in crisis. A determination of their ability to pay should be made after the crisis has been addressed. After resolution of the crisis, the policy provisions apply.

At admission and as financial circumstances in the individual's life change but at least annually, the organization must complete or update the **Application for Financial Assistance**.

If an individual fails to provide information concerning their financial status or third party payors within 60 days of the initiation of services or the expected review date, then, the individual may be charged the full charge using the rates established by DBHDD until they provide the required information. This decision to charge full fee is subject to an automatic administrative and clinical review as defined by this policy.

If the individual's ability to produce the required documentation is impaired by his/her mental illness/substance abuse, then the organization extends this 60 day time period until such time as the individual can be assisted in producing this information.

Financial verification information may be obtained from an independent source such as the Department of Labor.

C. SLIDING FEE SCALE

Organizations must use the **Behavioral Health Sliding Fee Scale for Community Based Services (Attachment B)** to determine the individual's charge for services.

The individual's required fee is based on their adjusted monthly income applied to the sliding fee scale. The adjusted monthly income from the application is applied to the appropriate scale according to family size (see definition of family).

Individuals who are charged a reduced charge based on the sliding fee scale may not be billed by the organization for the difference in cost for the service provided.

Providers may accept full payment from an individual who does not qualify for a reduced fee.

D. COLLECTION OF FEES FOR THOSE DETERMINED TO HAVE A REDUCED FEE

Organizations must make every effort to assure that individuals being served, or the legally responsible person(s), are aware of and understand the following:

- a. their responsibility to pay for services
- b. the amount the person is expected to pay
- c. their right to request an adjustment
- d. expectations of the organization regarding payment for services

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- e. their right to request a review of actions taken by the organization with regard to their payment
- f. the impact of payment or lack of payment upon their right to continue in service

E. REFUSAL TO PAY

A person is determined to refuse to pay for services when:

- a. It has been determined that they have the ability to pay part or all of the charge for services based on adjusted income applied to the sliding fee scale; **and**,
- b. they have the mental and emotional acuity to understand payment is expected and to understand the consequences of not paying but refuse to pay any outstanding debt; **and**,
- c. Payment is more than 90 days delinquent.

If an individual is determined to have the ability to pay, has the capacity to understand what it means to refuse to pay for services and refuses to pay, an administrative and clinical review of the circumstances must be conducted by the organization prior to denial of any services.

The **administrative review** includes consulting with the Individual about any change in financial status including loss of employment, changes in income, family crisis, the birth of a new child and so forth and, if appropriate, a re-determination of the Individual's ability to pay is conducted. The Individual must be given the opportunity to pay any new amount before any action may be initiated by the organization. The administrative review must be concluded within 30 calendar days of the Individual's refusal to pay.

If no resolution is reached from the administrative review, a **clinical review** must be conducted by a certified/licensed practitioner designated by the organization, in conjunction with the organization's staff who has the direct therapeutic relationship with the individual. The purpose of the clinical review is to determine mental and diagnostic status or other factors that might contribute to non-payment and to determine whether the individual is in crisis or at risk of inpatient care and/or dangerous to self or others. The individual must be notified of the review and if he/she chooses to participate, it must be scheduled to accommodate their particular situation (i.e., a convenient time, access to transportation, and so forth).

Individuals who present as dangerous to themselves or others, in crisis, or at risk of inpatient care must be served regardless of ability to pay status or their payment history with the organization. State funds will cover the full rate until such time as the crisis is resolved.

If the clinical review finds that the individual is dangerous to self or others, is in crisis or requires inpatient level of care, or if discontinuing services will result in crisis or inpatient care, then services must continue regardless of willingness to pay.

If the clinical review finds that the individual is not dangerous to self or others, not in crisis or not requiring inpatient level of care, every effort must be made to develop a payment schedule that is agreeable to all parties and will result in the individual staying active in service. If the individual remains unwilling to pay, he/she may be denied services

If services are denied due to the findings of the administrative and clinical reviews required by this policy, the following steps must occur within five (5) days after the reviews are concluded:

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- a. Notification of termination of service(s), as well as dates of the administrative and clinical reviews, and the reason(s) for the action must be communicated through face-to-face contact with the Individual and confirmed by mail with a certified return receipt requested. If a face-to-face contact is not possible due to the individual's refusal, documentation of the attempted meeting will suffice.
- b. The written notification mailed to the individual will include the statement that the individual may receive services if he/she agrees to pay the assessed rate or provides the information needed to assess their ability to pay for services (this may include a payback schedule over time) or if the individual experiences an acute crisis.
- c. An informational copy is sent to the Regional Coordinator for the county of residence of the individual.

The decision-making process associated with the termination of services must be thoroughly documented in the individual's record, including the findings of the administrative and clinical reviews and a copy of the written notice of termination of services if applicable.

F. PROVIDER POLICIES REGARDING PAYMENT FOR SERVICES AND MANAGEMENT OF ACCOUNTS RECEIVABLES

Organizations must develop policies and procedures that conform to the requirements of this policy. These policies and practices must include a provision that requires a posted notice informing all individuals that assistance will be provided to anyone who needs it in the completion of financial assistance applications and in the securing of any required verification. The notice must include a phone number and the name of a person or office within the provider organization where this assistance can be obtained. Staff are designated and trained to provide assistance. The review process addresses a process for individuals to use when they believe they have been assigned a payment amount that exceeds their ability to pay or a review of the collection of debt for services delivered.

The policy and procedures must establish the organization's processes in the following areas:

- a. **Verification:** The collection and verification of information contained in the application for financial assistance.
- b. **Individual Notification of Fee:** The notification process used to inform the individual of their responsibility for payment for services, the amount or percentage they will be expected to pay and the rates for services
- c. **Collection:** Services may not be denied due to lack of payment at the time of the appointment. The organization may take action in accordance with policy when payments are more than 90 days delinquent. In such circumstances, the individual will be reminded of the organization's policy.
- d. **Accounts Receivables:** Agencies may use a variety of approaches to collect outstanding Individual fees including mailing of bills and the use of collection agencies. Accounts on which no payment has been made in over 90 days should be considered delinquent and the policy developed by the organization must identify the steps to be taken to pursue payment and/or to write off the debt.
- e. **Review:** Any individual or designated representative may request an Administrative and Clinical Review of the following:
 - i. determination of the individual's ability to pay;
 - ii. the percentage of fee charged;
 - iii. refusal by the organization of admissions to or the discharge from services due to the individual's ability to pay; or

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- iv. collection of outstanding payments.

The organization's policy must clearly identify the process to be used and the organization must assure its staff and individuals are knowledgeable of the process.

The organization's process must include the following:

- i. The request for review must be communicated to the organization preferably in writing but a verbal request is acceptable.
- ii. The request for review must identify the decision being reviewed, the facts in support of the review and the relief sought.
- iii. The organization will have 30 calendar days to respond to the request for review.
- iv. The organization must review the request according to its policy.
- v. The review must be evaluated from a clinical and an administrative perspective.
- vi. The individual must be notified in writing within five (5) days of the review, with an informational copy sent to the Regional Coordinator for the county of residence of the individual.

LEGAL REFERENCES

Official Code of Georgia Annotated 37-2-4; Official Code of Georgia Annotated 37-2-11 (c)

Application for Financial Assistance for Community Behavioral Health Services

Today's Date: _____

If you need help in completing this form or if you have questions about this form a staff member will be happy to assist you.

Payment for services is expected. If you do not have health insurance, you can complete this form in order to determine if you qualify for state financial assistance in paying for your services. In order to qualify for this assistance, you will also need to provide proof of income such as copies of recent pay stubs or your most recent tax return.

In order for us to bill your health insurance company, Medicaid or Medicare, you will need to provide proof of your insurance, including the group number and policy number. You will be responsible for any co-payments or deductibles required by your insurance policy.

This application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief. Failure to provide accurate information may result in you being charged the full charge or in the denial of services.

Name: _____ CID # _____
Last First Middle Initial
(to be completed by the Provider Organization)

Address: _____

City, State & ZIP: _____

Phone Number: Home: (____) _____ Work: (____) _____

Social Security Number: _____ - _____ - _____

Method of Payment:

1. Self Pay 2. Medicaid #: _____ 3. Medicare #: _____

4. Insurance Company: _____

Group Number: _____ Policy Number: _____

Is pre-certification required? Yes No Verification of coverage complete? Yes No

5. Co-Insurance Company: _____

Group Number: _____ Policy Number: _____

Is pre-certification required? Yes No Verification of coverage complete? Yes No

6. Currently in Jail? Yes No County/City: _____

7. Employed Employer: _____ Unemployed Retired

TANF SSI Social Security

8. If unemployed, date of last employment: ___/___/___ Previous Place of employment: _____

_____ Did you have insurance coverage? Yes No If Yes, Name of the

Insurance Company: _____

Group Number: _____ Policy Number: _____

Income: (Combined Family/Guardian)

1. Are you claimed as a dependent on someone’s Federal or State income tax? Yes No
 If yes, what is the relationship? Parent Other Relative Legal Guardian Other
 If yes to above, the following questions apply to the household income. If the answer to the above is no, then report only the income of those individuals reported on your last tax return.

	Initial	Update	Update	Update
Dates of Application Reviews	Date:	Date:	Date:	Date:
	Amount	Amount	Amount	Amount
Monthly Income from Wages				
Individual Gross Wages	\$	\$	\$	\$
Spouse Gross Wages	\$	\$	\$	\$
(18 years of age or younger or as a dependent on income tax) Legal Guardian 1 Gross Wages	\$	\$	\$	\$
Legal Guardian 2 Gross Wages	\$	\$	\$	\$
Monthly Income from Other Sources				
SSI	\$	\$	\$	\$
TANF	\$	\$	\$	\$
V.A.	\$	\$	\$	\$
Child Support	\$	\$	\$	\$
Alimony	\$	\$	\$	\$

Social Security	\$	\$	\$	\$
Retirement/Pension payments	\$	\$	\$	\$
Trust Fund payments	\$	\$	\$	\$
Other regularly scheduled payments	\$	\$	\$	\$
Total Monthly Income	\$	\$	\$	\$
Allowable Monthly Deductions				
It may not be necessary to fill out the following section. You are welcome to discuss this with a staff member at this point.				
Child Support	\$	\$	\$	\$
Alimony	\$	\$	\$	\$
Monthly Child Care Payments necessary to work	\$	\$	\$	\$
Monthly non-court ordered Child Support Payments	\$	\$	\$	\$
Monthly Medical Expenses in excess of 5% of gross income	\$	\$	\$	\$
Total Allowable Deductions	\$	\$	\$	\$
Adjusted Monthly Income (Total Monthly Income Minus Total Allowable Deductions)	\$	\$	\$	\$
Number of Family Members (Including Self)				

Based on this information and the attached fee scale, the determined charge(s) for my services are listed below:

Service	Individual Fee Amount Per Established Period

- I affirm that the statements above are true and accurately reflect my current financial circumstances.
- I understand that I am responsible for payment for services provided to my dependents or myself.
- I understand that the organization may ask me for additional information to assist in making a final determination of my ability to pay.
- I further understand that the organization may verify the information provided and give my consent for the verification by signing this application.
- I understand that my financial status will be reviewed annually or as circumstances change.
- I also understand that I have the option to review the decision by following the review process.

Signature of Individual or Representative
 (If a minor, parent/guardian’s signature)

Date

Behavioral Health Sliding Fee Scale for Community-Based Services

Individuals whose adjusted income is at or below the poverty level for their family size in accordance with Health and Human Services Poverty Guidelines are determined not to have an ability to pay for services and therefore are not required to pay a fee.

Fee Scale

Adjusted Monthly Income			Family Size											
			1	2	3	4	5	6	7	8	9 Plus			
Low	to	High	Percentage of Rate to be Charged to the Consumer for Services Received											
\$0	to	\$866												
\$867	to	\$1,167												
\$1,168	to	\$1,468												
\$1,469	to	\$1,769	5%											
\$1,770	to	\$2,069	10%	5%										
\$2,070	to	\$2,370	20%	10%	5%									
\$2,371	to	\$2,565	30%	20%	10%	5%								
\$2,566	to	\$2,971	40%	30%	20%	10%	5%							
\$2,972	to	\$3,120	50%	40%	30%	20%	10%	5%						
\$3,121	to	\$3,276	60%	50%	40%	30%	20%	10%	5%					
\$3,277	to	\$3,440	70%	60%	50%	40%	30%	20%	10%	5%				
\$3,441	to	\$3,646	80%	70%	60%	50%	40%	30%	20%	10%	5%			
\$3,647	to	\$3,865	90%	80%	70%	60%	50%	40%	30%	20%	10%	5%		
\$3,866	to	\$4,057	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	5%	
\$4,058	to	\$4,343	100%	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	5%
\$4,344	to	\$4,519	100%	100%	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%
\$4,520	to	\$4,834	100%	100%	100%	100%	90%	80%	70%	60%	50%	40%	30%	20%
\$4,835	to	\$5,076	100%	100%	100%	100%	100%	90%	80%	70%	60%	50%	40%	30%
\$5,077	to	\$5,280	100%	100%	100%	100%	100%	100%	90%	80%	70%	60%	50%	40%
\$5,281	to	\$5,543	100%	100%	100%	100%	100%	100%	100%	90%	80%	70%	60%	50%
\$5,544	to	\$5,766	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	80%	70%
\$5,767	to	\$6,164	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	80%
\$6,165	and	higher	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%



Chapter: Developmental Disabilities Community Services
Subject: Planning Lists for Developmental Disabilities Services for Individuals Living in the Community

Applicability:

- Regional offices including Intake & Evaluation Units
- Community Providers & Support Coordination
- State Office

Original Effective Date: January 1, 2007
Revision #2 Effective Date: June 1, 2011
Scheduled Review Date: June 1, 2013
Approved:
Beverly D. Rollins 5/23/11

References:
Official Code of Georgia Annotated 37-2-4.1

Beverly D. Rollins, M.P.A., Executive Director Date
Division of Developmental Disabilities

Attachments:
Attachment A – Level of Need Update

J. Bryce McLaurin MD 5/24/11
J. Bryce McLaurin, M.D., Date
Assistant Commissioner of Programs
Frank E. Shelp 5/24/11
Frank E. Shelp, M.D., M.P.H., Commissioner Date

PLANNING LISTS FOR DEVELOPMENTAL DISABILITIES SERVICES FOR INDIVIDUALS LIVING IN THE COMMUNITY

POLICY

DBHDD maintains and regularly updates lists of individuals with developmental disabilities (DD) who live in the community, have undergone a preliminary screening and found to be eligible for and in need of community DD services due to a lack of available resources. The names of these individuals, their contact information, and information about their service needs are included in a Developmental Disabilities Community Planning List.

PROCEDURE FOR INDIVIDUALS TO BE PLACED ON THE DD COMMUNITY PLANNING LISTS

Persons requesting mental retardation/developmental disability (MR/DD) services complete an application for MR/DD services and submit the application to the Intake and Evaluation (I&E) Team. A face-to-face screening is completed within 14 business days of receipt of the application. The purpose of the initial screening is to determine service need and preliminary eligibility (screening provides presumed eligibility or ineligibility for waiver and non-waiver services; a comprehensive evaluation is intended to confirm eligibility status) of the individual for MR/DD services. The screener completes **Attachment A – Level of Need Update** which documents the individual and family circumstances related to the need for services, the services actually needed and

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the timeframe in which the services are needed. Additional details about the application process are contained in ***A Guide to Services for Persons with MR/DD*** which is provided at the face-to-face screening and is also available on the DBHDD website. Written notification of the determination of this initial screening is provided to the applicant by the I&E Manager.

- When the applicant is found to be eligible for and in need of services, and the needed services are available, he/she (or his/her family as appropriate) is provided with information regarding the comprehensive assessment process as well as the provider and support coordinator selection processes.
- When an applicant is found eligible for and in need of services, but the needed services are not currently available, he/she is placed on one of two Regional Planning Lists – the Long Term Planning List or the Short Term Planning List – based on the person’s identified needs at the time of the intake.
- An individual remains on the Planning List as long as he/she has unaddressed service needs.

DD Community Planning List Data

The Intake and Evaluation Team enters the following data regarding new Planning List Individuals into the Developmental Disabilities Web-Based Data Management System.

- Individual’s name, address, date of birth, Social Security #, CID#, county and region
- The name and contact information of the person’s legal representative (if applicable)
- Next of kin with contact information
- Date person is placed on the planning list
- Name of Regional Office Planning List Administrator if person is placed on the short term planning list.
- Services needed
- Services individual is currently receiving (and date services began)
- Information regarding reason and level of service need
- If short term planning list level of need which determines frequency of contacts

Regional Planning List Administrator Supervisor compiles monthly reports on number of contacts made and submits these reports to the Division of DD.

Management of the DD Community Planning Lists

The Regional Office Intake & Evaluation Team (Regional I&E Manager) is responsible for creation and management of the DD Community Planning Lists for their region.

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Addressing Immediate Individual’s Needs

Unfortunately, situations arise where an individual’s need for services becomes so severe and urgent that action must be taken immediately to address significant risks to health and safety. In such circumstances, it is not an option for an individual with MR/DD to wait indefinitely for additional resources. When the Regional Office learns of an individual’s circumstances for which an immediate system response is required, the I &E Manager and Planning List Supervisor coordinate the response. If it is determined that additional, immediate resources are required and that such resources are not available in the region, the Regional I&E Manager, Regional Coordinator or Regional Services Administrator contacts the Executive Director or Chief Financial Officer of the Division of Developmental Disabilities to request assistance.

Short Term Planning List

All individuals on the Short Term Planning List are assigned a Planning List Administrator (PLA). The PLA contacts the individual and members of his/her support network at least quarterly (more frequently if necessary). Individuals are contacted at a frequency based on their Level of Need. The PLA advises the individual and support network members of any identified alternative service options and any anticipated changes in the needs of an individual. The PLA identifies changes in the needs of an individual, and the PLA documents these changes. The form is reviewed by the PLA and forwarded to the Regional I&E Manager. The Regional I&E Manager meets with the PLA and the PLA Supervisor to discuss any significant changes in an individual’s needs as well as appropriate responses. In the event that the change in needs results in a critical or urgent need for additional services, the Regional I&E Manager is informed immediately.

Long Term Planning List

Individuals on the Long Term Planning List are not assigned a PLA. An individual and/or his or her family are contacted by mail at least annually by the Regional I&E Team. A letter is sent to verify contact information and encourage individuals and/or their family to inform the Regional I&E Team if their need for services change. The Regional I&E Team contacts the individual and/or their family on an annual basis to determine the level of need. The purpose of this contact is to confirm the continued need for services and to document any changes in the individuals/family circumstances. If contact with the individual and/or his or her family results in changes that may necessitate a change in Planning List status, a Regional I&E Team member follows up with telephone contact. If no changes are noted, information regarding the contact with the individual/family is kept on file by the Regional I&E Team.

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Prioritization for Available Services

The Regional I&E Manager uses data from the intake process, along with the input of other Regional I&E staff and PLA staff, to make decisions regarding the allocation of resources as resources become available.

Recommendations on prioritization for new resources are made in accordance with the following guidelines:

1. Individuals having **Immediate Needs** as documented on **Attachment A - Level of Need Update Form**.
2. Individuals documented to have **Level 1 Short Term Need** are the second level of priority.
3. Individuals documented to have **Level 2 Short Term Need** are the third priority, and
4. Individuals documented to have **Level 3 Short Term Need** are the fourth priority.

When an individual is prioritized ahead of other individuals as specified in the above hierarchy, the Regional I&E Manager documents the rationale for the decisions and maintains such documentation on file.

Services Targeted at Preventing a Crisis or a Need for More Intensive Services

Additional services become available to Regions through attrition, implementation of utilization management strategies or through new state appropriations. In the case of new state appropriations, the region receives an increase in its total waiver allocation with an expected number of new consumers that are to be served. Appropriately, the most intensive services are usually approved for those individuals with the most intensive and urgent needs. However, to the extent possible, the Regional I&E Manager utilize the input of I&E staff, Regional Office and the PLA when considering the needs of all individuals on the two Planning Lists. When possible, a more proactive approach to allocating a less intensive (and less expensive) service such as a day/employment or family support type service in the short-term may result in avoiding or delaying an individual and family crisis. Thus, by allocating some less intensive services, the demand for intense, more expensive services may be reduced in the future. Of course, such decisions are made in light of the total resources available and the needs of all individuals on the Planning Lists.

Georgia Department of Behavioral Health and Developmental Disabilities

Level of Need Update

Date of Update: / /

I. Personal Information (Update Address/Phone as needed)

<i>Name:</i>			
	<i>* First</i>	<i>* Middle</i>	<i>* Last</i>
<i>Address:</i>			
	<i>* Street/Apartment number (if applicable)</i>	<i>* City</i>	
			() -
	<i>* County</i>	<i>* State</i>	<i>* Zip code</i> <i>* Telephone:</i>
<i>* Race:</i>			
Select One...			
<i>* Birth date:</i>	/ /	<i>* SSN#:</i>	- - <i>* Medicaid #:</i>
<i>CID#:</i>		<i>* Primary Diagnosis:</i>	Select One...
<i>Supporting Documentation Included:</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Secondary Diagnosis:</i>	

<i>* Primary Contact for Correspondence:</i>		<i>* Relationship to Individual</i>	
<i>* Address:</i>		<i>* Telephone:</i>	() -
<i>Next of Kin:</i>		<i>Relationship to Individual</i>	
<i>Address:</i>		<i>Telephone #:</i>	() -

II. Present Planning List Status:

<i>Findings</i>	<i>Due to:</i>
<input type="checkbox"/> Immediate Need	
<input type="checkbox"/> Short Term List – Level 1	
<input type="checkbox"/> Short Term List – Level 2	
<input type="checkbox"/> Short Term List – Level 3	
<input type="checkbox"/> Long Term List	

Georgia Department of Behavioral Health and Developmental Disabilities Level of Need Update

Services Needed – Short Term					
<input type="checkbox"/> Community Residential (CRA)	<input type="checkbox"/> Community Living Supports RN (CLS-RN)	<input type="checkbox"/> Community Access Group	<input type="checkbox"/> Supported Employment Group (SEG)		
<input type="checkbox"/> Community Living Supports (CLS)	<input type="checkbox"/> Community Living Supports LPN (CLS-LPN)	<input type="checkbox"/> Community Access Individual	<input type="checkbox"/> Supported Employment Individual (SEI)	<input type="checkbox"/> Respite	
<input type="checkbox"/> Specialized Medical Supplies (SMS)	<input type="checkbox"/> Environmental Accessibility	<input type="checkbox"/> Adult Speech Therapy	<input type="checkbox"/> Community Guide	<input type="checkbox"/> Individual Directed Goods and Services	<input type="checkbox"/> Transportation
<input type="checkbox"/> Specialized Medical Equipment (SME)	<input type="checkbox"/> Adult Occupational Therapy	<input type="checkbox"/> Adult Physical Therapy	<input type="checkbox"/> Behavior Support Consultation	<input type="checkbox"/> Natural Support Training (NST)	<input type="checkbox"/> Vehicle Adaptation

Services Needed – Long Term					
<input type="checkbox"/> Community Residential (CRA)	<input type="checkbox"/> Community Living Supports RN (CLS-RN)	<input type="checkbox"/> Community Access Group	<input type="checkbox"/> Supported Employment Group (SEG)		
<input type="checkbox"/> Community Living Supports (CLS)	<input type="checkbox"/> Community Living Supports LPN (CLS-LPN)	<input type="checkbox"/> Community Access Individual	<input type="checkbox"/> Supported Employment Individual (SEI)	<input type="checkbox"/> Respite	
<input type="checkbox"/> Specialized Medical Supplies (SMS)	<input type="checkbox"/> Environmental Accessibility	<input type="checkbox"/> Adult Speech Therapy	<input type="checkbox"/> Community Guide	<input type="checkbox"/> Individual Directed Goods and Services	<input type="checkbox"/> Transportation
<input type="checkbox"/> Specialized Medical Equipment (SME)	<input type="checkbox"/> Adult Occupational Therapy	<input type="checkbox"/> Adult Physical Therapy	<input type="checkbox"/> Behavior Support Consultation	<input type="checkbox"/> Natural Support Training (NST)	<input type="checkbox"/> Vehicle Adaptation

Georgia Department of Behavioral Health and Developmental Disabilities
Level of Need Update

III. Reason For Updated Level of Need

Comments	
<p><i>Document changes in support needs/living situation/health/etc. as well as services being considered, that contributed to the request for services at this time (include current daily activities):</i></p>	

Georgia Department of Behavioral Health and Developmental Disabilities

Level of Need Update

DOCUMENTATION OF NEED FOR SERVICES

Immediate Need (person needs service immediately)

- Death of a caregiver with no other supports (i.e., other family) available.
- Caregiver incapacitated with no other supports (i.e., other family) available (due to physical or psychological reasons)
- Caregiver unable or unwilling to continue providing care (Person dropped off; caregiver not found).
- Current Placement poses an immediate danger to health and/or safety of the individual or others.
- Other family crisis with no caregiver support available.
Specify: _____

Short Term Need (person needs services within 6 months): Y/N

Level 1 Short Term Need (1-4)

- 1. There has been a death or other family crisis in the family, significantly jeopardizing the capacity of the caregiver to provide care.
- 2. Caregiver is ill and will soon be unable to continue providing care.
- 3. Person has behavioral issues posing potential serious bodily harm to self or other or behavior is likely to come to the attention of law enforcement.
- 4. Individual's health or behavioral needs have increased and needs cannot be met by current caregivers without jeopardy to health or safety.

Level 2 Short Term Need (5 – 10)

- 5. Caregiver is ill and will soon be unable to continue to provide care.
- 6. Person has a caregiver(s) who would be unable to work if services are not provided.
- 7. Person is scheduled to leave jail, prison, DJJ, or DBHDD Forensic Services in the next 6 months and does not have an adequate natural support system.
- 8. Caregiver has diminished capacity to meet needs.
- 9. Behavioral issues are moderate to severe but do not currently pose a danger to self or others.
- 10. Person is "aging out" of DFCS residential placement within 6 months and does not have an adequate support system.

Georgia Department of Behavioral Health and Developmental Disabilities Level of Need Update

Level 3 Short Term Need (11 - 14)

- 11. Inappropriate placement, awaiting proper placement (can manage for a short tem)
- 12. Person has an aging caregiver (age 60+) who will soon not be able to continue to providing care.
- 13. Person has exited special education or will exit within next 6 months and needs day/employment services.
- 14. Circumstances or person or caregiver demonstrate clear need for alternative living arrangements with 6 months. Specify:

IV. Change/Add Planning List Status and Service Needs

<i>Short Term Level of Need</i>	
<input type="checkbox"/> Immediate Need	
<input type="checkbox"/> Short Term List – Level 1	
<input type="checkbox"/> Short Term List – Level 2	
<input type="checkbox"/> Short Term List – Level 3	

<i>Services Needs Added – Long Term</i>					
<input type="checkbox"/> Community Residential (CRA)	<input type="checkbox"/> Community Living Supports RN (CLS-RN)	<input type="checkbox"/> Community Access Group		<input type="checkbox"/> Supported Employment Group (SEG)	
<input type="checkbox"/> Community Living Supports (CLS)	<input type="checkbox"/> Community Living Supports LPN (CLS-LPN)	<input type="checkbox"/> Community Access Individual	<input type="checkbox"/> Supported Employment Individual (SEI)	<input type="checkbox"/> Respite	
<input type="checkbox"/> Specialized Medical Supplies (SMS)	<input type="checkbox"/> Environmental Accessibility	<input type="checkbox"/> Adult Speech Therapy	<input type="checkbox"/> Community Guide	<input type="checkbox"/> Individual Directed Goods and Services	<input type="checkbox"/> Transportation
<input type="checkbox"/> Specialized Medical Equipment (SME)	<input type="checkbox"/> Adult Occupational Therapy	<input type="checkbox"/> Adult Physical Therapy	<input type="checkbox"/> Behavior Support Consultation	<input type="checkbox"/> Natural Support Training (NST)	<input type="checkbox"/> Vehicle Adaptation

Georgia Department of Behavioral Health and Developmental Disabilities Level of Need Update

Services Needs Added – Short Term					
<input type="checkbox"/> Community Residential (CRA)	<input type="checkbox"/> Community Living Supports RN (CLS-RN)	<input type="checkbox"/> Community Access Group	<input type="checkbox"/> Supported Employment Group (SEG)		
<input type="checkbox"/> Community Living Supports (CLS)	<input type="checkbox"/> Community Living Supports LPN (CLS-LPN)	<input type="checkbox"/> Community Access Individual	<input type="checkbox"/> Supported Employment Individual (SEI)	<input type="checkbox"/> Respite	
<input type="checkbox"/> Specialized Medical Supplies (SMS)	<input type="checkbox"/> Environmental Accessibility	<input type="checkbox"/> Adult Speech Therapy	<input type="checkbox"/> Community Guide	<input type="checkbox"/> Individual Directed Goods and Services	<input type="checkbox"/> Transportation
<input type="checkbox"/> Specialized Medical Equipment (SME)	<input type="checkbox"/> Adult Occupational Therapy	<input type="checkbox"/> Adult Physical Therapy	<input type="checkbox"/> Behavior Support Consultation	<input type="checkbox"/> Natural Support Training (NST)	<input type="checkbox"/> Vehicle Adaptation

Staff Completing the Form (Include Name, Credentials, Position, Title)	Date

V. Regional Office Review:

Notes:	
Updated STPL: (Date)	Entered into CIS (Date)
Updated LTPL: (Date)	
Supervisor (Include Name, Credentials, Position, Title)	Date



Chapter: Developmental Disabilities Community Services
Subject: Prevention of Choking for Individuals with Developmental Disabilities Living in the Community

Applicability: All Developmental Disability Community Service Providers

Effective Date: July 1, 2010

Scheduled Review Date: July 2011

References:

none

Approved:

Handwritten signature of Beverly D. Rollins

Beverly D. Rollins, M.P.A., Executive Director Division of Developmental Disabilities

Attachments:

- Attachment A: Definitions regarding food size
Attachment B: Guidelines for possible modified diet choices
Attachment C: Risk Factors for Choking, Aspiration, Aspiration Pneumonia, and those with Dysphagia
Attachment D: Preventative/Safety Measures for Choking, Aspiration, Aspiration Pneumonia, and those with Dysphagia
Attachment E: Signs/Symptoms of Dysphagia, Choking, Aspiration, and Aspiration Pneumonia
Attachment F: Things to Include in an Individual's Plan for Mealtimes

Handwritten date: 6/23/10

Date

Handwritten signature of Frank E. Shelp

Frank E. Shelp, M.D., M.P.H., Commissioner

Handwritten date: 6/28/10

Date

Prevention of Choking for Individuals with Developmental Disabilities Living in the Community

POLICY

The Department of Behavioral Health and Developmental Disabilities (DBHDD) expects providers of developmental disability (DD) services to ensure that persons with developmental disabilities do not become choking victims by:

- Assessing risk
Putting actions in place based on assessment

DEFINITIONS

- Aspiration - The entry of secretions or foreign material into the trachea and lungs.
Aspiration Pneumonia - The entry of secretions or foreign material into the trachea and lungs which produces an inflammation of the lungs
Choking - An obstructed airway, usually by a foreign object
Dysphagia - Difficulty swallowing
Pica - eating one or more nonnutritive substances on a persistent basis for a period of at least one month.
Provider - For the purposes of this policy, the term provider includes organizations that provide developmental disabilities residential services that are financially

DBHDD	SUBJECT: Prevention of Choking for Individuals with Developmental Disabilities Living in the Community	Policy: 02-801
		Page 2 of 3

supported in whole or in part by funds authorized through DBHDD. In this policy, the word organization is also used to refer to a provider.

PROCEDURES

All providers ensure compliance with the DBHDD Provider Manual Community Service Standards, including all standards specific to personal safety:

- Train staff regarding specialized diets.
- Individualize diets.
- Fine chop all foods, as needed, before the person gets to the table.
- Protocol for an unconscious choking victim.
- Thoroughly discuss history of choking and risky mealtime behaviors of eating rapidly and food stuffing in the Individual Service Plan (ISP), behavior plan, and nursing care plan.
- Ensure all staff working with an individual have access to information about that person's dietary needs readily available in the living and working area.

DD Providers immediately review each individual's Health Risk Screening Tool (HRST) when it is completed or updated, in order to ensure that the following information is included in the Individualized Service Plan (ISP) and is readily available to all staff working with these individuals:

- Discussion and documentation by the appropriate medical staff, for example: dietitian, primary care physician, etc. for conditions that cause the individual to be at risk of choking.
- Definition of the type of diet prescribed with portion size and the size of pieces specified, for example: chopped diet = mechanically cut (meat chopped into pieces no larger than ¼"; fruit & vegetables chopped into fruit cocktail-size pieces, etc.). See attached charts for reference.
- The appropriate techniques to use to assist an individual who is at risk from choking during mealtimes and when eating snacks.
- Documentation of the following: the training needed, the staff responsible for conducting the training, the due dates for initial and follow up training, and the frequency of the training.

Provider agencies are advised to consider extraordinary precaution and possible exclusion of the following foods if warranted for the safety of some individuals. This consideration should be given specifically for sausages and hotdogs that are of questionable nutritional value and may be particularly dangerous.

EXAMPLES OF CHOKABLE FOODS, not inclusive:

- sausage, hot dog (whole chunks)
- cherries with pits
- meat (whole chunks)

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- hard candy
- nuts
- popcorn kernels
- raisins
- raw apples, pears, carrots, beans
- stringy foods
- whole olives
- whole grapes
- peanut butter

All providers:

- Develop an individualized protocol for staff to use when working with each individual who is at risk for choking, based on an individualized assessment of each individual completed by the appropriate licensed health care practitioner. This should include information regarding type of diet, preparation of food in safe location away from individual at risk of choking, definitions regarding food size and portion, who should be called if a choking incident occurs, what emergency techniques should be implemented, emergency contact numbers, etc.
- Ensure that all staff have received training and know how to access and implement the protocol.
- Ensure that the protocol and any pertinent information are readily available to all staff in the living and work area. This may include positioning information in the area where meals are prepared in inconspicuous places, for example on the inside door of a kitchen or a chart like the one attached on the refrigerator door. When making decisions about what to place in the area and where to place information, use a common sense approach.

Working together we can ensure that citizens with developmental disabilities are less likely to choke and ensure choking is preventable to the extent possible.

Attachment A – Definitions regarding food size

Attachment B – Guidelines for possible modified diet choices

Attachment C – Risk Factors for Choking, Aspiration, Aspiration Pneumonia, and those with Dysphagia

Attachment D – Preventative/Safety Measures for Choking, Aspiration, Aspiration Pneumonia, and those with Dysphagia

Attachment E – Signs/Symptoms of Dysphagia, Choking, Aspiration, and Aspiration Pneumonia

Attachment F – Things to Include in an Individual's Plan for Mealtimes

DEFINITIONS REGARDING FOOD SIZE

<p style="text-align: center;">PUREE</p> <p>MECHANICALLY BLENDED Using extra liquid. SMOOTH. NO LUMPS. Baby food consistency</p>
<p style="text-align: center;">GROUND</p> <p>MECHANICALLY PROCESSED Granules the size of rice or taco meat. May need to add some liquid or condiment to help mix.</p>
<p style="text-align: center;">CHOPPED</p> <p>MECHANICALLY CUT Meat chopped into ¼ inch pieces. Fruits & vegetables chopped into fruit cocktail-size pieces.</p>
<p style="text-align: center;">BITE-SIZE</p> <p>ALL food items cut or broken by hand into ½ inch size pieces.</p>
<p style="text-align: center;">REGULAR</p> <p>No extra preparation needed.</p>

GUIDELINES FOR POSSIBLE MODIFIED DIET CHOICES

PUREED	GROUND	CHOPPED	BITE-SIZE
<ul style="list-style-type: none"> • All beverages (thickened as prescribed) • Hot cereal (except oatmeal) • Syrup • Margarine/butter • Yogurt (NO fruit chunks) • Broth (thickened as prescribed) • Tomato soup (thickened as prescribed) • Mashed potatoes • Sour cream • Applesauce • Cotton candy • Soft serve ice cream • Flavored syrup for ice cream • Custard pie filling • Cheesecake filling • Whipped cream • Pudding (except rice or bread pudding) • Custard 	<ul style="list-style-type: none"> • Oatmeal • Cold cereals (krispies or flakes soaked in milk) • Small curd cottage cheese • Ground taco meat • Shredded cheese • Tuna salad (NO celery, NO onions) • Banana (mashed with a fork) • Plain Popsicle (unless on thickened liquids – No nuts, NO coatings, etc) • Jello (unless on thickened liquids) • Plain hand-dipped ice cream (NO nuts, NO chunks, NO sprinkles) 	<ul style="list-style-type: none"> • Scrambled eggs (cut/broken into ¼ inch pieces) • Muffins (cut/broken into ¼ inch pieces, soaked in milk) • Pancakes, waffles, French toast (cut/broken into ¼ inch pieces, soaked in milk, syrup) • Cooked vegetables (cut/broken into ¼ inch pieces, mashed with fork) • Spaghetti (cut/broken into ¼ inch pieces) • Sloppy Joe meat (cut/broken into ¼ inch pieces) • Soft taco with ground meat (cut/broken into ¼ inch pieces) • Burritos with ground meat (cut/broken into ¼ inch pieces) • Egg salad • Tuna salad (onions, celery - ok) • Ice cream (nuts, chunks, sprinkles – ok) • Plain cookies (cut/broken into ¼ inch pieces, softened in milk, NO nuts, NO raisins) • Plain chocolate candy bar (cut/broken into ¼ inch pieces, softened in milk, NO nuts, NO caramel, etc.) • Single plain M&M's • Cupcakes/snack cakes (cut/broken into ¼ inch pieces) • Single potato/tortilla chips (cut/broken into ¼ inch pieces) • Watermelon (cut/broken into ¼ inch pieces, seedless) • Crackers (cut/broken into ¼ inch pieces, softened in soup, milk, juice) 	<ul style="list-style-type: none"> • ALL food items are cut/broken into ½ inch size pieces to include traditional finger foods (e.g. sandwiches, cookies, raw fruit)

Always follow the individual meal plan and the recommendations of the medical staff. Information provided above is only for guidelines.

RISK FACTORS

FOR CHOKING, ASPIRATION, ASPIRATION PNEUMONIA, AND THOSE WITH DYSPHAGIA

(Include but are not limited to the following):

- Eating too fast
- Absence of or difficulty chewing
- Poorly fitted dentures, gum diseases or caries
- Difficulty swallowing (coughing, during or after eating, choking episodes, gagging on food/liquids, diagnosis of reflux, rumination, cerebral palsy, narrowing of throat, holding food in mouth)
- Environmental factors (distractions while eating)
- Improper positioning while eating (may result in food residual, food in cheek, residual food in mouth following swallowing and/or eating, food and/or liquid through nose or mouth)
- Behaviors (stealing food and stuffing in mouth, Pica, packing too much food in mouth)
- History of Aspiration/Aspiration Pneumonia
- Medical conditions such as malnutrition, dehydration, neurological disorders, CVA, respiratory disease, disorders or deformities of the skeletal or muscular system (may result in poor positioning), movement disorders and GI disorders
- Environmental issues such as improper diet or liquid (texture or consistency), improper eating utensils, crowded, noisy and rushed situations
- Medications that cause muscle relaxation, sedation or dry mouth
- Altered levels of consciousness

PREVENTIVE /SAFETY MEASURES

FOR CHOKING, ASPIRATION, ASPIRATION PNEUMONIA, AND THOSE WITH DYSPHAGIA

(Include but are not limited to the following):

- Create a calm and cheerful environment.
- Allow time to eat at one's own pace. Never rush an individual.
- If the individual eats too rapidly, cue to slow rate, take small bites and chew food.
- Monitor individual during food & fluid intake.
- Position individual properly during food & fluid intake.
- Follow the physician's orders.
- Always alert the nurse or other supervisor if the consumer is having difficulty or has signs of aspiration during the meal/snack.

SIGNS/SYMPTOMS

OF DYSPHAGIA, CHOKING, ASPIRATION, AND ASPIRATION PNEUMONIA

- Coughing, especially during or after a meal
- Choking
- Gurgling voice quality or changes in voice
- Congestion
- Upper Respiratory Infection/congestion
- Unusual drooling
- Frequent throat clearing
- Complaints of throat or chest discomfort
- Awakens at night coughing or gagging
- Wet or wheezy sounding breathing or breathing difficulty
- Persistent low grade fever, generalized malaise
- Frequent elevated temperatures
- Tearing or watering of eyes
- Spillage of food and/or liquid from mouth
- Prolonged or difficulty chewing
- Slower rate of swallowing, or swallowing several times after one bite
- Slow gradual weight loss
- Poor intake by mouth or refusing food or fluids
- Pocketing food or holding food in mouth
- Significant delay in swallowing
- Facial grimacing
- Dehydration
- Pneumonia or history of pneumonia
- Reddening of the face
- Chronic clear nasal secretions

THINGS TO INCLUDE IN AN INDIVIDUAL'S PLAN FOR MEALTIMES

**FOR THOSE AT RISK FOR CHOKING, ASPIRATION,
ASPIRATION PNEUMONIA, AND THOSE WITH DYSPHAGIA**
(If applicable, the plan may include but is not limited to the following):

- The consumer's specific trigger (i.e. pocketing food; history of aspiration)
- Typical behaviors that increase risk for aspiration of choking
- Choking/Dysphagia/Aspiration Risk Level (minimal, moderate or severe)
- Behavioral precautions
- Special precautions (i.e. putting food on consumers unaffected strong side, requiring a rest period before meals, or avoiding excessive sedation)
- Food texture, consistency, and requirements for portions
- Fluid texture, consistency, and requirements for portions
- Calorie restriction
- Mealtime equipment/Adaptive feeding equipment
- Drinking
- Specific skills to maintain/acquire
- Communication / Sensory issues
- Positioning during meals
- Emergency techniques and contact numbers
- What to do if an individual begins to choke
- Consumer picture and full name if there's a possibility of confusion about the consumers identity




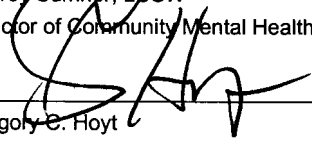
Chapter: Administrative Issues Related to Behavioral Health & Developmental Disabilities Service Delivery
Subject: Professional Licensing and Certification Requirements and the Reporting of Practice Act Violations

Applicability:
DBHDD State & Regional Offices, Hospitals, and State-Operated Community Services; Community Providers of DBHDD Services

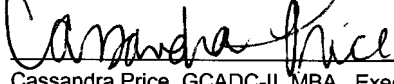
Original Effective Date: November 1, 2008
Revision #1 Effective Date: April 15, 2010
Scheduled Review Date: April 2011
Approved:

References: **Physicians:** Title 43 Chapter 34 Articles 1 and 2 of the Georgia Code. **Registered Nurses:** Title 43 Chapter 26 Article 1 of the Georgia Code. **LPN's:** Title 43 Chapter 26 Article 2 of the Georgia Code. **Optometrists:** Title 43 Chapter 30 of the Georgia Code. **Psychologists:** Title 43 Chapter 39 of the Georgia Code. **Professional Counselors, Social Workers, Marriage and Family Therapists:** Title 43 Chapter 10A of the Georgia Code. **Certified Addiction Counselors:** Title 43 10A of Georgia Code (exemptions), **Dentists, Dental Hygienists, Dental Assistants:** Title 43 Chapter 1. **Dietetics:** Title 43 Chapter 11A. **Occupational Therapists:** Title 43 Chapter 28. **Physical Therapists:** Title 43 Chapter 33. **Physicians' Assistants:** Title 43 Chapter 34 Article 4. **Respiratory Care:** Title 43 Chapter 34 Article 6. **Orthotics and Prosthetics:** Title 43 Chapter 34 Article 8. **Podiatry:** Title 43 Chapter 35. **Speech-Language Pathologists and Audiologists:** Title 43 Chapter 44.

 3/18/10
Audrey Sumner, LCSW Date
Director of Community Mental Health, Division of Mental Health

 3/18/10
Gregory C. Hoyt Date
Director, Hospital Operations

 3/23/10
Beverly D. Rollins, M.P.A., Executive Director Date
Division of Developmental Disabilities

 3/23/10
Cassandra Price, GCADC-II, MBA, Executive Director Date
Division of Addictive Diseases

 3/25/10
Frank E. Shelp, M.D., MPH, Commissioner Date

Attachments:

None

PROFESSIONAL LICENSING AND CERTIFICATION REQUIREMENTS AND THE REPORTING OF PRACTICE ACT VIOLATIONS

POLICY

It is the policy of DBHDD that possession of a valid professional license or certification issued by the respective State Licensing Board or nationally recognized Certification Board is required for anyone occupying a position of employment and performing a function that by State law requires a valid professional license or certification issued by the respective State Licensing Board or nationally recognized Certification Board (ADACB-GA/IC&RC or GACA/NAADAC). It is the responsibility of the employing or contracting agency to verify and maintain a current copy of the person's license or certification prior to employment and at least annually thereafter. If the individual is providing one of the professional services covered by the practice acts but is doing so pursuant to a stated exception in the act, such as those for students, interns and others who may work under direction and/or supervision while working toward licensure or certification, it is the responsibility of the employing or contracting agency to ensure compliance with any requirements for supervision and/or direction of this work. Upon knowledge of the potential violation of this requirement, the agency head is to report that to the respective licensing board as outlined in its regulations and to the DBHDD as outlined in this policy.

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APPLICABILITY

This policy is applicable to State and Regional Offices of the DBHDD, State Hospitals, State-operated Community Services, and Provider Agencies with a contract, letter of agreement, or provider agreement with DBHDD to provide mental health, addictive diseases and/or developmental disabilities services. This policy covers services which require a professional license or qualification according to the practice acts of the state of Georgia and includes, but is not limited to, the practice of law, medicine, nursing, optometry, podiatry, physical therapy, speech pathology and audiology, occupational therapy, dentistry, dietician, psychology, addiction counseling, professional counseling, social work and/or marriage and family therapy.

PROCEDURES

1. If any employee of DBHDD or any contractor acting on behalf of DBHDD receives information that indicates there is reason to believe that an individual employed by DBHDD or a Provider Agency may be providing professional services governed by the state's practice acts without a valid license or certification or without meeting one of the listed exceptions to licensure and/or any associated restrictions on such practice (e.g. only under supervision and/or direction), the administrator of the Provider Agency or DBHDD program/facility and the DBHDD Provider Network Management (PNM) Section must be notified within three (3) business days.
2. If a Provider Agency or DBHDD have reason to believe that an individual under contract or in its employment may have provided professional services in violation of practice act requirements and the services were funded in whole or in part by DBHDD funds (including but not limited to state contracted, fee-for-service, and/or Medicaid), the Provider Agency or DBHDD facility/program director is required to report such activity to PNM at the DBHDD state office and immediately restrict the practitioner's job duties until such time as it is determined that the practitioner is in compliance with practice act requirements. The agency also must report such activities to the Professional Licensing Boards Division of the Georgia Secretary of State's Office or the certifying Certification Board within 3 business days of the discovery and provide PNM with a copy of the complaint.
3. If the individual in question is a DBHDD employee, the employee's clinical supervisor and the administrator of the DBHDD facility/program for which the employee works are responsible for filing the complaint with the Professional Licensing Boards Division of the Georgia Secretary of State's Office or the certifying Certification Board within 3 business days. A copy of the complaint is provided to PNM.
4. When a formal complaint is filed with the Professional Licensing Boards Division or certifying Certification Board ("the Board"), the Provider Agency or DBHDD

DBHDD	SUBJECT: : Professional Licensing and Certification Requirements and the Reporting of Practice Act Violations	Policy: 04-101
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facility/program filing the complaint supplies the Board with information that may assist the Board in making a determination regarding possible unlicensed practice.

5. Once the Board's investigation of the complaint is complete and the Board's findings are received by the Provider Agency or DBHDD facility/program making the complaint, PNM is provided with a copy of the results. PNM staff notify the Program Integrity Unit at the Department of Community Health (DCH) of the results of the Board's investigation if the agency is a provider of Medicaid services.
6. When a Provider Agency or DBHDD program/facility has reason to believe an employee may have engaged in unlicensed or uncertified professional practice or if the Professional Licensing Boards Division or the certifying Certification Board confirms that unlicensed or uncertified practice has occurred, the Provider Agency or DBHDD program/facility employing the individual in question is required to do the following:
 - a. provide PNM with a written attestation that they have taken appropriate action to limit the individual's duties to services consistent with the individual's credentials and in compliance with the practice acts within three business days. In addition, Provider Agency or DBHDD program/facility may not submit claims or encounters for services provided by practitioners in violation of the practice acts.
 - b. provide PNM and the DBHDD Regional Office with a corrective action plan that addresses the operation deficiencies in the organization that resulted in the unlicensed practice within 10 business days.
7. If the Board issues a public order or any other public communication regarding a sanction against the subject of the complaint as part of its handling of the complaint and informs the Provider Agency or DBHDD program/facility of such order or communication, PNM staff immediately notify DBHDD Regional and State offices and facilities and DBHDD's providers of the order.
8. PNM maintains records of all reports received, complaints filed, and related Professional Licensing Board Division or Certification Board determinations.
9. Any and all reimbursement for services provided by practitioners not having the required professional license or credential is subject to recoupment by DBHDD and DCH.
10. It is the responsibility of the employer to verify licensure and/ or certification status.

ATTENTION

The Department of Behavioral Health and Developmental Disabilities (DBHDD) utilizes the Department of Community Health (DCH) Institutional Review Board (IRB) to ensure protection of human subjects. Policies and procedures regarding the protection of human subjects and operation of the IRB are developed and maintained by DCH.

Therefore, the DCH Protection of Human Subjects policy and procedures constitute the DBHDD directive on this topic.

Please see the attached policy, procedure, and manual.

 <p data-bbox="454 283 998 357">GEORGIA DEPARTMENT OF COMMUNITY HEALTH</p>	<p data-bbox="1047 210 1201 388">Index: Updated: Review: Page:</p>	<p data-bbox="1226 210 1404 388">POL7901 1/1/2010 6/1/2012 1 of 3</p>
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SUBJECT: Protection of Human Subjects

POLICY

The policy of the Department of Community Health (DCH) is to assure the protection of the rights of human subjects in research activities that are conducted in association with the Department. The Department will assure subjects' rights by following the policies and procedures contained in 45 CFR, Part 46, "Protection of Human Subjects"; 21 CFR, Part 50, "Protection of Human Subjects"; and 21 CFR, Part 56, "Institutional Review Boards." The Department is guided by the ethical principles set forth in the report of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research entitled: "The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research." A Departmental sponsor is designated when the research is not conducted by an agent of the Department.

A. Authority

- [45 CFR, Part 46, "Protection of Human Subjects"](#)
- [21 CFR, Part 50, "Protection of Human Subjects"](#)
- [21 CFR, Part 56, "Institutional Review Boards"](#)

B. Applicability

This policy and related procedures apply to research that is conducted either by the Department or is sponsored by the Department and involves human subjects. Applicability is not limited to federally sponsored projects.

C. Definitions

"Research" means a systematic investigation designed to develop or contribute to generalized knowledge. Routine program evaluation is excluded under this definition.

"Human subject" means a living individual about whom an investigator conducting research obtains data through intervention or interaction with the individual, or obtains identifiable private information.

"Identifiable private information" means any information about an individual's behavior that: occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, **or** has been provided for specific purposes and which the individual can reasonably expect not to be made public (e.g., a medical record), **and** the information is individually identifiable (i.e., the identity of the individual is or may be ascertained by the investigator or associated with the information).

"Conducted by the Department" means any research activity that is conducted by an employee of the Department or is funded by the Department.

“Sponsored by the Department” means any research activity which requires the support of the Department for granting access to subjects or information. A “sponsor” is an employee of the Department who assumes certain responsibilities for a research project.

D. Responsibilities

1. It is the responsibility of the Commissioner to establish and maintain an Institutional Review Board (IRB) that is competent to assure the protection of the rights of human subjects by appointing members according to the policies listed in [45 CFR, Part 46.107](#), “IRB Membership.” Each member will receive orientation to the Board and will participate in a program of continuing education to maintain skills and knowledge. Each member’s home division/office is responsible for supporting the activities of the appointed member.

2. The DCH IRB is responsible to assure the rights of human subjects by following the policies and procedures written in 45 CFR, Part 46; and 21 CFR, Parts 50 & 56.

3. It is the responsibility of each involved division and office to ensure that all research involving human subjects conducted or sponsored by the division/office is approved by the DCH IRB. When the research involves access to confidential information and is conducted by a departmental employee or agent, the investigator’s division or office is responsible for following the provisions indicated in laws, rules, regulations, etc., concerning access to and release of the information held in confidence.

4. It is the responsibility of the Administrator of the IRB to issue procedures to implement this policy. The procedures include a manual: “Guidance to Researchers Using Human Subjects”

5. It is the responsibility of the researcher to follow the procedures contained in the manual: “Guidance to Researchers Using Human Subjects.”

6. It is the responsibility of the departmental sponsor to assure that the research project does not have a negative impact on the provision of service that is being offered. The sponsor is aware of problems and adverse findings during the conduct of the project and apprises the Board of these events. When the research involves access to confidential information, the sponsor assures that all provisions of applicable laws, rules, regulations, etc. are followed concerning the release of and access to the confidential information.

E. History

Update of Georgia Department of Human Resources Policy, “Protection of Human Subjects,” POL7901, effective 2/9/2000. Updated 1/1/2010.

 <p data-bbox="451 283 998 367">GEORGIA DEPARTMENT OF COMMUNITY HEALTH</p>	<p data-bbox="1079 283 1209 409">Index: Revised: Review:</p>	<p data-bbox="1242 283 1396 409">PRO7901 1/1/10 2/1/11</p>
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SUBJECT: Protection of Human Subjects

PROCEDURE

1. Institutional Review Board:

1.1. Board membership

The Review Board consists of at least eight members with varying backgrounds to promote complete and adequate review of research activities conducted or sponsored by the involved department(s). Members are appointed to meet the following representative criteria: a) two medical doctors who have training and experience in a medical field sufficient to be able to assess medical risks; b) a person who has training and experience in the conduct of scientific investigations; c) a person whose primary concern is not in the area of scientific investigation; d) a legal professional who has experience with the types of issues confronted by the Department and its consumers; e) a person who is not, and whose immediate family is not, affiliated with the Department except as a member of this Board; and, f) a person who has training and experience in working with the consumers of the Department. Additionally, the Board should include diverse membership with regard to race, gender, and cultural backgrounds and shall include persons knowledgeable of institutional commitments and regulations and standards of professional conduct and practice.

Members are appointed by the Commissioner for staggered two-year terms. Alternate members may be appointed. Alternates are nominated and appointed in the same manner as primary members and serve two-year-terms. They have the same representative capacity as primary members for whom they serve as alternates. An alternate member cannot replace a primary member at a convened meeting unless he/she has received and reviewed the same material that the primary member has received or would have received. An alternate has no vote if the member for whom they are an alternate is present. There is a chairperson and vice-chairperson who are elected by the members of the Review Board for a term of two years.

An Administrator and an Executive Secretary are DCH employees in the Division of Public Health.

1.2. Meetings of the Board

Meetings of the Review Board are scheduled to ensure timely review of all projects. A majority of the membership constitutes a quorum, including at least one member whose primary concerns are in the nonscientific area. A majority vote is required for approval of a motion. If a quorum is interrupted during the proceedings, actions on studies are suspended until a quorum is again attained.

All projects approved using the expedited review process are included on the agenda of the next convened meeting of the Board. Votes are recorded and reported numerically.

The Administrator coordinates all human subjects protection activities to ensure that all appropriate procedures are implemented. The Administrator is responsible for revising and

implementing policies and procedures to ensure the IRB's compliance with regulations and guidelines applicable to research involving human subjects. The Administrator reviews applications for completeness and compliance with regulations. Additionally, the Administrator is responsible for:

- a. reviewing all applications and determining if they meet the criteria for approval without detailed review or for expedited review;
- b. assigning a Review Coordinator for each project to be reviewed;
- c. reviewing and approving agenda prior to meetings of the Board;
- d. assisting Review Coordinators in writing meeting summaries;
- e. providing members with available information to assist them in carrying out the functions of the Board;
- f. recommending to the Commissioner appropriate members for the Board;
- g. providing IRB orientation sessions periodically to new IRB members and Departmental Sponsors; and
- h. serving as a liaison between the Board and the DCH management, the Office of Human Research Protections, the Food and Drug Administration, and other Federal Agencies.

1.4. Functions of Chairperson

The Chairperson, the Vice-Chairperson, or a designee presides at all convened meetings of the Board. The Chairperson serves as a resource to the Administrator in all matters of administration and may perform any of the functions of the Administrator when appropriate.

1.5. Functions of the Review Coordinator

After the Administrator performs an initial review of an application, he or she assigns it to a Board member who serves as the Review Coordinator for the project until it is closed by the Board. The Administrator makes a recommendation regarding the type of review (see section 4.1. of the manual). If the Review Coordinator disagrees with the recommended type of review, he or she contacts the chairperson and they resolve the issue. The Review Coordinator is responsible for a detailed initial review, for communication with the investigators, and for tracking the project until it is closed. Specifically, the responsibilities are:

- a. upon receipt of the application, performs a detailed review to identify issues, missing information, unanswered questions, or other needed information;
- b. contacts the investigator, prior to application being placed on the agenda, to resolve the identified issues, missing information, etc.
- c. notifies the Administrator when the application is ready to be placed on the meeting agenda;
- d. presents the application at the convened meeting of the Board; (The presentation lasts a maximum of 5 minutes and identifies, at a minimum: (1) the involvement of DCH, (2) the purpose and design of the study, (4) subject information - vulnerable, how many, where, how recruited, etc., and, (5) issues for discussion.)
- e. after the Board members discuss the issues, including any other issues identified by other Board members, recommends a decision to either table the application, approve it with conditions, or approve it with no conditions;
- f. writes a detailed description of the presentation, discussion, and decisions made at the Board meeting regarding the application and forwards the description to the Executive Secretary and Administrator within two working days of the meeting;
- g. receives (from the Executive secretary) all correspondence regarding the project and responds appropriately;

h. oversees the continuing review process including timely notification of the investigators, and functions a, b, c, d, e, and f, stated above, as they relate to the continuing review.

1.6. Functions of the Executive Secretary

The Executive Secretary is responsible for:

- a. providing necessary staff assistance, and making recommendations to the Administrator and Chairperson;
- b. in conjunction with the Review Coordinators, receiving and issuing all communications with applicants;
- c. in conjunction with the Review Coordinators and the Administrator, recording and publishing minutes of the meetings of the Board;
- d. communicating with Board members, including scheduling meetings;
- e. maintaining records;
- f. in conjunction with the Review Coordinators, insuring timely continuing reviews of all projects, including notifying investigators when reports are due;
- g. entering appropriate data to the database; and,
- h. assuring that a quorum is met and maintained throughout the proceedings at all convened meetings of the Board.

1.7. Record Keeping

The Executive Secretary maintains adequate documentation of the Board's activities, including the following:

- a. copies of applications reviewed, including all attachments, progress reports submitted by investigators, statements of significant new findings provided to subjects, and reports of adverse events;
- b. minutes of IRB meetings which are sufficient in detail to show attendance at meetings, actions taken by the IRB, the vote tally on all actions, the basis for requiring changes in or for disapproving applications, and a written summary of discussion of issues and their resolution;
- c. records of continuing review activities;
- d. copies of all correspondence; and,
- e. a list of Board members identified by name, earned degrees, representative capacity, indications of experience sufficient to describe each member's chief anticipated contributions to Board deliberations, and a description of each member's affiliation with the Department.

These records are retained for at least three years, except that all records related to research that is conducted are kept for at least three years after the completion of the research project.

These records are available for inspection and copying by authorized persons during normal business hours. They are housed in the Division of Public Health, Office of the General Counsel.

2. Auxiliary Review Committees

Institutions or divisions within the Departments which conduct or support a significant amount of research may elect to form an internal committee for oversight of research activities within their organizational unit. The functions of any internal committee may supplement the functions and responsibilities of the Department's Institutional Review Board, but do not substitute for any required activities of the Board.

3. Application for Approval and Guidance to Researchers

This information is contained in the "Guidance to Researchers Using Human Subjects Manual."

See attached Manual, Directive # [MAN7901](#).

A. History

Replaces PRO7901, revised date of 2/1/03. Updated 1/1/2010.

[GO BACK TO POL7901](#)

 <p data-bbox="451 317 1013 394">GEORGIA DEPARTMENT OF COMMUNITY HEALTH</p>	<p data-bbox="1089 310 1227 432">Index: Revised: Review:</p>	<p data-bbox="1263 310 1430 432">MAN7901 1/1/10 2/1/11</p>
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GUIDANCE TO RESEARCHERS USING HUMAN SUBJECTS

MANUAL

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1. Introduction

The Department of Community Health maintains an Institutional Review Board which is charged with assuring that the rights of human subjects of research conducted or sponsored by the Department are protected as outlined in federal and state policies and regulations. The Board is guided by the ethical principles set forth in the publication: "The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research."

All research projects that involve human subjects must be submitted to the Board and approved by the Board prior to their initiation. These and other requirements for continuing contacts between the investigators and the Board are enumerated in this manual. The Board has the authority to suspend or terminate approval for research projects when certain requirements are not met. Approval of research projects is based on the determination that all aspects of the project are in accordance with the procedures that are outlined in this manual and other applicable regulations and considerations.

Insuring the rights of human subjects of research is a collaborative effort of all those persons who are involved with the research project. The procedures that are outlined in this manual constitute the minimum framework to assure that subjects' rights are protected. It is the Board's responsibility to assess whether or not these minimum standards are met based on what is submitted to them. It is in the conduct of the research project, however, that the standards are implemented. The process of protecting subjects' rights, then, hinges on the performance of the investigators as they carry out the project.

It is hoped that the intent of these procedures will be helpful as a guide to investigators as they make the innumerable decisions necessary to conduct a research project. If there are questions, the Board may be reached at:

Georgia Department of Community Health
Institutional Review Board
2 Peachtree Street, NW, Suite 15-248
Atlanta, Georgia 30303-3142
404-657-6390

2. Application Process

2.1. Who should apply for approval

Approval must be obtained for all research involving human subjects that is conducted by or sponsored by the Department. These terms are defined within the policy statement. Approval must be obtained prior to any involvement of the subjects. The approval by the Board is limited to no more than a 12-month period and must be renewed at least annually to continue the involvement of subjects. Researchers must have no involvement with subjects unless they have current approval from the Board.

2.2. Application Procedures

Applications for approval are filed with the Executive Secretary of the Board. Applications are submitted using the attached two forms: "Application for Approval of Research Using Human Subjects," and "Format Guide for Consent Form."

Note that item # 15 of the application relates to situations where the investigator requests a waiver or alteration of the requirement for authorization for the release of confidential information. If applicable, all elements of that item must be addressed in order for the waiver/alteration and the study to be approved.

Applicants are to follow the instructions listed on the forms. Note that the information that appears in bold print should be replicated by the applicant on both the application form and the consent form. Note that the information that is italicized is to be substituted by the applicant with information that applies to the research project under consideration. The information that is submitted on the application form should represent the procedures, forms, activities, etc. that is subject to the DCH IRB approval. The approval will be only for what is contained in the application - not for the entire protocol (assuming there is a protocol and it is different). Please submit a paper copy of page one of the application and one copy of the entire protocol (if applicable). If at all possible, please submit an electronic copy of the application to tzmatthews@dhr.state.ga.us. No application will be considered until all the information is received by the Board. A complete application package includes: 1) a completed and signed "Application for Approval of Research Using Human Subjects;" 2) the proposed consent form; 3) any questionnaires or other written instructions to be given to subjects; and 4) an investigator's brochure, if the study is conducted under the Investigational New Drug regulations.

The IRB approves an English language version of all submitted materials. If the investigator translates any of the materials, it is his or her responsibility to assure an appropriate and accurate translation.

Note that the application should be submitted at least six weeks prior to the desired start time. Note also that no activity may begin until approval from the Board is received.

3. Informed Consent

Except as provided elsewhere in this directive, no investigator may involve a human subject in a research project unless the investigator has obtained the legally effective informed consent of the subject or the subject's guardian. An investigator shall seek such consent only under circumstances that provide the prospective subject or the guardian sufficient opportunity to consider whether or not to participate and that minimize the possibility of coercion or undue influence. The information that is given to the subject and/or the guardian shall be in language that is understandable to the subject or guardian. No informed consent shall contain any language that waives or appears to waive any of the subject's legal rights or appears to release the investigator, the sponsor, or the institution or its agents from liability for negligence.

The IRB approves an English language version of informed consent. If the investigator translates the script, it is his or her responsibility to assure an appropriate and accurate translation.

When the application has been approved, the IRB Executive Secretary will stamp the approved consent form and return the stamped copies to the Principal Investigator. These stamped copies are to be used in the study.

The Board does not review or approve consents or authorizations for the release of confidential information that is held by the Department. Investigators are encouraged to include this language on a form separate from the consent form.

3.1. Elements of Informed Consent

The minimum elements of informed consent are found on the form that is attached to this procedure: "Format Guide for Consent Form." When appropriate, one or more of the following elements of information shall also be provided to each subject as part of the consent form:

- a. a statement that the particular treatment or procedure may involve risks to the subject (or to the embryo or fetus, if the subject is or may become pregnant) which are currently unforeseeable;
- b. anticipated circumstances under which the subject's participation may be terminated by the investigator without regard to the subject's consent;
- c. any additional costs to the subject that may result from participation in the research;
- d. all appropriate alternatives to participation, including nonparticipation;
- e. the consequences of a subject's decision to withdraw from the research and procedures for orderly termination of participation by the subject;
- f. a statement that significant new findings developed during the course of the research which may relate to the subject's willingness to continue participation will be provided to the subject;
- g. the approximate number of subjects involved in the study;
- h. if the design includes treatment and control groups (and/or placebo control groups), statements that describe how the subject will be assigned to groups; and,
- i. for certain subjects, including patients in any institution of the Division of Mental Health, Developmental Disabilities and Addictive Diseases, a statement from the subject's attending physician that the subject understands the informed consent and is competent to give consent for participation in the study.

3.2. Situations When Written Consent Not Required

The Board may approve a consent procedure which does not include, or which alters, some or all of the elements of informed consent set forth above, or waive the requirement to obtain informed consent provided the Board finds and documents that the research or demonstration project is to be conducted by or subject to the approval of state or local government officials and is designed to study, evaluate, or otherwise examine: public benefit of service programs; procedures for obtaining benefits or services under those programs; possible changes in or alternatives to those programs or procedures; or possible changes in methods or levels of payment for benefits or services under those programs; and, the research could not practicably be carried out without the waiver or alteration.

The Board may approve a consent procedure which does not include, or which alters, some or all of the elements of informed consent, or waive the requirements to obtain informed consent provided the Board finds and documents that:

1. The research involves no more than minimum risk to the subjects;
2. The waiver or alteration will not adversely affect the rights and welfare of the subjects;
3. The consent cannot practicably be obtained and the research could not practicably be carried out without the waiver or alteration; and,
4. Whenever appropriate, the subjects will be provided with additional pertinent information after participation.

The Board may waive the requirement for a signed consent form (but not the requirement for informed consent) in situations where the only record linking the subject and the research would be the signed consent document or in situations, such as phone interviews, where a signature is not feasible. An example would be an anonymous mailed questionnaire. In this situation, a cover letter could contain the elements of informed consent and a signature of the subject would not be required.

There are certain other "emergency" situations, detailed in 21 CFR , 50.23 &.24, where an intervention may occur without prior informed consent.

4. Approval Process

All actions of the Board concerning an application are communicated in writing to the investigator and the sponsor.

4.1. Types of Review and Criteria

The Board may follow one of three procedures for review of an application, depending on the characteristics of the project. The types of review and the criteria for each type are listed below.

4.1.1. Approval Without Detailed Review

Applications for projects in which the only involvement of human subjects is in categories that are described below may be approved by the Chairperson without further review. The categories are:

a. research conducted in established or commonly accepted education settings, involving normal educational practices, such as research on regular and special education instructional strategies, or research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods;

b. research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior unless 1) the information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects, and 2) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation;

c. research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior that is not exempt under subparagraph 2. above, if 1) the human subjects are elected or appointed public officials or candidates for public office or 2) federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter;

d. research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects;

e. research and demonstration projects which are conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine: 1) public benefit or service programs, 2) procedures for obtaining benefits or services under those programs, 3) possible changes in or alternatives to those programs or procedures, or 4) possible changes in methods or levels of payment for benefits or services under those programs; (For projects in this category, the investigator must submit, along with the other requirements for application, the agreement concerning confidentiality of records and the statement from the appropriate official that the proposed project meets the requirements of O.C.G.A. 15-18-101 and other DCH Directives.)

f. taste and food quality evaluation and consumer acceptance studies if: 1) wholesome foods without additives are consumed, or 2) a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.

4.1.2. Expedited Review

For applications for projects meeting the below described eligibility requirements for expedited review, the review may be performed by the chairperson or by one or more Board members, designated by the Chairperson, who are experienced reviewers. In reviewing the research, the reviewers may exercise all the authorities of the Board except the reviewers may not disapprove the research. The reviewers may approve the application, or they may require modifications and grant approval once these modifications have been made. If they do not approve the application, it will be forwarded to the Board for a full Board review.

The eligibility requirements for expedited review are as follows: the application represents minor changes in a currently approved project, or the research is found to involve no more than minimum risk to the subject and appears on the list below: (Minimal risk means that the probability and magnitude of harm or discomfort

anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.)

- a. collection of hair and nail clippings, in a non-disfiguring manner; deciduous teeth, and permanent teeth if patient care indicates a need for extraction;
- b. collection of excreta and external secretions including sweat, uncannulated saliva, placenta removed at delivery, and amniotic fluid at the time of rupture of the membrane prior to or during labor;
- c. recording of data from subjects 18 years of age or older using non-invasive procedures routinely employed in clinical practice (This includes the use of physical sensors that are applied either to the surface of the body or at a distance and do not involve input of matter or significant amounts of energy into the subject or an invasion of the subject's privacy. It also includes such procedures as weighing, testing sensory acuity, electrocardiography, electroencephalography, thermography, detection of naturally occurring radioactivity, diagnostic echography, and electroretinography. It does not include exposure to electromagnetic radiation outside the visible range [for example, x-rays, microwaves]);
- d. collection of blood samples by venipuncture in amounts not exceeding 450 milliliters in an eight week period and no more often than two times per week, from subjects 18 years of age or older and who are in good health and not pregnant;
- e. collection of both supra- and subgingival dental plaque and calculus, provided the procedure is not more invasive than routine prophylactic scaling of the teeth and the process is accomplished in accordance with accepted prophylactic techniques;
- f. voice recordings if made for research purposes such as investigations of speech defects;
- g. moderate exercise by healthy volunteers;
- h. the study of existing data, documents, records, pathological specimens, or diagnostic specimens;
- i. research on individual or group behavior or characteristics of individuals, such as studies of perception, cognition, game theory, or test development, where the investigator does not manipulate subjects' behavior and the project will not involve stress to subjects;
- j. research on drugs or devices for which an investigational new drug exemption or an investigational device exemption is not required.

4.1.3. Full Board Review

Full Board review is required for all eligible projects that do not meet the criteria for either of the two above categories of review.

4.2. Review Criteria

In order to approve a research project, the Review Board will determine if all of the following are met:

- a. risks to subjects are reasonable in relation to any anticipated benefits to subjects and the importance of the knowledge to be gained;
- b. risks to subjects are minimized by using procedures that are consistent with sound research design, and, whenever appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes;
- c. selection of subjects is equitable;
- d. appropriate measures are in place to obtain and document the prior informed consent of the subjects or the subjects' guardians;
- e. there are adequate provisions for protecting the confidentiality of data which identify individual subjects; and
- f. there are adequate provisions for monitoring the collected data to ensure the safety of subjects and to protect their privacy by maintaining anonymity or confidentiality of the data.

For research projects that involve the participation of vulnerable subjects, there are specific requirements contained in the federal regulations. Compliance with these regulations will be assessed by the Board when a project involves any of these groups of subjects. The types of subjects and the associated federal regulation(s) are listed below.

Fetuses, pregnant women, and human in vitro fertilization - 45 CFR 46.201-46.211

Prisoners - 45 CFR 46.301-46.306

4.3. Continuing Review

Approval to conduct a project may be granted for a period of no more than one year. If the project is not completed by the end of the approved period, the investigator must apply for a continuation of the approval. The length of the approval period and the extent of continued review will be determined by the Board at the time of approval and will be communicated to the investigator. The Board will contact the investigator prior to the end of the approved period to solicit the required information in order to review the project for continued approval. The information requested on the "Application for Continuing Approval" is compiled at this time by the investigator and submitted to the Board. The Board considers the request and notifies the investigator of the decision.

If the investigator wishes to amend the protocol after it has been approved, she or he submits the following information to the Executive Secretary:

_A letter which contains the request for the change, lists the changes requested, and indicates how the changes (deletions and additions) are indicated,

_A copy of the originally approved application, with the changes highlighted as indicated in the accompanying letter,

_A "clean" copy of the application that contains the proposed changes.

4.3.1. Frequency and Extent Considerations

The length of time of approval for each project will be based on a consideration of the vulnerability of the subject population and the extent of risks to subjects. Special attention will be given to projects involving new procedures or treatments and projects involving placebo control groups. The following is a frequency guideline for approval periods:

- a. New drug trials - 6 month approval period;
- b. Projects involving pregnant women, children, or other vulnerable populations - 9 to 12 month review period; and
- c. Projects involving minimal risks to subjects - 12 month approval period.

The extent of the continued review will be determined by an assessment of the vulnerability of the subject population, the extent of risks to the subjects, and a consideration of other factors of the research administration and design. For example, for projects for which the investigator is not a DCH employee, the Board may require the DCH sponsor to perform an on-site visit of the project to determine compliance with the procedures stated in this manual. Another example is that for projects for which the sponsor and the investigator are the same person, an uninvolved person may be asked to perform an on-site monitoring of the project.

4.3.2. Suspense or Termination of Projects

The Review Board may suspend or terminate approval of research that is not being conducted in accordance with requirements for the protection of human subjects and any research associated with unexpected serious harm to subjects. Any suspension or termination of approval will include a statement of the reasons for the Board's action and will be reported promptly to the investigator, to the Division or Office of the Department of Community Health, and, if appropriate, to the U. S. Department of Health and Human Services (DHHS), the Food and Drug Administration (FDA), and other organizations. If it is determined after the fact that any of these procedures were not followed in the course of the research project, then written notification of such findings will be sent to the investigator and all appropriate organizations, including the institution with which the investigator is affiliated.

The continuation of a research project after the expiration of the Board's approval is a violation of federal regulations. If the Board's approval has expired, research activities must stop. No new subjects may be enrolled in the project. If the investigator is actively pursuing renewal of approval with the Board and the Board believes that there are no overriding safety or ethical concerns, then the Board may exercise flexibility in allowing the project to continue for a brief time needed to complete the review process.

When the Board, in addition to stopping all research activities terminates study approval, any subjects currently participating should be notified that the study has been terminated. Procedures for withdrawal of enrolled subjects should consider the rights and welfare of the subjects. If follow-up of subjects for safety

reasons is permitted/required by the Board, the subjects should be so informed and any adverse events or outcomes should be reported to the Board.

5. Responsibilities of Investigators

It is the responsibility of the investigator to design the project in such a way that minimizes risks to subjects and to continuously monitor the activities of the project to assure that the risks remain at a minimum. It is the responsibility of the investigator to report in writing the following information to the Board:

- a. Any reports requested by the Board, including continuing review information;
- b. Any changes in the project's protocol, including a change of DCH Sponsor or a change of Principal Investigator; and,
- c. Adverse events associated with the project.

Any proposed changes in previously approved projects must be approved by the Board and cannot become effective prior to being approved. Consideration of changes will be accomplished in the manner described for initial approval of applications. Changes in Sponsors or Investigators do not require the approval of the Board but the new Sponsor and/or Investigator must sign page one of the application and send it to the IRB Executive Secretary.

In addition to reporting to the Board, the investigator must report adverse events as required to the Food and Drug Administration and must indicate to the Board such notification. The Board will acknowledge these reports in writing and will indicate one of the following: 1) the Board will review the report at the next meeting and the project may continue until a formal Board action is taken; or 2) the project must be discontinued immediately. The chairperson of the Board has the authority to make the decision concerning which course of action will be followed.

6. Appeals

A decision to disapprove a research project may be appealed by submitting a written request for reconsideration by the Review Board, including any additional data pertinent to the decision. Upon receipt, the request and any related documents will be conveyed to the Board for reconsideration. The reconsideration will be accomplished in the manner described for initial review. A negative decision by the Board cannot be reversed except by a vote of Board members.

**APPLICATION FOR APPROVAL OF RESEARCH
 USING HUMAN SUBJECTS**

Revised 5/7/10

Title of Research Project:

Principal Investigator	* Department Sponsor
Name:	Name:
Position:	Position:
Affiliation	Affiliation:
Address:	Address:
e-mail address:	e-mail address:
Telephone Number:	Telephone Number:
**Signature:	*Signature:

*Required if the principal investigator is not a Departmental employee.

**Your signature indicates that you have read the DCH's "Guidance to Researchers Using Human Subjects Manual" and that you understand and agree to follow the procedures specified in the Manual. Your signature further attests that you assume responsibility for assuring that all aspects of and personnel involved with this project follow the specified procedures.

Date you would like approval for project to begin: _____
 (Should be at least 6 weeks from date of submission to IRB)

Date you anticipate last contact with subjects: _____

Date you anticipate completion of project: _____

PLEASE COMPLETE THE APPLICATION AND E-MAIL TO: tzmatthews@dhr.state.ga.us

AND

MAIL ONE COPY OF THIS PAGE WITH SIGNATURES AND ONE COPY OF THE PROTOCOL (IF APPLICABLE) TO THE DCH INSTITUTIONAL REVIEW BOARD

(Or mail 11 copies of the application and one copy of the protocol)

**APPLICATION FOR APPROVAL OF RESEARCH
USING HUMAN SUBJECTS**

Respond to all 15 statements listed below. Applications should not be over five pages (excluding page 4). Do not respond to any statement with "see attachments."

1. Research Abstract

State rationale and research question or hypothesis. Clearly explain why you are conducting this research. Describe the anticipated benefits and the importance of the knowledge to be gained. Give a brief literature review that demonstrates the relevance of the study.

2. Design

Identify your research design and specific factors or variables, conditions, or groups in your study and any control conditions. Indicate the number of subjects assigned to each group, how they will be assigned to groups, and describe plans for data analysis.

3. Research Subjects

a. Number and description of subjects

Describe subject characteristics (age, gender, diagnosis, etc.).

b. Method of selection/recruitment of subjects

Attach copies of any fliers, advertisements, etc. that will be used.

c. Compensation

Describe any incentives or compensation offered for participation.

4. Procedures Summary

Describe all of the procedures of the study. State in chronological order what the subjects are expected to do, or describe what procedures the subjects will be involved with. If deception is necessary, justify and describe. Submit debriefing procedures that include an explanation to subjects about how and why they were deceived, as well as providing an educational summary. If access to other information is desired, state what and how this will be accomplished.

5. Materials

List, in sequence, all questionnaires and/or tasks to be given to subjects. Attach a labeled copy of all written instruments to each copy of this application. If the study is conducted under the Investigational New Drug regulations, attach copies of the investigator's brochure

6. Confidentiality Assurances

If the results of participation are not public or anonymous, then describe how confidentiality of information will be maintained. Describe how long information, data, or other items will be kept. Describe destruction techniques. If data, information, or other items are to be kept indefinitely, so state, and give purpose of retention and method to assure continued confidentiality.

7. Risks Summary

a. Current Risks Describe any psychological, social, legal, economic, or physical discomfort, stress, or harm that might occur to subjects as a result of their participation in this research. Describe how these risks will be held to the absolute minimum.

b. Future Risks Describe any future risks that subjects may experience as a result of their participation in this research. Describe how these risks will be kept at an absolute minimum.

8. Benefits

a. To Subjects

Describe any potential beneficial effects that participation in this research might have for subjects.

b. To Humankind

Identify any potential benefits that humankind in general will gain from this research.

9. Vulnerable Subjects

If vulnerable subjects (including minors) are involved, outline procedures that will be used to obtain their agreement to participate (in addition to informed consent from parents or guardians). Describe any other procedures that will be used to safeguard the rights of vulnerable subjects.

10. Informed Consent

Describe the procedure that will be used to obtain legally effective informed consent from subjects. Attach copies of the form to be used. If written informed consent will not be obtained, describe why you are requesting a waiver of this requirement.

11. Funding Information

State the source of funding associated with the research.

12. Institutional Information

For projects whose principal investigator is not a DCH employee, describe any program of institutional oversight of human subjects protections that apply to this research. Give the number of the OHRP or other federally-approved Assurance for the protection of human subjects that is held by the institution.

13. Investigator Information

Describe any training that the investigator has received concerning human subjects protections.

14. Approvals from other IRBs

Please list all other IRBs from which you seek approval. Please attach (or send when obtained) the written notification of the outcome of the request.

15. Waiver/Alteration Request

If the study involves access to confidential information that is held by the Department and you wish a waiver/alteration of the requirement for obtaining authorization from individuals for the release of information about them, please respond to all the items on page 4 of this application. This page will be signed by the IRB Executive Secretary and returned to you after the Board has approved the application and the waiver/alteration request.

WAIVER/ALTERATION REQUEST

1. Describe why you are requesting a waiver of or an alteration to the requirement for obtaining authorization from individuals for the release of confidential information about them.
2. Describe the information that you wish to obtain from the Department.
3. Describe your plan to protect the information from improper use and disclosure.
4. When will the identifiers (any information specific to an individual or any links to that information) be destroyed?
5. Describe any circumstances under which you would disclose the information that you obtain.
6. List other institutions to which you are applying for this waiver. Please attach (or send when received) the written notification of the outcome of the request.

FOR IRB USE ONLY

DCH IRB #
Title of Study:

The DCH IRB reviewed this study either ____ at the convened meeting OR ____ under expedited review and approved it on

The Board approved the above-described waiver or alternation and determined that:

- The use or disclosure of the confidential information involves no more than a minimal risk to the privacy of individuals;
- An adequate plan exists to protect the identifiers from improper use and disclosure;
- An adequate plan exists to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law;
- Adequate written assurance exists that protect the confidential information from being reused or disclosed except (1) as required by law, (2) for authorized oversight of the research study, or (3) for other research that is approved by the DCH IRB;
- The research could not practicably be conducted without the waiver or alteration; and,
- The research could not practicably be conducted without access to and use of the confidential information.

Executive Secretary

Date

Georgia Department of Community Health Institutional Review Board
FORMAT GUIDE FOR CONSENT FORM

(This guide contains the minimum elements that are necessary for approval of research using human subjects. Additional information may be required in some circumstances. Refer to the "Guidance to Researchers Using Human Subjects Manual" for more information. The language in the form should be understandable to the subjects and be stated in the first person.)

I agree to participate in the research titled (title of research) which is being conducted by (investigator's name, title, affiliation, phone number). I understand that my participation is entirely voluntary. I understand that I can withdraw my consent at any time (without penalty OR describe penalty) and can have the results of my participation, to the extent that it can be identified as mine, returned to me, removed from the record, or destroyed.

The following points have been explained to me:

- 1. The reason for the research is (give a short justification).**
- 2. The benefits that I may expect for the research are (list specific benefits to the subject).**
- 3. The procedures are (Describe all of the procedures of the study, including what will happen to the subject, including the time, place, and duration. Describe any questionnaires that are used. In studies involving experimental treatments, identify the parts that are new or experimental, and indicate how they differ from other procedures that could be followed. If deception is necessary, state: "In order to make this study a valid one, some information about my participation will be withheld until after the study.")**
- 4. The discomforts or stresses that I may face during this research are (List discomforts or stresses or, if none are foreseen, then include this statement: "No discomforts or stresses are foreseen.")**
- 5. Participation involves the following risks (List all potential physical, psychological, social, or legal risks. Also list the steps to be taken if harm should come to the subject, including any availability of medical treatment. List a contact -name & phone number - in case of injury. If no risks are foreseen, then include this statement: "No risks are foreseen.")**
- 6. The results of my participation will not be confidential, but (describe any controls on access to data). (OR) The results of my participation will be anonymous. (OR) The results of my participation will be confidential, and will not be released in any individually identifiable form without my prior written consent, unless otherwise required by law. (Describe any special procedures regarding anonymity or confidentiality. For example, describe how data will be stored, how identifiers will be removed, give erase dates for tapes, give date data will be destroyed, etc. If data, tapes, or other items are to be kept indefinitely, so state, with purpose for retention, and method to assure confidentiality. If data, information, or other items are to be kept indefinitely, so state, and give purpose of retention and method to assure continued confidentiality.)**
- 7. The investigator will answer any questions I have about the research, now or during the course of the study.**
- 8. I may contact (Investigator's IRB - name of contact person, phone number and address), who is not directly involved with this research, if I have any questions about my rights as a subject in this study.**

(Under some circumstances the following assurance is necessary: I have examined (name of subject) and found him/her to be competent to give informed consent for participation in this study.

Printed Name of Physician _____
Signature _____ Date _____

Signature of Investigator Date Signature of Subject Date

PLEASE SIGN BOTH COPIES OF THIS FORM. KEEP ONE COPY AND RETURN THE OTHER TO THE INVESTIGATOR.

APPLICATION FOR CONTINUING APPROVAL

Georgia Department of Community Health

Institutional Review Board

Rev. 5/10

DCH IRB Project Number:

(If you do not have an electronic copy of this form, you may attach a separate page and respond to these items by number.)

Please respond to the following requests about the previous twelve months of the study.

1. What is the stage of the project?
 - a. Initial preparation
 - b. Data Collection
 - c. No further involvement with subjects
 - d. Data analysis complete, project closed

2. Since DCH IRB approved the project, have all changes been submitted to the Board for review and approval prior to their being implemented?
(If not, project activities must stop until approval is received.)

3. Have all approved procedures been followed?
(If not, attach an explanation.)

4. Has the project resulted in any risks to subjects that were not identified in the approved protocol?
(If yes, attach an explanation.)

5. How many subjects have been enrolled in the study? If the study does not involve contact with subjects, skip to # 10.

6. How many subjects have dropped out or have been withdrawn from the study? Please explain circumstances.

7. How many complaints have been lodged against the study, what were the nature of the complaints, and how were they resolved?

8. Have the subjects experienced any unexpected adverse events or unanticipated problems? Please explain.

9. If appropriate, please attach a summary of any recent literature, findings, or other relevant information, especially information about risks associated with the study and describe how this is communicated to subjects.

10. If there has been no direct contact with subjects, please check the appropriate statement below:
 All contact with subjects is complete, OR
 Study involves no direct contact with subjects.

This completed form and its attachments are an accurate report of the progress and status of the study.

Signature of Investigator

Date

Signature of Sponsor

Date

[BACK TO POL7901](#) & [PRO7901](#)



Chapter: Information Management and Information Technology
Subject: Confidentiality and HIPAA

Applicability:
DBHDD, including the state office, regional offices, state operated DBHDD hospitals and any state operated community programs.

Effective Date: September 1, 2011
Full Implementation Date: November 1, 2011
Next Review Date: September 2013

Approved:

Attachments:

- Attachment A:** Notice of Privacy Practices
- Attachment B:** Authorization for Release of Information

Elizabeth Bentley Watson 8/22/11
 Elizabeth Bentley Watson, Esq. Date
 Privacy Officer

Frank E. Shelp 8/22/11
 Frank E. Shelp, M.D., M.P.H., Commissioner Date

POLICY

The right of an individual to confidentiality and privacy of his/her health care information, including information about mental health, developmental disabilities, or addictive disease, is protected by state laws and regulations and by federal laws and regulations. Individuals also have certain legal rights regarding access to their own records and information.

It is the policy of the Department of Behavioral Health and Developmental Disabilities (DBHDD) to ensure compliance with applicable state and federal laws and regulations regarding confidentiality and privacy. These laws and regulations govern topics including but not limited to:

- Mental health information
- Developmental disability information
- Addictive disease information
- Protected health information (PHI) as defined by HIPAA
- Rights of individuals regarding their protected health information
- Notice of Privacy Rights
- Disclosures of protected health information
- Reporting of violations and breaches, and resulting sanctions
- Complaints
- Business Associates
- Accounting of disclosures
- AIDS confidential information
- Medicare/Medicaid information
- Open Records Act requests.

When there is a conflict between state and federal law, DBHDD shall seek legal counsel regarding the conflict. Generally, DBHDD will follow the law which provides greater

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access to and rights of the individual, or which provides the greatest protection of confidentiality and privacy. HIPAA does not supersede or negate more stringent federal and state laws, rules and regulations. In the event of an apparent conflict in laws, or between the confidentiality laws regarding any specific program and the terms of this policy, the responsible employee shall seek direction from Legal Services.

Unless otherwise specifically stated, DBHDD policy and procedures regarding confidentiality do not compel or require disclosure. If there is an exception to the rule of confidentiality and a disclosure is allowed, such disclosure is not required unless a law, rule or regulation, or DBHDD policy or procedure states that the disclosure is required.

APPLICABILITY

State laws and regulations on confidentiality of mental health, developmental disabilities, and addictive disease information, as well as other health information, govern the Department of Behavioral Health and Developmental Disabilities (DBHDD) and its facilities, as defined herein. DBHDD is also a “covered entity” as defined in, and as governed by, the Health Insurance Portability and Accountability Act of 1996 and its regulations (HIPAA).

This policy is therefore applicable to any facility or program that is a part of DBHDD, including the state office, regional offices, state operated DBHDD hospitals and any state operated community programs. All employees, agents, trainees, volunteers and contractors of DBHDD shall abide by federal and state laws and regulations regarding confidentiality, relevant DBHDD policies and procedures, and all federal laws regarding the disclosure and use of confidential and protected health information. DBHDD providers, as defined herein, who are under contract or have a letter of agreement with DBHDD through DBHDD and its Regional Offices have an independent duty to follow state confidentiality laws; if they are also covered entities under HIPAA, they have an independent duty to follow HIPAA and its regulations. If they also conduct business functions on behalf of DBHDD, they are also business associates of DBHDD and must comply with applicable provisions of the HIPAA through a Business Associate Agreement with DBHDD.

This policy and associated forms are available as resources for providers, but DBHDD makes no representation or warranty that compliance with the provisions of this policy will ensure a provider's compliance with all applicable laws and regulations. Providers should seek their own legal counsel regarding compliance with laws and regulations on the subject matter of this policy.

DEFINITIONS

Unless a different meaning is required by the context, the terms as used in this policy and procedures and in all DBHDD policies and procedures regarding confidentiality and

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HIPAA shall have the following meanings:

Accounting of disclosures – A history of when and to whom disclosures of protected health information are made for purposes other than treatment, payment, and health care operations and certain other exceptions.

Advance directive for health care – A document voluntarily executed by an individual in accordance with O.C.G.A. § 31-32-5. A living will or a durable power of attorney for health care may be an advance directive.

AIDS confidential information – Information which permits identification of an individual and discloses that the individual;

- Has been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)
- Has been or is being treated for AIDS
- Has been determined to be infected with any type of Human Immunodeficiency Virus (HIV) as defined in Georgia law
- Has submitted to an HIV test
- Has had a positive OR a negative result from an HIV test
- Has sought and received counseling regarding AIDS, **OR**
- Has been determined to be a person at risk of being infected with AIDS.

Authorization – Permission by an individual or a person legally authorized to consent on the individual's behalf, to the release or use of protected health information relating to the individual.

Breach – The acquisition, access, use or disclosure of protected health information in a manner not permitted by HIPAA or this policy which compromises the security or privacy of the protected health information.

Business associate – A person or entity who is not a member of DBHDD's workforce and who, on behalf of DBHDD, performs or assists in the performance of a function or activity involving the use or disclosure of individually identifiable health information.

Chief Medical Officer – The physician with overall responsibility for treatment or habilitation services at a facility or a physician appointed in writing as the designee of such chief medical officer.

Clinical record – A written record pertaining to an individual, including all medical records, progress notes, charts, admission and discharge data, and all other information recorded by a facility or other entities responsible for an individual's care and treatment or habilitation, and pertaining to the individual's hospitalization and treatment or habilitation. Such other information as may be required by rules and regulations of DBHDD shall also be included. The clinical record may be maintained electronically.

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Confidential – The property that data or information is private and is not made available or disclosed to persons who are not authorized to access such data or information.

Confirmed positive HIV test – The results of at least two separate types of HIV tests, both of which indicate the presence of HIV.

Court – In the case of an individual who is 17 years of age or older, the probate court for the county of residence of the individual or the county in which such individual is found, and, in the case of an individual who is under the age of 17 years, the juvenile court for the county of residence of the individual or the county in which such individual is found.

Covered entity – A health care provider, health plan, or health care clearinghouse that transmits any health information in electronic form in connection with a HIPAA transaction; DBHDD is a covered entity.

De-identified information – Health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Department – The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), including its duly authorized agents and designees.

Designated record set – A group of records maintained by or for DBHDD that is used, in whole or in part, by or for DBHDD to make decisions about individuals, including but not limited to clinical and billing records.

Determined to be infected with HIV – Having a confirmed positive HIV test or having been clinically diagnosed as having AIDS.

Diagnosis (with regard to alcohol or drug abuse) – Any reference to an individual’s alcohol or drug abuse or to a condition which is identified as having been caused by that abuse which is made for the purpose of treatment or referral for treatment.

Direct treatment relationship – A treatment or service relationship between an individual and a health care provider that is not an indirect treatment relationship. In an indirect treatment relationship, the health care provider delivers health care to the individual based on the order of another health care provider and the health care provider typically provides services or products, or reports the diagnosis or results associated with the health care, directly to another health care provider, who provides the services or products or reports to the individual.

Disclosure – The release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information. Disclosure includes the affirmative verification of another person’s communication of individually identifiable health information, or the communication of any information from the record of an individual who has been identified. “Release” also means disclosure, for purposes of this policy.

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Facility – Any hospital, community mental health center, or other facility that is state owned or state operated and is utilized for the diagnosis, care, treatment, or hospitalization or services of individuals for mental illness, developmental disability or addictive disease.

Guardian – A person appointed by written court order to be legally responsible for the person of an adult or of a minor. The individual for whom a guardian is appointed is known as the “ward.” Whenever "individual" is used in confidentiality and HIPAA policies and procedures, a guardian is entitled to exercise the individual’s rights on behalf of the individual (ward). “Guardian” as used in this policy does not include a conservator or a guardian of property alone.

Health and Human Services (HHS) – The federal government department that has overall responsibility for implementing HIPAA.

Health care – Care, services, or supplies related to the health of an individual. Health care includes, but is not limited to, the following:

- (1) Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and
- (2) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

Health care agent – A person appointed by an individual to act for and on behalf of an individual, as set forth in an advance directive for health care executed by the individual.

Health care provider – A provider of health care services, and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business. NOTE: For purposes of this policy, the term “health care provider” follows the definition in HIPAA and refers to all health care providers generally. This term is not limited to those providers who have contracts, letters of agreement, or other legal or funding arrangements with DBHDD. **See** the separate definition of “provider” in this policy.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – Public Law 104-191– A Federal law that governs the use, access, and disclosure of protected health information (see definition) regarding individuals. HIPAA gives HHS the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care consumers, health care providers, payers, and employers; to specify the types of measures required to protect the security and privacy of personally identifiable health care information; and to specify requirements for reporting breaches of HIPAA to HHS and others. As defined in DBHDD confidentiality and HIPAA policies and procedures, HIPAA refers to the federal act and also to related federal regulations known as the Privacy Rule, the Security Rule, and

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regulations implementing the “Health Information Technology for Economic and Clinical Health Act” (“HITECH Act”), located at 45 CFR Parts 160, 162, and 164.

Individual – Any person who is seeking, applying for, currently receiving, or formerly received treatment or services from DBHDD or any of its state operated facilities or programs or providers, for mental illness, developmental disability, or addictive disease or co-occurring combinations thereof. For purposes of this Policy, “individual” means the person who is the subject of protected health information.

Individually identifiable health information – Any information, including demographic information collected from an individual, that is created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual, and identifies the individual, or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. Individually identifiable health information contains some or all of the following elements:

- Name
- All address information
- Zip codes
- E-mail addresses
- Dates (except year) directly related to an individual, including dates of birth, admission, discharge, death
- Age, if over 89 years
- Telephone numbers
- Fax numbers
- Social Security number
- Medical record numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate numbers
- License numbers
- Device identifiers
- URLs
- IP addresses
- Facial photographs
- Biometric identifiers
- Any other unique identifying number, characteristic, or code

Minimum necessary – When using or disclosing protected health information or when requesting protected health information, the process of making reasonable effort to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure or request.

Notice of Privacy Practice – A notice that provides a clear explanation of DBHDD’s privacy practices and the privacy rights of individuals regarding their personal health information.

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Person at risk of being infected with HIV – Any person who may have already come in contact with or who may in the future be reasonably expected to come in contact with the body fluids of an HIV infected person.

Person legally authorized to sign – A person authorized by law to give authorization for release of an individual's protected health information. These persons include: for minors, the parent, the court-appointed guardian or the court-appointed custodian; for adults, the court-appointed guardian of the person, if any. An individual may give his/her agent in an advance directive the authority to sign for release of the individual's protected health information, except for alcohol or drug information.

Personally identifying information – Any item, collection or grouping of information which contains the name of an individual or any unique grouping of information which makes an individual identifiable as if a name were affixed (such as address, telephone number, individual diagnosis, etc.).

Privacy – HIPAA regulations protect an individual's right to the privacy or confidentiality of his/her health care information to keep it from falling into the hands of people who are not legally authorized to obtain it. The HIPAA privacy regulations require health care providers to obtain a signed authorization to disclose PHI, unless otherwise authorized by applicable law or regulation.

Privacy Coordinator – The individual designated by a state hospital or Regional Office with responsibility for obtaining and maintaining a working knowledge of DBHDD's confidentiality and security policies and procedures, to respond to confidentiality and HIPAA-related inquiries arising within the hospital or region, provide information regarding the complaint process and the reporting process, and maintain adequate documentation of these activities.

Privacy Officer – The individual designated by DBHDD with responsibility for obtaining and maintaining a working knowledge of the Department's confidentiality and privacy policies and procedures, to respond to confidentiality and HIPAA-related inquiries arising within DBHDD, provide information regarding the complaint process and reporting process, and maintain adequate documentation of these activities. The Privacy Officer also has responsibility for coordination of Privacy Coordinators and for overseeing certain HIPAA-related reporting.

Privacy Rule – Standards for Privacy of Individually Identifiable Health Information, which implements the privacy requirements of the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at 45 CFR parts 160 and 164.

Privileged – Protected by law from unauthorized disclosure. Privilege gives the legal right to an individual to prevent disclosure of communications between the individual and his/her: psychiatrist, licensed psychologist, or between an individual and his/her licensed

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clinical social worker, clinical nurse specialist in psychiatric/mental health, licensed professional counselor or licensed marriage and family counselor during psychotherapy.

Protected Health Information (PHI) – All individually identifiable health information (e.g., name, diagnosis, medical record number, billing information, etc.) that is transmitted or maintained by a covered entity in any form or medium, including orally. **See** “individually identifiable health information,” above. Protected health information excludes education records covered by the Family Educational Rights and Privacy Act (FERPA) and employment records held by DBHDD in its role as employer.

Provider – Organizations or persons approved to serve individuals with mental illness, developmental disabilities and/or addictive diseases, wherein those services are financially supported in whole or in part by funds authorized through DBHDD. Providers typically have a contract or letter of agreement with DBHDD. (NOTE: For purposes of this policy, the term “provider” means only those entities which have contracts, letters of agreement or other legal or funding arrangements with DBHDD. **See** the separate and more general definition for “health care provider” as that term is used in this policy.)

Psychotherapy notes – Notes recorded in any medium by 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 clinical record. Psychotherapy notes excludes medication and prescription monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

Records – Any information, whether recorded or not, received or acquired in connection with an individual’s treatment or services. “Records” includes administrative and other documentation (such as incident reports) that relates to and identifies an individual, regardless of whether it is part of the individual’s clinical record.

Record holder – The health care provider of treatment or services that maintains records or clinical records.

Release – See definition of “disclosure.”

Representatives – The persons designated under Title 37 of the Georgia Code to receive certain notices and, unless objected to by the individual, to consult with the facility regarding the individual’s individualized plan and treatment under such plan.

Security Officer – The individual designated by DBHDD with responsibility for obtaining and maintaining a working knowledge of the HIPAA Security Rule and, as appropriate, the Department’s confidentiality and security policies and procedures, to respond to inquiries regarding the Security Rule arising within the Department, provide information regarding the security complaint process and reporting process, and maintain adequate

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documentation of these activities. With the Privacy Officer, has responsibility for coordination of Privacy Coordinators and for certain Security Rule related reporting.

State - The State of Georgia.

Workforce – Employees, volunteers, trainees, and other persons under the direct control of DBHDD, whether or not they are paid by DBHDD.

PROCEDURES

- A. DBHDD shall implement policies and procedures that are designed to comply with confidentiality laws and HIPAA. Policies and procedures shall be reasonably designed and take into account the size and type of activities that relate to PHI undertaken by DBHDD. These policies and procedures shall:
1. Restrict access and use based on specific roles of members of DBHDD's workforce;
 2. Establish criteria to limit routing disclosures to minimum necessary to achieve the purpose of the disclosure;
 3. Limit requests to other covered entities to what is reasonably necessary for the particular use or disclosure; and
 4. Control when staff requests or discloses the entire clinical record. There must be specific justification of the need for the entire clinical record.
- B. DBHDD shall document confidentiality and HIPAA privacy policies and procedures, either on paper or in electronic form. Any change to a policy or procedure shall be documented. In addition to policies and procedures, any correspondence or other documents required to be created or maintained by DBHDD under such policies and procedures shall be maintained on file for six years, or longer if required under other applicable laws, regulations or policies.
- C. It is the policy of DBHDD that all information about individuals, whether oral or written and regardless of the form or location in which it is maintained, is confidential and may be disclosed only in accordance with applicable state and federal laws and regulations. DBHDD shall not confirm or deny whether an individual is receiving or has received services, unless such disclosure is authorized in writing by a valid authorization signed by the individual or authorized by applicable law.
- D. DBHDD shall maintain a clinical record for each individual. When disclosure is allowed, the original clinical record may be examined only under supervision by designated staff of the facility, at the facility which maintains custody of the record, at reasonable times as determined by the facility. The original clinical record shall not be removed from the facility unless authorized by an attorney in the Office of the Attorney General or specially appointed assistant attorney general representing DBHDD. The clinical record shall not be a public record.

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- E. DBHDD shall establish standards relating to uses and disclosures, and de-identification and re-identification of PHI it creates, collects and maintains.
- F. Any disclosure authorized by law or any unauthorized disclosure of confidential or privileged information about an individual or communications shall not in any way abridge or destroy the confidential or privileged character of the information disclosed, except for the purpose for which such authorized disclosure is made. Any person making a disclosure authorized by law shall not be liable to the individual or any other person.
- G. DBHDD shall have administrative, technical and physical safeguards to protect the privacy of PHI. DBHDD shall have safeguard standards and access controls for PHI it collects and maintains.
- H. DBHDD shall provide adequate notice to individuals of the uses and disclosures of PHI it may make by providing a Notice of Privacy Practices to persons seeking or receiving services. DBHDD shall document its compliance with the notice requirements by retaining copies of the notices it issues. DBHDD shall not require individuals to waive their rights as provided in the notice as a condition of treatment, payment or eligibility for benefits.
- I. DBHDD will establish and implement minimum necessary requirements for uses and disclosures of PHI. DBHDD shall make reasonable efforts to limit PHI used, disclosed or requested from another covered entity to the minimum necessary to accomplish the intended purpose of the use, disclosure or request.
- J. DBHDD shall obtain a written authorization for release of information from an individual before using or disclosing PHI relating to the individual for any purpose not otherwise permitted or allowed by confidentiality laws or HIPAA. DBHDD shall maintain policies and procedures governing the form of authorization for release of information, and the procedures for making authorized disclosures.
- K. DBHDD shall maintain policies and procedures to protect the confidentiality of alcohol and drug abuse information as governed by federal law and regulations. It is the policy of DBHDD that an individual with alcohol or drug abuse records may be entitled to protections of the confidentiality of such information that are more stringent than the protections provided by HIPAA or by state law. Records pertaining to alcohol abuse or drug abuse may be produced in response to a court order issued by a court of competent jurisdiction pursuant to a full and fair show cause hearing, except for matters privileged under the laws of this state. Records pertaining to alcohol abuse or drug abuse shall not be produced in response to a subpoena alone. Records which are produced must bear notice to the recipient concerning restrictions on further use or disclosure by the recipient.
- L. DBHDD shall maintain policies and procedures to protect the confidentiality of AIDS confidential information, as that term is defined by law, including but not

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limited to procedures for making authorized disclosures in accordance with applicable laws.

- M. DBHDD shall have a method to allow individuals to exercise their right to request that DBHDD amend PHI or a record about the individual in a designated record set used in whole or in part to make decisions about the individual, for as long as DBHDD maintains the PHI in the designated record set.
- N. DBHDD shall maintain policies and procedures to permit an individual to request a restriction of disclosures. DBHDD is not required to agree with the restriction.
- O. DBHDD shall establish policies and procedures for an individual to access and inspect his/her PHI in a designated record set for as long as DBHDD maintains the PHI in the designated record set. DBHDD shall provide for state law exceptions limiting an individual's access to his/her PHI under certain circumstances when the individual is currently an inpatient of a facility.
- P. DBHDD shall keep an accounting of when and to whom disclosures of PHI are made for purposes other than treatment, payment and health care operations, and shall be able to give an accounting of those disclosures to an individual, if requested. Authorizations from an individual to DBHDD are included in the information that is to be tracked and accounted for. A disclosure of PHI that does not require an authorization may, in some cases, have a tracking and accounting requirement.
- Q. DBHDD shall maintain policies and procedures:
 1. for representatives of individuals, as defined in Title 37 of the Georgia Code, to be named by individuals or by DBHDD;
 2. for certain required disclosures to representatives; and
 3. for certain disclosures to and consultation with representatives, unless the individual objects.
- R. DBHDD shall obtain from its business associates reasonable assurances that they will appropriately safeguard PHI disclosed by DBHDD and that agents, employees and subcontractors of the business associates agree to the same conditions applicable to the business associates with respect to such information. DBHDD shall include HIPAA compliance requirements in contracts, other written agreements and expressions of understanding, with business associates to whom DBHDD discloses PHI.
- S. DBHDD shall mitigate, to the extent practicable, any known harmful effect resulting from a use or disclosure of PHI by DBHDD or a business associate, provided such disclosure is in violation of DBHDD policies and procedures or the requirements of the confidentiality laws or HIPAA.
- T. DBHDD shall develop and communicate to individuals a process for filing complaints about the department's privacy practices or perceived violations of

DBHDD	SUBJECT: Confidentiality and HIPAA	Policy 23-100
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confidentiality laws or HIPAA. Such process shall include expectations regarding cooperation with investigations regarding complaints and for reporting as required for compliance reviews.

- U. DBHDD shall have policies and procedures documented so that employees are aware of what actions are prohibited and punishable. Such policies and procedures shall provide for sanctions that comply with the HIPAA standard for sanctions against members of DBHDD’s workforce who fail to comply with its privacy policies and procedures. Appropriate sanctions shall be imposed for violations of DBHDD’s privacy policies and procedures, or related protocols, standards or directives. DBHDD policies and procedures shall provide appropriate protection for whistleblowers. Sanctions that may be imposed by DBHDD are cumulative of those that may be imposed by statute or regulation.

- V. Neither DBHDD or its employees, workforce members, or agents, shall intimidate, threaten, coerce, harass, discriminate against, or take other retaliatory action against any individual or other person for:
 - Exercising any right established, or for participation in any process provided for, by DBHDD policies and procedures regarding confidentiality and HIPAA;
 - Filing a complaint regarding DBHDD policies or procedures or compliance with such policies or procedures;
 - Testifying, assisting, or participating in an investigation, compliance review, proceeding, or administrative hearing regarding violations of HIPAA;
 - Opposing any act or practice made unlawful by HIPAA regulations, provided the individual or person has a good faith belief that the practice opposed is unlawful, and the manner of opposition is reasonable and does not involve a disclosure of protected health information that violates HIPAA regulations.

- W. DBHDD facilities have custody of a variety of types of records, such as incident reports and other administrative records, which may contain confidential or protected health information about an individual. It is the policy of DBHDD to protect confidential and protected health information according to law, when such information is in records that are requested under the Georgia Open Records Act, in administrative hearings, in lawsuits, or by any other lawful means.

- X. DBHDD shall train all current and newly hired members of its workforce on its privacy policies and procedures as necessary and appropriate for them to carry out their functions within DBHDD, according to a training plan for HIPAA awareness. Newly hired persons shall be trained within a reasonable time after being hired. If the functions of workplace members are materially affected by a change in DBHDD policies, training will be provided within a reasonable time after such change in policy.

- Y. DBHDD shall designate a Privacy Officer who shall be responsible for receiving complaints and to provide privacy practice information. The Privacy Officer shall develop and implement, and maintain an adequate working knowledge of

DBHDD	SUBJECT: Confidentiality and HIPAA	Policy 23-100
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DBHDD's privacy and security policies and procedures and of the confidentiality laws and HIPAA, to respond to HIPAA related inquiries arising within DBHDD, provide information regarding the complaint process and maintain adequate documentation of these activities. The Privacy Officer shall submit reports of privacy related activities periodically to the Commissioner of the Department upon request.

- Z. DBHDD shall designate a Security Officer who shall be responsible for receiving complaints regarding security and to provide Security Rule information. The Security Officer shall obtain and maintain an adequate working knowledge of DBHDD's privacy and security policies and procedures and of the confidentiality laws and HIPAA, respond to Security Rule related inquiries arising within DBHDD, provide information regarding the security complaint process and maintain adequate documentation of these activities. The Security Officer shall submit reports of security related activities periodically to the Commissioner of the Department upon request.

- AA. The Privacy Officer and Security Officer shall work jointly and coordinate on appropriate policies, procedures, reports and projects as applicable.

- BB. DBHDD may appoint Privacy Coordinators at the regional, institutional or other administrative level, who are responsible for receiving complaints. Privacy Coordinators shall obtain and maintain a working knowledge of DBHDD's privacy and security policies and procedures and of confidentiality laws and HIPAA. Privacy Coordinators must submit reports as required to the Privacy Officer and Security Officer.

- CC. DBHDD shall maintain policies and procedures regarding reporting of violations of confidentiality rights and HIPAA. Violation of DBHDD privacy policies and procedures shall be communicated to the Privacy Coordinator, and then to the Privacy Officer, and additionally to the Security Officer as appropriate. Violation reports shall include the date of discovery and the date of breach if known; a brief description of what happened; a brief description of the types of PHI involved in the breach; a description of any actions taken to investigate the breach, actions taken within the work unit to mitigate harmful effects of the violation and prevent recurrence; any steps the individual should take to protect himself/herself from potential harm from the breach; contact information for the individual to ask questions of the Privacy Coordinator or investigator; and if known, the name and title of the violator, information about the violator's intent and information on previous similar occurrences. Violation reports shall be in writing for documentation purposes.

- DD. DBHDD shall maintain policies and procedures regarding identification of breaches of HIPAA and reporting of breaches. Privacy Coordinators, in consultation with the Privacy Officer and/or the Office of Legal Services, shall determine whether violations also constitute breaches and ensure that notifications

DBHDD	SUBJECT: Confidentiality and HIPAA	Policy 23-100
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are made, as required by the HITECH Act and HIPAA, to the individual, the Secretary of HHS, and the news media.

- EE. DBHDD shall allow authorized revisions of confidentiality and HIPAA policies and procedures in response to changes in administrative, operating or programmatic requirements. The DBHDD Privacy Officer must approve any and all revisions.
- FF. DBHDD shall adopt supplemental internal privacy policies and procedures where necessary to meet the requirements of specific programs, activities, or federal or state laws and regulations. Such policies and procedures shall conform to those of the Department, confidentiality laws and HIPAA, and are subject to review by the DBHDD Privacy Officer.
- GG. DBHDD shall examine and revise its confidentiality and HIPAA policies and procedures on an ongoing basis and as necessary to satisfy requirements of confidentiality laws and HIPAA.
- HH. DBHDD maintains policies and procedures regarding its activities which may address confidentiality or disclosures that are a part of such activity. The provisions of this policy apply generally to those policies and procedures unless specifically stated otherwise in such policies. Questions regarding policy applicability or interpretation should be sent to the Office of Legal Services. Such policies and activities include, but are not limited to:
 - 1. Research involving human subjects
 - 2. Reporting of abuse, neglect, or exploitation
 - 3. Required reporting of diseases or injuries
 - 4. Required reporting of criminal conduct
 - 5. Protection and Advocacy under federal regulations; and
 - 6. Advance Directives.

LEGAL REFERENCES

- 1. 42 United States Code Annotated, 290dd-2
- 2. 42 CFR Part 2
- 3. 45 CFR Parts 160 and 164.
- 4. Official Code of Georgia Annotated 24-9-40 and 24-9-47; 31-9-22.1; 31-32-1 et seq.; 37-1-1; 37-2-2; Chapter 3 of Title 37; 37-3-166 (Mental Illness); Chapter 4 of Title 37; 37-4-125 (Developmental disability); Chapter 7 of Title 37; 37-7-166 (Substance Abuse).
- 5. Rules and Regulations of the Department of Human Resources, Chapter 290-4-6, "Patients' Rights."

REFERENCE MATERIALS

- 1. SAMHSA and the Office of the National Coordinator (ONC) for Health Information Technology Frequently Asked Questions (FAQs) for Applying the Substance Abuse Confidentiality Regulations to the Health Information Exchange (HIE).



Georgia Department of Behavioral Health & Developmental Disabilities

Name of Individual/Consumer/Patient/Applicant

Social Security Number AND/OR Date of Birth

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize:

(Name of Person or Agency to whom information should be given - requesting agency)

(Address)

to obtain from:

(Name of health care provider holding the information - releasing agency)

(Address)

the following type(s) of information from my records (and any specific portion thereof):

I authorize the disclosure of alcohol or drug abuse information, if any.(Please see paragraph 2 below)

Initials

I authorize the disclosure of information, if any, concerning testing for HIV (human immunodeficiency virus) and/or treatment for HIV or AIDS (acquired immune deficiency syndrome) and any related conditions.

for the purpose of:

- 1. I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except as set forth in paragraph 2 below).
2. I understand that, pursuant to 42 C.F.R Part 2, alcohol and drug abuse records that I authorize to be disclosed pursuant to this document may not be further re-disclosed without my written consent, except by a court order that complies with the preconditions set forth at 42 C.F.R. 2.61 et seq., or the other limited circumstances specifically permitted by 42 C.F.R. Part 2. Any individual that makes such a disclosure in violation of these provisions may be reported to the United States Attorney and be subject to criminal penalties.
3. I understand that the Department or my healthcare provider will not condition my treatment, payment, or eligibility for any applicable benefits on whether I provide authorization for the requested release of information.
4. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and state law, and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)

one (1) year.

the period necessary to complete all transactions on matters related to services provided to me.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may revoke this authorization at any time by sending written notice of my withdrawal of this authorization to the staff of the healthcare provider who is providing services to me, OR to the Department's Privacy Officer at 2 Peachtree St. NW, Suite 22.240 Atlanta, GA 30303-3142. Fax: 404-657-2173

Date

Signature of Individual/Consumer/Patient/Applicant

Signature of Witness (Title or Relationship to Individual)

Signature of (check one): Date
Parent Guardian Court-appointed Custodian of Minor
Agent designated by Individual's Advance Directive

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

Date this authorization is revoked by Individual

Signature of Individual or legally authorized Representative

<p>Georgia Department of Behavioral Health & Developmental Disabilities</p> <p>Facility/Program/Hospital Name Address, City, State, Zip Contact numbers</p> <p>DBHDD Policies 23-100 and 23-101</p> <p>NOTICE OF PRIVACY PRACTICES FORM</p>	<p>Stamp Plate</p>
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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY THE DEPARTMENT AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This notice is effective September 1, 2011. It is provided to you under the Health Insurance Portability and Accountability Act of 1996 and related federal regulations (HIPAA). If you have questions about this Notice please contact your Treatment Provider or Services Provider, or the Department's Privacy Officer at the address below.

The Department of Behavioral Health and Developmental Disabilities (DBHDD) is an agency of the State of Georgia responsible for certain programs which deal with medical and other confidential information. Both federal and state laws establish strict requirements regarding the disclosure of confidential information, and the Department must comply with those laws. For situations where stricter disclosure requirements do not apply, this Notice of Privacy Practices describes how the Department may use and disclose your "protected health information" for treatment, payment, health care operations, and for certain other purposes. This notice also describes your rights regarding your protected health information. **Protected health information** is information that may personally identify you and relates to your past, present or future physical or mental health or condition and related health care services. The Department is required to provide you this Notice of Privacy Practices, and to abide by its terms, and may change the terms of this notice at any time. A new notice will be effective for all protected health information that the Department maintains at the time of issuance. The Department will provide you with any revised Notice of Privacy Practices by posting copies at its facilities, publication on the Department's website, in response to a telephone or facsimile request to the Privacy Officer, or in person at any facility where you receive services from the Department.

1. Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by the Department, its administrative and clinical staff and others involved in your care and treatment for the purpose of providing health care services to you, and to assist in obtaining payment of your health care bills.

a. Treatment: Your protected health information may be used to provide, coordinate, or manage your health care and any related services, including coordination of your health care with a third party that has your permission to have access to your protected health information, such as, for example, a health care professional who may be treating you, or to another health care provider such as a specialist or laboratory.

b. Payment: Your protected health information may be used to obtain payment for your health care services. For example, this may include activities that a health insurance plan requires before it approves or pays for health care services such as: making a determination of eligibility or coverage, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

c. Health Care Operations: The Department may use or disclose your protected health information to support the business activities of the Department, including, for example, but not limited to, quality assessment activities, employee review activities, training, licensing, and other business activities. Your protected health information may be used to contact you about appointments or for other operational reasons. Your protected health information may be shared with third party "business associates" who perform various activities that assist us in the provision of your services.

2. Other Permitted or Required Uses and Disclosures with Your Authorization or Opportunity to Object: Other uses and disclosures of your protected health information will be made only with your written authorization, which you may revoke at any time to the extent that the Department has not acted upon your authorization, **except** as permitted or required by law as described below. The Department may use and disclose your protected health information when you authorize in writing such use or disclosure of all or part of your protected health information. If you are hospitalized, the Department may use and disclose certain protected health information to your representative, as that term is defined in the Georgia Mental Health Code, upon your admission or discharge; you may be given a chance to object to certain other disclosures to your representative.

a. Confidentiality of Alcohol and Drug Abuse Patient Records: The confidentiality of patient records which disclose any information identifying you as an alcohol or drug abuser is protected by federal law and regulations. This information generally will not be disclosed unless you consent in writing, the disclosure is allowed by a court order, or the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation. Violation of these federal laws and regulations by the facility, treatment or service provider, or the Department, is a crime. You may report violations to appropriate authorities in accordance with the federal regulations. Federal regulations do not protect any information about a crime committed by you either at a facility or program or against any person who works at a facility or program or about any threat to commit such a crime. Federal regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

b. AIDS confidential information: AIDS confidential information, including HIV status or testing information, is confidential under state law. Generally, the Department will not disclose AIDS confidential information without your authorization. The Department may disclose this information in certain circumstances to protect persons at risk of infection by you, including your family and health care providers. The

Department may disclose AIDS confidential information in certain circumstances as part of your mental health commitment or by other legal procedures.

3. Permitted or Required Uses and Disclosures without Your Authorization or Opportunity to Object: The Department may use or disclose your protected health information without your authorization for continuity of your care or for your treatment in an emergency or when clinically required; when required to do so by law; for public health purposes; to a person who may be at risk of contracting a communicable disease; to a health oversight agency; to an authority authorized to receive reports of abuse or neglect; in certain legal proceedings, such as hearings regarding your hospitalization or commitment or to comply with workers' compensation laws; and for certain law enforcement purposes. Protected health information may also be disclosed without your authorization to a coroner or medical examiner, and to the legal representative of your estate.

4. Required Uses and Disclosures: Under the law, the Department must make certain disclosures to you, and to the Secretary of the United States Department of Health and Human Services when required to investigate or determine the Department's compliance with the requirements of HIPAA regulations beginning at 45 CFR Section 164.500.

5. Your Rights: The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

a. You have the right to inspect and copy your protected health information: You may inspect and obtain a copy of protected health information about you for as long as the Department maintains the protected health information. This information includes medical and billing records and other records the Department uses for making medical and other decisions about you. A reasonable, cost-based fee for copying, postage and labor expense may apply. Under federal law you may not inspect or copy psychotherapy notes; information compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding, or protected health information that is subject to a federal or state law prohibiting access to such information. While you are hospitalized, your physician may restrict your right to review your records if it would be harmful to your physical or mental health.

b. You have the right to request restriction of your protected health information: You may ask the Department not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations, and not to disclose protected health information to family members or friends who may be involved in your care. Such a request must state the specific restriction requested and to whom you want the restriction to apply. The Department is not required to agree to a restriction you request, and if the Department believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted, except as required by law. If the Department does agree to the requested restriction, the Department may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

c. You have the right to request to receive confidential communications from us by alternative means or at an alternative location: Upon written request to a person listed in section 6 below, the Department will accommodate reasonable requests for alternative means for the communication of confidential information with you, but may condition this accommodation upon your provision of an alternative address or other method of contact. The Department will not request an explanation from you as to the basis for the request.

d. You may have the right to request amendment of your protected health information: If the Department created your protected health information, you may request an amendment of that information for as long as it is maintained by the Department. The Department may deny your request for an amendment, and if it does so will provide information as to any further rights you may have with respect to such denial. Please contact one of the persons listed in section 6 below if you have questions about amending your protected health information.

e. You have the right to receive an accounting of certain disclosures the Department has made of your protected health information: This right applies only to disclosures for purposes other than treatment, payment or healthcare operations, and does not apply to any disclosures the Department made to you, to family members or friends or representatives, as defined in the Georgia Mental Health Code, who are involved in your care, or for national security, intelligence or notification purposes. You have the right to receive legally specified information regarding disclosures occurring in the six (6) years before your request, subject to certain exceptions, restrictions and limitations.

f. You have the right to obtain a paper copy of this notice from the Department, upon request.

6. Complaints: You may complain to us and to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint in writing with the Department facility providing your treatment or services, or your treatment provider or services provider under contract or agreement with the Department which maintains your protected health information at telephone _____, facsimile _____, or by mail to _____. You must state the basis for your complaint. Neither the facility, the provider, nor the Department will retaliate against you for filing a complaint. You may also contact the **Department's Privacy Officer by telephone at (404) 657-2282, facsimile (404) 657-2173, or by mail to 2 Peachtree Street NW, Room 22.240, Atlanta, Georgia 30303-3142,** for further information about the complaint process or this notice.

Please sign a copy of this Notice of Privacy Practices for your provider's and the Department's records.

I have received a copy of this Notice on the date indicated below.

Signature of Individual or Legally Authorized Person

Date

Stamp Plate




Chapter: Information Management and Information Technology
Subject: Notice of Privacy Practices

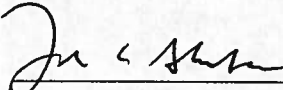
Applicability: DBHDD, including the state office, regional offices, state operated DBHDD hospitals and any state operated community programs.

Effective Date: September 1, 2011
Full Implementation Date: November 1, 2011
Next Review Date: September 2013
Approved:

Attachments:

Attachment A: Notice of Privacy Practices Form

 8/22/11
Elizabeth Bentley Watson, Esq. Date
Privacy Officer

 8/22/11
Frank E. Sheip, M.D., M.P.H., Commissioner Date

POLICY

It is the policy of DBHDD to provide adequate notice to individuals of the uses and disclosures of PHI it may make by providing a Notice of Privacy Practices to persons seeking or receiving services. DBHDD shall document its compliance with the notice requirements by retaining copies of the notices it issues. DBHDD shall not require individuals to waive their rights as provided in the Notice as a condition of treatment, payment or eligibility for benefits.

APPLICABILITY

DBHDD is a "covered entity" as defined in, and as governed by, the Health Insurance Portability and Accountability Act of 1996 and its regulations (HIPAA).

This policy is therefore applicable to any facility or program that is a part of DBHDD, including the state office, regional offices, state operated DBHDD hospitals and any state operated community programs.

This policy and associated forms are available as resources for providers, but DBHDD makes no representation or warranty that compliance with the provisions of this policy will ensure a provider's compliance with all applicable laws and regulations. Providers should seek their own legal counsel regarding compliance with laws and regulations on the subject matter of this policy.

DEFINITIONS

All defined terms used in this policy shall have the same meaning as defined in the Department of Behavioral Health and Developmental Disabilities' Confidentiality and HIPAA Policy #23-100.

DBHDD	SUBJECT: Notice of Privacy Practices	Policy: 23-101
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PROCEDURES

- A. All individuals seeking or receiving services are entitled to written notice of the privacy practices of the Department of Behavioral Health and Developmental Disabilities (DBHDD). DBHDD will ensure that a copy of the Notice of Privacy Practices (**Attachment A**) is provided to individuals, parents or legal custodians of minor individuals, and guardians of individuals who are seeking, applying for, or receiving services from DBHDD.
- B. The Notice must be in plain language and must include:
1. A header stating, "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."
 2. Information regarding uses and disclosures of PHI.
 3. Statement of an individual's privacy rights regarding protected health information.
 4. DBHDD's responsibilities under the Privacy Rule.
 5. A description of any federal or state laws or regulations that may apply in addition to, or instead of, HIPAA regulations.
 6. How to file complaints with the provider, DBHDD, or the Secretary of Health and Human Services.
 7. Name or title and phone number of the designated contact for more information on DBHDD's privacy practices.
 8. Effective date of the Notice.
- C. The Notice of Privacy Practices (Attachment A) must be used, without alteration of the substantive content, by DBHDD state-owned or state-operated facilities or programs. The facility or program may add its name and address and the contact information for the designated contact person at the facility or program who can provide information on privacy practices.
- D. Individuals must be given the Notice of Privacy Practices on the date of first service delivery, including services delivered electronically, or in an emergency treatment situation, as soon as reasonably practicable after the emergency treatment situation.
1. If the first service delivery to an individual is delivered electronically, the covered health care provider must provide electronic notice automatically and contemporaneously in response to the individual's first request for service.
 2. The individual who is the recipient of electronic notice retains the right to obtain a paper copy of the notice upon request.
- E. DBHDD must make good faith efforts to obtain a written acknowledgment of receipt of the Notice of Privacy Practices, even when it is given electronically. This acknowledgment may be made by the individual, parent or legal custodian (for minor individuals) or guardian of the person of an individual. In the event the individual, parent or legal custodian, or guardian declines to provide such an acknowledgment, the effort to obtain it and the reason why acknowledgment was not obtained, should

DBHDD	SUBJECT: Notice of Privacy Practices	Policy: 23-101
		Page 3 of 3

be documented. A copy of the Notice of Privacy Practices (signed if possible) will be kept in the individual's clinical record.

- F. Every individual, and his/her parent or guardian if applicable, is entitled to a copy of the Notice of Privacy Practices upon request.
- G. DBHDD facilities, including regional offices, must ensure that the Notice of Privacy Practices is posted at all times in a prominent location where it is reasonable to expect individuals who are seeking or receiving services to be able to read the Notice. Additional copies must be available for distribution upon request.
- H. DBHDD will post the Notice of Privacy Practices upon its website and make the Notice available electronically through its website.
- I. DBHDD will promptly revise and re-distribute and post its Notice of Privacy Practices whenever there is a material change to uses and disclosures, the individual's rights, DBHDD's legal duties, or other privacy practices stated in the Notice. Distribution shall include DBHDD staff, regional offices, state-owned or state operated facilities, and individuals. Distribution to providers shall be through publication in the Provider Manual or its updates. Notice must be provided to individuals within 60 days of a material revision to the Notice.
- J. DBHDD shall not require individuals to waive their rights as provided in the Notice of Privacy Practices as a condition of treatment, payment or eligibility for benefits.

LEGAL REFERENCES

45 C.F.R § 164.520

<p>Georgia Department of Behavioral Health & Developmental Disabilities</p> <p>Facility/Program/Hospital Name Address, City, State, Zip Contact numbers</p> <p>DBHDD Policies 23-100 and 23-101</p> <p>NOTICE OF PRIVACY PRACTICES FORM</p>	<p>Stamp Plate</p>
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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY THE DEPARTMENT AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This notice is effective September 1, 2011. It is provided to you under the Health Insurance Portability and Accountability Act of 1996 and related federal regulations (HIPAA). If you have questions about this Notice please contact your Treatment Provider or Services Provider, or the Department's Privacy Officer at the address below.

The Department of Behavioral Health and Developmental Disabilities (DBHDD) is an agency of the State of Georgia responsible for certain programs which deal with medical and other confidential information. Both federal and state laws establish strict requirements regarding the disclosure of confidential information, and the Department must comply with those laws. For situations where stricter disclosure requirements do not apply, this Notice of Privacy Practices describes how the Department may use and disclose your "protected health information" for treatment, payment, health care operations, and for certain other purposes. This notice also describes your rights regarding your protected health information. **Protected health information** is information that may personally identify you and relates to your past, present or future physical or mental health or condition and related health care services. The Department is required to provide you this Notice of Privacy Practices, and to abide by its terms, and may change the terms of this notice at any time. A new notice will be effective for all protected health information that the Department maintains at the time of issuance. The Department will provide you with any revised Notice of Privacy Practices by posting copies at its facilities, publication on the Department's website, in response to a telephone or facsimile request to the Privacy Officer, or in person at any facility where you receive services from the Department.

1. Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by the Department, its administrative and clinical staff and others involved in your care and treatment for the purpose of providing health care services to you, and to assist in obtaining payment of your health care bills.

a. Treatment: Your protected health information may be used to provide, coordinate, or manage your health care and any related services, including coordination of your health care with a third party that has your permission to have access to your protected health information, such as, for example, a health care professional who may be treating you, or to another health care provider such as a specialist or laboratory.

b. Payment: Your protected health information may be used to obtain payment for your health care services. For example, this may include activities that a health insurance plan requires before it approves or pays for health care services such as: making a determination of eligibility or coverage, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

c. Health Care Operations: The Department may use or disclose your protected health information to support the business activities of the Department, including, for example, but not limited to, quality assessment activities, employee review activities, training, licensing, and other business activities. Your protected health information may be used to contact you about appointments or for other operational reasons. Your protected health information may be shared with third party "business associates" who perform various activities that assist us in the provision of your services.

2. Other Permitted or Required Uses and Disclosures with Your Authorization or Opportunity to Object: Other uses and disclosures of your protected health information will be made only with your written authorization, which you may revoke at any time to the extent that the Department has not acted upon your authorization, **except** as permitted or required by law as described below. The Department may use and disclose your protected health information when you authorize in writing such use or disclosure of all or part of your protected health information. If you are hospitalized, the Department may use and disclose certain protected health information to your representative, as that term is defined in the Georgia Mental Health Code, upon your admission or discharge; you may be given a chance to object to certain other disclosures to your representative.

a. Confidentiality of Alcohol and Drug Abuse Patient Records: The confidentiality of patient records which disclose any information identifying you as an alcohol or drug abuser is protected by federal law and regulations. This information generally will not be disclosed unless you consent in writing, the disclosure is allowed by a court order, or the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation. Violation of these federal laws and regulations by the facility, treatment or service provider, or the Department, is a crime. You may report violations to appropriate authorities in accordance with the federal regulations. Federal regulations do not protect any information about a crime committed by you either at a facility or program or against any person who works at a facility or program or about any threat to commit such a crime. Federal regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

b. AIDS confidential information: AIDS confidential information, including HIV status or testing information, is confidential under state law. Generally, the Department will not disclose AIDS confidential information without your authorization. The Department may disclose this information in certain circumstances to protect persons at risk of infection by you, including your family and health care providers. The

Department may disclose AIDS confidential information in certain circumstances as part of your mental health commitment or by other legal procedures.

3. Permitted or Required Uses and Disclosures without Your Authorization or Opportunity to Object: The Department may use or disclose your protected health information without your authorization for continuity of your care or for your treatment in an emergency or when clinically required; when required to do so by law; for public health purposes; to a person who may be at risk of contracting a communicable disease; to a health oversight agency; to an authority authorized to receive reports of abuse or neglect; in certain legal proceedings, such as hearings regarding your hospitalization or commitment or to comply with workers' compensation laws; and for certain law enforcement purposes. Protected health information may also be disclosed without your authorization to a coroner or medical examiner, and to the legal representative of your estate.

4. Required Uses and Disclosures: Under the law, the Department must make certain disclosures to you, and to the Secretary of the United States Department of Health and Human Services when required to investigate or determine the Department's compliance with the requirements of HIPAA regulations beginning at 45 CFR Section 164.500.

5. Your Rights: The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

a. You have the right to inspect and copy your protected health information: You may inspect and obtain a copy of protected health information about you for as long as the Department maintains the protected health information. This information includes medical and billing records and other records the Department uses for making medical and other decisions about you. A reasonable, cost-based fee for copying, postage and labor expense may apply. Under federal law you may not inspect or copy psychotherapy notes; information compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding, or protected health information that is subject to a federal or state law prohibiting access to such information. While you are hospitalized, your physician may restrict your right to review your records if it would be harmful to your physical or mental health.

b. You have the right to request restriction of your protected health information: You may ask the Department not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations, and not to disclose protected health information to family members or friends who may be involved in your care. Such a request must state the specific restriction requested and to whom you want the restriction to apply. The Department is not required to agree to a restriction you request, and if the Department believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted, except as required by law. If the Department does agree to the requested restriction, the Department may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

c. You have the right to request to receive confidential communications from us by alternative means or at an alternative location: Upon written request to a person listed in section 6 below, the Department will accommodate reasonable requests for alternative means for the communication of confidential information with you, but may condition this accommodation upon your provision of an alternative address or other method of contact. The Department will not request an explanation from you as to the basis for the request.

d. You may have the right to request amendment of your protected health information: If the Department created your protected health information, you may request an amendment of that information for as long as it is maintained by the Department. The Department may deny your request for an amendment, and if it does so will provide information as to any further rights you may have with respect to such denial. Please contact one of the persons listed in section 6 below if you have questions about amending your protected health information.

e. You have the right to receive an accounting of certain disclosures the Department has made of your protected health information: This right applies only to disclosures for purposes other than treatment, payment or healthcare operations, and does not apply to any disclosures the Department made to you, to family members or friends or representatives, as defined in the Georgia Mental Health Code, who are involved in your care, or for national security, intelligence or notification purposes. You have the right to receive legally specified information regarding disclosures occurring in the six (6) years before your request, subject to certain exceptions, restrictions and limitations.

f. You have the right to obtain a paper copy of this notice from the Department, upon request.

6. Complaints: You may complain to us and to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint in writing with the Department facility providing your treatment or services, or your treatment provider or services provider under contract or agreement with the Department which maintains your protected health information at telephone _____, facsimile _____, or by mail to _____. You must state the basis for your complaint. Neither the facility, the provider, nor the Department will retaliate against you for filing a complaint. You may also contact the **Department's Privacy Officer by telephone at (404) 657-2282, facsimile (404) 657-2173, or by mail to 2 Peachtree Street NW, Room 22.240, Atlanta, Georgia 30303-3142,** for further information about the complaint process or this notice.

Please sign a copy of this Notice of Privacy Practices for your provider's and the Department's records.

I have received a copy of this Notice on the date indicated below.

Signature of Individual or Legally Authorized Person

Date

Stamp Plate




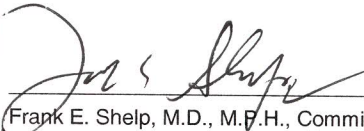
Chapter: Information Management & Information Technology
Subject: Reporting and Notification of Breaches of Confidentiality

Applicability: All DBHDD state operated facilities and programs, including Regional Offices

Creation Date: September 1, 2011
Last Reviewed Date: September 1, 2011
Last Revised Date: September 1, 2011
Full Implementation Date: November 1, 2011
Next Review Date: September 2013
Approved:

Attachments:
Attachment A: Privacy Violation Report Form

 8/31/11
Elizabeth Bentley Watson, Esq. Date
Privacy Officer

 8/31/11
Frank E. Shelp, M.D., M.P.H., Commissioner Date

POLICY

DBHDD and its business associates will notify an individual when there is a breach of HIPAA involving protected health information (PHI) relating to the individual, will notify the media of breaches when required by HIPAA, and will report breaches to the Secretary of the United States Department of Health and Human Services as required by HIPAA.

APPLICABILITY

This policy applies to all DBHDD state operated facilities and programs, including Regional Offices. Providers operating with DBHDD by contract or letter of agreement who are also "covered entities" under HIPAA have an independent duty to identify and report breaches of HIPAA as required by HIPAA law and regulations. Requirements of DBHDD business associates to report breaches are found in the DBHDD policy regarding business associates.

DEFINITIONS

Terms not defined below but defined in the DBHDD policy on Confidentiality and HIPAA (23-100) shall have the same meaning as defined in that policy.

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Breach – Not all violations of HIPAA are “breaches.” A violation of HIPAA is a breach if it also meets the following definition: The acquisition, use or disclosure of protected health information (PHI) in a manner not permitted by HIPAA, which compromises the security or privacy of the PHI.

The following are not breaches:

1. An unintentional acquisition, access, or use of PHI by an employee of DBHDD or a person acting under the authority of DBHDD, if the acquisition, access or use was made in good faith and within the scope of authority AND does not result in further use or disclosure in a manner not permitted by HIPAA.
2. An inadvertent disclosure by a person at DBHDD who is authorized to access PHI, to another person authorized to access PHI at DBHDD, when the PHI is not further used or disclosed in a manner not permitted by HIPAA.
3. A disclosure of PHI where DBHDD has a good faith belief that the unauthorized person to whom the disclosure is made would not reasonably have been able to retain the PHI.

Compromises the security or privacy – The violation poses a significant risk of financial, reputational, or other harm to the individual who is the subject of the PHI. If the violation involves a “limited data set” and does not include the identifiers listed in that definition and also the individual’s date of birth and zip code, it does not compromise the security or privacy of the PHI.

Date of discovery – The first day on which a violation of PHI is known by the facility, or would have been known by the exercise of reasonable diligence. The facility is deemed to have knowledge of a violation if the violation is known, or from the exercise of reasonable diligence would have been known, to any person other than the person committing the violation, who is a workforce member or agent. The date of discovery may be earlier than the date a complaint or report is received.

Limited data set – Protected health information that excludes the following direct identifiers of the individual or of relatives, employers or household members of the individual:

1. Names;
2. Postal address information, other than town or city, state, and zip code;
3. Telephone numbers;
4. Fax numbers;
5. Electronic mail addresses;
6. Social security numbers;
7. Medical record numbers;
8. Health plan beneficiary numbers;
9. Account numbers;
10. Certificate/license numbers;
11. Vehicle identifiers and serial numbers, including license plate numbers;
12. Device identifiers and serial numbers;

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13. Web Universal Resource Locators (URLs);
14. Internet Protocol (IP) address numbers;
15. Biometric identifiers, including finger and voice prints; and
16. Full face photographic images and any comparable images.

Secretary – The Secretary of the United States Department of Health and Human Services.

Substitute Notice – Notification reasonably calculated to reach the individual who is the subject of the breach, when there is insufficient or out-of-date contact information for the individual.

Unsecured protected health information (“unsecured PHI”) – PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of technology or a methodology specified by the Secretary of Health and Human Services in guidance issued on the HHS website.

Workforce – Under HIPAA, this means employees, volunteers, trainees, and other persons under the direct control of a covered entity, whether or not they are paid by the covered entity.

PROCEDURES

A. Identification of Breach

1. The facility or regional Privacy Coordinator or investigator reviews all HIPAA complaints and reports of potential violations within two business days of the date of discovery to determine whether there may be an urgent need to notify the individual of a breach involving his or her PHI. If the reviewer finds that there is possible imminent misuse of PHI, he/she will consult with the HIPAA Privacy Officer or with DBHDD Legal Services for consultation on whether an immediate notification is needed. Urgent notification may be made by telephone or other means, as appropriate, in addition to notification as described below.
2. HIPAA complaints and reports of violations shall be investigated promptly by the facility or region, pursuant to the DBHDD policy regarding HIPAA complaints. Investigations shall be completed no later than 30 days following the date of discovery.
3. Upon a finding of a violation of an individual’s privacy rights, the Violation Report form will be completed and provided to the Privacy Coordinator for the facility or office.
4. No later than 10 days following receipt of a report of violation, the Privacy Coordinator, in consultation with the HIPAA Privacy Officer or with DBHDD Legal Services, will determine (a) whether the violation also constitutes a breach as defined in this policy and (b) what reports and notifications, if any, need to be made, under this policy.

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5. Results of new information shall be reported to the Privacy Officer on the Violation Report form.

B. Notification to Individuals

1. The Privacy Coordinator will ensure that each individual whose unsecured PHI was disclosed in a breach of HIPAA, or is reasonably believed to have been accessed, acquired, used, or disclosed as a result of the breach, is notified of the breach.
2. Notification of a breach shall be made by the Privacy Coordinator without unreasonable delay, and in no case later than 60 calendar days after the date of discovery.
3. The notification shall be written in plain language, and shall include, to the extent possible:
 - a. A brief description of what happened, including the date of the breach and the date of discovery, if known.
 - b. A brief description of the types of unsecured PHI that were involved in the breach, such as whether full name, social security number, date of birth, home address, clinical record number, diagnosis, disability code, or other types of information were involved.
 - c. Any steps the individual should take to protect himself/herself from potential harm resulting from the breach.
 - d. A brief description of what the facility or office is doing to investigate the breach, to mitigate harm to individuals, and to protect against further breaches, AND
 - e. Contact information for the individual to ask questions or learn additional information from the Privacy Coordinator or investigator, including a toll-free telephone number, an e-mail address, or postal address. This does not require the facility or office to establish a toll-free number.
4. Notification shall be in writing and mailed by first-class mail to the individual at the last known address of the individual.
5. Notification may be made in one or more mailings as information is available.
6. If the facility knows the individual to be deceased and has the address of the next of kin, executor or administrator of the estate, or a person with authority to act on behalf of the individual's estate, notification goes to the either of these persons by first-class mail.

C. Substitute Notice

1. If the facility has insufficient or out-of-date contact information that precludes written notification to the individual, the facility or office shall use a substitute form of notice that is reasonably calculated to reach the individual.
2. The facility or office should make every attempt to identify a person to receive substitute notice who already is authorized to receive disclosures of information regarding the individual, such as the individual's representative under Georgia law, or a next of kin or family member whom the individual previously authorized

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to receive disclosures of information. If there is a problem identifying such a person, staff should consult Legal Services for the hospital or DBHDD, or the Privacy Officer.

3. It is not necessary to provide substitute notice to the next of kin or other contact regarding breaches of the PHI of a deceased individual, if there is insufficient or out-of-date contact information to reach such next of kin or other contact person.
4. When there is insufficient or out-of-date contact information regarding fewer than 10 individuals, substitute notice may be provided by an alternative form of written notice, telephone, or other means.
5. When there is insufficient or out-of-date contact information for 10 or more individuals, substitute notice shall:
 - a. Be by conspicuous posting for a period of 90 days on the home page of the facility, office, or DBHDD, or conspicuous notice in major print or broadcast media in geographic areas where the individuals likely reside; and
 - b. Include a toll-free phone number that remains active for at least 90 days where an individual can learn whether his/her protected health information may be included in the breach.

D. Urgent Situations

When DBHDD determines that urgency is required because of possible imminent misuse of unsecured protected health information, notice may be provided to individuals by telephone or other means, as appropriate, in addition to written notice.

E. Notification to the Media

1. For a breach of unsecured protected health information involving more than 500 residents of a State or jurisdiction, the facility or office shall notify prominent media outlets serving the State or jurisdiction.
2. Except when there is need for law enforcement delay as provided below, the facility or office shall provide notification to the media without unreasonable delay and in no case later than 60 calendar days after discovery of a breach.
3. Notice to the media shall, without disclosing the identity or protected health information of any individual, contain the same information as required for notice to an individual, to the extent possible.

F. Notification to the Secretary of Health and Human Services

In consultation with the Privacy Officer or Legal Services, the Privacy Coordinator shall make notification to the Secretary of violations that are determined to be breaches.

1. For breaches of unsecured protected health information involving 500 or more individuals, except when there is need for a law enforcement delay as provided below, the facility or office shall notify the Secretary contemporaneously with the notice to individuals, and in the manner specified on the HHS Web site.

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2. For breaches of unsecured protected health information involving less than 500 individuals, the facility or office shall maintain a log or other documentation of such breaches and, not later than 60 days after the end of each calendar year, provide notification to the Secretary for breaches occurring during the preceding calendar year, in the manner specified on the HHS Web site.
3. Instructions and forms for reporting to the Secretary are currently located at the following web page:
<http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brinstraction.html>

G. Law enforcement delay

If a law enforcement official states to a facility that a notification, notice, or posting required under these procedures would impede a criminal investigation or cause damage to national security, the Privacy Coordinator shall:

1. If the statement is in writing and specifies the time for which a delay is required, delay such notification, notice, or posting for the time period specified by the official; or
2. If the statement is made orally, document the statement, including the identity of the official making the statement, and delay the notification, notice, or posting temporarily and no longer than 30 days from the date of the oral statement, unless the Privacy Officer receives a written statement as described above during that time.

H. Documentation

Documentation of notifications and of compliance with these procedures must be maintained for a period not less than six (6) years from the time such documents are created.

LEGAL REFERENCES:

1. 45 CFR §§ 164.400 et seq.
2. Federal Register Vol. 74, pages 42740 and following, dated Monday, August 24, 2009.

**DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES
PRIVACY VIOLATION REPORT**

DATE: _____

TO: Privacy Officer
Department of Behavioral Health and Developmental Disabilities
2 Peachtree Street NW, Room 22.240
Atlanta, GA 30303
hipaa@dbhdd.ga.gov

THROUGH: _____
Facility/Program Administrator Title

FROM: **DBHDD Facilities and Offices:**

Privacy Coordinator Coordinator's Title and Work Unit

Facility Phone Number

OR: Business Associates:

Name of Business Associate Address City, State, Zip Code

Contact Person's Name & Title Contact Person's Phone(s) & e-mail

Please report potential violations of the HIPAA Privacy Rule using this form. Potential violations include unauthorized acquisition, access, use or disclosure of Protected Health Information (PHI).

As required by DBHDD Privacy Policies, I hereby submit the following information regarding a possible violation of the HIPAA Privacy Rule.

ALLEGED VIOLATION

Initial Report Yes No If this is an addendum, date of Initial Report: _____

Date of Discovery _____

Actual Occurrence date, if known _____

Number of individuals whose PHI was disclosed or involved: _____

Type of Violation: (check all that apply)

- Theft Loss Improper Disposal Hacking/IT incident Unauthorized Access/Disclosure
 Unknown Currently Under Investigation

Location(s) of violation: (check all that apply)

- Laptop Desktop Computer Network Server E-mail Other portable electronic device
 Electronic Medical Record Paper Currently Under Investigation Other: _____

Type of PHI involved: (check all that apply)

SSN? Yes No

DOB? Yes No

Demographic information Yes No Describe type: _____

Financial information Yes No Describe type: _____

Clinical information Yes No Describe type: _____

Other: _____
____ Currently Under Investigation

Description of the violation: Include location of violation, description of how the violation occurred, additional information regarding type of violation, type of media, and type of PHI involved. *Attach additional sheets if necessary.*

Safeguards in place prior to violation: (check all that apply)

- Firewalls Packet Filtering (router-based) Secure Browser Sessions Strong Authentication
 Encrypted Wireless Physical Security Logical Access Control Anti-virus Software
 Intrusion Detection Biometrics Currently Under Investigation Other: _____

Violator's Name, if known _____

Violator's Title, if known _____

Number of previous similar violations for this violator _____

Number of previous similar violations within this work unit _____

ACTIONS TAKEN (check all that apply)

- Security and/or Privacy Safeguards Mitigation Employee Sanctions Policies and Procedures
 Currently Under Investigation Other: _____

Describe actions taken to mitigate any potentially harmful effects of the violation. *Attach additional sheets if necessary.*

Describe all actions taken to reduce the possibility of recurrence of this violation within this work unit. *Attach additional sheets if necessary.*

Has this incident been determined to be a violation? Yes No

NOTIFICATION (IF REQUIRED)

If a violation, has violation been determined to constitute a breach? Yes No

Date of determination of breach: _____ By whom: _____

Notice of Breach to Individual(s) affected (if applicable): Individual: _____ Date: _____

Address or contact information where notification made: _____

Was Substitute Notice required? Yes No

To whom: _____ Relationship to Individual: _____

Address or contact information: _____

Media Notice (if required): Date: _____ Time: _____

Media Name(s): _____

Contact Person Name: _____ Contact Person phone: _____ E-mail: _____

Has a complaint been received or stated regarding this violation? Yes No If so, please attach a copy.

Has the complaint been resolved? Yes No If so, please attach a copy of relevant documents

Georgia Department of Human Resources Division of Mental Health, Developmental Disabilities and Addictive Diseases	DMHDDAD Policy # 3.200 – Protection of Individually Identifiable Health Information – Compliance with HIPAA
PROTOCOL 3.200-01: Individual Rights Regarding Protected Health Information	

INDIVIDUAL RIGHTS REGARDING PROTECTED HEALTH INFORMATION

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), an individual has the right to inspect and/or obtain a copy of his/her Protected Health Information (PHI), to request restriction of the uses and disclosures of his/her PHI, to request alternative means or location of communications of PHI, to correct or amend his/her PHI, and to receive an accounting of disclosures of PHI.

This protocol applies to all state owned and operated programs, and to all providers contracting with the Department through the regions. Each such entity is referred to in this protocol as the “record holder.”

I. Access to Protected Health Information (PHI)

A. Individual Access to One’s Own PHI.

1. A request for access to PHI must be acted upon within thirty-30-days of receipt; there may be one (1) extension for an additional thirty-30-days.
2. Reasonable fees may be charged for access to PHI based on actual cost, if the recipient agrees to the fees in advance.
3. The designated record sets that are subject to access by individuals must be documented. “Designated record set” includes the individual’s clinical record and billing records.
4. The titles of persons or offices responsible for receiving and processing requests for access to PHI must be documented.
5. Parents have the right to access and control health information about their minor children, with the following exceptions:
 - a) The fact that a minor has applied for substance abuse treatment may be disclosed to the parent, guardian, or court-ordered custodian only if:
 1. the minor gives written authorization
 - OR
 2. the clinical director of the program documents his/her finding that the minor child lacks capacity, either due to extreme youth or mental or physical condition, to make a rational decision on whether to authorize disclosure of substance abuse PHI.
 - b) Facts relevant to reducing a threat to the life or physical well-being of a minor applicant for substance abuse services or any other individual may be disclosed to the parent, guardian, or court-ordered legal custodian if, in the written opinion of the clinical director,
 1. the minor child lacks capacity to make a rational decision, either due to extreme youth or mental or physical condition, on whether to authorize disclosure of substance abuse PHI to the parent, guardian, or court-ordered legal custodian, AND
 2. the applicant’s situation poses a substantial threat to the life or physical well being of him/herself or any other person, which may be reduced by communicating relevant facts to the minor’s parent, guardian, or court-ordered custodian.
 - (c) For a minor who is undergoing substance abuse treatment by consent of his/her parent, guardian, or court-ordered custodian, disclosure of substance abuse PHI requires the consent of both the minor child and the parent/guardian.
6. All documentation related to requests for access to PHI must be retained for a minimum of six (6) years.

Georgia Department of Human Resources Division of Mental Health, Developmental Disabilities and Addictive Diseases	DMHDDAD Policy # 3.200 – Protection of Individually Identifiable Health Information – Compliance with HIPAA
PROTOCOL 3.200-01: Individual Rights Regarding Protected Health Information	

B. Denial of an Individual’s Access to His/Her Own PHI

1. Denials of requests for access must be in writing.
2. Access to an individual’s PHI may be denied without providing the individual an opportunity for review in the following cases:
 - a. Psychotherapy notes. “Psychotherapy notes” for purposes of this protocol and the Privacy Rule, is defined to mean notes recorded in any medium by a mental health professional documenting or analyzing the contents of a 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. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.
 - b. Information compiled in anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.
 - c. Information created or obtained in the course of research that includes treatment may be temporarily suspended for as long as the research is in progress.
3. An individual’s access to his/her own PHI may also be denied in the following circumstances, provided the individual is given the right to have the denial reviewed:
 - a) The chief medical officer or the individual’s treating physician has determined, in the exercise of professional judgment, that the access requested is detrimental to the individual’s physical or mental health. This restriction applies only to individuals who are currently being treated by the facility or program from which they are requesting records.
 - b) The PHI makes reference to another person (unless the other person is a health care provider) and the chief medical officer or the individual’s treating physician has determined, in the exercise of professional judgment, that the access requested is likely to cause substantial harm to such other person. However, names and PHI of other individuals who are patients or consumers will always be redacted, and this restriction is not subject to review.
 - c) The request for access is made by the parent of a minor, court-ordered custodian of a minor, guardian of the person of an individual, or a legal representative of the individual’s estate, and the chief medical officer or the individual’s treating physician has determined, in the exercise of professional judgment, that the provision of access to the requestor is reasonably likely to cause substantial harm to the individual or another person.
4. If a request to access PHI is denied, the individual has the right to have the denial reviewed by a licensed health care professional who is designated by the record holder to act as a reviewing official and who did not participate in the original decision to deny access; DMHDDAD must abide by the reviewing official’s decision as final.
5. If an individual’s request to access PHI is denied, the denial must comply with the requirements of the Privacy Rule, which include:
 - a. Making other information accessible.
 - b. Providing a timely, written denial in plain language that must include the basis for the denial, a statement of the individual’s right to have the denial reviewed (if applicable) and a description of the procedures for complaints to the record holder, DMHDDAD, DHR or the Secretary of DHHS.

Georgia Department of Human Resources Division of Mental Health, Developmental Disabilities and Addictive Diseases	DMHDDAD Policy # 3.200 – Protection of Individually Identifiable Health Information – Compliance with HIPAA
PROTOCOL 3.200-01: Individual Rights Regarding Protected Health Information	

- c. If the record holder does not maintain the PHI for which access has been requested, but knows where the requested PHI is maintained, the record holder must inform the individual where to direct the request for access.
- d. All requests for review must be promptly referred to the designated reviewing official; the designated official must make a determination within a reasonable period of time.
- e. All documentation related to denial of requests for access to PHI must be retained for a minimum of six (6) years.

II. Individual’s Restriction of Access by Others to His/Her Protected Health Information (PHI)

- A. Individuals must be permitted to request the restriction of use and disclosure of the individual’s PHI.
 - 1. The record holder does not have to agree to the request for restriction.
 - 2. If the record holder agrees to the request for restriction, both the record holder, DMHDDAD and their business associates shall honor the restriction, until the record holder or the individual requesting the restriction terminates the restriction.
 - 3. If the individual terminates the restriction, the record holder may use and disclose PHI as permitted under the Privacy Rule, applicable law and regulations, and Division policies; if the record holder terminates the restriction without the individual’s agreement, it may only terminate the restriction with respect to PHI that it creates or receives after it informs the individual of the termination.
 - 4. In the case of an emergency treatment situation, the record holder is allowed to release PHI to the health care provider and the health care provider will be requested to not further use or disclose the PHI.
 - 5. The record holder shall document the restriction to which it and the individual have mutually agreed in the individual’s clinical record.
 - 6. All documentation related to restricting access to PHI must be retained for a minimum of six (6) years.

III. Individuals must be permitted to request to receive communications of PHI from the record holder by alternative means or alternative locations.

- A. The record holder must accommodate reasonable requests.
- B. The record holder may require that the individual put the request in writing.
- C. The record holder may condition reasonable accommodation of the request on:
 - 1. When appropriate, information as to how payment, if any, will be handled, and
 - 2. Specification of an alternative address or other method of contact.
- D. The record holder may not require an explanation from the individual for the basis of the request.

IV. Amending Protected Health Information (PHI)

- A. Individuals may request the amendment of their PHI maintained in the designated record set (the individual’s clinical record or billing records).
 - 1. Requests for PHI amendments must be made in writing, and must include a reason to support the requested amendment; individuals must be informed in advance of these requirements.
 - 2. Requests for a PHI amendment must be acted upon no later than 5 days following receipt of the request.
 - 3. The record holder must respond to the request by providing the individual with a written acknowledgment, if the request includes sufficient information to permit a reply to be mailed to the individual.
- B. If a request for amendment of PHI is accepted, in whole or in part, the record holder must:
 - 1. Make the appropriate amendment to the PHI or record that is the subject of the request for amendment by, at a minimum, identifying the records in the designated record set that are affected

Georgia Department of Human Resources Division of Mental Health, Developmental Disabilities and Addictive Diseases	DMHDDAD Policy # 3.200 – Protection of Individually Identifiable Health Information – Compliance with HIPAA
PROTOCOL 3.200-01: Individual Rights Regarding Protected Health Information	

- by the amendment and appending or otherwise providing a link to the location of the amendment, while preserving the original record.
- 2. Timely inform the individual that the PHI amendment is accepted and obtain the individual's identification of, and agreement to have the record holder notify, the relevant persons with which the amendment needs to be shared as set forth below.
- 3. Make reasonable efforts to inform and provide the amendment, within a reasonable time, to persons identified by the individual as having received PHI about the individual and needing the amendment; and business associates that the record holder knows may have the PHI that is the subject of the amendment and who may have relied on such information to the detriment of the individual.

C. Denial of Request to Amend Protected Health Information (PHI)

- 1. An individual's request for amendment of PHI may be denied if the record holder determines that the PHI or record that is the subject of the request:
 - a. Was not created by the record holder, unless the individual provides a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment.
 - b. Is for information that is not part of the designated record set (the individual's clinical record and billing records).
 - c. Would not be accessible to the individual under section I.B. of this protocol.
 - d. Is accurate and complete.
- 2. If a request for amendment of PHI is denied, in whole or in part, the record holder must provide the individual with a timely, written denial, written in plain language and containing:
 - a) The basis for the denial.
 - b) The individual's right to submit a written statement disagreeing with the denial and how the individual might file such a statement which will be included in the individual's clinical record.
 - c) A statement that, if the individual does not submit a written statement of disagreement, the individual may request the record holder to include his/her request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment.
 - a) A description of how the individual may complain to the record holder, DMHDDAD, the Department of Human Resources (DHR) or to the Secretary of the Department of Health and Human Services (DHHS), including name, or title, and telephone number of the contact office or person designated to receive complaints.
- 3. The individual may submit to the record holder, DMHDDAD and/or DHR a written statement no more than two (2) pages in length, disagreeing with the denial of all or part of a requested amendment and the basis of such a disagreement.
- 4. A written rebuttal to the individual's statement of disagreement may be prepared, in which case the record holder must provide a copy to the individual who submitted the statement of disagreement.
- 5. The record holder must, as appropriate, identify the record or the PHI in the designated record set (the individual's clinical record and billing records) that is the subject of the disputed amendment and append or otherwise link the individual's request for amendment; the denial of the request, the individual's statement of disagreement, if any, and the record holder's rebuttal, if any, to the designated record set. If the individual has submitted a statement of disagreement, the record holder must include the written disagreement with any subsequent disclosure of the PHI to which the disagreement relates.
 - a) When subsequent disclosure described above is made using an electronic transaction that does not permit the additional material to be included, the record holder may separately transmit the

PROTOCOL 3.200-01:

Individual Rights Regarding Protected Health Information

material required by the Amending PHI section of this protocol to the recipient of the electronic transaction.

6. If the record holder is notified by another covered entity of an amendment to an individual's PHI, it must amend the designated record set (clinical record and billing record) maintained by the record holder.

D. The titles of persons or offices responsible for receiving and processing requests for PHI amendments must be documented.

E. All documentation related to amending PHI must be retained for a minimum of six (6) years.

V. Tracking Disclosures of Protected Health Information (PHI)

A. All disclosures of PHI will be tracked by documenting and retaining the accounting of all such disclosures; this documentation should contain the following information:

1. Date of disclosure.
2. Name of covered entity or individual who received the information and their address, if known.
3. Description of the information disclosed.
4. Purpose of the disclosure (or a copy of the individual's authorization or a copy of a written request for a disclosure for which authorization is not required).
5. The written accounting provided to an individual requestor.
6. Titles of persons or offices responsible for receiving and processing requests for accountings of disclosures.

B. Disclosures for purposes of treatment, payment or health care operations are excluded from the disclosure tracking and accounting requirements. Other excluded disclosures are those made:

1. Prior to the effective date of the rule (April 14, 2003).
2. To law enforcement officials or correctional institutions who have legal custody of the individual, where the disclosure is for treatment of the individual or the health and safety of other inmates and staff.
3. To the individual.
4. For national security or intelligence purposes.
5. To persons involved in the individual's care.
6. For notification purposes to the individual's guardian of the person or representative, as defined in the Georgia mental health code, when the disclosure relates to the individual's treatment or payment for treatment.

C. Individuals can request an accounting of disclosures for a period of up to six (6) years prior to the date of the request; disclosures made prior to April 14, 2003, the compliance date for the Privacy Rule, are excluded from this requirement.

D. An individual may receive one (1) disclosure accounting in a twelve-month period free-of-charge; a reasonable fee may be charged for more frequent accounting requests.

E. Individuals must be provided an accounting of disclosures within sixty (60) days of a request; if the record holder cannot provide an accounting of disclosures within the sixty-day period, it must provide information to the requestor as to the reason for the delay and the expected completion date; only one (1) extension is allowed per request.

Georgia Department of Human Resources Division of Mental Health, Developmental Disabilities and Addictive Diseases	DMHDDAD Policy # 3.200 – Protection of Individually Identifiable Health Information – Compliance with HIPAA
PROTOCOL 3.200-01: Individual Rights Regarding Protected Health Information	

- F. The record holder may temporarily suspend the right to an accounting to the individual of disclosures for health oversight agencies or law enforcement officials contingent upon submission to the record holder of a statement that indicates an accounting of disclosures will impede an investigation of the individual in question; the statement should include a time-frame for the exclusion period; the statement may be oral, but the exclusion period is then limited to thirty (30) days unless appropriate written documentation is received within that time; although the accounting of disclosure is not being released during this time, the record holder should continue tracking and storing the information for future release.
- G. Recurring disclosures to the same entity or individual that have a regular interval or an authorization with multiple disclosures may have a summary entry; the summary entry requires all of the information as described above for the first disclosure, plus an indication of periodic interval (monthly, weekly, etc.) and the date of the last disclosure.
- H. All documentation related to the tracking of disclosures of PHI must be retained for a minimum of six (6) years.

Georgia Department of Human Resources Division of Mental Health, Developmental Disabilities and Addictive Diseases	DMHDDAD Policy # 3.200 – Protection of Individually Identifiable Health Information – Compliance with HIPAA
PROTOCOL 3.200-02: Privacy Rule Administration - Complaints	
Attachments: Attachment A – Health Information Privacy Complaint Attachment B – Privacy Violation Report DELETED Attachment C – Complaint Report	

PRIVACY RULE ADMINISTRATION - COMPLAINTS

An individual may file a complaint relating to the HIPAA Privacy Rule either directly to the Division (DMHDDAD), to the Department (DHR), or to the Secretary of the Department of Health and Human Services (DHHS). Information on filing a complaint with the Secretary of Health and Human Services is available electronically at www.hhs.gov/ocr/privacyhowtofile.htm. A copy of the HHS complaint form is attached to this protocol as Attachment A. An individual may file a complaint with the Secretary at the following address:

Secretary of Health and Human Services
 200 Independence Avenue, SW
 Washington, DC 20201

An individual may file a complaint with the Department of Human Resources at the following address:

DHR Privacy Officer
 2 Peachtree Street NW
 Room 29.210,
 Atlanta, Georgia 30303-3142.

An individual may file a complaint with the DMHDDAD Privacy Coordinator at the following address:

Privacy Coordinator
 Division of Mental Health, Developmental Disabilities and Addictive Diseases
 2 Peachtree Street NW
 Room 22.240
 Atlanta, Georgia 30303-3142.

Upon request, the DMHDDAD Legal and Risk Management Section, Legal Services Officers or DMHDDAD Privacy Coordinator will provide forms and other information about the complaint process necessary to assist an individual wishing to file a complaint. DMHDDAD employees are not authorized to prepare complaints for individuals other than themselves.

- A. Complaints, whether filed directly with the Secretary of DHHS, with DHR, or with DMHDDAD, must be made in writing.
- B. Complaints must name the DHR Division, Office or facility against which the complaint is lodged.
- C. Complaints must describe the acts or omissions upon which the complaint is based.
- D. Complaints filed directly with the Secretary of DHHS must be filed within 180 days of the time the individual became aware, or should have been aware, of the violation.
- E. Complaints may include violations of DHR's and/or DMHDDAD's privacy practices as well as violations of the Privacy Rule itself. Violations may be reported on the "Privacy Violation Report" form, Attachment B of this Protocol.

- F. Individuals may file complaints about the content of DMHDDAD or DHR privacy policies and procedures or other matters governed by the Privacy Rule.
- G. DMHDDAD must receive and document complaints. Although not required by the Privacy Rule, the DMHDDAD Privacy Coordinator will provide a written acknowledgment of receipt of any complaint directed to the Privacy Coordinator within ten (10) days of receipt, provided adequate address information is available to permit the mailing of a written acknowledgment.
- H. All complaints received must be reported by the DMHDDAD Privacy Coordinator to the DHR Legal Services Office within ten (10) days of receipt. A copy of the complaint and the written acknowledgment satisfies this requirement. The complaint may be reported using the "Complaint Report," attached hereto as Attachment C.
- I. DMHDDAD must document complaints and their disposition, if any, and retain the records for six (6) years, or longer according to other applicable authorities, following the disposition or last activity regarding the complaint.
- J. DMHDDAD may not threaten, intimidate, coerce or retaliate against any individual filing a complaint. DMHDDAD may not require an individual to waive his or her rights under the HIPAA Privacy rule as a condition for the provision of treatment, payment, or eligibility for benefits.
- K. If the DMHDDAD denies an individual access to his or her own protected health information (PHI), a written denial must be issued describing how the individual may complain to the Secretary of DHHS and/or to DHR or the Division. The denial must include the name or title and telephone number of the person or office to which complaints may be made.
- L. Though not required by the Privacy Rule, DMHDDAD will make available upon request sample forms and appropriate information to individuals who wish to file complaints with the Secretary or DHR.
- M. The Privacy Coordinator of DMHDDAD may investigate or otherwise respond to complaints and recommend resolution where appropriate. If a violation is discovered as the result of an investigation, it must be reported to the DHR Privacy Officer, (See Attachment B). Complaint resolutions and dispositions must also be reported (See Attachment C).



DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF CIVIL RIGHTS (OCR)



HEALTH INFORMATION PRIVACY COMPLAINT

**If you have questions about this form, call OCR (toll-free) at:
 1-800-368-1019 (any language) or 1-800-537-7697 (TDD)**

YOUR FIRST NAME		YOUR LAST NAME	
HOME PHONE ()		WORK PHONE ()	
STREET ADDRESS			CITY
STATE	ZIP	E-MAIL ADDRESS <i>(if available)</i>	

Are you filing this complaint for someone else? Yes No

If Yes, whose health information privacy rights do you believe were violated?

FIRST NAME	LAST NAME
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Who (or what agency or organization, e.g., provider, health plan) do you believe violated your (or someone else's) health information privacy rights or committed another violation of the Privacy Rule?

PERSON/AGENCY/ORGANIZATION

STREET ADDRESS		CITY
STATE	ZIP	PHONE ()

When do you believe that the violation of health information privacy rights occurred?

LIST DATE(S)

Describe briefly what happened. How and why do you believe your (or someone else's) health information privacy rights were violated, or the privacy rule otherwise was violated? Please be as specific as possible. (Attach additional pages as needed)

Please sign and date this complaint.

SIGNATURE	DATE
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Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of the Privacy Rule issued pursuant to the Health Insurance Portability and Accountability Act of 1996. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible health information privacy violations, for internal systems operations, or for routine uses, which include disclosure of information outside the Department for purposes associated with health information privacy compliance and as permitted by law. It is illegal for a covered entity to intimidate, threaten, coerce, discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under the Privacy Rule. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to our web site at: www.hhs.gov/ocr/privacyhowtofile.html. To mail a complaint see reverse page for OCR Regional addresses.

(The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.)

Do you need special accommodations for us to communicate with you about this complaint (check all that apply)?

- Braille
 Large Print
 Cassette tape
 Computer diskette
 Electronic mail
 TDD
 Sign language interpreter (*specify language*): _____
 Foreign language interpreter (*specify language*): _____
 Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME		LAST NAME	
HOME PHONE ()		WORK PHONE ()	
STREET ADDRESS			CITY
STATE	ZIP	E-MAIL ADDRESS (<i>If available</i>)	

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed.)

PERSON / AGENCY / ORGANIZATION / COURT NAME(S)

DATE(S) FILED	CASE NUMBER(S) (<i>If known</i>)
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To help us better serve the public, please provide the following information for the person you believe had their health information privacy rights violated (you or the person on whose behalf you are filing).

- ETHNICITY (*select one*) RACE (*select one or more*)
 Hispanic or Latino
 American Indian or Alaska Native
 Asian
 Native Hawaiian or Other Pacific Islander
 Not Hispanic or Latino
 Black or African American
 White
 Other (*specify*): _____

PRIMARY LANGUAGE SPOKEN (<i>if other than English</i>)	HOW DID YOU LEARN ABOUT THE OFFICE FOR CIVIL RIGHTS?
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To mail a complaint, please type or print, and return completed complaint to the

OCR Regional Address based on the region where the alleged discrimination took place.

Region I - CT, ME, MA, NH, RI, VT Office for Civil Rights Department of Health & Human Services JFK Federal Building - Room 1875 Boston, MA 02203 (617) 565-1340; (617) 565-1343 (TDD) (617) 565-3809 FAX	Region V - IL, IN, MI, MN, OH, WI Office for Civil Rights Department of Health & Human Services 233 N. Michigan Ave. - Suite 240 Chicago, IL 60601 (312) 886-2359; (312) 353-5693 (TDD) (312) 886-1807 FAX	Region IX - AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions Office for Civil Rights Department of Health & Human Services 50 United Nations Plaza - Room 322 San Francisco, CA 94102
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<p>Region II – NJ, NY, PR, VI</p> <p>Office for Civil Rights</p> <p>Department of Health & Human Services</p> <p>26 Federal Plaza - Suite 3313</p> <p>New York, NY 10278</p> <p>(212) 264-3313; (212) 264-2355 (TDD)</p> <p>(212) 264-3039 FAX</p>	<p>Region VI - AR, LA, NM, OK, TX</p> <p>Office for Civil Rights</p> <p>Department of Health & Human Services</p> <p>1301 Young Street - Suite 1169</p> <p>Dallas, TX 75202</p> <p>(214) 767-4056; (214) 767-8940 (TDD)</p> <p>(214) 767-0432 FAX</p>	<p>(415) 437-8310; (415) 437-8311 (TDD)</p> <p>(415) 437-8329 FAX</p>
<p>Region III - DE, DC, MD, PA, VA, WV</p> <p>Office for Civil Rights</p> <p>Department of Health & Human Services</p> <p>150 S. Independence Mall West - Suite 372</p> <p>Philadelphia, PA 19106-3499</p> <p>(215) 861-4441; (215) 861-4440 (TDD)</p> <p>(215) 861-4431 FAX</p>	<p>Region VII - IA, KS, MO, NE</p> <p>Office for Civil Rights</p> <p>Department of Health & Human Services</p> <p>601 East 12th Street - Room 248</p> <p>Kansas City, MO 64106</p> <p>(816) 426-7278; (816) 426-7065 (TDD)</p> <p>(816) 426-3686 FAX</p>	<p>Region X - AK, ID, OR, WA</p> <p>Office for Civil Rights</p> <p>Department of Health & Human Services</p> <p>2201 Sixth Avenue - Mail Stop RX-11</p> <p>Seattle, WA 98121</p> <p>(206) 615-2290; (206) 615-2296 (TDD)</p> <p>(206) 615-2297 FAX</p>
<p>Region IV - AL, FL, GA, KY, MS, NC, SC, TN</p> <p>Office for Civil Rights</p> <p>Department of Health & Human Services</p> <p>61 Forsyth Street, SW. - Suite 3B70</p> <p>Atlanta, GA 30323</p> <p>(404) 562-7886; (404) 331-2867 (TDD)</p> <p>(404) 562-7881 FAX</p>	<p>Region VIII - CO, MT, ND, SD, UT, WY</p> <p>Office for Civil Rights</p> <p>Department of Health & Human Services</p> <p>1961 Stout Street - Room 1426</p> <p>Denver, CO 80294</p> <p>(303) 844-2024; (303) 844-3439 (TDD)</p> <p>(303) 844-2025 FAX</p>	

Burden Statement

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201.

**COMPLAINT REPORT
DEPARTMENT OF HUMAN RESOURCES**

Date:

TO: Privacy Officer
Department of Human Resources
2 Peachtree Street NW, Room 29.210
Atlanta, GA 30303

THROUGH: Privacy Coordinator FAX 404/657-6424 or 2173
DMHDDAD
2 Peachtree Street, NW, Room 22.240
Atlanta, GA. 30303

FROM: _____ Reporter's name _____ Reporter's title and work unit
_____ Work unit location (Hospital or community provider) Phone No.

Please report Complaints under the HIPAA Privacy Rule using this form.

As required by DHR Privacy Policies, I hereby submit the following information regarding a complaint received under the HIPAA Privacy Rule.

Date received:	
Date acknowledged:	
Basis for the complaint. Attach additional sheets if necessary.	
Is the complaint related to a known violation?	
Complainant's name or identification number.	
Has an investigation been made?	
If yes, summarize findings. Attach additional sheets if necessary.	
Describe actions taken to mitigate any potentially harmful effects of the matter complained of. Attach additional sheets if necessary.	
Describe actions taken to reduce the possibility of recurrence. Attach additional sheets if necessary.	
If resolved, state resolution.	
Complainant notified?	
If yes, notice date.	

Georgia Department of Human Resources Division of Mental Health, Developmental Disabilities and Addictive Diseases	DMHDDAD Policy # 3.200 – Protection of Individually Identifiable Health Information – Compliance with HIPAA
PROTOCOL 3.200-06: Sanctions	

Sanctions

This protocol describes the process for specific sanctions for breaches of confidentiality, violations of the Privacy Rule and/or violations of DMHDDAD’s privacy practices, policies, procedures, and protocols. Sanctions which may be imposed by the Division are cumulative of those which may be imposed by statute or regulation.

Specific components and considerations include:

- A. DMHDDAD will establish and apply appropriate sanctions against members of its workforce (employees, volunteers, trainees, or others who come under its direct control), who fail to comply with DHR or DMHDDAD privacy policies, procedures, and protocols, or with requirements relating to the privacy of individually identifiable health information.
- B. DMHDDAD facilities, programs and contracted providers must have written policies, procedures, OR protocols for the application of appropriate sanctions for violations. State hospitals, state operated community programs, and any provider of DMHDDAD services by contract or by memorandum of understanding with DHR, are responsible for ensuring that their policies on sanctions are made known to their employees and agents.
- C. DMHDDAD must document any sanctions that are applied against members of its workforce.
- D. Sanctions do not apply to whistleblowers, provided that
 - a. The workforce member making a disclosure of protected health information (PHI) believes that:
 1. The care, services, or conditions provided by DMHDDAD potentially endanger one or more individuals, workers, or the public, OR
 2. The workforce member or business associate believes, in good faith, that DMHDDAD has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, AND
 - b. The disclosure of PHI made by the workforce member is to:
 1. An appropriate oversight agency, including but not limited to the Long Term Care Ombudsman program, or a public health authority,
 2. An appropriate healthcare accreditation organization, or
 3. An attorney for the purposes of determining the legal options with regard to the conduct of the workforce member or business associate.
- E. Sanctions do not apply to workforce members who are victims of a criminal act and disclose protected health information (PHI) to a law enforcement official. The disclosed PHI must be about a suspected perpetrator of the criminal act and is limited to the following information:

- a. Name and address;
- b. Date and time of treatment.

References: DHR HIPAA Privacy Policies 4.0, 4.1; 45 CFR §§ 164.502(j) and 164.530(e); OCGA §§ 37-3-166, 37-4-125, 37-7-166, and 45-1-4.

Georgia Department of Human Resources Division of Mental Health, Developmental Disabilities and Addictive Diseases	DMHDDAD Policy # 3.200 – Protection of Individually Identifiable Health Information – Compliance with HIPAA
PROTOCOL 3.200-08: Business Associates	
Attachments: Attachment A - Business Associate Agreement	

Business Associates

In accordance with Division Policy 3.200 regarding the HIPAA Privacy Rule, the Division and its hospitals and state operated programs and contracted service providers shall identify their business associates.

- A. DMHDDAD shall have an agreement with each business associate. All state-owned or state operated facilities and providers under contract or letter of agreement with the department and/or the division shall also have business associate agreements with entities that perform or assist in performing functions involving the use of individually identifiable health information.
1. DMHDDAD and state-owned or state-operated facilities shall use the business associate terms provided in standard DHR contracts, or the separate business associate agreement issued by the division (see Attachment A) for all such agreements. A copy of all such agreements must be kept on file.
 2. Providers having a contract or letter of agreement with the division will ensure that they have business associate agreement(s) with their agents or subcontractors and that the agreements are HIPAA compliant. The provider must keep a copy of the agreement(s) on file.
 3. Business associate agreements and all documentation relating to the business associate's performance under the Privacy Rule must be retained for as long as the business associate performs or assists in performing functions involving the use of individually identifiable health information, or for six (6) years, whichever is longer.
 4. DMHDDAD shall have access to the business associate agreements of providers upon request.
- B. Disclosures to business associates are subject to minimum necessary requirements. In all cases, DMHDDAD and state-owned or state-operated facilities will ensure that, pursuant to the Official Code of Georgia Annotated, Sections 37-3-166, 37-4-125, and 37-7-166, relating to the treatment of clinical records, the release of clinical records will be conducted as provided by those statutory provisions and by relevant provisions of the HIPAA Privacy Rule. To the extent that any business associate(s) receives such clinical records, the business associate(s) will also adhere to the Georgia Code and the Privacy Rule regarding the treatment and release of such clinical records. Privileged information shall not be released by DMHDDAD or its business associate(s) without proper authorization.
- C. DMHDDAD must inform business associates of the requirement to safeguard PHI and that business associates must provide appropriate training programs for their employees. DMHDDAD may allow business associates access to selected DMHDDAD training materials for these purposes.
- D. Business associates shall be included in policy updates through the Provider manual and through communications from the DHR Privacy Officer and/or the Division Privacy Coordinator. Business associates will be informed of applicable training programs and compliance audits through the Division Training Coordinator, Regional Coordinator, or Privacy Coordinator, as applicable.
- E. If DMHDDAD accepts an amendment to an individual's PHI, the division must make a reasonable effort to inform business associates it knows that have the PHI that is the subject of the amendment and which may have relied on the information to the detriment of the individual. Amendment(s) to PHI will be covered by the procedures outlined in the protocol on individuals' rights.
- F. If DMHDDAD accepts restrictions on the use or disclosure of an individual's PHI, the division's business associates must honor the restrictions.

- G. DMHDDAD state office staff who are responsible for deploying policy and maintaining contracts will keep informed and aware of all business associate relationships and have a mechanism to be notified of changes to those relationships.
- H. DMHDDAD is not considered to have violated Privacy Rule requirements if a business associate disclosed PHI as a whistleblower.
- I. DMHDDAD must mitigate as best it can, any harmful effects from uses and disclosures by its business associates that violate DHR or DMHDDAD privacy policies and procedures.
- J. DMHDDAD must make a good faith effort to obtain satisfactory assurances that each business associate will adhere to Privacy Rule requirements, and if the effort is unsuccessful, document the attempt and the reason such assurance could not be obtained. In such cases, disclosure of PHI may be made to the business associate to the extent necessary to carry out DMHDDAD's legally mandated activities.
- K. DMHDDAD is authorized to terminate any agreement(s) with business associates if the conduct of any business associate(s) constitutes a material breach of the agreement. DMHDDAD will, where feasible, provide an opportunity for the business associate to cure the breach. Where neither termination nor cure is possible, DMHDDAD will report the violation to the Secretary of Health and Human Services.
- L. DMHDDAD will ensure that, upon termination of the agreement with a business associate, protected health information will be returned or destroyed according to the provisions of the contract and in compliance with the HIPAA Privacy Rule.

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement is made and entered into by and between the Georgia Department of Human Resources ("DHR") and the Contractor named below. The parties acknowledge that DHR is "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA) and the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 ("Privacy Rule"). The Privacy Rule requires DHR to obtain satisfactory assurance that Contractor will appropriately safeguard the privacy and provide for the security of Protected Health Information ("PHI") within Contractor's possession, custody or control. Contractor is a Business Associate of DHR as that term is defined under HIPAA and the Privacy Rule. Accordingly, for good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, in order to establish the permitted and required uses and disclosures of PHI, the parties agree as follows:

Contractor will not use or disclose PHI except as permitted or required by this agreement or by law, and when using or disclosing PHI, will make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of such use or disclosure. Contractor will establish and use appropriate safeguards to prevent unauthorized use or disclosure of PHI. Contractor will promptly report any unauthorized use or disclosure promptly to DHR, and will ensure that any individual or organization to whom it provides PHI agrees to the same conditions and restrictions with respect to PHI that are applicable to the Contractor. Contractor will allow individuals access to their own PHI, an opportunity to request amendment of such PHI, and all information required to provide an accounting of disclosures of PHI as provided by the Privacy Rule. Contractor will make its internal practices, books and records relating to use or disclosure of PHI to both DHR and the Secretary of Health and Human Services for purposes of determining DHR's compliance with the Privacy Rule. Upon termination of this agreement, Contractor will return all PHI to DHR, retaining no copies of such PHI, and will assure that its agents and subcontractors treat PHI in their possession or control in the same manner. This agreement may be terminated upon notice by DHR if the Contractor violates any material term hereof.

IN WITNESS WHEREOF, DHR and Contractor have caused this Business Associate Agreement to be executed in duplicate on the ____ day of _____, 200__.

GEORGIA DEPARTMENT OF HUMAN RESOURCES

By: _____
Authorized Signature

CONTRACTOR

Typed or Printed Name of Contractor

By: _____
Authorized Signature

Georgia Department of Human Resources Division of Mental Health, Developmental Disabilities and Addictive Diseases	DMHDDAD Policy # 3.200 – Protection of Individually Identifiable Health Information – Compliance with HIPAA
PROTOCOL 3.200-10: Disclosure and Authorization for Disclosure of Protected Health Information	
Attachments: Attachment A – Authorization for Use or Disclosure of Protected Health Information DELETED	

DISCLOSURE AND AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

DMHDDAD may disclose protected health information (PHI) of an individual upon the individual’s request. DMHDDAD shall have a written authorization from an individual before using or disclosing PHI for any purpose not otherwise permitted by law or allowed by the Privacy Rule.

- A. Authorization forms must be in plain language and must contain the following:
 - 1. Description of the information to be used or disclosed.
 - 2. A description of the purpose of the use or disclosure.
 - 3. Name of the facility or provider authorized to use or disclose the PHI.
 - 4. Name of the receiving person or entity of the use or disclosure.
 - 5. A description of the purpose of the use or disclosure.
 - 6. An expiration date, specified time period, or event triggering expiration.
 - 7. A statement regarding the individual’s right to revoke the authorization and a description of how the individual may revoke the authorization.
 - 8. The individual’s signature and date of signature.
 - 9. If signed by a parent of a minor, legal custodian of a minor, guardian of the person, or other person legally authorized to sign disclosure of PHI, a description of that person’s authority to act for the individual.
 - 10. The signature of a witness and date of signature.
 - 11. A statement that DMHDDAD will not condition treatment, payment, or eligibility for benefits on the individual’s providing authorization for the requested use or disclosure.

- B. An authorization is rendered invalid if:
 - 1. The expiration date, specified time period, or event triggering expiration is known to have occurred.
 - 2. The authorization is known by the provider to have been revoked.
 - 3. The authorization has been combined with any other document.
 - 4. The individual’s treatment, payment, or health operations are conditioned on signing an authorization.

- C. The facility or provider must give a copy of every fully completed and signed authorization to the person who signed it, and must maintain the original in the individual’s clinical record permanently.

- D. The attached form, **Attachment A** “Authorization for Use or Disclosure of Protected Health Information,” is required for use by state owned or operated facilities or programs. The facility or program may customize the form to include facility or program letterhead, space for the individual’s identification, and the like. No changes in content are permitted without the approval of the Division Privacy Coordinator or the DHR Privacy Officer. If necessary, the authorization may be amended to show that it is valid for the time period necessary to complete the transaction for which the disclosure is made.

- E. Providers of services through contract or letter of agreement may utilize the attached form. Any form utilized by providers must be compliant with the Privacy Rule and the terms of this protocol.

- F. An individual may revoke an authorization at any time, in writing, except to the extent that the entity holding the individual's records has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.
- G. An individual who is an adult and who does not have a court-ordered guardian of the person may sign an authorization for disclosure of his/her protected health information. Other persons legally entitled to sign an authorization include:
1. For minor children, a parent, the court-appointed guardian, or a person to whom legal custody of the child has been given by order of a court.
 2. For incompetent adults, the court-ordered guardian of the person.
 3. For deceased individuals, the legal representative of the individual's estate.
 4. For an adult who has signed a durable power of attorney for health care, if the durable power of attorney is in effect at the time, the agent named by the individual.
- H. DMHDDAD may use or disclose protected health information without an individual's written consent or authorization and without giving the individual the opportunity to agree or object in certain circumstances. Such uses and disclosures include the following:
1. When required by law.
 2. AIDS confidential information may be reported or disclosed according to law (OCGA sections 24-9-47; 31-22-9.2).
 3. For public health activities (See OCGA section 31-12-2).
 4. About victims of abuse, neglect, or exploitation (See OCGA section 30-5-4).
 5. For health oversight activities (including audits, investigations, and inspections).
 6. In response to a subpoena or court order from a court of competent jurisdiction, except for privileged matters, and except that substance abuse information may not be disclosed in response to a subpoena, but requires a court order. (OCGA sections 37-3-166, 37-4-125).
 7. A law enforcement officer in the course of a criminal investigation may be informed only:
 - a. whether an individual is or has been a patient in a facility that is not solely a substance abuse facility, as well as the individual's current address, if known, and
 - b. during investigation of a crime on premises of a facility that is not solely a substance abuse facility or against facility personnel or a threat to commit such a crime, a law enforcement officer may be informed as to the circumstances of the incident, including whether the individual allegedly committing or threatening to commit the crime is or has been a patient in the facility, and the name, address, and last known whereabouts of any alleged patient perpetrator.
 8. About deceased persons in response to a valid subpoena from a coroner or medical examiner; to a funeral director in the event the deceased person had an infectious or communicable disease at the time of death, or to the legal representative of the individual's estate (OCGA sections 31-12-2; 31-21-3; 37-3-166, 37-4-125, 37-7-166).
 9. For organ and tissue donation (OCGA section 44-5-143).
 10. For disaster relief purposes (OCGA section 31-12-2).
 11. For the individual's continued treatment (OCGA section 37-3-166, 37-4-125, 37-7-166).
 12. For emergency treatment (OCGA section 37-3-166).
- I. Special rules apply to a disclosure which identifies the individual as a person with a substance abuse diagnosis. The hospital or provider should seek legal and policy review before making any disclosure of substance abuse information without an authorization. Disclosures may not be made unless:
1. The disclosure is for emergency medical care of the individual.
 2. The disclosure is ordered by a court, following a full and fair show cause hearing as described in federal substance abuse confidentiality regulations.
 3. The disclosure is for research activities, audit and evaluation activities, if the party receiving the information has agreed in writing to preserve confidentiality.
 4. Certain information on crimes on program premises or against program personnel.
 5. The disclosure is for reports of suspected child abuse or neglect, as required under state law.
- J. Procedures for Responding to Subpoenas or Discovery Request in a Civil (non-criminal) Case

- a. Protected health information of an individual which does not disclose substance abuse may be produced in response to a subpoena of a court of competent jurisdiction or a Requests for Production of Documents or other discovery request ONLY when EITHER:
 - i. The hospital or provider holding the record receives satisfactory written assurances from the party seeking the protected health information that
 - 1. the party seeking information has made a good faith attempt to provide written notice to the individual (or, if the individual's location is unknown, to mail a notice to the individual's last known address),
 - 2. the notice includes sufficient information about the proceeding in which the information is sought to permit the individual to raise an objection to the court, AND
 - 3. The time for the individual to raise objections to the court has elapsed and no objections were filed, or all objections filed by the individual have been resolved by the court, and the disclosures sought are consistent with such resolution, OR
 - ii. the parties to the dispute giving rise to the request have agreed to a qualified protective order and have presented it to the judge, OR the party seeking the information has requested a qualified protective order from the court. A qualified protective order must prohibit the parties to the case from using or disclosing the protected health information for any purpose other than the litigation or proceeding, and must require that the protected health information either be returned to the hospital or provider, or be destroyed at the end of the litigation or proceeding.
- b. The hospital or provider holding the requested protected health information may, with the assistance of a legal advisor or counsel, undertake to provide the notice and/or obtain the qualified protective order described above. This should generally be done only when there is no reasonable possibility that the party seeking the information will accomplish these requirements.
- c. If the protected health information which is sought requires a disclosure that the individual has a substance abuse diagnosis (including a health diagnosis that is secondary to or related to substance abuse), the hospital or provider may not follow these procedures. Instead, the requestor must be informed that it is necessary to have either the individual's authorization for use or disclosure of substance abuse information, or a court order based on a full and fair show cause hearing as outlined in the federal regulations on "Confidentiality of Alcohol and Drug Abuse Patient Records" at 42 CFR sections 2.1 and following.

K. Procedures for Disclosures for Law Enforcement Purposes

A provider may disclose PHI other than substance abuse information in response to a criminal court order or subpoena in a criminal case, provided that the judge issuing the court order or the attorney issuing the subpoena gives assurances that:

- a. The information sought is relevant and material to a legitimate law enforcement inquiry;
- b. The request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought; and
- c. De-identified information could not reasonably be used.

L. Redaction or De-Identification of Records

- a. In the event records are sought by means of a request covered by the Open Records Act of Georgia, the provider must seek legal counsel on whether records may be produced.
- b. To the extent that any records are required by law to be produced, all identifiers of the individual AND his or her relatives, employers, or household members, must be redacted as follows:
 - i. Name
 - ii. Address
 - iii. Dates relating to the individual, including date of birth, admission and discharge dates, and date of death
 - iv. Age, if over age 89
 - v. Telephone and fax numbers
 - vi. E-mail address
 - vii. Social security number

- viii. Medical record number
- ix. Health plan beneficiary number
- x. Account numbers
- xi. Driver's License number and other certificate/license numbers
- xii. Vehicle identifiers and serial numbers, including license plate number
- xiii. Device identifiers and serial numbers
- xiv. URLs
- xv. Internet Protocol (IP) address numbers
- xvi. Biometric identifiers, including finger and voice prints
- xvii. Full face photographs and any comparable images identifying the individual
- xviii. Any other unique number, characteristic (such as physical description, tattoos, or the like).



Chapter: Developmental Disabilities Community Services

Subject: Recruitment and Application to Become a Provider of Developmental Disabilities Services

Applicability:

Potential Providers of Developmental Disabilities Services, Regional Offices, Support Coordination, Intake & Evaluation

Original Effective Date: July 1, 2010

Revision #2 Effective Date: July 1, 2011

Scheduled Review Date: July 2012

Approved:

Beverly D. Rollins 5/19/11
Beverly D. Rollins, M.P.A., Executive Director Date

Division of Developmental Disabilities

J. Bryce McLaulin 5/23/11
J. Bryce McLaulin, M.D., Date

Assistant Commissioner of Programs

Frank E. Shelp 5/24/11
Frank E. Shelp, M.D., M.P.H., Commissioner Date

Attachments:

- Attachment A – Letter of Intent to Provide Services Form
- Attachment B – New Site Inspection Checklist
- Attachment C – Identified Technical Schools for Direct Support Professional Training
- Attachment D – Assets Form

RECRUITMENT AND APPLICATION TO BECOME A PROVIDER OF DEVELOPMENTAL DISABILITIES SERVICES

POLICY

DBHDD recruits and qualifies a provider base determined by the needs of individuals with developmental disabilities. This recruitment and qualifying is accomplished through the use of a prequalification process and a two-phase application and training process. Recruitment cycles will occur two times per year, beginning July 1 and January 1 of each fiscal year (FY). Successful completion of the prequalification process and two-phase application and training process will result in recommendation to The Department of Community Health for Medicaid provider number to be issued. The Department of Community Health will make the final decision in the issuance of a Medicaid provider number.

GENERAL INFORMATION

DBHDD may elect at any time to revise these policy requirements, the time frames for the phases, the content of the training, or other aspects of the provider recruitment and application process.

DBHDD reserves the right to Request for Proposal (RFP) any developmental disabilities services. Providers selected through the RFP process may not be subject to this policy.

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DBHDD considers any Potential Agency Provider /individual whose records reveal a history of termination and/or suspension of Contract or Letter of Agreement with the Department (or the former Department of Human Resources) for any health and/or safety concern, but may deny such potential agency provider/individual participation in the provision of developmental disabilities services.

DBHDD does not guarantee to any potential agency provider or individual that it will refer individuals with developmental disabilities. Individuals with developmental disabilities and their families always have a choice in the selection of providers.

DEFINITIONS

Developmental Disabilities Professional (DDP) – An individual that meets the qualifications of one or more of the DDP designations which are found in “Community Standards for All Providers” section of the current year Provider Manual located at the DBHDD website: www.dbhdd.georgia.gov.

Director -- An individual responsible for corporate or management oversight of the potential agency provider with one of the following qualifications:

1. A bachelor’s degree in a human service field (such as social work, psychology, education, nursing, or closely related field) or business management and two years of experience in service delivery to persons with developmental disabilities, with at least one year in a supervisory capacity; or
2. An associate degree in nursing, education or a related field and four years of experience in service delivery to persons with developmental disabilities, with at least one year in supervisory capacity.

Emergency Situations – The following constitute emergency situations:

- Death of immediate family member;
- A doctor’s verification of accident, illness, or hospitalization of individual approved to participate in training process; or
- A natural disaster.

Immediate Family Member – Immediate family includes the individual’s spouse, child, parent, brother and sister. Immediate family also includes any other person who resides in the individual’s house AND is recognized by law as a dependent of the individual.

Individual Provider – Sole Proprietor or Individual legally responsible for providing a New Options Waiver or Comprehensive Supports Waiver home and community based service as allowed by Department of Community Health policy.

Letter of Intent to Provide Services Form – A form letter provided by DBHDD which must be completed by the potential provider, outlining their intent to become a Medicaid approved provider of developmental disabilities services.

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No Show – Failure to appear or more than 15 minutes late for any of the training dates and times.

Nonprofit Organization – An organization as qualified and approved as a tax-exempt organization under section 501(c)(3) of the Internal Revenue Code

Nurse – For the purpose of this policy, Nurse means a Registered Nurse (RN) or Licensed Practical Nurse (LPN) with a current license to practice in the State of Georgia.

Potential Agency Provider - Corporation, Partnership, Limited Liability Corporation (LLC), or other entity legally responsible for providing New Options or Comprehensive home and community based waiver services as allowed by Department of Community Health policy.

Potential Provider – for the purposes of this policy, the term potential provider includes both Agency Providers and Individual Providers.

Pre-Qualifier – Items listed in this policy that are required before the potential provider may proceed with the Phase I process.

Provider Forum – An interactive informational session held prior to the beginning of each recruitment cycle that will allow for potential providers to discuss Letter of Intent, Pre-Qualifiers, Medicaid Application, and DBHDD Application Policy Submission Requirements.

Recruitment Cycle – A six month cycle of recruitment, prequalification determination and two-phase application and training process for potential providers beginning July 1 and January 1 of each FY.

Request for Proposal (RFP) – A request for proposal is a document that an organization posts to elicit bids from potential vendors for a product or service.

Technical Assistance Workshop – Workshop held at the end of each recruitment cycle to offer technical assistance and support to potential agency providers, or individual providers who were unsuccessful in their Letter of Intent and Pre-Qualifier submission.

PROCEDURES

Identification of Need for Additional Providers

The Department of Behavioral Health and Developmental Disabilities/Division of Developmental Disabilities (Division of DD) maintains a short term planning list, a long term planning list and transition list for individuals eligible for developmental disabilities services. These planning lists are sorted by needs of the individual, service area, and service type. The Division of DD utilizes the demographics of these lists to recruit for potential provider types based on need in specific regions and counties and will prioritize the processing of potential providers according to the aforementioned criteria.

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Announcement of Recruitment of Potential Providers

The Division of DD distributes an Announcement for Recruitment of Potential Providers based on identified needs, service area and service type. Distribution of the announcement occurs at least 30 calendar days prior to the beginning of each recruitment cycle. The announcement will be located on the Department of Behavioral Health and Developmental Disabilities website at www.dbhdd.georgia.gov.

Informational Session for Potential Providers

The Division of DD will hold Provider Forums prior to the beginning of each recruitment cycle period to meet with potential providers. The Provider Forums will supply information concerning Letter of Intent, Pre-Qualifiers, Medicaid Application, and DBHDD Application Policy Submission Requirements.

Process for Qualifying Potential Providers

The Division of DD utilizes a prequalification determination and two-phase process to recruit and qualify potential providers of developmental disabilities services.

Potential Agency Providers or Individual Providers unsuccessful at becoming a developmental disabilities provider, after two recruitment cycle period attempts, will be required to wait a minimum of twelve (12) months before again beginning the recruitment cycle process to qualify as a developmental disabilities provider.

Prequalification Determination Process

A. Interested potential agency providers, or potential individual providers must submit a completed **Letter of Intent to Provide Services Form (Attachment A)**. Applicable *PRE-QUALIFIERS* listed below must be sent with the Letter of Intent to Provide Services Form. All potential agency providers or potential individual providers must meet the requirements of *Pre-qualifiers* specific to an agency, or individual service.

B 1. The Agency *Pre-qualifiers* include:

- Resumes of Director, agency Nurse and Developmental Disabilities Professional (DDP) who meet qualifications outlined in current Fiscal Year Provider Manual *Community Standards for All Providers*
- Current Secretary of State registration
- Current Applicable licenses, such as, Georgia Nurse License, Private Home Care, Community Living Arrangement, Occupational Therapy, Physical Therapy. Any license related to the service listed in the Letter of Intent must be submitted. A Personal Care Home License will be accepted for the provision of Respite Services only.
- **New Site Inspection Checklist (Attachment B)** completed and signed by Potential Provider as applicable to all Community Residential Alternative Provider. This Site inspection checklist will be verified by Regional Office during Phase I of the two-phase process. Verification must result in approval of site inspection by Regional Office, or no application will be accepted and

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potential provider must wait until next recruitment cycle to begin a new process.

- Proof that the potential agency provider has operated an agency which has provided a Medicaid reimbursable comparable service, such as, residential for the aging population if applying to do residential services, etc., for a minimum of one year immediately prior to submission of *Letter of Intent to Provide Services Form and Pre-qualifiers* or,
- If the agency has not provided a Medicaid reimbursable comparable service for a minimum of one year immediately prior to submission of *Letter of Intent to Provide Services Form and Pre-qualifiers*, then the owner/s must submit proof of completion of technical certificate of credit of Direct Support Professional training offered within Georgia's **Identified Technical Schools for Direct Support Professional Training (Attachment C)**. The owner/s must also hold at minimum any degreed credentials identified by the Department of Behavioral Health and Developmental Disabilities that meet a Director or Developmental Disabilities Professional (DDP) designation. The owner/s must also complete Phase II (see below **Phase II – Training and Competency Assessment**) mandatory training.
- Three professional reference letters, signed and on professional letterhead.
- A 12-month pro-forma (projected) operating budget which outlines and includes expenses such as: professional fees, employee salaries and other employee costs, facility costs and utilities, transportation, service contracts, administrative cost, other support services, etc and identify all revenue sources based on the numbers of individuals to projected be served.
- Appropriate signed or attested corporate Federal and State tax returns for most recent fiscal year. Personal tax returns will not be accepted. Non profit pre-qualifiers must submit Internal Revenue Service exempt status determination letters and Internal Revenue Service exempt organization information returns (IRS Form 990).
- Applicable financial statement. The following applicable financial statement must be submitted:
 - An “audited” financial statement that includes statement of financial position/balance sheet, statement of revenue and expenditures (For Profit Agencies), statement of operational/functional expenses (Not for Profit Agencies), statement of cash flow and the signed auditor’s opinion letter which provides either a qualified or unqualified opinion on how the companies financial statements were prepared and presented. These audited financial statements must be prepared and certified by an American Institute of Certified Public Accountants (AICPA) registered public accountant, and certified that the financial statements meet the requirements of the U.S. generally accepted accounting principles (GAAP).
- Proof of liquid assets equal to at least three (3) times the monthly expenses listed in budget (three months of operating capital). Proof must be submitted on **Assets Form (Attachment D)** and must be certified with the signature of

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a representative from the financial institution where the corporate (not personal) account is established. The Assets Form must also be notarized. Corporate or personal lines of credit will not be accepted. Operating capital must be unrestricted.

B 2. The Individual *Pre-qualifiers* include:

- Individual Resume.
- Current Applicable License or Certification/s required for:
 - Adult Occupational Therapy Services
 - Adult Physical Therapy Services
 - Adult Speech and Language Therapy Services
 - Behavioral Supports Consultation Services
 - Community Living Support LPN Services
 - Community Living Support RN Services
 - Community Residential Alternative LPN Services
 - Community Residential Alternative RN Services
- Transcripts that identify required hours of training or education specific to service applying to provide, as applicable.
- Individual providers for any service not listed as a professionally licensed required service must provide the waiver service for at least one year through self-direction prior to submission of a *Letter of Intent to Provide Services Form and Pre-qualifiers*. In addition, these individual providers must provide evidence of satisfactory performance of self-directed service provision through documentation from the support coordination agency, fiscal intermediary, and other sources as appropriate.
- Individual providers of non-professionally licensed services and licensed services must also submit any required information listed within the Medicaid manuals for each defined service. NOW and COMP Medicaid manuals are located at www.mmis.georgia.gov. Defined services are in the Part III NOW and COMP Manuals.
- National Criminal Background Check – The Provider Development Coordinator requests that individual providers complete a national criminal background check upon the successful processing of the pre-qualifiers.

C. No provider agency may add additional services or sites after the initial approval until they have completed the following:

- provided a minimum of twelve (12) months of services approved in their initial application, AND
- have successfully achieved full accreditation and/or complete compliance with the Standards Compliance Review, for a minimum of six (6) months. Provisional status of any type will not be accepted.

D. The *Letter of Intent to Provide Services Form and Pre-qualifiers* are submitted to the Provider Development Coordinator of the Division of Developmental Disabilities within 31 calendar days of each recruitment cycle (July 1, and/or January 1).

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- *Letters of Intent to Provide Services Form and Pre-qualifiers* in the first recruitment cycle must not be postmarked prior to July 1, and must be received via US Postal Service certified return receipt requested no later than July 31.
- *Letter of Intent to Provide Services Form and Pre-qualifiers* in the second recruitment cycle must not be postmarked prior to January 1, and must be received via U.S. Mail, certified, and return receipt requested no later than January 31.

Letter of Intent to Provide Services Form and Pre-qualifiers received by DBHDD that are postmarked prior to the beginning date, or postmarked after the closing date of each recruitment cycle will not be processed. *Letter of Intent to Provide Services Form and Pre-qualifiers* that are not sent via US Postal Service certified return receipt requested will not be processed. Information must arrive in hardcopy format in a notebook, organized with each pre-qualifier section tabbed. No handwritten documents accepted; except signatures. *Letter of Intent to Provide Services Form and Pre-qualifiers* that are not submitted as requested in this policy will not be processed.

Information must be submitted to:

Provider Development Coordinator
Division of Developmental Disabilities
Department of Behavioral Health & Developmental Disabilities
Suite 22-102
2 Peachtree Street, NW
Atlanta, Georgia 30303

- E. Within 30 calendar days of receipt of *Letter of Intent to Provide Services Form*, the Provider Development Coordinator will send an *Invitation Letter* via email correspondence to potential provider and Regional Office notifying successful completion of the *Pre-qualifiers* and inviting the potential provider to move forward in the Phase I process or notifying potential provider that they did not meet pre-qualifiers and will not be invited to move forward in the Phase I process. One correction attempt will be given for missing or incorrect documents, and any additional or corrected documents must be received within three (3) business days of notification,
- F. Potential Agency Providers or Individual Providers must meet **ALL** applicable *Pre-qualifiers* to be invited to move forward in the Phase I process. Any incomplete or deficient *Letter of Intent to Provide Services Form*, and/or incomplete or deficient *Pre-qualifiers*, not received within the correction period, will result in no invitation to move on to Phase I and Phase II of the process.

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- G. A Technical Assistance Workshop will be offered to all potential agency providers, and/or individual providers who are unable to meet the *Letter of Intent to Provide Services Form and Pre-Qualifiers* in their first recruitment cycle.
- H. The DBHDD application, application users guide, Medicaid application and site visit form to be used for Regional Office Site Visit verification (as applicable) will be provided in conjunction with the *Invitation Letter*.
- I. Email addresses listed in the *Letter of Intent to Provide Services Form* for potential agency providers or individual providers must be current and correct as correspondence from DBHDD is conducted via email. It is the responsibility of the potential provider to ensure that emails from DBHDD are accepted by their email system and do not go to the “spam” mailbox. Upon receipt of email notification from DBHDD, potential provider must return a reply of receipt email to emailing body.

Phase I - Application Submission and External Site Visit

- A. Potential Provider must submit DBHDD application, Medicaid application and approved external site visit verification within 30 calendar days of the *Invitation Letter* date. Potential provider is responsible for contacting Regional Office to request verification of Pre-qualifier site visit completed by potential provider. Verification must result in approval of site inspection by Regional Office, or no application will be accepted and potential provider must wait until next recruitment cycle to begin a new process.
- B. Submission of Application information must include:
 - 1) DBHDD and Medicaid application and all information requested in applications
 - 2) External Site Visit, as applicable
- C. Applications must be postmarked and sent via US Postal Service certified return receipt requested within this 30 day window of the *Invitation Letter* date. If received postmarked after the 30th calendar day, then the application will not be processed. Completed Applications must be submitted to:

Office of Provider Network Management
 Department of Behavioral Health & Developmental Disabilities
 Suite 23-247
 2 Peachtree Street. NW
 Atlanta, Georgia 30303

- D. Within 15 days of receipt of application, the Office of Provider Network Management will send *Notification Letter* via email correspondence to potential provider notifying successful completion of the Phase I, or notifying potential provider of unsuccessful completion of the Phase I: this *Notification Letter* will indicate whether they will/will not be invited to continue to the Training Phase (Phase II) of the process.

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Notification Letter will contain location(s) and dates for training. One correction attempt will be given for missing or incorrect documents, and additional or corrected documents must be received within three (3) business days of notification. Upon receipt of email notification from DBHDD, potential provider must return a reply of receipt email to emailing body.

- E. Any incomplete or incorrect applications or omissions of any application document not received within the correction period will result in closure of application and notification to The Department of Community Health that application was unsuccessful. Further correspondence regarding potential provider's application will be sent to potential provider from The Department of Community Health.

Phase II – Training and Competency Assessment

- A. Attendance at training by the Developmental Disability Professional, Nurse and Director of a potential agency provider or potential individual provider is mandatory for all days, times and modules of Phase II Training and Competency Assessment. The DDP, Nurse and Director of a potential agency provider, and/or potential individual provider must attend a mandatory two weeks of training on topics identified and presented by DBHDD.
- B. Upon receipt of *Notification Letter* of successful completion of Phase I, a potential provider must submit the Training Fee of \$250.00 per individual attending. This training fee must be submitted prior to attendance at training. Fees not received prior to first day of training will result in closure of application. Fees will not be accepted at training sites. Fees can be sent overnight delivery. A potential provider will be notified that their fee was successfully delivered via email within 24 business hours upon receipt of fee. Upon receipt of email notification from DBHDD, a potential provider must return a reply of receipt email to the emailing body.
- C. Fees must be paid by Cashier's Check or Money Order made payable to the Division of Developmental Disabilities and submitted to:
 - Provider Development Coordinator
 - Division of Developmental Disabilities
 - Department of Behavioral Health & Developmental Disabilities
 - Suite 22-427
 - 2 Peachtree Street, NW
 - Atlanta, Georgia 30303
- D. Refund of any training fee will be prorated at a rate of twenty-five dollars (\$25.00) per module not yet attended if potential provider withdraws application during the training and assessment process.
- E. State or Governmental Photo ID will be required at each training session, for each individual attending.

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- F. Absences due to an emergency must be verified. In the event of an emergency situation that precludes attendance at training, notification of emergency situations must be made via email, and followed up by written verification on agency letter head with attached original copy of medical verification (if applicable), to the Provider Development Coordinator on the business day following the documented emergency unless the nature of the emergency prevents the individual from contacting DBHDD. If so, the individual is to contact the Provider Development Coordinator at the first available opportunity.
- G. Absences that are not verified as defined in this policy will result in closure of application, forfeiture of refund and “unsuccessful completion” status for all individuals representing the potential provider.
- H. In the event of a verified, documented emergency situation, where any of the three potential provider attendees (DDP, nurse and director) or potential individual provider is not able to complete training, the potential provider application will be placed on hold. Applications placed on hold may require updated documents when reopened. All required attendees (DDP, nurse and/or director) or potential individual provider who did not complete the training will be required to complete training during the next available training cycle. In this circumstance, training fees will carry over to the next available training cycle. If training is not completed in next available training cycle, the application will be closed.
- I. There will be no refunds for “no shows”. No shows will result in closure of application, forfeiture of refund, and “unsuccessful completion” status for all individuals representing the potential provider.
- J. The Division of DD reserves the right to alter the topics taught and amount of time devoted to each topic. Training topics are listed below:
1. Health Risk Screening Tool (HRST)
 2. Individual Service Plan
 - Implementation of the ISP
 - Documentation Requirements Based Upon Service
 3. Supports Intensity Scale
 4. Person Centered Training
 - Health, Safety, Well Being & Holistic Needs
 - Choice & Rights
 - Person Centered Service Delivery
 5. Provider Requirements
 - Personnel Requirements for Specific Services
 - Professional Staff
 - Mandatory Disqualification Standards
 - Training of Staff/Orientation
 - Introduction to Policies and Procedures for All Providers
 - Accreditation/Certification Standards

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- Certification Tool
- Medication
- Introduction to NOW/COMP Medicaid Manuals
- Service Specific Requirements
- Self-Direction of Services
- 6. Quality Management
 - Individual Rights
 - Quality Assurance and Monitoring of Services
 - Quality Improvement Plans
 - Grievance Procedures – Internal and External
- 7. Behavior Support
 - Applied Behavior Analysis
 - Best Practice Standards for Behavior Support Services and Other Relevant Policies
 - Safety Planning
 - Crisis Protocols
 - Staff Training Topics and Technique
- 8. Medicaid Policy
 - Billing Medicaid
 - Program Integrity
 - Medicaid Audits
- 9. Reporting/Investigation Critical Incidents and Deaths
- 10. Crisis Planning

K. Developmental Disabilities Professionals, Nurses and Directors and Owner/s (as applicable) will be given a competency assessment at the end of each module, and be provided with a discussion session following the assessment. Completed assessments will be returned by potential provider to trainer at end of each module session and discussion.

L. This training does not transfer to new employment, or consultation as a DDP, Nurse, or Director with different potential providers or current approved providers.

Requirement for Successful Completion of All Phases

All Phases of Process are required to be successfully completed within the six month cycle (July 1 – December 31, or January 1 – June 30) after the *Letter of Intent to Provide Services Form and Pre-qualifiers* were submitted.

Ongoing Recruitment of Some Services:

Division of DD may elect to do ongoing recruitment of some services, including:

- A. Direct Care Services
 - Environmental Accessibility Adaptations
 - Specialized Medical Supplies
 - Specialized Medical Equipment

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- Vehicle Adaptations

B. Therapy Services Professionally Licensed Services

- Community Residential Alternative/Community Living Support Nursing RN
- Community Residential Alternative/Community Living Support LPN Services
- Adult Occupational Therapy
- Adult Physical Therapy
- Adult Speech Language Therapy
- Behavioral Supports Consultation

C. Single Provider Services

- Financial Support Services (application made through the Division of Community Health)
- Support Coordination
- Community Guide Services

REFERENCE MATERIALS:

Department of Behavioral Health and Developmental Disabilities - Provider Information - Provider Toolkit

www.dbhdd.georgia.gov

Georgia Department of Community Health/Georgia Health Partnership – Georgia Web Portal

<https://mmis.georgia.gov>

Healthcare Facility Regulation – Licensing Body

www.dch.georgia.gov

Small Business Association

<http://www.sba.gov/localresources/district/ga/index.html>

Score/Small Business Mentoring and Training

<http://www.score.org/index.html>

Rights

Universal Declaration of Human Rights

<http://www.ohchr.org/EN/Issues/Pages/UDHRIndex.aspx>

The Developmental Disabilities Assistance and Bill of Rights Act of 2000

<http://www.acf.hhs.gov/programs/add/ddact/DDACT2.html>

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Human Rights Education Associates
http://www.hrea.org/index.php?base_id=152

United Nations Council for Human Rights
<http://www.ohchr.org/EN/Issues/Pages/WhatareHumanRights.aspx>

United Nations Enable
<http://www.un.org/disabilities/>

Quality Assurance / Improvement

Georgia Quality Management System
www.dfmc-georgia.org

Centers for Medicare & Medicaid Services (CMS) Quality Framework
<http://www.ncdhhs.gov/mhddsas/statspublications/reports/hcbsqualityframework.pdf>

GEORGIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES
Division of Developmental Disabilities

LETTER OF INTENT TO PROVIDE SERVICES FORM

SERVICE SITE

(Legal name and address must be registered with the Georgia Secretary of State's office)

Legal Name:			
Tax ID #:			
Corporate Street Address:			
City:	County:	State:	Zip Code:
Service Site Name:			
Service Site Address:			
City:	County:	State:	Zip Code:
Mailing Address (if different):			
City:	County:	State:	Zip Code:
Owner:			
Telephone:		Fax:	
Email Address:		Website:	
Director:			
Telephone:		Fax:	
Email Address:		Website:	
Nurse:			
Telephone:		Fax:	
Email Address:		Website:	
Developmental Disabilities Professional:			
Telephone:		Fax:	
Email Address:		Website:	

EMAIL ADDRESSES MUST BE CURRENT AND CORRECT AS ALL FUTURE CORRESPONDENCE FROM DBHDD WILL BE CONDUCTED VIA EMAIL. IT IS THE RESPONSIBILITY OF THE POTENTIAL PROVIDER TO ENSURE THAT EMAILS FROM DBHDD ARE ACCEPTED BY YOUR EMAIL SYSTEM AND DO NOT GO TO THE "SPAM" MAILBOX.

List below the Waiver Services that you are applying to provide and the number of individuals to be served in each Service.

Waiver Service <i>Such as CRA, CLS, SE etc.</i>	Number of Individuals to be Served In Each Service	County of Service Provision	Region of Service Provision	Licensed Service Y/N?

In accordance with Department of Community Health (DCH) Healthcare Facility Regulation Division (HFR) [which was formerly known as Office of Regulatory Services or ORS], please indicate all applicable license(s) that you possess:

- Child Placing Agency (CPA) license
- Home Health Agency (HHA) license
- Private Home Care (PHC) license
- Community Living Arrangement (CLA) license
- Personal Care Home (PCH) license

Please list any services that the organization has delivered to citizens with developmental disabilities within the past five years.

Name of Service	Location of Service	Length Of Service

Please list any previous Contracts, Letters of Agreement (LOA) or Provider Agreements (PA) issued to the organization within the last five years by any of the following:

- the Department of Human Resources (DHR), Division of Mental Health, Developmental Disabilities & Addictive Diseases (DMHDDAD) – currently known as the Department of Behavioral Health and Developmental Disabilities (DBHDD)
- the Department of Human Resources (DHR), Division of Aging – currently known as the Department of Human Services (DHS), Division of Aging
- Department of Community Health (DCH)

List Agency Name Used On Contract or LOA	List all Key Personnel Names Such as CEO/President Key Management Staff, Relative or Board of Directors	Contact Phone Number And E-Mail Address of each Key Personnel Name Listed	Department Issuing Contract	Service Provided Such as Aging, ICWP, Source etc.

With this *Letter of Intent to Provide Services Form*, your organization must also submit all pre-qualifiers listed within the **Recruitment and Application to Become a Provider of Developmental Disabilities Services Policy**. Any incomplete *Letter of Intent to Provide Services Form*, and/or incomplete or deficient pre-qualifier will result in no invitation to move forward to the application process.

Under applicable state and federal laws, I do hereby affirm that I am the authorized agent to complete this document and that the information contained herein this document is complete, true, and correct.

Name of Organization (please print)

Owner / Title (please print)

Signature of Owner/ Title

Date

**MR/DD
NEW SITE INSPECTION CHECKLIST**

Contracted Provider Making Request:		Date Request Emailed to the Region:	
Contracted Provider's CRA #:		Region of Responsibility for the Individual:	
Person Responsible for Ensuring Placement Meets Requirements:			
Phone:	Ext:	Email:	Targeted Move-In Date for the Individual:
Reason for Move: _____ New Allocation _____ Internal Move w/in Agency _____ New Admission to Agency _____ Other (Explain):		Support Coordination Agency: _____ Support Coordinator: _____	

Complete the following section(s) for EACH individual identified for placement in the home:

<p>#1: Name _____ Axis I _____ _____ Axis II _____ Axis III _____ Requires Assistance: Ambulation ___ Transfer ___ Uses Medical Equipment: (describe) _____ Medical Issues: (describe) _____ Behavior Issues: (describe) _____</p>		<p>#2: Name _____ Axis I _____ Axis II _____ Axis III _____ Requires Assistance: Ambulation ___ Transfer ___ Uses Medical Equipment: (describe) _____ Medical Issues: (describe) _____ Behavior Issues: (describe) _____</p>
<p>#3: Name _____ Axis I _____ _____ Axis II _____ Axis III _____ Requires Assistance: Ambulation ___ Transfer ___ Uses Medical Equipment: (describe) _____ Medical Issues: (describe) _____ Behavior Issues: (describe) _____</p>		<p>#4: Name _____ Axis I _____ Axis II _____ Axis III _____ Requires Assistance: Ambulation ___ Transfer ___ Uses Medical Equipment: (describe) _____ Medical Issues: (describe) _____ Behavior Issues: (describe) _____</p>

Sub Contractor Name:		Sub Contractor Phone:	
Site Name (if applicable):		Alternate Phone:	
Street:		Additional SubContractor Info / Extenuating Circumstances (if any):	
City:	Zip:		
County:			
Licensed PCH: ___ YES ___ NO		Licensed CLA: ___ YES ___ NO	
Host Home: ___ YES ___ NO		Host Home Family Name:	
If YES, License #:		Host Home Family Name:	
License Date (From):	(To):	Capacity:	
Met	Criteria		
	OVERALL CONDITION OF THE HOME		
	Home is clean, no odors		
	Heating and air conditioning systems operational and provides adequate heat and air		
	No needed repair work around the home, yard, deck		
	All areas are lighted sufficiently		
	Provides an area for use by residents and visitors that affords privacy		
	Furnishings and housekeeping present a clean and orderly appearance		
	No visible evidence of infestation		
	KITCHEN/LAUNDRY		
	Provides laundering facilities, at minimum 1 washer and 1 dryer		
	Provides common space, such as living room, and kitchen, for use by the residents without restriction		
	Food is stored properly		
	Maintains a 3-day supply of non-perishable foods for emergency needs. Check expiration dates on food		
	RESIDENT BEDROOMS		
	All bedrooms provide at a minimum 80 square feet for each resident		
	Bedrooms have at least one window		
	All bedrooms have standard non portable bed with springs and clean mattress		
	No Bedroom is a pass-through to reach another room or bathroom		
	All bedrooms have an adequate closet or wardrobe for each resident		
	All Bedrooms have lighting fixtures sufficient for reading and other activities		
	Sufficient bedding for all residents: Two sheets/pillow/pillowcase/blanket/bedspread for each bed		
	All bedrooms have doors that can be closed; occupant & staff have keys; no double-cylinder locks		

Met	Criteria
	BATHROOMS
	Provides at least one functional toilet, lavatory, and bath/shower per 4 residents
	One fully handicap accessible bathroom if any resident requires handicap access
	Grab bars and non-skid surfacing in all showers/bath areas
	Bath linens are present and sufficient
	Bathrooms and toilet facilities have a window that can be opened or forced ventilation
	Tub/ shower has a shower curtain or door
	Plumbing/bathroom fixtures are in good working order & are clean & sanitary
	Toilet tissue is available for use at each commode
	Hand-washing facilities have hot and cold running water, liquid soap, and paper towels
	EXTERIOR/ YARD
	The yard area is free from hazards, nuisances, refuse, and litter
	Residents dependent upon a wheelchair have at least 2 accessible exits
	Proper storage/disposal of garbage
	SAFETY
	Space heaters are not present
	Stairways/ramps have handrails; exterior stairways/decks/porches w/handrails on open sides unless low to ground
	Sufficient AC powered smoke detectors, with battery back up (Should keep record of when changed)* or Sufficient and operable smoke and carbon monoxide detectors in Host/Life Sharing Homes.
	Charged, 5 lb multipurpose ABC fire extinguisher on each floor & basement and checked w/in the last 12 months
	Exterior doors are equipped with locks that do not require keys to open the door from the inside
	The storage/disposal of biomedical wastes/hazardous wastes comply with applicable rules and standards
	Wall-mounted electric outlets and lamps or light fixtures are safe and operational
	Poisons, caustics, dangerous materials are to be stored in labeled, appropriate containers away from medication & food
	Provides sufficient hot water not exceeding 120 degrees Fahrenheit
	An evacuation plan w/ clear instructions is provided and a diagram posted (Posted diagram not required for Host Home)
	Supply of first-aid materials available w/ band aids, antiseptic, gauze, tape, and a appropriate thermometer in home
	Sufficient safety precautions taken to prevent unauthorized access to in-ground or above ground swimming pool
	(Host Homes) Fire arms stored in locked cabinet and ammunition store seperately
	Fireplace securely screened and/or equipped with protective guards while in use.
	Stairways, halls, doorways and exits from the rooms and from the house are unobstructed.
	Flammable and combustible supplies/equipment stored away from the heat sources.
	First Aid Kit in vehicle and Fire extinguisher in vehicle

Notes and Information:

SITE MEETS ALL CRITERIA: YES _____ NO _____ **LICENSE ATTACHED:** YES _____ NO _____

Inspector Signature	Date:
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Printed Name:	Title
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RC or Support Coord. Signature	Date Reviewed:
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Printed Name:	Title
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Regional Coordinator or Designee Signature	Date Approved:
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Identified Technical Schools for Direct Support Professional Training

Athens Technical College
800 U.S. Hwy. 29 N
Athens, GA 30601-1500
www.athenstech.edu

Central Georgia
Technical College
3300 Macon Tech Drive
Macon, GA 31206
www.centralgatech.edu

Lanier Technical College
2990 Landrum Education Drive
Oakwood, GA 30566
www.laniertech.edu

Moultrie Technical College
800 Veterans Parkway North
Moultrie, GA 31788
www.moultrietech.edu

North Georgia
Technical College
1500 Hwy 197 N.
Clarkesville, GA 30523
www.northgatech.edu

Savannah Technical College
5717 White Bluff Road
Savannah, GA 31405-5591
www.savannahtech.edu

Southern Crescent
Technical College
501 Varsity Road
Griffin, GA 30223
www.sctech.edu

Wiregrass Georgia
Technical College
4089 Val Tech Road
Valdosta, GA 31602
www.wiregrass.edu



Georgia Department of Behavioral Health & Developmental Disabilities

Frank E. Shelp, M.D., M.P.H., Commissioner

Beverly D. Rollins, M.P.A., Executive Director

Division of Developmental Disabilities

Two Peachtree Street NW, Suite 22.210, Atlanta, Georgia 30303-3142

Telephone: 404-463-8037

As a pre-qualifier requirement a potential new provider must show proof of liquid assets equal to at least three (3) times the monthly expenses listed in budget (three months of operating capital). Proof must be submitted on this PROOF OF LIQUID ASSETS VERIFICATION below and must be certified or notarized from the financial institution where the corporate, not personal, account is established. Corporate or personal lines of credit will not be accepted. Operating capital must be unrestricted.

PROOF OF LIQUID ASSETS VERIFICATION

Name of Bank: _____

Address of Bank: _____

Corporate or Business Name of Provider: _____

Address of Provider: _____

Federal Employer ID No _____

Owner of Agency _____

To be completed by Pre-qualifying Corporation/Business

I hereby authorize the State of Georgia Department of Behavioral Health and Developmental Disabilities to make inquiries regarding my financial circumstances for the purpose of complying with pre-qualifier requirements for submitting a provider services Letter of Intent with the department.

Printed Name of Owner _____ Date: _____

Signature of Owner _____ Title: _____

The Corporation/Business listed above has indicated that they have assets in your institution. Please confirm by completing the following information.

To be completed by Bank/Financial Institution and include attachment of most current supporting bank balance account statement.

Corporate Account Name	Date Opened	Account Number	Account Balance	Average 6-Months	(Based on Current Balance)		
					Holds(\$)	Pledged(\$)	Restricted(\$)
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

I certify under penalty of law that the information provided in this section and all attachments were prepared under my direction or supervision. The information submitted is true, accurate, and complete.

Signature of Owner _____ Date: _____

Signature of Bank Officer or Cashier _____ Date: _____

Notarized by: _____ Date: _____



Chapter: Administrative Issues Related to Behavioral Health & Developmental Disabilities Service Delivery
Subject: Region of Responsibility Determination

References:

Official Code of Georgia Annotated (O.C.G.A.) 37-2-6.2 (a) 11 and O.C.G.A. 37-2-11 (a)

Applicability:

State Hospitals, Community Providers of Behavioral Health and Developmental Disabilities Services, Crisis Stabilization Programs, Regional Offices

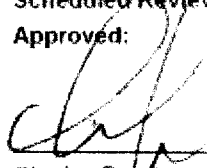
Attachments:

Attachment A – DBHDD Map of Regions

Original Effective Date: July 1, 2010

Scheduled Review Date: July 2011

Approved:

 6/23/10
Charles Ringling, Date
DBHDD Regional Coordinator Team Leader

 6/30/10
Frank E. Shelp, M.D., M.P.H., Commissioner Date

REGION OF RESPONSIBILITY DETERMINATION

POLICY

It is the policy of the Department of Behavioral Health and Developmental Disabilities (DBHDD) to allocate resources by region for the purpose of developing appropriate community based services and for accountability of those resources. It is expected that those resources be used to meet the needs of the citizens in the respective DBHDD regions. It is also expected that in order to address the individual needs, people may receive services in any region, if they so choose.

This policy addresses determination of and documentation of region of responsibility and associated issues. Nothing in this policy should be interpreted to reduce in any way the obligation of Providers and State Hospitals to deal with crisis/emergency situations that occur within their regions and to respond to essential service needs while residency and responsibility questions are being resolved. Further, nothing in this policy should be interpreted to constrain the freedom of individuals to seek services wherever they wish regardless of residency and responsibility determinations.

DEFINITIONS

Individual – For the purposes of this policy, the term individual refers to a recipient or participant in mental health, addictive diseases, and/or developmental disabilities services.

Provider – For the purposes of this policy, the term provider includes all organizations that provide behavioral health and/or developmental disability services that are financially supported in whole or in part by funds authorized through DBHDD.

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Services – For the purposes of this policy, services refers to all behavioral health and/or developmental disabilities services offered by Providers (including Crisis Stabilization Programs) and by State Hospitals operated by DBHDD.

PROCEDURES

A. Guidelines for Determining Region of Responsibility

1. DBHDD assigns counties to regions. See **Attachment A – DBHDD Map of Regions** for the current configuration of DBHDD Regions. DBHDD may elect to periodically change the counties assigned to each region, and/or the number of regions in the state.
2. At the time an individual enters services, the region of responsibility is assigned. Most commonly the individual’s county of residence identifies their region of residence which then becomes the region of responsibility. It is recognized that some circumstances may lead to a change. The guidelines in this policy are used in making initial and subsequent determinations of region of responsibility.
3. For the purposes of this policy, each individual is assigned a region of residence except those identified in this policy as exceptions.
4. For an adult, the region of responsibility is determined by the individual’s county of residence.
5. If the individual enters services via hospital admission, the county of residence recorded by the hospital determines the region of responsibility and remains so until evidence to the contrary is provided by the DBHDD Regional Office.
6. If an individual moves from one region to another for reasons unrelated to any services needs, the county of residence determines the new region of responsibility.
7. The individual’s region of residence is the region of responsibility until such time as subsequent event(s) affect that determination.
8. Individuals residing in long term care facilities such as nursing homes, with no plans to return to another residence, are considered residents of the region in which their long term care facility is located.
9. The region of residence for individuals considered homeless (because they do not have a residence or permanent place to live) is determined by the county in which they are currently staying.

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10. For an individual under age 18, the county of residence of the custodial parent(s) or legal guardian determines the region of responsibility, regardless of the location of the minor's residence. When a Department of Human Services, Division of Family and Children Services (DFCS) office retains legal custody of an individual, whether adult or minor, the region in which the DFCS office is located is the responsible region.
11. If a minor's custodial parent/legal guardian relocates to another county, the county in which the new residence is located determines the region of responsibility, regardless of the location of the minor's residence. If a minor's custodial parent/legal guardian relocates out of state, the region of responsibility remains the last region in Georgia in which the parent(s)/guardian resided.
12. If an individual moves to another region for reasons that, by definition, are intended to be temporary (foster home, nursing home for rehabilitation, a halfway house, a trial visit), the original region of responsibility remains the region of responsibility.
13. If a Provider initiates a change of region for an individual, the Provider is obligated to gain approval from the Regional Office of origin. The Regional Office of origin then seeks approval from the receiving Regional Office. This approval is documented via email. Any transfer of funds associated with region of responsibility is accomplished through the Budget Allocation System (BAS).
14. If an individual independently obtains services in a region other than his/her region of residence, the county of residence determines the region of responsibility.
15. If the Regional Office initiates a change of region for an individual, that office is obligated to gain approval from the receiving regional office. This approval is documented via email. Any transfer of funds associated with region of responsibility is accomplished through the Budget Allocation System (BAS).
16. If an individual is discharged from a state hospital and is subsequently readmitted to a state hospital from a location other than the original region of responsibility, the circumstances of the discharge and placement may affect the determination of region of responsibility for the readmission.
 - If the individual was discharged to a location intended to be temporary, the original region of responsibility remains the responsible region.
 - If the individual voluntarily moved to a location intended to be permanent, the new county of residence determines the region of responsibility even if the individual has been in the new region only a short time.
17. Other extenuating circumstances regarding establishing the region of responsibility may be mutually agreed upon by the affected regions.

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B. Exceptions

The following individuals will not be assigned a region of responsibility:

- Out-of-state individuals, i.e., those who are admitted to a hospital or crisis stabilization program for whom discharge planning involves the individual returning to another state for continued services.
- Adults admitted to state institutions from Department of Corrections (DOC) who will be returning to the DOC upon hospital discharge.
- Youth admitted to services from Department of Juvenile Justice (DJJ) facilities who will be returning to a DJJ facility upon discharge.
- Individuals who have not verified their lawful presence in the United States.

Lawful presence means that the person is a citizen of the United States, or is a non-citizen whose physical presence in the United States is authorized under the immigration laws of the United States. Categories of lawful presence include but are not limited to: citizenship, legal permanent residence, legal temporary residence, visitor with a visa, legal temporary worker, refugee, person with approved asylum status, or temporary protected status from a country of origin under warfare or environmental disaster. For additional information, see the DBHDD policy regarding verification of lawful presence in United States for individuals seeking DBHDD Services.

C. Steps to Take When the Regions Cannot Agree Upon Region of Responsibility

When an individual's region of responsibility cannot be determined at the regional level, formal request for a determination of region of responsibility is submitted to the person responsible for managing regional operations or designee for resolution; the region currently bearing responsibility for the individual is responsible to request a decision.

For individuals who are in state hospitals, if region of responsibility cannot be determined at the regional level within a time period appropriate for adequate hospital discharge planning, the regional hospital administrator submits a request for determination of region of responsibility to the region of origin. A formal request for a determination of region of responsibility is then submitted to the person responsible for managing regional operations or designee for resolution.

Georgia Department of Behavioral Health & Developmental Disabilities

REGIONAL MAP

(Effective July 1, 2010)

STATE HOSPITALS

- 1** Northwest Georgia Regional Hospital
- 2** Georgia Regional Hospital at Atlanta
- 3** West Central Georgia Regional Hospital
- 4** Central State Hospital (DD & Forensic only)
- 5** East Central Regional Hospital
- 6** Southwestern State Hospital
- 7** Georgia Regional Hospital at Savannah



Department of Behavioral Health and
Developmental Disabilities
Information Management Unit

Created: June 29, 2010

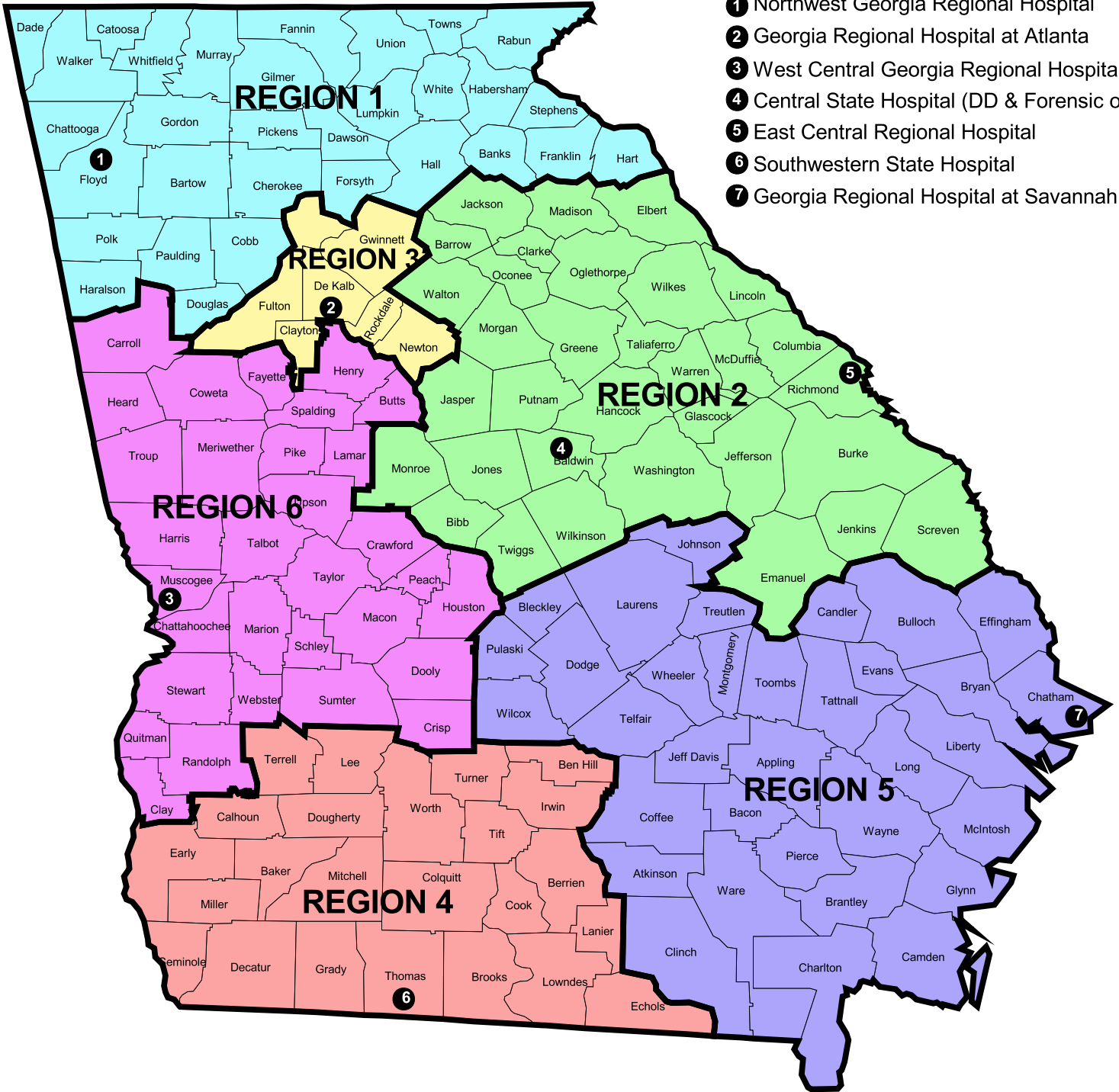
Georgia Department of Behavioral Health & Developmental Disabilities

REGIONAL MAP

(Effective July 1, 2010)

STATE HOSPITALS

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- 2** Georgia Regional Hospital at Atlanta
- 3** West Central Georgia Regional Hospital
- 4** Central State Hospital (DD & Forensic only)
- 5** East Central Regional Hospital
- 6** Southwestern State Hospital
- 7** Georgia Regional Hospital at Savannah



Department of Behavioral Health and
Developmental Disabilities
Information Management Unit

Created: June 29, 2010

DBHDD



Chapter: Administrative Issues Related to Behavioral Health & Developmental Disabilities Service Delivery
Subject: Reporting and Investigating Deaths and Critical Incidents in Community Services

References:

Official Code of Georgia Annotated (O.C.G.A):
31-8-81; 37-1-2; 37-1-20; 37-2-1 et seq.; 37-3-166;
37-3-2; 37-4-125; 37-4-3; 37-7-166; 37-7-2; 30-5-1
et seq.; 19-7-5; 16-6-5.1

Effective Date: April 1, 2011

Scheduled Review Date: April 2012

Approved:

Beverly D. Rollins 2/25/11

Beverly D. Rollins, M.P.A., Executive Director Date
Division of Developmental Disabilities

Cassandra Price 2/25/11

Cassandra Price, Executive Director Date
Division of Addictive Diseases

Applicability:

- Public and Private Community Providers
- OTP & State-operated Community Programs
- State DBHDD Office
- Regional DBHDD Offices
- Self-directed DD Services

Attachments:

- Attachment A – Definitions
- Attachment B – Death Report Form
- Attachment C – Critical Incident Report Form (CIR)
- Attachment c1 – Critical Incident Report Form (CIR) (Supplemental)
- Attachment D – Reporting to Other Agencies
- Attachment E – Investigative Report Format
- Attachment e1 – Investigative Report
- Attachment F – Request for Extension
- Attachment G – Corrective Action Plan

J. Bryce McLaulin MD 2/24/11

J. Bryce McLaulin, M.D., Executive Director Date
Division of Mental Health

Frank E. Shelp 3/1/2011

Frank E. Shelp, M.D., M.P.H., Commissioner Date

I. POLICY

It is the policy of the Department of Behavioral Health and Developmental Disabilities (DBHDD) to maintain a safe and humane environment for individuals, and to prevent abuse, neglect and exploitation of individuals. DBHDD uses a standardized process for reporting and investigating deaths and critical incidents that involve individuals being served in all types of community services.

II. DEFINITIONS

Category I Incidents

- Death-Unexpected
- Suicide
- Alleged Individual Abuse-Physical
- Alleged Neglect
- Alleged Individual Abuse-Psychological
- Alleged Sexual Abuse

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- Alleged Individual to Individual Sexual Assault
- Alleged Exploitation - Staff to Individual
- Medication errors with adverse consequences
- Seclusion or restraint resulting in injury requiring treatment
- Suicide attempt that results in medical hospitalization

Category II Incidents

- Death-Expected
- Alleged Individual Abuse-Verbal
- Individual who is unexpectedly absent from a community residential program or day program
- Vehicular accident with injury while individual is in an agency vehicle or is being transported by staff
- Incident occurring in the presence of provider staff which required the intervention of law enforcement services
- Criminal conduct by individual
- Aggressive act between individuals resulting in injury requiring treatment beyond first aid
- Hospitalization of an individual in a community residential program

Category III Incidents

- Death
- Individual injury requiring treatment beyond first aid (not related to possible staff misconduct)
- Staff injury caused by an individual and requiring treatment
- Aggressive act between individuals with injury requiring minor first aid

See **Attachment A: Critical Incident Definitions & Reporting/Investigating Requirements** for definitions of incidents.

Community Provider: Any person or entity providing community-based disability services through a contract with or authorized by DBHDD and/or providing Medicaid services authorized by DBHDD. "Community Provider" includes any state owned or operated community program. For purposes of this policy, community provider includes services provided through a subcontractor.

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Community Residential Individual: An individual receiving services in a staffed home or a host home and/or an individual receiving community living support 24 hours/7 days a week.

Corrective Action Plan: A document which identifies and analyzes problems within the provider organization and prescribes corrective action steps which, when implemented, are likely to prevent the recurrence of similar problems and improve the quality of services. A corrective action plan must identify the person(s) responsible for ensuring that action steps are completed and reviewed for efficacy and establish a schedule for completion and follow-up of all action steps.

Crisis Support Home: A home that serves up to four (4) individuals diagnosed with a Developmental Disability and who are experiencing an emotional/behavioral change and/or distress that leads to a disruption of essential functions, which has not responded to Intensive-In-Home Support services.

Critical Incident: Any event that involves an immediate threat to the care, health or safety of any individual in community residential services, in community crisis home services, on site with a community provider, in the company of a staff member of a community provider, or enrolled in participant-directed services. Critical incidents that must be reported to DBHDD are listed in **Attachment A**.

Critical Incident Database: DBHDD web-based system for entering data about critical incidents.

High-Visibility Incident: Critical incidents as defined in this policy, which have system-wide impact, have impact upon, or relevance to, any ongoing litigation of DBHDD, or may have significant impact upon, or significant relevance to, issues of DBHDD public concern and/or are likely to be reported in the media.

Individual: For purposes of this policy, a person enrolled with a community provider or state-operated community service provider for disability services, or receiving community crisis services, or participating in self-directed developmental disabilities services.

Investigative Report: A written summary of an investigation conducted by the Office of Incident Management and Investigations or by a community provider regarding an alleged critical incident or death.

Participant-Directed Services: A model for service delivery in which individuals have the option to control and direct Medicaid funds identified in a personalized budget, and in which the individuals live in their own homes. The individual hires

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and dismisses direct support staff, and works with a support coordinator to receive assistance needed with self-directing services.

Person of Interest: Staff accused of abuse, neglect or exploitation of an individual receiving disability services.

Senior Executive Manager: The individual authorized by the agency to review for accuracy and completeness incident reports, investigative reports and corrective action plans prior to submission to DBHDD.

Support Coordinator/Planning List Administrator: In DBHDD developmental disability services, the independent case manager for each individual.

Temporary Intermediate Support (TIS) Home: A home that serves up to four (4) children ages 10 thru 17 years of age, diagnosed with a Developmental Disability and who are undergoing an acute crisis that presents a substantial risk of imminent harm to self or others.

III. PROCEDURES FOR REPORTING INDIVIDUAL DEATHS AND CRITICAL INCIDENTS

A. Reporting Deaths (Category I and II)

1. Community providers will immediately notify parents/guardians, Regional Office, support coordinators and other stakeholders, as indicated.
2. For deaths in a residential or community crisis home setting, community provider requests that the coroner/medical examiner conduct an autopsy and provides sufficient facts to the coroner/medical examiner regarding the death.
3. In the event that the coroner/medical examiner decides not to perform an autopsy, the provider documents the coroner/medical examiner's decision, and if known, the rationale for the decision.
4. The provider submits the **Death Report Form** (Attachment B) to the Office of Incident Management and Investigations electronically. The report must be submitted on the same day as the individual's death or on the next business day if the death occurred after business hours or on a weekend or holiday.

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5. The senior executive manager is responsible for ensuring that the ***Death Report Form*** (Attachment B) is submitted as required.
6. For deaths that must be reported to other agencies or offices as required by law or regulation, the community provider is responsible at all times for notifying such agencies and offices in a timely manner. (See Attachment D – ***Reporting to Other Agencies***)
7. The Office of Incident Management and Investigations obtains a copy of the death certificate from the Department of Community Health. This copy must not be reproduced or released outside DBHDD.

B. Reporting Deaths (Category III)

1. The provider submits the ***Death Report Form*** (Attachment B) to the Office of Incident Management and Investigations electronically. The report must be submitted on the same day as the death, or discovery of the death, or on the next business day if the death occurred after business hours or on a weekend or holiday.
2. The senior executive manager is responsible for ensuring that the ***Death Report Form*** is submitted as required.

C. Reporting all other Category I and II Critical Incidents (excluding deaths)

1. Upon discovery of a critical incident, providers immediately take any action necessary to protect individuals' health, safety and rights. These actions may include:
 - Removal of an employee from direct contact with any individuals when the employee is alleged to have been involved in physical abuse, neglect, sexual assault, verbal abuse or exploitation, until such time as the community provider has sufficiently determined that such removal is no longer necessary; and
 - Other measures to protect the health, safety and rights of the individual, as necessary.
2. The community provider immediately notifies:
 - The individual's guardian and/or next of kin, as appropriate with respect to confidentiality regulations;
 - The Office of Incident Management and Investigations if there is reasonable suspicion that a crime has been committed; and

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- Law enforcement, as needed, subject to applicable rules, regulations and consideration of confidentiality.
3. For all other Category I critical incidents (excluding deaths), the community provider submits the **Critical Incident Report** form (Attachment C) electronically to the Office of Incident Management and Investigations on the same day as the Category I incident, or the discovery of the incident, or on the next business day if the incident occurred after business hours or on a weekend or holiday.
 4. For all other Category II critical incidents, (excluding deaths) the community provider submits the **Critical Incident Report** form (Attachment C) electronically to the Office of Incident Management and Investigations within 24 hours of the Category II incident, or discovery of the incident, or on the next business day if the incident occurred after business hours or on a weekend or holiday.
 5. When an individual has an assigned support coordinator, the provider notifies the support coordinator of the critical incident by giving them a copy of the Critical Incident Report.
 6. For critical incidents that must be reported to other agencies or offices as required by law or regulation, the community provider is responsible at all times for notifying such agencies and offices in a timely manner (See Attachment D – **Reporting to Other Agencies**).

D. Reporting Category III Critical Incidents (excluding deaths)

1. Upon discovery of a critical incident, providers immediately take any action necessary to protect individuals' health, safety and rights.
2. The community provider immediately notifies:
 - The individual's guardian and/or next of kin, as appropriate with respect to confidentiality regulations;
 - The Office of Incident Management and Investigations if there is reasonable suspicion that a crime has been committed; and
 - Law enforcement, as needed subject to applicable rules, regulations and consideration of confidentiality.
3. The community provider submits the **Critical Incident Report** form (Attachment C) electronically to the Office of Incident Management and Investigations within 48 hours of the Category III incident, or discovery

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of the incident, or on the next business day if the incident occurred after business hours or on a weekend or holiday.

4. When an individual has an assigned support coordinator, the provider notifies the support coordinator of the critical incident and provides a copy of the Critical Incident Report.
5. For critical incidents that must be reported to other agencies or offices as required by law or regulation, the community provider is responsible at all times for notifying such agencies and offices in a timely manner (See Attachment D – **Reporting to Other Agencies**).

E. High Visibility Incidents

1. The community provider immediately reports all incidents that are high visibility to the Office of Incident Management and Investigations by telephone. This call must be made as soon as possible, but at least within two (2) hours of discovery of the incident.
2. A **Critical Incident Report** form (Attachment C) must be submitted electronically on the same day as the high visibility incident or on the next business day if the incident occurred after business hours or on a weekend or holiday.
3. The Office of Incident Management and Investigations notifies the Director of Communications, the Regional Coordinator, and the appropriate Division Director of high visibility incidents.

F. Reports of Incidents made by persons other than staff of community providers

1. Individuals, family members of individuals, support coordinators, or any other persons may initiate reports of critical incidents as needed.
2. In participant-directed services, the individual's support coordinator has responsibility for gathering information from the individual's support system about critical incidents as they occur. The support coordinator then reports critical incidents as required by this policy.
3. All support coordinators report critical incidents upon discovery, if the incident has not already been reported by the community provider.

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4. If the support coordination agency submits a Critical Incident Report, they must notify the provider of the submission by giving them a copy of the report.
5. When information about a critical incident is received from any person other than support coordinators, the staff receiving the information completes and submits the applicable incident report form.
6. When information about a critical incident is received by the Office of Incident Management and Investigations, the staff receiving the information completes the applicable incident report form.

G. Agency Managerial Review of ***Death Report and Critical Incident Report*** Forms

1. Administrators of community providers or support coordination agencies perform a managerial review of all Death Report Forms and Critical Incident Reports. The reviewer at a minimum:
 - Reads the Death Report Form or Critical Incident Report;
 - Reads all statements and reports associated with the incident;
 - Requires and ensures the completion of any incomplete or missing documentation; and
 - Signs by attestation as the managerial reviewer on the ***Death Report Form*** (Attachment B) or ***Critical Incident Report*** form (Attachment C).
2. The Office of Incident Management and Investigations reviews all Death Report Forms and Critical Incident Reports for completeness and contacts the provider for additional information, as appropriate.

H. Responsibility for Investigations

1. The Office of Incident Management and Investigations reviews on the day received all incident reports of Category I incidents. If that office assumes responsibility for the investigation, the provider is notified the same day for reports received before 3 p.m. on a business day. If the Category I incident report is received after 3 p.m., the provider is notified on the next business day regarding responsibility of the investigation.
2. The Office of Incident Management and Investigations reviews all Category II incident reports. It is the responsibility of the provider to

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complete the investigation for the Category II incident within timeframes established in section IV.

3. The Office of Incident Management and Investigations reviews all Category III incident reports. An investigation is not required unless the Office of Incident Management and Investigations determines that one is necessary. If this determination is made, the provider agency is notified by the Office of Incident Management and Investigations.

IV. PROCEDURES FOR INVESTIGATING INDIVIDUAL DEATHS AND CRITICAL INCIDENTS

A. For investigation of Category I and II Critical Incidents

1. The provider must designate staff who will be responsible for conducting any investigations pursuant to this policy.
2. The investigator, at a minimum:
 - Interviews individuals, staff and other involved parties;
 - Reviews all related documentation; and
 - Collaborates with outside agencies, as applicable.
3. The individual served who is the subject of the incident must be offered an opportunity to speak with the investigator.
4. All investigations must be thorough and must address, at a minimum, those items identified in the **Investigative Report Format** (Attachment E).
5. If, at any time during the investigation, evidence of criminal conduct is discovered, the investigator immediately notifies the Office of Incident Management and Investigations and the senior executive manager. The senior executive manager will review applicable rules, regulations and confidentiality provisions, and notify law enforcement when appropriate.
6. If law enforcement authorities initiate an investigation regarding the incident, the community provider staff cooperates with law enforcement and ensures that such cooperation is in compliance with confidentiality laws and regulations.

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7. If, at any time during an investigation, it appears that a community provider or its staff has failed to protect the health, safety and/or welfare of the individuals in its care, the Office of Incident Management and Investigations requests that the Regional Coordinator take immediate steps to protect such individuals, including the removal of the individual(s) to another community provider, if needed. The Regional Coordinator, or his/her designee, notifies the Office of Incident Management and Investigations of actions taken.
8. The investigator completes the investigation and submits the typed **Investigative Report** (Attachment e.1) to the Office of Incident Management and Investigations within thirty (30) calendar days following the date of the incident or discovery of the incident. The report may be submitted electronically with electronic signatures.
9. If there is a compelling reason why the investigation cannot be completed within thirty (30) days, a **Request for Extension** form (Attachment F) is completed and submitted electronically to the Office of Incident Management and Investigations outlining the reasons and giving an expected completion date. Such requests must be received by the Office of Incident Management and Investigations at least five (5) calendar days prior to report due date. In response to the request, the Office of Incident Management and Investigations will establish a new deadline, based on circumstances, but not beyond thirty (30) calendar days.

B. Corrective Action Plans and Follow-up

1. Upon completion and review of the Investigative Report, the Office of Incident Management and Investigations notifies the community provider/support coordination agency if there is need for a **Corrective Action Plan** (CAP) form (Attachment G).
2. A CAP must be submitted to the Office of Incident Management and Investigations within the timeframe established by the request.
3. The Office of Incident Management and Investigations accepts or makes recommendations for changes to the CAP and involves the Regional Coordinator as necessary.
4. For CAPs that are not completed successfully by contracted providers, the Regional Coordinator coordinates appropriate contract actions with DBHDD Legal Services.

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- C. Distribution of Investigative Reports and Corrective Action Plans
 - 1. When an investigation is completed by the Office of Incident Management and Investigations, that report and any subsequent Corrective Action Plans are sent to the Regional Coordinator.
 - 2. It is the responsibility of the Regional Coordinator to follow-up with the provider when necessary, and to ensure that the provider has taken the appropriate corrective steps to correct unsafe conditions.

V. DATA ENTRY AND ANALYSIS

- A. Procedures for Data Entry
 - 1. DBHDD maintains a critical incident database to identify patterns and to perform trend analysis.
 - 2. Access to the critical incident database must be granted by the Office of Incident Management and Investigations and is limited to staff of providers or agencies operated by, or under contract or Letter of Agreement (LOA) with DBHDD.
 - 3. Each provider agency designates one or more persons to be responsible for entering critical incident and death information into the database. Entries must be made within one business day of the incident or knowledge of the incident.
- B. Procedures for Data Analysis
 - 1. The critical incident reporting processes are monitored by the Office of Incident Management and Investigations for timeliness and accuracy.
 - 2. Information about incidents is utilized in the Department's quality improvement initiatives to evaluate the quality of services.

Critical Incident Definitions & Reporting/Investigating Requirements

Category	Incident Type	Definition	Reporting & Investigating Requirements
I, II, or III	High Visibility	Critical incidents as defined in this policy, which have system-wide impact, have impact upon, or relevance to, any ongoing litigation of DBHDD, or may have significant impact upon, or significant relevance to, issues of DBHDD public concern and/or are likely to be reported in the media.	<p>Reporting requirements: Notify the Office of Incident Management and Investigations of the high visibility incident by phone within two (2) hours of discovery of the incident.</p> <p>Submit a typed Critical Incident Report electronically on the same day as the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.</p> <p>Investigating requirements: If the Office of Incident Management and Investigations directs the community program or support coordinator to conduct the investigation, the Investigative Report will be submitted by mail or electronically within 30 days of the incident or discovery of the incident.</p>
I	Death-Unexpected	<p>An unexpected death is when the cause of death is not attributed to a terminal diagnosis or diagnosed disease process where the reasonable expectation of the outcome is death.</p> <p>Includes the death of any individual:</p> <ul style="list-style-type: none"> • Receiving residential services or receiving 24/7 community living support • Occurring on site of a community provider • In the company of staff of a community provider • Absent without leave from residential services. 	<p>Reporting requirements: Submit a typed Death Report Form electronically on the same day as the individual death or on the next business day if the death occurred after business hours or on a weekend/holiday.</p> <p>Investigating requirements: If the Office of Incident Management and Investigations directs the community program or support coordinator to conduct the investigation, the Investigative Report will be submitted by mail or electronically within 30 days of the incident or discovery of the death.</p>
I	Suicide	Self-inflicted death of individual receiving services.	<p>Reporting requirements: Submit a typed Death Report Form electronically on the same day as the individual death or on the next business day if the death occurred after business hours or on a weekend/holiday.</p>

Critical Incident Definitions & Reporting/Investigating Requirements

			<p>Investigating requirements: If the Office of Incident Management and Investigations directs the community program or support coordinator to conduct the investigation, the Investigative Report will be submitted by mail or electronically within 30 days of the incident or discovery of the death.</p>
I	Alleged Individual abuse-Physical	<p>Any interaction or physical contact, motion, or action that is directed toward an individual by someone other than another individual (peer), which may cause harm or pain. Examples include shoving, hitting, slapping, pinching, shaking, kicking, punching, misuse of seclusion or restraint, unreasonable confinement, misuse of medication or excessive force during the provision of services.</p>	<p>Reporting requirements: Submit a typed Critical Incident Report electronically on the same day as the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.</p> <p>Investigating requirements: If the Office of Incident Management and Investigations directs the community program or support coordinator to conduct the investigation, the Investigative Report will be submitted by mail or electronically within 30 days of the incident or discovery of the incident.</p>
I	Alleged Neglect	<p>The failure of an employee or an organization to provide goods, services and/or supervision necessary to avoid physical harm.</p>	<p>Reporting requirements: Submit a typed Critical Incident Report electronically on the same day as the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.</p> <p>Investigating requirements: If the Office of Incident Management and Investigations directs the community program or support coordinator to conduct the investigation, the Investigative Report will be submitted by mail or electronically within 30 days of the incident or discovery of the incident.</p>

**Critical Incident Definitions &
Reporting/Investigating Requirements**

I	Alleged Individual Abuse- Psychological	Any act by someone other than another individual (peer) that causes or could reasonably be expected to cause emotional distress to an individual. Examples include but are not limited to use of intimidation to achieve compliance, retaliation, purposely not intervening in a behavior that is demeaning to the individual, deliberately inflicting mental pain, anxiety, confusion, humiliation, harassment, or coercion.	<p>Reporting requirements: Submit a typed Critical Incident Report electronically on the same day as the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.</p> <p>Investigating requirements: If the Office of Incident Management and Investigations directs the community program or support coordinator to conduct the investigation, the Investigative Report will be submitted by mail or electronically within 30 days of the incident or discovery of the incident.</p>
I	Alleged Sexual Abuse	Any sexual contact between an employee and an individual. An employee encourages or allows sexual contact between individuals, one of whom is not consenting.	<p>Reporting requirements: Submit a typed Critical Incident Report electronically on the same day as the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.</p> <p>Investigating requirements: If the Office of Incident Management and Investigations directs the community program or support coordinator to conduct the investigation, the Investigative Report will be submitted by mail or electronically within 30 days of the incident or discovery of the incident.</p>
I	Alleged Individual to Individual Sexual Assault	Sexual contact between individuals using force or violence, or the threat of force or violence, includes touching, rape or sodomy.	<p>Reporting requirements: Submit a typed Critical Incident Report electronically on the same day as the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.</p> <p>Investigating requirements: If the Office of Incident Management and Investigations directs the community program or support coordinator to conduct the investigation, the Investigative</p>

Critical Incident Definitions & Reporting/Investigating Requirements

			Report will be submitted by mail or electronically within 30 days of the incident or discovery of the incident.
I	Alleged Exploitation-Staff to Individual	Selfish or unethical advantage or gain of an individual by staff.	<p>Reporting requirements: Submit a typed Critical Incident Report electronically on the same day as the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.</p> <p>Investigating requirements: If the Office of Incident Management and Investigations directs the community program or support coordinator to conduct the investigation, the Investigative Report will be submitted by mail or electronically within 30 days of the incident or discovery of the incident.</p>
I	Medication errors with adverse consequences	Medication error includes omission and wrong dose, time, person, medication, route, position, technique/method and form. Adverse consequences are those that cause the individual discomfort or jeopardize his/her health and safety. Does not include refusal of medication by individual.	<p>Reporting requirements: Submit a typed Critical Incident Report electronically on the same day as the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.</p> <p>Investigating requirements: If the Office of Incident Management and Investigations directs the community program or support coordinator to conduct the investigation, the Investigative Report will be submitted by mail or electronically within 30 days of the incident or discovery of the incident.</p>
I	Seclusion or restraint resulting in injury requiring treatment	<p>Seclusion or restraint includes physical holding, as well as mechanical restraints, and time-out. This would not include postural supports or restraints for medical or surgical procedures.</p> <p>Injury includes any physical harm or damage that requires first aid or more serious treatment.</p>	<p>Reporting requirements: Submit a typed Critical Incident Report electronically on the same day as the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.</p> <p>Investigating requirements: If the Office of</p>

Critical Incident Definitions & Reporting/Investigating Requirements

			Incident Management and Investigations directs the community program or support coordinator to conduct the investigation, the Investigative Report will be submitted by mail or electronically within 30 days of the incident or discovery of the incident.
I	Suicide attempt that results in medical hospitalization	The individual receiving any type of services (including outpatient services) is hospitalized for medical reasons related to injuries from a suicide attempt.	<p>Reporting requirements: Submit a typed Critical Incident Report electronically on the same day as the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.</p> <p>Investigating requirements: If the Office of Incident Management and Investigations directs the community program or support coordinator to conduct the investigation, the Investigative Report will be submitted by mail or electronically within 30 days of the incident or discovery of the incident.</p>
II	Death-Expected	<p>An expected death is when the cause of death is attributed to a terminal diagnosis or diagnosed disease process where the reasonable expectation of the outcome is death.</p> <p>Includes the death of any individual:</p> <ul style="list-style-type: none"> • Receiving residential services or receiving 24/7 community living support • Occurring on site of a community provider • In the company of staff of a community provider • Absent without leave from residential services. 	<p>Reporting requirements: Submit a typed Death Report Form electronically on the same day as the individual death or on the next business day if the death occurred after business hours or on a weekend/holiday.</p> <p>Investigating requirements: The Investigative Report will be submitted by mail or electronically within 30 days of the incident or discovery of the death.</p>
II	Alleged Individual Abuse-Verbal	Any language by someone other than another individual (peer) that may be threatening, demeaning, discriminatory, pejorative, derogatory or aggressive.	<p>Reporting requirements: Submit a typed Critical Incident Report electronically within 24 hours of the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.</p> <p>Investigating requirements: The Investigative</p>

Critical Incident Definitions & Reporting/Investigating Requirements

			Report will be submitted by mail or electronically within 30 days of the incident or discovery of the incident.
II	Individual who is unexpectedly absent from a community residential program or day program	Individual has left the residence or the day program without knowledge of staff and whose location is not known. Would include all absences where law enforcement is notified.	<p>Reporting requirements: Submit a typed Critical Incident Report electronically within 24 hours of the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.</p> <p>Investigating requirements: The Investigative Report will be submitted by mail or electronically within 30 days of the incident or discovery of the incident.</p>
II	Vehicular accident with injury while individual is in an agency vehicle or is being transported by staff	The injury required treatment beyond minor first aid. The injury received is severe enough to require the treatment of an individual by a licensed medical doctor, osteopath, podiatrist, dentist, physician’s assistant, or nurse practitioner, further, the treatment received may be provided within the facility or outside the facility where it may range from treatment at a doctor’s private office through treatment at the emergency room of a hospital. Treatment beyond first aid would not include diagnostic procedures.	<p>Reporting requirements: Submit a typed Critical Incident Report electronically within 24 hours of the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.</p> <p>Investigating requirements: The Investigative Report will be submitted by mail or electronically within 30 days of the incident or discovery of the incident.</p>
II	Incident occurring in the presence of provider staff which required the intervention of law enforcement services	Includes 911 calls from staff for assistance, as well as reports to law enforcement of theft of individual property by employees or non-employees while at the provider site or accompanied by staff.	<p>Reporting requirements: Submit a typed Critical Incident Report electronically within 24 hours of the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.</p> <p>Investigating requirements: The Investigative Report will be submitted by mail or electronically within 30 days of the incident or discovery of the incident.</p>
II	Criminal conduct by individual	Conduct while on the site of the provider or when accompanied by staff.	Reporting requirements: Submit a typed Critical Incident Report electronically within 24 hours of the incident or on the next business day

Critical Incident Definitions & Reporting/Investigating Requirements

			<p>if the incident occurred after business hours or on a weekend/holiday.</p> <p>Investigating requirements: The Investigative Report will be submitted by mail or electronically within 30 days of the incident or discovery of the incident.</p>
II	Aggressive act between individuals resulting in injury requiring treatment beyond first aid	<p>Assaults occurring at the provider site or while in the company of provider staff.</p> <p>The injury received is severe enough to require the treatment of an individual by a licensed medical doctor, osteopath, podiatrist, dentist, physician’s assistant, or nurse practitioner, further, the treatment received may be provided within the facility or outside the facility where it may range from treatment at a doctor’s private office through treatment at the emergency room of a hospital. Treatment beyond first aid would not include diagnostic procedures.</p>	<p>Reporting requirements: Submit a typed Critical Incident Report electronically within 24 hours of the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.</p> <p>Investigating requirements: The Investigative Report will be submitted by mail or electronically within 30 days of the incident or discovery of the incident.</p>
II	Hospitalization of an individual in a community residential program	<p>Any emergency admission to a medical or psychiatric facility, either directly or through the facility’s emergency room. Would not include planned admissions, such as for elective surgery.</p>	<p>Reporting requirements: Submit a typed Critical Incident Report electronically within 24 hours of the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.</p> <p>Investigating requirements: The Investigative Report will be submitted by mail or electronically within 30 days of the incident or discovery of the incident.</p>
III	Death	<p>The death of any individual enrolled with DBHDD and actively receiving services. Excludes deaths defined as Category I-Unexpected, Suicide and Category II-Expected. Includes the death of an individual receiving DD self-directed services.</p>	<p>Reporting requirements: Submit a typed Death Report Form electronically on the same day as the individual death or on the next business day if the death occurred after business hours or on a weekend/holiday.</p> <p>Investigating requirements: Upon request by</p>

Critical Incident Definitions & Reporting/Investigating Requirements

			the Office of Incident Management and Investigations.
III	Individual injury requiring treatment beyond first aid	Includes accidents; does not include illness. The injury received is severe enough to require the treatment of an individual by a licensed medical doctor, osteopath, podiatrist, dentist, physician's assistant, or nurse practitioner, further, the treatment received may be provided within the facility or outside the facility where it may range from treatment at a doctor's private office through treatment at the emergency room of a hospital. Treatment beyond first aid would not include diagnostic procedures.	<p>Reporting requirements: Submit a typed Critical Incident Report electronically within 48 hours of the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.</p> <p>Investigating requirements: Upon request by the Office of Incident Management and Investigations.</p>
III	Staff injury caused by an individual and requiring treatment	Injury that is related to an aggressive act by an individual.	<p>Reporting requirements: Submit a typed Critical Incident Report electronically within 48 hours of the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.</p> <p>Investigating requirements: Upon request by the Office of Incident Management and Investigations.</p>
III	Aggressive act between individuals with injury requiring minor first aid	Assaults occurring at the provider site or while in the company of provider staff. Minor first aid is meant to include treatments such as the application of band-aids, steri-strips, dermabond, cleaning of abrasions, application of ice pack for minor bruises, and use of OTC medications such as antibiotic creams, aspirin and acetaminophen.	<p>Reporting requirements: Submit a typed Critical Incident Report electronically within 48 hours of the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.</p> <p>Investigating requirements: Upon request by the Office of Incident Management and Investigations.</p>

DEATH REPORT FORM

Send typed form to DBHDDincidents@dbhdd.ga.gov

Incident # _____

Date of Report _____

Date of Death: _____

Date of Discovery of Death: _____

Time of Death: _____

Community Provider reporting: _____

If reporting provider is a subcontractor, who is primary contractor? _____

DBHDD Region # _____ Person Completing Report _____

Contact Person: _____ Contact Person phone #: _____

Name of site and/or specific location where death occurred (i.e.: Hospital Name, Unit name/number, Name of CLA/PCH, etc): _____

Check appropriate box Community Residential Program CLA Crisis Stabilization Crisis Support Home Day Program Host Home In Community Local Hospital PCH PRTF Personal Residence Respite TIS

Other (please specify): _____

Individual information

Name (first, last) _____ DOB _____ Age at Time of Death _____ Sex Female Male

Address _____ City _____ State GA Zip _____ County _____

Medicaid Waiver? Yes No CID/MHID # _____ SS# _____ Race _____

Admission Date _____ Disability: MH DD AD Check box if participant directed services

List agency services in which individual was enrolled: _____

How was death discovered? _____

Date of last contact with individual: _____ Reason for last contact: _____

Medical History (check all that apply)

Accidents Bowel Obstruction Cancer Cerebrovascular disease (stroke) Choking Chronic Liver Disease
 Chronic Lower Respiratory Disease Diabetes Diseases of Heart Hypertension Medication-Related
 Pneumonia/Influenza Septicemia Suicide Unknown

Has autopsy been ordered? Yes <input type="checkbox"/> No <input type="checkbox"/>	If not state reason:
--	----------------------

Cause of death, when known: _____

Were there unusual circumstances surrounding death (i.e. accident, homicide, etc)? Yes No If yes, please describe. _____

DEATH REPORT FORM

Medications given to individual one (1) week prior to the point of death

Medication	Dose	Route	Frequency

Category of Death

<input type="checkbox"/>	Category I-Death-Unexpected
<input type="checkbox"/>	Category I-Suicide
<input type="checkbox"/>	Category II-Death-Expected
<input type="checkbox"/>	Category III-Death

Brief description of incident-(include who; what; where; when; how; and any precipitating factors that may have contributed to the death, including any medical conditions that have been diagnosed-

Notifications

Agency	Name	Date	Time	Method of Notification
Adult Protective Services				
CPS/DFCS				
Healthcare Facility Regulation				
Support Coordinator/Planning List Administrator				
Family/Legal Guardian				
Other				

Managerial Review

Community provider staff/title:

Date: _____

By checking this box, I attest that the above entry for community provider staff/title verifies my review of the incident

CRITICAL INCIDENT REPORT FORM (CIR)

Send typed CIR to DBHDDincidents@dbhdd.ga.gov

Incident # _____

Date of Report _____

Date of Incident: _____

Date of Discovery of Incident: _____

Time of Incident: _____

Community Provider reporting: _____

If reporting provider is a subcontractor, who is primary contractor? _____

DBHDD Region # _____ Person Completing Report _____

Contact Person: _____ Contact Person phone #: _____

Name of site and/or specific location where incident occurred (i.e.: Unit name/number, Name of CLA/PCH, etc): _____

Check appropriate box Community Residential Program CLA Crisis Stabilization Crisis Support Home Day Program Host Home In Community Local Hospital PCH PRTF Personal Residence Respite TIS

Other (please specify): _____

Individual(s) Information*

Name (first, last) _____ DOB _____ Age at Time of Incident _____ Sex Female Male

Address _____ City _____ State GA Zip _____ County _____

Medicaid Waiver? Yes No CID/MHID # _____ SS# _____ Race _____

Admission Date _____ Disability: MH DD AD Check box if participant directed services

List agency services in which individual is enrolled: _____

Treatment required:

None Minor first aid Treatment beyond first aid Medical hospitalization

Brief description of injury: _____

Name (first, last) _____ DOB _____ Age at Time of Incident _____ Sex Female Male

Address _____ City _____ State GA Zip _____ County _____

Medicaid Waiver? Yes No CID/MHID # _____ SS# _____ Race _____

Admission Date _____ Disability: MH DD AD Check box if participant directed services

List agency services in which individual is enrolled: _____

Treatment required:

None Minor first aid Treatment beyond first aid Medical hospitalization

Brief description of injury: _____

*Add additional individuals on supplemental form c.1. If supplemental form is used, please check

CRITICAL INCIDENT REPORT FORM (CIR)

Type of Incident

	Check		here if incident is high visibility <input type="checkbox"/> **
<input type="checkbox"/>	Alleged Exploitation-Staff to Individual		
<input type="checkbox"/>	Alleged Individual Abuse-Physical		
<input type="checkbox"/>	Alleged Individual Abuse-Psychological		
<input type="checkbox"/>	Alleged Individual to Individual Sexual Assault		
<input type="checkbox"/>	Alleged Neglect		
<input type="checkbox"/>	Alleged Sexual Abuse		
<input type="checkbox"/>	Medication errors with adverse consequences		
<input type="checkbox"/>	Seclusion or restraint resulting in injury requiring treatment		
<input type="checkbox"/>	Suicide attempt that results in medical hospitalization		

	Check		here if incident is high visibility <input type="checkbox"/> **
<input type="checkbox"/>	Aggressive act between individuals resulting in injury requiring treatment beyond first aid		
<input type="checkbox"/>	Alleged Individual Abuse-Verbal		
<input type="checkbox"/>	Criminal Conduct by Individual		
<input type="checkbox"/>	Hospitalization of an Individual in a community residential program		
<input type="checkbox"/>	Incident occurring in the presence of provider staff which required intervention of law enforcement services		
<input type="checkbox"/>	Individual who is unexpectedly absent from a community residential program or day program		
<input type="checkbox"/>	Vehicular accident with injury while individual is in an agency vehicle or is being transported by staff		

	Check		here if incident is high visibility <input type="checkbox"/> **
<input type="checkbox"/>	Aggressive act between individuals with injury requiring minor first aid		
<input type="checkbox"/>	Individual Injury requiring treatment beyond first aid (not related to possible staff misconduct)		
<input type="checkbox"/>	Staff injury caused by an individual and requiring treatment		
<input type="checkbox"/>	Incident that does not meet Category I or II criteria		

Brief description of incident-(include who; what; where; when; how; and any precipitating factors that may have contributed to the event, including any medical conditions that have been diagnosed; also include steps taken by facility to prevent further incidents)-

****Notify Incident Management & Investigations Section at 404-657-1139 for High Visibility Incidents**

CRITICAL INCIDENT REPORT FORM (CIR)

Person(s) of Interest

Name _____	Contact # _____	Date of Birth _____
Name _____	Contact # _____	Date of Birth _____
Name _____	Contact # _____	Date of Birth _____
Name _____	Contact # _____	Date of Birth _____

Staff Injured

Name _____	DOB _____	Contact # _____	Description of Injury _____
Name _____	DOB _____	Contact # _____	Description of Injury _____
Name _____	DOB _____	Contact # _____	Description of Injury _____
Name _____	DOB _____	Contact # _____	Description of Injury _____

Witnesses to Incident

Name _____	Contact # _____	Staff <input type="checkbox"/>	Individual <input type="checkbox"/>	Other <input type="checkbox"/>
Name _____	Contact # _____	Staff <input type="checkbox"/>	Individual <input type="checkbox"/>	Other <input type="checkbox"/>
Name _____	Contact # _____	Staff <input type="checkbox"/>	Individual <input type="checkbox"/>	Other <input type="checkbox"/>
Name _____	Contact # _____	Staff <input type="checkbox"/>	Individual <input type="checkbox"/>	Other <input type="checkbox"/>
Name _____	Contact # _____	Staff <input type="checkbox"/>	Individual <input type="checkbox"/>	Other <input type="checkbox"/>
Name _____	Contact # _____	Staff <input type="checkbox"/>	Individual <input type="checkbox"/>	Other <input type="checkbox"/>

Notifications

Agency	Name	Date	Time	Method of Notification
Adult Protective Services				
CPS/DFCS				
Healthcare Facility Regulation				
Support Coordinator/Planning List Administrator				
Family/Legal Guardian				
Other				
Other				
Other				
Other				
Other				

Managerial Review

Community provider staff/title: _____

Date: _____

By checking this box, I attest that the above entry for community provider staff/title verifies my review of the incident.

CRITICAL INCIDENT REPORT FORM (CIR) supplemental

Send typed CIR supplemental to DBHDDincidents@dbhdd.ga.gov

Incident date _____

Incident # _____

Individual (s) Information

Name (first, last) _____ DOB _____ Age at Time of Incident _____ Sex Female Male

Address _____ City _____ State GA Zip _____ County _____

Medicaid Waiver? Yes No CID/MHID # _____ SS# _____ Race _____

Admission Date _____ Disability: MH DD AD Check box if participant directed services

List agency services in which individual is enrolled:

Treatment required:

None Minor first aid Treatment beyond first aid Medical hospitalization

Brief description of injury:

Name (first, last) _____ DOB _____ Age at Time of Incident _____ Sex Female Male

Address _____ City _____ State GA Zip _____ County _____

Medicaid Waiver? Yes No CID/MHID # _____ SS# _____ Race _____

Admission Date _____ Disability: MH DD AD Check box if participant directed services

List agency services in which individual is enrolled:

Treatment required:

None Minor first aid Treatment beyond first aid Medical hospitalization

Brief description of injury:

Name (first, last) _____ DOB _____ Age at Time of Incident _____ Sex Female Male

Address _____ City _____ State GA Zip _____ County _____

Medicaid Waiver? Yes No CID/MHID # _____ SS# _____ Race _____

Admission Date _____ Disability: MH DD AD Check box if participant directed services

List agency services in which individual is enrolled:

Treatment required:

None Minor first aid Treatment beyond first aid Medical hospitalization

Brief description of injury:

Incidents to report to other agencies, in addition to DBHDD*

Individual Group	Incidents(s) to Report	Report to whom?	Timeframe
Disabled adults in personal care homes or CLAs	Death of a resident; rape of resident; allegation of abuse, neglect or exploitation	HFR-Long Term Care Section	24 hours, or the next business day
Children in outdoor therapeutic programs	Death or serious injury (requiring extensive medical care and/or hospitalization of any camper in care); suicide attempts; abuse	HFR-Childcare Licensing Section Fax form to HFR	48 hours, or the next working day
Disabled adult or elder person in the <u>community</u> or <u>outside</u> of a personal care home or community living/group home	Abuse or neglect	Call Adult Protective Services 1-888-774-0152	Immediately or next business day
Child under the age of 18	Abuse or neglect	Local law enforcement and/or local DFCS office	Immediately notify law enforcement if there is immediate danger
Persons in narcotic treatment programs	Death; serious injury at program requiring medical care; rape occurring at program; abuse, neglect or exploitation of patient by staff; emergency situation that affects safe operation of program	HFR-Health Care Section Fax report to HFR	Within 24 hours or next business day

*This is only a summary. The reader must obtain detailed instructions and definitions directly from the applicable regulatory agency.

INVESTIGATIVE REPORT FORMAT

To the User: This format is used for the summary of an investigation. However, not all of the items listed below will be necessary for all incidents. It is the responsibility of the agency to comply with the requirements of Policy with regard to content. The "Guidelines" are to help the writer answer questions that may be applicable to the incident. Please do NOT include the questions in the submitted Investigative Report.

Date of Report:

Provider Agency:

Contact Person:

Sub-Contractor:

Investigator:

Date of Incident(s):

Type of Incident(s): *Same as listed on CIR or Death Report Form*

DBHDD Region:

Individual Name: Include ALL individuals that were included on the CIR

Address:

Date of Birth:

Age at time of incident:

CID/MHID #:

SUMMARY OF ALLEGATION(S)/INCIDENT:

Guidelines

What happened? Who reported it and to who was the incident or allegation reported to?

Where, When and How was it reported?

(List each allegation or problem area separately)

CHRONOLOGY OF INCIDENT:

Guidelines

What happened from the time of the immediate precipitating or causal events of the incident or allegation until the time of the investigation? (Date and time of each significant event)

What or who is the source of information?

If occurring at a residential site/group home/program site, when was assistance (such as emergency or administrative) requested?

Was the individual examined for injury? If the staff was directed to or decided to obtain medical treatment, when was it obtained and, if not obtained immediately, what was the reason for waiting?

INVESTIGATIVE METHODS:

Guidelines

Date and time investigation initiated

What physical, written documents, interviews, witness statements, and evidence was collected and considered?

What agencies were involved with incident?

What agencies were notified of the incident?

Individual Profile:

Guidelines

Include diagnoses, medications if relevant to the investigation, functional abilities (verbal, ambulatory, level of supervision required, etc.), maladaptive behaviors, including existence of a Behavior support plan. Could the individual participate in the investigation (able to understand, remember the incident)?

Provider Profile:

Guidelines

Business status (for or not for profit) and scope (in numerous states, number of counties, etc.), primary services provided (residential, day, etc.), average number of individuals served and their disabilities, description of the site where incident occurred (if relevant to incident). If residential, PCH, CLA or host home?

People Interviewed:

Guidelines

Witnesses, including other individuals or staff

List name and title of persons interviewed

Include date of birth of the person of interest

Summary of Interviews:

Guidelines

List relevant information obtained in each (separate) interview.

Be sure to give information regarding person interviewed, such as job title, training, relationships, etc, bias or credibility issues, etc.

DOCUMENTS REVIEWED:

As needed: Incident report, individual's records, staff training records/personnel file, time sheets, home logs, agency policies

SUMMARY OF DOCUMENTS REVIEWED:

Guidelines

Include information from "Documents Reviewed" section as relevant to the investigation.

If this is a death, include any information available from the coroner or others about the possible cause of death. Also include any information about the individual's condition prior to death (medical issues, most recent physical exams, follow-up appointments). If suicide, were suicide risk assessments done? Note: death is NOT an allegation and should not be "substantiated."

CONCLUSIONS:

Guidelines

*Do the findings substantiate or not substantiate the reported allegation/incident? Against who? (List each allegation or problem area, and then respond to each separately)
Could the allegation/incident be substantiated but the cause remains undetermined?
Did staff respond to the incident in a timely and appropriate manner?
Did staff follow established procedures when responding to the incident?*

RECOMMENDATIONS:

Guidelines

What actions can be taken by the provider to make corrections and prevent recurrence?

ATTACHMENTS: (if applicable)

Guidelines

*Witness statements
Interview statements
Agency policies & procedures (specifically related to investigation and needed for explanation of the investigative findings)
Photographs
Graphs, charts, maps*

Investigated By:

Name/Title

Date

Reviewed and Approved By:

Agency Director (or Designee)

Date

INVESTIGATIVE REPORT

Investigative Report can be sent in the mail or submitted electronically to DBHDDincidents@dbhdd.ga.gov within 30 days of incident or discovery of incident.

Date of Report:

Provider Agency:

Contact Person:

Sub-Contractor:

Investigator:

Date of Incident(s):

Type of Incident(s):

DBHDD Region:

Individual Name:

Address:

Date of Birth:

Age at time of incident:

CID/MHID #:

SUMMARY OF ALLEGATION(S)/INCIDENT:

CHRONOLOGY OF INCIDENT:

INVESTIGATIVE METHODS:

Individual Profile:

Provider Profile:

People Interviewed:

Summary of Interviews:

DOCUMENTS REVIEWED:

SUMMARY OF DOCUMENTS REVIEWED:

CONCLUSIONS:

RECOMMENDATIONS:

ATTACHMENTS: (if applicable)

Investigated by:

Name/Title

Date

Reviewed & Approved by:

Date

Request for Extension

Instructions: Complete the form below (please type the information) and email to DBHDDincidents@dbhdd.ga.gov or fax to the Office of Incident Management and Investigations (404-657-2187). The request must be approved by a responsible executive manager.

Date of Request:

Incident Report #:

Individual(s) Name:

Date of Incident:

Provider Agency Name:

Reason(s) for the request:

Expected completion date:

Name/title of requesting party

Date

Approved by Name/title:

Date

Typed signature verifies review/approval of request

CORRECTIVE ACTION PLAN

Provider Name: _____ **Date of Plan:** _____

Individual Name: _____ **Incident #:** _____ **Date of Incident:** _____

Issue	Identified Problem	Corrective Steps	Target Date	Responsible Person

Person Responsible for CAP: _____

Contact Number: _____

Managerial Review of Corrective Action Plan

Community Provider Manager Name: _____




Title: _____ **Date:** _____

Typed signature verifies I have reviewed/approved the CAP



Chapter: Behavioral Health Community Services

Subject: Requirements to Ensure that Families Complete the Application Process for Medicaid and PeachCare For Kids

Applicability: Child and Adolescent Providers	Effective Date: January 1, 2011
References: none	Scheduled Review Date: January 2012
Attachments: none	Approved:  Wendy White Tiegreen, M.S.W. Date Director, Medicaid Coordination
	 J. Bryce McLaulin, M.D. Date Executive Director, Division of Mental Health
	 Frank E. Shelp, M.D., M.P.H., Commissioner Date

REQUIREMENTS TO ENSURE THAT FAMILIES COMPLETE THE APPLICATION PROCESS FOR MEDICAID AND PEACHCARE FOR KIDS

POLICY

This policy is to establish:

1. Children and adolescents served by the Department of Behavioral Health and Developmental Disabilities (DBHDD) must be evaluated for coverage for Medicaid and PeachCare for Kids public insurance benefits to ensure efficient and effective utilization of services and funding.
2. Parents and legal guardians of children and adolescents lacking Medicaid or PeachCare for Kids coverage must actively engage in the application process in conjunction with DBHDD providers and be tracked throughout the eligibility determination by providers to completion.
3. Continuation of Fee for Service funding by DBHDD is contingent on receiving a documented denial within the last six (6) months for public insurance benefits for one of the following reasons:
 - Over income PeachCare for Kids; or
 - Over income for Medicaid provided that the child or adolescent is in the household of a state employee or covered under private insurance; or
 - Failure to meet citizenship or immigration status.

DBHDD	SUBJECT: Requirements to Ensure that Families Complete the Application Process for Medicaid and PeachCare For Kids	Policy: 01-106
		Page 2 of 2

PROCEDURES

1. Upon presenting for services to a DBHDD provider, children and adolescents must be screened for Medicaid and/or PeachCare for Kids eligibility using the Georgia Medicaid Management Information System (GAMMIS) at <https://www.mmis.georgia.gov>.
2. Providers in conjunction with the parent or legal guardian must submit an application for any child or adolescent found currently lacking coverage for Medicaid or PeachCare for Kids within fifteen (15) days of presenting for services unless the parent or legal guardian can provide documentation of a valid denial as established in this policy section. Application must be submitted through the local county Division of Family and Children Services (DFCS) office, Right from the Start Medicaid (RSM) project, or by utilizing the PeachCare for Kids online application process at www.peachcare.org.
3. The provider must assist the parent or legal guardian in filling out the application and obtaining verification of eligibility such as proof of income and citizenship status in order to complete the eligibility process.
4. A determination of eligibility for Medicaid is required by DFCS or RSM within forty-five (45) days of receipt of application. A determination of eligibility for PeachCare for Kids is required by the Department of Community Health within ten (10) days of submission of verification of eligibility. The provider will check the application status every fifteen (15) business days until a final determination has been made.
5. Children and adolescents found to be ineligible for Medicaid due to income may still be eligible for PeachCare for Kids. If a denial for Medicaid coverage due to income is received from DFCS or RSM, an additional application to PeachCare for Kids must be made. PeachCare for Kids will automatically refer potentially eligible children and adolescents to Medicaid as appropriate.
6. Procedural denial for failure to provide verification of eligibility, whereabouts unknown, or expiration of certification are not valid denial reasons and applicants must re-apply or come into compliance with application requirements.
7. Providers will have access to a monthly list of all Fee for Service individuals prepared by DBHDD. Providers will be required to annotate current application status, approval, or documented denial reason.
8. Continuation of DBHDD Fee for Service funding beyond 60 days is contingent upon documentation of application for Medicaid and/or PeachCare for Kids benefits, monthly annotation of application status, and obtaining a documented denial (as outlined in this policy).




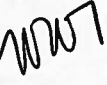
Georgia Department of Behavioral Health & Developmental Disabilities
Frank E. Shelp, M.D., M.P.H., Commissioner

Office of Medicaid Coordination
Two Peachtree Street, NW, Suite 23-392, Atlanta, Georgia, 30303

January 28, 2011

TO: DBHDD Child and Adolescent Providers

FROM: Monica Parker, Director 
Child & Adolescent Community Mental Health

Wendy White Tiegreen, Director 
Medicaid Coordination

SUBJECT: Policy #01-106
Requirements to Ensure that Families Complete the Application Process
for Medicaid and PeachCare for Kids

This correspondence is to provide further operational guidance for compliance to Policy #01-106.

Payor Accountability:

It has been the existing policy of DBHDD that "an organization must vigorously pursue payment for services so that public resources can be maximized to meet the needs of citizens that have been determined to be unable to pay or who can not pay the full maximum rate for services." Policy #01-106, Requirements to Ensure that Families Complete the Application Process for Medicaid and PeachCare for Kids, complements existing policy by providing greater accountability in order to ensure that the maximum number of children and adolescents can be served in the most efficient and effective comprehensive health care model.

Operational Procedures

In order to facilitate this process, DBHDD has put into place a monthly report listing consumers for which fee-for-service payments were made. This report can be found on the GTA Electronic Reporting website with the Report ID HRMH1MPFFS. Providers will be required to annotate in the comment section the status of application for all fee-for-service child and adolescent consumers by the last business day of the month of the report. Annotated reports should be returned to DBHDD Regional C&A Specialists beginning February 28th, 2011 and monthly thereafter. Specific operational procedures for submission of the report by Region will be provided in a forthcoming memo.

The comment section should be annotated with one of the following status indicators:

- Application pending as of XX/XX/XX (date application submitted to DFCS/PCK)
- Application denied with reason for and date of denial
- Application approved with Medicaid effective date of XX/XX/XX

Attached to this memo are instructions on how to access the GTA website as well as a sample report. Compliance to Policy #01-106 will be tracked by both DBHDD Regional and State Office staff. DBHDD staff will provide technical assistance on eligibility policy to providers upon request and based on scheduling availability. To request TA please email Brian Dowd, Medicaid and Grants Manager at brdowd@dhr.state.ga.us.

It is important to note that per policy #01-106 continuation of fee for service funding past 60 days is contingent on receiving a denial for state funding insurance coverage for one of the following three reasons:

- Over income for PeachCare for Kids
- Over income for Medicaid provided that the child or adolescent is in the household of a state employee or has private insurance or
- Failure to meet citizenship or immigration status

DBHDD recognizes that this is a new initiative and as a provider organization you can expect additional updates on operations related to this policy. Thank you in advance for your work in supporting these youth in accessing all available health resources.

C: DBHDD Management Team
DBHDD Regional Coordinators



Georgia Department of Behavioral Health & Developmental Disabilities
Frank E. Shelp, M.D., M.P.H., Commissioner

Office of Medicaid Coordination
Two Peachtree Street, NW, Suite 23-392, Atlanta, Georgia, 30303

February 18, 2011

TO: DBHDD Child and Adolescent Providers

FROM: Monica Parker, Director *MP*
Child & Adolescent Community Mental Health

Wendy White Tiegreen, Director *WWT*
Medicaid Coordination

SUBJECT: Policy #01-106-Report Submission
Requirements to Ensure that Families Complete the Application Process
for Medicaid and PeachCare for Kids

This correspondence is to provide further operational guidance for compliance to Policy #01-106.

Submission of Report HRMH1MPFFS:

Pursuant to requirements outlined in Policy #01-106 and the provider guidance memo released January 28th, 2011, the requirement for C&A Fee for Service providers to submit report HRMH1MPFFS for review starting February 28th has been delayed until March 31st, 2011 and monthly thereafter.

Form HRMH1MPFFS cannot currently be submitted electronically through the Ebill2 website. HRMH1MPFFS contains personal health information which must be protected. Therefore, DBHDD will be establishing a dedicated email account for report submission by providers via a password protected attachment. Each provider will be assigned a password to utilize for submission of the report. Providers can choose the most convenient attachment format for submission. (EXCEL, Word, etc.)

DBHDD will send out further guidance for report submission including the established email account and procedures for password protecting information as soon as possible. Please take this opportunity to obtain the current FFS HRMH1MPFFS report, released March 1st, and annotate the current status of the application process for a March 31st submission. It is important to note that per policy #01-106 continuation of fee for service funding past 60 days is contingent on receiving a denial for state funding insurance coverage.

We appreciate your compliance with this new policy requirement as we work with you to establish procedures that are administratively efficient while protecting the personal health information of the individuals we serve.

If you have question related to this guidance or Policy #01-10 please contact Brian Dowd, DBHDD Medicaid and Grants Manger, at brdowd@dhr.state.ga.us or at 404-232-1189.

C: DBHDD Management Team
DBHDD Regional Coordinators

Brief Instructions for Ebill2

The Georgia Technology Authority (GTA) operates a website, <http://ebill2.gagta.com>, for the secure distribution of reports, files, and documents to a variety of users. DBHDD uses this website to distribute reports and files to its providers.

These brief instructions for using the website are provided to assist new users in getting started, and to assist experienced users who have not previously printed reports from the website. Important instructions concerning first-time printing are provided below in the section titled "Installing Print Handlers." The full user guide is posted on Ebill2 as HRMH-GUIDE along with your reports.

Each provider must have a Recipient ID and a password in order to use the website. Only one Recipient ID and password are assigned to each provider, and this single ID and password must be shared by all members of the organization who have a valid need for access to the data included in the reports. Each organization must establish internal procedures for maintaining and updating the password and coordinating use of the Recipient ID and password among its authorized users. Remember that these reports include consumer data; therefore, the Recipient ID and password must be kept in a secure manner.

If your organization has not yet obtained its Recipient ID and initial temporary password, you may obtain one by emailing MHMRIS@dhr.state.ga.us. You will receive the Recipient ID and temporary password via email. You should change the temporary password to one of your own choosing the first time you sign on to Ebill2. The password change will take effect on the following business day. This means that you can sign on as many times as you wish on the first day using the temporary password, then begin using the new password the next business day. It is very important that you **update your password every month** so that your password won't expire. It is the provider's responsibility to keep this password updated so that it does not expire.

It may help if you understand a few basic principles about Ebill2 before you get started. The Ebill2 website does not produce reports on demand; it is merely a mechanism for distributing copies of reports that have already been produced. It is similar in function to a file cabinet or bulletin board where reports produced by DBHDD can be maintained so that they can be seen or downloaded by the appropriate recipients. When you sign on to Ebill2 with your organization's Recipient ID, you will see only the reports containing information for your organization, and you won't see those for any other providers.

LOGGING IN TO EBILL2:

- Using Internet Explorer, enter the website's address: <http://ebill2.gagta.com>
- The following screen will appear:

The screenshot shows the Georgia Technology Authority's Electronic Reporting System login page. The page is displayed in Microsoft Internet Explorer. The browser's address bar shows the URL <http://ebill2.gagta.com/>. The page features a navigation menu on the left with links for Security Statement, FAQs, Feedback Form, and Instructions. The main content area includes a welcome message and a sign-in form. The sign-in form has two sections: one for 'Ebilling User I.D.' and 'Password' with a 'Sign In' button, and another for 'BSG Info User I.D.' and 'Password' with a 'Sign In' button. Red arrows point to the 'Sign In' buttons and the 'BSG Info User I.D.' field with labels: '2a. Enter Recipient ID', '2b. Enter password here', '2c. Press "Enter" here to view reports', and '1. Press "Enter" here to change password'.

Step 1:


The first time you sign in, and at least once a month thereafter, change your password by clicking on the "Change Password" box. The password maintenance screen will then appear, where you should enter your Recipient ID and old and new passwords in the appropriate boxes. The password change will take effect the following business day.


Step 2:
















To view reports, enter your Recipient ID and password in the boxes shown above, then tab to the "Sign In" bar and press "Enter."

- Following Step 2, a list of reports will appear. See the following page for the current list and for directions on navigating through the list.


PROVIDER REPORTS AVAILABLE ON EBILL2 AS OF 1/4/2011:











 SSGInfo

 Report

-  -NOTICE2 READ THIS: IF YOU CAN NOT PRINT FROM EBILL2 WEB SERVER
-  HRMH-GUIDE EBILL USER GUIDE FOR VIEWING/DOWNLOADING REPORTS & FILES
-  HRMH-PFLAY RECORD LAYOUTS: ALL PROVIDER FILES
-  HRMH1MPFFS MONTHLY PROVIDER REPORT: LIST OF CONSUMERS WITH FFS PAYMENTS
-  HRMH1MPNCR MONTHLY PROVIDER REPORT: NON-FFS ENCOUNTERS X CONSUMER
-  HRMH1MPNBR MONTHLY PROVIDER REPORT: NON-FFS ENCOUNTERS X BUDGET PROGRAM
-  HRMH1MPNCR MONTHLY PROVIDER REPORT: NON-FFS ENCOUNTERS X CONSUMER
-  HRMH1MPPBR MONTHLY PROVIDER REPORT: FFS ENCOUNTERS X BUDGET PROGRAM
-  HRMH1MPPCR MONTHLY PROVIDER REPORT: FFS ENCOUNTERS X CONSUMER
-  HRMH1P\$PMF MONTHLY PROVIDER FILE: FFS ENCOUNTERS
-  HRMH1P\$UMF MONTHLY PROVIDER FILE: NON-FFS ENCOUNTERS
-  HRMH1P\$XMF MONTHLY PROVIDER FILE: SUSPENSED ENCOUNTERS (FFS & NON-FFS)
-  HRMH1PASEF ENCOUNTERS ACCEPTED MONTH-TO-DATE (FILE)
-  HRMH1PASER ENCOUNTERS ACCEPTED MONTH-TO-DATE (REPORT)
-  HRMH1PNSER ENCOUNTERS REJECTED: NOT INCL IN PROVIDER AGREEMENT (REPORT)

Click the icon to the left of a report name to see a listing of dated iterations of that report (example below):

 HRMH1PASER ENCOUNTERS ACCEPTED MONTH-TO-DATE (REPORT)

-  Aug 12, 2009 3:04:51 PM Available
-  Aug 7, 2009 10:34:13 AM Available
-  Aug 5, 2009 3:04:51 PM Available
-  Aug 3, 2009 3:48:53 PM Available
-  Jul 24, 2009 4:05:00 PM Available
-  Jul 10, 2009 9:48:58 AM Available
-  Jul 6, 2009 4:05:43 AM Available
-  Jul 5, 2009 9:49:44 PM RecallRequired
-  Jun 26, 2009 9:49:04 AM RecallRequired
-  Jun 19, 2009 9:33:57 AM RecallRequired

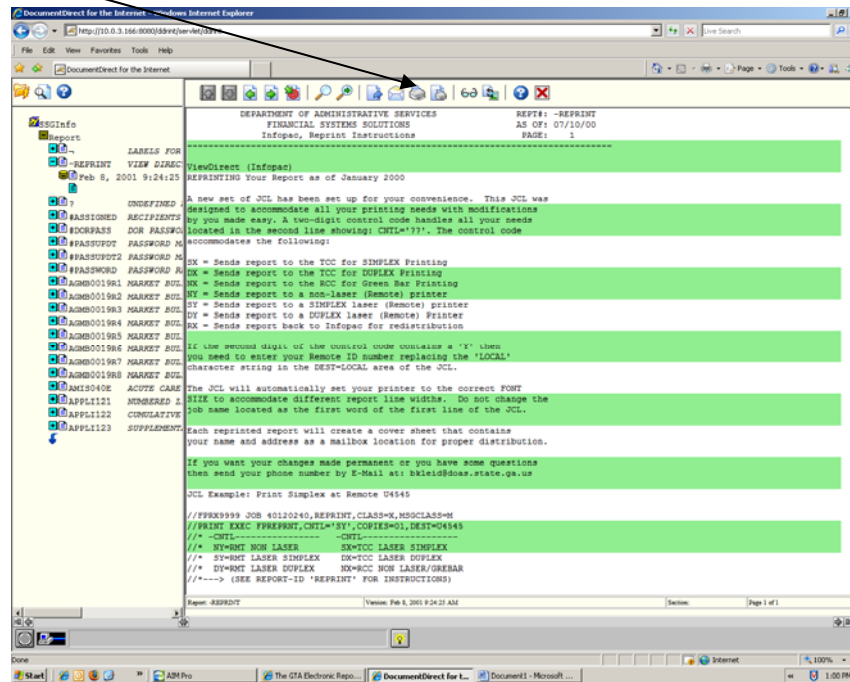
When you click on an icon to the left of a date, one of three things will happen:

- 1) If the word "Available" appears to the right of the date, you can continue to drill down through icons to open the report.
- 2) If the words "Recall Required" appear to the right of the date, you will receive the message "Recall request issued. Try again later." In this case, continue to click on the icon until the report is recalled. This usually only takes a few moments, but occasionally longer.
- 3) In either case, you may receive the message "The requested list is empty." In this case, your organization has no content for that report on that date. This happens when you have no service encounters included in that report for that date.

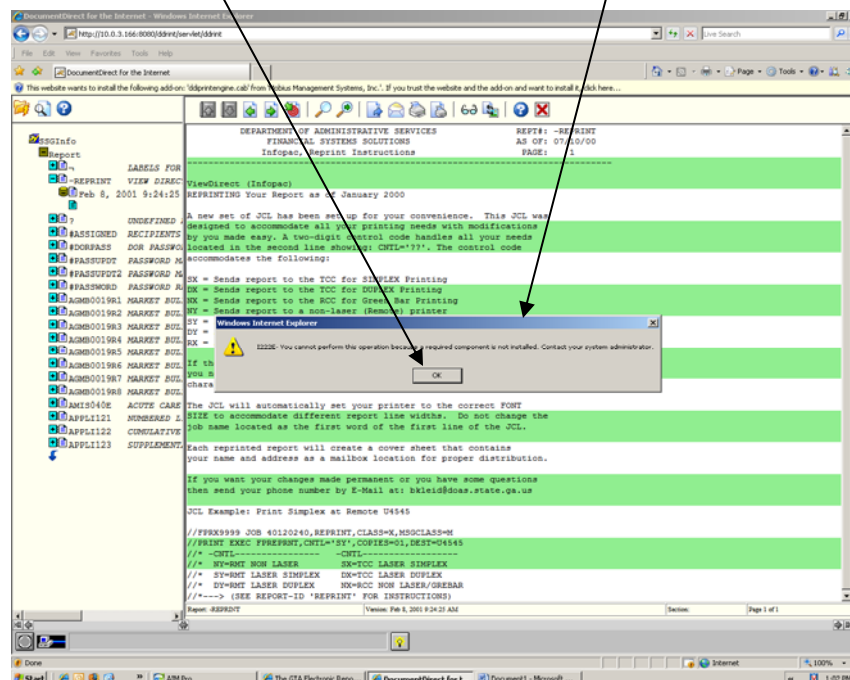
INSTALLING PRINT HANDLERS:

It may be necessary for you to download a new print driver to support Ebill2's printing function. If prompted, you must install the Mobius printer driver the first time you attempt to print. This is only necessary the first time you attempt to print. As with any download, you must have administrative authority for your PC to perform this function. Please contact your IT Support Team if you have any questions about your authority level.

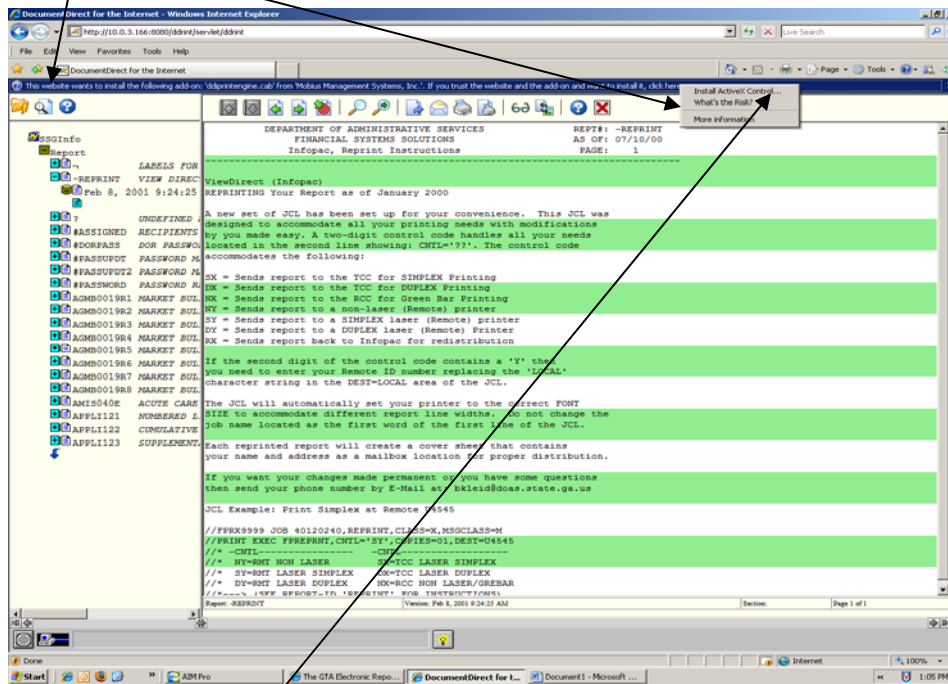
1. Log on and access the report you wish to print (using the instructions provided in the previous pages). Click on the printer icon.



2. If you have a pop-up blocker, the download may produce the message box shown below. If this message appears, click the OK button in the message window. (If the message box did not appear, skip to step 3.)

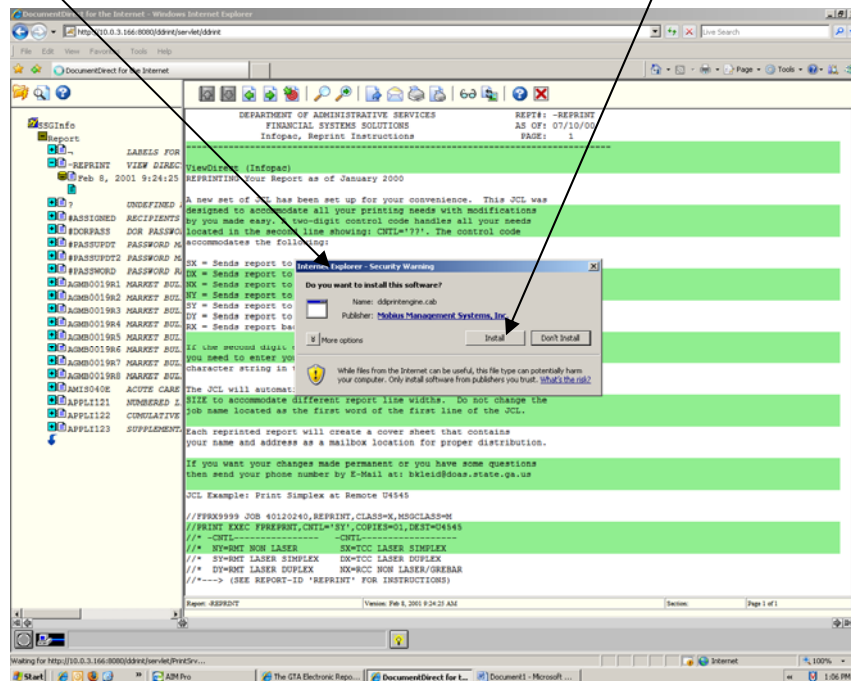


3. Click on the message line above the row of icons. The background for this line will change from yellow to blue and a pop-up window will appear as indicated below.



4. Click on the Install ActiveX Control option within the pop-up window.

5. A new message window will appear as shown below. Click on the Install button in the message window.



NOTE: It is recommended that you shut down and restart your PC once the installation is complete.

Following this one-time installation, you should be able to perform normal print requests.

PROGRAM ID: HRMH0417
REPORT ID: HRMH1MPFFS

GEORGIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES
LIST OF CONSUMERS FOR WHOM FEE-FOR-SERVICE PAYMENTS WERE MADE
FOR PROCESSING PERIOD: 2010-12

PAGE NO: 1
RUN DATE: 12-27-2010

PROVIDER LA: 999 - SAMPLE PROVIDER

LAST NAME	FIRST NAME	CID	COUNTY	COMMENTS
ACONSUMER	ALICE	123456789	FULTON	_____
BCONSUMER	BRADLEY	234567890	DEKALB	_____
CCONSUMER	CLARA	345678901	FULTON	_____
DCONSUMER	DENNIS	456789012	DEKALB	_____
ECONSUMER	EDWARD	567890123	FULTON	_____



Chapter: Administrative Issues Related to Behavioral Health & Developmental Disabilities Service Delivery
Subject: Requests for Waivers of the Standards for DBHDD Services

References:
Official Code of Georgia Annotated 37-2-4

Applicability:
Community Providers of DBHDD Services DBHDD
State and Regional Offices

Attachments:

Attachment A - Request for Waiver of Standards
Attachment B - Tracking Form for Request for Waiver
of Standards

Original Effective Date: April 21, 1998
Revision #2 Effective Date: June 1, 2011
Scheduled Review Date: June 1, 2013

Approved:
Beverly D. Rollins 5/23/11
Beverly D. Rollins, M.P.A., Executive Director Date
Division of Developmental Disabilities

Cassandra Price 5/24/11
Cassandra Price, Executive Director Date
Division of Addictive Diseases

Bryce McLaulin 5/24/11
Bryce McLaulin, M.D., Date
Assistant Commissioner of Programs

Frank E. Shelp 5/26/11
Frank E. Shelp, M.D., M.P.H., Commissioner Date

REQUESTS FOR WAIVERS OF THE STANDARDS FOR DBHDD SERVICES

POLICY

DBHDD has a standard process for review and approval of requests for waivers of standards that are contained in the Provider Manual for Mental Health, Developmental Disabilities and Addictive Diseases Providers (Provider Manual).

When the enforcement of one or more of DBHDD standards creates an undue hardship or barrier for individuals to access a needed service, DBHDD reviews the standard and situation in order to determine whether a waiver of the requisite standard(s) for a limited period of time is warranted. The waiver request and review process assures a continuing commitment to an individual's health and safety, compliance with requirements of external funding, regulatory entities, and accreditation/certification requirements. All approved waivers of DBHDD standards expire **at the end of the specified approved time period, not to exceed one year** following their approval, unless otherwise specified in this policy.

DBHDD	SUBJECT: Requests for Waivers of the Standards for DBHDD Services	Policy: 04-107
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PROCEDURES

A. Limitations regarding waivers of standards

Waivers are not granted under any circumstance to allow unlicensed or non-certified staff to provide, authorize or supervise, any services that are required to be performed by a licensed/certified practitioner.

Waivers of standards of professional designations previously granted under this policy are not applicable to the meeting of provider qualifications specified in the Developmental Disability Medicaid waivers.

As of June 30, 2008, no further requests are accepted for a waiver of a standard related to DBHDD professional designations included in the Provider Manual:

- Mental Health Professional (MHP)
- Substance Abuse Manager (SAM)
- Substance Abuse Professional (SAP)
- Mental Health Clinician (MHC)

All existing waivers previously granted for the above professional designations expire at the earlier of the two following dates:

- either one year after their approval (as already specified in this policy), OR
- at the time that the Medicaid State Plan Amendment is implemented.

B. Process for requesting approval of waivers of standards

A service provider, individual, family member, advocate, or other interested party may request that a standard be waived when the standard creates an undue hardship or barrier for individuals to access a needed service.

Waiver requests are sent to the DBHDD Regional Coordinator or designee, accompanied by a completed **Request for Waiver of Standards** form (See Attachment A).

For requests related to waivers of standards other than professional designation, relevant information is included on **Attachment A - Request for Waiver of Standards** form, including:

- Justification of the reason for a waiver of standards due to an undue hardship or barrier for individuals to access a needed service;
- Plan for improvement or changes needed in order for services to be available in accordance with the standards;
- A recommendation and affirmation of the identified need for a waiver signed by the Director of the provider organization.

DBHDD	SUBJECT: Requests for Waivers of the Standards for DBHDD Services	Policy: 04-107
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C. Process for review and approval of waivers of standards

1. The Regional Office completes an initial review to determine if the request falls within DBHDD guidelines.
2. Within five (5) days after receiving a waiver request, the DBHDD Regional Coordinator or designee submits the request, along with his/her recommendations, to the appropriate DBHDD State Disability Office.
3. The DBHDD State Disability Office approves or disapproves the requested waiver within five (5) business days after involving appropriate DBHDD staff in the review of the request. The decision is documented on the **Tracking Form for Request for Waiver of Standards** (see Attachment B).
4. The DBHDD Medicaid Coordinator approves or disapproves the requested waiver within five (5) business days after receipt from the DBHDD State Disability Office.
5. All approved waivers expire at the end of the specified approved time period, not to exceed one year following approval.
6. The DBHDD State Disability Office is responsible to notify the provider (or other requesting party) by letter of the decision that has been made. The letter outlines the decision regarding the waiver request; if the request is approved, the expectations for the provider (or other requesting party) are outlined as contained in section C of this policy.
7. The Regional Coordinator or designee and the DBHDD Medicaid Coordinator are copied on the letter.
8. For waivers of standards for services that are audited or monitored by a DBHDD External Review Organization or other contracted entity, the DBHDD State Disability Office copies that entity on the letter.
9. The DBHDD State Disability Office maintains a record of the information regarding the waiver request in the **Tracking Form for Request for Waiver of Standards** in the DBHDD Shared Drive.

D. Provider Responsibilities following approval of a waiver request

1. The provider must maintain on file a copy of all approved waiver requests and have such waiver(s) available for review by DBHDD or its representatives.
2. The provider must notify the Regional Coordinator or designee when there is any change to services for which the waiver was requested.
3. For waivers of standards for services that are audited/monitored by a DBHDD External Review Organization or other contracted entities, the provider must produce a copy of the waiver letter at the time of the audit in order for the External Review Organization or other contracted entity to appropriately incorporate the approved waiver into the audit/monitoring activity.

DBHDD	SUBJECT: Requests for Waivers of the Standards for DBHDD Services	Policy: 04-107
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E. Waiver requests for more than one year:

All approved waivers expire **at the end of one year** following their approval. If the petitioner believes there are special circumstances justifying an extension beyond one year, they may apply again prior to the expiration date, completing another ***Request for Waiver of Standards*** form with updated documentation.

Request for Waiver of Standards

To: _____ Region: _____
(Regional Coordinator or designee)

From: _____ Contact: _____
(Provider agency applying for waiver) (Agency contact person)

Request for waiver of standard(s) related to:

Justification for request:

Waiver Period Requested: _____ through _____
(12 month maximum)

Describe what the organization is doing to ensure that individuals' needs are met as pertains to the requested waiver:

Please provide additional information:

Recommendations: I hereby recommend approval of the requested waiver. I give my assurance that approval of this waiver will not adversely affect the safety and welfare of individuals receiving services.

Agency Director Date Clinical Director Date

Policy: Request for Waiver of the Standards for DBHDD Services

Tracking Form for Request for Waiver of Standards

	A	B	C	D	E	F	G	H	I	J
	Description of waiver of standards that has been requested	Provider organization applying for waiver	Date request submitted to Regional Office	Briefly describe the nature of the request.	Time to resolution (12 month max)	Regional Coordinator or designee recommendation (approve or disapprove)	Date request submitted to DBHDD Disability Office	DBHDD Disability Office Decision	DBHDD Medicaid Coordinator Decision	Notification to Provider
1										
2										
3										
4										
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6										
7										
8										
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10										
11										
12										



Chapter: Developmental Disabilities Community Services
Subject: State Funded Respite for Individuals with Developmental Disabilities

Applicability:
Community Providers of Developmental Disability Services, State Office, Regional Offices, Support Coordination Agencies

Original Effective Date: January 1, 2010
Scheduled Review Date: January 2012
Approved:

Beverly D. Rollins

Beverly D. Rollins, M.P.A., Executive Director (Acting), Division of Developmental Disabilities

References:
NOW and COMP waiver (<http://dch.georgia.gov>)

12/14/09

Date

Frank E. Shelp

Frank E. Shelp, M.D., M.P.H., Commissioner

Attachments:
none

12-16-09

Date

STATE FUNDED RESPITE FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

POLICY

It is the policy of the Department of Behavioral Health & Developmental Disabilities (DBHDD) to help support community living by making provision for respite opportunities. This policy establishes the procedures to access state funded Respite Services.

DEFINITIONS

For the purpose of this document, the following definitions will apply:

Caregiver: The person with whom the individual resides in his/her "natural" home.

Developmental Disability: A disability that is present in early life and prior to age 22 with related conditions similar to the limitations in everyday life functions present for someone with mental retardation.

Individual: A person with a developmental disability.

Provider Agency: An organization approved to serve individuals with developmental disabilities wherein those services are financially supported in whole or in part by funds authorized through DBHDD.

DBHDD	SUBJECT: State Funded Respite for Individuals with Developmental Disabilities	Policy: 02-102
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Regional Office: Field operation offices of the Department of Behavioral Health and Developmental Disabilities (DBHDD).

Respite Services: Service which offers brief periods of support or relief for caregivers of individuals with disabilities.

TYPES OF RESPITE

Maintenance/Scheduled Respite provides brief periods of support or relief for caregivers or individuals with disabilities. Maintenance/Scheduled Respite is planned or scheduled Respite and is provided (1) when families or the usual caretakers are in need of additional support or relief; or (2) when the individual needs relief or a break from the caretaker. Maintenance/Scheduled Respite may be provided in-home or out-of-home.

Emergency Respite is intended to be a short term service for an individual experiencing a crisis (usually behavioral) who requires a period of structured support and/or programming. Emergency Respite may also be necessitated by unavoidable circumstances, such as death of a caregiver or loss of residential placement. Emergency Respite may be provided In-Home or Out-Of-Home.

PHILOSOPHY

Caregivers are able to support and care for an individual when additional supports are provided. With a range of supports, the individual is able to continue living in the community.

State funds may be used to pay for the following respite services:

- When families or the usual caretakers are in need of additional support or relief;
- When the individual needs relief or a break from the caretaker;
- When an individual needs structured, short term support; or
- When relief from caregiving is necessitated by unavoidable circumstances, such as a family emergency.
- Respite may be provided in-home (service provided in the individual's home) or out-of home (individual receives services outside of his/her own home).
- No more than two (2) weekends per month; exceptions must be granted by the DBHDD Division of Developmental Disabilities.

State funds may not be used to pay for:

- Vacation
- Sleep-over (multiple individuals with DD in a private residence).
- Slumber parties, etc.
- Transition period from Community Living Support (CLS) to Community Residential Alternative (CRA) services.

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ELIGIBILITY CRITERIA

An individual is eligible for state funded Respite only if he/she:

- is a legal resident of the state of Georgia, AND
- has a developmental disability diagnosis;

AND Meets One (1) or more of the following criteria:

- Is currently on Short Term Planning List. **OR**
- Receives Comprehensive (COMP) waiver service and is also living in their family home for Maintenance/Scheduled Respite or living in any residential site for Emergency Respite. **OR**
- In case of an emergency (individual at risk of being homeless or other emergency). **OR**
- Has Respite services in the ISP under the New Options Waiver (NOW) and has exhausted the allotted amount of thirteen (13) overnight days allowed by this waiver service. *Note: An individual receiving NOW services must first receive respite services through the NOW.* **OR**
- Requests Maintenance/Scheduled Respite after review for Medicaid eligibility by the local Division of Family and Children Services (DFCS) office and referral to the Regional Intake and Evaluation, if applicable, for individual accessing state funded Respite for the first time or at the annual information updates for all others. *Note: Individuals eligible for Medicaid waiver services requesting Maintenance/Scheduled Respite may receive state funded Maintenance/Scheduled Respite services after referral to the Regional Intake and Evaluation for application for waiver services.* **OR**
- Individuals determined ineligible for Medicaid waiver services but who meet developmental disability (DD) eligibility criteria may access state funded Maintenance/Scheduled Respite services only after review for Medicaid eligibility by the local DFCS office. This ineligibility for Medicaid waiver must be documented. Caregiver should provide this documentation to the Respite provider agency in order to access Respite services. Individuals in this category are also eligible for Emergency Respite.

EXCLUSIONARY CRITERIA

The following exclusionary criteria apply:

- Individuals that received Respite Services through Natural Support Enhancement (NSE) or through the four (4) Respite Services procedural codes in the MRWP waiver who have transitioned into the New Options Waiver (NOW) need to obtain Respite Services through the NOW.
- Respite Services are available in the NOW and participants being served in the NOW receive Respite Services as a NOW service. State funded (100%) Respite Services are not available for NOW participants except in an emergency or until the thirteen (13) allotted days in the NOW have been exhausted for Maintenance/Scheduled Respite.

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- Individuals residing in COMP residential sites (i.e., Personal Care Homes, Community Living Arrangements, Host/Life Sharing homes) cannot receive Respite Services except in an emergency.

PROCEDURES

A. Accessing Maintenance/Scheduled State Funded Respite Services for Individuals on the Short Term Planning List or NOW/COMP Waiver

- The individual's caregiver, Planning List Administrator (PLA) or Support Coordinator (SC) submits a request along with the Respite application to the local contracted Respite provider agency. *Note: The PLA refers individuals on the short term planning list to the Respite provider agency.*
- The contracted Respite provider agency reviews the request to determine availability of funding through their contracted Respite budget and assists with the final completion of the application.
- If funds for Maintenance/Scheduled Respite are not available within the contracted provider agency's Respite budget, placement is then approved/disapproved by the Regional Coordinator or designee, based on the availability of additional resources for the Respite provider agency contract.
- Maintenance/Scheduled Respite resources are available for up to thirty (30) days for eligible individuals based on the availability of state funds the per twelve month fiscal year beginning July 1st and ending June 30th.

B. Accessing Maintenance/Scheduled State Funded Respite Services for Individuals NOT on the Short Term Planning List or NOW/COMP Waiver

Individuals not currently on the Short Term Planning List or NOW/COMP waiver must:

1. Be a legal resident of the state of Georgia with a developmental disability diagnosis.
2. Meet one or more of the **ELIGIBILITY CRITERIA** specified previously in this policy.
3. Be reviewed for Medicaid eligibility by the local DFCS office. The caregiver provides the Respite provider agency with documentation of ineligibility.
4. Be referred to the Regional Intake and Evaluation for application for waiver services, if applicable.

For Individuals Determined Eligible for Medicaid and Waiver Services, the following steps are then completed:

- An individual determined eligible for Medicaid and waiver services submits an application for Medicaid and waiver services.
- The contracted Respite provider agency may provide state funded Maintenance/Scheduled Respite pending approval of Respite services subsequent to the application for waiver services.

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- The Regional Intake and Evaluation section informs Respite provider agencies of any pending waiver application submitted.
- The individual's caregiver submits a request for state funded Respite to the contracted Respite provider agency.
- The contracted Respite provider agency reviews the request to determine availability of funding through their contracted Respite budget and assists with the final completion of the application.
- If funds for Maintenance/Scheduled Respite are not available within the contracted provider agency's Respite budget, placement is then approved/disapproved by the Regional Coordinator or designee based on the availability of funds.

For Individuals Determined Non-Eligible for Medicaid Who Meet Developmental Disability (DD) Eligibility Criteria the following steps are completed:

- The individual's caregiver provides documentation of non-eligibility for Medicaid to the contracted Respite provider agency.
- The individual's caregiver submits a request for state funded Respite to the contracted Respite provider agency.
- The contracted Respite provider agency reviews the request to determine availability of funding through their contracted Respite budget and assists with the final completion of the application.
- If funds for Maintenance/Scheduled Respite are not available within the contracted provider agency's Respite budget, placement is then approved/disapproved by the Regional Coordinator or designee.

C. Accessing Emergency Respite Services

- Primary diagnosis of mental retardation or developmental disability must be documented.
- Completed agency Respite services application within two (2) business days of initiation of emergency Respite service delivery.
- Current support or residential placement is unstable/unavailable.
- No other formal or informal supports are available to the Individual.
- Specific plan to transition individual back to his/her permanent home is presented at the time of admission. The plan should be developed and implemented by the Planning List Administrator (PLA), Support Coordinator (SC), or Regional Office designee when applicable.

Referral for Service

Referrals for Emergency Respite may come from the individual's caregiver, Planning List Administrator (PLA), Support Coordinator (SC), or Regional Office designee. The contracted Respite provider agency may request that the DBHDD Regional Office designee review any caregiver's request for emergency Respite. If funds for Emergency Respite are not available within the contracted provider agency's Respite budget, placement is then approved/disapproved by the

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Regional Coordinator or designee. The Regional Coordinator or designee must be notified of any emergency Respite placements within 24 hours.

- If determined appropriate for placement, the referring source ensures completion of the respite application.
- Individuals will NOT be placed (except in extreme emergency) without a specific plan for discharge (including date, location and responsible party).
- Agency Respite services application must be completed within two (2) business days of initiation of Respite service delivery.

Case Management

- Case management services are integral to ensuring that individuals do not remain in Emergency Respite placement.
- The assigned Support Coordinator (SC), Planning List Administrator (PLA), or Regional Office designee is responsible for monitoring the placement and ensuring that the individual's placement does not exceed the approved time limit.
- The Regional Office designee maintains communication with contracted Respite provider agencies to ensure that Emergency Respite services are not utilized as long-term placement.

D. Additional Requirements for State Funded Respite Services

- Each Regional Office maintains a list of DBHDD contracted Respite provider agencies with which the region contracts for the provision of Respite.
- It is the contracted Respite provider agency's responsibility to ensure that Respite Services are provided only in approved Respite sites that meet the specified requirements to provide Respite. (*Note: Refer to New Options Waiver, Part III, Chapter 2500, Specific Program Requirements for Respite Services*).
- The contracted Respite provider agency maintains a list of Approved Respite Sites and Persons Approved to Provide Respite (including addresses and contact information). The contracted Respite provider agency doesn't add a site or approved person to the list until they have documentation on hand that the site or approved person meets all requirements to provide Respite Services. (*Note: Refer to New Options Waiver, Part III, Chapter 2500, Specific Program Requirements for Respite Services*).
- State funds cannot be used to purchase or reimburse Respite Services provided by any person who is not included on the List of Persons Approved to Provide Respite.
- Each month the Region's Contracted Respite Agencies submits a Respite report to the Regional Office and the MEIRS report to the DBHDD Budget and Finance office. The monthly Respite report includes, but is not limited to the individuals served in Respite during the report month, the address of Respite site, contact information, and other pertinent information.

Georgia Department of Human Resources Division of Mental Health, Developmental Disabilities & Addictive Diseases	DHR Online Directive Information System (ODIS) Directive # 6001-501 <i>Replaces DMHDDAD Policy #6811.1</i> Page 1 of 4
ODIS Policy: Maintenance of Safety for Division of MHDDAD Consumers and Staff SUBJECT: Verification of lawful presence in United States for individuals seeking MHDDAD Services	
Applicability: Division of MHDDAD Hospitals State-Operated Community Services Community Providers of MHDDAD Services	Original Effective Date: July 1, 2007 Version Date: June 20, 2008 Revision Effective Date: July 1, 2008 Approved:
Attachments: Attachment A - MHDDAD Verification Form for Lawful Presence in United States Attachment B - DMHDDAD Criteria for Mental Health Inpatient and Developmental Disability Facility Services Attachment C - Affidavit of Lawful Presence in the United States Attachment D - O.C.G.A. Section 50-36-1	 Gwendolyn B. Skinner, Director, Division of MHDDAD 6/27/08 Date

POLICY STATEMENT

Verification of lawful presence in United States is required for adults seeking MHDDAD Services from DHR hospitals, state-operated community services and/or community providers of MHDDAD services. In accordance with Georgia law, all programs and services receiving funding from the Department of Human Resources Division of Mental Health, Developmental Disabilities & Addictive Diseases or other state, federal or local funds are required to verify that adults who receive **MHDDAD Services** other than **MHDDAD Emergency Services** are lawfully present in the United States.

Verification of lawful presence for those under age 18 is not required; children and adolescents under age 18 who meet Division of MHDDAD criteria for services are served, regardless of whether the child/adolescent is lawfully present in the United States.

MHDDAD Emergency Services are provided to adults, children and adolescents without regard to whether they are lawfully present in the United States.

Adults who require **MHDDAD Services** other than **MHDDAD Emergency Services** but whose lawful presence in the United States can not be verified do not qualify to receive **MHDDAD Services** provided by state or federal funds.

AUTHORITY

O.C.G.A. Section 50-36-1

DEFINITIONS

Lawful Presence – For the purpose of this policy, lawful presence means that the person is a citizen of the United States, or is a non-citizen whose physical presence in the United States is authorized under the immigration laws of the United States. Categories of lawful presence include but are not limited to: citizenship, legal permanent residence, legal temporary residence, visitor with a visa, legal temporary worker, refugee, person with approved asylum status, or temporary protected status from a country of origin under warfare or environmental disaster.

DIVISION: MHDDAD	SUBJECT: Verification of lawful presence in United States for individuals seeking MHDDAD Services	ODIS Policy #6001-501 <i>Replaces DMHDDAD Policy #6811.1</i>
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The ***MHDDAD Verification Form for Lawful Presence in United States*** (Attachment A) contains a detailed list of various types of verification.

MHDDAD Services – For the purpose of this policy, **MHDDAD Services** refers to (a) services provided by the Department of Human Resources (DHR) Division of Mental Health, Developmental Disabilities & Addictive Diseases, through its hospitals and state-operated community services, as well as (b) community behavioral health or developmental disabilities services that are fully or partially paid for by funds from DHR Division of Mental Health, Developmental Disabilities & Addictive Diseases via a contract, provider agreement or letter of agreement.

MHDDAD Emergency Services – For the purpose of this policy, **MHDDAD Emergency Services** are those services that would be provided to an individual who meets the criteria for inpatient services (as defined in O.C.G.A. 37-3-1(9.1) or 37-7-1(14.1) or 37-4-1(13.1) see ***DMHDDAD Criteria for Mental Health Inpatient and Developmental Disability Facility Services*** (Attachment B), as well as services designed to address needs of consumers who are in emergency situations. For the purpose of this policy, this includes persons whose assessment indicates a LOCUS score of “5” or “6” as well as those whose ASAM score is 3.7 or higher, or persons with developmental disabilities for whom adequate natural supports are not available and whose developmental disability is of such severity that the individual meets the following criteria:

- (1) The individual has mental retardation. OR
- (2) The individual has a severe chronic disability attributable to cerebral palsy or epilepsy. OR
- (3) The individual has a condition (i.e. Autism, Autism-spectrum, Asperger’s or Pervasive Developmental Disorder) *other than mental illness*, which is found to be closely related to mental retardation, is likely to last indefinitely, and requires similar treatment and services.
AND
- (4) The impairment for those conditions outlined above results in substantial limitations in three or more of the following functional areas:
 - Self-care skills such as feeding, toileting, dressing and bathing;
 - Understanding and use of verbal and non-verbal language in communication with others;
 - Mobility;
 - Self-direction in managing one’s social and personal life and the ability to make decisions necessary to protect one’s self; and/or
 - Ability to live without extraordinary assistance.

PROCEDURES

For adults who are seeking either **MHDDAD Emergency Services** or non-emergency **MHDDAD Services**, the hospital, community provider, or Regional Intake and Evaluation Office completes the following steps:

1. Complete appropriate assessment to determine what **MHDDAD Services** the individual needs.
2. Serve adults requiring **MHDDAD Emergency Services** without regard to lawful presence status. Although lawful presence status is gathered from all those who seek **MHDDAD Services**, the process for acquiring that lawful presence information must not

DIVISION: MHDDAD	SUBJECT: Verification of lawful presence in United States for individuals seeking MHDDAD Services	ODIS Policy #6001-501 <i>Replaces DMHDDAD Policy #6811.1</i>
		Page 3 of 4

interfere with the individual receiving the **MHDDAD Emergency Services** that he/she requires.

3. Obtain information regarding both lawful presence as needed for completion of **MHDDAD Verification Form for Lawful Presence in United States** (Attachment A)
4. Place the **MHDDAD Verification Form for Lawful Presence in United States** and a copy of the individual's document(s) that verify lawful presence in the consumer's clinical record.
5. Record information regarding verification of lawful presence in applicable management information systems (for example, MICP, BHIS/Avatar).

If an individual is unable to provide documents that verify lawful presence but indicates that he/she is in fact lawfully present in the United States, the following steps are completed:

1. The individual or his/her guardian completes and signs an **Affidavit of Lawful Presence in the United States** (Attachment C).
2. The **Affidavit of Lawful Presence in the United States** is placed in the consumer's clinical record.
3. The MHDDAD Services provider utilizes the federal Systematic Alien Verification for Entitlements (SAVE) program to verify lawful presence. Information about SAVE can be obtained from the U.S. Citizenship and Immigration Service website by going to <http://www.uscis.gov> and searching for SAVE.
4. Until eligibility verification is made through the SAVE or other designated program, the affidavit is accepted as verification of lawful presence.

Adults who can not provide verification of lawful presence in the United States and who do not sign an affidavit of lawful presence can not receive **MHDDAD Services** except for **MHDDAD Emergency Services**. However, DHR hospitals, state-operated community services and community providers will attempt to refer such individuals to other programs and services, as available, that do not receive federal, state, or local funding.

ADDITIONAL INFORMATION

State Hospitals provide emergency services and Individuals in crisis often do not have the required documents with them to verify their legal status. Therefore, hospitals may not have the opportunity to verify legal status prior to referring individuals for outpatient services after discharge from the hospital. Community providers are expected to verify legal status for these individuals just as they would for any new consumer seeking services.

Adults who do not otherwise qualify for **MHDDAD Emergency Services** or **MHDDAD Services** as defined in this policy, but who can pay full fee for behavioral health or developmental disability services from community providers, may receive those services as long as the fees for those services are based on a determination of the cost of the services and are not underwritten or subsidized by state or federal funds. The provider of those services for full fee must maintain documentation of:

1. the cost accounting utilized to determine the fees charged to these persons who have not verified lawful presence in the United States, and
2. the collection of the full fee from those individuals.

As appropriate, providers of MHDDAD Services offer information to individuals regarding organizations recognized by the Board of Immigration Appeals (BIA) as having enough

DIVISION: MHDDAD	SUBJECT: Verification of lawful presence in United States for individuals seeking MHDDAD Services	ODIS Policy #6001-501 <i>Replaces DMHDDAD Policy #6811.1</i>
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knowledge and experience to provide services to immigrants and that charge or accept only very small fees for those services. For a list of these BIA-recognized organizations, see <http://www.usdoj.gov/eoir/statspub/recognitionaccreditationroster.pdf>

Information about free legal service providers is also offered to individuals as appropriate. The Office of the Chief Immigration Judge has a list of recognized free legal service providers for people who are in immigration proceedings; see <http://www.usdoj.gov/eoir/probono/states.htm> for Georgia organizations that provide free legal services and/or referrals for such services to indigent individuals in immigration removal proceedings. Some of these organizations may also charge a nominal fee for legal services to certain low income individuals.

Attachment D, O.C.G.A. Section 50-36-1 provides a copy of the Georgia law that sets forth the requirements that this policy addresses.

DMHDDAD VERIFICATION CHECKLIST FOR LAWFUL PRESENCE IN U.S.

NAME: _____

Per Georgia Law, an individual's LAWFUL PRESENCE IN THE UNITED STATES must be verified for All Non-Emergency Mental Health, Addictive Diseases & Developmental Disabilities Services provided to adults. If you are a recipient of SSI, Medicaid, or Medicare, no further verification is needed.

In order to verify lawful presence in the U.S., please provide one of the following:

Evidence of Citizenship:

- U.S. Passport
- Certificate of Naturalization (DHS Forms N-550 or N-570).
- Certificate of U.S. Citizenship (DHS Forms N-560 or N-561).
- U.S. birth certificate.
- Certification of birth issued by the Department of State (Form DS-1350).
- Report of Birth Abroad of a U.S. Citizen (Form FS-240).
- Certification of Birth Abroad (FS-545).
- U.S. Citizen I.D. card (DHS Form I-197).
- American Indian Card issued by the Department of Homeland Security with the classification code "KIC."
- Northern Mariana Identification Card.
- Evidence of civil service employment by the U.S. government before June 1976.
- Official military record of service showing a U.S. place of birth.
- Extract of a hospital record on hospital letterhead established at the time of the person's birth that was created 5 years before the initial application date and showing a U.S. place of birth (for children, record must have been created near the time of birth).
- Life or health or other insurance record, which shows a U.S. place of birth that was created at least 5 years before the initial application date (or near time of birth for children).
- Religious record recorded in the U.S. within 3 months of birth showing the birth occurred in the U.S. and showing either the date of the birth or the individual's age at the time the record was made. The record must be an official record recorded with the religious organization. (Entries in a family bible are not considered religious records.)
- Early school record showing a U.S. place of birth. The school record must show the name of the child, the date of admission to the school, the date of birth, a U.S. place of birth, and the name(s) and place(s) of birth of the applicant's parents.
- Federal or state census record showing U.S. citizenship or a U.S. place of birth.
- Institutional admission papers from a nursing home, skilled nursing care facility or other institution and was created at least 5 years before the initial application date and indicates a U.S. place of birth.
- Medical (clinic, doctor, or hospital) record and was created at least 5 years before the initial application date and indicates a U.S. place of birth (for children under 5, record is created near time of birth).
- Other document that shows a U.S. place of birth and that was created at least five years previously such as Seneca Indian tribal census record, a Bureau of Indian Affairs tribal census records of Navajo Indians, a U.S. State Vital Statistics official notification of birth registration, a delayed U.S. public birth record that was recorded more than 5 years after the person's birth, a statement signed by the physician or midwife who was in attendance at the time of birth, and Bureau of Indian Affairs Roll of Alaska Natives.

Other Acceptable Evidence of Lawful Presence:

- Georgia Driver's License or Georgia-issued state identification card
- "Green Card" for legal permanent residents, Form I-551. The person's passport also may bear a stamp saying "I-551" to document permanent residence
- Certificate of Indian Blood; US American/Alaska Native tribal document; or Native American Tribal Document
- Visa for a person who is a non-immigrant visiting lawfully
- Employment Authorization Document for lawful temporary workers
- Form I-94 for refugees or persons granted asylum in the US, or a letter or order giving temporary approval status from an immigration judge or border official
- Social Security Card
- Unrestricted Social Security Card for a refugee or asylee, or person given Temporary Protected Status from a country under warfare or disaster
- "Approval letter" from U.S. Citizenship and Immigration Services (USCIS) or an immigration judge
- Temporary Resident Card, Form I-688 from USCIS

DMHDDAD VERIFICATION CHECKLIST FOR LAWFUL PRESENCE IN U.S.

If you do not have any of the above and you are lawfully present in the United States, please contact staff of the facility where you are seeking services to complete an affidavit of lawful presence.

THIS SIDE IS COMPLETED BY STAFF

NAME: _____

CONSUMER NUMBER: _____

All documents that verify lawful presence in US must be either ORIGINALS or copies CERTIFIED by issuing agency.

Verification of Lawful Presence in US has been provided?	Yes	No
---	------------	-----------

Copy on file of verification document?	Yes	No
---	------------	-----------

If verification was <u>not</u> provided, is service required for emergency situation?	Yes	No
--	------------	-----------

Verification Reviewed by _____

Date _____

DMHDDAD CRITERIA FOR MENTAL HEALTH INPATIENT AND DEVELOPMENTAL DISABILITY FACILITY SERVICES

Mental Health Inpatient Services Criteria:

OCGA § 37-3-1(9.1):

"Inpatient" means a person who is mentally ill and:

(A)(i) Who presents a substantial risk of imminent harm to that person or others, as manifested by either recent overt acts or recent expressed threats of violence which present a probability of physical injury to that person or other persons; or

(ii) Who is so unable to care for that person's own physical health and safety as to create an imminently life-endangering crisis; and

(B) Who is in need of involuntary inpatient treatment.

Developmental Disability Facility Services Criteria:

OCGA § 37-4-2(13.1):

"Mentally retarded person requiring temporary and immediate care" means a person who is mentally retarded, and:

(A) Who presents a substantial risk of imminent harm to himself or others;

(B) Who is in need of immediate care, evaluation, stabilization, or treatment for certain developmental, medical, or behavioral needs; and

(C) For whom there currently exists no available, appropriate community residential setting for meeting the needs of the person.

Addictive Disease Inpatient Criteria:

OCGA § 37-7-1(14.1) "Inpatient" means a person who is an alcoholic, a drug dependent individual, or a drug abuser and:

(A)(i) Who presents a substantial risk of imminent harm to that person or others, as manifested by either recent overt acts or recent expressed threats of violence which present a probability of physical injury to that person or other persons; or

(ii) Who is incapacitated by alcoholic beverages, drugs, or any other substances listed in paragraph (8) of this Code section on a recurring basis; and

(B) Who is in need of involuntary inpatient treatment.

Affidavit of Lawful Presence in the United States

State of Georgia
County of _____

Personally appeared before the undersigned officer, duly authorized by law to administer oaths in the State of Georgia, _____
(Consumer's name), who after being duly sworn, deposes and states from his/her own personal knowledge as follows:

I hereby do swear or affirm that I am:

(INITIAL ONE blank below as applicable)

_____ a United States citizen or legal permanent resident 18 years of age or older,

OR

_____ a qualified alien or non-immigrant under the federal Immigration and Nationality Act lawfully present in the United States, and I am 18 years of age or older.

Further affiant sayeth naught.

Signature

Printed name

Sworn to and subscribed before me this _____
Day of _____, 20____.

Notary Public
My commission expires:

(Notary seal)

50-36-1. Verification requirements, procedures, and conditions; exceptions; regulations; criminal and other penalties for violations.

(a) Except as provided in subsection (c) of this Code section or where exempted by federal law, on or after July 1, 2007, every agency or a political subdivision of this state shall verify the lawful presence in the United States of any natural person 18 years of age or older who has applied for state or local public benefits, as defined in 8 U.S.C. Section 1621, or for federal public benefits, as defined in 8 U.S.C. Section 1611, that is administered by an agency or a political subdivision of this state.

(b) This Code section shall be enforced without regard to race, religion, gender, ethnicity, or national origin.

(c) Verification of lawful presence under this Code section shall not be required:

(1) For any purpose for which lawful presence in the United States is not required by law, ordinance, or regulation;

(2) For assistance for health care items and services that are necessary for the treatment of an emergency medical condition, as defined in 42 U.S.C. Section 1396b(v)(3), of the alien involved and are not related to an organ transplant procedure;

(3) For short-term, noncash, in-kind emergency disaster relief;

(4) For public health assistance for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases whether or not such symptoms are caused by a communicable disease;

(5) For programs, services, or assistance such as soup kitchens, crisis counseling and intervention, and short-term shelter specified by the United States Attorney General, in the United States Attorney General's sole and unreviewable discretion after consultation with appropriate federal agencies and departments, which:

(A) Deliver in-kind services at the community level, including through public or private nonprofit agencies;

(B) Do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient's income or resources; and

(C) Are necessary for the protection of life or safety;

(6) For prenatal care; or

(7) For postsecondary education, whereby the Board of Regents of the University System of Georgia or the State Board of Technical and Adult Education shall set forth, or cause to be set forth, policies regarding postsecondary benefits that comply with all federal law including but not limited to public benefits as described in 8 U.S.C. Section 1611, 1621, or 1623.

(d) Verification of lawful presence in the United States by the agency or political subdivision required to make such verification shall occur as follows:

(1) The applicant must execute an affidavit that he or she is a United States citizen or legal permanent resident 18 years of age or older; or

(2) The applicant must execute an affidavit that he or she is a qualified alien or nonimmigrant under the federal Immigration and Nationality Act 18 years of age or older lawfully present in the United States.

(e) For any applicant who has executed an affidavit that he or she is an alien lawfully present in the United States, eligibility for benefits shall be made through the Systematic Alien Verification of Entitlement (SAVE) program operated by the United States Department of Homeland Security or a successor program designated by the United States Department of Homeland Security. Until such eligibility verification is made, the affidavit may be presumed to be proof of lawful presence for the purposes of this Code section.

(f) Any person who knowingly and willfully makes a false, fictitious, or fraudulent statement of representation in an affidavit executed pursuant to subsection (d) of this Code section shall be guilty of a violation of Code Section 16-10-20.

(g) Agencies or political subdivisions of this state may adopt variations to the requirements of this Code section to improve efficiency or reduce delay in the verification process or to provide for adjudication of unique individual circumstances where the verification procedures in this Code section would impose unusual hardship on a legal resident of Georgia.

(h) It shall be unlawful for any agency or a political subdivision of this state to provide any state, local, or federal benefit, as defined in 8 U.S.C. Section 1621 or 8 U.S.C. Section 1611, in violation of this Code section. Each state agency or department which administers any program of state or local public benefits shall provide an annual report with respect to its compliance with this Code section.

(i) Any and all errors and significant delays by SAVE shall be reported to the United States Department of Homeland Security and to the Secretary of State which will monitor SAVE and its verification application errors and significant delays and report yearly on such errors and significant delays to ensure that the application of SAVE is not wrongfully denying benefits to legal residents of Georgia.

(j) Notwithstanding subsection (f) of this Code section any applicant for federal benefits as defined in 8 U.S.C. Section 1611 or state or local benefits as defined in 8 U.S.C. Section 1621 shall not be guilty of any crime for executing an affidavit attesting to lawful presence in the United States that contains a false statement if said affidavit is not required by this Code section.

(Code 1981, 50-36-1, enacted by Ga. L. 2006, p. 105, 9/SB 529.)

Cross references. - Registration of Immigration Assistance Act, [43-20A-1](#) et seq.

Code Commission notes. - Pursuant to Code [Section 28-9-5](#), in 2006, "or" was deleted at the end of paragraph (c)(4), a semicolon was substituted for a period at the end of subparagraph (c)(5)(C) and "Homeland" was inserted following "United States Department of" in subsection (i).

Editor's notes. - Ga. L. 2006, p. 105, 1, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Georgia Security and Immigration Compliance Act.' All requirements of this Act concerning immigration or the classification of immigration status shall be construed in conformity with federal immigration law."

PART VII

Consumer Data: Collection, Reporting and Management

**Provider Manual for
Community Mental Health,
Developmental Disabilities and
Addictive Diseases
Providers**

Fiscal Year 2012



**Georgia Department of Behavioral
Health & Developmental Disabilities**

October 2011

Consumer Data: Collection, Reporting and Management

The Division of MHDDAD is implementing a new comprehensive data collection and utilization management system titled the Multi-Purpose Information Consumer Profile (MICP). The MICP will be used to capture data regarding basic consumer demographics and service detail on all consumers served by the Division. This new form is being implemented in order to streamline and consolidate multiple data collection processes for registration, authorization, and reporting of publicly funded services. For individuals receiving behavioral health services through the Division, as of July 1, 2006 the MICP registration, assessment, and discharge forms will become active and replace the MHMRIS registration, PERMES data reports, TRIGRS authorizations, and the Mental Health and Addictive Disease Core Customer reporting forms. APS Healthcare is the Division's agent for managing this data collection. Please refer to their website at www.apsero.com for additional reporting details and updates as they occur.

The Division sponsors consumer satisfaction and perception of care surveys for all adult populations. These surveys generally require no direct action from service providers. However, providers are expected to make their facilities and consumers available to teams who gather the survey responses.

NOTE: This is meant to cover access to consumers and facilities by the Georgia Mental Health Consumer Network when conducting the PERMES AMH and AAD surveys as well as the NCI Consumer Surveys (currently completed by the Support Coordination Agencies).

Providers of developmental disability services who serve ten or more waiver or state funded adults in residential, day or employment services (including subcontractors) are expected to complete – on an annual basis -- the National Core Indicators Provider Staff Turnover and Board Membership Survey. The survey instrument and instructions for completion will be sent directly to providers.

PART VIII

Financial Policies, Reporting Requirements and Forms

Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers

Fiscal Year 2012



**Georgia Department of Behavioral Health &
Developmental Disabilities**

October 2011

DBHDD

FINANCIAL ACCOUNTABILITY

I. Fiscal Accountability

- A.** The Contractor agrees to maintain sufficient records to show fiscal and program responsibilities and to maintain sufficient books, records and ledgers for the purpose of inspection, monitoring and auditing. Financial records should accurately account for the expenditure of State and Federal funds using accepted State and Federal accounting procedures and should comply with the following:
1. Financial Management System: The Contractor represents that its financial management system currently complies and will continue to comply with all the standards for financial management systems specified in 45 CFR Parts 74.20 through 74.25, 74.27, and 74.28.
 2. Maintenance of Cost Records: The Contractor agrees to maintain records pertaining to costs incurred on this Contract in a manner consistent with the requirements of 45 CFR Parts 74.53, and 74.20 through 74.28.
 3. Contractor Purchasing Activity: All Contractor or Subcontractor purchases of supplies, equipment, and services, regardless of whether by sealed bids or by negotiation and without regard to dollar value, shall be conducted in a manner that provides maximum open and free competition in accordance with 45 CFR - Parts 74.40 through 74.48.
- B.** The Contractor agrees to submit detailed budgets reflecting budget allocations for Contracts Unit approval. Budget revisions may be periodically submitted for Region approval.
- C.** The Contractor agrees, unless otherwise specified by DHR's Office of Financial Services or the Contracts Unit, to submit a monthly report of revenue, expense and revenue applied to expense for each program in accordance with funding, accounting and reporting policy and procedures no later than the 8th calendar day following the end of each month.
- D.** The Contractor agrees to report fees generated on a quarterly basis to the Division and to identify how those fees will be used by the Contractor to maintain or increase the quantity and quality of disability services.
- E.** The Contractor agrees that any fee or program income generated as a result of this contract activity shall be expended in compliance with the Grants-to-Counties Manual Part II.K.1.

USE OF PROGRAM INCOME

I. Requirements Applicable to Program Income Generated under Performance Based Contracts, Fixed Rate Contracts and Expense Reimbursement Contracts

Program income or fee income is income earned by a recipient from activities of which part or all of the cost is borne as a direct cost by a grant or counted as a direct cost towards meeting a cost sharing or matching requirement of a grant. Some examples of program income are Medicaid fees, client fees, and SSI. The use of program income is governed by the DHR Program Income Policy contained in Part II K1 of the *DHR Grants to Counties Manual*. A copy of this policy is included within the Appendices to this section.

A. Program income must be reported as revenue within the "budget program" that generated the income (i.e. fee income earned in Mental Health Services – Adult is reported as revenue in MH Services – Adult, fee income earned in Substance Abuse Services - Children is reported as revenue in SA Services – Children, SSI received in Mental Retardation Services is reported as revenue in Mental Retardation Services, etc.); however, it does not have to be expended within the "program" that generated it. Certain restrictions apply since program or fee income is being partially generated via federal funds (CMHS, SAPT and SSBG Block Grants).

B. There are three (3) program areas for purposes of expending program income. The program income generated may be expended as follows:

1. Mental Health Programs: Program income generated during the current year and those amounts on hand at the end of the fiscal year in the Mental Health Services - Adult, Mental Health Services – Children, or the TAPP program may be expended in either program listed above at the discretion of local management. Income on hand and carried forward into the subsequent fiscal year is also governed by Section II. A - C of the DHR Program Income Policy.
2. Addictive Diseases Programs: Program income generated during the current year and those amounts on hand at the end of the fiscal year in the Substance Abuse Services - Adult, Addictive Diseases Services – Children, or Substance Abuse Prevention Services program may be expended in either program listed above at the discretion of local management. Income on hand and carried forward into the subsequent fiscal year is also governed by Section II. A - C of the DHR Program Income Policy.
3. Developmental Disabilities Programs: Program income generated during the current year and those amounts on hand at the end of the fiscal year in the Developmental Disabilities Services or Autism Services program may be expended in either program listed above at the discretion of local management. Income on hand and carried forward into the subsequent fiscal year is also governed by Section II. A - C of the DHR Program Income Policy.

C. Program income generated in Federal Categorical Grant Programs can only be spent in the specific Federal Categorical Grant Program that generated the income. Program income generated in the other Community Mental Health, Developmental Disabilities and Addictive Diseases Programs per Section B above can be spent in the Federal Categorical Grant Programs in the same disability; i.e. fees generated in either of the mental health programs can be spent in a federal categorical funded mental health program.

D. The Division has elected the Additional Costs Alternative to govern the use of program income in Community Mental Health, Developmental Disabilities and Addictive Diseases programs.

E. Grant/Contract Programs Financed Directly to Boards and Private Non-Profit Agencies: While you may have restrictions regarding fee income generated in programs funded with grants awarded directly to public/private boards, with approval by the Division, you may be allowed to spend fee income generated by other DHR funded programs in the program funded with the direct grant.

II. Special Requirements Applicable to Contracted Funds Carryover under Performance Based Contracts, Fixed Rate Contracts and Expense Reimbursement Contracts

Restrictions placed on the carryover of funds paid by DHR under a contract with the Division/Regional Office are specified below:

A. Performance Based Contracts: Any surplus grant-in-aid-funds at the end of the contract period may be carried over into the next fiscal year. The carryover funds may be expended without program area restrictions or time limitations. Program Income must be reported and expended as outlined in the above part I. Requirements Applicable to Program Income Generated under Performance Based Contracts, Fixed Rate Contracts and Expense Reimbursement Contracts.

B. Fixed Rate Contracts: Any surplus grant-in-aid funds in a fixed rate contract may be expended in any other program regardless of disability. These funds do not have to be expended within the following fiscal year. Program Income must be reported and expended as outlined in the above part I. Requirements Applicable to Program Income Generated under Performance Based Contracts, Fixed Rate Contracts and Expense Reimbursement Contracts.

C. Expense Reimbursement Contracts: Any surplus grant-in-aid- funds cannot be carried over into the next fiscal year and must be returned to DHR.

PROCEDURES FOR AUTHORIZATION

Contractors must submit all budget documents with a recognized signature for fiscal authorizations. Signatures and mailing addresses of the individual(s) designated to receive fiscal correspondence and reports are maintained on file for verification purposes.

In order to establish authorization signatures, contractors should complete and submit the DHR Division of Mental Health, Developmental Disabilities and Addictive Diseases *Authorized Signatures, Mailing Addresses and Telephone Numbers Form* included within the Appendices to this section.

The *Form* should be completed and submitted with the contractor's original budget documents.

I. Public Contractors

Either the Board Chairman or Executive Director of the entity may establish an authorized signature.

II. Private Contractors

The Chairperson or President of the entity must establish the authorized signature.

III. Delegated Authority

Authorization to sign budget revisions may be delegated by providing appropriate information on the *Form*. The delegated signature authority specified must be the same as the delegated signature authority provided in the contract with the Division/Regional Office.

EQUIPMENT, PROPERTY AND VEHICLES

Note: A provider may not use state or Federal funds to (1) construct or purchase buildings or facilities, (2) purchase real estate or (3) make permanent improvement to property. The only exceptions would be if legislative authority specifies or Federal regulations permit the use of funds for this purpose **and** the provider's contract with the Division/Regional Office stipulates that funds can be used to acquire or improve real property.

I. Performance Based Contract

Any equipment including vehicles purchased under a performance-based contract is the property of the contractor. The exception is if the contractor titles a vehicle to the state for the purposes of insurance coverage, then the vehicle belongs to the State and therefore must (a) be maintained in the DHR Vehicle Management System and (b) returned to the State if the provider does not continue to provide services under contract. The inventory requirements for any vehicle titled to the state are outlined below under the Expense Reimbursement Contract portion of this section.

NOTE: Any equipment or vehicles bought previously by a Contractor under a reimbursement based contract that is currently on the DHR Property Management System must continue to be inventoried on that system until it is properly disposed of.

II. Fixed Rate Contract

Any equipment including vehicles purchased under a fixed rate contract becomes the property of the contractor upon completion of performance of the contract. The exception is if the contractor titled the vehicle or equipment to the state for the purposes of insurance coverage, then the equipment or vehicle belong to the State and must be returned to the State if the provider does not continue to provide services under the contract.

III. Expense Reimbursement Contract

Any equipment including vehicles purchased under an expense reimbursement contract is the property of the state and all applicable equipment and inventory policies apply.

A. Board of Health Providers

The Contractor agrees:

1. To maintain detailed property records on all equipment (non-expendable personal property) purchased in total, or in part, with funds received from the Division during the term of this contract. Property records shall be maintained accurately and shall include:
 - A description of the property;
 - Manufacturer's serial number, model number, national stock number, or other identification number;

- Source of the property including Federal program name;
 - Acquisition date (or date received, if the property was furnished by the Department), and cost;
 - Percentage (at the end of the budget year) of federal participation in the cost of the project or program for which the property was acquired;
 - Location, uses, and condition of the property and the date the information was reported;
 - Unit acquisition cost;
 - Property Decal number;
 - Ultimate disposition data, including date of disposal, sales price, and method used to determine current fair market value. Disposition must have prior Department and Region written approval.
 - A physical inventory of property shall be taken and the results reconciled with the property records at least once every two years. Any differences between quantities determined by the physical inspection and those shown in the accounting records shall be investigated to determine the causes of the difference. The Contractor shall, in connection with the inventory, verify the existence, current utilization, and continued need for the property. A control system shall be in effect to ensure adequate safeguards to prevent loss, damage, or theft of the property. Any loss, damage, or theft of non-expendable property shall be investigated and fully documented; the Contractor shall promptly notify the Region.
2. Adequate maintenance procedures shall be implemented to keep the property in good condition.
 3. Upon termination of any service program included in this contract, or in the event that the contract is terminated prior to the expiration or is not renewed, contractor agrees to properly dispose of all state property as follows:
 - a. Prepare Form 5086, Equipment Status Change Form listing all state equipment in the Contractor's possession and send this form to the Division/ Regional Coordinator for final disposal determination.
 - b. Upon notification by the Office of Technology and Support, Contractor agrees to transport the state property to the designated state surplus facility. Expenses incurred by the Contractor in transporting this equipment may be charged to the terminated contract.
 4. The Contractor agrees that this equipment cannot be transferred or otherwise disposed of without written Region approval.
 5. Should the Contractor elect to maintain property records on State Property System, the Contractor agrees to follow procedures outlined in the DHR Property Management Manual.

The Regional Coordinator will confirm, by written notification to the Office of Technology and Support, that all surplus property listed on completed Form 5086 has received proper disposition.

B. Public and Private Providers:

The Contractor agrees:

1. That all non-expendable personal property purchased, in total or in part, with funds received from the Division/Regional Office during the term of the contract and all previous contracts with the Department of Human Resources is property of the State of Georgia and the Department and is subject to the rules and regulations of the Department throughout the life and disposition of said property. Said property cannot be transferred or otherwise disposed of without prior written approval of the DHR Asset Services Section
2. To adhere to all policies and procedures as promulgated in the DHR Administrative Policy and Procedures Manual, Part IX, the DHR Property Management Manual, and if applicable the DHR Vehicle Management Manual, which are by reference made a part of the contract. Contractor understands that the requirements for inventory of property (at least every two years) and a control system to safe guard against loss, damage or theft as contained in the DHR Property Management Manual shall be followed.
3. The property records shall be maintained accurately and reported on Form number 5111, Detailed Equipment Listing, within 10 days after acquisition of such property to the Regional Coordinator. The Regional Coordinator will forward the completed form #5111 to the DHR Asset Services Section, Room 32.452, 2 Peachtree Street, N.W., Atlanta, Georgia 30303.
4. For any Department owed vehicles operated under this contract, the contractor agrees to submit to the Department, the Utilization and Data report furnished by the Asset Services Section in accordance with the DHR Vehicle Management Manual, Chapter 4, Part G.
5. In the event a contract is terminated prior to its expiration or is not renewed, Contractor agrees to properly dispose of all state property as follows:
 - a. Prepare Form 5086, Equipment Status Change Form listing all state equipment in the Contractor's possession and send this form to the Regional Office Director/Regional Coordinator for final disposal determination.
 - b. Upon notification by the Office of Technology and Support, Contractor agrees to transport the state property to the designated state surplus

facility. Expenses incurred by the Contractor in transporting this equipment may be charged to the terminated contract.

The Regional Coordinator will confirm, by written notification to the Office of Technology and Support, that all surplus property listed on completed Form 5086 has received proper disposition.

BUDGET AND REPORTING OVERVIEW

The program structure required for budget development and submission, and the associated program structure to be utilized for the monthly reporting of expenditures is specified in the list of *MHDDAD Budget and Expense Programs*, included among the Appendices to this section.

The budget consists of *Form 1262 Budget Expense and Resource Summary* for Payment for Services or Fixed Rate programs and *Form 1189 Budget Expense and Resource Summary* for Expense Reimbursement programs, which also may be found within the Appendices, along with several supporting *Budget Schedules*. Supporting Budget Schedules can be revised without a revised *Form 1262 Summary* or *Form 1186 Summary* if the changes do not result in a change in the dollar amounts budgeted in the affected expense accounts.

I. BUDGET SUBMISSION:

Documents required for budget submission:

- A. *Form 1262 Budget Expense and Resource Summary* or *Form 1186 Budget Expense and Resource Summary* - Original and two copies
- B. Budget Schedules - Original and two copies
- C. Other Attachments - Original and two copies

II. DEADLINE FOR BUDGET REVISIONS:

Although budget revisions may be submitted at any time during the fiscal year, the final budget revision as well as any outstanding schedules must be postmarked by midnight, May 31. Should this date fall on a weekend or holiday, the deadline will be the next workday. This deadline is necessary in order to permit the approval and processing of the budget prior to the closeout of the fiscal year. The Funding Specifications Annex of the Board/Agency's contract with DHR specifies the minimum parameters which would necessitate a budget revision be filed.

III. EXPENDITURE REPORTS

Monthly Income and Expenditure Reports (MIERs) at the program and subprogram levels must be submitted by file transfer or keying the MIERs into UAS using the E1MIER process on to the Uniform Accounting System (UAS) via a Georgia Online (GO) network. Agencies without GO access should mail or fax the MIER form as specified by the Contracts Unit.

The MIERs are to be submitted and approved by the eighth of each month following the month for which expenses are being reported unless otherwise specified by DHR's Office of Financial Services or the Region. This means the MIERs should be submitted to the appropriate region/contracts unit no later than the eighth of the month unless otherwise specified by the Contracts Unit, so they can be approved.

Year End Closeout MIERs usually have to be approved by July fifth, therefore should be submitted to the Region for approval by July third or by the deadline set by DHR's Office

of Financial Services or the Region.

MIER forms for the Expense Reimbursement contracts are included among the Appendices to this section as **Forms 1192** for Budget Program Level Reporting. The MIERS forms for Payment for Service and Fixed Rate contracts are included among the Appendices to this section as **Form 1261**. The Payment for Services budget programs/service programs structure is included within the Appendices to this section.

IV. STATE/FEDERAL FUNDS REIMBURSEMENT

A. Reimbursement is made based on one of three methods as specified in the Funding Annex of the Board/Agency's contract with the Division/Regional Office. The three reimbursement methods are:

1. Performance Based
2. Fixed Rate
3. Expense Based

B. Should an advance of funds be granted at the beginning of the fiscal year, a reconciliation process at year-end will occur to reclaim any unexpended portion of the advance.

C. Reimbursement checks will not be issued by DHR until

1. Receipt of the Monthly Income and Expenditure Reports (MIERS)
2. Receipt by the Region of all required supporting service documentation.
3. Region approves and releases MIERS for payment.

PAYMENT FOR SERVICE REIMBURSEMENT

I. BUDGETING

The *Budget Expense and Resource Summary Form 1262*, included among the Appendices at this section, is used to budget the Grant in Aid (GIA) contract for the program.

622.003 Payment for Service or Fixed Rate Contract - The Grant in Aid funds for the program are budgeted to this SCOA (State Chart of Accounts).

8001 - Grant-In-Aid – State and Federal funds allocated by DHR are budgeted within this Fund Source.

The 622.003 amount and the 8001 amount with match the total Grant in Aid contract amount.

II. REPORTING

Reimbursement is made based upon Grant in Aid (GIA) expenditures as reported monthly on *Form 1261, Monthly Income and Expense Report, Budget Program Level*, and *Service Program Level*, included among the Appendices at this section.

Service Program Level

622.002 Payment for Service or Fixed Rate Contract - At the Service Program Level, the GIA funds are expensed to this SCOA **8000 Grant-In-Aid** – State and Federal funds allocated by DHR are reported on this Fund Source.

The 622.002 amount for the Service Program will balance to the 8000 amount for that Service Program.

Budget Program Level

622.003 Payment for Service or Fixed Rate Contract - At the Budget Program Level, the GIA is expensed to this SCOA **8001 Grant-In-Aid** – State and Federal funds allocated by DHR are reported on this Fund Source.

The 622.003 amount will balance to the 8001 amount for the Budget Program.

The total 8000 Grant in Aid for all contracted Service Programs will be the amount entered for 8001 Grant in Aid and the total 622.002 for all contracted Service Programs will be the amount entered for 622.003.

FIXED RATE CONTRACT REIMBURSEMENT

I. BUDGETING

The *Budget Expense and Resource Summary Form 1262*, included among the Appendices at this section, is used to budget the Grant in Aid (GIA) contract for the program.

622.003 Payment for Service or Fixed Rate Contract - The Grant in Aid funds for the program are budgeted to this SCOA (State Chart of Accounts) .

8001 - Grant-In-Aid – State and Federal funds allocated by DHR are budgeted within this Fund Source.

The 622.003 amount and the 8001 amount with match the total Grant in Aid contract amount.

II. REPORTING

Reimbursement is made based upon Grant in Aid (GIA) expenditures as reported monthly on *Form 1261, Monthly Income and Expense Report, Budget Program Level*, and *Service Program Level*, included among the Appendices at this section.

Service Program Level

622.002 Payment for Service or Fixed Rate Contract - At the Service Program Level, the GIA funds are expensed to this SCOA **8000 Grant-In-Aid** – State and Federal funds allocated by DHR are reported on this Fund Source.

The 622.002 amount for the Service Program will balance to the 8000 amount for that Service Program.

Budget Program Level

622.003 Payment for Service or Fixed Rate Contract - At the Budget Program Level, the GIA is expensed to this SCOA **8001 Grant-In-Aid** – State and Federal funds allocated by DHR are reported on this Fund Source.

The 622.003 amount will balance to the 8001 amount for the Budget Program.

The total 8000 Grant in Aid for all contracted Service Programs will be the amount entered for 8001 Grant in Aid and the total 622.002 for all contracted Service Programs will be the amount entered for 622.003.

EXPENSE REIMBURSEMENT CONTRACT

I. FORMS

A. BUDGETING

The *Budget Expense and Resource Summary Form 1189*, included among the Appendices at this section, is used to budget all expenses by State Chart of Accounts (SCOAs) and Fund Source revenues for the program level for the services purchased under contract with the Division/Regional Office.

B. REPORTING

Reimbursement is made based upon actual state and federal expenditures as reported on *Form 1192, Monthly Income and Expense Report*, included among the Appendices at this section

II. DIRECT SALARIES AND FRINGE BENEFITS

A. BUDGETING

1. All salaries and fringe benefits are budgeted in SCOA 511.001, including local salary and local fringe benefits supplements.
2. For items with a unit cost of **\$1,000 or greater**, *Form 1240 Supporting Budget Schedule: Equipment Purchases*, included among the Appendices at this section, must be approved prior to purchase. Revisions to the detailed listing of equipment are required only if the unit cost increases by \$100 or 10%, whichever is greater. However, the total expenditure on equipment may not be greater than 110% of the approved budgeted equipment amount as specified in the Master Contract.

Items with a unit cost of **less than \$1,000** are budgeted in Account 643.001, but are not detailed on the schedule.

3. The portion of the total salaries and fringe benefits that are local supplements must be listed on *Form 1244, Supporting Budget Schedule Non-Participating Expenses*, included among the Appendices at this section. The positions do not have to be detailed.

4. Programs operating under the Merit System are assessed merit system charges and personal liability charges on all budgeted positions. In order to keep these charges to a minimum, contractors should utilize positions at 100% to the extent feasible. For example, if the contractor has two (2) or more incumbents on the same job class, with the same job descriptions, and they are not full time employees, every effort should be made to match employees and use one (1) position at 100% utilization.

B. REPORTING

Actual expenses incurred are reported monthly using the State Chart of Account (SCOAs) which tie back to the broad budget expense categories.

511.001 Salaries - Salary payments to all employees on permanent, temporary, skilled or unskilled positions paid on an annual, monthly, semi-monthly, or weekly basis.

511.002 Local Salary Supplement -Salary greater than the approved Georgia state Merit System Pay Schedule.

511.201 Overtime - Salary paid to employees for work in excess of 40 hours per week. Pay should be in accordance with Fair Labor Standards Act and DHR/Merit System applicable policies.

513.001 Hourly Labor - Salary payments to employees paid on an hourly basis.

514.001 Employer's Cost for Social Security. NOTE: Only the Medicare portion of the tax is applicable to hourly wages paid by agencies operating under the Georgia State Merit System rules.

514.002 FICA Local Supplement - Employer's cost for Social Security (both OASDI and Medicare) resulting from additional salary remunerated in accordance with account 511.002.

514.201 FICA Overtime - Employer's cost for Social Security (both OASDI and Medicare) resulting from additional salary remunerated in accordance with account 511.201.

515.001 Retirement - Employer's cost of any retirement program.

516.001 Health Insurance - Employer's cost of health insurance.

516.002 Health Insurance Local Supplement - Employer's cost of any health insurance resulting from additional salary remunerated in accordance with account 511.002.

516.201 Health Insurance Overtime - Employer's cost of health insurance resulting from additional salary remunerated in accordance with account 511.201.

517.001 Personal Liability Insurance - Employees - Includes premiums or other costs related to legal actions against employees personally for acts executed in performance of

job related duties.

518.001 Unemployment Insurance - Includes payments made to Department of Labor either as contributory or reimbursable.

519.001 Workers' Compensation - Includes payments made to Department of Administrative Services, Fiscal Division - Workers' Compensation Trust Fund for workers' compensation insurance coverage for employees.

520.001 Assessments by Merit System - Quarterly charges by the Merit System of Personnel Administration for operations.

C. SUPPORTING SCHEDULE(S)

Form 1244, Supporting Budget Schedule Non-Participating Expenses, included among the Appendices at this section, should be used to support Direct Salaries and Fringe Benefits local supplements.

III. OTHER OPERATING

A. BUDGETING

1. All expenses of the program, with the exception of personnel, equipment, and intra/interagency transactions, are budgeted in SCOA 627.001

2. For items with a unit cost of **\$1,000 or greater**, ***Form 1240 Supporting Budget Schedule: Equipment Purchases***, included among the Appendices at this section, must be approved prior to purchase. Revisions to the detailed listing of equipment are required only if the unit cost increases by \$100 or 10%, whichever is greater. However, the total expenditure on equipment may not be greater than 110% of the approved budgeted equipment amount as specified in the Master Contract.

Items with a unit cost of **less than \$1,000** are budgeted in Account 643.001, but are not detailed on the schedule.

3.. Building rents must be supported with a lease agreement. Three separate "Statements of Comparable Rent", *DHR Form 5465* must also support rents in the Contractor's files. Copies of these are available from the Regional Office. Lease agreements must conform to the following criteria:

- a. Landlord must be clearly identified.
- b. Property must be clearly described, giving type of structure (i.e., brick three bedroom, two story office building), square footage, street address, etc.
- c. Term of lease may not span beyond a single fiscal year, since current year

funds are intended to cover only current year expenditures or costs. However, lease agreements may contain an option to renew the lease for a subsequent fiscal year. Generally, this option should be exercised within 60 days prior to the beginning of the next fiscal year, and thus at a time when appropriations for that fiscal year have become effective under a General Appropriations Act. Georgia's constitution prohibits the obligation of state funds beyond one fiscal year. The Attorney General's Opinion 74-115 dated August 23, 1974 to the State Auditor states "*A state agency may not incur a fiscal obligation beyond that authorized by currently effective appropriations; contracts incurring an obligation dependent upon future appropriations or the continuation of any other source of state funds are invalid.*" The Director of the Office of Audits has stated that it will not permit the obligation of current fiscal year funds to meet the total cost of a multi-year lease.

- d. Must contain a cancellation clause or a funds availability clause.
- e. Must state monthly rental rate.
- f. Security deposits, late fees, bad check charges, application fees and attorney fees are prohibited.
- g. Both parties must initial all additions/deletions/changes.
- h. Must be signed by the landlord and official agent of the Board for public contractors, and the landlord and the President/Chairman of the Board for private contractors.

B. REPORTING

Actual expenses incurred are reported monthly using the SCOA's which tie back to the broad budget expense categories:

612.001 Motor Vehicle Expense - Includes expenses for fuel, service, repair, or other costs of vehicles owned and operated by the agency. Also includes the required maintenance service or repair of leased vehicles.

614.001 Supplies and Materials - Includes all types of consumable supplies and materials used in operation of the agency.

614.006 Food Supplies - Consumable food items.

614.018 Pharmaceuticals - Drugs only.

615.001 Repairs and Maintenance - Expenditures for minor repairs and maintenance of buildings, grounds or equipment, and maintenance contracts or charges for maintenance service.

617.001 Utilities - Includes monthly charges for electricity, natural gas, fuel oil,

purchased steam, city water and sewer charges.

618.001 Printing - Includes the cost of printing letterhead stationery, forms, purchase orders, and any other printed matter.

620.001 Insurance and Bonding - Includes fidelity bonds on employees and hazard coverage on real and personal property or liability coverage required by statute. Also includes workers compensation insurance for non-employees where coverage is required.

622.001 Direct Benefits to Clients - Medical expenses and personal care items for clients residing in a residential program funded by the Department. Such expenditures should only be made on a case by case basis and after it has been determined that no other party or agency resources are available.

622.002 Performance/Fixed-Rate Payments - Amount of funds earned by the provider based on a monthly contractual amount.

622.031 Work Activity Payments - Payments to clients for skills or acquisition/development. Only work activity revenue may be used to pay clients' salaries.

622.044 Room and Board - Payment made to a contractual provider for client residential services. The payment covers housing and meals for the client.

622.045 Respite Care - Payments made to a contractual provider to care for a client. Respite care is provided in order to free the regular caretaker (either personal or purchased provider) from his/her responsibility on a short-term basis.

622.046 Training - Payments made to a contractual home provider for training services to clients.

622.047 Personal Allowance - An allowance provided each residential client for his/her own personal use. From this allowance, the client should purchase his/her clothing, hair cuts, personal hygiene items, medical costs, and if level of funds are sufficient, entertainment costs, etc.

EXCEPTION: Clients residing in Children and Adolescents' Therapeutic Foster Care are not to receive a Personal Allowance Benefit. This clientele's personal care items, clothing and medical expenses must be recorded as 622.001, Direct Benefit to Clients, in accordance with each client's Individualized Service Plan and the definition of account 622.001.

627.001 Other Operating Expenses - Expenditures for costs not properly included in any of the other accounts. Examples include freight, express, storage, linen service, outside laundry, agency subscriptions and dues, and registration fees.

633.001 Computer Software - Expenditures for electronic data processing and

prepackaged and custom software systems.

640.001 Travel - Includes all expenses for lodgings, meals, use of personal vehicle, leased vehicles, or other costs incurred by employees in job-related activities. Similar eligible expenses incurred by individuals other than employees should be reimbursed as per diem and fees. (account 651.001).

648.001 Building Rents - Includes monthly rentals and lease contracts for office space, program space, warehousing and other storage. Costs of renovations and modifications of leased facilities also should be classified in this account if such expenditures constitute rental payments in lease agreements.

651.001 Per Diem and Fees - Compensation for services rendered by an individual, firm or agency on a per diem, hourly, or fee basis, and payments for reimbursable expenses such as travel, postage, telephone, etc. Appropriate services to be purchased by this method are for the delivery of a specific product for a short duration of time. The relationship between the organizations or organization and individual cannot be that of an "employee-employer".

653.001 Contracts - Includes payments made for agreements between two or more persons to perform, purchase or serve and are enforceable by law. Includes all contracts other than accounts specific to a contractual agreement (i.e., contracted janitorial services would be reported under Account 615.001, Repairs and Maintenance).

673.001 Telecommunications - Includes all charges for telecommunications such as telephone and telegraph, and costs of facsimile machines.

681.001 Postage - Includes all postage costs.

C. SUPPORTING SCHEDULE(S)

1. Form 1244, Supporting Budget Schedule: Non-Participating Expenses, included among the Appendices at this section, is used to budget those items that are ineligible for state and federal and other program income participation.
2. Form 1243 Supporting Budget Schedule: Depreciation Charges, included among the Appendices to this section, is used to budget the allowable charges for occupied facilities owned by Contractors/Community Service Boards. A completed depreciation schedule using federally approved depreciation guidelines must be attached.

IV. EQUIPMENT

A. BUDGETING

The annual projected cost of material items of a non-expendable nature are budgeted in SCOA 643.001 (Equipment).

For items with a unit cost of **\$1,000 or greater**, *Form 1240 Supporting Budget Schedule: Equipment Purchases*, included among the Appendices at this section, must be approved prior to purchase. Revisions to the detailed listing of equipment are required only if the unit cost increases by \$100 or 10%, whichever is greater. However, the total expenditure on equipment may not be greater than 110% of the approved budgeted equipment amount as specified in the Master Contract.

Items with a unit cost of **less than \$1,000** are budgeted in Account 643.001, but are not detailed on the schedule.

B. REPORTING

641.001 Motor Vehicle Equipment Purchases - Includes all vehicles licensed for use on the highway, i.e., automobiles, station wagons, vans, buses, motor homes, light duty trucks and heavy duty cargo carrying trucks. All motor vehicle purchases charged to this account must be on the appropriate property inventory system.

643.001 Equipment (\$1,000 or more) - Includes expenditures for items of tangible property of a generally nonexpendable nature, such as a movable unit of furniture or furnishings, an instrument or apparatus, a machine, or a training device, maintaining its utility over a period of time which is characteristic of and definable for items of its class. Also includes motorized vehicles not used on public roads such as lawn mowers, farm tractors, etc. Items in this expenditure category will have an original acquisition cost of **greater** than the statutory definition of movable personal property set forth in the Official Code of Georgia Annotated, Title 50-16-161 (currently \$1,000).

644.001 Lease/Purchase of Equipment - Includes the payments made on lease/purchase or installment purchases agreements. All equipment received for which charges are made to this account should be recorded on the appropriate property inventory system when received and for the total acquisition price.

645.001 Rental of Equipment - The payments made for the rental of equipment if for more than three (3) months. Less than three (3) months is reported in Account 619.001.

646.001 Equipment (Less than \$1,000) - Includes expenditures for items of tangible property of a generally nonexpendable nature, such as a movable unit of furniture or furnishings, an instrument or apparatus, a machine, or a training device, maintaining its utility over a period of time which is characteristic of and definable for items of its class. Items in this expenditure category will have an original acquisition cost of **less** than the statutory definition of movable personal property set forth in the Official Code of Georgia Annotated, Title 50-16-161 (currently \$1,000).

C. SUPPORTING SCHEDULE(S)

Form 1240, Supporting Budget Schedule: Equipment Purchases, is used to list anticipated equipment purchases or leases that will be expensed in accounts

1. 641.001, Motor Vehicle Equipment Purchases
2. 643.001, Equipment (\$1,000 or more)
3. 644.001, Lease/Purchase of Equipment, and
4. 645.001, Rental of Equipment

V. REVENUES BY FUND SOURCE

All revenue and/or income must be budgeted and expensed through the Uniform Accounting System (UAS). Every DHR provider's grant award(s) and/or contract program(s) must be reviewed by the Division to determine accurate budget and reporting categories, and whether fee income generated by other DHR funded programs may support it. Specific instructions and explanations for budgeting and reporting resources are as follows:

A. BUDGETING

1. 8001 (Grant-In-Aid) – State and Federal funds allocated by DHR are budgeted within this Fund Source.
2. 8002 (DHR Contracts) - Used to budget revenue contracts with other DHR agencies.
3. Funds received from taxing authorities are budgeted in the following Fund Sources:
 - a. 6001 (County Participation) is used to budget local match requirement.
 - b. 6004 (County Non-Participating) is used to budget county funds in excess of required match.
 - c. 6006 (Municipal) is used to budget funds received from cities, towns, etc.
 - d. 6020 (Hospital Authority) is used to budget funds received from hospitals.
4. Revenue from the Fund Sources listed below must be identified and described on **Form 1272, Supporting Budget Schedule Revenue**, which is included among the Appendices at this section.
 - a. 6013 (DOE Contracts)
 - b. 6018 (Contractual Agreements)
 - c. 6021 (Other Local Funds)
 - d. 7014 (Federal Grants)
5. Program Income - Income earned by a recipient from activities of which part or all of the cost is borne as a direct cost by a grant or counted as a direct cost towards meeting a cost sharing or matching requirement of a grant. Fund balances at June 30 each year must be budgeted and expensed within the subsequent twelve-month period, as detailed at paragraph 6 below. Income is budgeted in the Accounts as follow:
 - a. 6008 is used to budget Outpatient Medicare fees.

- b. 6009 is used to budget Outpatient Medicaid Current Year fees.
 - c. 6017 is used to budget fees received directly from clients, on client's behalf from government agencies, private insurance and other third party payees.
 - d. 6032 is used to budget Medicaid Waiver Current Year fees in Mental Retardation programs.
 - e. 6024 is used to budget a Fund Balance from Prior Year
 - f. 6028 is used to budget Medicaid receipts for pharmacy services.
6. Local programs may carry forward program income generated during one fiscal year into the next fiscal year in accordance with DHR Program Income Policy contained in ***Part II.K.1. of the DHR Grants to Counties Manual*** (included among the Appendices at this section.) The Division has elected the Additional Cost Alternative to govern the use of program (fee) income generated during one fiscal year and on hand at June 30 in Community Mental Health, Developmental Disabilities and Addictive Diseases programs.

B. REPORTING

Receipt and application of resources, except for revenue generated through the Fund Sources listed below are reported on ***1192 Monthly Income and Expense Report***, included among the Appendices at this section, in the same manner stated at VI Revenue, A. Budgeting.

- 1. 6017 (Other Fees) for reporting purposes, is used as follows to distinguish client fees:
 - a. 6015 is used to report direct pay client fees.
 - b. 6016 is used to report client fees resulting from private insurance.
 - c. 6017 is used to report all other client fees that are not defined above, such as SSI/SSA.
- 2. 6024 (Fund Balance from Prior Year) surplus funds resulting from excess of program income over expenses in the prior year are reported expensed in this account. The fund balance from the prior year must be expensed during the next state fiscal year.

C. SUPPORTING SCHEDULE (S)

Form 1272, Supporting Budget Schedule: Revenue, included among the Appendices to this section, is used to describe and identify resources budgeted in the following Fund Sources:

- 6013 (DOE Contracts)
- 6018 (Contractual Agreements)
- 6021 (Other Local Funds)
- 6040 (Intra/Inter Agency Transactions), and
- 7014 (Federal Grants)

CONTRACTING AND SUBCONTRACTING BY CONTRACTOR

Required Approvals

As specified in Paragraph 115, of the contract, the Division's approval is not required of the Contractor to enter into a subcontract for services specified in the contract. The Contractor must provide at the time the contract is signed a list of all subcontractors to include but not limited to, the disability group or groups served and the services provided and the expected annual cost of services

Contents of Subcontracts

- A. Any subcontracts of the Contractor will be in writing and clearly state the service or product being acquired through said subcontract with a detailed description of cost.
- B. Any subcontracts of the Contractor for the provision of consumer services and/or operational services addressed in whole or in part by the Provider Manual will incorporate a certification to be signed by the subcontractor indicating the subcontractor has received and will comply with the Provider Manual.
- C. Any subcontracts by the Contractor will require subcontractors to comply with all provisions of the federal and state laws, rules, regulations and policies.

Responsibility For Subcontractor's Performance

As specified in the contract, the contractor agrees to be responsible for the subcontractor's performance and compliance with applicable provision of the contract and the Provider Manual. The Contractor will ensure that the subcontractor both understands and abides by all pertinent provisions of the contract, the Provider Manual and any regulations applicable to the subcontractor. The contractor also must ensure that the subcontractor receives the Provider Manual and all revisions to the Provider Manual.

Compliance with State's Minority Business Policy

Contractors who by virtue of their contract with the MHDDAD/Regional Office are allowed to subcontract will follow the State's Minority Business policy. The policy of the State of Georgia is that minority business enterprises shall have a fair and equal opportunity to participate in the purchasing process. The State encourages all companies to subcontract portions of any State contract to minority business enterprises.

INSURANCE REQUIREMENTS

I. Requirements Applicable to Public Providers (e.g., Community Service Boards and County Boards of Health) The following shall be adhered to by public providers throughout the term of the contract, any renewal thereof, and as otherwise specified herein:

A. Insurance Certificate: The Provider shall procure and maintain insurance which shall protect the Provider and the State from any claims for bodily injury, property damage, or personal injury which may arise out of operations under the Contract. The Provider shall procure the insurance policies at the Provider's own expense and shall furnish the State an insurance certificate listing the State as certificate holder. The insurance certificate must document that the liability insurance coverage purchased by the Provider includes contractual liability coverage to protect the State. In addition, the insurance certificate must provide the following information:

1. Name and address of authorized agent,
2. Name and address of insured,
3. Name of insurance company (licensed to operate in Georgia),
4. Description of coverage in standard terminology,
5. Policy period,
6. Limits of liability,
7. Name and address of certificate holder,
8. Acknowledgment of notice of cancellation to the State,
9. Signature of authorized agent,
10. Telephone number of authorized agent,
11. Details of policy exclusions in comment section of Insurance Certificate.

B. The Provider also agrees to procure and maintain insurance coverage to document that the following types of insurance coverage have been purchased by the Provider :

1. Workers' Compensation Insurance

To insure the statutory limits as established by the General Assembly of the State of Georgia (NOTE: A self-insurer must submit a certificate from the Georgia State Board of Workers' compensation stating the Provider qualifies to pay its own workers' compensation claims.) The Workers' Compensation Policy must include Coverage B - Employer's Liability Limits of:

Bodily Injury by Accident -	\$ 500,000 each accident
Bodily Injury by disease -	\$ 500,000 each employee
	\$1,000,000 policy limits

Provider shall require all Subcontractors performing work under his Contract to obtain an insurance certificate showing proof of Workers' Compensation Coverage.

2. Commercial General Liability Policy:*

Combined Single Limits: \$1,000,000 per person
 \$3,000,000 per occurrence

The Commercial General Liability Policy must insure provider's officers, board members and employees in their individual capacities and must be on an "occurrence" basis.

*A Comprehensive General Liability Policy may be substituted for the Commercial General Liability Policy if the Comprehensive General Liability Policy has been endorsed to insure contractual liability, broad form property damage, and personal injury liability.

3. Business Automobile Liability Policy:

Combined Single Limits: \$1,000,000 per Person
 \$3,000,000 per Occurrence

All policies must be on an "occurrence" basis, unless expressly otherwise stated.

- C. The foregoing policies shall contain a provision that coverage will not be canceled or allowed to lapse until at least thirty (30) days prior written notice has been given to DHR. Certificates of Insurance showing such coverage to be in force, or a resolution requesting D.O.A.S. to assist in the purchase, shall be filed with DHR prior to commencement of any work under this Contract. The foregoing policies shall be obtained from D.O.A.S. (with the consent and approval of D.O.A.S.) or insurance companies licensed to do business in Georgia and acceptable to DHR. The forgoing policies shall be obtained from and maintained with insurance companies that are licensed to do business in Georgia and also either have a minimum Best Rating of A or have been specifically approved in writing by the Department. Evidence of insurability under these provisions shall be directed to the Division. It shall be the responsibility of the Provider to require any Subcontractor to indemnify and hold harmless the Division, DHR and the State; to secure insurance coverage sufficient to cover possible liability, and to obtain a certificate or certificates evidencing that such insurance is in effect. In addition, the Provider shall indemnify and hold harmless the Division, DHR and the State from any liability arising out of the Provider's or Subcontractor's untimely failure to secure adequate insurance coverage as prescribed herein. All such coverage shall remain in full force and affect during the initial term of the Contract and any renewal or extension thereof.

- D. At the request of the Division, the Provider will supply all necessary underwriting data for the purchase of insurance coverage through the Department of Administrative Services

(D.O.A.S.), including workers' compensation, unemployment insurance, general liability, vehicle liability, fidelity bond and property insurance. The Provider will remit in a timely manner required premiums for vehicle liability and fidelity bond insurance to the Department of Administrative Services.

- E. For insurance coverage provided by the D.O.A.S., the D.O.A.S. shall have the authority to examine and copy any records of the Provider to facilitate the investigation of any claim covered by such insurance. The Provider shall make available to D.O.A.S. all such records incidental to any investigation of a claim notwithstanding any other provisions of law which designates such records as confidential or which prohibits disclosure of such records; provided, that D.O.A.S. shall be bound by such provisions of law and shall not make further disclosure of such records.

II. Requirements Applicable to Private Providers The following shall be adhered to by private provides throughout the term of the contract, any renewal thereof, and as otherwise specified herein:

- A. Insurance Certificate: The Contractor shall, at its expense, procure a Commercial General Liability Insurance Policy, including personal and advertising liability (or a Comprehensive General Liability Policy) with endorsement to insure contractual liability, broad form property damage, personal injury, personal and advertising liability, and other insurance policies in coverage amounts of \$3 million per occurrence and \$1 million per person, with endorsement waiving right of subrogation against the State, the Indemnities, the Fund and insurers participating thereunder. The Provider shall procure the insurance policies at the Provider's own expense and shall furnish the State an insurance certificate listing the State as certificate holder.
- B. Fidelity Assurance Bonds: Private Non-Profit Contractors who are requesting an advance of funds under the contract MUST be bonded. The bond may be a blanket bond covering all contract positions, or it may be a position bond, listing specific positions. If a position bond is used, each position scheduled must be for the minimum amount required. While it is customary to list the chief executive officer on the bond, the bond must cover anyone handling funds or authorizing expenditures. The bond must be made payable to the State of Georgia, Department of Human Resources or payable jointly to the Contractor and DHR. If the Contractor has a very large bond covering its entire operation, it can assign, through an endorsement or rider, the required portion of the bond to DHR.

The bond amount is determined by calculating the total amount of the contract (total amount is inclusive of local match, donor funds, in-kind match, certified costs, certified public expenditure, certified cash transfers, budgeted State and Federal funds) by the percentage listed below and comparing that to the amount of the advance. The larger of the two figures must be the amount of the bond. The Contractor will submit to the Regional Office a binder, certificate of insurance or a copy of the bond. If a binder letter is used, the binder must include the name of the bonding company, bond number, period of coverage, amount of coverage, who is covered, and statement that the bond is payable to DHR or jointly payable to DHR and the Contractor.

III. Fidelity/Assurance Bond Schedule

<u>Total Contract Budget</u>	<u>Amount of Bond</u>
up to \$50,000	25%
\$50,000 to 54,999	24%
\$55,000 to 59,999	23%
\$60,000 to 64,999	22%
\$65,000 to 69,999	21%
\$70,000 to 74,999	20%
\$75,000 to 79,999	19%
\$80,000 to 84,999	18%
\$85,000 to 89,999	17%
\$90,000 to 94,999	16%
\$95,000 to 99,999	15%
\$100,000 to 199,999	14%
\$200,000 to 399,999	13%
\$400,000 and up	12%

FY10 BUDGET & EXPENSE NUMBERS

DMHDDAD PROGRAM STRUCTURE

MENTAL HEALTH – ADULTS

Budget Program	Service Programs
Grant-In-Aid Fund Source - 8001	Grant-In-Aid Fund Source - 8000
101 Core Services Provider	
	120 Diagnostic Assessment & IRP Planning
	121 Crisis Intervention
	122 Physician Assessment and Care
	123 Nursing Assessment and Health Services
	124 Medication Administration
	126 Community Support Individual
	128 Individual Counseling
	129 Group Training / Counseling
	130 Family Training / Counseling
190 Core Capacity Services	
	* Budget 190 is a stand alone budget. Budgets and Expenses should be reported using this budget number.

FY10 BUDGET & EXPENSE NUMBERS

DMHDDAD PROGRAM STRUCTURE MENTAL HEALTH – ADULTS (continued)

Budget Program Grant-In-Aid Fund Source - 8001	Service Programs Grant-In-Aid Fund Source - 8000
103 Crisis Services Provider	133 Mobile Crisis Services (Capacity) 134 Crisis Stabilization Program 135 Community-Based Inpatient Services
104 Consumer/Family Support Services Provider	136 Respite 137 Consumer / Family Assistance
105 Peer Support Services Provider	138 Peer Support
106 Employment Services Provider	139 Supported Employment
107 Residential Services Provider	144 Structured Residential 148 Housing Supplements
108 Intensive Treatment Services Provider	152 Assertive Community Treatment (ACT)
109 Mental Health Day Services Provider	155 Psychosocial Rehabilitation
110 MH Intensive Day Services Provider	159 Intensive Day Treatment
119 Other Contracted Services	NEW * To be assigned as contracted

OTHER BUDGET / FUND SOURCES
001 Special Projects MH Services - Adult
002 McKinney Homeless Grant
003 Homeless Services - State
010 Transition Assistance For Probationers/Parolees
011 Treatment Court - Mental Health
020 TANF MH Outpatient

FY10 BUDGET & EXPENSE NUMBERS

DMHDDAD PROGRAM STRUCTURE

MENTAL HEALTH - CHILDREN & ADOLESCENTS

Budget Program	Service Programs
Grant-In-Aid Fund Source - 8001	Grant-In-Aid Fund Source - 8000
201 Core Services Provider	
	220 Diagnostic Assessment & IRP Planning
	221 Crisis Intervention
	222 Physician Assessment and Care
	223 Nursing Assessment and Health Services
	224 Medication Administration
	226 Community Support Individual
	228 Individual Counseling
	229 Group Training / Counseling
	230 Family Training / Counseling
290 Core Capacity Services	
	* Budget 290 is a stand alone budget. Budgets and Expenses should be reported using this budget number.

FY10 BUDGET & EXPENSE NUMBERS

DMHDDAD PROGRAM STRUCTURE

MENTAL HEALTH - CHILDREN & ADOLESCENTS (continued)

Budget Program
Grant-In-Aid Fund Source - 8001

Service Programs
Grant-In-Aid Fund Source - 8000

203 Crisis Services Provider

- 233 Mobile Crisis Services (Capacity)
- 234 Crisis Stabilization Program
- 235 Community-Based Inpatient Services

204 Consumer/Family Support Services Provider

- 257 Child and Family Support Services

207 Residential Services Provider

- 244 Structured Residential
- 246 Therapeutic Foster Care
- 247 Therapeutic Group Home
- 248 Housing Supplements

208 Intensive Treatment Services Provider

- 253 Intensive Family Intervention

219 Other Contracted Services

NEW * To be assigned as contracted

OTHER BUDGET / FUND SOURCES

301 Special Projects MH Services - Children

FY10 BUDGET & EXPENSE NUMBERS

DMHDDAD PROGRAM STRUCTURE ADDICTIVE DISEASES - ADULTS

Budget Program Grant-In-Aid Fund Source - 8001	Service Programs Grant-In-Aid Fund Source - 8000
701 Core Services Provider	
	720 Diagnostic Assessment & IRP Planning
	721 Crisis Intervention
	722 Physician Assessment and Care
	723 Nursing Assessment and Health Services
	724 Medication Administration
	726 Community Support Individual
	728 Individual Counseling
	729 Group Training / Counseling
	730 Family Training / Counseling
790 Core Capacity Services	
	* Budget 790 is a stand alone budget. Budgets and Expenses should be reported using this budget number.

FY10 BUDGET & EXPENSE NUMBERS

DMHDDAD PROGRAM STRUCTURE

ADDICTIVE DISEASES – ADULTS (continued)

Budget Program	Service Programs
Grant-In-Aid Fund Source - 8001	Grant-In-Aid Fund Source - 8000
703 Crisis Services Provider	
	733 Mobile Crisis Services (Capacity)
	734 Crisis Stabilization Program
	735 Community-Based Inpatient Services
704 Consumer/Family Support Services Provider	
	736 Respite
	737 Consumer / Family Assistance
705 Peer Support Services Provider	
	738 Peer Support
706 Employment Services Provider	
	739 Supported Employment
707 Residential Services Provider	
	744 Structured Residential
	748 Housing Supplements
709 Addictive Disease Day Services Provider	
	756 Substance Abuse Day Treatment
710 Opioid Maintenance Treatment Provider	
	763 Opioid Maintenance Treatment
711 Substance Abuse Detox Services Provider	
	765 Residential Detox
	766 Ambulatory Detoxification
719 Other Contracted Services	
	NEW * To be assigned as contracted

FY10 BUDGET & EXPENSE NUMBERS

DMHDDAD PROGRAM STRUCTURE

ADDICTIVE DISEASES – ADULTS (continued)

Budget Program
Grant-In-Aid Fund Source - 8001

Service Programs
Grant-In-Aid Fund Source - 8000

Treatment Court Services

611 Treatment Court - AD

TANF / RFW Services

620 Non-TANF Outpatient

621 TANF Outpatient

622 Ready for Work Outpatient - State

623 RFW TANF Residential

624 Non-TANF Residential

625 TANF Residential

626 Ready for Work Residential - State

627 TANF SA Safe Port

628 TANF AD Support Services

OTHER BUDGET / FUND SOURCES

601 Special Projects SA Services - Adult

602 HIV Early Intervention Services

603 Demand Reduction Drug Treatment Prog

FY10 BUDGET & EXPENSE NUMBERS

DMHDDAD PROGRAM STRUCTURE

ADDICTIVE DISEASES - CHILDREN & ADOLESCENTS

Budget Program	Service Programs
Grant-In-Aid Fund Source - 8001	Grant-In-Aid Fund Source - 8000
801 Core Services Provider	
	820 Diagnostic Assessment & IRP Planning
	821 Crisis Intervention
	822 Physician Assessment and Care
	823 Nursing Assessment and Health Services
	824 Medication Administration
	826 Community Support Individual
	828 Individual Counseling
	829 Group Training / Counseling
	830 Family Training / Counseling
890 Core Capacity Services	
	* Budget 890 is a stand alone budget. Budgets and Expenses should be reported using this budget number.

FY10 BUDGET & EXPENSE NUMBERS

DMHDDAD PROGRAM STRUCTURE

ADDICTIVE DISEASES - CHILDREN & ADOLESCENTS (continued)

Budget Program	Service Programs
Grant-In-Aid Fund Source - 8001	Grant-In-Aid Fund Source - 8000
803 Crisis Services Provider	
	833 Mobile Crisis Services (Capacity)
	834 Crisis Stabilization Program
	835 Community-Based Inpatient Services
804 Consumer/Family Support Services Provider	
	857 Child and Family Support Services
807 Residential Services Provider	
	844 Structured Residential
	846 Therapeutic Foster Care
	847 Therapeutic Group Home
	848 Housing Supplements
808 Intensive Treatment Services Provider	
	853 Intensive Family Intervention
811 Addictive Disease Detox Services Provider	
	865 Residential Detox
	866 Ambulatory Detox
819 Other Contracted Services	
	NEW * To be assigned as contracted
OTHER BUDGET / FUND SOURCES	
901 Special Projects SA Services - Children	
902 Governor's Emergency Fund - SA	

FY10 BUDGET & EXPENSE NUMBERS

DMHDDAD PROGRAM STRUCTURE

DEVELOPMENTAL DISABILITIES – ADULTS and CHILDREN & ADOLESCENTS

Budget Program
Grant-In-Aid Fund Source - 8001

Service Programs
Grant-In-Aid Fund Source - 8000

400	Developmental Disabilities
------------	-----------------------------------

Day & Employment Services

Day Supports

- | | |
|-----|---|
| 401 | Day Supports - Community Based Habilitation |
| 402 | Day Supports - Facility Based Habilitation |
| 403 | Day Supports - Prevocational |
| 404 | Day Supports - Community Based Employment |

Comprehensive Day Services

- | | |
|-----|----------------------------|
| 405 | Comprehensive Day Services |
|-----|----------------------------|

Supported Employment

- | | |
|-----|---|
| 406 | Community Based Employment - Individual |
| 407 | Community Based Employment - Group - Enclaves |
| 408 | Community Based Employment - Mobile Crews |

Personal Living & Residential Services

- | | |
|-----|--------------------------------|
| 411 | Community Residential Supports |
|-----|--------------------------------|

Supportive Services

- | | |
|-----|----------------------------------|
| 421 | Behavioral Support Team Services |
| 422 | Family Supports - M.R. |
| 423 | Respite |

OTHER BUDGET / FUND SOURCES

- | | |
|-----|--|
| 501 | Special Projects - DD Services |
| 502 | Special Appropriation - MR |
| 503 | Special Appropriation - Rehab Project New Hope |
| 510 | DD Family Support |
| 511 | Autism Services |
| 520 | TANF Mental Retardation Funds |

FY11 UAS Budget & Expense Numbers

**MENTAL HEALTH & ADDICTIVE DISEASE
CORE SERVICES**

		MENTAL HEALTH		ADDICTIVE DISEASES	
		ADULT	C&A	ADULT	C&A
CORE SERVICES		101	201	701	801
	Behavioral Health Assessment & Service Plan Development	131	231	731	831
	Psychological Testing	132	232	732	832
	Diagnostic Assessment	120	220	720	820
	Crisis Intervention	121	221	721	821
	Psychiatric Treatment	122	222	722	822
	Nursing Assessment & Health Services	123	223	723	823
	Medication Administration	124	224	724	824
	Community Support - Individual	126	226	726	826
	Individual Outpatient Services	128	228	728	828
	Group Outpatient Services	129	229	729	829
	Family Outpatient Services	130	230	730	830
	Legal Skills / Competency Training	161	-	761	-
	Community Transition Planning	162	262	762	862

- NOTES: 1. Budget Program Numbers appear in the shaded areas.
2. Service Program Numbers (Subprograms) for expense reporting appear in the non-shaded areas.

	Core Capacity Services	190	290	790	890
	Fixed Rate Services	191	291	791	891
	Reimbursement	192	292	792	892
	C&A Fee For Service - Adjustments	-	298	-	898
	C&A Fee For Service	-	299	-	899

- NOTES: 1. The above numbers are stand alone budget programs. Budgets and Expenses should be reported against these numbers.

FY11 UAS Budget & Expense Numbers

**MENTAL HEALTH & ADDICTIVE DISEASE
SPECIALTY SERVICES**

		MENTAL HEALTH		ADDICTIVE DISEASES	
		ADULT	C&A	ADULT	C&A
CRISIS SERVICES		103	203	703	803
	Crisis Stabilization	134	234	734	834
	Community Based Inpatient MH & AD Svcs	135	235	735	835
	Mobile Crisis Services - Capacity	133	233	733	833
CONSUMER / FAMILY SUPPORT SERVICES		104	204	704	804
	Respite	136	-	736	-
	Consumer / Family Assistance	137	-	737	-
	Child & Family Support Services	-	257	-	857
	Behavioral Assistance	-	258	-	858
PEER SUPPORT SERVICES		105		705	
	Peer Support	138	-	738	-
EMPLOYMENT SERVICES		106		706	
	Supported Employment	139	-	739	-
RESIDENTIAL SERVICES		107	207	707	807
	Independent Residential Services	141	-	741	-
	Semi-Independent Residential Services	142	-	742	-
	Intensive Residential Services	143	-	743	-
	Structured Residential	-	244	-	844
	Housing Supplements	148	248	748	848
	Outdoor Therapeutic Program	-	250	-	850
	Psychiatric Residential Treatment Facility (PRTF)	-	249	-	-
INTENSIVE TREATMENT SERVICES		108	208	708	808
	Assertive Community Treatment	152	-	-	-
	Intensive Family Intervention	-	253	-	853
DAY SERVICES		109	209	709	809
	Psychosocial Rehabilitation	155	-	-	-
	Structured Activity Supports	-	270	-	870
OPIOID MAINTENANCE TREATMENT SERVICES				710	
	Opioid Maintenance Treatment	-	-	763	-
ADDICTIVE DISEASE DETOX SERVICES				711	811
	Substance Abuse Residential Detox	-	-	765	865
	Substance Abuse Ambulatory Detox	-	-	766	866
OTHER CONTRACTED SERVICES		119	219	719	819
	* TO BE ASSIGNED AS CONTRACTED	*	*	*	*
	Screening & Referral for the Deaf	180	-	-	-
	Intensive Case Management (Region 3 Pilot)	181	-	781	-
	Care Management Agency	-	281	-	-

NOTES: 1. Budget Program Numbers appear in the shaded areas.

2. Service Program Numbers (Subprograms) for expense reporting appear in the non-shaded areas.

FY11 UAS Budget & Expense Numbers

**MENTAL HEALTH & ADDICTIVE DISEASE
OTHER CONTRACTED SERVICES**

		MENTAL HEALTH		ADDICTIVE DISEASES	
		ADULT	C&A	ADULT	C&A
TAPP SERVICES PROVIDER					
	TRANSITION ASSIST. FOR PROB AND PAROLEES	010	-	-	-
TREATMENT / DRUG COURT SERVICES					
	TREATMENT COURT SERVICES - MH	011	-	-	-
	TREATMENT COURT SERVICES - AD	-	-	611	-
READY FOR WORK / TANF SERVICES PROVIDER					
???	TANF MENTAL HEALTH OUTPATIENT	020	-	-	-
	READY FOR WORK OUTPATIENT - SAPT BG	-	-	620	-
	READY FOR WORK OUTPATIENT - TANF GRANT	-	-	621	-
	READY FOR WORK OUTPATIENT - STATE	-	-	622	-
	RFW TANF RESIDENTIAL	-	-	623	-
	READY FOR WORK RESIDENTIAL - SAPT BG	-	-	624	-
	READY FOR WORK RESIDENTIAL - TANF GRANT	-	-	625	-
	READY FOR WORK RESIDENTIAL - STATE	-	-	626	-
	TANF SA SAFE PORT	-	-	627	-
	TANF AD SUPPORT SERVICES	-	-	628	-
	READY FOR WORK - TRANSITIONAL HOUSING	-	-	630	-
	READY FOR WORK - ADMINISTRATION	-	-	631	-

NOTES: 1. The above numbers are stand alone budget programs. Budgets and Expenses should be reported against these numbers.

FY11 UAS Budget & Expense Numbers

**MENTAL HEALTH & ADDICTIVE DISEASE
OTHER BUDGET PROGRAMS / FUND SOURCES**

		MENTAL HEALTH		ADDICTIVE DISEASES	
		ADULT	C&A	ADULT	C&A
MENTAL HEALTH SERVICES - ADULT					
	SPECIAL PROJECTS - ADULT MH SERVICES	001	-	-	-
	MCKINNEY HOMELESS GRANT	002	-	-	-
	HOMELESS SERVICES - STATE	003	-	-	-
	JAIL DIVERSION & TRAUMA RECOVERY FOR VETS	012	-	-	-
MENTAL HEALTH SERVICES - CHILD & ADOLESCENT					
	CARE MANAGEMENT AGENCY	-	302	-	902
ADDICTIVE DISEASE SERVICES - ADULT					
	HIV EARLY INTERVENTION SERVICES	-	-	602	-
	SBIRT (GA BASICS)	-	-	605	-
ADDICTIVE DISEASE SERVICES - CHILD & ADOLESCENT					
	SPECIAL PROJECTS - C&A AD SERVICES	-	-	-	901
	CLUBHOUSE PROGRAM	-	-	-	906

*NOTES: 1. The above numbers are stand alone programs. Budgets and Expenses should be reported against these numbers.

FY11 UAS Budget & Expense Numbers

DEVELOPMENTAL DISABILITIES

	BUDGET	EXPENSES
DEVELOPMENTAL DISABILITIES	400	
DAY SUPPORTS		
COMMUNITY ACCESS GROUP	-	401
COMMUNITY ACCESS INDIVIDUAL	-	402
PREVOCATIONAL	-	403
SUPPORTED EMPLOYMENT		
SUPPORTED EMPLOYMENT INDIVIDUAL	-	406
SUPPORTED EMPLOYMENT GROUP	-	407
RESIDENTIAL		
COMMUNITY RESIDENTIAL SUPPORTS	-	411
COMMUNITY LIVING SUPPORTS	-	412
BEHAVIORAL SUPPORT TEAM SERVICES	-	421
FAMILY SUPPORTS - M.R.	-	422
RESPIRE	-	423

- *NOTES: 1. Budget Program Numbers appear in the column labeled budget.
 2. Service Program Numbers (Subprograms) for expense reporting appear in the column labeled expenses below the appropriate budget number.

OTHER BUDGET PROGRAMS / FUND SOURCES

	BUDGET	EXPENSES
OTHER PROGRAMS / FUNDING		
SPECIAL PROJECTS - DD SERVICES	501	-
SPECIAL APPROPRIATION - MR	502	-
AUTISM SERVICES	511	-
DD FAMILY SUPPORT	510	-
TANF MENTAL RETARDATION FUNDS	520	-

- *NOTES: 1. Budget Program Numbers appear in the column labeled budget.
 2. Service Program Numbers (Subprograms) for expense reporting appear in the column labeled expenses below the appropriate budget number.

Georgia Department of Human Resources
BUDGET EXPENSE and RESOURCE SUMMARY for Region _____
Payment For Services or Fixed Rate Contract

Number
Description

DIVISION: 030 Mental Health, Developmental Disabilities & Addictive Diseases **REPORT CCYYMM:** _____
LOCAL AGENCY: _____ **BUDGET APPROVAL CODE:** 0
BUDGET PROGRAM: _____ **BUDGET REVISION:** _____

PROPOSED EXPENSES

SCOA	Description	CURRENT BUDGET	+	ADJUSTMENT +/-	=	REVISED BUDGET
622.003	Payment for Services or Fixed Rate Contract	_____		_____		_____

PROPOSED RESOURCES

Fund Source	Description	CURRENT BUDGET	+	ADJUSTMENT +/-	=	REVISED BUDGET
8001	Payment for Services or Fixed Rate Contract	_____		_____		_____

AGENCY SIGNATURE

I certify that to the best of my knowledge, the information on this summary is a true and accurate statement of the expenses and consumers served for the specified month.

Authorized Agency Signature

Date

Title

DMHDDAD SIGNATURE

Reviewed By:

Authorized DMHDDAD Signature

Date

Georgia Department of Human Resources

MONTHLY INCOME AND EXPENSE REPORT for Region _____
Payment For Services or Fixed Rate Contract

	<u>Number</u>	<u>Description</u>	
DIVISION:	<u>030</u>	Mental Health, Developmental Disabilities & Addictive Diseases	REPORT CCYYMM: _____
LOCAL AGENCY:	_____	_____	REPORT BASIS (CASH): <u>C</u>
BUDGET PROGRAM:	_____	_____	BUDGET REVISION: _____

AGENCY SIGNATURE	
<p>I certify that to the best of my knowledge, the information on this summary is a true and accurate statement of the expenses and consumers served for the specified month.</p>	
_____ Authorized Agency Signature	_____ Date
_____ Title	
DMHDDAD SIGNATURE	
<p>Reviewed By:</p>	
_____ Authorized DMHDDAD Signature	_____ Date

Georgia Department of Human Resources

BUDGET EXPENSE and RESOURCE SUMMARY for Region _____
Expense Reimbursement Contract

Number _____ Description _____

DIVISION: 030 Mental Health, Developmental Disabilities & Addictive Diseases **REPORT CCYMM:** _____

LOCAL AGENCY: _____ **BUDGET APPROVAL CODE:** 0

BUDGET PROGRAM: _____ **BUDGET REVISION:** _____

PROPOSED EXPENSES				
SCOA	Description	CURRENT BUDGET	+ ADJUSTMENT +/-	= REVISED BUDGET
	Direct Salaries			
511.001	Salaries	_____	_____	_____
	Other Operating			
627.001	Other Operating Expenses	_____	_____	_____
	Equipment			
643.001	Equipment (\$1000 or more)	_____	_____	_____
TOTAL PROPOSED EXPENSES		=====	=====	=====

PROPOSED RESOURCES				
Fund Source	Description	CURRENT BUDGET	+ ADJUSTMENT +/-	= REVISED BUDGET
6001	County Participating	_____	_____	_____
6002	County Cash Match	_____	_____	_____
6004	County Non-Participating	_____	_____	_____
6006	Municipal	_____	_____	_____
6008	Outpatient Medicare Fees	_____	_____	_____
6009	Outpatient Medicaid CY Fees	_____	_____	_____
6013	DOE Contracts	_____	_____	_____
6015	Client Fees	_____	_____	_____
6016	Private Insurance	_____	_____	_____
6017	Other Fees	_____	_____	_____
6018	Contracts	_____	_____	_____
6020	Hospital Authority	_____	_____	_____
6021	Other Local Funds	_____	_____	_____
6024	Prior Year Program Income	_____	_____	_____
6028	Medicaid Pharmacy	_____	_____	_____
6030	MRDS Work Activity	_____	_____	_____
6032	Medicaid Waiver CY Fees	_____	_____	_____
6039	Outpatient Medicaid PY Fees	_____	_____	_____
6042	Insurance Reimbursement	_____	_____	_____
6047	Medicaid Waiver PY Fees	_____	_____	_____
7014	Direct Federal Funds	_____	_____	_____
8001	GRANT-IN-AID	_____	_____	_____
8002	DHR Contracts	_____	_____	_____
TOTAL PROPOSED RESOURCES		=====	=====	=====

Georgia Department of Human Resources
BUDGET EXPENSE and RESOURCE SUMMARY for Region _____
Expense Reimbursement Contract

	<u>Number</u> _____	<u>Description</u> _____	
DIVISION:	<u>030</u>	Mental Health, Developmental Disabilities & Addictive Diseases	REPORT CCYYMM: _____
LOCAL AGENCY:	_____	_____	BUDGET APPROVAL CODE: <u>0</u>
BUDGET PROGRAM:	_____	_____	BUDGET REVISION: _____

AGENCY SIGNATURE	
I certify that to the best of my knowledge, the information on Page 1 of this summary is a true and accurate statement of the revenues and expenses for the specified month.	
_____ Authorized Agency Signature	_____ Date
_____ Title	
DMHDDAD SIGNATURE	
Reviewed By:	
_____ Authorized DMHDDAD Signature	_____ Date

Georgia Department of Human Resources
MONTHLY INCOME AND EXPENSE REPORT for Region _____
Expense Reimbursement Contract

Number _____ Description _____

DIVISION: 030 **Mental Health, Developmental Disabilities & Addictive Diseases** **REPORT CCYYMM:** _____

LOCAL AGENCY: _____ **REPORT BASIS (CASH):** C

BUDGET PROGRAM: _____ **ACCUAL CCYYMM:** _____

CURRENT EXPENSES

SCOA	Description	Amount	SCOA	Description	Amount
511.001	Salaries	_____	622.001	Direct Benefits to Clients	_____
511.002	Local Salary Supplement	_____	622.002	Pay For Services/Fixed Rate	_____
511.201	Overtime	_____	622.031	M.R. Work Activity Salaries	_____
513.001	Hourly Labor	_____	622.044	Room and Board	_____
514.001	FICA	_____	622.045	Respite Care	_____
514.002	FICA-Local Supplement	_____	622.046	Training	_____
514.201	FICA-Overtime	_____	622.047	Personal Allowances	_____
515.001	Retirement	_____	627.001	Other Operating Expenses	_____
516.001	Health Insurance	_____	633.001	Computer Software	_____
516.002	Health Ins – Local Supplement	_____	640.001	Travel	_____
516.201	Health Ins – Overtime	_____	640.002	Travel Supplement	_____
517.001	Personal Liability Ins - Employee	_____	641.001	Motor Vehicle Equip Purchases	_____
518.001	Unemployment Insurance	_____	643.001	Equipment (\$1000 or more)	_____
519.001	Workers Compensation	_____	644.001	Lease Purchase of Equipment	_____
520.001	Assessment by Merit System	_____	645.001	Rental of Equipment	_____
612.001	Motor Vehicle Expense	_____	646.001	Equipment (Less than \$1000)	_____
614.001	Supplies and Materials	_____	648.001	Building Rent	_____
614.006	Food Supplies	_____	651.001	Per Diem & Fees	_____
614.018	Pharmaceuticals	_____	653.001	Contracts	_____
615.001	Repairs and Maintenance	_____	673.001	Telecommunications	_____
617.001	Utilities	_____	681.001	Postage	_____
618.001	Printing	_____			
620.001	Insurance and Bonding	_____			
			TOTAL		_____

FUND SOURCES TO COVER CURRENT EXPENSES

Fund Source	Description	AMOUNT	Fund Source	Description	AMOUNT
6001	County Participating	_____	6021	Other Local Funds	_____
6002	County Cash Match	_____	6024	Prior Year Program Income	_____
6004	County Non-Participating	_____	6028	Medicaid Pharmacy	_____
6006	Municipal	_____	6030	MRDS Work Activity	_____
6008	Outpatient Medicare Fees	_____	6032	Medicaid Waiver CY Fees	_____
6009	Outpatient Medicaid CY Fees	_____	6039	Outpatient Medicaid PY Fees	_____
6013	DOE Contracts	_____	6042	Insurance Reimbursement	_____
6015	Client Fees	_____	6047	Medicaid Waiver PY Fees	_____
6016	Private Insurance	_____	7014	Direct Federal Funds	_____
6017	Other Fees	_____	8001	GRANT-IN-AID	_____
6018	Contracts	_____	8002	DHR Contracts	_____
6020	Hospital Authority	_____			
			TOTAL		_____

GA DHR GRANTS-TO-COUNTIES			
POLICY AND PROCEDURES MANUAL	4/79	1	PART 11 K 1
SECTION 1: POLICY			

SUBJECT: USE OF PROGRAM INCOME
 Legal Reference: 1. Code of Federal Regulations: 45 CFR-Part 74
 2. Georgia Code Annotated: 99-144

- A. For purposes of this policy, program income shall be defined as income from all sources earned by a grantee from the grant supported program(s). This policy does not apply to interest income, income such as sales of property, royalties, copyright, etc. as defined in 45 CFR 74.43 through 74.47.
- B. The DHR policy on program income is established pursuant to 45 CFR-Part 74, Sub-part F (Grant Related Income). These regulations establish the requirements for the receipt and expenditure of general program income in all Federal grants and contracts administered by DHR either directly or through sub-grants to other agencies. The general provisions as incorporated by DHR in this policy have been expanded to apply to State funds utilized by grantees, sub-grantees, and contractors as well.
- C. General program income shall be retained by the recipient and used in accordance with one or a combination of the alternatives indicated below.
 - 1. Deduction Alternative: Under this alternative, the income is used for allowable costs of the project or program. If there is cost sharing or matching requirements, costs borne by the income may not count toward satisfying that requirement. Therefore, the maximum percentage of Federal participation is applied to the net amount determined by deducting the income from total allowable costs and third party in-kind contributions. This alternative may always be used and must be used if neither of the following alternatives is specifically allowed under the provisions of the DHR grant award document.
 - 2. Cost Sharing or Matching Alternative: Under this alternative, the income is used for allowable costs of the project or program but, in this case, the costs borne by the income may count toward satisfying a cost sharing or matching requirement. Therefore the maximum percentage of Federal and State participation is applied to total allowable costs and third party in-kind contributions. This method may be used only when specifically allowed in writing by the DHR grant award document.
 - 3. Additional Costs Alternative: Under this alternative, the income is used for costs which are in addition to the allowable costs of the project or program but which nevertheless, further the objectives for which the grant was made. Provided that the costs borne by the income further the broad objectives of the grant, they need not be of a type specifically allowable under the provision of Appendix C of 45 CFR-Part 74. This method may be used only when specifically allowed in writing by the DHR grant award document. Example of purposes for which the income may be used are set forth as follows:
 - A. Expanding or extending the project or program beyond the grant period.
 - B. Supporting other projects or programs that further the broad objectives of the statute.
 - C. Obtaining equipment or other assets needed for the project or program, or for their actives that further the statute=s objectives.

GA DHR GRANTS-TO-COUNTIES

POLICY AND PROCEDURES MANUAL

4/79

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PART 11 K 1

May 2000

- D. All such funds are subject to the appropriate budgeting, accounting, auditing reporting and other financial requirements of the Department including those found elsewhere in this manual.
- E. Within the scope of these regulations, DHR recommends that all such program income be retained by the grantee and used, immediately if needed, to expand the range or improve the quality of services authorized under the State/local grant agreement. Otherwise, such funds should be deducted from the total costs in which DHR and/or Federal grant funds may participate. However, in some cases where specifically allowed by the DHR grant award document, program income can be counted towards satisfying a cost sharing or matching requirement.

SECTION II: PROCEDURES

- A. Initial DHR Grant Award Document: Prior to the beginning of each state fiscal year (July 1), the appropriate Division will notify the grantee of the grant amount available for the program(s) for the fiscal year. The grantee and Division must then execute the DHR grant award, including a detailed budget plan for the fiscal year July 1 to June 30. Both an estimate of program income revenue and expenditures must be included in this budget. The grantee must also attach a fee/rate/program income schedule for the program.
 - 1. It is intended that program income will be budgeted and used as it is earned. If, however, a balance of program income funds exists as of June 30 of any fiscal year, it may be carried forward into the next fiscal year for 12 months. The funds may be budgeted at the time the initial annual grant award document is executed for the following fiscal year. Prior year funds must be distinguished from projected current year income and treated as a separate fund source. A detailed plan for assuring utilization of prior year income within that fiscal period must be attached to the DHR grant award document.
- B. Budget revisions: Budget amendments will be processed during the year in accordance with appropriate budget procedures included elsewhere in this manual. Any changes in projected program income and expenditures must be incorporated into the grant award by revision.
- C. Reporting: Monthly Grants-to-Counties reimbursement requests must include both revenues and expenditures by fund source, including program income. These are for reporting purposes only. Detailed transaction records for audit purposes must be maintained by the grantee on each fund source including current and/or prior year program income.

SECTION III: PROPONENCY AND AUTHENTICATION

Proponent Division/Office:	Office of Budget Administration
Proponent Section:	N/A
Contact Name:	Dotty Roach
Section Telephone:	(404) 656-4472 GIST 221-4472

Attachments: None

Commissioner

May 2000

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "Subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal contract number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.
 (b) Enter the full names of the individuals(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI)
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (Planned) Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be make.
12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.
13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.
14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with Federal officials. Identify the Federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.
15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.
16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget. Paperwork Reduction Project (03 48-0046), Washington, D.C. 20503.

DISCLOSURE OF LOBBYING ACTIVITIES
 Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352

<p>1. Type of Federal Action:</p> <div style="border: 1px solid black; height: 20px; margin-bottom: 5px;"></div> <ul style="list-style-type: none"> <input type="checkbox"/> contract <input type="checkbox"/> grant <input type="checkbox"/> cooperative agreement <input type="checkbox"/> loan <input type="checkbox"/> loan guarantee <input type="checkbox"/> f. loan insurance 	<p>2. Statue of Federal Action</p> <div style="border: 1px solid black; height: 20px; margin-bottom: 5px;"></div> <ul style="list-style-type: none"> <input type="checkbox"/> bid/offer/application <input type="checkbox"/> initial award <input type="checkbox"/> post-award 	<p>3. Report Type</p> <div style="border: 1px solid black; height: 20px; margin-bottom: 5px;"></div> <ul style="list-style-type: none"> <input type="checkbox"/> initial filing <input type="checkbox"/> material change <p>For Material Change Only: year _____ quarter _____ date of last report _____</p>
<p>4. Name and Address of Report Entity:</p> <p><input type="checkbox"/> Prime <input type="checkbox"/> Subawardee Tier _____, if known:</p> <p>Congressional District, if known: _____</p>		<p>5. If reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime</p> <p>Congressional District, if known: _____</p>
<p>6. Federal Department/Agency:</p>	<p>7. Federal Program Name/Description:</p> <p>CFDA Number, if applicable: _____</p>	
<p>8. Federal Action Number, if known:</p>	<p>9. Award Amount, if known:</p> <p>\$ _____</p>	
<p>10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI)</p>		<p>b. Individuals Performing Services (including address if different from No. 10a)</p> <p>(last name, first name, MI)</p>
<p>(attach Continuation sheet(s) if necessary)</p>		
<p>11. Amount of Payment (check all that apply):</p> <p>\$ _____ <input type="checkbox"/> actual <input type="checkbox"/> planned</p>	<p>13. Type of Payment (check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> a. retainer <input type="checkbox"/> b. one-time fee <input type="checkbox"/> c. commission <input type="checkbox"/> d. contingent fee <input type="checkbox"/> e. deferred <input type="checkbox"/> f. other, specify; _____ 	
<p>12. Form of Payment (check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> a. cash <input type="checkbox"/> b. in-kind: specify: nature _____ value _____ 		
<p>14. Brief Description of Services Performed or to be Performed and Date(s) of Service, including officer(s), employee(s), or Member(s) contacted, for Payment indicated in Item 11: (attach Continuation sheet(s) if necessary)</p>		

15. Continuation Sheet(s) SF-LLL-A attached: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.</p>	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____
Federal Use Only:	

DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Reporting Entity: _____ Page ____ of ____

Georgia Department of Human Resources
SUPPORTING BUDGET SCHEDULE: EQUIPMENT PURCHASES
 for the Fiscal Year July 1, 20__ through June 30, 20__

Division #030			Program #		
Local Agency #	Local Agency Name	Program Name	Budget Revision #		
Description	No Units	Program	Unit Cost	Total Cost	
Total					

I certify that the information on this schedule is a complete and accurate detail of Equipment Purchases.

- DHR: Approval
 Approval w/Exception
 Disapproval

Board Chairperson or Executive Director

Signature

Date

Form 1240 (2-00)

May 2000

Georgia Department of Human Resources
SUPPORTING BUDGET SCHEDULE: INTRA/INTER AGENCY TRANSACTIONS
 for the Fiscal Year July 1, 20__ through June 30, 20__

Division #030			Program #		
Local Agency #	Local Agency Name	Program Name	Budget Revision #		
Program #	Program Name	Transaction Purpose		Annual Amount	

NOTE: For each transaction, attach a cost allocation plan indicating the basis of valuation.

- DHR: Approval
 Approval w/Exception
 Disapproval

I certify that the information on this schedule is a complete and accurate detail of Intra/Inter Agency Transactions.

Board Chairperson or Executive Director

Signature **Date**

Form 1241 (2-00)

May 2000

Georgia Department of Human Resources
SUPPORTING BUDGET SCHEDULE: DEPRECIATION CHARGES
 for the Fiscal Year July 1, 20__ through June 30, 20__

Division #030			Program #		
Local Agency #	Local Agency Name	Program Name	Budget Revision #		
Address of Property	Depreciation Base (1)	Useful Life	Depreciation Method (2)	Depreciation Charge (3)	

- 1) Original acquisition cost less land and state/federal participation.
- 2) Straight line, double declining balance, or sum of the years digits.
- 3) Attach a schedule of depreciation charges over the useful life of the property, for each piece of property.

DHR: Approval
 Approval w/Exception
 Disapproval

I certify that the information on this schedule is a complete and accurate detail of Depreciation Charges.

Board Chairperson or Executive Director

Signature **Date**

Form 1243 (2-00)

May 2000

Georgia Department of Human Resources
SUPPORTING BUDGET SCHEDULE: NON-PARTICIPATING EXPENSES
 for the Fiscal Year July 1, 20__ through June 30, 20__

Division #030		Program #	
Local Agency #	Local Agency Name	Program Name	Budget Revision #
Expense Category	Description	Position # (if applicable)	Annual Amount

I certify that the information on this schedule is a complete and accurate detail of Non-Participating Expenses.

DHR: Approval
 Approval w/Exception
 Disapproval

Board Chairperson or Executive Director

Signature **Date**

Form 1244 (2-00)

May 2000

Georgia Department of Human Resources
SUPPORTING BUDGET SCHEDULE: REVENUE
 for the Fiscal Year July 1, 20__ through June 30, 20__

Division #030		Program #	
Local Agency #	Local Agency Name	Program Name	Budget Revision #
Revenue Category	Description	Position # (if applicable)	Annual Amount

I certify that the information on this schedule is accurate.

- DHR: Approval
 Approval w/Exception
 Disapproval

Board Chairperson or Executive Director

Signature **Date**

Form 1272 (2-00)

May 2000