



Children's Mental Health Bureau Non-Medicaid Services Provider Manual

October 1, 2015

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Chapter 1 - Children's Mental Health Bureau (CMHB) Non-Medicaid Services Programs

Introduction

It is the goal of the Bureau to provide comprehensive and easy to navigate information regarding the Non-Medicaid services. As such, this proposed manual titled, "Children's Mental Health Bureau Non-Medicaid Services Provider Manual" (manual), dated October 1, 2015 supersedes the previous version dated September 19, 2014. The majority of the information provided in this manual remains the same as in its predecessor and has been simply been reformatted, however, there are changes that are important to note:

- (a) Non-Medicaid respite services have been added to this manual and the previous rules pertaining to this service are being repealed. As such, all of the CMHB Non-Medicaid service requirements are located in one place.
- (b) Language has been added to clarify how R&B and SOCA may be used for youth in state or tribal custody;
- (c) Further information pertaining to income guidelines including the determination of family income and how income is calculated for joint income, Social Security Income, SSI and SSDI; and
- (d) To further define the acceptable uses for Non-Medicaid funding sources.

Overview

The Children's Mental Health Bureau (CMHB) in the Developmental Services Division administers the CMHB non-Medicaid services programs for youth with serious emotional disturbances. Supplemental Services Program (SSP), Room and Board Account (R&B), System of Care Account (SOCA), and Respite care services are CMHB non-Medicaid services that are for short-term use and are not entitlement programs.

SSP, R&B, and SOCA

Planning efforts toward family reunification must be the primary objective, with transition planning essential for youth in out-of-home care. Goals consistent with SSP, R&B, and SOCA include:

- (a) prevent youth placement at a higher level of care;
- (b) step youth down from psychiatric residential treatment facility (PRTF) level of care;
- (c) return the youth to his/her home;
- (d) stabilize the family to increase the likelihood that the youth can remain at home; and/or
- (e) maintain the youth in his/her current "in-home" placement and avoid higher levels of care.

SSP, R&B, and SOCA are only available when Healthy Montana Kids Plus (HMK Plus/Medicaid) or Healthy Montana Kids (HMK/CHIP) with Extended Mental Health Benefit plan do not cover the requested service. Services are provided under capped appropriations. Services will not be authorized beyond available funding.

Youth means: a person who is less than 18 years of age without regard to sex or emancipation.

EXCEPTIONS: For the purpose of this manual, the reference of a youth may be a person who has not yet attained age 19 if the person is enrolled in a secondary school program or is enrolled in HMK. A youth may be an individual who has not yet attained age 20 if still in secondary school and covered by HMK Plus.

SSP, R&B, and SOCA services must be:

- (a) specified in the integrated treatment plan of the youth;
- (b) identified as part of a planning process that includes the family and youth, when appropriate;
- (c) related to the mental health needs of the youth;
- (d) not eligible for reimbursement from any other source; and
- (e) prior-authorized by CMHB.

SSP, R&B, and SOCA may not be used for the following:

- (a) therapeutic group care (except for room and board);
- (b) therapeutic foster care (except for room and board);
- (c) inpatient hospitalization;
- (d) cash assistance;
- (e) public assistance provided by TANF, e.g. food, rent, utilities, clothing, etc;
- (f) to extend coverage limits to services already covered under Medicaid or HMK extended; and
- (g) items that are purely recreational in nature.

Funding for therapeutic group or therapeutic foster care must have a written plan in place for appropriate discharge. Placement priority must be given to a group home or therapeutic foster home closest to the community in which the family resides. The CMHB may require documentation of all providers who were contacted for services for the child as well as the dates they were contacted.

It is crucial that youth have permanency. In the event a youth is unable to return to the family home or parent/legal representative refuses to take a youth home or make suitable arrangements for another appropriate caretaker upon discharge from the group home or foster care, the therapeutic group home or foster care provider must make efforts towards improved permanency and stability which may require multi-agency planning, including a referral to Child and Family Services for assistance with permanency for the youth. When it is anticipated that a youth will need adult services, a referral for the appropriate adult service must be scheduled no less than six months prior to the 18th birthday of the youth.

Parental contributions are expected whenever possible. The SSI of the youth and adoption or guardianship subsidies are expected to be used toward the cost of room and board when the youth is out of the home. When a youth has an adoption subsidy, the parent must contact the Child and Family Services adoption Subsidy Program Officer to renegotiate the subsidy and request consideration for the balance of room and board from post adoption funds. If the CMHB receives written verification from a CFS representative knowledgeable and involved with the funding of post adoption services, CMHB may consider assisting with funding.

Funding may be terminated if the parent/legal representative is not participating in the treatment of the youth. If a parent/legal representative elects not to have the youth return to their home following initial non-Medicaid services approval, funding may be terminated. When the youth is in an out of home placement funded by non-Medicaid services, the parent/legal representative is expected to:

- (a) participate in family therapy;
- (b) maintain regular telephone contact; and
- (c) have in person visits when possible.

Chapter 2 – Supplemental Services Program (SSP)

The purpose of SSP is to strengthen families and support their ability to work. SSP is reimbursed by state general fund Maintenance of Effort (MOE) from Temporary Assistance for Needy Families (TANF) and is considered a non-assistance program by TANF. Youth receiving SSI, adoption or guardianship subsidies, or who are enrolled in a Medicaid waiver may be over income for SSP. SSP must be the fund of first choice for all applicable service requests if the youth/family meets the eligibility criteria.

Services must be directed at the stabilization and preservation of the family and the youth and ultimately at treatment of the youth in the home environment if the youth is out of the home. SSP requires that discharge be to the parent (biological or adoptive) or specified relative caretaker within the fifth degree (refer to appendix for definitions). An acceptable alternative is the home of a specified caretaker relative within the fifth degree of kinship who is willing to become the legal representative of the youth.

- These funds are for short-term use and cannot exceed four months in a twelve month federal fiscal year (October 1-September 30), regardless of service cost or the service provided. The four months do not have to be consecutive.
- There must be a one month break between two month service periods in consecutive federal fiscal years. Services provided on any day in a month make that month count as one of the four allowed.
- The four-month time limit for SSP applies to the entire family. Therefore, if one child uses the entire four months for services, no other family member is eligible for SSP funding until the beginning of the next federal fiscal year.
- Flexible funding within other agencies and from other sources, when available, must be considered prior to, or in conjunction with, SSP funds.

For SSP funded services except for room and board, the following is required:

(a) The CMHB **MUST** be invited to participate in all treatment team meetings held during the time non-Medicaid services funding is provided. The CMHB has the discretion to attend or utilize a different format to review the service funded. Funding may be terminated if the CMHB is not invited to participate in treatment team meetings held on behalf of the youth by the agency receiving funding.

(b) For each month of non-Medicaid service funding, the provider must submit the Monthly Report form to the CMHB by the 10th working day of the following month. The Monthly Report form will be attached to the authorization letter. The report form can be found on the bureau web site:

<http://www.dphhs.mt.gov/dsd/CMB/CMHBforms.aspx>. The completed report must either be sent via fax, telephone, USPS mail and/or secure e-mail.

Eligibility Criteria

In order to be considered eligible for SSP the youth must:

- (a) have a qualifying SED diagnosis as defined in ARM 37.87.903;
- (b) receive HMK Plus (Medicaid) or HMK (CHIP) Extended Mental Health Benefit Plan;

(c) have a countable family income at or below 185% of the Federal Poverty Level (FPL). A youth cannot be counted as a family of one for income purposes. Countable income and family size will be determined according to HMK rules;

(d) be in the legal custody of a parent or parents (biological or adoptive) or another specified caretaker relative.; and

(e) if the request is for room and board, have a prior authorization for TGH therapeutic services from Healthy Montana Kids Plus (HMK Plus/Medicaid) or Healthy Montana Kids (HMK/CHIP).

A youth may NOT receive SSP funding when the youth:

(a) is in the custody of any state or tribal agency;

(b) has been adjudicated as a delinquent youth or youth in need of intervention under provisions of the Montana Youth Court Act;

(c) has pending or active charges either in youth court or adult court, the youth may be ineligible for SSP funding;

(d) is absent from home greater than 90 consecutive days, except 1) for the purpose of receiving medical care, including residential treatment or therapeutic group home or 2) to attend boarding school if they are expected to return to the parent at the end of the school year;

(e) it is determined that a youth will NOT return to a parent or a relative caretaker within the fifth degree of kinship. CMHB must be notified when this determination is made. SSP funding will be terminated. This applies to youth entering Job Corps, Project Challenge, or independent living arrangements.

*****See Appendix A for frequently asked questions and definitions pertaining to SSP.**

Chapter 3 – CMHB Room and Board Account

CMHB Room and Board Account

CMHB Room and Board Account is directed to therapeutic group homes and therapeutic foster care in order to prevent youth from going into higher levels of care and is reimbursed with state general fund as authorized by the 2013 Legislature. If all other eligibility requirements are met, the youth may be considered for Room and Board Account funding. The income limit for CMHB Room and Board Account is up to 400% of federal poverty level. Income limits must be evidenced by the Non-Medicaid Services Program Financial Attestation and countable income and family size is determined in accordance with HMK rules. Approvals are limited to four months with full applications required for additional time periods.

Eligibility Criteria

In order to be considered eligible for CMHB Room and Board Account a youth must:

- (a) have a qualifying SED diagnosis as defined in ARM 37.87.903;
- (b) receive either HMK Plus or HMK Extended Mental Health Benefit Plan;
- (c) have a countable family income at or below 400% of the Federal Poverty Level (FPL). A youth cannot be counted as a family of one for income purposes. Countable income and family size will be determined according to HMK rules;
- (d) be receiving treatment in Montana; and
- (e) have a prior authorization for TGH therapeutic services from Healthy Montana Kids Plus (HMK Plus/Medicaid) or Healthy Montana Kids (HMK/CHIP).

The following sliding fee schedule is applied to determine the level of funding provided:

Federal Poverty Level	% of Funding Provided
0 to 185%	100%
186 to 250%	95%
251 to 300%	85%
301 to 400%	80%
≥401%	0%

***CMHB Room and Board Account may not be used to pay room and board for out-of-state placements.**

Chapter 4 – System of Care Account (SOCA)

The purpose of this service is to allow high risk youth with multi-agency service needs to be served in the least restrictive and most appropriate setting. The funding for System of Care Account (SOCA) comes from CMHB's general fund appropriation, as authorized by 52-2-309, MCA. Multi-agency service needs means the youth is currently involved with at least two of the following governmental agencies, either formally or informally.

- Children's Mental Health Bureau
- Developmental Disabilities
- Child and Family Services
- Chemical Dependency
- Youth Court
- Department of Corrections
- Tribal agencies (please list)
- Special Education (as identified as a youth with special education needs and has an Individualized Education Plan).

The services the youth receives:

- (a) must provide for the care and protection and mental, social, and physical development of the high risk youth with governmental multi-agency service needs; and
- (b) must maintain the youth in a community setting or return the youth to a community setting as a priority.

For SOCA funded services except for room and board, the following is required:

- (a) The CMHB **MUST** be invited to participate in all treatment team meetings held during the time non-Medicaid services funding is provided. The CMHB has the discretion to attend or utilize a different format to track the service funded. Funding may be terminated if the CMHB is not invited to participate in treatment team meetings held on behalf of the youth by the agency receiving funding.
- (b) For each month of non-Medicaid service funding, the provider must submit the Monthly Report form to the CMHB by the 10th working day of the following month. The Monthly Report form will be attached to the authorization letter. The report form can be found on the bureau web site:
<http://www.dphhs.mt.gov/dsd/CMB/CMHBforms.aspx>

The completed report must either be sent via fax, telephone, USPS mail, or secure e-mail.

Eligibility Criteria

In order to be considered eligible for SOCA the youth must

- (a) have a qualifying SED diagnosis as defined in ARM 37.87.903;
- (b) receive HMK Plus; and
- (c) the youth must be at high risk for one of the following:
 - (i) needing more restrictive level of care;

- (ii) remaining in restrictive level of care if no other appropriate placement options are available;
 - (iii) posing a safety risk to self or others; and
 - (iv) having multiple treatment or placement failures.
- (d) if the request is for room and board, have a prior authorization for TGH therapeutic services from Healthy Montana Kids Plus (HMK Plus/Medicaid) or Healthy Montana Kids (HMK/CHIP).

Chapter 5 – Non-Medicaid Respite

Non-Medicaid respite care services are temporary short-term relief services that allow family members, who are regular care givers of a youth with a serious emotional disturbance to be relieved of their care giver responsibilities.

- (1) Providers of CMHB non-Medicaid respite care services must be a licensed:
 - (a) mental health center; or
 - (b) therapeutic foster home.
- (2) Persons delivering CMHB non-Medicaid respite care services must be employed by a provider agency or be a therapeutic foster parent.
- (3) The individualized treatment plan must document CMHB non-Medicaid respite care in accordance with ARM 37.106.1916(1)(c).
- (4) The provisions of ARM 37.85.402 apply for purposes of provider enrollment.
- (5) The provisions of ARM 37.85.414 apply for purposes of provider record keeping and retention.
- (6) A provider of CMHB non-Medicaid respite care services must ensure that its employees or a licensed therapeutic foster parent providing the services are:
 - (a) physically and mentally qualified to provide this service to the youth;
 - (b) aware of emergency assistance systems and crisis plans;
 - (c) knowledgeable of the physical and mental conditions of the youth;
 - (d) knowledgeable of the safety, risks, and proper administration or supervision of medications the youth requires; and
 - (e) capable of administering basic first aid.

Eligibility Criteria

- (1) The youth must be receiving the following Medicaid funded mental health services:
 - (a) home support services (HSS);
 - (b) therapeutic foster care (TFC) services; or
 - (c) upon authorization by the department.
- (2) The youth must be 17 years of age or younger.

Chapter 6 – SSP and SOCA Covered Services

SSP and SOCA covered services may include:

Mental Health Treatment

(a) In-home support and/or therapy for the youth and the family or the family alone if the youth is out of the home. These services will be billed on a fee-for-service basis;

(b) Training and education to include parenting classes, parental education on mental illness, or Wellness Recovery Action Plan (WRAP) training; and

(c) Evaluation of the parent or relative/legal representative in order to assess that person's ability to meet the needs of the youth, with an emphasis on making recommendations to support the person in this role.

Community-Based Services

Community- Based services including developmentally appropriate activities that promote the inclusion and social skills development for the youth. This may also include opportunities to strengthen the culture of the youth.

Hard Services (equipment)

Hard services (equipment) not covered by HMK Plus or HMK Extended Mental Health Benefit Plan that are beyond the ability of the family to provide. Expenses under this category may not include construction, appliances, or transportation methods. Equipment must be

(a) specified in the treatment plan of the youth; and

(b) be considered necessary to treat the youth's serious emotional disturbance.

Transportation

Transportation related to the mental health needs of the youth when it is not covered by HMK Plus or HMK Extended Mental Health Benefit Plan. Requirements for transportation related services are as follows:

(a) Transportation reimbursement requires additional prior authorization from CMHB bureau chief and fiscal services. CMHB Non-Medicaid Services Program may not pay an additional amount when travel is covered at Medicaid rates.

(b) efforts must be made to cost share with the parent;

(c) travel requires additional approval from the department;

(d) original receipts must be submitted to CMHB for reimbursement;

(e) travel rates will be reimbursed at the same rate as state employee travel rates including per diems.

(f) CMHB may pay to pre-purchase airline tickets and hotel reservation in some situations;

(g) an advance for meals, mileage or related travel expenses is not available; and

(h) unless otherwise stated, Non-Medicaid Services Program will use state travel policy and procedure for both in-state and out-of-state travel.

For more information about Medicaid Transportation and per Diem requirements, look at ARM 37.86.2402 and the state travel policies.

Specialized Discharge Training

Training, either in the community or at the facility, must be for caregivers and providers who will serve the child after discharge.

(a) Training and travel costs for the parents or other family members responsible for direct care of the youth must be related to preparing for the discharge of the youth and eventual return home within one month.

(b) Other caregivers, including those employed by a provider or a school, may also be authorized to travel for this purpose. Travel costs may only include transportation costs not covered by HMK Plus. (See Transportation for detail.)

Case Consultation

When this service is needed from a member of the care team of the youth and that service is not covered by HMK Plus or HMK. For example, when a youth receives therapy from an individual practitioner, that individual may assist the care team to develop treatment goals for the youth. All providers will receive the established fee for the services.

Other Services

Other services that meet all of the above eligibility criteria and support the purpose of the non-Non-Medicaid services may be considered at the discretion of the department as funding allows.

Chapter 7 – Request for SSP, R&B, and SOCA

All applications for SSP, R&B, and SOCA must be reviewed and approved by the CMHB. Electronic forms can be obtained on our website at: <http://www.dphhs.mt.gov/dsd/CMB/CMHBforms.aspx>

Do not email completed requests. Email does not meet Health Insurance Portability and Accountability Act (HIPAA) standards. Faxes must be HIPAA compliant.

- Requests must be submitted on the current Non-Medicaid Services application form available online or requested from the CMHB.
- Requests can be completed electronically and that is the preferred method. Requests that cannot be easily read or are incomplete will be returned to the applicant for correction.
- Medicaid coverage must be verified by the case manager of the youth before the application is submitted;
- HMK Extended Mental Health Benefit Plan enrollment must be verified by the CMHB.
- Requests for Non-Medicaid Services must provide enough information to help the CMHB understand how the funding will support the youth and family to remain or return home and to manage or recover from the symptoms of the illness of the youth.
- The application for all three funding sources **MUST** specify how the parent or relative/legal representative will be involved. Description of the family's past involvement is helpful. CMHB staff may request additional information before approving or denying the request.

CMHB will provide a written decision within fifteen (15) work days after the receipt of a completed application. When the request is approved, the department's designee will send a letter of approval (for all providers and services) setting forth the conditions, limits, rates, etc., to the provider identified for the service requested, to the youth case manager or referral source, and to the parent/legal representative. Approval may be provided for all, or only a portion, of the requested services at the discretion of CMHB.

If the request is *denied*, a letter will be sent to the parent/legal representative with a copy to the case manager, provider or other referral source. The letter will include a rationale for the denial.

If a denial is due to an incomplete application or financial attestation the provider must submit a new complete application in order to be considered; the Department will not retroactively authorize days.

Chapter 8 – Billing and Payment

SSP, R&B, and SOCA

Billing for SSP, R&B, and SOCA is submitted to CMHB (**not through HMK Plus or HMK**). The authorization letter will include billing instructions. Please refer to the letter for specific information regarding submission of the bill.

The provider must have a letter of approval from CMHB to receive payment for non-Medicaid services. Once the service has been provided, the provider can submit a monthly billing to CMHB based upon approved rates, limits, etc. as set forth in the letter of approval.

Billing for services must be on the provider's standard invoice form or letterhead and include the:

- (a) name of the service being billed;
- (b) dates and amount of the service provided;
- (c) rate (fee) for service and total billed;
- (d) name of the identified youth receiving services;
- (e) name of the provider of the service; and
- (f) the name, email, and phone number of a contact person for clarifying any invoice questions.

A W-9 form must be submitted with the billing or be on file with CMHB. The W-9 form may be obtained from the IRS website at:

<http://www.irs.gov/pub/irs-pdf/fw9.pdf>

- Billing must be **submitted within 10 workdays** following the month in which services were provided.
- CMHB may withhold payment if requested information, reports, etc. are not provided in a timely manner.
- Payment is limited to the services provided and to the terms set forth in the letter of approval provided by CMHB.
- Once the CMHB approves the invoice, it is processed for payment.

When a youth leaves or is no longer in need of SSP, SOCA or R&B, the provider must submit a discharge notification form prior to, or within 5 days, of the last date for which service is authorized to the CMHB financial officer via fax, USPS mail ~~and~~/or secure e-mail.

Respite

Providers must submit claims to the department's Medicaid Management Information System (MMIS) contractor according to requirements set forth in ARM 37.85.406. Payments will be made to the provider through the department's MMIS contractor.

- (1) Reimbursement for respite care services is as provided in the department's Medicaid fee schedule, as adopted in ARM 37.85.105.
- (2) Providers of respite care services must accept the amounts payable under this rule as payment in full for the respite care services provided.
- (3) Retroactive funds for CMHB non-Medicaid respite care services are not available.
- (4) CMHB non-Medicaid respite care services are limited to available funding each state fiscal year.

Appendix A

SSP: Frequently Asked Questions

1. Q: Does using SSP impact the TANF five-year time clock?

A: No. The use of these funds does not impact the five year time clock. Only “assistance” funds impact the time clock.

2. Q: Can a family use SSP for a one month period and then six months later, use the remaining three months?

A: Yes, as long as six months later still falls within the federal fiscal year. (October 1 through September 30). Four months of eligibility begins each federal fiscal year.

3. Q: If a family accesses SSP funds late in the month, does that constitute a month?

A: Yes. Any day in a month constitutes a month. For that reason, it may be preferable to begin the service early in the month.

4. Q: Medicaid transportation reimbursement rates are much lower than actual costs. Can SSP funds be used to assist with these additional costs?

A: No. SSP funds cannot be used to supplement Medicaid transportation rates. However, the SSP may be accessed for transportation, meals and hotel costs if the travel has been denied by Medicaid Transportation AND meets other SSP criteria. For example, Medicaid Transportation may cover airfare and hotel costs for one night when a parent picks up a youth discharging from a treatment facility. If Medicaid Transportation does not reimburse for the day of parent training at the facility, the uncovered meals, hotel and transportation may be covered at Montana state travel rates by SSP *if the travel has been pre-approved*.

5. Q: What if a family has more than one child with SED?

A: TANF rules allow a maximum of four months of service per family per federal fiscal year. In this case, the referral source should anticipate the needs of **all** SED youth in the family for the four month period.

6. Q: A family has two children in out of home care. When figuring the maximum family income for this program, are the youth in residential treatment centers counted in the family size?

A: Include these children in the family size if they've lived in the home 50% of the time during the last twelve months.

7. Q. Do you count all the adults in the family household?

A. The adults who are counted in the family size are those related to the youth receiving services by parentage, adoption/guardianship or marriage to a parent.

8. How is income calculated when parents have joint custody?

A. Both parents income is included on the income attestation. For family size only include the number of individuals living in the youth's primary residence plus the other legal parent.

9. Q. Do you include an 18 year old youth living in the home in family size?

A. All minor children in the family under age 18 are counted if they live in the home 50% of the time or more. Youth under age 23, living in the home at least 50% of the time, and attending school, including college, are also counted in the family.

10. Q. What if a plan does not call for reunification? For example, a youth is in an out of state and it becomes apparent after he has been there for a while that he/she will not be able to return to live with family.

A. Once it becomes clear that a youth cannot return home to his or her family, the child will lose eligibility for the use of the SSP funds. The child may still be eligible for other CMHB services.

11. Q. What else can be done for services after the four month limit?

A. The parent/guardian/another agency can assume responsibility for reimbursing the services. When supplemental services are no longer available after four months, the youth may still have their other coverage for mental health services through HMK Plus, HMK Extended Benefit.

12. Q. Is the four month limit within the federal fiscal year? Can you use four months at the end of the year and then an additional four months at the beginning of the next fiscal year for a total of eight consecutive months?

A. No. There must be a one month interval without services between two consecutive federal fiscal years.

13. Q. The manual states that a family cannot access SSP funds if they are receiving TANF cash assistance, does this include food stamps?

A. No.

14. Q. Regarding the four month limit, is there a difference between group home and foster care? Would each have four months of eligibility?

A. No. There is a four month limit on services regardless of the service provided.

15. Q. How do SSP and HMK work together?

A. A youth who is eligible for the HMK Extended Mental Health Benefit and whose family income is below 185% of poverty may be eligible for SSP.

16. Q. Will a rationale for a denial be provided in the appeal process?

A. Yes.

17. Q. If a youth loses HMK Plus coverage, will SSP pay for case management (under case consultation) for the case manager to find other funding, fill out forms for eligibility, etc.?

A. No. Case management is not the same as case consultation.

18. Q. Will SSP cover case management services for youth on HMK?

A. Not at this time.

19. Q. Could SSP be used to support a summer program, certain socialization activities?

A. Community-based services include developmentally appropriate activities that promote the youth's inclusion and social skills development. A summer program or other socialization activities must address specific symptoms of the youth's serious emotional disturbance and be included in the youth's treatment plan to be considered eligible for SSP. All other eligibility criteria of SSP must also be met.

20. Q. When would a youth with insurance coverage be eligible for SSP?

A. A youth with insurance coverage AND enrolled in HMK Plus may be eligible for SSP. A youth with insurance coverage is not eligible for HMK.

21. Q. Do all youth on HMK have access to SSP?

A. No. Only those on the HMK Extended Mental Health Benefit whose income is below 185% of poverty.

22. Q. Can a youth enroll in HMK, the HMK Extended Mental Health Benefit and SSP at the same time?

A. Yes. The three separate applications processes for these benefits could be coordinated for services to begin at the same time. HMK benefits begin on the first day of a month. Application for HMK Extended Mental Health Benefit requires an additional clinical assessment of the youth submitted so that a determination of SED can be made. Verification of Extended Benefit eligibility is necessary before SSP can be authorized.

23. Q. If HMK Plus does not cover the full cost of a service such as a music therapy program, can SSP help with the unreimbursed costs?

A. No. This is considered “supplanting.” Any agency that accepts HMK Plus for a reimbursable service must consider that reimbursement as full payment.

SSP Definitions

Month means: any day in the month. For example, services provided on July 25 constitutes one of the four allowable months. The four month period does not have to be consecutive.

Federal fiscal year means: October 1st through September 30th.

Specified Caretaker Relative to the fifth degree of kinship means: any relations by blood, marriage or adoption that is within the fifth degree of kinship to the youth. A specified relative caretaker may be one of the following:

- (a) Father, mother, grandfather, grandmother, brother, sister, uncle, aunt, first cousin, nephew, niece;
- (b) Great grandparent, great-great grandparent, great-great-great grandparent, great aunt, great uncle, great-great aunt and uncle;
- (c) Stepfather, stepmother, stepsister, stepbrother;
- (d) One who legally adopts the youth and his/her parent as well as the natural and other legally adopted children of such persons, and other relatives of the adoptive parents;
- (e) Spouses of anyone named in the above groups even after the marriage is terminated by death or divorce; or
- (f) First cousin once removed.

Custody means: the person (parent, relative) or entity (Child and Family Services (CFS), Department of Corrections (DOC), the District Court, or Tribal Court or Social Services, etc.) who has the legal authority and responsibility to provide for the day-to-day needs of the youth and to authorize treatment or placement.