Children's Mental Health Bureau
Non-Medicaid Services including Room and Board Application

Date of application: ____________________ Name of Youth: ____

Date of Birth: _________________________ Social Security Number: ____

This request is for: ☐ Initial Stay ☐ Continued Stay

Facility Name: ____

Proposed dates of service: ____

Is the youth living with family? ☐ Yes ☐ No If not, please complete the following:

Name of current placement and provider: ____

Date of Admission: ___________________ Address: ____

Contact person and phone number: ____

Email Address: ____

Name of youth's parent/legal guardian: ____

Mailing Address: _________________________________ City: ________________ State: _________ Zip: __________

Phone Number: __________________________________ Legal relationship to youth: ___________________________

Name of person submitting request: ____

Agency: ____ Phone Number: __________________________________

Mailing Address: _________________________________ City: _________________ State: __________ Zip: __________

Email Address: ____ Fax Number: ___________________________

Youth Case Manager: ☐ Yes ☐ No

If no, please identify relationship to the youth: ____

Supplemental Services Program (SSP) Check all boxes that apply. The youth:

- ☐ Receives HMK +/Medicaid or HMK/CHIP;
- ☐ Has a Serious Emotional Disturbance (SED) as defined in ARM 37.87.903;
- ☐ Is in the legal custody of a parent (biological or adoptive) or another specified relative caretaker;
- ☐ Is living or planning to live with either parent (biological or adoptive) or specified relative caretaker;

- ☐ Has not been adjudicated by the court;
- ☐ Has a current authorization from CMHB or from HMK’s third-party administrator for the therapeutic group home services OR has been accepted by a provider for therapeutic foster care services, if the request is for room and board.

CMHB Room and Board Account (R&B). Check all boxes that apply. The youth:

- ☐ Receives HMK+/Medicaid or HMK/CHIP;
- ☐ Has a Serious Emotional Disturbance (SED) as defined in ARM 37.87.903;
- ☐ Will receive the services in Montana;
- ☐ Has a current authorization from CMHB or from HMK’s third party administrator for therapeutic group home services OR has been accepted by a provider for therapeutic foster care services.

System of Care Account (SOCA) Check all boxes that apply. The youth:

- ☐ Receives HMK+/Medicaid;
- ☐ Has a Serious Emotional Disturbance (SED) as defined in ARM 37.87.903;
- ☐ Meets the requirements of “youth” as defined in ARM 37.87.102;
- ☐ Has a current authorization from CMHB for therapeutic group home services OR has been accepted by a provider for therapeutic foster care services, if the request is for room and board;
- ☐ Is at high risk for at least one of the following:
    - ☐ Needing a more restrictive level of care;
    - ☐ Remaining in a restrictive level of care if no other appropriate placement options are available;
    - ☐ Posing a safety risk to self or others;
    - ☐ Has history of multiple treatment and/or placement failures.
- ☐ Is currently involved with the following governmental agencies:
    - ☐ Children’s Mental Health Bureau
    - ☐ Developmental Disabilities Program
    - ☐ Child and Family Services; formally (legal involvement)
    - ☐ Child and Family Services; informally
    - ☐ Treatment Bureau
    - ☐ Youth Court; formally (e.g., formerly adjudicated, probation, parole)
    - ☐ Youth Court, informally (e.g., not adjudicated, informal probationary agreement)
    - ☐ Department of Corrections (Youth)
    - ☐ Tribal or BIA Social Services or Tribal Youth Court
    - ☐ Special Education (identified as having special education needs, e.g., has IEP or 504 plan)

Describe the nature of the involvement of each agency selected above:

Does the youth have pending criminal charges? If so, please describe:

Youth's primary diagnosis **that meets the SED criteria** (including DSM diagnostic code):

Name and credentials of licensed or in-training mental health professional who confirmed SED diagnosis:

What specific diagnosis-related behaviors/symptoms are targeted in the plan to use SSP/RBA/SOCA funding?

Family Involvement:
Describe how the plan to use SSP/RBA/SOCA funding involves the family:

Describe the discharge plan including with whom the youth will reside upon discharge and the support the youth and family will receive following the use of SSP/RBA/SOCA funding. The plan must be comprehensive and contain clear documentation of family/guardian involvement:

Services Requested: See the CMHB Non-Medicaid Services Manual for a description of each category.

- ☐ Room and board for therapeutic group home
- ☐ Other services (please describe):

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Insurance and Benefits Information Check all that apply:

- ☐ HMK+/Medicaid
  - ☐ Family Income Related HMK+/Medicaid
  - ☐ Adoption Subsidy HMK+/Medicaid
    - ☐Monthly subsidy amount: $____________________ State youth adopted: ____________________
  - ☐ Guardianship Subsidy HMK+/Medicaid
    - ☐Monthly subsidy amount: $____________________ State guardianship ordered: _____________
  - ☐ SSI Related HMK+/Medicaid
    - ☐Monthly SSI amount: $__________________________

      Please explain the type of SSI received. (Youths' individual income under SSI, SSDI, is the youth receiving SSI under their parents' benefits, death benefits?): _________________________________

      If other, please clarify: __________________________
- ☐ HMK/Chip
- ☐ If the family is willing to contribute other financial assistance towards the cost of room and board, note the amount here:

  $____________ per month.

PLEASE READ THE FOLLOWING:

*If the youth receives an individual income of SSI, or has an adoption or guardianship subsidy, CMHB expects that amount to go towards the cost of room and board prior to CMHB financial assistance.

*If the youth entered a guardianship or adoption through Child and Family Services in the state of Montana, please assist the family to contact the Foster Care & Guardianship Program Manager or the Post Adoption Program Manager and request a subsidy renegotiation.

A CMHB Non-Medicaid Services Program application is complete when:

- ☐ All fields of the application are adequately addressed;
- ☐ The application is signed by a parent/guardian;
- ☐ The application for room and board is signed by the individual completing the application which may include a representative of the admitting facility, group home manager, a hospital discharge planner, or a case manager.
- ☐ The application for services other than room and board is signed by a licensed or in-training mental health professional on the youth's team, to indicate the services are necessary to support the youth's mental health needs.

This application will not be processed until all information is completed and received by CMHB Regional staff.

____________________________________ __________________________

Signature of individual completing the application for room and board funding — Date

____________________________________ __________________________

Signature of licensed or in-training mental health professional requesting funding for services **other** than room and board — Date

Parent/Legal Guardian: I attest that I am the parent/ legal representative of the youth listed. I have been involved in the development of this plan and agree to support it. I further attest the information I've provided in the application is correct and accurate to the best of my knowledge. I understand that failure to provide accurate information and adhere to the plan could jeopardize this funding and future funding for my family.

____________________________________ __________________________

Signature of parent/legal guardian — Date

This must be signed by the same person listed as custodian or legal representative on the application.

***Please send completed applications to the individual assigned to the youths' home county listed below.**

Fax, mail, or send requests via the State of Montana Secure File Transfer Service (ePass)* to:

Kelley Tippett, CMHB, PO Box 4210, Helena, MT 59620-4210; Kelley.Tippett@mt.gov; fax (406) 444-5913

- Big Horn, Blaine, Broadwater, Carbon, Cascade, Chouteau, Fergus, Gallatin, Glacier, Golden Valley, Hill, Jefferson, Judith Basin, Lewis and Clark, Liberty, Madison, Meagher, Musselshell, Park, Petroleum, Phillips, Pondera, Roosevelt, Rosebud, Silver Bow, Stillwater, Sweet Grass, Teton, Toole, Wheatland

Trish Christensen, CMHB, PO Box 4210, Helena, MT 59620-4210; Trish.Christensen@mt.gov; fax (406) 329-1332

- Beaverhead, Carter, Custer, Daniels, Dawson, Deer Lodge, Fallon, Flathead, Garfield, Granite, Lake, Lincoln, McCone, Mineral, Missoula, Powder River, Powell, Prairie, Ravalli, Richland, Sanders, Sheridan, Treasure, Valley, Yellowstone, Wibaux

*Please note: If sending electronically, **applications must be sent via the State of Montana Secure File Transfer Service (ePass) or using encryption software.** Failure to securely send applications containing identifying member information is a violation of HIPAA and all submissions not received in a secure manner will be deleted.