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

Date of application: _____ Name of Youth: _____

Date of Birth: _____ Social Security #: _____

This request is for: ☐ Initial Stay ☐ Continued Stay

Facility Name and Address: _____

_____

Proposed dates of service: _____

Has the youth been admitted to a Psychiatric Residential Treatment Facility or Acute Inpatient Treatment within the last 12 months? ☐ Yes ☐ No

If so, please list facility and dates of treatment:

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 representative: Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Relationship to youth: _____

Name of person submitting request: _____ Today's date: _____

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 countable family income at or below 185% of federal poverty level (FPL) as evidenced by a CMHB Non-Medicaid Services Program financial attestation.
- [ ] Has a family that does not receive TANF Cash Assistance or Child Support Supplement OR that agrees to terminate this assistance during the requested funding period.
- [ ] 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 countable family income at or below 275% of Federal Poverty Level (FPL)**;**
- [ ] 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;
- [ ] Is under age 18;
- [ ] Has a countable family income at or below 275% of the Federal Poverty Level (FPL);
- [ ] Has a current authorization from CMHB for therapeutic group home services OR has been accepted by a provider for therapeautic 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
  - [ ] Prevention Services Bureau (aka: Chemical Dependency 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)

Describe the nature of the involvement for each agency checked:

Does the youth have pending or active criminal charges? If so, Please describe:

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: _____

☐ SSI Related HMK+Medicaid Monthly SSI amount: $_____

☐ HMK/Chip

☐ Private Insurance (Name of insurance Company) _____

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

Date of confirmed SED diagnosis: _____

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:

CMHB Room and Board Account and System of Care Account may be authorized for up to 120 days. Use of SSP funds in any month counts as one of four allowable months per federal fiscal year. For example, services funded July 30th would only be funded until October 31st.

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

☐ **Room and board for therapeutic group home:**

If youth receives SSI, adoption or guardianship subsidy, CMHB expects that amount to go toward the cost of room and board prior to CMHB financial assistance. Note the amount here: $_____ per month.

If the family is willing to contribute other financial assistance toward the cost of room and board, note the amount here: $_____ per month.

Additional Information

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

- ☐ All fields of the Application are adequately addressed
- ☐ The Application and Non-Medicaid Services Program financial attestation are signed by a parent/guardian;
- ☐ 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.

OR

- ☐ The Application for room and board is signed by a hospital discharge planner, group home manager or therapeutic foster care treatment manager.

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

_____ _____

Signature of Licensed or In Training Mental Health Professional Date

OR

Hospital Discharge Planner, Group Home Manager, Case Manager, or Admitting Facility Representative

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. **I agree that while the above listed person is receiving SSP funding, my household will not receive TANF cash assistance or Child Support Supplement**.

_____

Signature of Parent/ Legal Representative Date

This must be signed by the same person listed as custodian or legal representative on the application.
Fax, mail, or send requests via the State of Montana Secure File Transfer Service (ePass)* to:

Theresa Holm, CMHB, PO Box 4210, Helena MT 59620-4210; THolm2@mt.gov; fax (406) 444-5913

- 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, Silver Bow, Stillwater, Sweet Grass, Teton, Toole, Wheatland

Trish Christensen, CMHB, 2685 Palmer, Suite E, Missoula MT 59808; Trish.Christensen@mt.gov; fax (406) 329-1332

- Beaverhead, Big Horn, Carter, Custer, Daniels, Dawson, Deer Lodge, Fallon, Flathead, Garfield, Granite, Lake, Lincoln, McCone, Mineral, Missoula, Powder River, Powell, Prairie, Ravalli, Richland, Roosevelt, Rosebud, 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. **If you do not hear about the status of your application within 72 hours, please follow up with a Regional Resource Specialist to ensure it was received.**

Non-Medicaid Services
ATTESTATION

Identifying Information:

Youth's Last Name _____ First Name _____

Birth Date _____ Social Security # _____

Part A: Family Income

(1.) Employment:

Fill out the income tables below. Use this income list to estimate your household income. List all income currently received or expected for the next 12 months.

List all family members who work. List full time, part-time, seasonal, and temporary jobs, tips, commissions received or expected. *Please be specific*. If hours/pay vary, give a range (example, 20-30 hours a week). **Include current or seasonal unemployment received or expected under the Other Income section (3).**

	Name of Employer	Start Date	Average Hours worked per week	Pay or wages per hour	If you earn tips, average tips earned per week	If this job is seasonal, weeks or months worked per year	Calculate Annual income

(2.) Self-Employment and Rental Income and Expenses:

Self-Employment means you are your own boss. List business income and expenses received or expected or attach a copy of your 1040 tax form, including the schedules.

First name of income earner	Name of Employer	Start Date	Yearly income before expenses	Yearly Depreciation expense (if any)	All other yearly business expenses	Calculate Annual income

(3) Other Income:

List income received or expected by all family members, including children. (See table below.) If income varies, please provide a range (for example, $100 to $500 weekly or 3 to 6 payments yearly of an estimated amount.

First name of income earner	Type of income	Amount Received	How often is this amount received	Calculate Annual Income

Other Income – Includes but is not limited to:

- Subsidized adoption payments or guardianship payments
- Supplemental Security Income (SSI)
- Temporary Assistance to Needy Families (TANF)
- Worker's Compensation
- Unemployment benefits
- Social Security Disability or Retirement (monthly amount you receive plus the Medicare premium)
- Social Security Survivor's Benefits
- Child support and alimony
- Veteran's benefits
- Military Allotments
- Pensions, retirements or 401K income
- Railroad retirement or disability
- Interest, dividend or CD income
- Government payments on land
- Royalties or leases (mineral, grazing, etc.)
- Gifts

(4) Adjusted Countable Income:

	Total Amount
Total Family Income (sections 1, 2, and 3)	$
Deduct $1,440 for each employed person (maximum $2,880 per year)	$
Subtotal	$
Deduct $200/month for each child for who you pay childcare (maximum $2,400 annual amount)	$
Total Adjusted COUNTABLE Income	$

Adjusted Countable Income is used when determining poverty level.

Part B: Family Size

List family members living in the household (including youth applying for SSP).

☐ **Yourself** ☐ **Your spouse** ☐ **Your Children** ☐ **Child's other parent**

Name – first, middle initial, last	**What is this person's relationship to youth**	**Date of Birth (Mo/Date/Yr)**	**Age**	**Gender M or F**	**Is this person in K-12 School(Y or N)**	**Is this person in college (Y or N)**
	Youth					

Total number who count as family members for determining family size: _____

Family Size (determined from Part B):_____

Countable Income (determined from Part A, section 4): _____

I _____attest that I am the custodian of the youth listed. I further attest that the information I have provided is correct and accurate to the best of my knowledge.

Signature of Parent/Guardian_____Date_____

CMHB only:

CMHB Regional staff completes: ☐ SSP ☐ Room and Board Account ☐ SOCA

Approvals:

This SSP request was approved by:

CMHB Regional Staff _____Date: _____

This Room and Board Account request was approved by:

CMHB Designee_____ Date: _____

This SOCA request was approved by:

CMHB Supervisor/Bureau Chief _____Date: _____

Denial:

The request was denied by:_____Date: _____

Attach copy of denial letter to parent/guardian, referral source and cc to CMHB central office.