

## PROCEDURE MANUAL

To implement

# **The Child Mental Health Treatment Act**

**Section 27-10.3-101, et seq., C.R.S.**



Colorado Department of Human Services  
Behavioral Health Services  
Division of Mental Health  
Revised May, 2008

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## FOREWORD/INTRODUCTION

The Child Mental Health Treatment Act (CMHTA) was enacted through H.B. 99-1116 to address the nationwide issue of families struggling to access mental health services for their children. In many cases, families were subjected to unnecessary legal and system involvement solely to obtain necessary mental health services for their children. Contributing factors to this issue included public and private health insurance limitations, inadequate supplies of mental health services, limited availability of services through mental health agencies and schools, attitudes about families of children with serious mental health needs, and difficulties meeting eligibility rules.

Since its inception, the CMHTA has provided essential services to children and their families who might have otherwise been disrupted by unnecessary dependency and neglect actions, and other system and legal entanglements. Anecdotal comments by parents have indicated that they and their children have experienced positive outcomes in mental health functioning and other life domains, in some instances providing life-changing experiences. Conversely, some parents have commented that obtaining CMHTA services was a complex and sometimes confusing and frustrating experience. With these positive and challenging experiences in mind, this manual is intended to support and strengthen the work of mental health agencies in implementing this landmark legislation and its contribution to systems of care.

## I. DEFINITIONS

“Ability to pay” is the amount of income and assets of the legally responsible person(s) available to pay for the individual cost of mental health treatment and room and board for a child in residential treatment.

“BHO” means Behavioral Health Organization

“Care Management” means arranging for continuity of care and the array of services necessary for treating the child, and the authority to rescind authorization for any treatment services with proper notice.

"Child at Risk of Out-of-Home Placement" means a child who, although not otherwise categorically eligible for Medicaid, meets the following criteria:

- A. Has been diagnosed with a mental illness, as defined in Section 27-10-102(8.5), C.R.S.;
- B. Requires the level of care provided in a residential child care facility pursuant to Section 25.5-5-306, C.R.S., or that is provided through in-home or community-based programs and who, without such care, is at risk of out-of-home placement;
- C. If determined to be in need of placement in a residential child care facility, is determined to be eligible for Supplemental Security Income; and,
- D. For whom it is not appropriate or warranted to file an action in dependence or neglect pursuant to Title 19, Article 3, C.R.S.

"Children who are Medicaid Eligible" means a child who, with a covered mental health diagnosis, is eligible for services through the Medicaid Mental Health Capitation Program.

“CMHTA” means the Child Mental Health Treatment Act (C.R.S. 27-10.3-101)

“CMHC Liaison” means the contact person at a particular community mental health center that acts as a link between families, the CMHC and BHS/DMH with regards to CMHTA.

“Community –Based Services” includes, but is not limited to, therapeutic foster care, intensive in-home treatment, intensive case management, and day treatment.

"Community Mental Health Center" or “CMHC” means either a physical facility or a group of service providers under unified administration or otherwise affiliated with one another that provides, at a minimum, the following services for the prevention and treatment of mental illness in persons residing in a particular community in or near the facility or group so situated:

- A. Inpatient services;
- B. Outpatient services;
- C. Partial hospitalization;
- D. Emergency services; and,
- E. Consultative and educational services.

"Cost of Care" includes mental health treatment not covered by Medicaid, and room and board.

"County Department" means the county or district department of social services/human services.

"Disability Determination Services (DDS)" – a Colorado Department of Human Services agency responsible for determining whether an individual meets the Supplemental Security Income (SSI) disability requirements.

"DMH" means the Colorado Department of Human Services Behavioral Health Services-Division of Mental Health.

"Mental Health Agency" means the community mental health center serving children in a particular geographic area and authorized by the Colorado Department of Human Services pursuant to the Rules and Regulations for the Colorado Public Mental Health System (2CCR 502-2), or the Behavioral Health Organization, serving children in a particular geographic area who are receiving Medicaid.

"Plan of Care" means the form submitted by the CMHC to BHS/DMH that outlines the plan for CMHTA-funded services.

"Resident" means a child receiving residential mental health treatment under the Child Mental Health Treatment Act.

"Professional Person" means a person who is licensed to practice medicine or psychology in Colorado as defined in Section 27-10-102(11), C.R.S.

"Residential Treatment" means services provided by a therapeutic residential child care facility or psychiatric residential treatment facility licensed as a residential child care facility pursuant to Section 26-4-527, C.R.S., which has been approved by the State Department to provide mental health treatment.

"Responsible Persons" means parent(s) or legal guardian(s) of a minor.

"Supplemental Security System (SSI)" – SSI is a benefit available through the federal Social Security Administration. In order to qualify for SSI and individual must meet the income and disability requirements.

"State Department" means the Colorado Department of Human Services, which includes the Division of Mental Health.

## **II. APPLICATION FOR MENTAL HEALTH TREATMENT FOR CHILDREN**

The Child Mental Health Treatment Act allows families to access mental health treatment for children with a mental illness who are Medicaid eligible as well as those who are at risk of out-of-home placement, and for whom a dependency and neglect action is unnecessary. Additionally, the law provides for an assessment process, treatment funding (based on a sliding scale) for children not categorically eligible for Medicaid, referrals between mental health agencies and county departments, appeal processes for families when services are denied, and interagency conflict resolution.

### **Evaluation and Assessment**

Any responsible person(s) may apply to a mental health agency on behalf of his or her minor child for mental health treatment. Once the request has been made, the mental health agency will evaluate the child and clinically assess the child's need for mental health services. The mental health agency is responsible to perform a face-to-face assessment and formulate a decision according to the following parameters after the request has been made:

1. Emergency- defined as a condition that appears to require unscheduled, immediate or special mental health intervention in response to a crisis situation involving the risk of imminent harm to the person or others. Emergency situations shall be completed within six (6) hours of the initial assessment request.
2. Urgent- defined as a condition that appears to, if not addressed within twenty-four (24) hours, be likely to escalate to an emergency situation. Urgent situation evaluations shall be completed within twenty-four (24) hours of the initial assessment request.
3. Routine- defined as all other situations, shall be completed within three (3) business days of the initial request.

Note: If the mental health agency requires additional time to make a decision following an assessment and the responsible person(s) agrees, then the mental health agency may take up to, but no more than, fourteen (14) calendar days to provide a decision. If the responsible person(s) does not agree, the notification timelines referenced above remain in effect.

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Once a decision has been made, the mental health agency will notify the responsible person(s) orally and in writing within the time allowed for the completion of the evaluation.

Verbal notification should be face-to-face with the responsible person(s) when possible. The written decision must contain notice of the applicable criteria for mental health treatment, the factual basis for the decision, the grievance procedures and a signed statement by the responsible person(s) indicating they agree with the decision, they disagree or they disagree and wish to file a grievance.

Regardless of whether a child is deemed eligible for services under the Child Mental Health Treatment Act or not, a **Community Mental Health Center/Behavioral Health Organization Eligibility Form** must be completed for all children assessed for residential placement by the evaluating agency and returned to the Division of Mental Health via fax (303.866.7428) This also applies to the **Community Mental Health Center/Behavioral Healthcare Organization Discharge Form** on all children discharged from a residential placement, regardless of their Medicaid status. (See appendix for forms)

### **III. RESPONSIBILITIES OF THE COMMUNITY MENTAL HEALTH CENTERS**

If the mental health agency determines that the child meets the criteria for mental health services under the Child Mental Health Treatment Act, the mental health agency will be responsible for the provision of Child Mental Health Treatment Act services (subject to the availability of state appropriations). These services include, but are not limited to:

1. Mental health assessments: including CCAR's
2. Community based services;
3. Care management services;
4. Residential treatment services; and,
5. Non-residential mental health transition services for youth.

It is the responsibility of the mental health agency to work in collaboration with the family regarding treatment planning, service coordination and identifying potential community-based or residential treatment services. If a child is in need of residential placement, yet a facility cannot be identified or a similar level of intensity can be provided through alternate methods, the community mental health center may utilize community based services to maintain the child in the home or in a different venue such as therapeutic foster care.

Once an appropriate treatment plan has been identified, the community mental health center must submit a **Plan of Care** form for approval to the Division of Mental Health prior to implementing Child Mental Health Treatment Act funded services. **Plan of Care** forms are to be updated or revised when appropriate to do so. (See appendix for **Plan of Care** form as well as instruction sheet.)

The CMHC will be responsible for collecting all financial information from the responsible person(s) and attaining a signed **Child Mental Health Treatment Act Financial Agreement Form**. The community mental health center will determine the responsible person(s)' portion of treatment costs using the "Schedule of Basic Child Support Obligations" in section 14-1-115, C.R.S. For community-based services, the community mental health center will use the "Calculation to Determine Parent/Guardian Contribution for Community Based Services" form (see financial aspects for further information).

The community mental health center is responsible for maintaining a comprehensive record for each child receiving services through Child Mental Health Treatment Act funding and will make records available for review by the State Department. The service plan in the clinical record will need to reflect any services provided directly by the center.



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### Data Reporting

The CMHC is responsible for reporting the following data on non-Medicaid eligible and the BHO on Medicaid eligible children to DMH via the **Community Mental Health Center/Behavioral Health Organization Eligibility Form**:

- ◆ **Number of assessments provided,**
- ◆ **In-home family mental health treatment,**
- ◆ **Family preservation services,**
- ◆ **Residential treatment recommendations/admit,**
- ◆ **Referred to county department for a dependency or neglect investigation,**
- ◆ **Post-residential follow-up services.**

Other Data the CMHC/BHO is responsible for reporting to DMH that is not included in the Eligibility Form includes:

- ◆ **Assessment requested but not performed, and the reasons that the assessment was not performed,**
- ◆ **Assessment was performed but the mental health agency did not provide services, and the reasons that services were not provided, including whether the family refused the services offered,**
- ◆ **Community-based treatment, including but not limited to therapeutic foster care services,**
- ◆ **Costs associated with the provision of the mental health treatment services (provided the Plan of Care and Billing forms),**
- ◆ **Profiles of the children and families served (provided by the CCAR-Colorado Client Assessment Record).**

## IV. FINANCIAL ASPECTS

### General

H.B. 99-1116 created the Child Mental Health Treatment Act (C.R.S. 27-10.3-101), which makes provisions for the State to participate in the costs of care for children placed in residential treatment. State funds are also made available for additional services such as community based, and pre/post and transitional mental health services. Once the family or responsible person(s) has applied for mental health services on behalf of the child, the mental health agency and family/responsible person(s) will determine what mental health services are appropriate and then submit a **Plan Of Care** form to the State Division of Mental Health. The State's share of the cost of care is the portion of expenses not covered by private insurance, Medicaid, the family's share based on a sliding scale, and the SSI benefit payment, less the personal needs allowance.

### Payment Process for Child Mental Health Treatment Act (CMHTA) Services

For children who have capitated Medicaid at the time residential treatment is required, the corresponding BHO will be responsible for residential costs as well as community-based services. The following pertains to children who are **not categorically eligible for Medicaid**.

#### Child Support Payment

A monthly Child Support Payment will be determined for each child, based on the family/responsible person's gross monthly income and the "Schedule of Basic Child Support Obligations" in section 14-1-115, C.R.S. The Community Mental Health Center determines the support payment based on this schedule, and the family pays the Child Support Payment directly to the residential facility each month to cover Room and Board (also called Child Maintenance) costs.

#### First 30 Days

Subject to available appropriations, the State will pay for the first 30 days of Room and Board (Child Maintenance) and Treatment for children determined eligible for services by the Community Mental Health Center, minus the monthly Child Support Payment, after any private insurance benefits have been applied. The residential facility will submit an invoice to the Division of Mental Health for reimbursement of these costs.

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### Supplemental Security Income (SSI) Eligibility

A child who is not **categorically eligible for Medicaid** at the time residential treatment is required, must become SSI eligible in order to qualify for benefits through the CMHTA beyond the first calendar month of residential treatment. The SSI application is essential because if the child qualifies for SSI, the child will then become eligible for Medicaid. **SSI and Medicaid eligibility are necessary for the State to contribute to treatment costs beyond the first 30 days.**

There are criteria that must be met in determining SSI eligibility. The first is the SSI financial eligibility criteria. In order to meet the SSI financial eligibility criteria, the child must be absent from the home, or expected to be absent from the home for at least 30 days, and not have income in excess of SSI limits (for limits please call the SSA -Social Security Administration at 800-772-1213).

The second criterion is the SSI disability eligibility criteria. In order to meet this criteria, comprehensive documentation to support the disability claim is essential. Such information may come from previous and/or current health care and other treatment providers, including CMHTA-related assessment reports. Disability Determination Services is responsible for disability determination based on SSI criteria.

If SSI eligibility is determined, benefits will be assigned on behalf of the child. Although these benefits will likely be assigned to the family as the representative payee for the child, the monthly benefit payments (minus a \$30 personal needs allowance that should be applied by the residential treatment facility for the child's needs) must be forwarded to the residential facility to cover the Child Maintenance costs. The best way to accomplish this is for the family to assign the facility to be the payee. The family must also continue to pay the monthly Child Support Payment that was determined.

SSI benefit payments and Medicaid eligibility will be retroactive to the first day of the month following the date of SSI eligibility. If the SSI application is filed in a timely manner, this date of eligibility will be approximately 30 days after the child enters the residential facility for treatment. It is important to help families navigate through this complicated procedure to ensure that applications are completed correctly and in a timely manner. This will also help reduce denials due to application errors.

**If the child is determined not eligible for SSI, the parent is financially liable for the cost of care beyond the first 30 days of treatment.**

For more information and application packets please contact the Social Security Administration at 800-772-1213 or visit their website at [www.socialsecurity.gov/disability/](http://www.socialsecurity.gov/disability/).

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### Residential Treatment Billing Procedures

1. The residential treatment provider will be reimbursed for room and board charges based on their rate approved by the CDHS Division of Child Welfare for the fiscal year.
2. The residential treatment provider will be reimbursed for therapeutic services provided to the child based on the approved Medicaid rates for therapeutic services in a TRCCF or the approved Medicaid per diem rate for PRTF.
3. The residential treatment facility must first bill any private insurance available to cover the costs.
4. The responsible person(s) will pay the monthly support payment to the residential facility to be applied to the room and board charge for the child's residential treatment. This payment is determined by the Community Mental Health Center using the Child Support Guidelines (C.R.S. 14-10-115).
5. Once the child becomes SSI eligible, the residential treatment facility will receive the child's SSI benefit payment, minus the personal needs allowance (\$30), either from the family or directly from Social Security. The balance of the benefit payment is applied to the room and board cost for the child's care in the residential facility.
6. For the first 30 days, the residential treatment provider will bill the cost of treatment to the Division of Mental Health. Once Medicaid eligibility is established, these charges will be billed directly to Medicaid using the automated system.
7. The residential facility bills the State Division of Mental Health the remaining costs of room and board.

The Community Mental Health Center will have parents whose child is determined to be at-risk of out-of-home placement sign the **Child Mental Health Treatment Act Financial Agreement Form** (see appendix for copy of form) which contains a statement of full disclosure of financial risk to the responsible person(s) as well as liability for the costs of treatment.

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### Community Based Services

To bill for community-based services for children who qualify under the CMHTA:

1. The mental health center must first bill any private insurance available to cover the costs.
2. If the child has capitated Medicaid, the corresponding BHO will be responsible for payment.
3. If none of the first two steps apply or there is a remaining balance from step number one, then the mental health center must submit a **Plan of Care** form to the State Division of Mental Health. (The CMHTA Program Coordinator in conjunction with the CMHC Liaison will review Plan of Care forms initially and periodically.)
4. The responsible person(s) portion for community-based services is determined by dividing the monthly support payment (set by the Child Support Guidelines) by the average monthly cost for residential treatment. This amount is not to exceed 50% of the Residential Monthly Support Payment from the Child Support Guidelines. (Calculation assistance is available on the state web site: [http://www.cdhs.state.co.us/dmh/Documents/CMHTA\\_PercentageContributionCalculation.xls](http://www.cdhs.state.co.us/dmh/Documents/CMHTA_PercentageContributionCalculation.xls).)

All billings to the State should be directed to:

CMHTA Billing Coordinator  
Colorado Department of Human Services  
3824 W. Princeton Circle  
Denver, CO 80236  
Fax: 303-866-7428

You may find the following forms:

**Residential Facility Billing Form (TRCCF)**  
**PRTF Billing Form (pre-eligibility period only)**  
**Transition Services Billing Form (Community Based)**

At: [http://www.cdhs.state.co.us/dmh/cmhta\\_forms.htm](http://www.cdhs.state.co.us/dmh/cmhta_forms.htm)

## V. INTERAGENCY REFERRALS

Serving children and families through the CMHTA frequently requires contact and collaboration between mental health agencies and other child-serving systems. Perhaps the most crucial among these are county departments of human/social services. The information below summarizes key information about this relationship:

- A. Mental Health Agency referral to a county human/social services department [27-10.3-104 (2), C.R.S.]
  1. If at any time the mental health agency determines that there is reasonable cause to know or suspect that a child has been subjected to abuse or neglect, the mental health agency must immediately contact the appropriate county department.
  2. Within ten days after the referral to the county department, the mental health agency should meet with the county department and the family. Upon referral to the county department, the county department proceeds with an assessment to determine if there is sufficient basis to believe that physical or sexual abuse or neglect or some other form of abuse or neglect of a child's physical well-being has occurred warranting a dependency or neglect action.
- B. County human/social services department referral to a mental health agency [19-3-308 (1.5) (b.)]
  1. If, during the investigation and assessment process, the county department determines that the family's issues may be attributable to the child's mental health status, rather than dependency or neglect issues, and that mental health treatment services through the CMHTA may be more appropriate, the county department shall contact the mental health agency.
  2. Within ten (10) days after the commencement of the investigation, the county department meets with a representative from the mental health agency and the family. The county department, in conjunction with the mental health agency, jointly determines whether mental health services should be provided by the mental health agency or the county department.
- C. If the mental health agency and county department are unable to determine which entity is responsible for providing services to a child and family, and local dispute resolution processes have been exhausted, either or both agencies may request the State to convene a representative committee to resolve the matter. This process is outlined below:

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1. A mental health agency and/or a county department may request dispute resolution by contacting:
  - Director
  - Colorado Department of Human Services
  - Division of Field Administration
  - 1575 Sherman St.
  - Denver, CO 80203
  - Fax: 303-866-3905
2. The request to invoke the dispute resolution process shall be in writing and submitted within five (5) calendar days of either agency recognizing that a dispute exists.
3. The written request for dispute resolution shall include, at a minimum, the following information:
  - A) County department and mental health agency involved in the dispute, including a contact person at each;
  - B) Child's name, age, and address;
  - C) Parent or guardian address, phone number and email address;
  - D) Pertinent information regarding the child including, but not limited to, medical or mental health status/assessment;
  - E) Reason for the dispute, any efforts to resolve the matter locally, and any pertinent information regarding the child;
  - F) Information about the child's mental health status pertaining to the dispute; and,
  - G) Parent or guardian's perspective on the matter, if known.
4. Within ten (10) calendar days of receiving the dispute resolution request, the Division of Field Administration shall convene a committee in order for each side to present their position.
5. The committee shall consist of, at a minimum, members who represent a third party mental health agency and county department of human/social services, the Division of Mental Health, the Division of Child Welfare, and the Department of Health Care Policy and Financing.

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6. The Division of Field Administration shall provide notice to both agencies that the state department will resolve the dispute.
7. Each party will have an opportunity to present its position to the committee. Interested parties will be allowed to present written or oral testimony at the discretion of the committee.
8. After both agencies present their positions, and other parties present as appropriate, the committee will have five (5) working days to issue its determination in writing to the disputing agencies. The committee's decision shall constitute final agency action, which binds the agency determined responsible for the provision of necessary services.



## **VI. DISPUTE RESOLUTION**

There are two types of dispute resolution processes included in the rules for H.B. 99-1116, Child Mental Health Treatment Act. One covers disputes between parents and mental health centers concerning denials of mental health treatment. The other deals with disputes between county departments and mental health agencies.

### **Dispute resolution for Denial of Mental Health Treatment**

There are two appeal processes that entail a clinical review. The first appeal is the mental health agency review and the second is the clinical review at the state level.

#### Mental Health Agency Review

All initial and continued stay denials should be communicated to the responsible person(s) orally and in written form within the time allowed for the completion of the evaluation. The notification process is essentially the same as described in the evaluation and assessment section. Denials must also include non-CMHTA alternative services and resources and information about CMHTA appeal rights. If the MH agency is unable to determine whether the child is CMHTA-eligible based on available information, the agency must provide a timeline for completing the assessment once necessary information is made available.

If the responsible person(s) disagrees with the decision and decides to exercise their right to file a grievance, either in writing or orally, the CMHC will have two (2) working days to complete the internal grievance review process and communicate a decision to the responsible person(s) in writing and orally. Along with the required information provided in the initial decision notification, the CMHC must provide information about the process for a clinical review, which is described below. If the CMHC requires more than 2 days to complete the internal review, the CMHC may take up to 5 days to complete the review if the responsible person(s) agrees. If the responsible person(s) is not agreeable, the two (2) working day timeline remains in effect.

#### Clinical Review – State Level.

The responsible person(s) will have up to five (5) working days after the CMHC final denial of requested residential services to request a clinical review. The clinical review will be comprised of an objective third party, at the state department, who is a professional person. The requests may be in writing or oral, but the oral request must be followed up with a written request made to:

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Director, Behavioral Health Services  
Colorado Department of Human Services  
3824 W. Princeton Avenue  
Denver, CO 80236  
Fax: 303-866-7428

Unless waived by the responsible person(s), the clinical review should include:

1. A review of the mental health agency denial of residential services;
2. A face-to-face evaluation of the child, so long as the responsible person(s) arranges transportation of the child for the evaluation;
3. A review of the information and evidence provided by the responsible person(s).

The responsible person(s) will be advised of the name and credentials of the reviewing professional, as well as any mental health agency affiliations of the reviewing professional. At that time, the responsible person(s) may request to have an alternate reviewing professional at the state department so long as any delay caused by the request is waived by the responsible person(s).

A decision will be made within three (3) working days of the receipt of the request for a clinical review and communicated orally and in writing by the reviewing professional to the responsible person(s), Division of Mental Health and the mental health agency. The written decision will include the relevant criteria and the factual basis of the decision.

If the clinical review finds residential treatment to be necessary, the mental health agency will make the appropriate arrangements to provide said treatment within 24 hours of the decision. If a residential facility placement is not available within 24 hours, the state review must recommend appropriate alternatives including emergency hospitalization, if appropriate.

If the professional person requires more than (3) working days to complete the face to face evaluation, or if the responsible person(s) require more time to obtain evidence for the clinical review, the responsible person(s) may waive the three day deadline, so long as it is confirmed in writing. If waived, the face-to-face evaluation will be completed within six (6) days.

The state department review will be the final agency action for non-Medicaid eligible children. The responsible person(s) of a Medicaid eligible child will be notified of further appeal actions that may be taken pursuant to Section 8.058 of the Colorado Department of Health Care Policy and Financing's Medical Assistance Manual (10 CCR 2505-10).

### **Dispute Resolution For County Departments and Mental Health Agencies**

A State-level formal dispute resolution process, including a timeline, is available to resolve disputes between county departments and mental health agencies to be used only after referral follow-up processes and locally established resolution processes have been exhausted. The process includes the following:

1. A mental health agency and/or a county department may request dispute resolution by contacting:

Director  
Colorado Department of Human Services  
Division of Field Administration  
1575 Sherman St.  
Denver, CO 80203  
Fax: 303-866-3905

2. The request to invoke the dispute resolution process shall be in writing and submitted within five (5) calendar days of either agency recognizing that a dispute exists.
3. The written request for dispute resolution shall include, at a minimum, the following information:
  - County department and mental health agency involved in the dispute, including a contact person at each;
  - Child's name, age, and address;
  - Parent or guardian address, phone number and email address;
  - Pertinent information regarding the child including, but not limited to, medical or mental health status/assessment;
  - Reason for the dispute, any efforts to resolve the matter locally, and any pertinent information regarding the child;
  - Information about the child's mental health status pertaining to the dispute; and,
  - Parent or guardian's perspective on the matter, if known.

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4. Within ten (10) calendar days of receiving the dispute resolution request, the Division of Field Administration shall convene a committee in order for each side to present their position.
5. The committee shall consist of, at a minimum, members who represent a third party mental health agency and county department of human/social services, the division of mental health, the division of child welfare, and the department of health care policy and financing.
6. The division of field administration shall provide notice to both agencies that the state department will resolve the dispute.
7. Each side will have an opportunity to present its position to the committee. Interested parties will be allowed to present written or oral testimony at the discretion of the committee.
8. After both agencies present their positions, and other parties present as appropriate, the committee will have five (5) working days to issue its determination in writing to the disputing agencies. The committee's decision shall constitute final agency action, which binds the agency determined responsible for the provision of necessary services.

## VI. STEP-BY-STEP GUIDE

### STEP 1- The Assessment.

A parent or guardian contacts the CMHC requesting services for their child under the CMHTA. The CMHC determines the level of crisis and performs an evaluation and a face-to-face assessment based on the following guidelines:

1. Emergency- defined as a condition that appears to require unscheduled, immediate or special mental health intervention in response to a crisis situation involving the risk of imminent harm to the person or others. Emergency situations shall be completed within six (6) hours of the initial assessment request.
2. Urgent- defined as a condition that appears to, if not addressed within twenty-four (24) hours, be likely to escalate to an emergency situation. Urgent situation evaluations shall be completed within twenty-four (24) hours of the initial assessment request.
3. Routine- defined as all other situations, shall be completed within three (3) business days of the initial request.

If the mental health agency requires additional time to make a decision following an assessment and the parent or guardian agrees, then the mental health agency may take up to, but no more than, fourteen (14) calendar days to provide a decision. If the responsible person(s) does not agree, the notification timelines referenced above remain in effect.

The face-to-face assessment should include a thorough mental health evaluation, including: presenting problem /chief complaint, history of the problem, treatment history, medication history, functioning in all settings, family/social history, current family situation, mental status, and diagnostic impressions. **\*At some point of the assessment process a completed CCAR is required.**

It is important to have the parent or guardian provide as much documentation of the child's history as possible. This includes school and medical records as well as any previous treatment and/or hospitalizations. The CMHC may need to provide assistance in educating the parent or guardian on how to attain these records. Other helpful information may include consultation with other providers, teachers, and family.

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### Step 2- The Decision Process

If the CMHC determines the child does not meet criteria for services under the Child Mental Health Treatment Act, the CMHC is to inform the parent/guardian of the appeal rights/instructions and offer alternative resources.

If the CMHC determines the child meets the criteria for mental health services under the Child Mental Health Treatment Act and the child is **categorically eligible for Medicaid**, the corresponding BHO must be notified. The BHO will be responsible for treatment management as well as costs for services. **(Do not continue after this Step)**

If the CMHC determines the child meets the criteria for mental health services under the Child Mental Health Treatment Act and the child is **not categorically eligible for Medicaid**, the CMHC, in collaboration with the parent/guardian, will determine the appropriate treatment service option. **(Continue with the following Steps)**

All decisions will be communicated orally and in writing within the allotted time given for the completion of the assessment. The written decision must contain notice of the applicable criteria for mental health treatment, the factual basis for the decision, the grievance procedures and a signed statement by the responsible person(s) indicating they agree with the decision, they disagree, or they disagree and wish to file a grievance.

After the decision has been made, the CMHC will complete a **Community Mental Health Center/Behavioral Health Organization Eligibility Form** on **all** requests, regardless of the disposition recommendations.

### Step 3- Deciding on Services

The child meets the criteria for “at risk of out-of-home placement” and therefore is eligible for services under the CMHTA. The CMHC will work in collaboration with the parent or guardian in determining treatment options.

If residential placement is the most appropriate plan, then the CMHC will assist the parent/guardian in locating a facility.

### **Alternatives to Residential Placement**

Community-based services may be used as an alternative to residential placement as long as the child continues to meet criteria for “at risk of out-of-home placement”. Services may include, but are not limited to: therapeutic foster care, day treatment, intensive in-home treatment, respite, mentoring, transportation, and specialized therapy.

## Procedure Manual

### Step-4 An Appropriate Service Course is Identified

The CMHC will collect all financial information from the parent/guardian and attain a signed **Child Mental Health Treatment Act Financial Agreement Form**.

For residential placements the CMHC will determine the parent/guardian's Child Support Payment based on the "Schedule of Basic Child Support Obligations" in section 14-1-115, C.R.S (regardless if the placement is a TRCCF or PRTF). *This is paid by the parent/guardian directly to the residential facility each month to cover Room and Board (also called Child Maintenance) costs. (Please refer to the Financial Aspects section for detailed information.)*

For Community-Based service options the CMHC will determine the Child Support Payment using the **Parent/Guardian Contribution for Community-Based Services** form. **(Please refer to the Financial Aspects section for detailed information.)**

When it is determined the child will require residential/therapeutic foster care service the CMHC should assist the family in applying for SSI on behalf of the child, as SSI and Medicaid eligibility are necessary for the State to contribute to treatment costs beyond the first 30 days. **It is essential that the family apply for SSI at the earliest opportunity.** The CMHC should also inform the family that if the child is determined not eligible for SSI, the parent is financially liable for the cost of care beyond the first 30 days of treatment.

Once all the above information is gathered, the CMHC will submit a **Plan of Care** to DMH for approval prior to implementing CMHTA-funded services. . *Please remember that **Plan of Care** forms are to be updated or revised when appropriate to do so.*

### STEP-5 The Care Manager

The CMHC is to assign a care manager when the child receives services under the CMHTA, either in residential treatment or in the community. The care manager will communicate with the family and the provider on a regular basis to assure that services are being delivered as expected and that adequate progress is being made.

For residential services, the care manager will monitor progress and can recommend that a child be discharged if criteria for ongoing care are not being met. The appeal rights outlined in (section VI) apply if the parent/guardian disagrees with this recommendation.

The care manager will coordinate with providers, arrange for contracts if necessary, and monitor service delivery and progress in community based services. The care manager is responsible for assuring that coordination with DMH for approvals is timely and ongoing.

## Procedure Manual

### Step-6 Billing for Services

For residential placement, the residential facility will bill the state directly. TRCCF's will use the **CMHTA Placement Billing Form** and PRTF's will use the **Pre-Eligibility Period Billing Form** for the 1st 30 days. PRTF's are to bill Medicaid Fee for Service (per diem rate) after the 1<sup>st</sup> 30 days.

For Community-Based services, the CMHC will bill the state using the **CMHTA Billing Form**. Community-Based services include, but are not limited to, therapeutic foster care, day treatment, intensive in-home treatment, respite, mentoring, transportation, specialized therapy, etc.

*\*All services billed to the State must have been approved by the State via the **Plan of Care**.*

### Step-7 Discharges

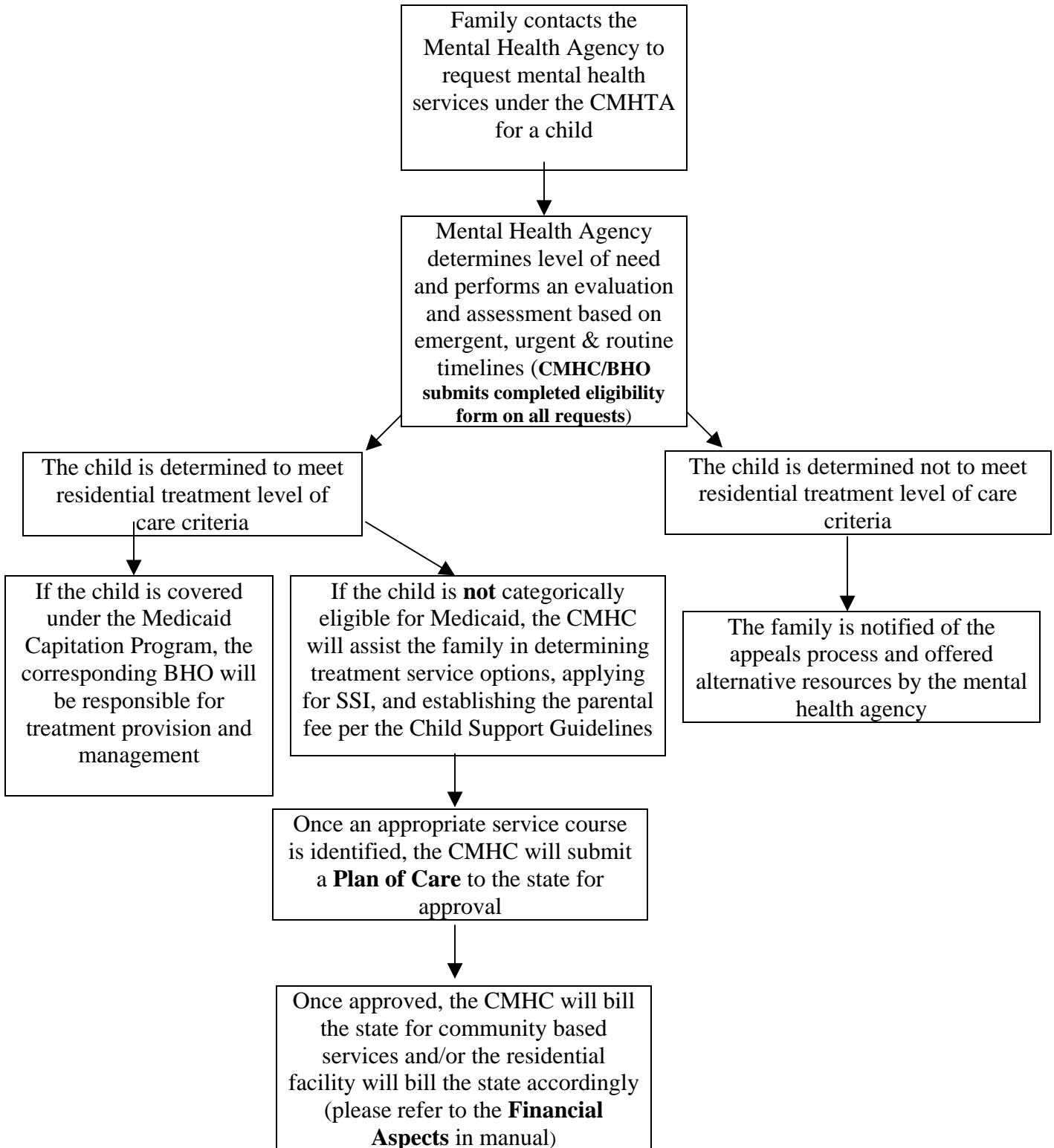
When a child discharges from a residential facility, the facility must submit a **CMHTA Residential Facility Discharge Form**.

The CMHC, in collaboration with the parent/guardian and the residential facility, may elect to utilize a transitional plan incorporating community-based services. A **plan of care** must be updated and submitted to the State. (Please refer to Steps-4 through 6)

When a child discharges from the CMHC/BHO, a **CMHC/BHO Discharge Form** must be submitted to the state.



## CMHTA Process



## CMHTA FORMS FLOW CHART

