



Multi-System Youth Custody Relinquishment Prevention Program Overview for Updates and Applications for Additional / Shifted Funds

The State of Ohio's program to prevent custody relinquishment for youth with multi-system needs was created in SFY20 pursuant to Section 333.95 of AM Sub H.B. No. 166 with the goal of preventing transfer of custody to the child protection system solely for the purpose of obtaining funding to access treatment. The custody relinquishment prevention program is referred to as the Multi-System Youth (MSY) Program.

The MSY Program is sponsored by the Ohio Family and Children First (OFCF) Cabinet, including the Ohio Departments of Children and Youth, Developmental Disabilities, Education and Workforce, Mental Health and Addiction Services, Medicaid, and Youth Services.

State MSY Custody Relinquishment Prevention Program Principles, Applicability to Updates and Additional Funds

- **Children and youth served by the MSY program must either be at risk for custody relinquishment or have been recently relinquished for a short period of time (ex: 30 days) solely to access care.** Children and youth must remain in the custody of viable caregivers to receive additional MSY program funding.
- **Children and youth served by the MSY program must have multi-system needs and be using creative multi-system supports.**
 - ✓ Children and youth receiving MSY funding must be actively engaged in care coordination provided by a Family and Children First Council (FCFC) or by OhioRISE.
 - ✓ Local and/or regional systems are expected to actively support the child/youth and their caregiver(s) before, during, and after receipt of MSY program funding.
 - ✓ Care teams must continue creative care planning, even when children and youth are receiving out of home care.
- **Care funded by the MSY Program must be clinically appropriate and provided in the least restrictive setting possible to support the child or youth's needs.**
 - ✓ Children and youth receiving MSY program funds for out of home care must transition to home and community-based living arrangements as soon as clinically appropriate.
 - ✓ Applicants seeking additional funding for out-of-home must include an updated CANS assessment or other clinical documentation indicating the continued need for out-of-home treatment.
- **Each child or youth served by the MSY program must be supported by one or more legal guardians who are willing to actively participate in the young person's care planning and treatment.** Guardians of children and youth who receive MSY Program funding for out-of-home care must continue to be willing to have the young person return to the home as quickly as clinically appropriate.
- **The MSY Program is intended to address acute needs and prevent immediate custody relinquishment.** When the team working to support the child/youth anticipates the need for longer-term services and supports, they are expected to conduct sustainability planning to identify long-term funding sources for longer term care.
- **The MSY Program is intended to assist caregivers when local resources and other payment sources have been exhausted.** The State MSY Program is the funder of last resort and can only be accessed when local funds, health insurance, annual post-adoption assistance funds, and other sources of funding are used first. MSY Program funding cannot be used to supplant other funds.

Multi System Youth Program Update Form & Application for Additional / Shifted Funds

FCFCs should email updates and applications to MSYUpdates@medicaid.ohio.gov

CMEs should email updates and applications to OHRMSYapplications@aetna.com

All updates and applications must be encrypted when emailed.

Updates regarding child/youth and teaming while using State MSY Program (Program) funds must be provided using this form. The State MSY team may request updates at any time.

- **Urgent updates** regarding disruptions in and/or changes in providers of care funded by the MSY Program must be submitted within 14 days of the disruption or change.
 - ✓ The State MSY team may request additional updates following a disruption or a change in provider.
 - ✓ Please note: MSY funds cannot be spent on a new provider of care without authorization of a shifted funds request from the State MSY Team. Authorization of shifted of funds is not guaranteed.
- **Routine updates** for all children/youth receiving Program funds must be submitted at least every 90 days and prior to or concurrent with submission of an application for additional funding.
 - ✓ Organizations that fail to submit complete and detailed updates may be required to submit additional information and/or provide updates more frequently than every 90 days.
 - ✓ Incomplete or untimely updates will result in automatic denial of requests for additional funding.
- **Final updates** should be submitted within 90 days following the end of the State MSY program funding period for each child/youth served by the MSY program.
 - ✓ Failure to submit timely final updates may result in paused reviews of the requesting organization’s other MSY Program applications.

Applications for additional or shifted funds must be detailed and complete to be considered by the State MSY program. Authorization of additional or shifted funding is not guaranteed. Applications must:

- Be completed and submitted prior to the date that additional or shifted funds are needed. The State MSY team strongly recommends applications be submitted at least two weeks prior to the requested start date additional funds and at least one week prior to the requested start date for shifted funds.
- Be accompanied or preceded by complete and thorough updates (see information above). Failure to submit timely and complete updates will result in automatic denial of subsequent applications for additional or shifted funding.

SECTION 1: Submission Type, Funding History, Recommendations History

Requestor Information				
Organization Type: <input type="checkbox"/> Family and Children First Council <input type="checkbox"/> OhioRISE Care Management Entity				
Agency / Organization Name			Requestor Name	
County	Phone Number		Email	
Child/Youth Demographics				
Name			Social Security Number	
Date of Birth	Age in Years & Months	Gender/Gender Preference		Race/Ethnicity
Home Street Address		City		State Zip Code
Phone Number	Legal Guardian			County
Primary Insurer (if Medicaid, include ID #)			Secondary Insurer (if applicable)	

SECTION 2: Submission Type, Funding History, State MSY Team Recommendation Updates

Type of Submission		
<input type="checkbox"/> Routine update	<input type="checkbox"/> Urgent update	<input type="checkbox"/> Final update
Are you applying for additional or shifted MSY funding to support the child/youth's treatment?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Funding for this child/youth previously authorized by the State of Ohio's MSY Program. Insert rows as needed		
Date(s) of Services	Amount(s)	Provider(s)
to	\$	
to	\$	
State MSY Team Recommendations Updates		
Provide a running list of recommendations provided by the State MSY Team throughout the case (all recommendations provided by the State Team over time, not just the most recent) and an update from the child/youth's Team in response to each recommendation. Insert rows as needed.		
Recommendation	Update	

SECTION 3: Urgent Update Information

Provide the following information based on Team support and planning to address a disruption and/or change provider. All urgent updates must be accompanied by an updated care plan; urgent out of home updates must be accompanied by a discharge summary from the discharging out of home provider.

General Updates	
When did the disruption or change in provider occur?	
What led to the disruption or change?	
Who is working to support the child/youth and caregiver(s) during the transition?	
What services and/or supports were quickly put in place as a result of the disruption or change?	
What additional supports do the child/youth and/or the OhioRISE CFT or FCFC Service Coordination Team need at this point of transition?	
When is the next OhioRISE CFT or FCFC Service Coordination Team meeting?	
Out of Home Treatment Updates	
Where is the child/youth living now?	
Is child/youth is receiving treatment from a new out of home care provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	
IF YES	Date of admission: Provider(s) of service(s) and address:
Funder of new provider (note: shifting of MSY funds is not guaranteed):	

SECTION 4: Routine Update Information

Provide updates regarding the child/youth, caregiver(s), and team since MSY funding was most recently authorized.

Teaming and Local System Involvement

Has there been a change in custody and/or new interaction with the local Public Children's Services Agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES	How does this impact care for the child/youth? How does this impact sustainability and/or discharge planning?
Have there been changes in care coordination (new organization or care coordinator)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES	Describe the change and work completed to transition the child/youth's care and team.
Who is actively working to support the child/youth and caregiver(s) through participation in the FCFC Service Coordination Team or OhioRISE Child and Family Team (CFT) [the Team]?	<input type="checkbox"/> School or education provider <input type="checkbox"/> County child protection <input type="checkbox"/> County Board of Mental Health / Addiction Services <input type="checkbox"/> County Board of Developmental Disabilities <input type="checkbox"/> Juvenile Justice <input type="checkbox"/> Local Health Department and/or Bureau of Medical Handicaps <input type="checkbox"/> Opportunities for Ohioans with Disabilities/Employment <input type="checkbox"/> Service and support providers (describe) <input type="checkbox"/> Natural supports (describe) <input type="checkbox"/> Other		
Is the Team experiencing challenges with engaging individuals or systems that should be part of the Team?	<input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES	Describe the barriers and how the Team is working to alleviate them.
Child/Youth Treatment and Engagement Updates			
Describe the child's/youth's overall engagement in the services and supports funded by the MSY Program	<input type="checkbox"/> Declined to participate <input type="checkbox"/> Partially engaged <input type="checkbox"/> Fully engaged If barriers to engagement exist, describe the barriers and steps being taken to alleviate them:		
How has the child/youth recently responded to treatment?	<input type="checkbox"/> Condition improved <input type="checkbox"/> Condition declined <input type="checkbox"/> No change in condition		
Is the child/youth compliant with medication therapy? <input type="checkbox"/> Not applicable (not prescribed meds)	<input type="checkbox"/> Declined <input type="checkbox"/> Partial adherence <input type="checkbox"/> Full adherence If barriers to engagement exist, describe the barriers and steps being taken to alleviate them:		
If the child's/youth's condition and/or behaviors have not improved or declined, what adjustments are being made, how are these adjustment supported by the Team? <input type="checkbox"/> Not applicable			
Are the child's/youth's educational needs being met?	<input type="checkbox"/> Yes <input type="checkbox"/> No	IF NO	Describe the barriers and how the Team is working to alleviate these barriers
Caregiver, Family, and Living Arrangement Updates <i>Please note, caregiver engagement in the child's/youth's care is a requirement of the MSY Program.</i>			
Have there been any changes in the caregiver(s) willingness to ensure the child/youth can remain in the home or return to the home following out of home treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES	Describe the changes and the impact this will have on the child/youth.
Are there any barriers to the child/youth remaining in or returning to the caregiver(s)' home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES	Describe the barriers and how the Team is working to alleviate these barriers.
Describe the caregiver(s)' engagement in the child's/youth's care coordination.	<input type="checkbox"/> Declined to participate <input type="checkbox"/> Partially engaged <input type="checkbox"/> Fully engaged If barriers to engagement exist, describe the barriers and steps being taken to alleviate them:		

Describe the caregiver(s)' engagement in family therapy and/or other services and supports necessary to assure family integration for the child/youth.	<input type="checkbox"/> Declined to participate <input type="checkbox"/> Partially engaged <input type="checkbox"/> Fully engaged Dates of family therapy service: If barriers to engagement exist, describe the barriers and steps being taken to alleviate them:		
Describe any other relevant new caregiver and/or family dynamics that will impact the child/youth.			
For children/youth receiving out of home care, describe the following: <input type="checkbox"/> Not applicable (not receiving out of home care)	The frequency of caregiver(s) visits with the child/youth, any barriers in assuring visits regularly occur.		
	Has the child/youth participated in community and/or home visits?	<input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES Describe the experience(s) of the child/youth and caregiver(s)/family.
			IF NO Why Not?

Updated Assessments

List all recent assessments and/or clinical recommendations currently being used to inform care coordination and treatment planning. Include copies of the assessments with your supporting documentation.

Please note:

1. A CANS assessment update must be completed at least every 90 days while in receipt of MSY funding for out of home care. Requests for additional funding for out of home care must include a recommendation for continued out of home care in an updated CANS assessment or other updated clinical documentation.
2. An ASAM assessment is recommended for all children/youth with substance use disorders (SUDs). An ASAM assessment must be completed no more than 30 days prior to requesting additional funds for out of home SUD care.

Assessment Type	Date Completed	Recommended level of care

Clinical Recommendations

What levels and types of services and supports have recently been recommended by clinicians involved in the child's/youth's care?	
How are the clinical recommendations being incorporated into the child/youth's Care Plan, and if receiving out of home treatment, the discharge plan?	

Information about the recommending clinician(s):

Name	Credential(s)	Relationship to child/youth

SECTION 5: Sustainability Planning and PASSS

The MSY Program is intended to address acute needs and prevent immediate custody relinquishment. The Program is not intended to provide long-term funding to support long-term needs. Instead, the MSY Program can help fill in gaps while longer-term funding and services are put into place by the child's/youth's care Team.

How long does the Team anticipate the child/youth will need the types of services and supports that have been funded by the MSY Program?	
If the Team anticipates the child/youth will need extended services and supports that are currently being funded by the MSY Program, what funding sources are being explored to support the child/youth's long-term needs?	<input type="checkbox"/> Not applicable, extended services and supports are not likely to be needed
If the child or youth was adopted, do the caregivers receive adoption assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not adopted	
IF YES	All families receiving adoption assistance must apply for PASSS or exhaust PASSS prior to requesting MSY Program funding. PASSS must be applied for at the start of each new state fiscal year (July 1). Does the family need to apply for or reapply for PASSS? <input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 6: Final Update Information

Provide information based on recent Team support and plans to continue supporting the child/youth and their caregiver(s). Final updates for out of home care must be accompanied by a discharge summary and updated care plan.

Child/Youth Treatment and Engagement Updates	
How is the child/youth doing?	
How are the caregiver(s) and, if applicable, other family members doing?	
Describe the team of people that continue to support the child/youth and their caregiver(s) following the receipt of MSY funding.	
Describe the services and supports in place to support the long-term needs of the child/youth and their caregivers(s).	
What is the team doing to assure the child/youth and their caregiver(s) continue to get what they need following use of the MSY program?	
Describe any other relevant dynamics and/or barriers the Team will work to address as they support the child/youth and their caregiver(s)	

SECTION 7: Supporting Documentation

Check supporting documentation included with the update.

<p>All urgent, routine, and final updates <u>must</u> include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> An updated FCFC Service Coordination Plan or OhioRISE Child and Family Centered Care Plan (CFCP) <input type="checkbox"/> Team meeting notes indicating local system partner engagement and support of the child/youth and caregiver(s) <input type="checkbox"/> Progress notes from treatment provider(s) <p>Routine updates for out of home care <u>must</u> include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Updated assessments and/or clinical documentation that inform care coordination and treatment planning. If applying for additional funding for out of home care, the assessment or clinical documentation must indicate continued recommendations for out of home care. <ul style="list-style-type: none"> <input type="checkbox"/> Describe assessment or other clinical documentation: <input type="checkbox"/> Describe assessment or other clinical documentation: <input type="checkbox"/> Updated Discharge Plan – check at least one of the following: <ul style="list-style-type: none"> <input type="checkbox"/> An updated State Assistance Request Form Discharge Plan is included in Section 6, and/or <input type="checkbox"/> A separate detailed and thorough discharge plan is attached <p>Urgent and final updates for out of home care <u>must</u> include:</p>
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A discharge summary from the out of home care provider

Other

New PASSS award letter or verification of PASSS application

Other supporting documentation (describe):

SECTION 8: Request for Additional or Shifted State Assistance

Indicate the type(s) of assistance you are requesting by selecting items 1-5 below.

Funding requests may not be authorized until provider(s) of services are identified and the child/youth is accepted for service provision by the provider(s).

1. Technical assistance

Have you tried other TA? Please note, trying these avenues is not required to apply for TA

- Leveraging your organization's clinical leadership Contacting the OhioRISE Plan's Clinical Escalation Team (for OhioRISE enrollees)
 Making a referral for a System of Care ECHO <https://socoohio.org/soc-echo/> Other (describe)

Describe current barriers that could be addressed with technical assistance:

2. Funding for care coordination/wraparound to prevent custody relinquishment or for a relinquished child/youth.

Provider(s) of service(s):	Amount: \$	<input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days	Start date:	End Date:
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Detailed description of how funds will be used:

3. Funding for in-home and/or community supports to prevent custody relinquishment or for a relinquished child/youth transitioning to a community setting.

Provider(s) of service(s):	Amount: \$	<input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days	Start date:	End Date:
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Detailed description of how funds will be used for each provider listed:

Will the child/youth's primary or secondary insurance provide any amount of coverage for the supports: Yes No

IF NO: please provide an explanation for the gap in coverage (i.e., allowable amount has been exhausted, preferred provider doesn't accept insurance, etc.) and include documentation verifying coverage is not available.

<input type="checkbox"/> 4. Funding for out-of-home treatment to prevent custody relinquishment. <i>Cost and tentative discharge planning information must be provided below.</i>				
Provider(s) of service(s) and address:		Amount: \$	<input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days	Start date: _____ End Date: _____
Describe the treatment setting (e.g., QRTP, mental health or child protection group home, treatment home, I/DD waiver setting, etc.):				
Is the child/youth already being served in this out-of-home treatment setting? <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES	What date did the youth start receiving out-of-home treatment from this provider? What funding sources have been used to support the out-of-home treatment to date?	
Does the CANS or another clinical assessment recommend out of home care?			<input type="checkbox"/> Yes <input type="checkbox"/> No	IF NO Please do not apply for MSY funding for out-of-home care
Does the child/youth's care coordination team believe the child will gain therapeutic benefit from out of home treatment?			<input type="checkbox"/> Yes <input type="checkbox"/> No	IF NO Why not?
Does the child/youths OhioRISE Child and Family-Centered Care Plan or FCFC Plan of Care include a goal of out-of-home care?			<input type="checkbox"/> Yes <input type="checkbox"/> No	IF NO Why not?
Estimated daily itemized costs and payor coverage associated with the out-of-home funding request. Check and describe all that apply.				
Type of service	Daily Amount	OhioRISE Coverage	Medicaid MCO Coverage	Private Insurance Coverage
<input type="checkbox"/> Room & board	\$	N/A	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Treatment	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> 1:1 Supports	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other supportive services (describe):	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Out-of-home Care Updated Discharge Plan				
Goals	How will state funds be used to advance treatment goals for the child/youth prior to discharge?			
Timing	Anticipated date of discharge from this out-of-home treatment setting: _____ <input type="checkbox"/> Unknown because child/youth is not yet in out of home care Factors that will be considered when determining discharge date:			
Teaming	Who is actively participating in the care coordination team responsible for discharge planning, making decisions about and/or coordinating treatment?			
	Team member name	Contact information	Role in supporting the child/youth during the transition	

Living Arrangements	Where will the child/youth live in a family setting after discharging from out-of-home treatment funded by MSY?		
	If there isn't a plan for where the child/youth will live in a family setting after discharge, what steps will be taken during the first month of out-of-home treatment to identify where the child/youth will live in a family setting after discharge?		
	What will the caregivers do within the first month of out-of-home treatment to prepare for the child/youth's return?		
Treatment services needed to return to the community	Treatment Service	Provider	Funding Source
	If providers of the services indicated above are not available, what will the team do within the first month of out-of-home treatment to create access to similar services at an appropriate intensity?		
	What steps will be taken to coordinate aftercare with these providers:		
	Would the child/youth benefit from any of the above treatment services starting prior to the child/youth being discharged from the treatment facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES	Please explain:
Supports needed to return to the community	What supports will the child/youth need after discharge from out-of-home treatment?		
	What supports will the child/youth's caregivers need after discharge from out-of-home treatment?		
	What funding sources will be used to pay for the supports identified above?		