Multi-System Youth Custody Relinquishment Prevention Program Overview

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

- **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.** Funding will only be authorized for care provided on or after the date of application and for dates of service after custody return.
- **Children and youth served by the MSY program must have multi-system needs and be using creative multi-system supports**. All applicants must have a local/regional team working to coordinate and follow their care. The team must be actively working to use creative solutions to serve the unique needs of the child/youth and their caregiver(s). *Information about the team and creative solutions must be outlined in section 3 of the application.*
- **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.**
  - ✓ Applicants seeking funding for out-of-home care must document recent use of intensive levels of community-based care. The availability of intensive community care varies greatly across the state. In many cases, even when specific evidence-based and evidence-informed practices are not available, a mix of other outpatient services and supports – including natural supports – should be exhausted before using out-of-home care.
  - ✓ All applications for out-of-home care require a recent (within 30 days) CANS assessment recommending out-of-home care or other clinical documentation indicating the need for out-of-home care. Applications for out-of-home substance use disorder care require a recent (within 30 days) ASAM assessment recommending a residential level of care.
- **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 be willing to have the young person return to the home as quickly as clinically appropriate. *Legal guardians must affirm their commitments using the Requestor and Legal Guardian Attestation Form.*
- **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/youth's care team.
- **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, post-adoption assistance funds, and other sources of funding are used first. MSY Program funding cannot be used to supplant other funds. *Information about exhaustion of local resources and other payment sources must be documented in section 5 of the application.*

Multi-System Youth Custody Relinquishment Prevention Program Application

FCFCs should email applications to MSY@medicaid.ohio.gov.
OhioRISE care coordinators should email applications to OHRMSYapplications@aetna.com.
All applications must be encrypted when emailed.

All sections of the application must be completed. Incomplete applications will not be processed and will be returned to the submitter for completion.

☐Check this box when the child/youth is at risk for custody relinquishment or other significant challenges within the next 3 business days. Provide a brief explanation of the circumstances and key dates.

☐Check this box if the youth is currently hospitalized.

Date of hospitalization:	Anticipated date of discharge:

SECTION 1: Child / Youth and Caregiver Information

Requestor Information			
Organization Type: ☐ Family and Children First Council ☐ 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)*	

Caregivers, Living Arrangements, Adoption Assistance, Custody Relinquishment

Caregiver Name	**Relationship**

Where is the child/youth living now?
If the child/youth is not living at home now, when did they last live at home and what caused that to change?
Describe others living in the home now, or others who will be in the home when child/youth returns:
Describe any concerning family or relational dynamics between the child/youth and their caregivers:

If the child/youth lives at home, describe any barriers to the child/youth successfully remaining in the family home. If the child/youth is living out of the home, describe any barriers to them returning to a family home:	
Outline supports the child/youth's caregivers and family need for the child/youth to successfully live at home:	
If the child or youth was adopted, do the caregivers receive adoption assistance? ☐ Yes ☐ No ☐ Not adopted	
IF YES	All families with an adopted child/youth must apply for PASSS or exhaust PASSS prior to requesting MSY Program funding. **A copy of the PASSS award letter or verification of PASSS application must be submitted with this application.** Information regarding PASSS: https://ohiokan.jfs.ohio.gov/passss/ Date of last application for PASSS funding: Status of last application: ☐ Pending ☐ Awarded ☐ Denied Current PASSS award: Amount: $ Dates: to Covered services:

Is the youth at risk of custody relinquishment? ☐ Yes ☐ No	IF YES: briefly describe the factors contributing to the risk of custody relinquishment:
Has the youth recently been relinquished solely for the purposes of accessing treatment? ☐ Yes ☐ No	IF YES: describe the factors that led to relinquishment and indicate when custody will transition back to the family if funding is authorized:

OhioRISE Enrollment and Care Coordination		
OhioRISE Enrollment: ☐ OhioRISE Program ☐ OhioRISE Waiver ☐ Not Enrolled		
IF NO	Has the youth been offered / referred for a CANS assessment to determine OhioRISE eligibility? ☐ Yes ☐ No IF NO, why?	
IF YES	OhioRISE Care Coordination Engagement: ☐ Yes ☐ No ☐ Declined OhioRISE Care Coordination Tier: ☐ 1 ☐ 2 ☐ 3	Notes about tier assignment:
	If enrolled in OhioRISE and not engaged in OhioRISE care coordination ('No' or 'Declined' above) detail the reason why:	

Strengths	
Child/youth strengths	
Caregiver strengths	
Brief Overview of Behavioral, Physical Health, and Intellectual/Developmental Disabilities (I/DD) Challenges	
Behavioral health and/or I/DD diagnoses	
Other relevant diagnoses	
Physical health challenges	
Trauma history	

Safety considerations	

Assessments

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

Please note:

1. A CANS assessment must be completed no more than 30 days prior to requesting funding for out-of-home care.
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 funding for out-of-home SUD care.

Assessment Type	Date Completed	Recommended level of care

Clinical Indications

What levels and types of services and supports have recently been recommended by clinicians involved in the child/youth's care? Ex: intensive community-based mental health and/or I/DD services, short-term out-of-home stabilization care, residential treatment services to address XX diagnoses, etc.

Information about the recommending clinician(s):

Name	Credential(s)	Relationship to child/youth

SECTION 2: History of Services and Supports

Indicate **all** current and **previous** services that have been used to support the child/youth's multi-system needs.

Individual Counseling

Has youth ever had individual counseling? ☐ Yes ☐ No

IF NO: why?

Is youth **currently** linked with individual counseling? ☐ Yes ☐ No

IF YES	Agency:	Name of provider:
	Approx. date service began:	Duration of service:
	Youth engagement in service: ☐ Declined to participate ☐ Barriers to engagement ☐ Fully engaged Describe engagement and barriers to engagement, if any:	
	Youth response to service: ☐ Condition improved ☐ Condition declined ☐ No change in condition	
IF NO	List **all previous encounters** including approximate dates of service, reason for discontinuation, youth engagement and response, caregiver engagement, and summary of clinical recommendations at discharge.	

Family Counseling

Has youth ever had family counseling: ☐ Yes ☐ No

IF NO, why?

Is youth **currently** linked with family counseling? ☐ Yes ☐ No

IF YES	Agency:	Name of provider:
	Approx. date service began:	Duration of service:
	Youth engagement in service: ☐ Declined to participate ☐ Barriers to engagement ☐ Fully engaged Describe engagement and barriers to engagement, if any:	
	Youth response to service: ☐ Condition improved ☐ Condition declined ☐ No change in condition	
	Caregiver engagement in service: ☐Declined to participate ☐Barriers to engagement ☐Fully engaged Describe barriers to engagement, if any:	
IF NO	List **all previous encounters,** including approximate dates of service, reason for discontinuation, youth engagement and response, caregiver engagement, and summary of clinical recommendations at discharge.	

Intensive In-Home and Community-Based Services

Intensive in-home and community-based services include, but are not limited to: Intensive Home-Based Treatments (IHBT), Applied Behavior Analysis (ABA) Therapies, Intensive Outpatient Programs (IOP), Partial Hospitalization Programs, and Mobile Crisis Response

Has youth ever had intensive levels of in-home and/or community-based services? ☐ Yes ☐ No

IF NO, why?	☐ Not available in area ☐ Time constraints prevent child/youth/family's participation ☐ On waitlist ☐ Other (describe):
IF NO, explain	How has the team supporting the child/youth creatively worked to create an intensive level of care and supports for the young person?

Has youth ever had **Intensive Home-Based Treatment (IHBT)** services? ☐ Yes ☐ No

IF YES	☐ Current ☐ Past	Start Date: End Date (if past):
	Which type of intensive in-home treatment: ☐ IHBT ☐ FFT ☐ MST ☐ Other (CBFT, PLL, etc.):	
	Agency:	Name of provider:
	Youth engagement in service: ☐ Declined to participate ☐ Barriers to engagement ☐ Fully engaged Describe engagement and barriers to engagement, if any:	
	Youth response to service: ☐ Condition improved ☐ Condition declined ☐ No change in condition	
	Caregiver engagement in service: ☐Declined to participate ☐Barriers to engagement ☐Fully engaged Describe barriers to engagement, if any:	
	If past service, reason for discontinuation and summary of clinical recommendations at discharge:	

Has youth ever had **Applied Behavior Analysis (ABA)** therapy? ☐ Yes ☐ No

IF YES	☐ Current ☐ Past	Start Date: End Date (if past):
	Agency:	Name of provider:
	Youth engagement in service: ☐ Declined to participate ☐ Barriers to engagement ☐ Fully engaged Describe engagement and barriers to engagement, if any:	
	Youth response to service: ☐ Condition improved ☐ Condition declined ☐ No change in condition	
	Caregiver engagement in service: ☐Declined to participate ☐Barriers to engagement ☐Fully engaged	

	Describe barriers to engagement, if any:	
	If past service, reason for discontinuation and summary of clinical recommendations at discharge:	
Has youth ever had **Intensive Outpatient Program (IOP)** services? ☐ Yes ☐ No		
IF YES	☐ Current ☐ Past	Start Date: End Date (if past):
	IOP is/was for: ☐ Mental Health ☐ Substance Use Disorder	
	Agency:	Name of provider:
	Youth engagement in service: ☐ Declined to participate ☐ Barriers to engagement ☐ Fully engaged Describe engagement and barriers to engagement, if any:	
	Youth response to service: ☐ Condition improved ☐ Condition declined ☐ No change in condition	
	Caregiver engagement in service: ☐Declined to participate ☐Barriers to engagement ☐Fully engaged Describe barriers to engagement, if any:	
	If past service, reason for discontinuation and summary clinical recommendations at discharge:	
Has youth ever had **Partial Hospitalization Program (PHP)** services? ☐ Yes ☐ No		
IF YES	☐ Current ☐ Past	Start Date: End Date (if past):
	PHP is/was for: ☐ Mental Health ☐ Substance Use Disorder	
	Agency:	Name of provider:
	Youth engagement in service: ☐ Declined to participate ☐ Barriers to engagement ☐ Fully engaged Describe engagement and barriers to engagement, if any:	
	Youth response to service: ☐ Condition improved ☐ Condition declined ☐ No change in condition	
	Caregiver engagement in service: ☐Declined to participate ☐Barriers to engagement ☐Fully engaged Describe barriers to engagement, if any:	
	If past service, reason for discontinuation and summary clinical recommendations at discharge:	
Has youth ever had **Mobile Crisis Response** services, including **MRSS**? ☐ Yes ☐ No		
IF YES	☐ Current ☐ Past	Start Date: End Date (if past):
	Agency:	Name of provider:
	Youth engagement in service: ☐ Declined to participate ☐ Barriers to engagement ☐ Fully engaged Describe engagement and barriers to engagement, if any:	
	Youth response to service: ☐ Condition improved ☐ Condition declined ☐ No change in condition	
	Caregiver engagement in service: ☐Declined to participate ☐Barriers to engagement ☐Fully engaged Describe barriers to engagement, if any:	
	If past service, reason for discontinuation and summary clinical recommendations at discharge:	
Respite		
Has youth ever had respite? ☐ Yes ☐ No		
IF NO, explain	Would the youth and family benefit from respite? ☐ Yes ☐ No. IF YES… Have both agency-provided and natural respite sources been explored? ☐ Yes ☐ No	

	What barriers are preventing the use of respite and how have you attempted to alleviate the barriers?		
IF YES	☐ Current ☐ Past	Start Date:	End Date (if past):
	Name of provider(s) and/or natural support(s):		
	Frequency of service:		
	Reason(s) for the service:		
	Youth response to the service:		
	Caregiver response to the service:		
	If past service, reason for discontinuation:		
Psychiatry, Medication Therapy			
Is youth currently prescribed medications to address behavioral/developmental needs? ☐ Yes ☐ No			
IF YES	Current medications:		
	Prescriber(s) credential: ☐Psychiatrist/psych APRN or PA ☐ Primary Care Provider (i.e. pediatrician)		
	Agency(ies):	Name(s) of provider:	
	Approx. date service(s) began:	Duration of service(s):	
	Youth compliance with medication therapy:☐ Declined ☐Partial adherence ☐Full adherence Describe barriers to engagement, if any:		
	Youth response to service: ☐Condition improved ☐Condition declined ☐No change in condition		
	Caregiver engagement in service: ☐Declined to participate ☐Barriers to engagement ☐Fully engaged Describe barriers to engagement, if any:		
IF NO	List **all previous encounters** including past medications used, approximate dates of service, youth adherence, caregiver engagement, and summary of clinical recommendations provided upon stopping therapy.		
Emergency Department Visits to Address Psychiatric, Developmental, Substance Use Needs (within past 12 mo.)			
Has youth visited an emergency department for psychiatric, developmental, SUD reasons? ☐ Yes ☐ No			
IF YES	Approx. number of visits:	Date of last visit:	
	Reason for each ED visit(s), clinical recommendations provided upon discharge:		
Inpatient Admissions to Address Psychiatric, Developmental, Substance Use Needs (within past 12 mo.)			
Has youth had a hospital admission for psychiatric, developmental, SUD reasons? ☐ Yes ☐ No			
IF YES	Approx. number of admissions:	Date of last admission:	
	Reason for admission, name of hospital for each psychiatric inpatient admission(s), and summary of clinical recommendations provided upon discharge:		
Services to Address Intellectual and Developmental Disabilities, incl. I/DD Waiver, Other County Board Services			
Does the youth have needs that could be met by the I/DD system? ☐ Yes ☐ No			
Has child/youth been referred for a county board I/DD assessment? ☐ Yes ☐ No Referral Date:			
Eligible for CBDD services (non-waiver): ☐ Yes ☐ No ☐Not yet determined			
Has child/youth received I/DD waiver level of care assessment? ☐ Yes ☐ No Assessment Date:			
IF YES	Waiver status If enrolled, which waiver?		

Is the youth currently receiving services to support I/DD needs? ☐ Yes ☐ No	
IF YES	Describe the type of service(s), approximate dates of service(s), and frequency of service(s):
	Youth response to the service:
	Caregiver response to the service:
IF NO	List **all previous services** including types of service(s), approximate dates, reason for discontinuation, youth engagement and response, caregiver engagement, and summary of clinical recommendations at discharge.

Congregate Out-of-Home Treatment		
Is youth currently receiving **congregate treatment at a residential facility**? ☐ Yes ☐ No		
IF YES	Name and address of residential facility treatment provider:	
	Admission Date:	Anticipated Discharge Date:
	Type of treatment provider: ☐ QRTP ☐ Other Residential ☐ ICF/IID ☐ PRTF ☐ Other:	
IF NO	Has youth ever received out-of-home treatment: ☐ Yes ☐ No	
	Approx. number of admissions:	Date of last admission:
	Dates of service, name of treatment provider, type of treatment, reason for each admission, reason each stay was discontinued, and summary of clinical recommendations upon discharge:	
Is youth currently receiving **congregate treatment at a therapeutic group home**? ☐ Yes ☐ No		
IF YES	Name and address of therapeutic group home:	
	Start date:	Anticipated discharge date:
	Therapeutic services being delivered by the group home:	
IF NO	Has youth previously lived in a therapeutic group home? ☐ Yes ☐ No	
	List name(s) of any previous therapeutic group homes where the youth received care, approximates dates, reasons for each stay, therapeutic services delivered, reason each stay was discontinued, and summary of clinical recommendations upon discharge:	

Treatment Home / Treatment Foster Home	
Is youth currently receiving treatment while in a **treatment home / treatment foster home**? ☐ Yes ☐ No	
IF YES	Name and address of treatment home:
	Therapeutic services currently delivered by the treatment home:
IF NO	Has youth previously lived in a treatment home / treatment foster home? ☐ Yes ☐ No
	List name(s) of any previous treatment homes where the youth resided, approximates dates, reasons for each stay, and reason each stay was discontinued:

Other:
Describe any other current or previous behavioral health and I/DD related services:

SECTION 3: Current & Past Involvement with Local Child-Serving Systems, Creative Team Approaches

Indicate the child/youth and family's involvement with local / state systems.

☐ **School or Education Provider**		
Actively participates in youth's Care Coordination Team ☐ Yes ☐ No ☐ NA		
Name of school or education provider:		
How often is the child/youth receiving education (days, hours):		
Has there been a recent change in school or education provider: ☐ Yes ☐ No	IF YES	Describe the reason for change:
Special education: eligibility category (IEP, 504, others):		
Basis for eligibility determination (from ETR):		
Types of specially designed services:		
History of intensity and frequency of behavior and/or truancy:		
Progress report (current and previous):		
Contributors to below average academic performance:		

☐ **County Child Protection**	Involvement is: ☐ Current ☐ Past	Open Case: ☐ Yes ☐ No
Actively participates in youth's OhioRISE CFT or FCFC Service Coordination Team: ☐ Yes ☐ No ☐ NA		
Is youth currently in custody? ☐ Yes ☐ No If NO, is the PCSA considering taking custody? ☐ Yes ☐ No	Youth was previously in custody: ☐ Yes ☐ No If YES, list dates of custody: to	
Circumstances that lead to involvement with this system:		

☐ **County Board of Mental Health / Addiction Services**	Involvement is: ☐ Current ☐ Past
Actively participates in youth's OhioRISE CFT or FCFC Service Coordination Team: ☐ Yes ☐ No ☐ NA	
Describe involvement:	

☐ **County Board of Developmental Disabilities (CBDD)**	Involvement is: ☐ Current ☐ Past
Actively participates in youth's OhioRISE CFT or FCFC Service Coordination Team: ☐ Yes ☐ No ☐ NA	
Describe involvement:	

☐ **Juvenile Justice**	Involvement is: ☐ Current ☐ Past
Actively participates in youth's OhioRISE CFT or FCFC Service Coordination Team: ☐ Yes ☐ No ☐ NA	
Circumstances that lead to involvement with this system:	

Is MSY Program funding being requested for services that are court-ordered? ☐ Yes ☐ No	IF YES	Do you have clinical documentation recommending the services? ☐ Yes ☐ No *Please include clinical documentation with the application*
Youth has been adjudicated delinquent: ☐ Yes ☐ No	IF YES	Highest-level adjudication: ☐ Status ☐Misdemeanor ☐Felony Youth is/will be on probation/parole: ☐ Yes ☐ No
Currently in a DYS or County Youth Detention facility: ☐ Yes ☐ No	IF YES	Describe reason for detention, length of detention, name of facility, and anticipated release date:

☐ **Local Health Dept. and/or Bureau of Medical Handicaps**	Involvement is: ☐ Current ☐ Past
Actively participates in youth's OhioRISE CFT or FCFC Service Coordination Team: ☐ Yes ☐ No ☐ NA	
Describe involvement:	

☐ **Opportunities for Ohioans with Disabilities/Employment**	Involvement is: ☐ Current ☐ Past
Actively participates in youth's OhioRISE CFT or FCFC Service Coordination Team: ☐ Yes ☐ No ☐ NA	
Describe involvement:	

☐ **Other System(s):**	Involvement is: ☐ Current ☐ Past
Actively participates in youth's OhioRISE CFT or FCFC Service Coordination Team: ☐ Yes ☐ No ☐ NA	
Describe involvement:	

Describe the creative approaches the team is currently using and has attempted to use to support the unique needs of the child/family and their caregivers.

SECTION 4: Request for 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://socohio.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: $	☐ 30 days ☐ 60 days ☐ 90 days ☐ Other	Start date:	End Date:

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: $	☐ 30 days ☐ 60 days ☐ 90 days ☐ Other	Start date:	End Date:

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.

☐ **4. Funding for out-of-home treatment to prevent custody relinquishment.** ***Cost and tentative discharge planning information must be provided below.***			
Provider(s) of service(s) and address:	Amount: $	☐ 30 days ☐ 60 days ☐ 90 days ☐ Other	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? ☐ Yes ☐ 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?	☐ Yes ☐ 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?	☐ Yes ☐ 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?	☐ Yes ☐ 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**
☐ Room & board	$	N/A	N/A	☐ Yes ☐ No
☐ Treatment	$	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ 1:1 Supports	$	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Other supportive services (describe):	$	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Out-of-home Care Tentative 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: ☐ 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**

<table>
<tr><td rowspan="3">Living Arrangements</td><td>Where will the child/youth live in a family setting after discharging from out-of-home treatment funded by MSY?</td><td colspan="3"></td></tr>
<tr><td>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?</td><td colspan="3"></td></tr>
<tr><td>What will the caregivers do within the first month of out-of-home treatment to prepare for the child/youth’s return?</td><td colspan="3"></td></tr>
<tr><td rowspan="5">Treatment services needed to return to the community</td><td colspan="4"><table>
<tr><th>Treatment Service</th><th>Provider</th><th>Funding Source</th></tr>
<tr><td></td><td></td><td></td></tr>
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<tr><td>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?</td><td colspan="3"></td></tr>
<tr><td>What steps will be taken to coordinate aftercare with these providers:</td><td colspan="3"></td></tr>
<tr><td>Would the child/youth benefit from any of the above treatment services starting prior to the child/youth being discharged from the treatment facility? ☐Yes ☐No</td><td>IF YES</td><td colspan="2">Please explain:</td></tr>
<tr><td rowspan="3">Supports needed to return to the community</td><td>What supports will the child/youth need after discharge from out-of-home treatment?</td><td colspan="3"></td></tr>
<tr><td>What supports will the child/youth’s caregivers need after discharge from out-of-home treatment?</td><td colspan="3"></td></tr>
<tr><td>What funding sources will be used to pay for the supports identified above?</td><td colspan="3"></td></tr>
</table>

SECTION 5: Local Fund Use Attestation for Funding Requests

Technical Assistance applicants can skip this section.

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, post-adoption assistance funds, and other sources of funding are used first. MSY Program funding cannot be used to supplant other funds.

Describe how local funds have been used and exhausted prior to applying for MSY funds. Include detailed information about funding sources, how and when funds have been used, and amounts. **MSY funding will not be authorized if local resources are not first used and exhausted.**

Check the boxes below to indicate each of the specific financial resources that have been explored and/or exhausted to support the child/youth and their caregiver(s) as they are facing the risk of custody relinquishment.

Resource Explored?	**Child / Family Eligible?**	**Reasonably exhausted?**
☐ Local Child Protection System Funding	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Local FCFC Funding, which may include: • FCFC Flexible pooled funding • MSY-PCSA funds • Family Centered Services and Supports (FCSS) • Local pooled funding	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Local Developmental Disabilities Board Funding	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Local Mental Health / Addiction Board Funding	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Post Adoption Special Services Subsidy (PASSS)	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Private health insurance	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Medicaid / Medicaid Managed Care	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ OhioRISE	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ OhioRISE Flex Funds	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ OhioRISE 1915 (c) Waiver	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Prevention, Retention, and Contingency (PRC)	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Child Support	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ SSI/SSDI, SS Survivor's Benefits	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
☐ Other (describe)		

SECTION 6: Supporting Documentation

Check additional supporting documentation included with the application.

☐ FCFC Service Coordination Plan or OhioRISE Child and Family Centered Care Plan (CFCP) **(required for all)**

☐ Assessments that inform care coordination and treatment planning **(required for all out of home care)**
Type of Assessment:
Type of Assessment:
Type of Assessment:

☐ PASSS award letter or verification of PASSS application **(required if child/youth is adopted)**

☐ Hospital (inpatient and/or emergency room) discharge summary

☐ Mental health or substance use treatment plan ☐ Developmental Disabilities Service Plan

☐ Educational records (Progress reports, IEP, 504 Plan, ETR, Disc) ☐ Other supporting documentation