|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name and Contact Information County Child Welfare Department Representative** | | | | | |
| Name: |  | | | | |
| Title: |  | | | | |
| Agency Name: |  | | | | |
| Address: |  | | | | |
| City: |  | State: |  | Zip Code: |  |
| Phone: |  | E-mail: |  | | |

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| --- | --- | --- | --- | --- | --- |
| **Name and Contact Information County Mental Health Department Representative** | | | | | |
| Name: |  | | | | |
| Title: |  | | | | |
| Agency Name: |  | | | | |
| Address: |  | | | | |
| City: |  | State: |  | Zip Code: |  |
| Phone: |  | E-mail: |  | | |

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| **PART A: Potential Subclass Members Identified During the Reporting Period** | | | |
| **Item #** | **Information Requested** | **Column 1**  **Beneficiary Count** | **Column 2**  **Next Steps/Timelines** |
| 1 | Potential Subclass Members |  |  |
| 2 | Potential Subclass Members who received a mental health assessment and do not meet medical necessity criteria for SMHS. |  |  |
| 3 | Potential Subclass Members who have been referred to MHP for a full mental health assessment to determine medical necessity criteria for SMHS, and have not yet been assessed. |  |  |
| 4 | Potential subclass members who were unknown to the MHP during the reporting period. |  |  |

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| **PART B: Services Provided to Identified Subclass Members at Any Time During the Reporting Period** | | | |
| **Item #** | **Information Requested** | **Column 1**  **Beneficiary Count** | **Column 2**  **Timelines** |
| 1 | Subclass Members |  |  |
| 2 | Receiving Intensive Care Coordination (ICC). |  |  |
| 3 | Receiving Intensive Home Based Services (IHBS). |  |  |
| 4 | Receiving intensive Specialty Mental Health Services (SMHS) through a Wraparound Program or Full Service Partnership Program consistent with the Core Practice Model (CPM), but not claimed as ICC and IHBS.  *Do not include youth already counted in 2 or 3 above.* |  |  |
| 5 | Receiving other intensive SMHS, but not receiving ICC or IHBS.  Examples of intensive SMHS may include:  Therapeutic Behavioral Services (TBS), Intensive Treatment Foster Care (ITFC), or Multidimensional Treatment Foster Care (MTFC).  *Do not include youth already counted in 2, 3, or 4* |  |  |
| 6 | Receiving mental health services not reported in 2, 3, 4, & 5 above (include children who are receiving mental health services outside of the Medi-Cal mental health system, i.e. services paid for by private insurance or other sources). |  |  |
| 7 | Not receiving mental health services (neither through Medi-Cal nor through any other program or funding source). |  |  |
| 8 | Declined to receive ICC or IHBS. |  |  |

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| **PART C: Projected Services** | | | |
| **Item #** | **Service** | **Projected number of subclass members to be receiving services by August 31st** | **Strategy/Timeline Description**  Provide County action steps and timelines to be used to provide (and claim for) ICC and IHBS to subclass members. |
| 1 (a) | ICC |  |  |
| 1 (b) | IHBS |  |  |

**Is your county experiencing the following implementation barriers?**

|  |  |  |
| --- | --- | --- |
| Hiring | Yes | No |
| Training | Yes | No |
| Service Availability | Yes | No |
| County Contracting Process | Yes | No |

Please provide an explanation for any Yes responses above. Are there other barriers not listed above? Explain and add pages, as needed.

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