

APPENDIX CMH-1

TEMPORARY SASS ELIGIBILITY NOTICE

Notice of Eligibility and Referral for
Illinois Children’s Mental Health
Screening, Assessment and Support Services

Date of Notice:

Effective _____, the child or teenager named below is eligible for mental health Screening, Assessment and Support Services (SASS). This SASS mental health coverage will end at midnight on _____.

Keep this notice. You may need to show it to get services for your child.

Name	Date of Birth	Recipient ID Number
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The SASS agency named below will assess your child’s need for mental health services.

This agency will decide whether your child can receive mental health services in the community. If a doctor decides your child needs to be admitted to a hospital, the agency will work with the hospital to plan for services in the community after discharge. The agency will provide or arrange for all of your child’s SASS mental health services. The agency will coordinate your child’s care. It is important that you work closely with the agency.

Your child’s mental health services have to be approved ahead of time. Talk to your SASS agency about the treatment plan. Covered services may include community mental health services and transportation to and from a clinic, doctor’s office or hospital for treatment. Your child may also be covered for certain medications, crisis intervention, assessment and planning as well as treatment.

You have the right to choose providers to treat your child. If you want the state of Illinois to pay for your child’s treatment, you must choose a provider that is enrolled in this program. Talk to your SASS agency about available providers.

If your child has a mental health emergency and needs help right away, call your SASS case manager at _____. Persons using a TTY can call _____.

Notice to Providers: To verify eligibility for the person named above, use the MEDI internet system at <http://www.myhfs.illinois.gov/>, your REV vendor or HFS’ Automated Voice Response System (AVRS).

HFS 3780D (N-07-04)

IL 478-2504

APPENDIX CMH-2

FAMILY RESOURCE DEVELOPER (FRD) JOB DESCRIPTION

Current emerging research recognizes the benefits to consumer families of direct contact with a Family Resource Developer (FRD) as part of the care team. The position should be an effective resource for peer/consumer information and support for SASS children. The FRD should also serve as an efficient channel for consumer feedback to the SASS provider. The following guidelines have been developed to assist SASS programs for using the positions as intended.

Selections 1 and 2 highlight qualifications and competencies to be considered in hiring for the position. Section 3 discusses responsibilities of the SASS provider in relation to the FRD position. Sections 4,5,6 and 7 present a MENU of options from which the individual job description can be assembled as per the needs of the SASS children and community.

SECTION 1 FRD - Qualifications

- FRD must be a parent or caregiver who has navigated multiple child serving systems on behalf of a child or adolescent with Severe Emotional Disturbance (SED) as a consumer of the mental health system.
- FRD must have, at a minimum, a high school diploma or equivalency.
- FRD must have a valid driver's license, access to a fully insured motor vehicle, proof of insurance, and meet the employers driving record criteria.
- FRD must pass a State of Illinois background check, as required by employing SASS provider.

SECTION 2 FRD - Competencies

Ability to demonstrate the following:

- To work collaboratively as a member of a team that includes families, children, SASS provider staff and other providers in the community.
- To communicate effectively in both written and verbal formats.
- To demonstrate sensitivity to the impact of ethnicity, race, culture, economic differences, sexual orientation, differing lifestyles, religious background, and individualized family values as they impact upon consumers of service.
- To organize work activities and maintain records.
- To utilize reporting procedures as directed by the SASS provider.
- To be resourceful and knowledgeable about community resources.
- To show initiative and be self-motivated in the position of FRD.
- To show good judgment in discharging the responsibilities of the position and in advocating for the best interests of children.
- To learn, understand, and adhere to the SASS provider's policies, procedures, structure and table of organization.
- To understand the SASS provider's mission, vision and values, and be able to impart them.
- To prioritize activities in collaboration with the supervisor.
- To know when to ask for help.
- To navigate multiple systems of care, i.e., education, mental health, juvenile justice, healthcare, Department of Child and Family Services, etc.
- To have effective interpersonal skills.

SECTION 3 SASS Provider's Responsibilities to FRD Position

- Commitment from SASS Provider's executive director, board of directors and staff to support the FRD position.
- Prepare the SASS provider's culture to accept, support and integrate the role of the FRD.
- Provide orientation to SASS provider's context: How the FRD position relates to other programs and overall SASS provider's organization.
- Provide training for all job responsibilities, i.e., mental illness, parents' rights, youth's rights, documentation, reporting, confidentiality, mandated training, abuse and neglect issue.

- Provide a designated person who acts in the role of supervisor, and who holds regularly scheduled meetings with the FRD to discuss position activities.
- Provide the FRD with resources and support services as required to fulfill the responsibilities of the position, i.e., equipment for communication: computers, phones, fax machines, pagers, as well as, copier availability and clerical support.
- Provide flexible benefits to support a parent or caregiver of a child with SED, in the position of FRD in accord with SASS provider's policies, i.e., vacation, holidays, personal days, flexible hours, insurance benefits, relief time for emergencies, sick time, medical leave, etc.
- Reimbursement for business expenses consistent with the employers policies and procedures, i.e., travel time, mileage, tolls, parking per diem rate, hotels, telephone expenses, copies and travel.
- Allow portions of time for job related training and travel.
- Include the FRD in staff development activities and training.
- Provide the FRD with a formal evaluation of their work on a time schedule consistent with the employment policy of the SASS provider.
- Include the FRD in discussions and decisions about SASS services, policy, design of services, an advisory council, committees, etc.

SECTION 4 FRD - Parent Support Functions

- Provide information and link families to community resources.
- Participate in the orientation of new child's families to SASS services.
- Attend meetings with family members, in coordination with fellow team members, to advocate for and assist in the application for other services, i.e., court proceeding, school staffings, public assistance, etc.
- Maintain resource directory for the geographical area serviced by the SASS provider.
- Work with SASS provider to ensure family involvement in all aspects of services.
- Assist clinicians in identifying strengths and needs of the families.
- Increase engagement in care by assisting families in moving through the SASS provider intake process.
- Assist families in transition to other levels of service.
- Participate in the hospital discharge process by assisting with the development of sufficient parent support to enable follow through with the discharge plan.
- Be available to parents or caregivers via phone, pager or in person within SASS providers agreed upon time limits/assignment.
- Support consumer rights.
- Empower parents and families to make their own informed decisions about all aspects of services.
- Assist consumers in understanding, seeking and achieving the best possible outcomes for their child, including complete recovery.
- Attend SASS provider multi-disciplinary staffings when requested by the family or staff, in compliance with confidentiality restrictions.

SECTION 5 FRD - Education/Training Responsibilities

- Assist in increasing families' knowledge and understanding of what to expect when a child/family is involved with SASS services.
- Educate families regarding natural supports and community resources.
- Provide technical assistance and training for professional staff regarding family involvement.
- Give presentations to parents and professional groups as needed.
- Coordinate a space within the SASS provider where parents can access resources and information regarding mental health, i.e., Internet access, reading material, videotapes, self-help association information, handouts on diagnosis and medication.
- Recruit and educate parents to be advocates for children's mental health.
- Organize and conduct educational presentations on family consumer issues for other community agencies, i.e., schools, churches, community groups, etc.
- Provide information on linkage to parent organizations and supports.
- Provide consumer information on parent and youth rights and responsibilities.
- Participate with the SASS provider in policy development and implementation regarding changes in policies and procedures related to consumer/family needs.
- Conduct parent orientation to system of care, i.e., services, programs, etc.

SECTION 6 FRD - Program Evaluation Functions

- Recruit parents to involve them in evaluation, planning and implementation of services.
- Participate in the development, implementation, and evaluation of SASS services including such functions as: conducting focus groups, implementing consumer surveys, analyzing feedback received and formulating quality improvement plans.

SECTION 7 FRD - Meeting Attendance

Required:

Participate, as a member, in meetings, groups, or committees such as:

- Individual consultation with the supervisor
- A monthly FRD peer networking group
- SASS provider child and family centered consumer meetings

Suggested:

Participate, as a member, in meetings, groups or committees such as:

- Quarterly meeting with the executive director,
- DHS or DCFS consumer oriented meetings or advisory councils as indicated by the Departments,
- SASS provider quality assurance meetings,
- Relevant committee meetings.

APPENDIX CMH-3

INDIVIDUAL CARE GRANT PROGRAM SASS ICG SUPPORT PROTOCOL

ICG Facts

- The ICG program has received approximately 1,000 requests for applications per year over the past 3 years. Less than 1/3 of these requested applications are returned completed to the ICG program office.
- The ICG program funds approximately 450 severely emotionally disturbed children. ICG funding can be utilized for either residential treatment or intensive community based services.
- Approximately 24% of ICG recipients have successfully utilized ICG funding for intensive community based services.
- A “case management” pilot study conducted in fiscal years 2002 and 2003 showed that, of those children who utilized ICG funding for residential treatment the availability of an integrated community system decreased the amount of time spent in residential treatment and facilitated a coordinated transition home.

Since support and care coordination are key components of providing integrated services, DHS will implement a system that provides assistance to families at the time of the ICG application process, support while the ICG child is in residential care and support to the child utilizing intensive community based care. The SASS provider will serve as the administrative arm of the ICG program in the community and provide essential services to support ICG clients in short-term residential treatment, intensive community based care and during transition to a less restrictive level of care. DHS will reimburse SASS providers for the provision of comprehensive and coordinated care through the SASS support protocol and the SASS provider shall organize internal agency systems that are equipped to implement and carry out the protocol:

Application Assistance

Provide families with information that will help in the decision of applying for an Individual Care Grant.

Acquire and maintain knowledge about the Individual Care Grant program and Administrative Rule 135.

Assist families with the documentation compilation necessary to apply for an ICG.

Assist families in submitting a completed ICG application.

Reimbursement will be made upon submission of a completed application. Each completed application must be accompanied by a letter from the SASS provider with the child's name, Social Security number and date of completion.

It would be in the best interest of the SASS provider to facilitate timely receipt of the application.

Any application completed by a SASS provider that contains outdated material, or a completed application in which the child is ineligible due to age, (past the age of 17 years, 6 months) will not be reimbursable under this program.

Attend DHS/ICG training on ICG application process, protocol and rules.

Residential ICG Support

Acquire and maintain knowledge regarding the residential treatment facilities available to families.

Compile application packets for those families seeking residential services and assist with distribution to facilities.

Maintain ongoing facilitative relationships with families, schools and the child's community in order to support the service plan, including participation in the IEP meeting.

Provide no less than quarterly meetings with the family and residential case manager in person or by phone, if necessary.

Travel to the child's residential facility twice yearly if placed in Illinois, or an adjacent state (i.e. Indiana, Wisconsin). Travel once yearly if placed in any other state. During the visit, attend staffing and advocate for child and family. Assess and recommend supports to facilitate treatment plan, facilitate transition to intensive community based services, when indicated.

Provide biannual reports to ICG program office as specified for ICG recipients utilizing residential services.

Assist parents/guardians with completing the forms and documentation necessary to support the ICG recipient (e.g., annual review documentation)

Maintain communication with the family, client, facility and ICG program office.

Provide staff to attend DHS/ICG training, or meetings specific to residential care.

Acquire and maintain knowledge about the Individual Care Grant program, Administrative Rule 135 and protocols.

Assist with the transition planning when an ICG recipient transitions out of the ICG program, to residential or to adult services.

Maintain documentation of the support services rendered and provide that documentation to the DHS/ICG program office upon request.

Intensive Community Based Support

Acquire and maintain knowledge regarding intensive community based services.

The SASS provider shall have comprehensive knowledge regarding multi-disciplinary and multi-systems resources in the community.

The SASS provider shall offer the array of intensive community based ICG services, or have the ability to build and maintain relationships or alternate agreements with agencies or parties that can offer the array of community based ICG services.

These services include:

- Child Support Services
- Therapeutic Stabilization
- Behavior Management
- Young Adult Support Services

Complete an initial assessment with the child, family and other service providers such as school, residential and outpatient clinicians to develop a plan for services.

Maintain weekly communication with the family for the first month of community ICG services and at least monthly thereafter. Monitor satisfaction with the service provision. Assist the family with problem solving during the service delivery period.

Complete documentation necessary to obtain approval and authorization for community based ICG services.

- Initial Plan Development Form
- Initial Individual Services Plan- 30 days
- Cost Request Form
- Individual Service Plan – six-month report
- Diskette for Billing through ROC's system
- Annual Review Documentation

Assure that services provided through alternate arrangements follow the treatment plan and are provided as intended.

Coordinate and interface with the multiple providers involved with each ICG client so that the client receives comprehensive community based services.

Provide ongoing support functions to families regarding educational and other needs of the child, including advocating for the child within the school and support in the community. SASS should participate in IEP meetings.

Assist with the transition planning when an ICG recipient transitions out of the ICG program, to residential or to adult services.

Assist family with annual review documentation.

If a child is returning from residential treatment into the community, the SASS provider must communicate with the residential provider and ensure that a coordinated plan of care is available to the child and family at the time of discharge.

Provide staff to attend the DHS/ICG training, or meetings specific to intensive community-based care.

Maintain documentation of the support services rendered and provide that documentation to the DHS/ICG program office upon request.

DHS/ICG will only reimburse the SASS provider for intensive community based ICG services, whether those services are provided by SASS or provided through an alternate arrangement with another agency.

APPENDIX CMH-4

DHS APPROVED PHARMACEUTICAL CLASSES FOR NON-MEDICAID COVERED CHILDREN

The Medicaid prior approval requirements and drug utilization requirements, such as maximum daily dose and refill-to-soon limitations, will apply to the pharmaceutical services provided under the SASS program.

Below are the general categories of DHS Approved Pharmaceuticals for Children during the approved SASS period. For a complete listing refer to the Web site at <http://www.hfs.illinois.gov/sass/>.

- Anticholinergics
- Anti-Convulsants
- Antipsychotics
- Atypical Antipsychotics
- Beta-Adrenergic Blocking Agents
- Clonidine
- Novel Antidepressants
- Psychostimulants and Straterra
- Tri-Cyclic Antidepressants
- Tenex
- MAO Inhibitors – Monoamine Oxidase Inhibitors
- Sedative Hypnotics (Benzodiazepines, Ambien, and Newer)
- SSRIs - Serotonin Selective Reuptake Inhibitors

APPENDIX CMH-5

PROVIDER-BASED EXTENSION SUPPLEMENTAL

Community SASS providers may request an extension for up to 30 additional days of services for their agency and other involved Community Mental Health Providers utilizing the process detailed below:

WHEN TO MAKE AN EXTENSION REQUEST

- When a child is hospitalized within the last 30 days of SASS services
- When a child re-presents to the CARES line AND meets acuity within 14 days after the last day of the most current service period. Children that present in crisis to the CARES line 15+ days post-SASS services would be treated as a new referral
- When a SASS agency feels extended service time is needed to stabilize a child in crisis. Requests should be made 14 days prior to the end the client's current eligibility period.

WHAT CONSTITUTES A COMPLETE EXTENSION REQUEST PACKET

- Correctly completed Request For Extended SASS Services form
- All CSPI's completed within the current service period
- A CSPI dated within 5 days of the request

**Once a complete packet is received a decision will be sent within 3 business days via fax.*

HOW TO REQUEST AN EXTENSION

To request an extension for your SASS provider and other Community Mental Health Providers please submit a typed or clearly written Extension Request Packet via fax to:

SASS Extension Review Team
C/O Child and Adolescent Network
Fax Number: 1-773-794-4881

HOW TO ENSURE THE REQUEST FORM IS FILLED OUT CORRECTLY

Answer all questions.

- The request will not be processed without a correct RIN or without answers to all questions. An incomplete request will be sent back without a decision and delays the process.

Be Specific.

- For services provided or services anticipated by the SASS agency and/or other Community Providers please indicate the services, (i.e., intensive family therapy, therapeutic stabilization, individual therapy), frequency (# of times per week) and duration period (days, weeks, months). Clearly explain why mental health services cannot be provided in your outpatient program or referred to another outpatient program. The more information provided, the clearer a decision can be made without additional requests for information.

Do NOT use shortcuts.

- Do not use abbreviations, initials for your agency, or DSM-IV codes. The diagnoses must be clearly written on the request or your request will be returned. If more than one Axis I diagnosis exists, the primary diagnosis should be listed first.

Type your request into the template or write legibly.

HOW TO ENSURE A TIMELY RESPONSE

- Answer all the questions. This cannot be stressed enough.
- Send in the request packet 14 days prior to the end of the client's current service eligibility period.
- Provide an accurate fax number for responses to be sent and if possible, assign a person within your agency who would be responsible for receiving and distributing the results to the correct person.

HOW TO RESUBMIT ADDITIONAL INFORMATION

- Resubmit the Extension Request Packet with the additional information that may not have been included in the original request as soon as possible to avoid any disruptions in eligibility.

APPENDIX CMH-6

CLAIM PREPARATION AND MAILING INSTRUCTIONS FORM HFS 1443, PROVIDER INVOICE

Please follow these guidelines in the preparation of paper claims for imaging processing to ensure the most efficient processing by the Department:

- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script or any font that has connecting characters.
- Claims should be typed or computer printed in capital letters. The character pitch must be 10-12 printed characters per inch, the size of most standard Pica or Elite typewriters. Handwritten entries should be avoided.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as part of the original or as a result of photocopying a colored background, the print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold invoices or fasten attachment with staples.

A sample of Form HFS 1443 (Provider Invoice) may be found on the Department’s Web site: <<http://www.hfs.illinois.gov/medicalforms/>>. Instructions for completion of this invoice follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

- Required** = Entry always required.
- Optional** = Entry optional – In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claiming errors by the Department.
- Conditionally Required** = Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.
- Not Required = Fields not applicable to the provision of provider services.

COMPLETION

ITEM EXPLANATION AND INSTRUCTIONS

- Required** 1. **Provider Name** - Enter the provider's name exactly as it appears on the Provider Information Sheet.
- Required** 2. **Provider Number** - Enter the provider’s NPI.
- Required** 3. **Payee** - Enter the one-digit code of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet.

If no code is entered here, but the provider has designated more than one potential payee on the Provider Information Sheet, the claim will be rejected.
- Not Required 4. Role - leave blank.
- Not Required 5. Emer - leave blank.
- Not Required 6. Prior Approval – leave blank.
- Optional** 7. **Provider Street** - Enter the street address of the provider’s primary office. If the address is entered, the Department will, where possible, correct claims suspended due to provider eligibility errors. If the address is not entered, the Department will not attempt corrections.

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|-------------------------------|--|
| Conditionally Required | 8. Facility & City Where Service Rendered - This entry is required when Place of Service Code in Field 23 (Service Sections) is 99 (offsite). |
| Optional | 9. Provider City State ZIP - Enter city, state and ZIP code of provider. See Item 7 above. |
| Conditionally Required | 10. Referring Practitioner Name - Enter the name of the provider who referred the patient for services. |
| Required | 11. Recipient Name - Enter the patient's name exactly as it appears on the MediPlan Card, Temporary MediPlan Card, All Kids Card or Notice of Temporary All Kids Medical Benefits. Separate the components of the name (first, middle initial, last) in the proper sections of the name field. |
| Required | <p>12. Recipient No. - Enter the nine-digit number assigned to the individual as copied from the MediPlan Card, Temporary MediPlan Card, All Kids Card or Notice of Temporary All Kids Medical Benefits. Use no punctuation or spaces. Do not use the Case Identification Number.</p> <p>If the Temporary MediPlan Card does not contain the recipient number, enter the patient name and birthdate on the Provider Invoice and attach a copy of the Temporary MediPlan Card to the Provider Invoice. The Department will review the claim and determine the correct recipient number. See "Mailing Instructions" in this Appendix when a copy of the Temporary MediPlan Card is attached.</p> |
| Optional | 13. Birthdate - Enter the month, day and year of birth of the patient as shown on the MediPlan Card, Temporary MediPlan Card, All Kids Card or Notice of Temporary All Kids Medical Benefits. Use the MMDDYY format. |
| Not Required | 14. H Kids - leave blank. |
| Not Required | 15. Fam Plan - leave blank. |
| Not Required | 16. ST/AB - leave blank. |
| Required | 17. Primary Diagnosis - Enter the primary diagnosis which describes the condition primarily responsible for the patient's treatment. |
| Required | 18. Primary Diag. Code - Enter the specific ICD-9-CM or ICD-10 upon implementation, code for the primary diagnosis described in Item 17. |

Required	19. Taxonomy – Enter the appropriate ten-digit HIPAA Provider Taxonomy Code. Refer to Chapter 300, Appendix 5.
Optional	20. Provider Reference - Enter up to 10 numbers or letters used in the provider’s accounting system for identification. If this field is completed, the same data will appear on Form HFS 194-M-1, Remittance Advice, returned to the provider.
Conditionally Required	21. Ref Prac No - Enter the referring practitioner’s state license number, Social Security number or AMA number.
Not Required	22. Secondary Diag Code – leave blank.
	23. Service Sections: Complete one service section for each item or service provided to the patient.
Required	Procedure Description/Drug Name, Form and Strength or Size - Enter the description of the service provided or item dispensed.
Required	Proc. Code/NDC - Enter the appropriate CPT, HCPCS or NDC.
Conditionally Required	Modifiers – Enter the appropriate two-byte modifiers for the service performed.
Required	Date of Service - Enter the date the service was provided. Use MMDDYY format.
Required	Cat. Serv. - Enter the appropriate two-digit code for the category of service provided. The applicable codes are: 34 – Mental Health Rehab Option Services 47 – Mental Health Targeted Case Management Services
Conditionally Required	Delete - When an error has been made that cannot be corrected, enter an "X" to delete the entire Service Section. Only "X" will be recognized as a valid character; all others will be ignored.
Required	P.O.S. - Enter the two-digit Place of Service Code from the following list: 11 – Office (Onsite) 99 – Other Place of Service (Offsite)

Conditionally Required

Units/Quantity – Enter the appropriate number of units for the service.

Not Required

Modifying Units - leave blank.

Conditionally Required

TPL Code – If the patient's MediPlan or All Kids Card contains a TPL code, the code is to be entered in this field. If there is no TPL resource shown on the card, no entry is required. If more than one third party made a payment for a particular service, the additional payment(s) are to be shown in Section 25.

When the date of service is the same as the “Spendedown Met” date on the HFS 2432 (Split Billing Transmittal) attach the HFS 2432 to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields.

If Form HFS 2432 shows a recipient liability greater than \$0.00, the invoice should be coded as follows:

TPL Code	906
TPL Status	01
TPL Amount	the actual recipient liability as shown on Form HFS 2432
TPL Date	the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format.

If Form HFS 2432 shows a recipient liability of \$0.00, the invoice should be coded as follows:

TPL Code	906
TPL Status	04
TPL Amount	0 00
TPL Date	the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format.

**Conditionally
Required**

Status – If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank.

The TPL Status Codes are:

01 – TPL Adjudicated – total payment shown: TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box.

02 – TPL Adjudicated – patient not covered: TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.

03 – TPL Adjudicated – services not covered: TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered.

04 – TPL Adjudicated – spenddown met: TPL Status Code 04 is to be entered when the patient's Form HFS 2432 shows \$0.00 liability.

05 – Patient not covered: TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force.

06 – Services not covered: TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.

07 – Third Party Adjudication Pending: TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.

10 – Deductible not met: TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

**Conditionally
Required**

TPL Amount – If there is no TPL code, no entry is required. Enter the amount of payment received from the third party health resource. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" box.

Conditionally Required

TPL Date – A TPL date is required when any status code is shown. Use the date specified below for the applicable code:

Code	Date to be entered
01	Third Party Adjudication Date
02	Third Party Adjudication Date
03	Third Party Adjudication Date
04	Date from the HFS 2432
05	Date of Service
06	Date of Service
07	Date of Service
10	Third Party Adjudication Date

Required

Provider Charge - Enter the total charge for the service, not deducting any TPL.

Not Required

24. **Optical Materials Only** - leave entire section blank.

Sections 25 through 30 of the Provider Invoice are to be used: 1) to identify additional third party resources in instances where the patient has access to two or more resources and 2) to calculate total and net charges.

If a second third party resource was identified for one or more of the services billed in Service Sections 1 through 6 of the Provider Invoice, complete the TPL fields in accordance with the following instructions:

Conditionally Required

25 **Sect. #** - If more than one third party made a payment for a particular service, enter the Service Section Number (1 through 6) in which that service is reported.

If a third party resource made a single payment for several services and did not specify the amount applicable to each, enter the number 0 (zero) in this field. When 0 is entered, the third party payment shown in Section 25C will be applied to the total of all service sections on the Provider Invoice.

Conditionally Required

25A **TPL Code** - Enter the appropriate TPL Resource Code referencing the source of payment (General Appendix 9). If the TPL Resource Codes are not appropriate enter 999 and enter the name of the payment source in Section 35.

Conditionally Required

25B **Status** - Enter the appropriate TPL Status Code. See the Status field in Item 23 above for correct coding of this field.

Conditionally Required	25C TPL Amount - Enter the amount of payment received from the third party resource.
Optional	25D TPL Date - Enter the date the claim was adjudicated by the third party resource. (See the Adjudication Date field in Item 23 above for correct coding of this field.)
Conditionally Required	26 Sect. # - (See 25 above).
Conditionally Required	26A TPL Code – (See 25A above).
Conditionally Required	26B Status – (See 25B above).
Conditionally Required	26C TPL Amount – (See 25C above)
Conditionally Required	26D TPL Date – (See 25D above).
Conditionally Required	27 Sect. # - (See 25 above).
Conditionally Required	27A TPL Code – (See 25A above).
Conditionally Required	27B Status – (See 25B above).
Conditionally Required	27C TPL Amount – (See 25C above)
Conditionally Required	27D TPL Date – (See 25D above).

Claim Summary Fields: The three claim summary fields must be completed on all Provider Invoices. These fields are Total Charge, Total Deductions and Net Charge. They are located at the bottom far right of the form.

Required	28. Tot Charge - Enter the sum of all charges submitted on the Provider Invoice in Service Section 1 through 6.
Required	29. Tot Deductions - Enter the sum of all payments received from other sources. If no payment was received, enter three zeroes (000).

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|-------------------------------|---|
| Required | 30. Net Charges - Enter the difference between Total Charge and Total Deductions. |
| Required | 31. # Sects - Enter the total number of service sections completed correctly in the top part of the form. This entry must be at least one and no more than 6. Do not count any sections which were deleted because of errors. |
| Not Required | 32. Original DCN - leave blank. |
| Not Required | 33. Sect. – leave blank. |
| Not Required | 34. Bill Type – leave blank. |
| Conditionally Required | 35. Uncoded TPL Name - Enter the name of the third party health resource. The name must be entered if TPL code 999 is used. |
| Required | 36-37 Provider Certification, Signature and Date - After reading the certification statement, the provider must sign the completed form. The signature must be handwritten in black or dark blue ink. A stamped or facsimile signature is not acceptable. Unsigned Provider Invoices will not be accepted by the Department and will be returned to the provider when possible. The signature date is to be entered. |

MAILING INSTRUCTIONS

The Provider Invoice is a two-part form. The provider is to submit the original to the Department as indicated below. The copy of the claim is to be retained by the provider.

The pin-feed guide strip should be detached from the sides of continuous feed forms.

Routine claims are to be mailed to the Department in pre-addressed mailing envelopes, Form HFS 1444, Provider Invoice Envelope, provided by the Department.

Non-routine claims are to be mailed to the Department in pre-addressed mailing envelopes, Form HFS 2248, Special Handling Envelope, which is provided by the Department for this purpose. A non-routine claim is one to which one or more of the following documents are attached:

- Form HFS 1411, Temporary MediPlan Card
- Any other document

APPENDIX CMH-7

EXPLANATION OF PROVIDER INFORMATION SHEET

The Provider Information Sheet is produced when a provider is enrolled in the Department's Medical Programs. It will also be generated when there is a change or update to the provider record. This sheet will then be mailed to the provider and will serve as a record of all the data that appears on the Provider Data Base.

If, after review, the provider notes that the Provider Information Sheet does not reflect accurate data, the provider is to line out the incorrect information, note the correct information, sign and date the signature on the document and return it to the Provider Participation Unit in Springfield, Illinois. (See Topic CMH-205.2 for instructions.) If all the information noted on the sheet is correct, the provider is to keep the document and reference it when completing any Department forms.

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet is attached as Appendix CMH-7a. The item numbers that correspond to the explanations below appear in small circles ○ on the sample form.

FIELD	EXPLANATION
○ ₁ Provider Key	This number uniquely identifies the provider and is used internally by the Department.
○ ₂ Provider Name And Location	This area contains the Name and Address of the provider as carried in the Department's records. The three-digit County code identifies the county in which the provider maintains his primary office location. It is also used to identify a state if the provider's primary office location is outside of Illinois. The Telephone Number is the primary telephone number of the provider's primary office.
○ ₃ Enrollment Specifics	This area contains basic information concerning the provider's enrollment with the Department.
	Provider Type is a three-digit code and corresponding narrative which indicates the provider's classification.

Organization Type is a two-digit code and corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are:

- 01 = Individual Practice
- 02 = Partnership
- 03 = Corporation
- 04 = Group Practice

Enrollment Status is a one-digit code and corresponding narrative which indicates whether or not the provider is currently an active participant in the Department's Medical Programs. The possible codes are:

- B = Active
- I = Inactive
- N = Non Participating

Disregard the term MOCST if it appears in this term.

Immediately following the enrollment status indicator are the **Begin** date indicating when the provider was most recently enrolled in department's Medical Programs and the **End** date indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "ACTIVE" will appear in the **End** date field.

Exception Indicator may contain a one-digit code and corresponding narrative indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are:

- A = Exception Requested by Audits
- C = Citation to Discover Assets
- G = Garnishment
- S = Exception Requested by Provider Participation Unit
- T = Tax Levy

If this item is blank, the provider has no exception.

Immediately following the **Exception Indicator** are the **Begin** date indicating the first date when the provider's claims are to be manually reviewed and the **End** date indicating the last date the provider's claims are to be manually reviewed. If the provider has no exception, the date fields will be blank.

AGR (Agreement) indicates whether the provider has a form HFS 1413 (Provider Agreement) on file. If the value of the field is yes, the provider is eligible to submit claims electronically.

- 4 **Certification/
License Number** This unique number identifies the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **Ending** date indicating when the license will expire.
- 5 **S.S.#** This field is the provider's Social Security number or FEIN.
- 6 **Categories of Service** This area identifies special licensure information and the types of service a provider is enrolled to provide.
- Eligibility Category of Service** contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the Department's Medical Programs. The codes are:
034 – Mental Health Rehab Option Services
047 – Mental Health Targeted Case Management Services
- Each entry is followed by the date that the provider was approved to render services for each category listed.
- 7 **Payee Information** This area records the name and address of any persons or entities authorized to receive payments on behalf of the provider. Each potential payee is assigned a single-digit **Payee Code**, which is to be used on the claim form to designate the payee to whom the warrant is to be paid.
- If no payee number is designated on a claim form, but multiple payees are shown on the Provider Information Sheet, the claim will be rejected.
- Payee ID Number** is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes, therefore no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider.
- The **Medicare/PIN** or the **DMERC #** is the number assigned to the payee by the Medicare Carrier to crossover Medicare billable services. The **PIN** is the number assigned by Medicare to a provider within a group practice, if applicable.
- 8 **Signature** The provider is required to affix an original signature when submitting changes to the Department of Healthcare and Family Services.

Reduced Facsimile of Provider Information Sheet

MEDICAID SYSTEM (MMIS)
 PROVIDER SUBSYSTEM
 REPORT ID: A2741KD1
 SEQUENCE: PROVIDER TYPE
 PROVIDER NAME

STATE OF ILLINOIS
 DEPARTMENT OF PUBLIC AID
 PROVIDER INFORMATION SHEET

RUN DATE: 11/02/99
 RUN TIME: 11:47:06
 MAINT DATE: 11/02/99
 PAGE: 84

-- PROVIDER KEY --

000011111001

PROVIDER NAME AND ADDRESS
 COMMUNITY MENTAL HEALTH AGENCY
 1421 MY STREET
 ANYTOWN, IL 62000

PROVIDER GENDER:
 COUNTY 089-SCOTT
 TELEPHONE NUMBER 217-742-4567

PROVIDER TYPE: 036 - MENTAL HEALTH SERVICES PROVIDERS
 ORGANIZATION TYPE: 03 - CORPORATION
 ENROLLMENT STATUS B - ACTIV NOCST BEGIN 11/15/86 END ACTIVE
 EXCEPTION INDICATOR - NO EXCEPT BEGIN END
 AGR: YES BILL: NONE

D.E.A.#:
 RE-ENROLLMENT INDICATOR: N DATE: 11/15/86

CERTIFIC/LICENSE NUM - 000011111 ENDING 03/31/02

LAST TRANSACTION ADD

AS OF 04/21/97

UPIN#:
 SS #: 00000000
 CLIA#:

HEALTHY KIDS/HEALTHY MOMS INFORMATION: BEGIN DATE: / /

COS	ELIGIBILITY CATEGORY OF SERVICE	ELIG BEG DATE	COS	ELIGIBILITY CATEGORY OF SERVICE	ELIG BEG DATE	TERMINATION REASON
034	DMHDD Rehab Option Services					
047	DMHDD Targeted Case Management Services					

PAYEE CODE	PAYEE NAME	PAYEE STREET	PAYEE CITY	ST	ZIP	PAYEE ID NUMBER	DMERC#	EFF DATE
1	DBA: MEDICARE/PIN: 999999	1421 MY STREET	ANYTOWN	IL	62000	001010101-6200-01 VENDOR ID: 01		11/15/86

***** PLEASE NOTE: *****
 * ORIGINAL SIGNATURE OF PROVIDER REQUIRED WHEN SUBMITTING CHANGES VIA THIS FORM: DATE _____ X _____

APPENDIX CMH-8

DEPARTMENTS CONTACT INFORMATION AND OTHER RESOURCES

CMH Specific Resources

Local Area Network (LAN) Map	http://www.hfs.illinois.gov/sass/
Service definition and activity crosswalk	http://www.hfs.illinois.gov/sass/
59 IL Administrative Code 132	http://www.hfs.illinois.gov/sass/
All Kids/FamilyCare Application	http://www.allkids.com/application.html
Rule 132	http://www.hfs.illinois.gov/sass/
EMTALA	http://www.emtala.com/

DCFS Specific Resources

Administrative Rules Title 59 Mental Health Part 135	http://ilga.gov/
Consolidated Financial Report	http://www.state.il.us/dcfscost/rpt/cstmain.html
CSPI Manual and Summary Form	http://www.sasscares.org
DCFS CFS-600-3, Consent Release of Info.	http://www.state.il.us/dcfscost/docs/cfs600_3.htm
DCFS CFS 431A, Consent for Psych. Meds	http://www.state.il.us/DCFS/docs/CFS43-1A.pdf

DHS Specific Resources

USARF	http://www.dhs.state.il.us/page.aspx
Application by Adult for Admission of Minor	http://www.dhs.state.il.us/page.aspx
DHS Billing Manual	http://www.dhs.state.il.us/page.aspx
Administrative Rules Title 59 Mental Health	http://ilga.gov/

HFS Specific Resources

HFS Provider Enrollment Info	http://www.hfs.illinois.gov/enrollment/
Chapter 100	http://www.hfs.illinois.gov/handbooks/chapter100.html
Chapter 200	http://www.hfs.illinois.gov/handbooks/chapter200.html
Chapter 300	http://www.hfs.illinois.gov/handbooks/chapter300.html
89 IL Administrative Code 140	http://www.hfs.illinois.gov/lawsrules/

General inquiries regarding the SASS Program:

Healthcare and Family Services

SASS Statewide Administrator
1-217-557-1000
hfs.sass@illinois.gov

Department of Human Services

Director of Contract Management/
Child and Adolescent Services
1-773-794-4872

Department of Children and Family Services

SASS Statewide Administrator
1-312-814-1071

Inquiries regarding SASS billing:

Healthcare and Family Services

Bureau of Comprehensive Health Services
1-877-782-5565
hfs.sass@illinois.gov

Inquiries regarding pharmacy billing:

Healthcare and Family Services

Bureau of Pharmacy Services
1-877-782-5565

Inquiries regarding transportation:

Healthcare and Family Services

Bureau of Comprehensive Health Services
Transportation Manager
1-217-524-7143

First Transit

For Providers: 1-866-503-9040
For Parents: 1-877-725-0569
TTY 1-877-204-1012
Monday - Friday 8:00 AM - 5:00 PM.

APPENDIX CMH-9

DHS PHYSICIAN BILLING CODES

Physician psychiatric procedures covered through the SASS program¹, effective 07/01/2005

Place of Service		CPT ² Code	Description
Hospital Inpatient	Outpatient		
Yes	Yes	90801	Psychiatric diagnostic interview examination
Yes	Yes	90802	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication
Yes	No ³	90817	Individual psychotherapy, insight oriented, behavior modifying and/or supportive; in an inpatient hospital, partial hospital or residential care setting approximately 20 to 30 minutes; face-to-face with the patient; with medical evaluation and management services
Yes	No ³	90819	Individual psychotherapy, insight oriented, behavior modifying and/or supportive; in an inpatient hospital, partial hospital or residential care setting approximately 45 to 50 minutes; face-to-face with the patient; with medical evaluation and management services
Yes	No ³	90822	Individual psychotherapy, insight oriented, behavior modifying and/or supportive; in an inpatient hospital, partial hospital or residential care setting; approximately 75 to 80 minutes; face-to-face with the patient; with medical evaluation and management services
Yes	No ³	90824	Individual psychotherapy, interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication; inpatient hospital, partial hospital or residential care setting; approximately 20 to 30 minutes; face-to-face with the patient; with medical evaluation and management services
Yes	No ³	90827	Individual psychotherapy, interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication; inpatient hospital, partial hospital or residential care setting; approximately 45 to 50 minutes; face-to-face with the patient; with medical evaluation and management services
Yes	No ³	90829	Individual psychotherapy, interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication; in an inpatient hospital, partial hospital, or residential care setting; approximately 75 to 80 minutes; face-to-face with the patient; with medical evaluation and management services
Yes	No ³	90862	Pharmacologic management, including prescription, use, and review of medication with no more than with minimal medical psychotherapy
Yes	No ⁴	90870	Electroconvulsive therapy (includes necessary monitoring); single seizure (This procedure must have prior approval from DHS clinical psychiatrist)

¹ These procedures are covered currently as physician services available to individuals enrolled in the Medicaid/All Kids programs. This change extends coverage to children and adolescents enrolled in the SASS program who are not enrolled in Medicaid/All Kids

² *Current Procedural Terminology*

³ While not covered as a physician service, a physician, working with and through a community mental health center, may provide this service and the community mental health center may be reimbursed in accordance with 59 Ill. Admin. Code 132.

⁴ This procedure is only covered as an inpatient procedure with prior approval from DHS C&A clinical psychiatrist.

APPENDIX CMH-10

ORDERING SASS/CARES BROCHURES FROM HFS

Ordering Brochures for “Mental Health Crisis Services for Youth (SASS CARES for KIDS)”

The Mental Health Crisis Services for Youth (SASS CARES for KIDS) brochure, form number HFS 3838 for English or HFS 3838S for Spanish, can be ordered in two ways:

1. Visit the Healthcare and Family Services Web site at <http://www.illinois.gov/hfs/Pages/default.aspx> and enter the requested information. If you do not have a provider number, enter your 10-digit telephone number.
2. Fax a request to 1-217-557-6800, “Attention: Medical Desk, HFS Warehouse, 2946 Old Rochester Road, Springfield, IL.” Please include the HFS form number, the amount requested, your name, provider number, address and 10-digit phone number.

If you have any questions regarding ordering supplies, please contact Eric Oxencis (1-217-557-6905).

APPENDIX CMH-11

DHS ALL KIDS APPLICATION POLICY / FAQ

Exception Policy and Process for Community Mental Health Providers DHS Children, Adolescents and Young Adults

This policy and process applies to clients served in SASS ages 0 up to 18 ONLY. Children or adolescents without Medical Assistance, All Kids or INSURANCE will be considered for funding by the Division of Mental Health Child and Adolescent Program. Young Adults and Adults 18 and over will be served by the Division of Mental Health's Adult Services.

If the client is a child or adolescent, the following applies to the exception process:

- | | |
|---|---|
| A. Client has Medical Assistance | No Exception can be requested |
| B. Client has All Kids | No Exception can be requested
If you have questions about the All Kids co-pay, please refer to http://www.allkids.com/ |
| C. Client has Private Insurance | No Exception can be requested |
| D. Client has Private Insurance, but refused to utilize insurance | No Exception can be requested |
| E. Client has All Kids, but refused to utilize Insurance | No Exception can be requested |
| F. Client is UNINSURED | Exception can be requested
ONLY IF FAMILY REFUSES TO APPLY ** |
| 1. No insurance | |
| 2. No Medicaid program | |
| 3. No All Kids program | |
| 4. Undocumented | |
| 5. All insurance exhausted | |

**Note: The SASS provider is only responsible for assuring that the family applies for medical assistance or All Kids, and is not responsible for whether the application is approved or denied.

EXCEPTION PROTOCOL

1. If a child or adolescent is served in a Community Mental Health Agency (120 or 110), is not a SASS client and the family refuses to apply for medical assistance then funding of services should be provided by the agency's non-Medicaid or capacity grant. If a Child or Adolescent is currently a SASS client the following protocol applies.
2. If a Child or Adolescent is being served in the SASS program, and the family refuses to apply for medical assistance or All Kids then Immediately call Child and Adolescent Services, Division of Mental Health 1-773-794-4875
3. A request can be made 24 hours a day 7 days a week, by leaving a detailed voice message
4. Be prepared with the following information and leave it on the CONFIDENTIAL voice machine:
 - a. Client's name
 - b. D.O.B.
 - c. Temporary RIN
 - d. Date of Initial Screening
 - e. Community Mental Health Agency making the request
 - f. Address of the Community Mental Health Agency
 - g. Name of individual making the request
 - h. Phone number of the individual making the request
5. The reason for the request.
6. A response will be reported to the agency within one (1) business day.

You will receive a voice response to your request. The response will indicate whether the Exception was Granted or Denied.

**Screening, Assessment and Support Services (SASS)
Application Requirement for Youth with Temporary Eligibility
Frequently Asked Questions (FAQ)
Version 1.0 as of May 1, 2007**

1. Where can I find information on All Kids?

Information relating to All Kids comprehensive health insurance program available to every uninsured child in the State of Illinois can be found online at the following Web Site:<www.allkids.com>. In addition, information can be found by calling the All Kids Hotline number at 1-866-All-Kids (1-866-255-5437), from 8:00 AM to 8:00 PM.

2. How do we check on the status of applications once they are submitted?

Any provider enrolled with HFS can use the MEDI Internet Web site to verify eligibility, submit claims or check claim status. All of these features can be accessed free of charge through a standard personal computer linked to the Internet. No additional hardware or special software is needed to use the MEDI system. MyHFS is the secure Web site for the Illinois Department of Healthcare and Family Services. This Web site allows authorized users online access to departmental information on HFS All Kids and FamilyCare Programs. In addition, any provider can call the All Kids Hotline. Hotline staff will look up client eligibility for you. The All Kids Hotline number is: 1-866-255-5437. Only All Kids Application Agents can check on the status of an application that is still pending.

3. What happens if a child is All Kids eligible, a parent doesn't pay the premium, and then has another SASS incident? Do parents have to pay back premiums and if so, for how long back?

Like standard health coverage plans, eligibility for All Kids coverage is based upon payment of monthly premiums. Unlike standard health coverage, premiums are based upon family make-up and financial income. Families with children and adolescents that apply for and receive All Kids coverage are issued a medical card by HFS. This card represents HFS commitment to reimburse providers for services rendered to their clients. If, during a period of eligibility, a parent or family decides to stop paying their monthly premium, HFS will suspend their coverage while honoring the bill submission of providers serving a family/child during a time for which the family had presented an active medical card to the serving provider. Once a child's coverage has been canceled for non-payment of premiums, the child is ineligible for coverage for three months. The family must then reapply, pay all past-due premiums and pay the premium for the first month of the new enrollment period before coverage can begin.

The only exception to this policy is individuals with lapsed coverage who may reapply for coverage and qualify for Medicaid.

4. How are parents informed of their responsibility to pay for the premium for All Kids and the consequences if they don't?

Families that are approved for All Kids coverage are sent an approval notice that shows the date coverage begins and details any premiums or co-payments that the family is responsible for paying. Families who are responsible for paying a premium are also sent an initial statement and a monthly invoice.

5. Could you give some examples of the types of exceptions that DHS is willing to approve?

DHS will consider each application for an exception independently. If a client is uninsured, an exception can be requested only if the family refuses to apply for Medicaid or All Kids. The Exception Policy was sent out to SASS providers via e-mail on August 3, 2006. The e-mail is titled "Medicaid Application Process." There are examples in the policy document. Essentially, the policy states that an exception can be granted if the child is uninsured and refuses to apply for Medicaid or All Kids.

6. How can we check whether an application was rejected due to being incomplete?

Any provider enrolled with HFS can use the MEDI Internet Web site to verify eligibility, submit claims or check claim status. All of these features can be accessed free of charge through a standard personal computer linked to the Internet. No additional hardware or special software is needed to use the MEDI system. MyHFS is the secure Web site for the Healthcare and Family Services. This Web site allows authorized users online access to departmental information on HFS All Kids and FamilyCare Programs. In addition, any provider can call the All Kids Hotline. Hotline staff will look up client eligibility for you. The All Kids Hotline number is: 1-866-255-5437. Only All Kids Application Agents can have information on an application that is still pending or has been denied

7. How long does it take for a client's status to show up on MEDI once DHS has approved their application? We have had instances when the local DHS office has indicated an application has been approved, but it isn't showing up on MEDI as Medicaid eligible.

The approved application should be in the MEDI system within 48 hours after approval. Coverage under All Kids Share and Premium programs is authorized prospectively. Coverage may not begin for up to six weeks after an application is approved.

- 8. If a family indicates they will cooperate with completion of a Medicaid application, but after efforts to obtain the information needed to complete the application they request to terminate SASS services, how should the SASS agency proceed? Is this the type of instance for which an exception may be requested?**

Yes, a SASS provider should apply for an exception if the family refuses to apply for Medicaid or All Kids coverage.

- 9. Do we need to apply to All Kids when a child “ages out” of their Medicaid coverage, does not have a disability nor a child, leading one to believe he/she would not be All Kids eligible?**

The same age requirements apply to all levels of All Kids, and Medicaid. Once a child turns age 19, they no longer qualify for All Kids.

APPENDIX CMH-12

TRANSPORTATION SUPPLEMENTAL INFORMATION

Levels of Medically Necessary Transportation Reimbursed by HFS

Transportation providers are enrolled with the Department at the following levels of transport:

- Non-emergency Ambulance - Transportation of a patient whose medical condition requires transfer by stretcher and medical supervision. The patient's condition may also require medical equipment or the administration of drugs or oxygen, etc., during the transport.
- Medicar - Transportation of a patient whose medical condition requires the use of a hydraulic or electric lift or ramp, wheelchair lockdowns, or transportation by stretcher when the patient's condition does not require medical supervision, medical equipment, the administration of drugs or the administration of oxygen, etc.
- Taxicab - Transportation by passenger vehicle of a patient whose medical condition does not require a specialized mode.
- Service Car - Transportation by passenger vehicle of a patient whose medical condition does not require a specialized mode.
- Private Automobile - Transportation by passenger vehicle of a patient whose medical condition does not require a specialized mode.
- Other Transportation - Transportation by common carrier (e.g., bus, train or commercial airplane) for medically necessary services may also be utilized by HFS beneficiaries. These services require approval and special coordination with the HFS Transportation Manager.

APPENDIX CMH-13

SASS FLEX PROGRAM

Illinois Division of Mental Health Child and Adolescent Network

Purpose:

The SASS FLEX Program is intended to provide flexible funding to purchase alternative therapeutic services for children. These funds will be utilized to augment traditional mental health services where additional supports are needed in order to avoid placing a child in an institutional setting, such as a hospital or residential treatment center. SASS FLEX funds are to be used only when there is no other funding available.

SASS FLEX may be implemented in conjunction with the Local Area Network wrap efforts, but does **not require** formal Local Area Network (LAN) involvement. All requests for SASS FLEX funds must include documentation of collaborative community planning with the family and other relevant community systems.

Services:

1. To be eligible for SASS FLEX funding, youth must present with significant emotional and behavioral problems as determined by the SASS agency. There must not be alternate funding available (including reasonable contributions from the family) for the service requests.
2. The designated SASS program will be the fiscal agent, and will be responsible for making the SASS FLEX funds available to all child and adolescent mental health programs in its geographic area. The SASS program will also review requests from the C & A LAN.
3. The SASS supervisor or C & A Director or his or her designee, at the SASS program, will be responsible for serving as the SASS FLEX Coordinator. The Coordinator will review SASS FLEX requests within five working days of the date of the request, and will make an immediate decision such that families receive a timely response. The SASS FLEX coordinator will use judicious discretion in determining utilization of the Flex funds.
4. The client's therapist/ case manager or supervisor will be responsible for presenting the request for SASS FLEX funds to the SASS FLEX coordinator. This request will include a treatment plan including diagnosis and target behaviors that justify the **clinical** need for the requested resources. The Division of Mental Health, C & A Network will provide a request format (See Attachment A).

5. The SASS program will keep fiscal records of the SASS FLEX account, and the Coordinator will be apprized of the balance of the account. The total program funding will be limited to the amount issued each fiscal year, and will be replenished only at the beginning of the next fiscal year. The SASS program will keep a record of the requests that are funded as well as denied. The C & A Network will conduct an annual audit to assess the efficacy of the program. The SASS agency will submit a final report to the C & A Network Administrator by August 15, via fax at 1-773-794-4881.
6. There will not be a cap placed on the amount of funds that can be allocated to each client.
7. Each approved request may be granted for a maximum time period of 90 days. There should be a plan to terminate these services within 90 days, or find an alternate means of funding the therapeutic services. The funding must be used within the 90-day time period. If clinically indicated, a request for approval of a 90-day extension of funding can be made to the SASS FLEX coordinator.
8. SASS FLEX funds may be utilized for the following services when no other funding is available and clinical justification is made:
 - a. Rehabilitation/stabilization where the target behaviors from the treatment plan are being addressed.
 - b. Substance Abuse services when no other resources are available or appropriate.
 - c. Culturally specific mental health needs.
 - d. Therapeutic recreational activities that address target behaviors.
 - e. Behavior management intervention to ameliorate specific problem behaviors.
 - f. Child and family support services that address target behaviors.
 - g. Emergency psychotropic medication for the client/family.
 - h. Transportation to access mental health and other therapeutic services.
 - i. Funding to augment traditional mental health services or purchase mental health service that the agency does not have the capacity to provide.

SASS FLEX FUNDING REQUEST

Date of Request: _____

Request made to which SASS Agency: _____

Person/ Agency Making Request: _____

Request is from Program: 120____ 130 ____ 110____ LAN____

Child’s Name: _____ Age: _____

Child’s Diagnosis: _____

Service Requested (detail what is being requested):

Length of time service is being requested for: _____

Cost of Request: _____

Specify Target Behavior(s) being addressed and how this service fits into the treatment plan:

Identify other community providers who have been involved in service development and provision:

What attempts have been made to identify other sources of funding?

SASS FLEX RESPONSE

Request: Approved _____

Denied _____

Reason for Approval or Denial: _____

If approved, for what length of time and at what cost:

Name of SASS FLEX Coordinator: _____

Signature of SASS FLEX Coordinator: _____

Date Request was reviewed: _____

90 Day Follow Up

Did the approved services have the desired clinical outcome?

Yes _____ Somewhat _____ No _____

If yes, what has changed, if not what were the barriers: _____

Was the family able to access alternative funding to meet the needs SASS FLEX initially provided for? If not, what are the barriers? _____

Has the Child been able to remain in the community?	Yes _____	No _____
Has the child been hospitalized?	Yes _____	No _____
Has the child been placed in Residential Treatment?	Yes _____	No _____
Has the child been placed outside the home?	Yes _____	No _____

Is the child currently engaged in out patient treatment? Yes _____ No _____

Other comments regarding the efficacy of this SASS FLEX funding plan: _____

Attach parent feedback form.

**C & A NETWORK SASS FLEX PROGRAM
PARENT/GUARDIAN FEEDBACK FORM**

Dear Parent/Guardian:

Please provide us with feedback regarding your experience with the SASS FLEX Program.

- 1. Were the resources you received from the SASS FLEX program helpful to your child?

Yes No

- 2. Were the resources you received from the SASS FLEX program helpful to you in supporting your child at home?

Yes No

- 3. When the SASS FLEX funds ended were you able to find other sources of support to meet the needs that were funded through this program?

Yes No

- 4. Would you like to make any recommendations about how this program could be more useful to you?
