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JANICE K. BREWER, GOVERNOR
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TO: RBHA CEOs, TRBHA Directors and Grievance Coordinators

FROM: Laura K. Nelson, M.D.
Acting Deputy Director

Margaret Russell
Bureau Chief of Policy

SUBJECT: **POLICY CLARIFICATION: Notification of right to notice of action during interim and individual service planning**

DATE: May 15, 2009

This memorandum is intended to clarify the responsibilities of Tribal and Regional Behavioral Health Authorities (T/RBHAs) and T/RBHA providers in meeting the Arizona Department of Health Services/Division of Behavioral Health Services' (ADHS/DBHS) expectations regarding the following policy and forms:

- Provider Manual Section 3.9, Intake, Assessment and Service Planning
- Provider Manual Form 3.9.1, Behavioral Health Assessment and Service Plan, Part B: Core Assessment, Next Steps/Interim Service Plan
- Provider Manual Form 3.9.1, Behavioral Health Assessment and Service Plan, Part D: Behavioral Health Service Plan
- Provider Manual Form 3.9.2, Behavioral Health Assessment: Birth-5 and Service Plan, Part A: Core Assessment, Next Steps/Interim Service Plan
- Provider Manual Form 3.9.2, Behavioral Health Assessment: Birth-5 and Service Plan, Part C: Behavioral Health Service Plan

During the process of service planning, providers have the responsibility of informing behavioral health recipients of their rights related to the denial, limited authorization, suspension, termination or reduction of services. In order to ensure T/RBHA and provider compliance with federal and state mandates, ADHS/DBHS is implementing changes to the current Next Steps/Interim Service Plan and Behavioral Health Service Plan of the Core and Birth-5 assessments to provide Title XIX/XXI and Serious Mental Illness (SMI) behavioral health recipients with comprehensive and understandable information related to their notice and appeal rights. Updated versions of these documents containing the required notification language are attached to this memorandum.

While the Arizona Department of Health Services/Division of Behavioral Health Services is currently in the process of completing significant revisions to the behavioral health assessment and service planning documents, until such time as the new documents become available to T/RBHAs and T/RBHA providers, T/RBHAs and T/RBHA providers must implement and comply with changes addressed in this ADHS/DBHS Policy Clarification Memorandum. T/RBHA providers must begin using the updated versions of the service plans no later than **June 15, 2009**. Failure to implement the use of the updated documents may result in regulatory/contractual action, including but not limited to financial sanctions.

The required language has been incorporated into the new drafts of the Core and Birth-5 initial and individual service plans. T/RBHAs and T/RBHA providers will be provided with the new initial and individual service plans containing all of the requirements upon the finalization of these documents.

Questions regarding the implementation of this requirement may be directed to Margaret Russell at (602) 364-4658 or margaret.russell@azdhs.gov.

Name:_________________________

NEXT STEPS/INTERIM SERVICE PLAN

1. Identify specific people who may be supportive and helpful and who should be invited to be part of the person's ongoing Team, including phone numbers and action to be taken:____
____
____

2. Identify any additional documentation (e.g., medical records, IEP, probation report), which needs to be collected to assist in the ongoing assessment and service planning including the individuals and/or agencies and action to be taken to obtain this information:
____
____

3. Identify who the person and/or family/legal guardian/significant other should contact if the person needs immediate assistance before the next appointment:____
____

4. **Interim Service Plan.** Based on the person's presenting issues, your impressions and the preferences of the person and his/her family/legal guardian/significant other, describe in the Interim Service Plan on the next page recommended next steps (e.g., formation of Team, response to immediate risks and needs of the person, further assessment). Additionally, this Interim Service Plan should include:

- Any immediate next steps to be taken by the person and/or family/legal guardian/significant others.
- Referral to the person's primary care physician, if *physical health problems* have been identified.
- Additional considerations for urgent response for children removed by Child Protective Services (see shaded box below).

Assessors may also add a goal statement, if appropriate.

For urgent response for **children removed by Child Protective Services**, the assessor must include as part of the recommended next steps/interim service plan, identification of:

1. Actions needed to be taken immediately to mitigate the effects of the removal itself;
2. Supports and services the child's caregivers may need to meet the child's needs; and
3. A plan to ensure that even asymptomatic children are reassessed and observed for surfacing behavioral health needs within at least the next 23 days (or sooner if indicated).

The assessor may also provide any input he/she has regarding the types and amount/frequency of contact (e.g., visits, phone calls, e-mail), the child should have with parents, siblings, relatives and other individuals important to the child.

Name:_________________________

INTERIM SERVICE PLAN

Description of Next Steps (Action) to Be Taken	Who Will Be Responsible to Ensure Action Occurs	Where Action/Step Will Take Place (e.g., provider)	When Action/ Step Will Take Place

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☐ Yes, I am in agreement with the types & levels of services included in the Interim Service Plan.

☐ **Yes, I have received a copy of this plan.**

☐ No, I disagree with the types and/or levels of some or all of the services included in this plan. (By checking this box, I will receive the services that I have agreed to receive and may appeal the treatment team's decision to not include all the types and/or levels of services that I have requested.)

- ☐ I have received a Notice of Action (PM Form 5.1.1 if disagreement concerns a Title XIX/XXI covered service).
- ☐ I have received the Notice of Decision & Right to Appeal for Individuals with a Serious Mental Illness (PM Form 5.5.1 if disagreement pertains to a Non-Title XIX/XXI covered service).

Name:_________________________

INTERIM SERVICE PLAN

Service Plan Rights Acknowledgement for Persons who are Title XIX/XXI and/or SMI:
My service plan has been reviewed with me by my behavioral health provider. I know what services I will be getting and how often. All changes in the services have been explained to me. I have marked my agreement and/or disagreement with each service above. I know that in most cases, any reductions, terminations, or suspensions (stopping for a set time frame) of current services will begin no earlier than 10 days from the date of the plan. I know that I can ask for this to be sooner.

If I do not agree with some or all of the services that have been authorized in this plan, I have noted that above. I know if the service asked for was denied, reduced, suspended or terminated, that my behavioral health provider will give me a letter that tells me why the decision was made. That letter will tell me how to appeal the decision that has been made about my services. The letter will also tell me how I can request continued services.

My behavioral health provider has told me how the appeal process works. I know how I can appeal service changes I do not agree with. I know that I can change my mind later about services I agree with today. I know that if I change my mind before the changes go into effect, I will get a letter that tells me the reason my services changed. The letter will also tell me about my appeal rights.

I know that if I need more services or other services than what I am getting, I can call my behavioral health provider at (____) ____ - ______ to talk about this. My behavioral health provider will call me back within 3 working days. Once I have talked with my behavioral health provider, s/he will give me a decision about that request within 14 days. If the behavioral health provider is not able to make a decision about my request within 14 days, s/he will send me a letter to let me know more time is needed to make a decision.

____ ______________

Person/Guardian Signature Date

____ ________________ ___________

Assessor's Name (print) / Signature Credentials/Position Date

____ ________________ ___________

Behavioral Health Professional Reviewer Name (print) / Signature Credentials/Position Date

____

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Note: The assessor should make sure to provide the person/guardian with a copy of the interim service plan. The CPS specialist, however, should receive a copy of the entire next steps/ interim service plan section.

PART D: BEHAVIORAL HEALTH SERVICE PLAN

Name: ___________________________________ CIS Client ID# ____________ Program:________________________________ Today's Date: _____________
Individuals at Service Planning Meeting: ____
____

RECOVERY GOAL/PERSON-FAMILY VISION:

PERSON'S STRENGTHS:

Review Date (Objective Target Date): ________________

IDENTIFIED NEEDS and SPECIFIC OBJECTIVES (to address these needs)	Current Measure	INTERVENTIONS to MEET OBJECTIVES		Desired Measure	Achieved Measure (at target date)	Measure Met (Y/N)
		Specific Services and Frequency	Strengths Used			
1						
2						
3						

DISCHARGE PLAN (add discharge date if known):

☐ Yes, I am in agreement with the types and levels of services included in the ISP.

☐ **Yes, I have received a copy of this plan.**

☐ No, I disagree with the types and/or levels of some or all of the services included in this plan. (By checking this box, I will receive the services that I have agreed to receive and may appeal the treatment team's decision to not include all the types and/or levels of services that I have requested.)

☐ I have received a Notice of Action (PM Form 5.1.1 if disagreement concerns a Title XIX/XXI covered service).

☐ I have received the Notice of Decision & Right to Appeal for Individuals with a Serious Mental Illness (PM Form 5.5.1 if disagreement pertains to a Non-Title XIX/XXI covered service).

PART D: BEHAVIORAL HEALTH SERVICE PLAN

***<u>Service Plan Rights Acknowledgement for Persons who are Title XIX/XXI and/or SMI</u>*:**

My service plan has been reviewed with me by my behavioral health provider. I know what services I will be getting and how often. All changes in the services have been explained to me. I have marked my agreement and/or disagreement with each service above. I know that in most cases, any reductions, terminations, or suspensions (stopping for a set time frame) of current services will begin no earlier than 10 days from the date of the plan. I know that I can ask for this to be sooner.

If I do not agree with some or all of the services that have been authorized in this plan, I have noted that above. I know if the service asked for was denied, reduced, suspended or terminated, that my behavioral health provider will give me a letter that tells me why the decision was made. That letter will tell me how to appeal the decision that has been made about my services. The letter will also tell me how I can request continued services.

My behavioral health provider has told me how the appeal process works. I know how I can appeal service changes I do not agree with. I know that I can change my mind later about services I agree with today. I know that if I change my mind before the changes go into effect, I will get a letter that tells me the reason my services changed. The letter will also tell me about my appeal rights.

I know that if I need more services or other services than what I am getting, I can call my behavioral health provider at (____) ____ - ______ to talk about this. My behavioral health provider will call me back within 3 working days. Once I have talked with my behavioral health provider, s/he will give me a decision about that request within 14 days. If the behavioral health provider is not able to make a decision about my request within 14 days, s/he will send me a letter to let me know more time is needed to make a decision.

Person / Guardian ____ Date:_________

Clinical Liaison____ Date:_________ Other____ Date:___________

BH Prof. Rev.____ Date:__________ Other____ Date:___________

BEHAVIORAL HEALTH SERVICE PLAN REVIEW OF PROGRESS

Name:_________________________

I. Review of Progress

Provide a summary below of the progress the person has made toward meeting the objectives identified on the service plan. In addition, indicate any adjustments that are being made to the service plan objectives and/or measures, including the justification and any additional needs or strengths that have been identified.

II. Current Diagnostic Summary

Describe and explain any changes in diagnoses and functioning of person: ___________________________________

III. Team Members Present at Plan Review Meeting (CFT Planning):______________________________

IV. Date of Next Plan Review (CFT Planning) Meeting:_____________

V. Clinical Liaison (responsible for reviewing clinical record)

____ ______________ ___________
Clinical Liaison's Name (print) / Signature Credentials/Position Date

____ ______________ ___________
Behavioral Health Professional Reviewer Name (print) / Signature Credentials/Position Date

Name _____________________________________ Date of Birth ____________ Client CIS ID# ___________

NEXT STEPS/INTERIM SERVICE PLAN

1. **Interim Service Plan.** Based on the child's presenting issues, your impressions and the preferences of the child and his/her parents/caregivers, describe in the Interim Service Plan below recommended next steps (e.g., formation of a Team*, response to immediate risks and needs of the child, further assessment, appropriate referrals). Additionally, this Interim Service Plan should include:

   - Referral to the child's primary care physician, if *physical health problems* have been identified or if the child has not had regular well-child EPSDT visits.
   - Referral of any child under the age of 3 to AzEIP, if triggered by *the Developmental Checklist Addendum.*
   - Additional considerations for urgent response for children removed by Child Protective Services**

   The assessor may also add a goal statement, if appropriate.

*If an AzEIP IFSP team has been formed for the child, the Clinical Liaison will coordinate CFT functions with IFSP functions so as to avoid duplicative processes between systems and to ensure consistency and compatibility of service plans.

For urgent response for **children removed by Child Protective Services, the assessor must include as part of the recommended next steps/interim service plan, identification of:

1. Actions needed to be taken immediately to mitigate the effects of the removal itself;
2. Supports and services the child's caregivers may need to meet the child's needs; and
3. A plan to ensure that even asymptomatic children are reassessed and observed for surfacing behavioral health needs within at least the next 23 days (or sooner if indicated).

The assessor may also provide any input he/she has regarding the types and amount/frequency of contact (e.g., visits, phone calls, e-mail), the child should have with parents, siblings, relatives and other individuals important to the child.

Description of Next Steps (Action) to Be Taken	**Who Will Be Responsible to Ensure Action Occurs**	**Where Action/Step Will Take Place (e.g., provider)**	**When Action/ Step Will Take Place**

NEXT STEPS/INTERIM SERVICE PLAN (con't)

2. Identify any immediate next steps to be taken by the parent/caregiver (including how these next steps will be accomplished and where and when these steps will be taken):

____
____
____
____
____
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3. Identify specific people who may be supportive and helpful and who should be invited to be part of the child's Child and Family Team (or AzEIP Team), including phone numbers and action to be taken:

____
____
____
____
____

4. Identify any additional documentation (e.g., medical records, IEP), which needs to be collected to assist in the ongoing assessment and service planning including the individuals and/or agencies and action to be taken to obtain this information:

____
____
____
____
____

5. Identify who the parent/caregiver should contact if their child needs immediate assistance before the next appointment:

____
____
____
____
____

☐ Yes, I am in agreement with the types & levels of services included in the Interim Service Plan.

☐ No, I disagree with the types and/or levels of some or all of the services included in this plan. (By checking this box, my child/family will receive the services that I have agreed to receive and may appeal the treatment team's decision to not include all the types and/or levels of services that I have requested.)

☐ **Yes, I have received a copy of this plan.**

☐ I have received a Notice of Action (PM Form 5.1.1 if disagreement concerns a Title XIX/XXI covered service).

Service Plan Rights Acknowledgement for Persons who are Title XIX/XXI:
My child's service plan has been reviewed with me by my child's behavioral health provider. I know what services my child and family will be getting and how often. All changes in the services have been explained to me. I have marked my agreement and/or disagreement with each service above. I know that in most cases, any reductions, terminations, or suspensions (stopping for a set time frame) of current services will begin no earlier than 10 days from the date of the plan. I know that I can ask for this to be sooner.

If I do not agree with some or all of the services that have been authorized in this plan, I have noted that above. I know if the service asked for was denied, reduced, suspended or terminated, that my child's behavioral health provider will give me a letter that tells me why the decision was made. That letter will tell me how to appeal the decision that has been made about my child's and family's services. The letter will also tell me how I can request continued services.

My child's behavioral health provider has told me how the appeal process works. I know how I can appeal service changes I do not agree with. I know that I can change my mind later about services I agree with today. I know that if I change my mind before the changes go into effect, I will get a letter that tells me the reason my child's and family's services changed. The letter will also tell me about my appeal rights.

NEXT STEPS/INTERIM SERVICE PLAN (con't)

I know that if my child or family needs more services or other services than what we are getting, I can call my child's behavioral health provider at (____) ____- ______ to talk about this. My child's behavioral health provider will call me back within 3 working days. Once I have talked with my child's behavioral health provider, s/he will give me a decision about that request within 14 days. If the behavioral health provider is not able to make a decision about my request within 14 days, s/he will send me a letter to let me know more time is needed to make a decision.

Person/ Caregiver (print name)/ Signature/ Date	Guardian (print name)/ Signature (if required)/ Date
Parent (print name)/ Signature/ Date	Other (specify relationship) (print name)/ Signature/ Date

Assessor's Name (print) / Signature	Credentials/Position	Date
Behavioral Health Professional Reviewer Name (print) / Signature	Credentials/Position	Date

Agency

Note: The assessor should make sure to provide the parent/caregiver with a copy of the interim service plan. The CPS specialist, however, should receive a copy of the entire next steps/ interim service plan section.

PART C: BEHAVIORAL HEALTH SERVICE PLAN: *BIRTH – 5*

Name: ______________________________ CIS Client ID# __________ Program:___________________________ Today's Date: ___________
Individuals at Service Planning Meeting: ____
____

RECOVERY GOAL/CHILD-FAMILY VISION:

CHILD'S STRENGTHS:

Review Date (Objective Target Date): _______________

IDENTIFIED NEEDS and SPECIFIC OBJECTIVES (to address these needs)	**Current Measure**	**INTERVENTIONS to MEET OBJECTIVES**		**Desired Measure**	**Achieved Measure** (at target date)	**Measure Met** (Y/N)
		Specific Services and Frequency	**Strengths Used**			
1						
2						
3						

DISCHARGE PLAN (add discharge date if known):

☐ Yes, I am in agreement with the types and levels of services included in the ISP.

☐ No, I disagree with the types and/or levels of some or all of the services included in this plan. (By checking this box, my child/family will receive the services that I have agreed to receive and may appeal the treatment team's decision to not include all the types and/or levels of services that I have requested.)

☐ I have received a Notice of Action (PM Form 5.1.1 if disagreement concerns a Title XIX/XXI covered service).

☐ **Yes, I have received a copy of this plan.**

PART C: BEHAVIORAL HEALTH SERVICE PLAN: *BIRTH – 5*

Service Plan Rights Acknowledgement for Persons who are Title XIX/XXI:
My child's service plan has been reviewed with me by my child's behavioral health provider. I know what services my child and family will be getting and how often. All changes in the services have been explained to me. I have marked my agreement and/or disagreement with each service above. I know that in most cases, any reductions, terminations, or suspensions (stopping for a set time frame) of current services will begin no earlier than 10 days from the date of the plan. I know that I can ask for this to be sooner.

If I do not agree with some or all of the services that have been authorized in this plan, I have noted that above. I know if the service asked for was denied, reduced, suspended or terminated, that my child's behavioral health provider will give me a letter that tells me why the decision was made. That letter will tell me how to appeal the decision that has been made about my child's and family's services. The letter will also tell me how I can request continued services.

My child's behavioral health provider has told me how the appeal process works. I know how I can appeal service changes I do not agree with. I know that I can change my mind later about services I agree with today. I know that if I change my mind before the changes go into effect, I will get a letter that tells me the reason my child's and family's services changed. The letter will also tell me about my appeal rights.

I know that if my child or family needs more services or other services than what we are getting, I can call my child's behavioral health provider at (____) ____- ______ to talk about this. My child's behavioral health provider will call me back within 3 working days. Once I have talked with my child's behavioral health provider, s/he will give me a decision about that request within 14 days. If the behavioral health provider is not able to make a decision about my request within 14 days, s/he will send me a letter to let me know more time is needed to make a decision.

______________________________ ______________________________
Person/ Caregiver (print name)/ Signature/ Date | Guardian (print name)/ Signature (if required)/ Date

______________________________ ______________________________
Parent (print name)/ Signature/ Date | Other (specify relationship) (print name)/ Signature/ Date

Clinical Liaison____ Date:_________ Other____ Date:___________

BH Prof. Rev.____ Date:_________ Other____ Date:___________

PART C: BEHAVIORAL HEALTH SERVICE PLAN: *BIRTH – 5*

Name:__________________________

I. Review of Progress

Provide a summary below of the progress the child and family has made toward meeting the objectives identified on the service plan. In addition, indicate any adjustments that are being made to the service plan objectives and/or measures, including the justification and any additional needs or strengths that have been identified.

II. Current Diagnostic Summary

Describe and explain any changes in diagnoses and functioning of the child:

III. Team Members Present at Plan Review Meeting (CFT Planning):

IV. Date of Next Plan Review (CFT Planning) Meeting:_____________

V. Clinical Liaison (responsible for reviewing clinical record)

Clinical Liaison's Name (print) / Signature	Credentials/Position	Date
Behavioral Health Professional Reviewer Name (print) / Signature	Credentials/Position	Date