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**OVERVIEW**

This policy will provide comprehensive care management and coordination services to Medicaid beneficiaries with a serious mental illness or serious emotional disturbance.

**MENTAL AND  
BEHAVIORAL  
HEALTH****Mental Health  
Screening**

All children entering foster care, including temporary court wards (TCW) and permanent court wards (PCW) are required to have a mental health screening within 30-calendar days of out-of-home placement. The screening instrument must be completed by a person who knows the child best, before the child's early periodic, screening, diagnostic, and treatment (EPSDT)/well child exam. This may be the child's biological parent, foster parent, caregiver, or other adult who is very familiar with the child. The mental health screening is also to be performed during initial and subsequent periodic or yearly well child exams. The Children Services Administration (CSA) recommends a validated and normed screening instrument be used by the primary care provider for foster children. The following screening instruments are examples:

- Ages and stages questionnaire - social emotional (ASQ-SE) for children up to age 5 1/2 years.
- The pediatric symptom checklist (PSC), for children ages 5 1/2 years and older.

Verification that mental health screenings occurred must be documented on the EPSDT/well child exam form or an equivalent approved form; see [FOM 801, Health Services for Children in Foster Care](#).

Any mental health appointments must be documented as a mental health appointment in the health screens of the electronic case management record.

**Note:** Although the ASQ-SE or PSC is recommended, the primary care provider may use another screening tool or screening method, such as surveillance, in which a tool is not used.

## Case Manager Role

The case manager's role in the mental health screening process includes the following:

- Providing a copy of the completed screening assessment to the primary care provider. The screening instrument must be completed by a person who knows the child best before the child's well child exam.
  - The EPSDT/well child exam form indicates a psychosocial/behavioral assessment was completed, or a behavioral health screening tool was utilized.
- Uploading all documentation into the electronic case record, including but not limited to:
  - Completed screening tool(s), if applicable.
  - EPSDT/well child exam forms.
- Completing the appropriate referral(s) for services if the primary care provider indicates a need for further evaluation or services. If the child has received services through a community mental health services program (CMHSP) and/or the child's behaviors and doctor's screening indicate a possible serious emotional disturbance (SED), an intake appointment with the CMHSP must be scheduled. If the child does not meet criteria for CMHSP, refer the child to the behavioral health division of the child's Medicaid Health Plan (MHP) for assessment and treatment; see [FOM 801, Health Services for Children in Foster Care](#).
- Contact the child's mental health provider, community mental health (CMH), or the behavioral health division of the child's MHP to schedule an appointment for an assessment if a significant concern about a child's mental health or behavior arises between well child exams.
- Discuss the child's behaviors and any mental health concerns with the child's parents and foster parent at every monthly home visit; see [FOM 722-06H, Case Contacts](#).

## Early On Services and Assessment

Early On is Michigan's system for providing intervention to families of infants and toddlers, birth to age three, who have a diagnosed physical or mental health condition that has a high probability of resulting in developmental delays. Early On assists families in finding social, health, and educational services to promote the development of their infants and toddlers with special needs.

Early On emphasizes early identification and early referral to enhance the development of infants and toddlers with disabilities, to minimize their potential for delay, and to recognize the significant brain development that occurs during a child's first three years of life.

Children's Protective Services (CPS) is required to refer children to Early On during an investigation; see [PSM 713-01, CPS Investigation - General Instructions](#).

After foster care receives a new case from CPS, the case manager must check the status of the Early On referral and update the new case manager's contact information and the placement address and contact information. If there is not an active referral in the system, the case manager must complete a new referral within 30-calendar days of the initiation of the foster care case opening. Follow up on status of a referral is available at [www.1800earlyon.org](http://www.1800earlyon.org).

## MEDICAID HEALTH PLANS

[MHP](#) provides outpatient mental health visits for children with mild to moderate behavioral needs. A referral from the primary care provider is not required for these visits. The Michigan Department of Health and Human Services (MDHHS) provides a list of [MHP service area](#) behavioral health providers who can be contacted for appointments. If the MHP behavioral health provider determines the child's needs are greater than mild to moderate, the child must be referred to the CMHSP.

Every health plan is required to have a community health case manager. The community health case manager can collaborate with the caregiver to identify and schedule an appointment with one of the MHP's therapists or counselors for necessary services. An

appointment must be scheduled within 10 business days of the request.

**COMMUNITY  
MENTAL HEALTH  
SERVICES  
PROGRAM**

CMHSP and the organization with which they contract with must provide a comprehensive range of services and supports to children, adolescents, and adults with mental illness, intellectual and developmental disabilities (IDD), and substance use disorders in all 83 Michigan counties. The CMHSP network provides 24-hour emergency and crisis response services, screens admissions to state facilities and psychiatric hospitals, and acts as the single point of entry into the public mental health system.

CMHSP has an array of services and supports in the community for children and families. These services include but are not limited to:

- Psychiatric hospitalization.
  - Community-based freestanding psychiatric hospitals and psychiatric units in general hospitals.
  - Walter Reuther (formerly Hawthorn Center) is the only state-run hospital for children.
- Child and family therapy.
- Home-based services.
- Respite services.
- Wraparound services.
  - When a child is receiving Wraparound services and is placed in a child caring institution (CCI) or Walter Reuther, Wraparound support will continue for the child and family for a period of up to 180-calendar days for the purpose of ongoing planning to transition the child back into the community. The primary focus of Wraparound services will be the development of a plan to transition the child from the CCI or Walter Reuther back to the community as soon as possible.

- Children who are in a CCI or Walter Reuther and are not already receiving Wraparound services may be provided Wraparound services up to 180-calendar days prior to discharge for the purpose of transitioning successfully back to their home and community.
- Infant mental health services.
- Community living supports.
- Family support and training.
- Parent support partners.
- Medication management and psychiatric evaluation.
- Case management and supports coordinates.
- Child peer support.

For more information and a description of services; see [Child Welfare Medical and Behavioral Health Resources](#).

**Note:** When a child is denied or refused CMH services, please utilize the [CMH Appeals Process Job Aid](#) for further guidance.

## Serious Emotional Disturbance

SED is a term used in reference to children under the age of 18 with a diagnosable mental health or behavioral illness that severely disrupts their ability to function socially, academically, or emotionally.

A determination of SED is made by the CMHSP, based on the child's functioning, and measured using the Michigan Child and Adolescent Needs and Strengths Tool (MichiCANS), or the Devereux Early Childhood Assessment Infant/Toddler (DECA). An interview performed by a clinician with specialized training on the effects of trauma, loss, and prenatal substance exposure on children and adolescents is also completed. If a child is determined to have SED, a plan of service is developed and delivered through the CMHSP.

If the CMHSP determines the child does not have SED, the CMHSP may identify community resources, and the case manager must follow up with referrals.

### ***Waiver for Children with Serious Emotional Disturbance***

The children's Serious Emotional Disturbance Waiver (SEDW) provides services that are enhancements or additions to the Medicaid state plan coverage for individuals through age 21 who meet eligibility requirements. The SEDW enables Medicaid to fund necessary home and community-based services for children with SED who meet the criteria for admission to the state inpatient psychiatric hospital and are at risk of hospitalization without waiver services. A child in foster care is eligible for the waiver if all the following apply:

- Is under the age of 18 at the time of initial approval.
- Resides with their birth parent, a relative, or in a foster home that is willing to commit to caring for the child for at least one year.
- Has a primary Diagnostic and Statistical Manual of Mental Health Disorders (DSM), mental health diagnosis.
- Meets CMHSP contract criteria for and is at risk of inpatient hospitalization in the state psychiatric hospital.
- Demonstrates serious limitations that impair their ability to function in the community.

A total daily rate is paid to foster parents and relative caregivers caring for a child in foster care with a SEDW, unless they qualify for a higher rate for providing treatment foster care services or a determination of care (DOC) rate. The foster parent or relative caregiver should always be paid the higher rate if the option exists; see [FOM 903-03, Payments for Foster Family/Relative Care](#).

No more than two children qualified for the waiver may reside in the same out-of-home placement unless the placement is being made to reunify siblings. If the case manager is pursuing sibling reunification of three or more siblings who are qualified for the waiver in the same out-of-home placement, the case manager must contact the SEDW lead in the CMHSP providing services to the children to determine if joint placement is in the children's best interest prior to making placement; see the [SEDW Job Aid](#).

**Total Daily Rate With SEDW**

Age Group	SEDW Daily Rate	Daily Maintenance Rate	Total Daily Rate for Youth Receiving SEDW
0 - 12	\$32.76	\$22.35	\$55.11
13 - 18	\$29.41	\$26.69	\$56.10

### **Autism Spectrum Disorder**

Autism Spectrum Disorder (ASD) is a life-long neurological disability that is characterized by significant social-communication and behavioral deficits. The severity of this disorder can vary greatly from one individual to another. The term spectrum refers to the range of social communication and behavioral deficits. To learn more about the early signs of ASD, visit <https://www.michigan.gov/autism/>.

The screening tool for ASD is the Modified Checklist for Autism in Toddlers, Revised (M-CHAT-R). The M-CHAT-R should be administered at the EPSDT exam at ages 18 and 24 months by the primary care physician (PCP).

If the M-CHAT-R shows concerns, the PCP will contact the Prepaid Inpatient Health Plan (PIHP) to refer for further evaluation. The PIHP will contact the child's parent or caregiver to arrange a follow-up appointment for a comprehensive diagnostic evaluation. This evaluation is a neurodevelopmental review of cognitive, behavioral, emotional, adaptive, and social functioning using validated evaluation tools. CMHSP will conduct the evaluation and recommend a treatment plan for the child. The MHP will provide physical health care and potentially speech and occupational therapy if indicated and the CMHSP may provide applied

behavioral analysis services (ABA) or other CMHSP services to the child and family.

## **Intellectual and Developmental Disability**

IDD means either of the following:

- If applied to an individual older than five years of age, a severe, chronic condition that meets all the following requirements:
  - Is attributed to mental or physical impairment or a combination of mental and physical impairments.
  - Is manifested before the individual is 22 years old.
  - Is likely to continue indefinitely.
  - Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment or other services that are of lifelong or extended duration and are individually planned and coordinated.
  - Results in substantial, functional limitation in three or more of the following areas of major life activities:
    - Self-care.
    - Receptive and expressive language.
    - Learning.
    - Mobility.
    - Self-direction.
    - Capacity for independent living.
    - Economic self-sufficiency.
- If applied to a child from birth to age five, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined above.

Common examples of disabilities that may fall under this definition include intellectual disabilities, cerebral palsy, down syndrome, and autism.

The disability may be identified at a well child exam, by the school system, or by Early On with a recommendation for further

evaluation. When a child has been referred for further evaluation, the case manager must instruct the caregiver(s) to initiate services through the CMHSP. After the evaluation, the CMHSP may add additional services that cannot be provided through Early On, the school system, or the MHP.

CMHSP may be able to provide the Habilitation Supports Waiver (HSW). HSW is an intensive home and community based, active treatment and support program, designed to assist individuals with severe developmental disabilities to live independently with support in their community of choice. This program is designed as a community-based alternative to living in a group home.

### **Crisis Residential Services**

Crisis residential services are intended to provide a short-term alternative to inpatient psychiatric services. Services may only be used to avert an inpatient psychiatric admission or shorten the length of an inpatient stay.

Services are for children who are determined by CMH to meet psychiatric inpatient admission criteria or are at risk for admission, but who can be appropriately served in a less intensive setting.

Services must resolve the immediate crisis and improve the functioning level of the child to allow them to return to a less intensive community setting as soon as possible. The crisis residential services cover include:

- Psychiatric supervision.
- Therapeutic support services.
- Medication management/stabilization and education.
- Behavioral services.
- Milieu therapy.
- Nursing services.

Children who are admitted to the crisis residential services must be offered the opportunity to explore and learn more about:

- Crises.
- Substance abuse.
- Identity.
- Values.
- Choices and choice-making.

## Psychiatric Hospitalization

- Recovery and recovery planning.

Psychiatric hospitalization is a short-term service that should be accessed when a child presents a risk of harm to self/others that cannot be managed with community-based supports.

PIHP/CMHSP are responsible for managing and coordinating Medicaid-paid psychiatric inpatient hospitalizations for children in foster care. The PIHP/CMHSP provides screening and authorization/certification of requests for psychiatric admission and continuing stay for inpatient services, defined as follows:

- Screening - the PIHP is notified of the child's mental health status and is provided enough information to decide the most appropriate services. The screening may be provided on-site, face-to-face by PIHP/CMHSP personnel, or over the telephone (as determined by the PIHP/CMHSP).
- Authorization/certification - the PIHP/CMHSP has screened the child and approved the services requested.

After authorization, the PIHP/CMHSP will arrange hospitalization for the child. Psychiatric hospitalization without PIHP/CMHSP authorization is not reimbursable through Medicaid.

Psychiatric hospitalization cannot be paid with foster care funds. These placements require prior CMH approval and are paid by Medicaid.

When a child is placed in a mental health institution paid for by Medicaid and is discharged but not moved to another placement, this is considered a non-contracted placement.

**Note:** Children discharged from a hospital setting should not maintain placement in the hospital and **must** be moved to another placement.

Refer to the [Map of the Community Health Services Programs](#).

## Case Manager's Responsibilities

### *Child in Crisis Residential/ Psychiatric Hospital*

The case manager's responsibility when a child is in a psychiatric hospital or in a crisis residential is:

- Daily contact with the hospital or crisis residential on workdays for the first 30 days. Information being exchanged should cover; see [FOM 722-06H, Case Contacts](#):
  - Treatment progress.
  - Discharge planning, including any change in placement or complications to a successful discharge.
- Notification to the foster care psychotropic medication oversight unit (PMOU) if the child is prescribed psychotropic medication while hospitalized or in treatment at a crisis residential. The PMOU hotline number is 1-844-764-PMOU (7668).

**Note:** When a child is at risk of psychiatric hospitalization, please utilize the [Psychiatric Hospitalization Job Aid](#) for further guidance.

## Infant Mental Health

Infant mental health services are available to promote the social and emotional well-being of infants, toddlers (up to age three) and families within the context of secure and nurturing relationships. Infant mental health services support the growth of healthy attachment relationships in early infancy, reducing the risk of delays or disorders and enhancing enduring strengths.

Infants and toddlers that are targeted to receive infant mental health services are vulnerable to multiple factors that place them at risk for developing a variety of emotional, behavioral, social, and cognitive difficulties. Warning signs for potential social-emotional concerns in infants and toddlers are listed in the table below.

### **Warning Signs for a Potential Social-Emotional Concern**

<b><i>Infant</i></b> <b>(0-12 months)</b>	<b><i>Toddler</i></b> <b>(1-3 years)</b>
<ul style="list-style-type: none"> <li>• Resists holding.</li> <li>• Is difficult to comfort or console; has prolonged inconsolable crying.</li> <li>• Has sleeping or eating difficulties (sleeps or eats too much or too little).</li> <li>• Meets failure to thrive criteria.</li> <li>• Rarely seeks or makes eye contact or typically avoids eye contact with parents.</li> <li>• Appears unresponsive to efforts to interact or engage.</li> <li>• Rarely coos, babbles, or vocalizes.</li> <li>• Has limited ability to regulate emotions.</li> </ul>	<ul style="list-style-type: none"> <li>• Shows little preference for or excessive dependence on the parent(s) or other primary caregiver(s).</li> <li>• Does not show any apprehension about strangers.</li> <li>• Appears excessively irritable or fearful.</li> <li>• Has an inappropriate or limited ability to express feelings.</li> <li>• Lacks interest or curiosity about people or play.</li> <li>• Fails to explore the child's environment.</li> <li>• Often appears sad and withdrawn.</li> <li>• Inappropriate sexual, impulsive, or aggressive behavior.</li> <li>• Excessive fears that do not respond to reassurance.</li> <li>• Experiences frequent night terrors.</li> <li>• Extreme and frequent tantrums.</li> <li>• Experiences significant language delays.</li> <li>• Exhibits unusual need for order or cleanliness.</li> </ul>

**Note:** Additional detailed information on the social-emotional development of young children can be found at [MI Kids Matter](#).

### **Infant Mental Health Referrals**

Infants and toddlers displaying signs of social-emotional delays must be referred to a local CMHSP to be evaluated for infant mental health services. Referrals must also be made in the following scenarios:

- Upon receipt of the well-child exam (if concerns are noted).
- Within 14-calendar days of a child's second (or more) placement change.

- Within 14-calendar days of a request from the foster parent, relative caregiver, or birth parent for evaluation.

## FETAL ALCOHOL SPECTRUM DISORDER

Fetal alcohol spectrum disorder (FASD) is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioral, and learning disabilities. Often a person with FASD has a mixture of these impairments. FASD is not a diagnostic term.

### Case Manager Role in FASD

Conventional treatment for some behavioral problems may be ineffective for children with FASD. Without proper intervention, birth families and other caregiving families may struggle to maintain these children in their homes.

The case manager may consider the possibility of FASD by observing the child, reviewing the child's medical history, and reviewing the FASD identifiers listed below. If the results of pre-screening for FASD contain two or more of the three identifiers listed below (and are not associated with another known syndrome) and include the presence of three or more physical/behavioral markers, the child **must** be referred for a full FASD diagnostic evaluation.

The FASD identifiers include:

- Prenatal maternal alcohol use.
- Physical markers:
  - Difficulty with eating or feeding, examples are:
    - Trouble sucking.
    - Considered a picky or slow eater.
  - Difficulty falling asleep and staying asleep.
  - Speech problems or language delays.
- Behavioral markers:

- Difficulty with paying attention.
- Impulsivity.
- Difficulty with verbal receptivity.
- Overreacting to minor problems.
- Difficulty with reasoning and judgment.
- Acts younger than children the same age.

Full FASD diagnostic screenings are available at [Michigan FASD Diagnostic Centers](#). To learn more about FASD and prevention; see [Fetal Alcohol Spectrum Disorders](#).

Results of the FASD review by the case manager must be included when requesting a pre-10 waiver for placement of children less than 10 years old in residential or other institutional settings; see [FOM 722-03E, Placement Exception Requests and Approvals](#).

### ***Plan of Safe Care***

In any case that involves an infant born exposed to substances or who experienced or is experiencing withdrawal symptoms, or who has been diagnosed with FASD, the case manager must ensure a Plan of Safe Care (POSC) is in place; see [FOM 722-06, Case Planning](#).

## **PSYCHOLOGICAL TESTING STANDARDS**

Types of psychological testing and assessments include the following:

- Cognitive and neuropsychological assessment, the following are subsets of the assessment:
  - Abstract reasoning and categorical thinking.
  - Academic achievement.
  - Attention.
  - Cognitive ability.
  - Executive function.
  - Language.
  - Learning and memory.
  - Motor functions, sensorimotor, and lateral preference.
- Problem behavior testing and assessment.
- Family and couples testing and assessment.

- Social and adaptive behavior testing and assessment.
- Personality testing and assessment.
- Vocational testing and assessment, the following are subsets of the assessment:
  - Interests.
  - Work values.
  - Career development, maturity, and indecision.

The purposes of testing and assessments are as follows:

- Diagnosis.
- Neuropsychological evaluations.
- Intervention planning and outcome evaluation.
- Judicial and governmental decisions.
- Personal awareness, social identity, psychological health, growth, and action.

The process includes:

- Clarifying the purpose of the assessment.
- Driving the test selection and other sources of information needed to accomplish a purpose.
- Early results, which may lead to additional tests and measures.
- Integrating information such as collateral, tests, and characteristics.
- Reporting results.

**Note:** Medicaid payment is predicated on medical necessity.

## Psychological Evaluations

A psychological evaluation must be obtained from a local provider for any child who has suffered sexual abuse or severe physical abuse, mental illness, or is the alleged victim of human trafficking [MCL 722.954c\(4\)](#).

A psychological evaluation may include the following:

- The reason the testing is requested.

- Review of prior diagnostic testing, current and past treatment records.
- Clinical interviews with the child and adult informants.
- Test and assessment results including IQ, adaptive functioning, achievement, and others, as necessary.
- Diagnosis and needs.
- Recommendations to address the needs.

The evaluation must be conducted by a licensed mental health professional or a licensed social worker who is trained in children's assessment. For children ages two and younger, a developmental assessment will suffice. The results of the evaluation must be incorporated into the narrative of the appropriate service plan. The costs for such assessments are the responsibility of MDHHS; see [FOM 903-09, Case Service Payments](#).

**Note:** The Marschak Interaction Method (MIM) or other parent-child interaction technique may be conducted as part of a psychological or comprehensive trauma assessment but are not reimbursable on their own.

## MDHHS CONTRACTED BEHAVIORAL HEALTH SERVICES

Mental health services for children under the supervision of MDHHS are provided by either the MHP behavioral health services for mild to moderate or CMHSP for SED, ASD, and IDD. MDHHS also contracts for some behavioral health services that are not covered by Medicaid.

### Treatment Foster Care

Treatment foster care (TFC) is a placement option for children supervised by MDHHS who are diagnosed with SED and require an expertly trained foster home setting to meet their behavioral health needs. This service is not available statewide. Check current availability at [Treatment Foster Care Contractors](#).

Referrals for TFC are completed in the electronic case record in the placement exception request (PER) screens. The county director is the final approver for these placements. TFC PERs must be completed quarterly; see [FOM 903-03, Payment for Foster Family/Relative Care](#).

## Comprehensive Trauma Assessment

A comprehensive trauma assessment is an in-depth assessment of the impact of trauma a child has experienced, how the trauma impacts the relationship with the child's caregivers and the child's functioning, and recommendations for services or community supports for the child and family.

The purpose of the assessment is to obtain clinical recommendations to guide case managers in developing case plans to assist the child and family with addressing identified trauma, behaviors, and diagnoses that meet clinical criteria to heal and remain stable in the home setting.

These assessments are not intended to provide answers to best interest decisions, such as permanency, parenting time or placement. Best interest decisions should be made by the case manager based on a holistic review of the child's case and following supervisor discussion and support.

**Note:** Local office practice may require additional screening.

The child must be participating in and not benefiting from current services to be eligible for a trauma assessment.

To determine if a child is eligible for a comprehensive trauma assessment, staff must utilize the appropriate MDHHS Trauma Screening Checklist based on the age of the child:

- [MDHHS-5719, Trauma Screening Checklist \(Ages 0-5\)](#).
- [MDHHS-5720, Trauma Screening Checklist \(Ages 6-18\)](#).

Case managers are required to administer the MDHHS trauma screening checklist to each child victim involved in an ongoing CPS or foster care case according to the following timeframes:

- Within 30 calendar days of case opening.
- When a Category 1 CPS case transfers to foster care.

- Within 180-calendar days of the initial screening.
- Prior to case closure.

The score of the trauma screening checklist will determine if a referral for a mental health assessment or a comprehensive trauma assessment is necessary. Referral for mental health assessment/treatment or comprehensive trauma assessments are not intended as standard practice for every child, and should be based on the following:

TOTAL SCORE (Endorsements)	Recommended Action
0-3	No referral required based only on the results of the trauma screening checklist. Determine appropriate next steps for case planning on an individual basis.
4-5	Make a referral for the child to be assessed for mental health services. For children receiving Medicaid, refer to local CMH or MHP behavioral health providers.
6-10	Convene team to discuss current services the child may be receiving, including mental health services. If the child is not making progress, consider making a referral for a mental health assessment from current therapist or local CMH that incorporates trauma exposure and impact.
11+	Convene team to discuss current services the child may be receiving including mental health services. If the child is not making progress, consider making a referral for an assessment and determine appropriate type of assessment: mental health or comprehensive trauma. Section 1 on the trauma screening checklist must have at least one trauma exposure identified to refer for a comprehensive trauma assessment.

The child must meet the following eligibility criteria to be referred for a comprehensive trauma assessment:

- The child has a current open MDHHS foster care, CPS, or MDHHS juvenile justice (JJ) case. The current open MDHHS foster care, CPS, or MDHHS JJ case must remain open until the comprehensive trauma assessment report is completed and sent to the case manager, recommendations are reviewed with the family, plans for implementation, and the invoice is paid.

**Note:** CPS cases must be open as a category I or category II to be eligible for comprehensive trauma assessments. CPS investigations, category III, category IV, category V, and prevention cases are not eligible for comprehensive trauma assessments.

- The child must be aged 0-17.
  - Prior to referral any child less than three years of age must have been referred to all the following:
    - Medical professional/pediatrician.
    - Early On.
    - CMH for infant/early childhood mental health treatment services.

**Note:** At least one of the professionals listed above must recommend a referral for a comprehensive trauma assessment. Documentation of the decision to refer, including applicable reports must be included with the [MDHHS-5594, Trauma Assessment Referral](#).

In addition to the criteria above, the child must also meet one or more of the following eligibility criteria below:

- The child is struggling with functioning and behaviors in their current placement despite participating in services.
- The child entered care within the last 30-calendar days, and the current placement is in danger of disrupting due to the child's functioning and behaviors. The child has not been referred to or started services.
- The assessment is recommended by a current mental health clinician or current medical professional.
- The child is not benefiting from current services **and** received an 11+ on the trauma screening checklist.

- The assessment is court ordered.

When determined that a child should be referred for a comprehensive trauma assessment, the case manager must complete the DHHS-5594, Trauma Assessment Referral, and attach all supporting documents. The county director is the final approver and assigns a contractor to the referral based on the contractor rotation for the county's region. The case manager must enter a case service into the electronic case record and upload the MDHHS-5594, Trauma Assessment Referral, and supporting documentation into the document section of the electronic case record.

The case manager must route the case service to supervision for approval. The supervisor must route the case service to the behavioral health analyst within the Child Welfare Medical and Behavioral Health Unit for approval. The case service must be approved by the behavioral health analyst prior to sending the referral packet to the assigned contractor.

The contractor must complete all related contract activities and send the completed report to the referring case manager within 75 calendar days of the date the completed referral was sent to the contractor. The contractor must meet with the case manager and all team members, parents, caregivers, and mental health clinicians within 10-calendar days of assessment completion to review findings and recommendations. The case manager must ensure recommended services and action steps identified in the comprehensive trauma assessment report are implemented.

The established rate for the comprehensive trauma assessment is \$2,343.33. The contractor must complete the appropriate section of the [MDHHS-5594, Trauma Assessment Referral](#) and send it, along with the report, back to the case manager. The case manager must go into the previously added case service and add the date the report was received as the completion date. The case manager must complete the payment in the electronic case management system for a payment to be issued to the contractor. The payment must be entered and approved within 10 business days of receiving the MDHHS-5594, Trauma Assessment Referral, from the contractor.

Comprehensive trauma assessments are intended to provide information that will inform ongoing case and treatment planning. Although specific elements of a child's situation may change, in

nearly all circumstances an additional comprehensive trauma assessment is not necessary to incorporate new information into case and treatment planning. The changes that may prompt consideration of an additional trauma assessment are listed below:

- It has been a minimum of two years since the first comprehensive trauma assessment.
- All recommended services and action steps identified in the first comprehensive trauma assessment report have been implemented.
- Current services and interventions are not having an impact on the child's behaviors and/or mental health needs.
- There has been a significant traumatic event in the child's life.

**Note:** If the court orders an additional comprehensive trauma assessment, the court order must be attached to the comprehensive trauma assessment referral packet.

Additional comprehensive trauma assessment referral requests must be approved by the behavioral health analyst with the Child Welfare Medical and Behavioral Health Unit; see the [Comprehensive Trauma Assessment Job Aid](#) and [Children's Services Administration Trauma Protocol](#) for further instructions.

## Ancillary Services

Ancillary services are specific activities performed by a contractor that are necessary to complete a comprehensive trauma assessment, provide counseling services, or complete a qualified residential treatment program independent assessment. Ancillary services must be requested by the contracted provider. All ancillary services must be pre-approved by the case manager and supervisor on the [MDHHS-5599, Ancillary Service Approval](#). Ancillary services may be requested by the contractor at the time of referral or later as needed.

The following activities may be reimbursable ancillary services depending on the type of contracted service, which are indicated on the MDHHS-5599, Ancillary Service Approval:

***Allowable with Counseling and Comprehensive Trauma Assessments***

- Travel to perform the service off site (jail, home, residential facility, prison, etc.).
- Attendance at a family team meeting (FTM) or other meeting requested by the referring case manager.
- Appearance for court-ordered testimony and the court refuses to pay the witness fee. Verification of the court's refusal to pay must accompany this form.
- Preparation for court ordered testimony and travel time to court.
- Off-site observation at school, MDHHS, or placement agency foster care (PAFC) office.

***Allowable with Comprehensive Trauma Assessments***

- Partial assessment completed but cannot be finished due to client refusal or case manager determination that the assessment is no longer necessary.
- Conduct an additional parent/child relationship assessment.
- Review additional documents exceeding ten.
- Prepare a duplicate original hard copy report with signature.

***Allowable with Qualified Residential Treatment Programs (QRTP) Independent Assessments***

Partial assessment completed but cannot be finished due to client refusal or case manager determination that the assessment is no longer necessary.

**Documentation of  
Assessment  
Services**

Assessment services, such as comprehensive trauma assessments or psychological evaluations, regardless of the provider, must be documented in the appointment tab of the health profile in the electronic case record and the assessment report must be

uploaded in the electronic case record; see [Entering Frequent, Ongoing, Appointments into the System](#).

## Child Caring Institutions

CCIs are facilities organized for the purpose of receiving minor children for care, maintenance, and supervision, usually on a 24-hour basis, in buildings maintained by the institution for that purpose, and operate throughout the year.

When a child cannot be supported in a community-based setting, placement in a CCI may be considered. MDHHS contracts with CCIs to provide residential services based on a child's individual needs that include:

- General residential: A child presents risk at home, school, in the community, to self, others, and property. A child has exhibited a behavior(s) that has interfered with their ability to function adequately in a less restrictive setting, behaviors may include but are not limited to:
  - Aggressive episodes.
  - Stealing or petty theft.
  - Vandalism.
  - Inappropriate social interactions.
  - Reactions to past trauma.
- Mental health and behavioral stabilization (MHBS): A child currently experiencing or with a history of active unstable symptoms, which may include severely aggressive behavior toward self or others, psychotic symptoms such as, delusions, hallucinations, suicidal and homicidal ideations, or frequent severe emotional episodes.
- Developmentally disabled cognitively impaired (DDCI): A child who is experiencing significant adjustment problems at home, in school or in the community because of SED with or without substance use, or dependence symptoms, concurrent with cognitive impairment or developmental disability, emotional impairment, and behavioral concerns that cannot be addressed in a less restrictive placement.
- Substance abuse rehabilitation: A child experiencing substance use disorder with a significant impairment in an area of functioning.

- Youth with problematic sexual behaviors (YPSB): A youth displays problematic sexual behavior that impacted daily life functional areas, including relationships, school, family, or other domains to the extent continued services in the community do not provide sufficient support.
- Parent/baby: The parent/baby program is available to youth ages 13 and older who are pregnant or parenting and the youth's infant or toddler. The contractor must have the ability to serve both pregnant and parenting youth and the youth's infant or toddler(s).
- Specialized developmental disability (SDD): A child whose level of developmental impairment warrants a significant sensory sensitive individualized treatment setting. SDD is designed for children diagnosed with ASD, or children with IDD.
- Intensive stabilization (IS): A child with significant behavior challenges who may be stepping down from a hospitalization program or experiencing repeated placement instability. The child may be experiencing or have history of active unstable symptoms such as, delusions, hallucinations, suicidal/homicidal ideations, or frequent severe emotional episodes.
- Human trafficking survivor (HTS): A child who has experienced significant trauma and behavioral challenges resulting from commercial sexual exploitation or sex trafficking.

For both CCI and Walter Reuther placements, the case needs to be open to PIHP/CMHP. Mental health services initiated by the PIHP may be provided within the designated timeframes:

- Assessment of a child's needs for the purpose of determining the community-based service necessary to transition the child out of a CCI or Walter Reuther. This should occur up to 180-calendar days prior to the anticipated discharge from a CCI or Walter Reuther.
- Wraparound planning, case management or supports coordination. This should occur up to 180-calendar days prior to discharge from a CCI or Walter Reuther.

A case manager must complete a PER when a child in foster care is not making progress with community-based programming and residential services are being considered. The PER approval path is outlined in [FOM 722-03E, Placement Exception Requests and Approvals](#), page 27, [FOM 912, Residential Services: Caseworker Responsibilities](#), and [FOM 912-1, Residential Services: Residential Provider Requirements](#).

**Note:** For information on QRTP; see [FOM 912-1, Residential Services: Residential Provider Requirements](#).

## CONTRACTED COUNSELING SERVICES

### Fair Market Counseling

Contracted counseling services may be utilized by CPS, foster care, JJ, or direct support services for families including those who do not have Medicaid or another medical insurance.

For children in foster care, counseling should be obtained through the MHP or CMHSP. An exception to the use of MHP or CMHSP may be provided to a child in foster care or JJ by a mental health provider under contract with MDHHS, known as fair market contractor, under one of the following circumstances:

- The specific type of therapy is recommended by a mental health or trauma assessment and required to address mental health needs of the child, and the therapy is not available through the MHP's behavioral health services for mild to moderate needs or through the CMHSP for SED.
- Therapy was established with a fair market counselor while the child's case was monitored by ongoing CPS or prior to removal from the home. Decisions regarding continued service from the fair market counseling contractor are based upon:
  - The child's relationship with the counselor.
  - The success of the intervention.
  - The need for a specific therapy approach not available through the MHP or CMHSP.

- The therapist's role in the reunification or permanency plan. Consider the therapist's collaboration with the birth parent's therapist or other professionals and determine if a change might affect the forward momentum of the plan.
- The child is placed in a group home and individual or group counseling is provided to residents of the home through a contracted provider.

If one of the above circumstances apply, a [DHS-1556, Behavioral/Mental Health Exception](#), must be completed to provide a documentation of the need for fair market contracted counseling services for children in foster care. The DHS-1556, Behavioral/Mental Health Exception, must be completed by the case manager, authorized by the supervisor, and uploaded in the medical section of the child's case file in the electronic case record.

### **Referral Process for Contracted Counseling**

Within this section of the manual, the term client refers to either the child in foster care or the parents and caregivers that are part of the reunification household.

The child welfare case manager, in consultation with their supervisor, determines the client's eligibility for services. The CPS, foster care, or JJ case must be open at the time of referral. Contracted counseling services must end at the time of case closure. MDHHS foster care monitors must approve referrals from PAFC case managers and supervisors. To be reimbursed by MDHHS, a counseling contractor cannot accept referrals from any source other than MDHHS. Counseling contractors can be found at [Counseling Services](#).

#### ***CSA Counseling Contract Protocol***

The information included in the [Counseling Contract Protocol](#) is designed to outline the counseling contract services provided to children, youth, and families through MDHHS. The protocol will discuss the contracted counseling service requirements and address the roles and responsibilities of the contracted provider, case manager, and contract administrator.

When it is determined that counseling services are necessary and the client is eligible, the referral process requires the following steps be completed by the case manager:

- Contact with the counselor or therapist to discuss the referral and document in the social work contacts.
- Receives confirmation the counselor agrees to provide counseling services to the client.
- Completes the DHS-880, Child Welfare Counseling Services Referral. The following must be completed when filling out the form:
  - The period of eligibility and number of counseling units must be listed.
  - No more than 12 units may be initially authorized.
  - Obtain supervisor signature.
- Sends the DHS-880, Child Welfare Counseling Services Referral, to the counselor and documents in social work contacts.
- Files a copy of the referral in the child's electronic case record.
- Documents, discussion of the client's circumstances and preliminary goals and objectives with the counselor within social work contacts in the case service plan.

Counseling services cannot begin until the counselor receives the appropriate referral form and approvals.

Any extensions for continued service must be in writing, listing the number of counseling units authorized and the dates that the service is authorized. Extensions must be signed by the referring case manager, the supervisor, and approved by the county director on the DHS-880, Child Welfare Counseling Services Referral.

**Note:** The DHS-880, Child Welfare Counseling Services Referral, must be completed by the case manager if a referral is made to a contracted counselor. If the contracted counselor accepts Medicaid, Medicaid must be billed. The contract may only be billed when the client does not have Medicaid or if the contractor does not accept Medicaid.

## Ineligible Services

The following services are not counseling services for children in foster care and their families:

- Parenting classes, such as Love and Logic.
- Anger management classes.
- Work preparation and readiness classes.
- Independent living classes.
- Counseling services for children in foster care under the supervision of the PAFC provider.

**Note:** The PAFC provider is responsible for the cost of counseling services for children in foster care under their supervision. MDHHS does not provide counseling referrals for PAFC supervised foster care children.

## Service Delivery Requirements

Within 10 business days of receipt of a written referral from MDHHS, an initial session must occur between the counselor and client and assess the following:

- Current circumstances and view of the presenting concern.
- Developmental history, family structure, support system, and employment.
- Physical health, emotional and mental status.

The DHS-840, Counseling Services Assessment and Treatment Plan Report, provides ongoing client information and progress updates to the case manager. The DHS-840, Counseling Services Assessment and Treatment Plan Report, is:

- Completed monthly by the counselor.
- Submitted to the case manager within 10 business days following the end of each month.
- Inclusive of client progress made toward treatment objectives and indicative of any changes made in the treatment plan.

- An opportunity for the case manager to closely monitor the client's progress or lack of progress with the service and provide feedback to the client.

Within 10 business days following the end of the month of the initial interview with the client, the counselor submits a DHS-840, Counseling Services Assessment and Treatment Plan Report, to the referring MDHHS case manager. The report must address:

- Record of client sessions kept and missed appointments.
- Phone or other case contacts.
- Individual and family assessment.
- Working diagnosis, if applicable.
- Identified concerns.
- Client strengths.
- Specific objectives and time frames. The objectives listed in the counselor's treatment plan must be:
  - Behaviorally based and measurable.
  - Reflective of the interventions and strategies employed to achieve the overall goals of the counseling treatment sequence.
  - Developed by the counselor with the client and in consultation with the referring case manager.

### **Termination of Contractor Counseling Services**

When counseling services are terminated, the counselor must complete a [DHS-841, Counseling Services Termination Summary](#). The summary is submitted to the case manager no later than 10 business days following the end of the month in which services were terminated. The DHS-841, Counseling Services Termination Summary, report addresses the following:

- Diagnosis at termination.
- Treatment summary.
- Objectives and progress towards objectives.
- Total number of sessions offered to the client.
- Number of sessions attended.
- Cooperation in treatment.

**Monitoring Service  
Provision**

- Reason for closure.
- Recommendations.

Ongoing communication between the case manager and the counselor provides the best assurance for a good working relationship and effective service for the referred client. The case manager must keep the counselor informed of significant case developments, court hearings, permanency case conferences, changes in case managers, address changes, or upcoming case closure.

In monitoring the provision of services, the case manager must review reports submitted by the counselor to ensure:

- All information listed in the service delivery section is included.
- The report is specific to the client and reflects updated information.
- Other contract requirements such as the following are addressed:
  - Did the counselor contact the client within three business days of a missed appointment?
  - Did the counselor notify the case manager by phone each time two consecutive appointments were missed?

**Contracted  
Counseling  
Service  
Noncompliance**

Each contractor signs a counseling contract, which outlines the counselor's responsibilities, including the services to be delivered. If a counselor does not meet the requirements, the following action(s) must be taken:

- The case manager contacts the counselor, discusses the concerns, and documents the contact in the social work contacts.
- If the counselor does not address the concerns, the case manager notifies their supervisor, in writing, of the issue.

- The supervisor or designated local office contract monitor reviews the case manager's concerns and submits a written complaint to the local office director. The complaint must include:
  - The name, address, phone number and contract or provider number of the counselor.
  - A narrative explaining the specific contract violation and a chronology of attempts to collaborate with the counselor to rectify the concern.
- The local office director submits the written complaint outlining the details of any action taken to date to the assigned business service center analyst.

### **Required Counseling**

MCL 722.954c(6) states that the supervising agency must provide, in addition to any reunification, adoption, or other services provided to a child under the supervising agency's care, counseling services appropriate for minor victims of human trafficking.

### **Documentation of Counseling Services**

Counseling appointments for children in foster care, regardless of the provider, must be documented in the appointment tab of the health profile in the electronic case record for ongoing, regular appointments; see the job aid, [Entering Frequent, Ongoing, Appointments into the System.](#)

### **POLICY CONTACT**

Questions about this policy item may be directed to [Child Welfare Policy Mailbox \(Child-Welfare-Policy@michigan.gov\)](mailto:Child-Welfare-Policy@michigan.gov).