YES Waiver User Guide

Version 1.4

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TEXAS
Health and Human Services

Version History

Date	Version Number	Author	Document Changes
02/08/2019	1.1	Apryl Rosas	Updated CMBHS guidance on submitting YES Assessment, CE and IPC documents, and transfer procedure. Added CMBHS guidance on entering service notes, Medicaid Eligibility Verification, and overview of CE and IPC document types.
02/15/2019	1.2	Apryl Rosas	Updated Enrollment section: Inquiry line, inquiry list, and overview of enrollment forms. Added guidance on Medicaid fair hearings and notice of adverse action forms.
02/28/2019	1.3	Apryl Rosas	Updated YES Waiver Services section.
6/2/2022	1.4	Justin Hair	Added ARPA, technology funding, language

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General Guidelines

YES Waiver Overview

The Youth Empowerment Services Waiver, also known as the YES Waiver, provides comprehensive home and community-based mental health services to children and youth between the ages of 3 through 18 who are at-risk of institutionalization or out-of-home placement due to a **serious emotional disturbance (SED)**.

YES Waiver Policy Manual

The current YES Waiver Policy Manual can be found on the YES Waiver website. Each person who works with YES Waiver participants should read the manual and reference it as needed.

YES Waiver Contracts

YES Waiver contracts are formal agreements between the **Health and Human Services Commission (HHSC)** and the Local Mental Health Authority/Local Behavioral Health Authority (LMHA/LBHA) and/or Comprehensive Waiver Service (CWP) provider. These contracts outline the contractor's obligations related to the provision of YES Waiver services. These contracts include:

- Comprehensive Waiver Provider (YESPROV)
- Performance Contract Notebook (PCN)

These contracts provide specific detail related to the scope and quality of services provided to YES Waiver participants. Topics covered in contracts include but are not limited to:

- Deliverables and performance measures;
- Providing YES Waiver services;
- Enrolling and serving eligible participants;
- Service targets;
- Inquiry List management;
- Transition plan development and coordination;
- Implementation and maintenance of a quality management plan;
- Wraparound facilitation provision; and
- Utilization of targeted case management/intensive case management (TCM/ICM) to coordinate plans of care.

Contractually Required Regular Submissions

Submission of:	Submitted to:	Due Date
Inquiry List	**YES Inbox:** yeswaiver@hhsc.state.tx.us **MH Contracts:** mhcontracts@hhsc.state.tx.us	Monthly, on or before the 5th business day
Provider Network Development Report	**YES Inbox:** yeswaiver@hhsc.state.tx.us **MH Contracts:** mhcontracts@hhsc.state.tx.us	Quarterly, on or before the 15th business day

In addition to regular submissions, YES Waiver providers are required to submit the following information to HHSC according to the requirements outlined in contract:

- Notification of a waitlist;
- Request to HHSC for approval of a plan to operate a blended caseload; and,
- Request to HHSC for approval to exceed the 1:10 wraparound provider organizational caseload ratios.

Required Trainings

The YES Waiver serves children and youth with complex mental health needs, known as serious emotional disturbance (SED). Youth eligible for YES Waiver are those who cannot reasonably be served in a lower level of care and typically require the highest level of supports to meet their mental health needs. Because participants enrolled in YES Waiver require intensive supports, regular training of service providers is required by HHSC to ensure the safety and well-being of YES Waiver participants.

Required trainings include:

- Cardiopulmonary resuscitation (CPR) and First Aid certification
- Crisis and Safety Planning
- Critical Incident Reporting
- Health Insurance Portability and Accountability Act (HIPAA)
- Introduction to Wraparound
- Reporting of Abuse, Neglect, and Exploitation
- Restraint and Restrictive Intervention
- Service Documentation
- YES Waiver Training

Additionally, it is expected that all YES Waiver providers:

- participate in monthly Technical Assistance calls with HHSC YES Waiver staff;
- participate in Wraparound coaching support provided by the Texas Center; and
- be responsive to all requests for information from HHSC.

Wraparound Overview

HHSC chose the National Wraparound Implementation Center (NWIC) Wraparound Practice and Implementation Model to be the care coordination model for the YES Waiver.

Wraparound is an ecologically based process designed to build on the collective strengths and actions of a team. Wraparound is not a service or program, but a process designed for families whose children have complex needs, are involved in multiple systems, and for whom traditional services and approaches have not worked.

The Texas Center, in partnership with HHSC and NWIC, supports quality Wraparound practice through the provision of implementation support, training, coaching, and fidelity reviews. **Wraparound Facilitators** are required to follow the NWIC Wraparound Planning process to coordinate all aspects of care for Waiver participants.

All YES Waiver Wraparound Facilitators are required to attend and complete a 3- part Wraparound training series available through the Texas Center. Furthermore, it is expected that Wraparound Supervisors attend Advanced Supervisor Training and participate in monthly coaching support offered by the Texas Center.

For more information about Wraparound training, the varied coaching support available and implementation support, please visit the Texas Center.

Program Operations

Referrals to the YES Waiver

Referrals to the YES Waiver are initiated by contacting the YES Waiver inquiry line. Interested individuals can self-refer to the YES Waiver, or an individual's Legally Authorized Representative (LAR) can refer them. A LAR is any person who is authorized by law to act on behalf of an individual, including but not limited to, a parent, guardian, managing conservator, or medical consenter.

NOTE: For youth who are in DFPS conservatorship, the youth's CPS Caseworker can make a referral to the YES Waiver. For further guidance on working with children/youth in conservatorship, refer to the Youth in Conservatorship FAQs.

Inquiry Line

The inquiry line is a dedicated phone line with voicemail that every Local Mental Health Authority/Local Behavioral Health Authority (LMHA/LBHA) is required to maintain to receive calls from individuals interested in accessing services through the YES Waiver.

The phone number associated with the inquiry line must be toll-free. A staff member must answer the phone during regular business hours. It should be promoted widely through on- and off- line communication channels. HHSC encourages the LMHA/LBHA to publish the phone number on their website in a place that is easy to find.

HHSC requires the LMHA/LBHA guarantee that:

1. The inquiry line is a toll-free number operated by an LMHA/LBHA staff member;
2. The inquiry line is in operating condition and able to receive calls and voicemail messages;
3. Any voicemail messages associated with the inquiry line are accessible and recorded in English and Spanish; and
4. All calls received through the inquiry line are returned within 1 business day or 24 hours.

NOTE: The inquiry line may be an extension of the LMHA/LBHA agency-wide phone number if the operating system provides callers with an option to select the YES Waiver inquiry line.

Inquiry List

An inquiry list is used to document inquiries made to the YES Waiver inquiry line. Each LMHA/LBHA maintains the inquiry list for their service region. The inquiry list establishes the priority of YES Waiver assessment for interested individuals.

Individuals are assessed in the order in which their call was received.

LMHA/LBHAs must submit the inquiry list to HHSC no later than the 5th business day of each month. HHSC uses the inquiry list to monitor each LMHA/LBHA's current capacity needs and compliance to contractual requirements.

The following information must be documented in the inquiry list:

- Name of Individual
- Name of Legally Authorized Representative (LAR)

- Contact information for LAR including telephone number and mailing address, when possible
- Date the call was received by the LMHA/LBHA
- Date the call was returned to the individual and/or LAR
- Referral source
- Demographic Eligibility status
- Clinical Eligibility status
- Date of the scheduled Clinical Assessment, as applicable
- YES Waiver eligibility status
- Type of letter sent to the individual and/or LAR
- Date the letter was mailed to the individual and/or LAR
- Case status

NOTE: The LMHA is required to use the state-approved inquiry list template and inquiry list script. Further guidance on inquiry list requirements, including state- approved templates, can be found in Appendix A.

Withdrawal from Inquiry List

An individual's name must stay on the inquiry list pending an eligibility determination unless there is a valid reason for withdrawal. When an individual chooses to withdraw from the eligibility determination process, the request must be documented on the inquiry list and noted in participant records.

An individual may be withdrawn from the inquiry list when:

- The individual and/or their LAR requests to be removed from the eligibility determination process; or
- The LMHA/LBHA is unable to contact the individual and/or their LAR to complete the eligibility determination process AND good faith efforts to contact the family have been made.

Anytime the LMHA/LBHA is unable to determine an individual's eligibility for the YES Waiver, they must provide notice to the individual and/or their LAR that an eligibility determination cannot be made. The Letter of Withdrawal (Form 2811) must be sent to the LAR to notify them that their child or youth will be withdrawn from the eligibility determination process.

NOTE: The Letter of Withdrawal is not a formal denial of services and the LMHA/LBHA should not delete any names from the inquiry list. The individual and/or their LAR may request to be placed back on the inquiry list by contacting the LMHA/LBHA.

Letter of Withdrawal (Form 2811)

The Letter of Withdrawal form (Form 2811) serves as formal notice to the individual and/or their LAR that the LMHA/LBHA has attempted to complete the eligibility determination process but is unable to complete the assessment. This form must be sent to the individual and/or their LAR anytime an eligibility determination for YES Waiver cannot be completed.

Eligibility and Enrollment Overview

Eligibility Overview

To participate in the YES Waiver, an individual must meet all demographic eligibility and clinical eligibility requirements.

Part 1: Demographic Eligibility

For an individual to be eligible based on **demographic eligibility**, they must be a child or youth between the ages of 3-18 and live in a non-institutional setting with their legally authorized representative (LAR). They are also eligible if they are a legally emancipated minor and live on their own.

If a child or youth meets demographic eligibility criteria, they are eligible to receive a comprehensive clinical eligibility assessment. The clinical eligibility assessment must be completed within 7 days.

NOTE: Individuals who are currently residing in a private residential treatment center may meet demographic eligibility if the individual has a planned discharge date of 30 days or less. Individuals who do not have a planned discharge date of 30 days or less should be encouraged to call the LMHA/LBHA when the individual has an anticipated discharge date.

Part 2: Clinical Eligibility

The **clinical eligibility assessment** is a comprehensive assessment to determine whether a child or youth is at risk for out-of-home placement due to the severity of their mental health needs. This is the sole mechanism which determines a child or youth's clinical eligibility.

Children and youth must:

- Have a level of functioning that allows for full participation in the waiver program;
- Have a qualifying mental health diagnosis as their admitting diagnosis;
- Be at risk for out-of-home placement due to the severity of their mental health needs;
- Meet the criteria to be in a psychiatric hospital; and

- Have attempted other outpatient services, such as counseling offered through a community provider or school and continue to need a higher level of care.

The clinical eligibility assessment is completed by the Local Mental Health Authority/Local Behavioral Health Authority (LMHA/LBHA). The results of the assessment are submitted to HHSC online through **Clinical Management for Behavioral Health Services (CMBHS)**. HHSC issues a formal eligibility determination within 5 business days.

Withdrawal from Eligibility Determination Process

When an individual's eligibility for the YES Waiver is unable to be determined for any reason, the LMHA/LBHA must provide notice to the individual and/or their LAR by sending a Letter of Withdrawal (Form 2811).

NOTE: For further guidance, refer to the Withdrawal from Inquiry List section.

Eligibility Determination and Notification

Denial of Eligibility

If an individual does not meet demographic or clinical eligibility requirement for enrollment in the YES Waiver, the LMHA/LBHA is required to provide notice to the individual and/or their LAR within 7 business days. The LMHA/LBHA must send a Denial of Eligibility form (Form 2800) to the LAR indicating that their child or youth was found ineligible for YES Waiver.

The Denial of Eligibility form must be sent with the Fair Hearing Request form (Form 2801).

NOTE: Individuals who are ineligible for the YES Waiver may still be eligible to receive other mental health services offered through the LMHA/LBHA. The LMHA/LBHA should refer the individual to other resources offered within the community as appropriate.

Approval of Eligibility

When an individual meets all eligibility requirements for the YES Waiver, enrollment is authorized by HHSC for a 1-year period. Thereafter, participants are assessed annually to determine continued eligibility for ongoing enrollment.

Upon notification of initial eligibility, the LMHA/LBHA must send an Authorization of YES Waiver Services form (Form 2806) to the individual and/or their LAR indicating that their child or youth was found eligible for YES Waiver. This notice must be provided to the individual and/or their LAR within 5 business days.

NOTE: When an eligible individual is not currently enrolled in an approved Medicaid program, the LMHA/LBHA should provide the Pending Authorization of YES Waiver Services notice (Form 2807) in lieu of **Form 2806**. The LMHA/LBHA is allowed to assist the individual to apply for Medicaid. For further guidance, refer to Appendix C.

Initial Intake Meeting

When an individual is eligible for YES Waiver, the LMHA/LBHA must schedule an **initial intake meeting** within 7 business days of HHSC approval. At the initial intake meeting, the **Wraparound Facilitator** completes the enrollment process by:

- Providing the **Family Guide** to the LAR; and
- Completing the **Enrollment Packet** found in Appendix B.

The Wraparound Facilitator is also responsible for beginning the family engagement process in accordance with the Wraparound Process. This includes:

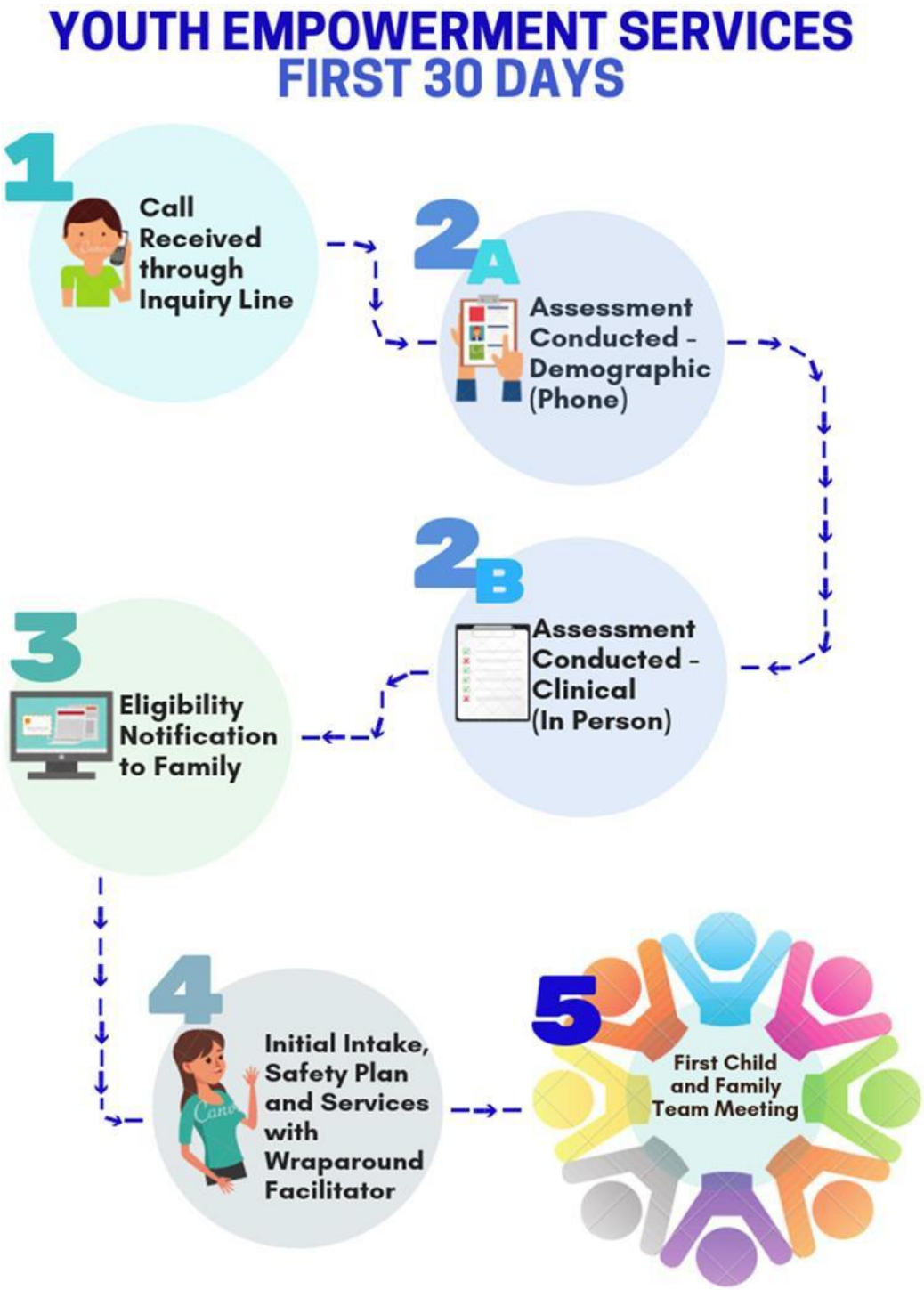
- Developing the Family Story and exploring and assessing the family's needs and strengths;
- Developing a Crisis and Safety Plan; and,
- Utilizing the family's identified needs to develop an initial Wraparound Plan of Care.

Finally, the Wraparound Facilitator is responsible for submitting the participant's initial **Individual Plan of Care (IPC)** to HHSC. Services requested on the initial IPC must reflect the Wraparound Plan of Care and should only include services which are identified as necessary to support the participant's Crisis and Safety Plan.

The Wraparound Facilitator must meet with the family again within 30 days for the first **Child and Family Team** meeting. At the first Child and Family Team meeting, the CFT will review and revise requested services to ensure they are appropriate to support the participant's needs.

For more information and resources on the Wraparound process, please refer to the Wraparound Overview section.

Figure 1 - Enrollment flowchart for the first 30 days in YES Waiver. For further guidance on the Initial Enrollment process, refer to the "Initial Enrollment Checklist" in Appendix B.



Medicaid Fair Hearings

A Medicaid Fair Hearing is an informal proceeding held before an impartial HHSC hearings officer in which an individual appeals an agency action. These hearings are not open to the public. While most Fair Hearings will be based on a denial of eligibility or service, an individual may also request a fair hearing for a failure to act with promptness to deliver a requested service.

NOTE: HHSC will contact the Local Mental Health Authority/Local Behavioral Health Authority (LMHA/LBHA) upon notification of a Fair Hearing request. HHSC will request additional information from the LMHA/LBHA. The LMHA/LBHA must provide the requested documentation in a timely fashion.

Notice of Agency Action

The LMHA/LBHA must provide **notice of agency action** to an individual and/or their LAR anytime:

1. An individual is determined to be ineligible for enrollment in the YES Waiver, or
2. Services for an enrolled participant are denied, reduced, suspended, or terminated.

Compliance with Federal Law

Notice of agency action must comply with federal law. Each notice must:

1. Explain what action is being taken;
2. Explain why the action is being taken;
3. Reference relevant policy; and
4. Inform the individual of the right to request a Fair Hearing on that particular action.

To ensure compliance, the LMHA/LBHA must use the HHSC approved Denial of Eligibility form (Form 2800) and Fair Hearing Request form (Form 2801).

Denial of Eligibility Form (Form 2800)

The Denial of Eligibility Form serves as formal notice to an individual and/or their LAR of the agency action. This form also notifies the individual of their right to appeal the action taken. The Denial of Eligibility form must be sent with the Fair Hearing Request form.

Fair Hearing Request Form (Form 2801)

The Fair Hearing Request Form may be used by the individual and/or their LAR to request a Fair Hearing. This form must be sent with the Denial of Eligibility form.

Process to Confirm Receipt Notice of Agency Action

Provide notice of agency action via certified mail, return receipt requested. The LMHA/LBHA may hand deliver a notice of agency action only when there is written acknowledgment that the individual and/or their LAR has received notice. Document this in the participant's record of care and include the reason for denial.

Timeframe for Timely Notification

Provide notice to the individual and/or their LAR in a timely manner.

Agency Action	Timeframe
Denial of continued enrollment or service(s)	10 days ***before*** services are denied, reduced, suspended, or terminated
Denial of initial enrollment or service(s)	Within 7 days of notification of denial

Service Delivery Pending Appeal

During the appeal process, the individual may have the right to receive continued benefits. If the individual is eligible to receive continued benefits pending the appeal, HHSC will contact the LMHA/LBHA directly with instructions.

NOTE: For further guidance on the Medicaid Fair Hearing process, contact your YES Waiver liaison or the YES Waiver at yeswaiver@hhsc.state.tx.us.

Medicaid Overview

An individual must be enrolled in an approved Medicaid program to receive services through the YES Waiver. Even if an individual has existing health care coverage through private insurance or another publicly funded health care program, such as the Children's Healthcare Insurance Program (CHIP), they are only eligible for the YES Waiver if they are enrolled in an approved Medicaid program. It is the responsibility of the Local Mental Health Authority/Local Behavioral Health Authority (LMHA/LBHA) to verify that the individual is enrolled in an approved Medicaid program.

Medicaid Maintenance

The LMHA/LBHA is responsible for verifying that the YES Waiver participant maintains their Medicaid eligibility throughout their enrollment year. The LMHA/LBHA must assist the individual to maintain

their Medicaid eligibility by monitoring the participant's Medicaid enrollment coverage dates. The LMHA can monitor Medicaid eligibility by submitting a monthly **Medicaid Eligibility Verification** request.

Verification of Medicaid

If you are uncertain about a client's Medicaid coverage be sure to:

- Confirm with the Legally Authorized Representative (LAR) by asking for a Medicaid ID card;
- Run a Medicaid Eligibility Verification;
- Check eligibility through TMHP website;
- Reach out to Benefits Specialist; or
- Contact your Medicaid Regional Point of Contact.

Loss of Medicaid

Many participants may experience the loss of Medicaid eligibility during their enrollment year. Common reasons for this to occur include:

- Failure to return a recertification packet
- Significant changes to family income in programs that use family income for eligibility determination
- Family enrollment in the Children's Health Insurance Program (CHIP)
- Changes to disability determination/loss of Supplemental Security Income (SSI)

When a participant loses Medicaid eligibility during their YES Waiver eligibility year, the LMHA/LBHA should notify the Comprehensive Waiver Provider (CWP). The CWP should not provide YES Waiver services until the participant's Medicaid eligibility is reinstated. During this period, the Wraparound Facilitator should continue to facilitate Child and Family Team meetings and coordinate services that are offered through the Texas Medicaid State Plan. The participant remains eligible for the YES Waiver unless it is determined by HHSC that they are no longer eligible for Medicaid.

Services delivered by the CWP to a participant who is not enrolled in Medicaid may not be reimbursed.

NOTE: For further guidance on the Medicaid application process, including a list of approved Medicaid program types, refer to Appendix C.

Complaints

A **complaint**, also known as a grievance, is any oral or written expression of dissatisfaction with a service or provider regarding the quality of care an individual is receiving. An individual is entitled to file a complaint at any time either orally or in writing. Complaints can include, but are not limited to:

- The quality of care of services provided;
- Interpersonal relationships, such as perceived rudeness of a provider or employee; and
- Failure to respect an individual's rights.

Common Complaints

Common complaints include:

- Service delivery
- Access to services
- Delay or lapse in services
- Communication with providers that may impede or hinder service delivery (i.e. service coordination, scheduling of appointments)
- Service coordination between providers
- Medicaid coverage
- Client Rights issues
- Allegations of waste, fraud, or abuse, and
- •Allegations of abuse, neglect, and exploitation

NOTE: Complaints are distinct from **Medicaid Fair Hearings** and are not related to the denial, suspension, or termination of YES Waiver services.

Health, Safety, and Well-Being

Any complaint that is related to an individual's health, safety, or well-being or which requires action at the local level or further investigation by a higher authority must be referred to the appropriate entity immediately. Based upon the situation, this may include contacting the Texas Department of Family Protective Services, the LMHA or LBHA crisis services, or local law enforcement. For more information and resources, refer to the Critical Incidents section.

Civil Rights Protections

HHSC policy, as well as federal and state laws and regulation, prohibit discrimination based on one or more of the following protected classes:

- Race
- Color
- National origin
- Sex
- Age
- Religion
- Disability
- Political beliefs
- Sexual Orientation

The HHSC Civil Rights Office is responsible to investigate allegations of violations of civil rights, including discrimination regarding the delivery of HHS services. These complaints should be referred to the HHSC Civil Rights Office at 888-388-6332.

Source: hhs.texas.gov/about-hhs/your-rights/civil-rights-office

Provider Responsibilities

The LMHA/LBHA and/or Comprehensive Waiver Provider (CWP) must address any YES Waiver related complaints received by a YES Waiver participant, their Legally Authorized Representative (LAR), or an individual acting on behalf of a YES Waiver participant.

If an individual is not satisfied with the outcome of the complaint, the LMHA/LBHA and/or CWP must provide the YES Waiver participant and/or their LAR with the appropriate contact information to file a complaint with HHSC. The LMHA/LBHA and/or CWP must not retaliate against a YES Waiver participant, their LAR, or any other person who files a complaint on behalf of a YES Waiver participant.

NOTE: HHSC will contact the LMHA/LBHA and/or CWP upon receipt of a complaint. The LMHA/LBHA and/or CWP must respond in a timely fashion to any request for additional case information.

Complaint Resolution

YES Waiver Providers should work to resolve all YES Waiver related complaints within 10 business days, when possible. Most complaints should be resolved within 30 days from receipt.

Document the Complaint

Upon notification of a complaint, the LMHA should begin the complaint resolution process by documenting the complaint and gathering additional details related to the case including:

- The date and time the complaint was received;
- The name of the YES Waiver participant;
- The name(s) of any other individual(s) involved in the complaint; and
- Background information on the complaint, including when and where the complaint occurred and why an individual is dissatisfied.

The LMHA/LBHA should maintain records of any action taken by the LMHA/LBHA to investigate and resolve the complaint including the resolution reached and the name of any staff involved in the complaint.

Respond to the Complaint

The LMHA/LBHA should reach out to the complainant to discuss the concerns raised and gather additional information. When speaking with the complainant, providers should:

1. **Listen and Empathize:** Listen to the complainant's concerns to understand their perspective and what other factors may be driving their concern. Ask for support from supervisory staff as needed.
2. **Identify a Solution:** Ask the complainant for a desired resolution and then work with them to identify a solution. Be sure to inform the complainant if their desired resolution is not possible based on policy and/or program guidelines. The solution should be mutually agreed upon and communicated to the complainant and all parties involved.
3. **Timeframe:** Once a solution has been identified and agreed upon, provide the complainant with an estimated time frame to their complaint.
4. **Follow Up:** After the complaint has been addressed, it is helpful to follow up with the complainant to make sure that their concerns have been completely addressed.

For additional support and guidance on policy-related questions and complaints, contact your HHS YES Waiver liaison.

Referring a Complaint

When a complaint is not related to the YES Waiver or cannot be resolved through the informal complaint process, the LMHA should refer the complaint to the Rights Protection Officer at the LMHA.

When a complaint has been escalated through all internal methods at the LMHA, including the Rights Protection Officer, and the complainant remains dissatisfied, the complainant should be referred to the HHSC Behavioral Health Ombudsman at 1-800-252-8154.

Clinical Services Overview

Clinical Eligibility

Once demographic eligibility is confirmed, the LMHA/LBHA must complete the clinical eligibility assessment. Clinical eligibility assessments must be completed by a qualified practitioner per YES Waiver policy guidelines.

Completing the clinical eligibility assessment requires a 2-part assessment process using the **YES Assessment (CANS)** and **Clinical Eligibility (CE)** documents in **CMBHS.**

The YES Assessment (CANS) includes the Child and Adolescent Needs and Strengths (CANS) Assessment and a community data questionnaire. The LMHA/LBHA must submit the YES Assessment (CANS) into CMBHS manually or electronically via a batch data transfer process from the LMHA/LBHA's system of origin, if available.

Of the five clinical eligibility criteria, Criteria A and B are based on the results from the CANS. If a potential participant does not meet Criterion A but the clinician recommends enrollment in YES Waiver, supporting documentation may be provided to YES Waiver staff for consideration during the determination.

Criterion C requires a yes or no answer to whether a potential participant has tried and failed outpatient therapy or partial hospitalization. If a psychiatrist has documented why an inpatient level of care is required, then this criterion is met.

Criterion D assesses whether a potential participant meets--or is likely to meet-- inpatient hospitalization guidelines without YES Waiver services. If the potential participant does not meet this criteria, a physician's signature must be obtained to verify that the criterion is not met.

Criterion E identifies whether the potential participant has a mental health primary diagnosis.

Clinical Eligibility Assessment Overview

The YES Waiver **clinical eligibility assessment** is a comprehensive assessment to determine whether a child or youth meets clinical requirements for the YES waiver. In accordance with YES Waiver policy, the clinical eligibility assessment reviews 5 key areas to determine eligibility for enrollment and participation in the program.

This information evaluates whether the child or youth:

- Has a level of functioning that allows for full participation in the waiver program;
- Has a qualifying mental health diagnosis as their admitting diagnosis;

- Is at risk for out-of-home placement due to the severity of their mental health needs;
- Meets criteria to be in a psychiatric hospital; and
- Has attempted other outpatient services, such as counseling offered through a community provider or school, and continue to need a higher level of care.

The Local Mental Health Authority/Local Behavioral Health Authority (LMHA/LBHA) gathers this information through the YES Waiver (CANS) Assessment tool and the Clinical Eligibility (CE) document. The assessment is then submitted to HHSC online through Clinical Management for Behavioral Health Services (CBMHS). HHSC reviews the submitted information and issues a formal eligibility determination within 5 business days. The LMHA/LBHA must notify the family of the eligibility determination within 7 business days of denial or authorization of enrollment.

NOTE: For further guidance on eligibility authorization notification, refer to the Eligibility Determination and Notification section. For further information regarding denial or authorization of enrollment, refer to the Enrollment section.

Initial Eligibility Assessment Requirements

For individuals not currently enrolled in the YES Waiver, the initial clinical eligibility assessment must be completed within 7 business days of determining that an individual meets demographic eligibility requirements.

The initial clinical eligibility assessment must be completed by a Licensed Practitioner of the Healing Arts (LPHA).

Annual Renewal Assessment Requirements

All YES Waiver participants must be assessed for ongoing eligibility on an annual basis. The LMHA/LBHA must submit a completed annual renewal assessment no later than 10 days before the participant's current eligibility end date. The annual renewal assessment follows the eligibility determination process as an initial eligibility assessment.

The annual renewal assessment may be completed by a Qualified Mental Health Provider (QMHP) however a LPHA must review the assessment and confirm the level of care recommendation.

NOTE: The LMHA/LBHA may complete the annual renewal assessment up to 30 days prior to the participant's current eligibility end date.

Transfers and Changes in CWP Providers

The Wraparound Facilitator is responsible for processing changes in service for YES Waiver participants. Participants who relocate to a new service area within the state will need to have their clinical eligibility transferred to the new service region. For further guidance, refer to the Transfer of Services section.

Referring Agency Checklist

1. Facilitate a child and family team meeting.
2. Identify where the participant will be moving/has moved and communicate critical information with the receiving agency. Be sure to obtain a release of information from the family.
   a. Family contact information
   b. Continuity of care issues
   c. Health and Safety Plan
   d. Last date of services
3. Contact the client's direct service providers.
   a. Confirm the last date of services.
   b. Confirm whether services have been delivered that still require service notes to be input into CMBHS. Confirm which services need to remain on IPC.
4. Work with CWP to determine service usage and remaining dollar or unit balances.
5. Submit and process documents in CMBHS.

Receiving Agency Checklist

1. Review information provided by the original agency
   a. Confirm with original CWP which services have already been provided. This guarantees that providers can be paid for services that have been rendered.
   b. Discuss with incoming CWP which services need to be continued or identify any changes to services.
   c. Confirm that units requested and dates match. Reminder: Original CWP cannot be paid for services provided after end date. Incoming CWP cannot be reimbursed for services that start before the original CWP end date.
2. Contact the participant, LAR, and DFPS caseworker if the participant is in substitute care, to schedule a face-to-face meeting within seven business days. At the initial meeting, the wraparound facilitator must work with the family to:
   a. Identify the child and family team members.
   b. Review and revise the participant's IPC as needed.

c. Review and revise the participant's crisis and safety plan as needed.

3. Submit and process incoming documents in CMBHS.

Terminations

Anytime a participant decides to end YES Waiver services, termination documentation must be submitted to HHSC. This documentation includes a Clinical Eligibility termination and a transition plan.

Transition plans are required when a client moves to a different level of care or ages out of YES Waiver to transition to adult services. Refer to the YES Waiver Policy Manual regarding acceptable reasons for a participant to terminate from services.

Client Safety

Critical Incidents

A **critical incident** is an actual or alleged event which creates a significant risk of serious harm to the health or welfare of a YES Waiver participant. Critical incidents also include any incident which creates a significant risk of serious harm to others by a participant.

Reporting Requirements

The wraparound facilitator must notify HHSC of all critical incidents through the use of Form 2803: Critical Incident Report within 72 hours of notification of the incident.

Examples of incidents that are required to be reported to HHSC include but are not limited to:

- Death of a participant;
- Allegations of abuse, neglect, or exploitation;
- Severe injury or illness of the participant requiring medical intervention or resulting in hospitalization;
- Medication management issues which may result in harm or adverse effect, including incorrect dosage;
- Criminal activity that results in the arrest or incarceration of a participant;
- Unplanned psychiatric or medical hospitalizations;
- Unsafe housing or displacement;
- Restraint or seclusion of the participant;

- Participant departure in which there is reason to believe the participant may be lost or in danger or resulting in the disruption of services;
- Parental relinquishment; or
- Other risk of harm to self or others.

NOTE: The LMHA/LBHA must provide HHSC with the DFPS or law enforcement case number(s) anytime DFPS or law enforcement are involved.

Reporting Process

When a critical incident involving a participant occurs, a report must be made to the participant's wraparound facilitator. Any staff who witness or receive notification of a critical incident must notify the wraparound facilitator within 24 hours. The wraparound facilitator is responsible for reviewing the report, gathering any supplemental information, and submitting a completed Form 2803: Critical Incident Report to HHSC within 72 hours of notification. All critical incidents must be submitted to yeswaiver@hhsc.state.tx.us.

NOTE: HHSC may contact the Local Mental Health Authority/Local Behavioral Health Authority (LMHA/LBHA) upon notification of a critical incident report. When HHSC requires additional information, the LMHA/LBHA must provide the requested information in a timely fashion.

Crisis Debrief

When the critical incident qualifies as a crisis, the wraparound facilitator must make contact with the participant's LAR and/or guardian within 72 hours to schedule a Child and Family Team meeting and debrief the crisis. The wraparound facilitator is required to meet with the CFT no later than 7 business days after notification of the incident. The CFT should discuss the factors contributing to the crisis incident, review actions taken during the crisis, and identify necessary updates to the crisis and safety plan.

NOTE: It is recommended that the CFT meet within 72 hours of notification of the incident to review and update the participant's crisis and safety plan.

Timeframe for Meeting with Family after Critical Incident

Required Participants	Required Action	Timeframe
• Wraparound Facilitator, • YES Waiver Participant, and • LAR	The Wraparound Facilitator must make contact with family and set up a CFT.	Within 72 hours of notification of crisis.

Required Participants	Required Action	Timeframe
• Wraparound Facilitator, • YES Waiver Participant, • LAR, and • Child and Family Team	Review and update the Crisis and Safety Plan and Wraparound Plan of Care.	Within 72 hours of notification of crisis but ***no later*** than 7 business days after notification of incident.

Abuse, Neglect, and Exploitation

YES Waiver providers must notify HHSC of any allegation of abuse, neglect, and exploitation (ANE) through the use of Form 2803: Critical Incident Report.

Additionally, a formal report to the Department of Family and Protective Services (DFPS) must be made. The LMHA/LBHA must provide HHSC with the DFPS report number.

What Is Abuse, Neglect, and Exploitation?

According to the DFPS:

- **Abuse** is mental, emotional, physical, or sexual injury to a child or person 65 years of age or older, or with disabilities failure to prevent such injuries.
- **Neglect** of a child includes failure to provide a child with food, clothing, shelter and or medical care and or leaving a child in a situation where the child is at risk of harm.
- **Exploitation** is misusing the resources of a person 65 years or older or an adult with disabilities for personal or monetary benefit.

Source: www.dfps.state.tx.us/Contact_Us/report_abuse_faqs.asp To learn more, visit:

www.dfps.state.tx.us/Child_Protection/Child_Safety/recognize_abuse.asp

Reporting Abuse, Neglect, and Exploitation

If there is any reason to suspect ANE, the DFPS recommends that individuals call the DFPS Texas Abuse Hotline. The DFPS Texas Abuse hotline can provide guidance to individuals on whether the signs observed are indicators of ANE and whether the situation requires further investigation.

Online: www.txabusehotline.org

Call: 1-800-252-5400

Relay Texas (*for individuals with hearing or speech loss*)**:** 7-1-1 or 1-800-735- 2989

Crisis and Safety Planning

Crisis and safety planning is crucial to ensure the well-being of YES Waiver participants. A crisis and safety plan is an easy-to-understand document which supports the participant and their family by identifying strategies designed to prevent a crisis from occurring and action steps that can be taken to guarantee the participant's safety in the event of a crisis.

The wraparound facilitator is required to develop the crisis and safety plan in collaboration with the participant and their LAR and/or guardian at the initial intake meeting. The crisis and safety plan must be reviewed and updated regularly.

To best support the family, the crisis and safety plan should:

- Address the participant's reason for referral;
- Be written in the family's language;
- Build on identified strengths of the family, team, and community;
- Reflect the family's culture and desires;
- List potential warning signs that a crisis may occur; and
- Include action steps for the participant and their family which address all identified safety concerns/potential crises.

Finally, all crisis and safety plans must include a contingency plan in the event the wraparound facilitator is unavailable. The contingency plan must include contact information the participant and/or their family may call for backup or emergency services and case management support.

Initial Crisis and Safety Plan

An initial crisis and safety plan must be developed during the initial intake meeting with the participant and their LAR and/or guardian. The initial crisis and safety plan is created to guarantee the safety of the participant and their family until the first Child and Family Team (CFT) meeting. This plan must consider safety related issues and address harm to self, harm to others, and any risk of imminent danger. The wraparound facilitator should not end the initial intake meeting until a crisis and safety plan has been developed.

The initial crisis and safety plan must be reviewed at the first CFT meeting. Updates should be made to the crisis and safety plan to include any additional team members or supports that have been identified by the CFT.

Monthly Review

Revisions to the crisis and safety plan may occur at any time to ensure the health and safety of the participant. The wraparound facilitator is required to review the crisis and safety plan at least once every 30 days during the Child and Family Team meeting.

During the CFT, the wraparound facilitator should review the participant's reason for referral and make updates which reflect:

- Newly identified challenges, crises, or safety concerns;
- Resources and techniques;
- Updates to CFT members and their contact information; and
- Updates to action steps assigned to specific individuals on the CFT.

In the event that a Child and Family Team meeting is cancelled, the wraparound facilitator must contact the participant and/or their LAR to review the crisis and safety plan.

NOTE: When the CFT determines that strategies on the crisis and safety plan must be modified, a new Individual Plan of Care (IPC) document may need to be submitted to reflect necessary changes to YES Waiver services.

Updating the Crisis and Safety Plan

In the event of a crisis, the wraparound facilitator is required to review the crisis and safety plan with the Child and Family Team and make appropriate modifications to the plan to prevent a crisis from re-occurring. Updates to the crisis and safety plan must occur no later than 7 business days after notification of the incident.

The participant's crisis and safety plan must be updated within 7 business days of discharge from an inpatient psychiatric setting.

Timeframe for Updating the Crisis and Safety Plan after Crisis

Required Participants	Required Action	Timeframe
• Wraparound Facilitator, • YES Waiver Participant, • LAR, and • Child and Family Team	Review and update the Crisis and Safety Plan and Wraparound Plan of Care.	Within 72 hours of notification of crisis but ***no later*** than 7 business days after notification of incident.

YES Waiver Services

The YES Waiver provides specialized mental health services and supports that help keep participants living at home and in their community. The services are intended to help meet the participant's mental health needs. The YES Waiver is not a full level of care and only offers the services listed below. Accordingly, wraparound facilitators should ensure the participant has access to a full continuum of services offered through the Medicaid State Plan in addition to YES Waiver. All services delivered to the participant, including those provided through the YES Waiver or other sources, should be outlined on the Wraparound Plan of Care.

YES Waiver Services

- Adaptive Aids and Supports*
- Animal-assisted therapy
- Art Therapy
- Community Living Supports
- Employment Assistance
- Family Supports
- Minor Home Modifications*
- Music Therapy
- Non-Medical Transportation
- Nutritional Counseling
- Paraprofessional Services
- Recreational Therapy
- Respite
- Supported Employment
- Supportive Family-Based Alternatives
- Transitional Funding*

*These services are not requested online in the IPC until the request has been approved by HHSC. For guidance on requesting these services, refer to the Flexible Funding Requests section.

Service Selection

The Wraparound process is central to identifying the services provided to the participant. The Wraparound Facilitator (WF) works with the Child and Family Team (CFT) to develop and update the Wraparound Plan of Care (POC) at least once a month.

The POC lists the family's mission, vision, strengths, and needs. The CFT then brainstorms different strategies to meet the identified needs. The selected strategies may include the use of Comprehensive Waiver Services after considering all other available resources such as those offered through the Medicaid State Plan.

Selected Comprehensive Waiver Services should be strengths-based, culturally competent, and driven by the family vision.

NOTE: The CFT may meet more frequently through the use of Emergency Family Team Meetings to update the Wraparound Plan of Care to support the participant's needs.

Service Authorization and Delivery

Once services have been identified through the CFT and documented on the POC, the Wraparound Facilitator submits a request for comprehensive waiver services by using the Individual Plan of Care (IPC) document in CMBHS. HHSC must approve the request before services are delivered to the participant.

After authorization, the Comprehensive Waiver Provider delivers the services to the participant. Services must be delivered as outlined on the Wraparound Plan of Care.

NOTE: The WF must ensure the amount, frequency and duration of each service is documented on the participant's Wraparound Plan of Care. HHSC may recoup funds when services are delivered in a manner inconsistent with the Wraparound Plan of Care, the YES Waiver Policy Manual, or the Comprehensive Waiver Provider contract.

Denial of Services

HHSC may reach out to the LMHA/LBHA to discuss service requests that do not align with policy requirements. HHSC may provide the LMHA/LBHA the opportunity to revise the request as needed. HHSC cannot approve requests that do not align with the YES Waiver Policy Manual, the Wraparound Plan of Care, the Comprehensive Waiver Provider contract, or other federal or state requirements.

The LMHA/LBHA must send a Denial of Eligibility form (Form 2800) General Guidelines to the LAR indicating that the requested YES Waiver services have been denied. The Denial of Eligibility form (Form 2800) must be sent with the Fair Hearing Request form (Form 2801).

NOTE: For further information, refer to the Complaints section.

Service Limitations

Comprehensive Waiver Provider services are suspended when the participant:

- Loses Medicaid coverage; or
- Is in an out-of-home placement, such as a residential treatment facility. Services may be terminated when a participant is in an out-of-home placement for more than 90 days.

The participant may still be eligible for certain services offered through the Medicaid State Plan. Wraparound Facilitators should work with the family to communicate potential limitations to service delivery.

Flexible Funding Requests

Requests for Flexible Funding for technology can be submitted using Form 8202, HCBS-AMH and YES Waiver Program Request for Technology Funding and Form 4116. This funding is time limited and will expire no later than August 31, 2023. Reimbursement is for eligible devices intended to increase the availability of remote delivery for mental health services. Devices must be purchased, owned by, and are the responsibility of the contract holder for YES Waiver services. Devices purchased within two (2) years of reimbursement must be returned to the YES Waiver program if a contract is terminated. Each type of purchase for technology must be reflected on the YES Waiver Encounter Invoice as described on the "Instructions" tab.

The YES Waiver offers individualized support through flexible funding such as adaptive aids, minor home modifications, and transitional funding. These services are available to all YES Waiver participants to prevent out-of-home placement. Flexible funding requests are intended to supplement the Child and Family Team's resources to meet the participant's needs. Flexible funds may only be requested after the CFT has explored resources offered through the Medicaid State Plan, the participant's Managed Care Organization, and community partners.

Flexible funds require a prior-authorization by HHSC before they are submitted on the Individual Plan of Care (IPC) document in CMBHS. After formal approval by HHSC, the Comprehensive Waiver Provider (CWP) purchases the approved request and is reimbursed for the cost.

Adaptive Aids and Supports and Minor Home Modifications should be reviewed and evaluated monthly to determine whether they remain an effective strategy to prevent out-of-home placement for the YES Waiver participant. The wraparound facilitator must document on the wraparound plan of care the review of the adaptive aid and support or minor home modification, how it is being utilized, and monitor efficacy of the support.

NOTE: Flexible Funding request forms can be found in Appendix B.

Minor Home Modifications

Minor Home Modifications are physical modifications to a participant's home that are medically necessary to support the participant's ability to function independently at home and in the community. Minor home modifications may be used to make necessary accessibility and/or safety related adaptations to a participant's home. If a minor home modification is requested and the YES Waiver participant and/or their Legally Authorized Representative do not own the home in which the modification will take place, the comprehensive waiver provider must obtain written agreement from the homeowner, landlord, or other property owner before a modification is authorized.

The annual service limit on all adaptive aids and minor home modifications combined is $5000 per individual plan of care.

All minor home modifications must adhere to Americans with Disabilities Act (ADA) requirements, meet Texas Accessibility Standards, meet applicable state and/or local building codes, and have a minimum one-year warranty.

The Wraparound Facilitator should ensure that the intervention is the most inclusive and person-centered option.

Some minor home modifications may be considered a restrictive intervention. Examples include:

- Door/window alarms added to a participant's environment
- Security cameras
- Locked access
- Restricted access to personal property

In these cases, the CWP must provide informed consent to the participant. Participants should be informed of their rights, including how to report abuse, neglect, and exploitation. This must be included on the participant's **Crisis and Safety Plan** or the **Wraparound Plan of Care**. For further guidance on allowable expenses, refer to the YES Waiver Policy Manual.

Transitional funding

Transitional funding can be used when a participant is transitioning to independent living in the community. This funding is used to assist the participant in setting up a household as they transition from an institution, provider operated setting, or family home to his or her own private community residence.

A participant may be eligible for transitional funding if they:

- Plan to rent an apartment or house;

- Are transitioning into another independent living situation, such as a dorm;
- Have a home, but it may need cleaning, pest eradication or allergen control before it can be occupied again; or
- Need belongings moved from an institution or private operated setting to their new residence in the community.

Transitional funding may include, but is not limited to, payment for:

- Security deposits required to lease an apartment or house, or deposits required to establish utility services for the home;
- Essential furnishings for the apartment or house;
- Moving expenses required to move into the house or apartment; and
- Site preparation services, such as pest eradication, allergen control, or a one-time cleaning before occupancy.

Transitional Funding may not be used for:

- Monthly rent or mortgage expenses;
- Current or future use of utilities;
- Service upgrades;
- Food items;
- Any diversional or recreational items or services, including televisions, video players or recorders, movies, games, computers, cable TV, satellite TV, exercise equipment, vehicles or other modes of transportation.

This is a one-time request that cannot exceed $2,500. For further guidance on allowable expenses, refer to the YES Waiver Policy Manual.

Adaptive Aids and Supports

Adaptive Aids and Supports (AAS) are one time goods and/or services that have been identified as necessary to assist the participant to remain in the home and/or community and avoid an out-of-home placement. Adaptive aids must be medically necessary to treat, rehabilitate, prevent or compensate for conditions related to the participant's mental health and enable YES participants to continue to perform activities of daily living (ADLs).

The annual service limit on all adaptive aids and minor home modifications combined is $5000 per individual plan of care.

All AAS requests must be individualized, developed through the CFT process, and be connected to a strategy to assist the participant to meet treatment goals. During the monthly CFT, the wraparound facilitator must document and show evidence that the AAS is being utilized and monitored for efficacy.

Before submitting a request for AAS, the Wraparound Facilitator must ensure that the requested AAS meets YES Waiver policy requirements. For further guidance on allowable expenses, refer to the YES Waiver Policy Manual.

Special Populations

Transition Age Youth

Transition age youth (TAY) are young adults between the ages of 16 through 24 who have persistent mental health needs. The Wraparound Facilitator must create a transition plan for participants approaching their 19th birthday. Start this plan no later than 6 months prior to the participant's birthday. A preliminary plan can be submitted to YES Waiver staff 6 months before their birthday. Attach the final transition plan to the participant's Termination CE.

The plan must include:

- Summary of mental health services
  - Past services received
  - Preferences for mental health community services
  - Responsiveness to past interventions
- Current:
  - Diagnosis
  - Medication
  - Level of functioning
- Ongoing needs
- Strengths
- Post-discharge services:
  - Upcoming appointments
  - Referrals provided
  - Any additional information regarding post-discharge supports and services

Youth in Conservatorship

Youth who are in Department of Family Protective Services (DFPS) conservatorship are eligible to receive YES Waiver services.

NOTE: If a youth is at imminent risk for relinquishment, contact your YES Waiver liaison.

Medical Consent

Every youth in DFPS conservatorship is required to have a medical consenter who is responsible for making medical decisions for the youth. A youth in conservatorship will have at least one primary and backup medical consenter appointed by the court. Only an authorized medical consenter can make medical decisions, including enrollment and termination of services in YES Waiver, on behalf of a youth in conservatorship.

The LMHA/LBHA may verify an individual is an authorized medical consenter by requesting a copy of the Designation of Medical Consenter form (Form 2085-B). A list of medical consenters can also be found in the youth's Health Passport at www.fostercaretx.com under the Contacts tab.

If the LMHA/LBHA has medical concerns regarding the child, including concerns about decisions made by the medical consenter, the LMHA/LBHA should contact the youth's DFPS caseworker or supervisor. The judge may also be contacted.

NOTE: In some cases, a youth 16 or 17 years old may act as their own medical consenter. For more information, visit www.dfps.state.tx.us/Child_Protection/Medical_Services/Medical_Consent.asp

Referral Process

A referral to the YES Waiver can only be made by the interested individual as a self-referral or by an individual's Legally Authorized Representative (LAR). For youth who are in DFPS conservatorship, the youth's CPS caseworker, managing conservator, or medical consenter can make a referral to the YES Waiver. When a referral is received for a youth in DFPS conservatorship, the LMHA/LBHA should verify the identity of the person making the call by gathering the name and contact information for the caseworker, managing conservator, and/or medical consenter.

Youth in conservatorship are assessed in the order in which their inquiry was received.

NOTE: If a youth is at imminent risk for relinquishment, the LMHA/LBHA must immediately submit the Reserved Capacity Screening form (Form 2804) to HHSC YES Waiver for review at yeswaiver@hhsc.state.tx.us.

Eligibility Assessment

To participate in the YES Waiver, an individual must meet all demographic eligibility and clinical eligibility requirements. Children and youth who are currently residing in a private residential treatment center may meet demographic eligibility if the child or youth has a planned discharge date of 30 days or less.

If the child or youth meets demographic eligibility criteria, they are eligible to receive a comprehensive in-person clinical eligibility assessment. The youth's medical consenter must be present at every clinical eligibility assessment for the youth. The caseworker is strongly encouraged to attend.

NOTE: Eligibility determinations are made in accordance with YES Waiver policy. If the individual does not meet eligibility requirements for enrollment in the YES Waiver, a court order cannot override the eligibility determination. For further guidance, refer to the Eligibility and Enrollment section.

Enrollment

When a youth is conservatorship is found eligible for enrollment in the YES Waiver, the LMHA/LBHA should follow the standard enrollment process. In addition to the enrollment packet, the wraparound facilitator should request the DFPS YES Waiver Enrollment sheet from the youth's case worker. This is a form that was created by DFPS to assist in identifying important information regarding the youth. Information will include important contact, important familial information, and limited details on the permanency plan for the youth.

Financial Assessment

Complete a financial assessment for a youth in conservatorship by using the youth's financial information.

Clinical Management for Behavioral Health Services Overview

Clinical Management for Behavioral Health Services (CMBHS) is the state sponsored electronic healthcare record system used by state contracted community mental health and substance use providers. CMBHS is the mechanism by which HHSC receives and reviews documentation including clinical eligibility documents related to a participant's eligibility for and enrollment in the YES Waiver.

Clinical Eligibility Document

The **Clinical Eligibility (CE)** document is a multi-purpose document in CMBHS which contains information related to an individual's clinical eligibility for or enrollment in YES Waiver. This document summarizes the individual's clinical history and is used to:

- Determine clinical eligibility for YES Waiver;
- Transfer an enrolled participant's YES Waiver services; or,
- End a participant's enrollment in YES Waiver.

HHSC reviews the information submitted by the Local Mental Health Authority/Local Behavioral Health Authority(LMHA/LBHA) and issues an approval or denial based on requirements as outlined in the YES Waiver Policy Manual.

NOTE: It is the responsibility of the LMHA/LBHA to ensure that all information on the CE is accurate.

Clinical Eligibility Document Types

There are several types of CE documents which include:

- Pending
- Initial
- Annual Renewal
- LMHA Transfer Out
- LMHA Transfer In
- Termination

The use of a specific document type will be dependent upon the situation. The most common situations encountered include:

- Initial assessment of an individual;
- Annual re-assessment of enrolled participants;
- Transfer of an enrolled participant's eligibility to a new service region; and
- Termination of enrollment.

NOTE: No document may remain in draft status. If a document is placed in draft status by HHSC, the LMHA/LBHA must respond to the document within 5 business days.

Initial Assessment

Pending CE

Submit a **Pending CE** for individuals who are not actively enrolled in an approved Medicaid type at the time of the clinical assessment. An approved Pending CE conditionally authorizes enrollment in the YES Waiver, pending Medicaid eligibility. The approved Pending CE document helps support medical necessity requirements for Medicaid.

Initial CE

Submit an **Initial CE** for individuals who are actively enrolled in an approved Medicaid type at the time of the assessment. An approved Initial CE authorizes enrollment in the YES Waiver for a period of 365 days.

NOTE: The Comprehensive Waiver Provider (CWP) cannot bill YES Waiver services for individuals who are not actively enrolled in Medicaid. For further guidance on Medicaid, including approved Medicaid types, refer to the Medicaid Overview section.

Annual Assessment

Annual Renewal CE

Submit an **Annual Renewal CE** for enrolled YES Waiver participants who are within one month of their current eligibility end date. This date can be found on a participant's current CE. The document may be submitted up to 30 days before the current CE end date and must be submitted at least 10 days before the current CE end date. This will ensure that there are no gaps in services. An approved Annual Renewal CE authorizes enrollment in the YES Waiver for an additional year or 365 days.

> **NOTE:** If an **Annual Renewal CE** is not received in a timely fashion, the LMHA/LBHA may be required to resubmit an **Initial CE**.

Transfer of Services

LMHA Transfer Out CE

Submit a **LMHA Transfer Out CE** for enrolled YES Waiver participants who will be moving outside of the current LMHA catchment area AND the participant is requesting to continue enrollment in YES Waiver. A LMHA Transfer Out CE document should not be submitted when the participant's relocation is:

- within the current LMHA catchment area, and
- expected to be temporary (less than 90 days), such as when the participant is visiting a family member.

All LMHA Transfer Out CEs should be coordinated with the receiving, or new, LMHA.

LMHA Transfer In CE

Submit a **LMHA Transfer In CE** for enrolled participants who have moved into the LMHA catchment area from a different LMHA catchment area. All LMHA Transfer In CEs should be coordinated with the sending, or old, LMHA.

For more information on the Transfer CE process, refer to the Transfer Process section.

Termination of Services

Termination CE

Submit a **Termination CE** when an enrolled YES Waiver participant leaves the program. All Termination CEs must include an acceptable reason for the participant's termination. Document this reason, as supported by YES Waiver policy, in the **Notes on Eligibility Type** section. Attach the participant's transition plan to the CE before submitting the Termination CE. An approved Termination CE authorizes the participant's termination from YES Waiver.

NOTE: Refer to the YES Waiver Policy Manual for acceptable reasons for termination.

Clinical Eligibility Document Sections

The **Clinical Eligibility (CE)** document has the following standard sections:

1. Eligibility Type
2. Performed On date
3. Notes on Eligibility Type
4. Start Date
5. End Date
6. Facility Question
7. Diagnosis Information
8. CANS Assessment Criteria
    a. Criteria A
    b. Criteria B
9. Additional Eligibility Criteria
    a. Criteria C
    b. Criteria D
    c. Criteria E

10. Notes on Clinical Eligibility
11. System Clinical Eligibility Determination
12. 12.Signatures
13. DSHS Review and Approval

See Figure 2 for Clinical Eligibility Document Sections.

CMBHS
Clinical Management for Behavioral Health Services

02/09/2019 - Build 1603

Provider Tools | Business Office | Data | Account Management | Help | Logout

Provider: | Client Name: | User Name: | Episode Of Care:
Location: | Client Number: | Local Case:

Yes Waiver Clinical Eligibility — CLI137

Edit | Close | Print | Attachments

* Eligibility Type
* Performed On — 0/00/2019
Notes on Eligibility Type
(Required when Eligibility Type is Termination)
* Start Date — 0/00/2019
* End Date — 0/00/2020
* Has Individual lived in a facility during the last 12 months (i.e RTC, State School, Group Home)? — * Yes No
If yes, please provide Facility details

1-5. SEE CE DOCUMENT SECTION

6. FACILITY QUESTION

7. DIAGNOSIS INFORMATION

Description	Code
Disruptive mood dysregulation disorder - F3481	F3481
Other specified trauma- and stressor-related disorder - F438	F438

View Complete Diagnosis Record

8A. CANS ASSESSMENT CRITERIA – CRITERIA A

CANS Assessment Criteria
Assessment Date — 0/00/2019
Criteria A

Child and Adolescent Needs and Strengths (CANS) Domain	Domain Score
Life Domain Functioning Domain	0
Developmental Needs: Cognitive	0
Developmental Needs: Developmental	0

8B. CANS ASSESSMENT CRITERIA – CRITERIA B

Criteria B

Child and Adolescent Needs and Strengths (CANS) Domain	Domain Score	Child and Adolescent Needs a	
Child Risk Behaviors: Suicide Risk	0	Caregiver Strengths and Needs: Involvement with Care	0
Child Risk Behaviors: Self Mutilation	0	Caregiver Strengths and Needs: Family Stress	0
Child Risk Behaviors: Other Self Harm	0	Caregiver Strengths and Needs: Safety	0
Child Risk Behaviors: Danger to Others	0	Life Domain Functioning: School	0
Child Risk Behaviors: Sexual Aggression	0	Life Domain Functioning: School Module - School Behavior	0
Child Risk Behaviors: Fire Setting	0	Life Domain Functioning: School Module - Attendance	0
Child Risk Behaviors: Delinquency	0	Psychiatric Hospitalization: Psychiatric Hospitalization	0
		Psychiatric Hospitalization: Psychiatric Hospitalization Module - Time Since Most Recent Discharge	0

View CANS Assessment

9. ADDITIONAL ELIGIBILITY CRITERIA

Additional Eligibility Criteria (optional when eligibility type is Termination)
Criteria C
* Outpatient therapy or partial hospitalization has been attempted and failed OR a psychiatrist has documented reasons why an inpatient level of care is required. * Yes No
Criteria D
* Check the Medicaid psychiatric inpatient hospitalization criteria below that the client meets.
None — View Criteria Details
Criteria E
* The Medicaid eligible youth must have a valid Axis I diagnosis as the principle admitting diagnosis. * Yes No

10. NOTES ON CLINICAL ELIGIBILITY

Notes on Clinical Eligibility

11. SYSTEM CLINICAL ELIGIBILITY DETERMINATION

System Clinical Eligibility Determination: NOT ELIGIBLE — Criteria A

12. SIGNATURES

Signatures

* By signing below, the Treatment Team indicates agreement that the chosen Waiver Services for this individual are not available through other resources and are necessary to prevent institutionalization and assure his/her health and safety.

Licensed Practitioner of the Healing Arts (LPHA) Signature
Qualified Mental Health Professional – Community Services Signature
* Client * Signed Refused Unable to Sign
* Legally Authorized Representative (LAR) Signed
No LAR, legally emancipated
No LAR, over 18 years old
Unable to Sign
Physician
Comprehensive YES Waiver Provider Representative
Physician signature is only required when individual is being denied Waiver Services based on Texas Medicaid Inpatient Psychiatric Admission Guidelines.

13. DSHS REVIEW AND APPROVAL

DSHS Review and Approval
Approved | Approved Based on Appeal | Denied — Reviewer Notes
DSHS Authorized Reviewer
* Document Status — Ready for Review
Document Status Date — 0/00/2019
Audit Information
Created By
Created Date — 0/00/2019
Last Saved By
Last Saved Date — 0/00/2019

Edit | Close | Print | Attachments

DSHS CMBHS Help Line: 1-866-806-7806

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Figure 2 - Clinical Eligibility Document Sections.

Eligibility Type

The **Eligibility Type** is a required field. For guidance on which type to select, refer to the Clinical Eligibility Types sections.

Performed On Date

The **Performed On** date is a required field. For **Initial CEs**, the Performed On date is the date of the in-person clinical eligibility assessment. For **Annual Renewal CEs**, the Performed On date will default to the first day of the new eligibility year.

CANS Assessment Criteria

The **CANS Assessment Criteria** is a required field for all CE types except Termination CE. This field will automatically populate with information from the participant's most recent **YES Assessment (CANS)**. The LMHA/LBHA should review the **Assessment Date** and confirm the date corresponds with the most recent YES Assessment (CANS). Do not submit a **Clinical Eligibility** document until the most recent YES Assessment (CANS) is in CMBHS.

Notes on Eligibility Type

The **Notes on Eligibility Type** field is a required field only when the CE type is Termination CE. For all other CE types, use this section to include additional information about the submitted CE. The LMHA/LBHA can document information such as barriers to timely submission.

NOTE: Do not use this section to provide information about the client's eligibility. List information related to eligibility in the **Notes on Clinical Eligibility Type** section.

Start Date

The **Start Date** is a required field. This field will automatically populate to the date the CE document is created. If an individual meets eligibility criteria, HHSC will update this section to reflect the date of formal enrollment in YES Waiver.

NOTE: HHSC authorizes enrollment in the YES Waiver for an eligibility period of 365 days.

End Date

The **End Date** is a required field. For **Initial** and **Annual Renewal CE** types, this field will automatically populate to 364 days after the start date and cannot be edited.

For **Termination CE** types, this field will automatically populate to the current date. This should be updated to reflect the client's last date of enrollment. No YES Waiver services can be delivered after a participant's CE end date.

NOTE: For participants who will be 19 years of age, the CE end date will populate to one day before the client's 19th birthday.

Facility Question

The **Facility Question** is a required field. This is a question about the participant's living situation. Mark **Yes** if the individual has lived in a facility during the last 12 months. Otherwise, mark **No**. If the response is Yes, include the facility name, date(s) of residence, and length of stay.

DIAGNOIS Diagnosis Information

Diagnosis Information is a required field. This field will automatically populate to

include the participant's most recent mental health diagnosis when it is available. The LMHA/LBHA is responsible for keeping this information up-to-date. Diagnosis information can be reviewed at any time by accessing the participant's **Client Workspace.**

NOTE: A clinical eligibility document cannot be created for participants who do not have a mental health diagnosis in the **Client Workspace** within the last year.

CANS Assessment Criteria

The **CANS Assessment Criteria** is a required field for all CE types except **Termination CE.** This field will automatically populate with information from the participant's most recent **YES Assessment (CANS).** The LMHA/LBHA should review the **Assessment Date** and confirm the date corresponds with the most recent **YES Assessment (CANS).** Do not submit a **Clinical Eligibility** document until the most recent **YES Assessment (CANS)** is in CMBHS.

NOTE: It is the responsibility of the LPHA to ensure that the CANS Assessment Criteria is accurate and reflects the needs of the individual.

Additional Eligibility Criteria

The **Additional Eligibility Criteria** section is a required field when the CE type is **Pending**, **Initial**, or **Annual Renewal.** These questions are required to determine clinical eligibility. For further guidance on how to respond to specific questions in this section, refer to the Clinical Eligibility section.

Notes on Clinical Eligibility

The **Notes on Clinical Eligibility** section is an optional field. The LMHA/LBHA should enter any information relevant to the eligibility determination process. For further guidance on what kind of information to include in this section, refer to the Clinical Eligibility section.

System Clinical Eligibility Determination

The **System Clinical Eligibility Determination** field will automatically populate to summarize information in the Clinical Eligibility document. This area will reflect the outcome of the assessment, including criterion met and not met. Even though this area may say **Eligible** or **Not Eligible**, eligibility can only be determined by HHSC.

Treatment Team Signatures

The **Signatures** section is a required field based on the type of assessment.

Signatures from the **Client** (YES Participant) and the **Legally Authorized Representative** are always required unless there are extenuating circumstances. Anytime the Client and/or LAR are **Unable to Sign**, the reason must be listed in the comments section. Wet signatures should be obtained for client records.

Signature Requirements	Initial CE	Annual Renewal	Termination
Licensed Practitioner of the Healing Arts	Yes	Yes	Yes
Qualified Mental Health Professional- CS	Yes*	Yes*	Yes
Physician	Yes**	Yes**	No
Client	Yes	Yes	Yes
Legally Authorized Representative	Yes	Yes	Yes
Comprehensive YES Waiver Provider	No	No	Yes

*A Qualified Mental Health Professional signature is required only when the QMHP has conducted the assessment.

**A Physician signature is required anytime the Client meets all eligibility criteria EXCEPT for Criterion D. By signing the Clinical Eligibility document, the physician confirms that the participant does not require an inpatient level of care AND recommends that HHSC deny enrollment in YES Waiver.

DSHS Review and Approval

The **DSHS Review and Approval** section is a read-only section. The LMHA/LBHA cannot change this. After a CE document has been submitted to HHSC for review, HHSC will update this section to reflect the participant's eligibility status as follows:

- **Approved:** HHSC has approved the LMHA/LBHA's request to enroll, transfer, or terminate a participant's clinical eligibility in YES Waiver.
- **Approved on Appeal:** HHSC has authorized an eligible participant's continued services until a fair hearing decision is made.
- **Denied:** HHSC has not approved the LMHA/LBHA's request to enroll, transfer, or terminate a participant's clinical eligibility in YES Waiver.

For further guidance on Clinical Eligibility document types, refer to the Clinical Eligibility section.

Creating a Clinical Eligibility Document

Before creating any **CE document**, review the participant's **Client Workspace.**

Make sure that:

- there is a mental health diagnosis at the LMHA location,
- there is a YES Assessment (CANS) within the last 90 days, and
- the client has an active Child and Adolescent Uniform Assessment (6-17) that is deviated to LOC-YES.

Pending, Initial, and Annual Renewal Document

To submit a **Pending**, **Initial**, or **Annual Renewal Clinical Eligibility (CE)** document:

1. Navigate to the **YES Waiver Clinical Eligibility** page by using the **Client Services** toolbar.
   a. Select Special Services Documentation.
   b. Select YES Waiver Services.
   c. Select YES Waiver Clinical Eligibility.
2. Once the CE document is open, select the appropriate **CE Type** from the options provided in the drop-down menu.
3. Enter the **Performed On** date. This date is the date of the in-person clinical assessment and should be the same date as the **CANS Assessment Date.**
4. Enter comments in **Notes on Eligibility Type** as needed
5. The **Start Date** and **End Date** will automatically populate based on the selected **CE Type.** HHSC may update this information as needed.
6. Complete the **Facility Question** by selecting **Yes** or **No.** If the response is

Yes, include the facility name, date(s) of residence, and length of stay.

7. Review the participant's diagnosis codes in the **Diagnosis Information** section. This information will auto-populate from the participant's most recent diagnosis.

   NOTE: Select **View Complete Diagnosis Record** at any time to view the

   participant's diagnosis record.

8. Review the **CANS Assessment Criteria** section. This information will auto- populate from the participant's most recent **YES Assessment (CANS).** The **Assessment Date** should be the same date as the Performed On date. **NOTE:** Select **View CANS Assessment** at any time to view the participant's most recent **YES Assessment (CANS).** The LPHA is responsible for ensuring that the YES Assessment (CANS) is accurate before submitting.
9. Complete the **Additional Eligibility Criteria.** Refer to the Clinical Eligibility section for further guidance.
   a. **Criteria C:** Outpatient therapy or partial hospitalization has been attempted and failed OR a psychiatrist has documented reasons why an inpatient level of care is required. Select Yes or No.
   b. **Criterion D:** Check the Medicaid psychiatric inpatient hospitalization criteria below that the client meets.
      ◊ Select **View Criteria Details** to review inpatient hospitalization criteria. The specific criterion will appear in a pop-up window. Select the criterion that the client meets. If no criterion is met, select **8.** None.

      NOTE: If a client DOES NOT meet **Criterion D** and all other Criterion are met, a physician's signature is required.

   c. **Criterion E:** The Medicaid eligible youth must have a valid Axis I diagnosis as the principle admitting diagnosis. Select **Yes** or **No.** This answer should align with information from the **Diagnosis Information** section.
10. Enter comments in **Notes on Clinical Eligibility** as needed.

    NOTE: If a client DOES NOT meet **Criterion A** and the clinician is requesting a waiver, supporting comments must be included in this section.

11. Complete **Signatures** section. Signatures should match the **Performed On** date. Refer to the Clinical Eligibility section for guidance on required signatures based on CE type.
12. Select **Ready for Review** from the options provided in the drop-down menu. 13.Select **Save.**

After the CE document's status is updated to **Ready for Review,** HHSC will review the document and issue an eligibility determination. The eligibility determination will appear at the bottom of the document as **Approved, Approved on Appeal,** or **Denied.** If additional information is required to determine eligibility, HHSC may place the document back in Draft status.

NOTE: If the CE document is denied, complete a new **Child and Adolescent Uniform Assessment (UA)** to request **LOC-4** or **LOC-A** from the Managed Care Organization (for Medicaid clients) and the Utilization Management department (for indigent clients). The participant's **UA** will reflect **LOC-YES** until it is changed.

Termination CE Documents

Before creating a **Termination CE** document, review the participant's **Client Workspace.** A Termination CE cannot be created for a participant when there is a previous **Individual Plan of Care** document that does not have a **TMHP authorization number.**

To submit a **Termination Clinical Eligibility (CE)** document:

1. Navigate to the **YES Waiver Clinical Eligibility** page by using the **Client Services** toolbar.
   a. Select Special Services Documentation.
   b. Select YES Waiver Services.
   c. Select YES Waiver Clinical Eligibility.
2. Once the CE document is open, select **Termination** from the options provided in the drop-down menu. The CE will automatically populate to include information from the **Initial** CE. The following fields are not required:
   a. Facility Question
   b. CANS Assessment Criteria. The CANS section will update to NA
   c. Additional Eligibility Criteria (Criteria C, D, E)
3. Enter the **Performed On** date. For unplanned terminations, this date should be the date the LMHA was notified that the family plans to leave the waiver. For planned terminations, this date should be the date of the last Child and Family Team meeting.
4. Select the reason for termination from the options provided in the drop-down menu in the **Notes on Eligibility Type.** This section is required and must

   indicate the participant's reason for termination.

   NOTE: Refer to the YES Waiver Policy Manual for further guidance on reasons for termination.

5. The **Start Date** will automatically populate.
6. Select the **CE End Date.** This date should be the last date of YES Waiver enrollment.

   NOTE: YES Services cannot be provided after the **CE End Date.**
7. Review the participant's diagnosis codes in the **Diagnosis Information** section. This information will auto-populate from the participant's most recent diagnosis. A **Termination CE** cannot be submitted if there is no diagnosis.

   NOTE: Select **View Complete Diagnosis Record** at any time to view the participant's diagnosis record.

8. Enter comments in **Notes on Clinical Eligibility.** This section is required and must include additional details regarding the participant's reason for termination.

NOTE: When **Participant no longer meets Waiver eligibility** is selected as the reason for termination, enter one of the following options as a comment:

- Not eligible for Medicaid services.
- No longer eligible at annual reassessment. Indicate which criterion is longer met.
- No longer resides within the service region. Indicate where the participant has moved.
- No longer resides with LAR. Indicate where the participant is living.

9. Complete the **Signatures** section and save document in **Ready for Review.** Signatures should match the **Performed On** date. Refer to the Clinical Eligibility section for further guidance on required signatures.
10. Attach the participant's transition plan to the Termination CE.
    - Select **Draft** from the options provided in the drop-down menu.
    - Select **Save.**
    - Select **Attachments.** Attach the transition plan.
    - Select **Edit** to return to the CE document.
11. Select **Ready for Review** from the options provided in the drop-down menu. 12.Select **Save.**

After the CE document has been placed in Ready for Review status, HHSC will review the document and approve or deny the request. Approval of a Termination CE will automatically create an Individual Plan of Care Termination document. This will close services for the participant.

NOTE: Do not create a Termination IPC document.

For information on LMHA Transfer Documents, refer to the Transfer Process section.

Termination Reason Justification Chart

CMBHS Selection	Description	Required Notes on Clinical Eligibility
Graduation	Participant has successfully achieved identified goals on their Wraparound Plan and no longer requires LOC-YES.	Comments must indicate that the Child and Family Team agrees that the participant has met goals.

CMBHS Selection	Description	Required Notes on Clinical Eligibility
Participant no longer meets Waiver eligibility	Participant: ● Has been denied for continued enrollment at annual renewal ● Is ineligible for Medicaid ● No longer lives within the service region ● No longer resides with LAR	Comments must indicate: ● the eligibility criterion not met at renewal; or ● that LAR has been notified of ineligibility by Medicaid; or ● the participant has moved and does not wish to transfer services. This can include moving out of state; or ● where the participant is currently residing. This may include "unable to locate."
Cost of services and supports provided exceed cost neutrality	Participant's plan of care exceeds the annual cost limit of $35,804.	Comments must indicate that the cost neutrality can no longer be maintained, and the participant has been referred to services suited to meet their needs. Notify HHSC when a participant has reached 80% of cost neutrality and prior to entering a Termination CE.
CMBHS Selection	**Description**	**Required Notes on Clinical Eligibility**
Participant in an out-of-home placement for more than 90 consecutive days	Participant has been placed in one of the following settings: ● juvenile justice center ● psychiatric hospital ● residential treatment center ● substance abuse treatment	Comments must indicate the name of the facility and the date of admission, if known. **NOTE:** A Termination CE is not required if the participant has not been or is not expected to be in an out-of-home for 90 days.
Participant turns 19 years of age	Participant has turned 19 years of age and is no longer eligible for the program.	Comments must indicate whether the participant has been transferred to transition-age- youth (TAY) or adult mental health services.

CMBHS Selection	Description	Required Notes on Clinical Eligibility
Participant and LAR choice	Participant and LAR: ● select hospital or institutional services ● choose to discontinue ● choose enrollment in another 1915(c) or 1915(i) program	Comments must indicate which hospital, institutional setting, or program the participant has chosen to enroll in. If participant/LAR choose to discontinue services for another reason, comments must indicate the reason. This may include non-engagement for 60 consecutive calendar days and good faith efforts have been documented.
Participant/LAR refuse waiver services for 90 consecutive days	Participant and LAR choose to not participate in YES Waiver services for 90 consecutive calendar days.	Comments must indicate whether good faith efforts have been attempted by the Wraparound Facilitator.
Participant placed in DFPS conservatorship and attempts to transfer services have been made	Participant has been placed in DFPS conservatorship and the new guardian has chosen to not continue YES Waiver services.	Comments must indicate that good faith efforts have been made to continue enrollment in YES Waiver.
Participant is deceased		Comments must indicate that a critical incident report has been made to HHSC.

YES Assessment (CANS)

A **YES Assessment (CANS)** must be created in order to submit a **Clinical Eligibility** document.
Make sure that:

- there is a **Local Case Number** in the **Client Profile,**
- there is a valid mental health diagnosis within the past year,
- there is a **MH Uniform Assessment** in CMBHS within the past 90 days, and
- the CANS in the LMHA/LBHA local system and the CANS in CMBHS are identical.

To submit a **YES Assessment (CANS):**

1. Navigate to the **YES Assessment (CANS)** page by using the **Client Services** toolbar.
    - Select Special Services Documentation.
    - Select **YES Waiver Services.**
    - Select **YES Assessment (CANS).**
2. Verify the participant's **Local Case Number.**
3. Enter a **Local Assessment Number** as needed.
4. Select **Referral Source** from the options provided in the drop-down menu.
5. Complete the **CANS.**
    - Enter the **CANS Assessment Date.** This date is the date the CANS was completed with the client.
    - Enter the **CANS Assessment Time.**

    NOTE: If there is a recent **Uniform Assessment,** the CANS information will automatically populate by selecting **Populate CANS Scores.** Review the CANS scores and the **CANS Assessment Date** to verify that the most recent one has popped up.
6. Select **Calculate LOC-R.** Deviation to LOC YES is not required on this document.

    NOTE: Although the **YES Assessment (CANS)** will show **LOC-R,** this will affect authorization.
7. Enter relevant **Notes.**
8. Select **Performed By** from the options provided in the drop-down menu.
9. Select **Next** or **Save and Continue** to continue with the assessment.
10. Complete the **Community Data** section.

    NOTE: If there is a previous **YES Assessment (CANS),** the **Community Data** information will automatically populate by selecting **Populate Community Data.**
11. Select **Closed Complete** from the options provided in the drop-down menu.
12. Select **Save.**

NOTE: It is the responsibility of the LPHA to ensure information submitted on the YES Assessment (CANS) is accurate and reflects the needs of the individual.

See Figures 3 & 4 for YES Assessment (CANS).

CMBHS
Clinical Management for Behavioral Health Services

02/28/2019 - Build 1603

Provider Tools | Business Office | Data | Account Management | Help | Logout

Provider: | Client Name: | User Name: | Episode Of Care:
Location: | Client Number: | Local Case:

YES Assessment (CANS) — YAC100

Save And Continue | Save | Cancel | Spell Check

Assessment Information

Local Case Number: * 000000000
Local Assessment Number:
CMBHS Assessment Number:
Assessment Type: YES CANS Asssessment
Referral Source: * None Selected

CANS | Community Data

Child and Adolescent Needs and Strengths (CANS) Texas Comprehensive

CANS Assessment Date: * mm/dd/yyyy
Assessment Time: * 00:00 hh:mm AM PM

Populate CANS Scores

CHILD RISK BEHAVIORS
0 = no evidence
1 = history, watch/prevent
2 = recent, act
3 = acute, act immediately

	0	1	2	3
Suicide Risk	*			
Self Mutilation	*			
Other Self Harm	*			
Danger to Others	*			
Sexual Aggression	*			
Runaway	*			
Delinquency	*			
Fire Setting	*			
Social Behavior	*			
Bullying	*			

CHILD BEHAVIORAL / EMOTIONAL NEEDS
0 = no evidence
1 = history or sub-threshold, watch/prevent
2 = causing problems, consistent with diagnosable disorder
3 = causing severe/dangerous problems

	0	1	2	3
Psychosis	*			
Mania	*			
Impulse / Hyper	*			
Depression	*			
Anxiety	*			
Oppositional	*			
Conduct	*			
Adjustment to Trauma	*			
Anger Control	*			
Substance Use	*			
Eating Disturbance	*			

LIFE DOMAIN FUNCTIONING
0 = no evidence of problems
1 = history, mild
2 = moderate
3 = severe

	N/A	0	1	2	3
Family	*				
Living Situation		*			
School		*			
Social Functioning		*			
Recreational		*			
Developmental		*			
Communication		*			
Judgment		*			
Job Functioning	*				
Legal		*			
Medical		*			
Physical		*			
Sexual Development		*			
Sleep		*			
Independent Living	*				

CAREGIVER STRENGTHS & NEEDS
Not applicable- no caregiver identified
0 = no evidence
1 = minimal needs
2 = moderate needs
3 = severe needs

	N/A	0	1	2	3
Supervision	*				
Involvement	*				
Knowledge	*				
Organization	*				
Social Resources	*				
Residential Stability	*				
Physical	*				
Mental Health	*				
Substance Use	*				
Developmental	*				
Access to Child Care	*				
Military Transitions	*				
Family Stress	*				
Safety	*				

CHILD STRENGTHS
0 = centerpiece
1 = useful
2 = identified
3 = not yet identified

	0	1	2	3
Family	*			
Interpersonal	*			
Optimism	*			
Educational	*			
Vocational	*			
Talents / Interests	*			
Spiritual / Religious	*			
Community Life	*			
Relationship Permanence	*			
Youth Involvement	*			
Natural Supports	*			

CULTURE
0 = no evidence
1 = minimal needs
2 = moderate needs
3 = severe needs

	0	1	2	3
Language	*			
Identity	*			
Sexual/Gender Identity	*			
Ritual	*			
Cultural Stress	*			

Psychiatric Hospitalization
0 - No
1 - Yes

	0	1
Has the child/youth ever been hospitalized for psychiatric reasons	*	

Crisis History: Number of crisis episodes in the past 90 days
0 = 0 episodes
1 = 1 crisis episode
2 = 2-3 crisis episodes
3 = 4 or more crisis episodes

	0	1	2	3
Number of Crisis Episodes	*			

Recommendation

Calculate LOC-R
Calculated Level of Care Recommendation (LOC-R)
Notes
Performed By: * None Selected

Document Status: * Draft
Document Status Date: 00/00/2019
Comments

Next | Save And Continue | Save | Cancel | Spell Check

DSHS CMBHS Help Line: 1-866-806-7806

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Figure 3 - YES Assessment (CANS) - CANS

CMBHS
Clinical Management for Behavioral Health Services

02/28/2019 - Build 1603

Provider Tools | Business Office | Data | Account Management | Help | Logout

Provider: | Client Name: | User Name: | Episode Of Care:
Location: | Client Number: | Local Case:

YES Assessment (CANS) YAC100

Save And Continue | Save | Cancel | Spell Check

Assessment Information

Local Case Number: * 000000000
Local Assessment Number:
CMBHS Assessment Number:
Assessment Type: YES CANS Asssessment
Referral Source: * None Selected

CANS | Community Data

Populate Community Data

Has the child/youth attended school at any time in the past 3 months? * None Selected

Current grade level or highest grade level completed? * None Selected

Education - Select all that applies to this client
- Is currently enrolled in school
- Is pursuing or received a GED
- Has Graduated
- 504 Plan
- Has some College Hours
- Long term suspension in most recent school year
- Special Education
- Other
- None

Primary Residence Type (Last 90 Days) * None Selected

Juvenile/Criminal Justice
- TCOMMI * Current Historical None
- Charges Pending * Current Historical None
- Probation * Current Historical None
- Parole * Current Historical None

Number of Arrests in the Last 30 Days? *

Children's Mental Health (CMH)
- * Currently receiving CMH services from LMHA/LBHA/CSP?
- Currently on a waitlist for CMH services
- Accessing MH services from provider other than LMHA/LBHA/CSP?
- None

Has the child ever had IDD Diagnosis? * Yes No

Home and Community Based Services
- Currently receiving in the following * None Selected Waiver
- Currently on a waitlist for the following * None Selected Waiver

Community Supports and Activities- Select all activities this client currently participates in
- Religious/spiritual practices
- Community Resource Coordination Group (CRCG) involvement
- SUD recovery activities
- Organized sports
- Scouting Organization
- Boy & Girl Club
- Mentorship Program
- LGBTQ Support Group
- Cultural Activities
- Extra-curricular school activities (Theater, Band, Clubs...)
- MH Peer Support
- Other
- None

Community tenure
In the last 12 months, select all the out of home placements this client experienced
- Psychiatric Hospitalization
- Residential Treatment Center (RTC) Placement
- Juvenile Justice Detention
- At Risk of Placement
- New DFPS placement (other than respite)
- Other
- None

Outpatient Services
In the last 12 months, select all the Outpatient options this client accessed:
- MH/SUD Partial Hospital Program (PHP)
- MH/SUD Intensive Outpatient Program (IOP)
- Cognitive/Behavioral or other traditional talk therapy
- Therapy targeting trauma related issues (e.g. TF-CBT, CPT, PE, EMDR)
- Applied Behavioral Analysis
- Group therapy
- Other
- None

LTSS Terms of Use Signed? * Yes No Unknown

LTSS Terms of Use Acknowledged By? * LAR Self Non-LAR

Notes

Document Status * Draft
Document Status Date 00/00/2019

Comments

Previous | Save And Continue | Save | Cancel | Spell Check

DSHS CMBHS Help Line: 1-866-806-7806

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Figure 4 - YES Assessment (CANS) - Community Data Questions

Additional YES Assessment (CANS) Considerations

Individuals with a Diagnosis of IDD

To be eligible for YES Waiver, a primary mental health (MH) diagnosis is required. However, even when there is no MH diagnosis or when the MH diagnosis is not considered primary, a CE is still required to be submitted to HHSC.

The **MH Uniform Assessment (MH UA)** will accept any diagnosis. If there is no MH diagnosis, the MH Uniform Assessment will calculate **LOC-9 Ineligible.** At this point, MH services are typically denied. However, a CE should still be submitted because only HHSC can deny enrollment.

To submit a CE, deviate the **MH UA** to **LOC-YES.** Comments in the MH UA can indicate the reason for deviation is to assess for mental health medical necessity and eligibility for YES Waiver. Move forward with completing the Clinical Eligibility in CMBHS. Upon notification of denial, deviate the **MH UA** back to **LOC-R.**

For Young Children (3-5)

The **Young Child CANS (3-5)** cannot be used to determine clinical eligibility for the YES Waiver. For children younger than 5, a **CANS (6-17)** must be manually entered into the **YES Waiver LMHA location.** Information from the Young Child CANS (3-5) cannot be auto-populated into the **YES Assessment (CANS).** The LMHA/LBHA must manually enter information into the YES Assessment (CANS). Later, the YES Assessment (CANS) should automatically populate from the previous YES Assessment (CANS).

For Young Adults (18+)

The **Adult Needs and Strengths Assessment (ANSA)** cannot be used to determine clinical eligibility for the YES Waiver. For a young adult who is 18, a **CANS (6-17)** must be manually entered into the **YES Waiver LMHA location.** Information from the ANSA cannot be auto-populated into the **YES Assessment (CANS).** The LMHA/LBHA must manually enter information into the YES Assessment (CANS). Later, the YES Assessment (CANS) should automatically populate from the previous YES Assessment (CANS).

Individual Plan of Care

The **Individual Plan of Care (IPC)** is a document in CMBHS which allows users to submit a request for YES Waiver services for a participant. Services submitted on the IPC:

- are developed through the Child and Family Team meeting,
- are intended to support a participant's mental health needs, and
- must be documented on the participant's Wraparound Plan.

IPCs are reviewed by HHSC to verify submissions are in compliance with policy requirements. Services should not be provided to a participant until they have been approved by HHSC and authorized by the Texas Medicaid and Healthcare Partnership (TMHP).

Individual Plan of Care Types

There are several types of IPC documents which include:

- Initial,
- Revision,
- Annual Renewal,
- LMHA Transfer Out,
- LMHA Transfer In,
- Outgoing Estimate, and
- Incoming Estimate.

The use of a specific document type will be dependent upon the situation. The most common situations encountered include:

- initial request for services,
- change in services, and
- transferring service providers.

Initial IPC

Submit an **Initial** IPC after the Wraparound Facilitator has met with the participant and their family at the intake meeting. Services requested on this IPC should be appropriate to support the participant until the initial Child and Family Team meeting is held. Services requested on the initial IPC should reflect the Wraparound Plan of Care and must be necessary to support the participant's Crisis and Safety Plan. The IPC request should only include enough units to last 45 days. If additional services or units are needed, submit a revision IPC.

Revision IPC

Submit a **Revision** IPC to request any change to services. Any change in service should be documented in the Wraparound Plan of Care. At minimum, a Revision IPC should be created and submitted every 90 days. The Revision IPC request should only include enough units to last 45 days. Revisions should be submitted after every CFT meeting to reflect changes to services.

- If the Child and Family Team ***has*** requested a change in services, document this under the **Notes on Clinical Eligibility.** The notes should reflect the proposed changes in service delivery, including type of service and units requested.

- If the Child and Family Team ***has not*** requested any change in services, document this under the **Notes on Clinical Eligibility.** The notes should indicate that no changes to service delivery have been made but that there has been an increase of requested unit(s).

Annual Renewal IPC

Submit an **Annual Renewal** IPC when a participant has been authorized for ongoing enrollment in YES Waiver.

LMHA Transfer Out IPC

Submit an **LMHA Transfer Out** IPC when a participant chooses to permanently relocate to a different catchment area, such as a different county, that is outside the LMHA Local Service Area. Complete this document only when the participant's relocation is not expected to be temporary. Coordination must occur between the participant's current, or sending, LMHA and the new, or receiving, LMHA to ensure continuity of care.

When submitting an LMHA Transfer Out IPC, the **Notes on Clinical Eligibility**

should identify:

- the city, county, or region the client will be moving to;
- the name of the region LMHA;
- the anticipated date the participant will move; and,
- the name of the Wraparound Facilitator (if known) and case manager (if known).

LMHA Transfer In IPC

Submit an L**MHA Transfer In** IPC when a participant, who has been authorized to receive YES Waiver services, has permanently relocated from a different LMHA catchment area. This document type can only be created when there is an authorized **LMHA Transfer Out** IPC. Coordination must occur between the

participant's previous, or sending, LMHA and the new, or receiving, LMHA to ensure continuity of care. Services requested on this IPC should be services that are appropriate to support the participant until the first Child and Family Team meeting is held with the participant's new Wraparound Facilitator. The LMHA should always make sure that services the participant has previously received through the sending LMHA are continued to the greatest extent possible.

Outgoing Estimate

Create an **Outgoing Estimate** IPC when a participant chooses to end services being provided by one Comprehensive Waiver Provider (CWP) and receive services through a new CWP.

Incoming Estimate

Create an **Incoming Estimate** IPC after a participant and family has their first Child and Family Team meeting with the new CWP. This document type can only be created when there is an authorized **Outgoing Estimate** IPC. Services requested on this IPC should reflect the services that will be provided by the new CWP.

Individual Plan of Care Sections

The IPC document has the following standard sections:

1. IPC Type
2. Performed On date
3. Notes on IPC Type
4. Annual IPC Begin Date
5. Annual IPC End Date
6. Annual Total Summary for All Waiver Services
7. YES Provider Name
8. TMHP Authorization Number
9. YES Waiver Services
    a. General
    b. Adaptive Aid and Supports
    c. Minor Home Modification
    d. Transitional Services
10. Non-Waiver Services
    a. Other Medicaid State Plan Services
    b. Services Provided by Other Funding Sources
11. Treatment Team Signatures
12. DSHS Review and Approval

See Figures 5, 6, & 7 for Individual Plan of Care (IPC) Document sections.

CMBHS
Clinical Management for Behavioral Health Services

02/28/2019 - Build 1603

Provider Tools | Business Office | Data | Account Management | Help | Logout

Provider: | Client Name: | User Name: | Episode Of Care:
Location: | Client Number: | Local Case:

Yes Waiver Individual Plan of Care (IPC) — IPC139

Save | Cancel | Spell Check

1-5. SEE IPC DOCUMENT SECTION

* IPC Type: None Selected
* Performed On: 00/00/2019
Notes on IPC Type
* Annual IPC Begin Date
* Annual IPC End Date

6. ANNUAL TOTAL SUMMARY

ANNUAL TOTAL SUMMARY FOR ALL WAIVER SERVICES	AMOUNT
Total Billable Amount	0.00
Estimated Annual Cost of Yes Waiver Services	0.00
Estimated Requisition Fee Cost	0.00
Total Estimated Cost	0.00
Remaining Amount	0.00
Total Paid Amount	0.00

YES Provider Name: None Selected
YES Wraparound/PE Service Provider Name: None Selected

Provider Contact
Provider Contact Information -

7. YES PROVIDER NAME

Yes Waiver Services: General

8. TMHP AUTHORIZATION

General Services — TMHP Authorization Number — TMHP Response File Date 0/00/0019

9A. YES WAIVER SERVICES – GENERAL

Edit General Service	Service Name	Requested Units	Unit Time	Unit Rate	Estimated Annual Cost	Units Documented As Of 0/00/2019	Amount Paid As Of 0/00/2019
Edit	Animal Assisted Therapy - Individual		15 min	19.36			
	Animal Assisted Therapy - Individual - Requisition Fee		15 min	1.94			
Edit	Animal Assisted Therapy -Group		15 min	19.36			
	Animal Assisted Therapy -Group - Requisition Fee		15 min	1.94			
Edit	Art Therapy - Individual		15 min	19.36			
	Art Therapy - Individual - Requisition Fee		15 min	1.94			
Edit	Art Therapy -Group		15 min	19.36			
	Art Therapy -Group - Requisition Fee		15 min	1.94			
Edit	Community Living Supports - Bachelor's Level Clinician		15 min	25.02			
Edit	Community Living Supports - Bachelor's Level Clinician - Group		15 min	25.02			
Edit	Community Living Supports - Master's Level Clinician		15 min	25.02			
Edit	Community Living Supports - Master's Level Clinician - Group		15 min	25.02			
Edit	Employment Assistance - YES		15 min	6.52			
Edit	Family Support Service - Individual		15 min	6.25			
Edit	Family Supports Services - Group		15 min	6.25			
Edit	Licensed Nutritional Counseling - Group		15 min	13.82			
Edit	Licensed Nutritional Counseling - Individual		15 min	13.82			
Edit	Music Therapy - Individual		15 min	19.36			
	Music Therapy - Individual - Requisition Fee		15 min	1.94			
Edit	Music Therapy -Group		15 min	19.36			
	Music Therapy -Group - Requisition Fee		15 min	1.94			
Edit	Non-medical transportation for YES Waiver participant		Per mile	0.55			
Edit	Paraprofessional Services - Individual		15 min	6.15			
Edit	Paraprofessional Services -Group		15 min	6.15			
Edit	Pre-Engagement Fee		15 min	3.96			
Edit	Recreational Therapy - Group		15 min	19.36			
	Recreational Therapy - Group - Requisition Fee		15 min	1.94			
Edit	Recreational Therapy - Individual		15 min	19.36			
	Recreational Therapy - Individual - Requisition Fee		15 min	1.94			
Edit	Respite - Camp		15 min	2.46			
Edit	Respite - In Home		15 min	5.22			
Edit	Respite DFPS Residential Child Care Child Placing Agency		Per Diem	67.98			
Edit	Respite DFPS Residential Child Care General Residential Operations (GRO)		Per Diem	115.44			
Edit	Respite DFPS Residential Child Care Mandated Family Rate		Per Diem	88.62			
Edit	Respite LCCC - TRSP Certified Preschool (ages 3 - 5)		Hour	5.61			
Edit	Respite LCCC - TRSP Certified School Age (ages 6 and older)		Hour	5.54			
Edit	Respite LCCC Preschool (ages 3 - 5)		Hour	5.32			
Edit	Respite LCCC School Age (ages 6 and older)		Hour	5.17			
Edit	Respite LCCH - TRSP Certified Preschool (ages 3 - 5)		Hour	5.17			
Edit	Respite LCCH - TRSP Certified School Age (ages 6 and older)		Hour	5.62			
Edit	Respite LCCH Preschool (ages 3 - 5)		Hour	4.90			
Edit	Respite LCCH School Age (ages 6 and older)		Hour	4.86			

Figure 5 - IPC Document (1/3)

9B. YES WAIVER SERVICES – ADAPTIVE AIDS & SUPPORTS

Yes Waiver Services: Adaptive Aids and Support

Adaptive Aids and Support Request (0)

Edit Adaptive Aid	Service Name	Requested Units	Unit Time	Unit Rate	Estimated Annual Cost	Units Documented As Of 0/00/2019	Amount Paid As Of 0/00/2019
Edit	Adaptive Aids and Support Request (0)	1.00	Encounter				
	Adaptive Aids and Support - Requisition Fee	1.00	Encounter				

Justification Box (Adaptive Aids and Support Request (0))

9C. YES WAIVER SERVICES – MINOR HOME MODIFICATIONS

Yes Waiver Services: Minor Home Modification

Minor Home Modifications Request (0)

Edit Minor Home Service	Service Name	Requested Units	Unit Time	Unit Rate	Estimated Annual Cost	Units Documented As Of 0/00/2019	Amount Paid As Of 0/00/2019
Edit	Minor Home Modifications Request (0)	1.00	Encounter				
	Minor Home Modifications - Requisition Fee	1.00	Encounter				

Justification Box (Minor Home Modifications Request (0))

9D. YES WAIVER SERVICES – TRANSITIONAL SERVICES

Yes Waiver Services: Transitional Services

Transitional Services Request (0)

Edit Transition Service	Service Name	Requested Units	Unit Time	Unit Rate	Estimated Annual Cost	Units Documented As Of 0/00/2019	Amount Paid As Of 0/00/2019
Edit	Transitional Services Request (0)	1.00	Encounter				
	Transitional Services - Requisition Fee	1.00	Encounter				

Justification Box (Transitional Services Request (0))

10A. NON-WAIVER SERVICES – OTHER MEDICAID STATE PLAN SERVICES

Non-Waiver Services: Other Medicaid State Plan Services

Edit Medicaid	Medicaid State Plan Services	Approved Units
Edit	Counseling (Family)	
Edit	Counseling (Group)	
Edit	Counseling (Individual)	
Edit	Crisis Service Array	
Edit	Family Case Management	
Edit	Family Partner	
Edit	Family Training (Group)	
Edit	Family Training (Individual)	
Edit	Flexible Community Supports	
Edit	Flexible Funds	
Edit	Intensive Case Management (Wraparound)	
Edit	Medication Training and Support (Individual)	
Edit	Medication Training and Support (Individual)	
Edit	Parent Support Group	
Edit	Pharmacological Management	
Edit	Psychiatric Diagnostic Interview Examination	
Edit	Respite Services: Community Based	
Edit	Respite Services: Program Based	
Edit	Routine Case Management	
Edit	Skills Training (Group)	
Edit	Skills Training (Individual)	

10B. NON-WAIVER SERVICES – SERVICES PROVIDED BY OTHER FUNDING SOURCES

Non-Waiver Services: Services Provided by Other Funding Sources

+ | Add new record

Edit Other Funding	Type of Service	Estimated # of Hours	Provider Name	Funding Source

No Records Found

Figure 6 – IPC Document (2/3)

Treatment Team Signatures

By signing below, the Treatment Team indicates agreement that the chosen Waiver Services for this individual are not availab... assure his/her health and safety. This IPC addresses all assessed needs and personal goals either through waiver services or other means.

11. TREATMENT TEAM SIGNATURES

* Case Manager: None Selected
* Licensed Practitioner Of Healing Arts (LPHA)
Physician
* Client: Signed / Refused / Unable to Sign
* Legally Authorized Representative (LAR): Signed
No LAR, legally emancipated
No LAR, over 18 years old
Unable to Sign
* Re-select YES Provider Name to Confirm: None Selected
* Provider Representative

To allow YES Service Providers access to information about your Waiver services, please sign the Authorization above:
By signing this YES Waiver Individual Plan of Care (IPC), I am giving permission to this Local Mental Health Authority (LMHA) or Wraparound Provider Organization (WPO) to disclose YES waiver records about me to the YES Waiver Service Providers named in this IPC. I authorize the disclosure of my YES Waiver Clinical Eligibility and this IPC for the purposes of service delivery and continuity of care and payment for my services from a third party payer. This Authorization expires when I stop receiving YES Waiver services from this provider if not properly revoked earlier. I understand that my eligibility for services cannot be conditional upon my signing this Authorization. However, services to be paid for by any third party are conditioned upon my signing this Authorization for disclosure to the third party when Authorization is required by law or for payment purposes. I am not guaranteed services on the basis of this Authorization. My health information may be protected under federal and state laws and may not be disclosed without my signed Authorization, unless otherwise provided for by state or federal law. Even if I refuse to sign this Authorization, my health information may be used or disclosed without this Authorization when allowed or required by law. Information disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected under HIPAA. I also understand that I may revoke this Authorization in writing to this provider at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires in accordance with the conditions specified in this document. This Authorization cannot be revoked if the use or disclosure is required for payment to this provider for services provided in reliance on this Authorization.

DSHS Review and Approval

12. DSHS REVIEW AND APPROVAL

Approve / Approve Based on Appeal / Deny
* Reviewer Notes
* DSHS Authorized Representative: None Selected
* Document Status: Draft
Audit Information
Created By
Created Date
Last Saved By
Last Saved Date

Save | Cancel | Spell Check

DSHS CMBHS Help Line: 1-866-806-7806

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Figure 7- IPC Document (3/3)

IPC Type

The **IPC Type** section is a required field. For guidance on which type to select, refer to the IPC Types section.

Performed On Date

The **Performed On Date** is a required field. This refers to the day that services were agreed upon in the Child and Family Team meeting.

Notes on IPC Type

The **Notes on IPC Type** section is not a required field. Information in this section should include changes to services, IPC start and end dates as applicable, and changes to service providers.

Begin Date

The **Begin Date** is a required field. For **Initial**, **Revision**, **Annual Renewal**, **Outgoing Estimate**, and **LMHA Transfer Out** IPC types, this field will automatically populate to the CE start date. For **Incoming Estimate** and **LMHA**

Transfer In IPC types, this field must be updated to reflect the first date services were transferred to the new LMHA or Comprehensive Waiver Provider.

End Date

The **End Date** is a required field. For **Initial**, **Revision**, **Annual Renewal**, **Incoming Estimate**, and **LMHA Transfer In** IPC types, this field will automatically populate to the CE end date. For **Outgoing Estimate** and **LMHA Transfer Out** IPC types, this field must be changed to reflect the last date of services provided by the LMHA or the Comprehensive Waiver Provider.

Annual Total Summary For All Waiver Services

The **Annual Total Summary for All Waiver Services** is a table which provides an overview of the annual cost of YES Waiver services used by the participant during their eligibility year. Monitor the participant's estimated cost for services throughout their eligibility year. An LMHA or CWP may not exceed the Total Billable Amount for a participant.

YES Provider Name

The **YES Provider Name** is a dropdown menu listing the names of all YES Waiver service providers. A YES Provider Name must be listed on the IPC when at least one service is requested on the participant's IPC. The selected provider should be the organization that will be providing services to the participant.

TMHP Authorization Number

The **Texas Medicaid Healthcare Partnership (TMHP) Authorization Number** is an auto-populated field that is generated when YES Waiver services have successfully been transmitted to TMHP. A separate TMHP authorization number will be received for the following sections:

- YES Waiver Services
- Adaptive Aids and Supports
- Minor Home Modifications
- Transitional Services

Review the IPC document to make sure that a TMHP authorization number has been received. Services should not be provided to a participant if the IPC does not have a TMHP authorization number. This number should generate on the IPC document within 24 hours of approval by HHSC. If a number does not generate, review the participant's **Medicaid Eligibility Verification** status.

YES Waiver Services

YES Waiver Services are services that are provided through the YES Waiver and delivered by the Comprehensive Waiver Provider.

Non-Waiver Services

Non-Waiver services are services that are provided through the Medicaid State Plan or through other funding sources.

Treatment Team Signatures

The **Treatment Team signatures** section is a required field based on the type of assessment. Signatures from the **Client** (YES Participant) and the **Legally Authorized Representative** are always required unless there are extenuating circumstances. Anytime the Client and/or LAR are **Unable to Sign**, the reason must be listed in the comments section.

Signature Requirements	IPC
Case Manager	Yes
Licensed Practitioner of the Healing Arts	Yes
Physician	Optional
Client	Yes
Legally Authorized Representative	Yes
Comprehensive YES Waiver Provider	Yes

DSHS Review and Approval

The **DSHS Review and Approval** section is a read-only section. The LMHA/LBHA cannot change this. After an IPC document has been submitted to HHSC for review, HHSC will update this section to reflect the participant's eligibility status as follows:

- **Approved:** HHSC has approved the LMHA/LBHA's request to add, reduce, or change a participant's service(s).
- **Approved on Appeal:** HHSC has authorized an eligible participant's

  continued services until a fair hearing decision is made.
- **Denied:** HHSC has not approved the LMHA/LBHA's request to add, reduce, or change a participant's service(s).

Creating an Individual Plan of Care (IPC) Document

Before creating any IPC, be sure to review the participant's **Client Workspace.** An IPC cannot be created for any participant who does not have a:

- Child and Adolescent Uniform Assessment in Closed Complete status, and
- **YES Waiver Clinical Eligibility** in **Ready for Review** or **Closed Complete** status.

Additionally, no IPC should be created for a participant who is not actively enrolled in Medicaid.

Reminder: Be sure to verify that a participant is currently enrolled in Medicaid prior to delivering services. If an IPC is created and submitted for a participant who is not currently enrolled in Medicaid for any reason, TMHP will not be able to provide an authorization number and the WPO will not be able to request payment for services provided.

Initial, Annual Renewal, and Revision IPC Document

To submit an **Initial**, **Annual Renewal**, or **Revision** IPC document:

1. Navigate to the **YES Waiver IPC Authorization** page by using the **Client Services** toolbar.
   a. Select Special Services Documentation.
   b. Select YES Waiver Services.
   c. Select YES Waiver IPC Authorization.
2. Once the IPC document is open, select the appropriate IPC Type from the list of options provided in the drop-down menu.
3. Enter the **Performed On** date. This date is the date services were agreed upon in the Child and Family Team meeting.
4. Enter comments in **Notes on IPC Type.** Comments should indicate any change to services.
5. The **Annual IPC Begin Date** and **Annual IPC End Date** will automatically populate to reflect CE Start and End dates.

   NOTE: If the **Initial** or **Annual Renewal** IPC is created before the CE

   document has been approved, this date will state "Waiting for YES Clinical Eligibility to be approved by DSHS"

6. The **Annual Total Summary For All Waiver Services** section will automatically populate to reflect the annual total billable amount of $35,804. **NOTE:** For **Initial** and **Annual Renewal** IPC documents, all other amounts should be "0.00" For Revision IPC documents, all other amounts will be updated to reflect estimated cost of services paid for and remaining balance.
7. Select **YES Provider Name** from the list of options provided in the drop- down menu.
8. Enter **YES Waiver Services: General** as needed

a. Select Edit next to the service requested. A text box will appear under the **Requested Units** column.

b. Enter the amount of requested units. The **Estimated Annual Cost** will update to reflect the request.

NOTE: Service request(s) should reflect the amount, type, and frequency of services agreed upon in the Child and Family Team meeting and documented on the Wraparound Plan of Care.

9. Enter **YES Waiver Services: Adaptive Aids and Support.** Refer to the IPC Service Request Process section for guidance.
10. Enter **YES Waiver Services: Minor Home Modification.** Refer to the IPC Service Request Process section for guidance.
11. Enter **YES Waiver Services: Transitional Services.** Refer to the IPC Service Request Process section for guidance.
12. Enter **Non-Waiver Services: Other Medicaid State Plan Services.** List services provided to the participant or to the LAR (for the benefit of the youth) that are paid through the Medicaid State Plan. Enter the total number of hours per year that the participant will likely receive the listed service. All participants should receive services for intensive case management.
13. Enter **Non-Waiver Services: Services Provided by Other Funding Sources.** List services provided to the participant or to the LAR (for the benefit of the youth) that are paid by non-Medicaid sources.
14. Complete **Treatment Team Signatures** section. Signatures should match the **Performed On** date. Refer to the Individual Plan of Care section for guidance.
15. Review **Annual Total Summary.** This has been updated to reflect the estimated cost of submitted units. The **Total Estimated Cost** should not exceed **Total Billable Amount.** If so, review and revise the IPC request.
16. Verify information is correct and that all requested units are documented. 17.Select **Ready for Review** from the options provided in the drop-down menu. 18.Select **Save.**

NOTE: Review the IPC to make sure that a **TMHP authorization number** has been received. Services should not be provided to a participant if the participant's IPC does not have a TMHP authorization number.

The **TMHP authorization number** should be generated within 24 hours after the IPC document has been approved by HHSC. When an **Annual Renewal** IPC is submitted early, the IPC will not generate an authorization number until after the participant's annual renewal period starts.

IPC Service Request Process

Adaptive Aids, Minor Home Modifications, Transitional Funding

Service requests for Flexible Funding cannot be submitted in CMBHS until they have been formally approved by HHSC.

To submit a request for Adaptive Aids and Supports, Minor Home Modifications, or Transitional Services funding:

1. Select **Edit** in the appropriate section: **Adaptive Aids and Supports**, **Minor Home Modifications**, or **Transitional Funding.**
2. Enter the total cost of the approved request in the **Unit Rate.** The

   Estimated Annual Cost will update to reflect the cost of the request.
3. The associated **Requisition Fee** will be automatically calculated at a pre- determined rate.
4. Enter comments in the **Justification Box.** Comments should include a brief justification of the approve request as well as the date of approval by HHSC.
5. Attach the approved request to the IPC.

NOTE: Request(s) for Adaptive Aids and Supports, Minor Home Modifications, or Transitional Funding may only be entered in CMBHS after formal approval by HHSC. Flexible Funding Forms can be found in Appendix B.

Transfer Process

The **Service Transfer Process** allows a YES Waiver participant to transfer their YES Waiver services to a new provider. A participant's services can be transferred if the participant has moved to a different LMHA/LBHA catchment area or if a participant chooses to change their Comprehensive Waiver Provider (CWP).

1. If the client has moved to a different Local Mental Health Authority (LMHA), this is considered a LMHA to LMHA transfer. The LMHA should follow the LMHA Transfer process.
2. If a client chooses a different service provider, this is considered a Comprehensive Waiver Provider (CWP) transfer. The LMHA should follow the CWP Transfer process.

LMHA Transfer Process

An LMHA to LMHA Transfer is a multi-step process that requires the submission of LMHA Transfer CE and IPC Transfer IPC documents in the following order.

1. LMHA Transfer Out

2. IPC Transfer Out
3. LMHA Transfer In
4. IPC Transfer In

Before beginning the transfer process, be sure to review the participant's Client Workspace. A transfer cannot be created for any participant who has an IPC or CE document in Draft or Ready for Review status.

NOTE: A participant's clinical eligibility cannot be transferred if they are not within

their current eligibility year.

LMHA Transfer Out

To begin the LMHA to LMHA transfer out process, first submit an **LMHA Transfer Out** CE document.

1. Navigate to the **YES Waiver Clinical Eligibility** page by using the **Client Services** toolbar.
   a. Select Special Services Documentation.
   b. Select YES Waiver Services.
   c. Select YES Waiver Clinical Eligibility.
2. Once the CE document is open, select the **LMHA Transfer Out** CE Type from the options provided in the drop-down menu. The CE document will auto- populate with information from the Initial CE and cannot be changed.
3. Enter the **Performed On** date. This date is the day of the last Child and Family Team meeting.
4. Enter comments in **Notes on Eligibility Type.** Include the name of the receiving LMHA, Wraparound Facilitator, and case manager, if known.
5. Select **Ready for Review** from the options provided in the drop-down menu.
6. Select **Save.**

Next, submit an IPC Transfer Out document.

1. Navigate to the **YES Waiver IPC Authorization** page by using the **Client Services** toolbar.
   a. Select Special Services Documentation.
   b. Select YES Waiver Services.
   c. Select YES Waiver IPC Authorization.
2. Once the IPC document is open, select the **LMHA Transfer Out** IPC Type from the list of options provided in the drop-down menu.
3. Enter the **Performed On** date. This date is the last date of services.
4. Enter comments in **Notes on Clinical Eligibility.** Comments should include the name of the receiving LMHA and the anticipated start date of services, if known.

5. Enter the **Annual IPC End** date. This date is the last date of services that will be provided to the participant.
6. Edit **YES Waiver Services: General.** Reduce all pre-approved YES Service Units to include only those services that the client will receive before the **Annual IPC End** date.

   NOTE: Include any services that have been provided but have not yet been billed through a service note. Do not include extra units that the client will not use before the **Annual IPC End** date.

7. Edit **YES Waiver Services: Adaptive Aids and Supports, Minor Home Modifications.** Revoke any requests that have been approved but not yet purchased.
8. Complete **Treatment Team Signatures** section. Signatures should match the **Performed On** date. Refer to the Individual Plan of Care section for guidance required based on CE type.
9. Verify all information is correct and units accurately reflect the participant's utilization.
10. Select **Ready for Review** from the options provided in the drop-down menu. 11.Select **Save.**

After the **IPC Transfer Out** has been approved and placed in **Closed Complete** by HHSC, create a **Discharge CANS.** The **Discharge CANS** will ensure that the receiving LMHA is able to transfer the client into their program.

LMHA Transfer In

To complete the transfer process, review the participant's **Client Workspace.** A CE cannot be created or submitted for a participant when:

- there is no mental health diagnosis at the LMHA location,
- there is no **YES CANS Assessment,**
- the client does not have an active **Child and Adolescent Uniform Assessment (6-17)** that is deviated to **LOC-YES**, and
- the previous CE and IPC are not in closed complete status.

To begin the transfer in process, first submit an **LMHA Transfer In CE** document.

1. Navigate to the **YES Waiver Clinical Eligibility** page by using the **Client Services** toolbar.
   a. Select Special Services Documentation.
   b. Select YES Waiver Services.
   c. Select YES Waiver Clinical Eligibility.
2. Once the CE document is open, select the **LMHA Transfer In CE** type from the options provided in the drop-down menu. The CE document will automatically populate with information from the Initial CE and cannot be changed.
3. Enter the **Performed On** date. This date is the date of the first in-person meeting with the participant and the LAR.

4. Select **Ready for Review** from the options provided in the drop-down menu.
5. Select **Save.**

Next, submit an **IPC Transfer In** document.

1. Navigate to the **YES Waiver IPC Authorization** page by using the **Client Services** toolbar.
   a. Select Special Services Documentation.
   b. Select YES Waiver Services.
   c. Select YES Waiver IPC Authorization.
2. Once the IPC document is open, select the **LMHA Transfer In IPC** type from the list of options provided in the drop-down menu.
3. Enter the **Performed On** date. This date is the date of the first in-person meeting with the participant and the LAR.
4. Enter comments in **Notes on Clinical Eligibility.** Comments should include the date the participant arrived at the LMHA.
5. Enter the **Annual IPC Begin Date.** This date refers to the first date of service.
6. Review the participant's **Annual Total Summary for All Waiver Services.** This section will reflect the participant's remaining billable amount for services.
7. Enter **YES Waiver Services: General** as needed.
8. Complete **Treatment Team Signatures** section. Signatures should match the Performed On date. Refer to the Individual Plan of Care section for guidance.
9. Review **Annual Total Summary.** This has been updated to reflect the estimated cost of submitted units. The **Total Estimated Cost** should not exceed **Total Billable Amount.** If so, review and revise the IPC request.
10. Verify information is correct and that all requested units are documented. 11.Select **Ready for Review** from the options provided in the drop-down menu. 12.Select **Save.**

Comprehensive Waiver Provider Transfer Process

A Comprehensive Waiver Provider (CWP) transfer requires the submission of an **IPC Outgoing Estimate** and an **IPC Incoming Estimate.** This section applies to LMHAs with more than one Comprehensive Waiver Provider.

First, submit an **IPC Outgoing Estimate IPC** document.

1. Navigate to the **YES Waiver IPC Authorization** page by using the **Client Services** toolbar.
   a. Select Special Services Documentation.
   b. Select YES Waiver Services.
   c. Select YES Waiver IPC Authorization.
2. Once the IPC document is open, select the **Outgoing Estimate IPC** type from the list of options provided in the drop-down menu.

3. Enter the **Performed On** date. This date is the last date of services.
4. Enter comments in **Notes on Clinical Eligibility.** Comments should include the name of the new CWP and the anticipated start date of services, if known.
5. Enter the **Annual IPC End Date.** This date refers to the last date of service.
6. Edit **YES Waiver Services: General.** Reduce all pre-approved YES Service Units to include only those services that the client will receive before the **Annual IPC End Date.**

   NOTE: Include any services that have been provided but have not yet been billed through a service note. Do not include extra units that the client will not use prior to the Annual IPC End date.

7. Edit **YES Waiver Services: Adaptive Aids and Supports, Minor Home Modifications.** Revoke any requests that have been approved but not yet purchased.
8. Complete **Treatment Team Signatures** section. Signatures should match the **Performed On** date. Refer to the Individual Plan of Care section for guidance.
9. Verify all information is correct and units accurately reflect the participant's utilization.
10. Select **Ready for Review** from the options provided in the drop-down menu. 11.Select **Save.**

After the **Outgoing Estimate IPC** has been approved and placed in **Closed Complete** by HHSC, a TMHP authorization number should generate on the IPC within 24 hours of IPC approval. An **Incoming Estimate IPC** cannot be created without this.

Next, submit an **Incoming Estimate IPC** document.

1. Navigate to the **YES Waiver IPC Authorization** page by using the **Client Services** toolbar.
   a. Select Special Services Documentation.
   b. Select YES Waiver Services.
   c. Select YES Waiver IPC Authorization.
2. Once the IPC document is open, select the **Outgoing Estimate IPC Type**

   from the list of options provided in the drop-down menu.

3. Enter the **Performed On** date. This date is the first date of service.
4. Enter comments in **Notes on Clinical Eligibility.** Comments should include the date the participant started services and services to be received.
5. Enter the **Annual IPC Begin Date.** This date refers to the first date of service.
6. Review the participant's **Annual Total Summary for All Waiver Services.** This section will reflect the participant's remaining billable amount for services.
7. Enter **YES Waiver Services: General** as needed.
8. Complete **Treatment Team Signatures** section. Signatures should match the **Performed On** date. Refer to the Individual Plan of Care section for guidance.

9. Review **Annual Total Summary.** This has been updated to reflect the estimated cost of submitted units. The **Total Estimated Cost** should not exceed **Total Billable Amount.** If so, review and revise the IPC request.

10. Verify information is correct and that all requested units are documented. 11.Select **Ready for Review** from the options provided in the drop-down menu. 12.Select **Save.**

Medicaid Eligibility Verification

The **Medicaid Eligibility Verification (MEV) Request** function in CMBHS is a data exchange process between TMHP and CMBHS that verifies a participant's Medicaid coverage.

Comprehensive Waiver Provider services cannot be billed when a participant is not actively enrolled in Medicaid. YES Waiver Claims cannot be submitted when a participant does not have a MEV request. The LMHA should review the client's MEV on a monthly basis before providing services.

Before creating an MEV request, review the participant's Client Profile to confirm:

- the participant has only one Medicaid Identifier listed in their profile, and
- the Medicaid Identifier is valid. A valid Medicaid Identifier will list a Begin Date and End Date.

NOTE: A Medicaid Identifier is considered valid when the number listed in CMBHS matches the Medicaid number listed in Texas Integrated Eligibility Redesign System (TIERS).

Submitting a MEV Request

To submit a **Medicaid Eligibility Verification** request:

1. Navigate to the **Medicaid Eligibility Verification** page by using the **Client Services** toolbar.
2. Select **Intake.**
3. Select Medicaid Eligibility Verification.
4. Enter the **Eligibility From Date.**
5. Enter the **Eligibility Through Date.**
6. Enter the **Client Information.**

   NOTE: If any information is wrong, update the client profile first. The MEV request will state "No Eligibility Segments Found" if the information in CMBHS does not match information found in TMHP.

7. Select **Submit.** A MEV document will be created in the Client Workspace once it has been processed by TMHP.

To review a Medicaid Eligibility Verification request, navigate to the **Client Workspace.**

YES Waiver Service Note

A **YES Waiver Service Note** documents services delivered to the participant. The YES Waiver Service Note checks treatment against what is on the participant's IPC. A YES Waiver Service Note is required for claims.

Before creating a **YES Waiver Service Note**, review the **Client's Workspace** to confirm the participant has a YES Waiver IPC authorized by TMHP.

To submit a **Service Note:**

1. Navigate to the **YES Waiver Service Provider Location.**
   a. Select **Account Management.**
   b. Select **Change Location.**
   c. Select **Provider Name** and location that ends with "YES Waiver Service Provider Location".
2. Navigate to the **YES Waiver Service Note** page by using the **Client Services** toolbar.
   a. Select Special Services Documentation.
   b. Select **YES Waiver Services.**
   c. Select **YES Waiver Service Note.**
3. Enter the **Service Date.** This is the date the YES Waiver service was provided.

   NOTE: The participant must have an authorized IPC.
4. The **Authorized IPC** will automatically populate to include IPC start and end dates.
5. Select the **Service Type** from the options provided in the drop-down menu. The options listed are based on the most recently authorized IPC.
6. Select the **Service Description** from the options provided in the drop-down menu.
7. The **TMHP Authorization number** will automatically populate to include the information from the authorized IPC.
8. Select the **Service Location** from the options provided in the drop-down menu.
9. Enter the **Start Time.**
10. Enter the **End Time.**
11. The **YES Waiver Service Note** will automatically populate the following fields based on start and end times:
    a. Duration
    b. Authorized Units
    c. Remaining Units

d. Service Units

e. Billing Unit

12. Enter comments in the **Comments** section as needed.

13. Select **Performed By** from the drop-down menu. This should be the provider who delivered services.

14. Select **Closed Complete** from the **Document Status.**

15. Select **Save.**

NOTE: Review the IPC to make sure that a TMHP authorization number has been received. Services should not be provided to a participant if the participant's IPC does not have a TMHP authorization number.

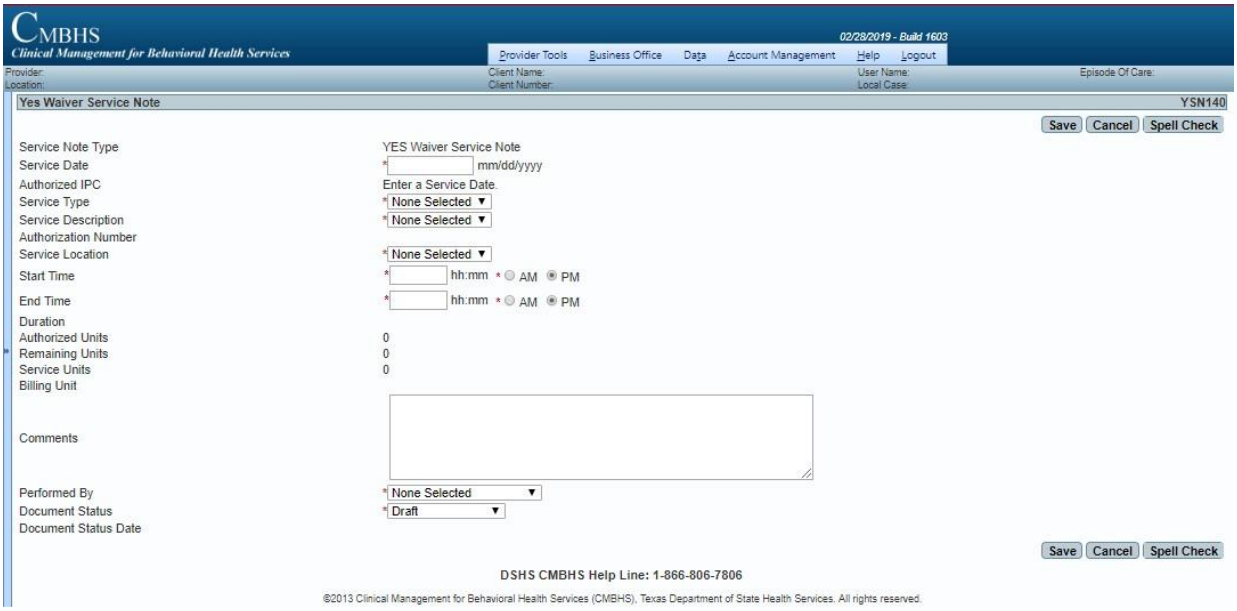

Figure 8 - YES Waiver Service Note

Glossary of Terms

Abuse—Abuse is mental, emotional, physical, or sexual injury to a child or person 65 years of age or older, or with disabilities failure to prevent such injury.

Activities of Daily Living (ADL)—Activities of Daily Living (ADL) means basic personal everyday activities, including but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

Appeal—A request for a review of an agency action, or failure to act, that may result in a fair hearing.

Appliances—Transitional funding can be used to purchase appliances such as a refrigerator, stove, washer, dryer, microwave oven, electric can opener, coffee pot or toaster if the participant identifies these appliances as needed items.

Centers for Medicare and Medicaid Services (CMS)—The Centers for Medicare and Medicaid Services (CMS) is the federal agency within US Health and Human Services responsible for administering Medicare and overseeing state administration of Medicaid. States submit a Medicaid state plan that serves as the contract between the state and CMS. CMS must approve the plan and any amendments to the plan. CMS also approves any waivers for which states can apply.

Child and Adolescent Needs and Strengths Assessment (CANS)—The Child and Adolescent Needs and Strengths (CANS) Assessment is a comprehensive multi- purpose tool developed for children's mental health services to support decision making. The Texas CANS Comprehensive serves as the psychosocial assessment, as well as a trauma screening and suicide screening tool, for all youth entering community mental health services in Texas. In addition, the Texas CANS Comprehensive is used to determine eligibility for community mental health services in Texas.

Child and Family Team (CFT)—A group of people—chosen with the family and connected to them through natural, community, and formal support relationships— who develop and implement the family's plan, address unmet needs, and work towards the family's vision within Wraparound.

Cleaning Supplies—Transitional funding can be used to purchase basic cleaning supplies such as a mop, broom, vacuum, brushes, soaps and cleaning agents required for the household.

Clinical Eligibility (CE) Year—A 12-month period of time starting on the date an authorized initial or renewal IPC begins.

Complaint—Any dissatisfaction with a service or provider regarding the quality of care an individual is receiving. When a complaint is made against a service provider, HHSC will reach out to the LMHA or CWP.

Community First Choice (CFC)—Community First Choice (CFC) is a federal option that allows states to provide home and community-based attendant services and supports to Medicaid recipients with

disabilities. To be eligible, an individual must require an institutional level of care. Individuals can receive CFC services and keep their spot on an interest list or continue to receive services in a waiver program.

CFC services must be provided in community-based settings.

Comprehensive Waiver Provider (CWP)—The Comprehensive Waiver Provider (CWP) is an entity contracted with HHSC who is responsible for delivering the YES Waiver Service Array to eligible and enrolled YES Waiver participants.

Critical Incident—A critical incident is an actual or alleged event which creates a significant risk of serious harm to the health or welfare of a participant. Critical incidents also include any incident which creates a significant risk of serious harm to others by a participant.

Deposit—Transitional funding may pay deposits, which include security deposits for residential leases and household utilities. All deposits must be in the participant's name.

Electronic Visit Verification (EVV)—Electronic Visit Verification (EVV) is a computer-based tracking system that electronically verifies the occurrence of personal attendant service visits by documenting the precise time a service delivery begins and ends.

Essential Furnishings—Household items that, if absent, would pose a barrier to the participant's transition into the community. This may include furniture, appliances, housewares and cleaning supplies.

Exploitation—Exploitation is misusing the resources of a person 65 years or older or an adult with disabilities for personal or monetary benefit. This includes taking Social Security or SSI (Supplemental Security Income) checks, abusing a joint checking account, and taking property and other resources.

Fair Hearing—An informal proceeding held before an impartial Health and Human Services hearings officer in which a client appeals an agency action.

Furniture—Transitional funding can be used to purchase furniture such as a bed, couch, or dining table if the participant's place of residence does not have the needed furniture and the absence of the item prevents the transition into the community.

Good Faith Effort—A minimum of two phone calls and two letters within a 60-day period.

Health Insurance Portability and Accountability Act (HIPAA)—The Health Insurance Portability and Accountability Act of 1996 (HIPAA) establishes standards for the privacy and security of health information as well as standards for protecting health information transmitted electronically. For more information, visit hhs.texas.gov/laws-regulations/legal-information/hipaa-privacy-laws

Household Utilities—Transitional funding can be used to pay for utility deposits to establish accounts in the participant's name or to pay for arrears on previous utilities if the account is in the participant's name and they

will not be able to get utilities unless the previous balance is paid. Transitional assistance cannot be used for payment toward utilities.

Housewares—Transitional funding can be used to purchase basic housewares such as pots, pans, dishes, silverware, cooking utensils, linens, towels, a clock, and other small items required to set up the household.

Individual Plan of Care (IPC)—The Individual Plan of Care (IPC) is a document within CMBHS which is used to request YES Waiver services.

Inquiry Line—A dedicated phone line with voicemail that every Local Mental Health Authority/Local Behavioral Health Authority (LMHA/LBHA) is required to maintain to receive calls from individuals interested in accessing services through the YES Waiver.

Inquiry List—An HHSC template that is used to document inquiries made to the YES Waiver inquiry line.

Legally Authorized Representative (LAR)—A legally authorized representative (LAR) is any person who is authorized by law to act on behalf of an individual, including but not limited to, a parent, guardian, managing conservator, or medical consenter.

Level of Care (LOC)—A determination given to an individual by HHSC as part of the eligibility determination process based on data submitted on the Child and Adolescent Needs and Strengths (CANS) Assessment.

Local Mental Health Authority/Local Behavioral Health Authority (LMHA/LBHA)—Local Mental Health Authority/Local Behavioral Health Authority (LMHA/LBHAs), also referred to as community mental health centers, provide community mental health services to eligible individuals.

Managing Conservator—Any person appointed for a minor in accordance with state law.

Medical Consenter—A Medical consenter is any person who is authorized to make medical decisions for children in the legal custody of the Texas Department of Family and Protective Services (DFPS). This includes foster parents, case managers for child placing agencies, professional staff of emergency shelters, cottage parents, relative and kinship caregivers, and certain DFPS staff and youth medical consenters.

Medicaid Eligibility Verification Request (MEV Request)—The Medicaid Eligibility Verification (MEV) Request function in CMBHS is a data exchange process between TMHP and CMBHS that verifies a participant's Medicaid coverage.

Neglect—Neglect of a child includes failure to provide a child with food, clothing, shelter, and or medical care and or leaving a child in a situation where the child is at risk of harm.

Ombudsman for Behavioral Health—The Ombudsman for Behavioral Health serves as a neutral party to help consumers, including consumers who are uninsured or have public or private health benefit coverage, and behavioral health care providers navigate and resolve issues related to consumer access to behavioral health care, including care for mental health conditions and substance use disorders.

Protected Health Information (PHI)—Protected health information is individually identifiable health information in any form that is created, received, maintained or transmitted by a HIPAA-covered entity, and relates to a person's healthcare condition, provision of healthcare, as further described in the HIPAA privacy rule.

Residential Leases—Transitional funding may be used to pay for security deposits as a one-time expense and the amount may be no more than the equivalent of two months' rent. Transitional funding may not be used to pay rent.

Residential Treatment Facility—Residential Treatment Centers are regulated by DFPS to provide placements and services to youth who require specialized services.

School Health and Related Services (SHARS)—The School Health and Related Services (SHARS) program reimburses independent school districts, including public charter schools, for providing Medicaid services to children with disabilities. This program covers certain health-related services documented in a student's Individualized Education Program. Services include audiology services, counseling, physician and nursing services, physical, speech, and occupational therapies, personal care services, psychological services, including assessments, and transportation in a school setting.

Serious Emotional Disturbance (SED)—A serious emotional disturbance (SED) is a term used in reference to children under the age of 18 with a diagnosable mental health problem that severely disrupts their ability to function socially, academically, and emotionally.

Service Claim—A request submitted by a program provider to be paid by HHSC YES Waiver for a service rendered.

Service Note—A YES Waiver Service Note documents services delivered to a YES Waiver participant. A YES Waiver Service Note is required to submit a claim.

Texas Department of Family and Protective Services (DFPS)—The Texas Department of Family and Protective Services (DFPS) is responsible for investigating charges of abuse, neglect or exploitation of children, elderly adults and adults with disabilities. DFPS also manages children in state conservatorship, or foster care.

Texas Medicaid & Healthcare Partnership (TMHP)—The Texas Medicaid & Healthcare Partnership (TMHP) administers Texas Medicaid and other state healthcare programs on behalf of HHSC.

Texas Medicaid State Plan—The Texas Medicaid State Plan, also known as the State Plan, serves as the contract between Texas and Centers for Medicare and Medicaid Services (CMS). The state plan describes the scope of the Medicaid program, including administration, eligibility, benefits, and provider reimbursement.

Transition Age Youth (TAY)—Transition age youth are young adults between the ages of 16 and 24 who have persistent mental health needs. Eligibility for Transition Age Youth mental health services is limited to young adults between the ages of 16 to 20.

Trauma Informed Care (TIC)—An approach to the delivery of behavioral health services that includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. TIC involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic.

Voluntary Disenrollment—Voluntary disenrollment are cases in which participants, or their legally authorized representative, choose disenrollment from the waiver.

Wraparound—Wraparound is a planning process that follows a series of steps to help children and their families realize their hopes. Additional resources can be found at the National Wraparound Initiative.