FY2026

Provider Policy and Procedure Manual

Mental Health Recovery Board

Serving Warren & Clinton Counties

Promulgation

These policies supersede all previous written Service Provider Policies and Procedures issued by the Mental Health Recovery Board Serving Warren and Clinton Counties (MHRB). In the event there is a conflict between the matters expressed in this manual and any other applicable laws or requirements, the applicable law or requirement shall prevail.

The contents of this manual are presented as a matter of information only and do not and are not intended to create any contractual obligations on the part of MHRB.

These policies and procedures are subject to change. If the policies and procedures are changed, MHRB will notify contracted providers in the manner and means it deems appropriate. Thereafter, each provider is expected to read and understand changes to policy, and follow the guidelines and processes set forth in the new or revised policy.

These policies and procedures were reviewed and if necessary, revised for Fiscal Year 2026.

The Service Provider Policies and Procedures Manual for Fiscal Year 2026 is hereby adopted and effective on July 1, 2025.

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Policy and Procedure Manual Change Log

Version	Date	Policy	Changes
FY26 v1.00	7/1/2025	Overall	• Revised document to have consistent branding and presentation • Modified policies to be in one document instead of multiple
		1-2	• Updated based on current poverty level data • Removed exemption from the collection of income documents for individuals who are enrolled as SED or SPMI
		1-3	• Modified name of the policy to be "Pre-Authorization for Service" • Added that a clinical reviewer will notify agency if supporting documentation is needed • Added SED Residential authorization to form
		1-6	• Formatting Changes to Attachment 1
		1-9	• Added details on Service to Minors • Added details on Therapeutic Mentoring • Removed Vocational Services • Added details on SED residential placement
		1-13	• Removed line stating that the procedure is approved by OhioMHAS
		1-14	• New Policy
		2-2	• Updated housing matrix
		2-4	• Added time limit of 18 months • Added language on individuals with no income
		2-5	• Eliminated Monthly Stipend
		2-6	• Added timeframe for DLA-20
		2-7	• ACT Service Authorization Policy eliminated
		2-8	• Removed "those who need case management" from SPMI definition to reduce confusion • Removed ICM-2 • Adjusted to be policy 2-7 after the elimination of the ACT Service Authorization Policy that was eliminated
		3-1	• General revisions based on crisis system evaluation
		3-5	• Modified based on services provided by probate monitor • Modified language based on "advise and coordinate"
		3-6	• Removed requirement for notification for outpatient restoration or maintenance of competency
		3-7	• Changed "crisis agency" to "provider agency"
		5-1	• SED Residential Placement policy eliminated and included in the Pre-Authorization for Services Policy • Replaced with SED Respite Funds policy • Removed MHRB Liability Waiver requirement from SED Respite Funds policy
		5-2	• Moved to Policy 5-1
		5-3	• Eliminated policy due to MRSS funding and requirements being provided by OhioMHAS
		5-4	• Eliminated policy and included information on services for minors in Policy 1-9
		6-1	• Added language that requirements in the provider responsibilities documents must be followed.

Continuum of Care Overview

Mental Health Recovery Board Serving Warren and Clinton Counties (MHRB) is a governmental entity responsible for planning, funding, monitoring and evaluating services and programs for residents with serious mental and emotional disorders and substance addiction in our jurisdiction (as defined in ORC 340.03). Funds for services come from various sources including the federal and state government, grants, and our local levy.

Mission Statement

The Mental Health Recovery Board Serving Warren and Clinton Counties supports a healthier community by investing in a system of mental health and substance use disorder services for the people of our counties.

Core Values

- **Stewardship.** We are efficient and ethical in using resources and are good stewards of the public's money.
- **Transparent.** We are open and honest with our community and those we serve.
- **Accountable.** We are responsible for our words, our actions, and our results.
- **Quality.** We are continuously learning, improving, and implementing best practices to address needs.
- **Responsive.** We are proactive and agile in meeting ever-evolving behavioral health needs.
- **Collaborative.** We are invested in partnering to maximize impact.
- **Equity.** We are fair and inclusive, respecting the lived experience of all people

Vision Statement

We will be transformative in our approach to the practice of behavioral health.

Strategic Goals

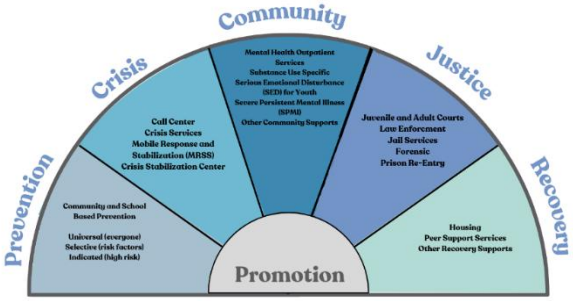
1. Maintain and enhance the trust and investment of the community, stakeholders, and providers in the Board's mission.
2. Increase investment in prevention strategies including expanding to targeted populations and topics.
3. Focus on continuous improvement of the crisis service system to better serve those in need.
4. Enhance and expand system partnerships.
5. Demonstrate fiscal responsibility while identifying ways to use funds to support new, innovative strategies.

Service Philosophy

Mental Health Recovery Board Serving Warren and Clinton Counties is committed to provide a full continuum of care to the residents of our service area. As financially feasible, this includes levels of treatment to Severely and Persistently Mentally Ill (SPMI), Seriously Mentally Ill (SMI), Youth with Serious Emotional Disturbance (SED), Mental Health Outpatient Program (MHOP) Clients and those suffering from substance use disorders (SUD). This is also extended to prevention and recovery support services in the areas of mental health, substance abuse, and problem gambling. Services will

be provided in various community settings and in collaboration with a multitude of systems in order to best meet the needs of the clients.

MHRB continues to address the full continuum of care in planning for FY26 services. For many years, the Institute of Medicine protractor model, was used to show four categories (Promotion, Prevention, Treatment, Recovery) that make up our system of care and the interaction between them.



However, in practicality we had put contracts and services into the service plan categories of Prevention, Community, Crisis, Justice, and Recovery. For FY26, we have moved to using the service plan categories in our planning and budget presentation, which does a much better job of demonstrating the investment into the local crisis system and criminal justice system.

The FY26 goals of Mental Health Recovery Board Serving Warren & Clinton Counties are to:

- Understand our system of care
- Meet the requirements of ORC 340.32
- Establish a sustainable, fiscally responsible budget, and
- Assure a stable reserve.

To reach our goals, the following objectives have been implemented:

- Apply principles identified in the MHRB Prioritization of Services White Paper
- Continue a system-wide service evaluation to determine return on investment
- Adjust grant-funded positions to be based on cost reconciliation
- Right-sizing contracts
- Discontinuing or modifying programs with low output or beneficial outcomes
- Develop partnerships with other entities to maximize resources

Populations and Services

MHRB has established the following populations and services for Warren and/or Clinton County residents:

Prevention and Community Education

- Who: Early childhood, elementary, middle school and high school aged youth and their families as well as small businesses, colleges and the community-at-large are included in the target population for this level of service. The population may include a range of people from infancy to elderly age groups. Prevention and community education services shall be based upon needs assessment and delivered to a population according to identified priorities.
- What: Preventive services and community education are focused on reducing the likelihood of mental, emotional, and behavioral (MEB) disorders within the general population. A variety of services and strategies can be utilized and are outlined in the Ohio Administrative Code.

- When: Services are typically available during regular business hours.
- Where: These services will largely be provided in community and school settings to best meet the needs of the target population. Some limited services may also be conducted in the clinical setting.

Outpatient Substance Use Disorder Treatment

Standard Outpatient Alcohol and Drug Program

- Who: Adults, adolescents, and families with a primary diagnosis of a substance use disorder (SUD), Individuals with a primary or secondary diagnosis related to problem gambling, and/or Individuals with Co-occurring (SUD and MH) Disorders.
- What: Outpatient Services begin once a client is admitted into services following an assessment. Once admitted the following services or combination of services may be provided; Group, Individual Counseling, Medication-Assisted Therapy, Crisis and/or Case Management. Peer Services are also available.
- When: Services may be provided in the day or evening to accommodate work schedules
- Where: These services may be office based or provided in the natural environment.

Intensive Outpatient Alcohol and Drug Program

- Who: Adults, adolescents and families with a primary diagnosis of a substance use disorder (SUD), Individuals with a primary or secondary diagnosis related to problem gambling, and/or Individuals with Co-occurring (SUD and MH) Disorders.
- What: Intensive Outpatient Service means structured individual and group alcohol and drug addiction activities and services that are provided at a certified treatment program site for a minimum of eight hours per week with services provided at least three days per week.
    - Intensive outpatient services shall include the following services:
    - Assessment
    - Individual counseling
    - Group counseling
    - Crisis intervention as needed
    - Peer Services as needed
- When: Services may be provided in the day or evening to accommodate work schedules.
- Where: These services may be office based or provided in the natural environment.

SUD Residential

- Who: Adults, adolescents and families with a primary diagnosis of a substance use disorder (SUD), Individuals with a primary or secondary diagnosis related to problem gambling, and/or Individuals with Co-occurring (SUD and MH) Disorders who meet ASAM level of care for Community Residential
- What: Community Residential Services
- When: 24/7
- Where: Women with Medicaid may contact any residential facility certified by Ohio MHAS to interview for placement. Additionally, women may be assessed by a provider organization for

a referral to Women's Recovery Center in Xenia, Ohio. Services are also available at Sojourner Residential Services in Franklin, Ohio.

Mental Health Outpatient Program:

- Who: The target population of this service plan is:
  - Children exhibiting behavioral evidence of mental health issues and their families.
  - Adolescent age youth exhibiting mental health disturbances, or those at high risk of substance abuse/dependency and/or mental health disturbances as indicated by familial, vocational, medical difficulties, juvenile court involvement or school disciplinary actions.
  - Adults exhibiting mental health issues as indicated by familial, vocational or medical difficulties, judicial or law enforcement involvement.
  - Special populations which may be seen through this service level include, but are not limited to, older adults, pre-school aged children, dually diagnosed individuals with mental health and development disability diagnoses.
- What: Mental Health Outpatient Treatment is defined as mental health services such as mental health assessment, behavioral health counseling & therapy, family counseling, and pharmacologic management (see OAC 5122-29 for definitions of each) provided on a short-term basis or less intense duration/frequency as deemed medically necessary by the mental health assessment.
- When: Services are available during regular business hours.
- Where: Services will be provided primarily in a mental health clinic environment or could be provided within partner agencies/entities (i.e., job training centers, schools, senior citizens centers) as deemed necessary

Severely and Persistently Mentally Ill (SPMI)/Seriously Mentally Ill (SMI):

- Who: The SMI/SPMI population is defined as 18 years or older that has a DSM 5 TR diagnosis lasting over 6 months and may have a history of psychiatric hospitalization. The following diagnoses are excluded:
  - Developmental disorders
  - Substance related disorders
  - Dementia or other physical conditions that mimic mental health conditions
- What: Services for the Seriously Mentally Ill and the Severely and Persistently Mentally Ill (SMI/SPMI) provides a continuum of services to enable the highest level of functioning and independence possible. Each individual is to reside in the least restrictive setting possible. The services necessary to support individuals in achieving these goals include, but are not limited to case management, individual/group therapy, psychopharmacological services, vocational linkage services, peer services, housing, residential group home setting, and hospitalization. There are additional services that address the needs of those involved in the criminal justice system, probate system, or are forensic clients.
- When: Services are available during regular business hours with some available around the clock 365 days per year.
- Where: Each individual is to reside in the least restrictive setting possible. Services will be provided in a mental health clinic environment but can also be conducted in community settings to best meet the needs of the clients.

Youth with Serious Emotional Disturbances (SED):

- Who: The target population of this service plan is youth identified with Serious Emotional Disturbance in accordance with OAC 5122-24-01. Waiver criteria of SED definition may be established and stipulated in the Community Collaborative plan addressing SED clients each fiscal year as deemed necessary and appropriate.
- What: SED Services are defined as mental health services such as mental health assessment, behavioral health counseling (individual, group), consultation (client specific), community psychiatric support treatment (individual and group), pharmacological management, and intensive home-based treatment. This service will provide necessary mental health services in sufficient quantity to meet the needs of the identified population. Family Peer Services as well as Respite/Family Bonding/Community Integration services are available for select clients/settings and available through the Recovery Plan.
- When: Primarily, services are available during regular business hours with some available on-call depending upon the intensity of the level of care.
- Where: Services will be provided in a mental health office environment but can also be conducted in community settings to best meet the needs of the clients. These levels/environments can include:
    - Office-Based Services
    - School-Based Services
    - Home Based Services
    - Intensive Home-Based Treatment (in accordance with OAC 5122-29-28)

Crisis Services

Emergency & Crisis Services

- Who: Crisis Services are a community safety net for any Warren/Clinton County resident of any age who is experiencing a crisis that places them at risk to self-harm, at risk to harm others, or a situation that excludes them from being able to care for themselves as to minimum daily needs. Mobile Response and Stabilization Services will be provided to youth aged 20 and under for any crisis situation as defined by the youth, family or referral source.
- What: Crisis services include hotline services (1-877-695-6333), crisis text line, face to face assessment, short term brief therapy, MRSS Peer services, and follow up subsequent to the crisis event.
- When: Services are available around the clock 365 days per year.
- Where: Hotline services are available via phone. Face to face assessments are at designated triage sites as well as homes, schools, and other sites in the community as requested by the individual, family or referral source. Short term brief therapy is available in the mental health office environment. Telehealth approaches may also be used within this program, if clinically appropriate.

Detoxification:

- Who: Adults with a primary diagnosis of substance use disorder (SUD) and in need of that level of care, based on complete diagnostic assessment.

- What: Detoxification is the process of removing toxic substances in a supervised setting which can be classified as ambulatory or residential depending on the needs of the individual in care, this is part of the MAT continuum.
- When: Services typically will be 3-5 days in a residential, supervised setting.
- Where: MHRB has service agreements in place with Beckett Springs, but referral will take place at completion of assessment with the crisis team, Hopeline and local provider staff at their offices or as an extension of crisis services, consumer would need to arrange transportation to get to the detoxification provider facility.

Risk Management - Hospital:

- Who: Any resident of Warren County or Clinton County
- What: Acute psychiatric hospitalization
- When: 24 hours per day
- Where: Summit Behavioral, and, for youth, any appropriate/available hospital through an Ad Hoc contract

Recovery Supports

Peer Services

- Who: Individuals from Warren and Clinton counties in a designated service plan (SPMI, SED, or SUD). Individuals who have or are at risk of behavioral health issues who are involved with partner agencies (jail, homeless shelter, etc.).
- What: Mental Health, SUD and Family Peer Support services.
- When: Services are typically available during regular business hours.
- Where: Eligible clients can receive services in the community, at school, treatment agencies, homeless shelters, jail setting, etc.

Vocational Linkage Service (Vocational)

- Who: Individuals from Warren and Clinton counties in a designated service plan (SPMI, SED, or SUD) of employment age receiving MHRB services.
- What: A continuum of vocational linkage and referral services that are responsive to the clients' diverse needs.
- When: Services are typically available during regular business hours.
- Where: Eligible clients can receive services in the community or in a jail setting.

Youth Short-term Residential

- Who: SED clients being currently served in the MHRB system, are not eligible for FCFC Service Coordination services and pooled funding/shared funding, and are not in the custody of an agency
- What: Short-term residential services
- When: 24 hours per day
- Where: An appropriate, licensed residential facility to meet the client's needs

Housing

- SPMI clients and Transitional Age Youth enrolled in the SED Plan (aged 18-21 years) engaged in services through MHRB, SUD clients in Recovery
- What: Housing based on Housing Matrix's Level of Care and Recovery Housing at designated locations
- When: As required by circumstance
- Where: Various locations throughout Warren County and Clinton County, and out of county locations as needed

SERVICE DELIVERY

Recovery-Oriented System of Care (ROSC)

MHRB embraces a ROSC which is built upon a framework in which a coordinated system ensures local entities offer community-based mental health and addiction prevention and wellness programs; treatment services; and recovery supports. These programs and services are established on strengths, incorporating a coordinated and collaborative approach across the community. A ROSC ensures access to a full continuum from prevention through recovery supports designed to help individuals and families achieve and sustain long-term health and recovery while also helping communities become healthy, safe, and drug-free.

ROSC is a coordinated network of community-based services and supports that builds on the strengths and resiliencies of individuals, families, and communities to achieve improved health, wellness, and quality of life for those with or at risk of mental illness or substance use disorders. By design, a ROSC provides individuals and families with more options to make informed decisions regarding their care. Services are designed to be accessible, welcoming, and easy to navigate. The fundamental value of a ROSC is the involvement of people in recovery, their families, and their communities to continually improve access to and quality of services. MHRB expects provider agencies to deliver services consistent with a ROSC.

Best Practices/Best Processes

Providers are expected to identify and provide evidence-based best *practices* in service delivery. There are a number of programs and strategies identified as best or promising practices with varying degrees of research, field recognition, and published practice guidelines. The Institute of Medicine's definition of Evidence Based Practices is: "therapeutic practices that maximize three core principles:

- They are supported by the best research evidence available that links them to desired outcomes
- They require clinical skill and expertise to select and apply a given practice appropriately
- They must be responsive to the individual desires and values of consumers, including a consideration of individual problems, strengths, personality, sociocultural context, and preferences" (Institute of Medicine, 2001).

"Best practices" generally share a similar set of criteria including: customer orientation, clinical excellence, continuity, integration and stewardship of funds. The provider's choice of service

approach(es) should also take into consideration the cultural background, trauma history, and/or disorders commonly seen in this level of care to ensure applicability and effectiveness.

Providers are expected to also identify and provide evidence-based *processes* in service delivery. Best processes cut across program models and focus on the processes occurring between the service recipients and practitioners. Best processes generally share the values embraced by Recovery & Resiliency including self-determination, involvement, respect, hope, outcome orientation, and functioning.

Staff Expectations

The provider's staff will supply any information or education relevant to the needs of the person served to the client and/or family. This can include, but not limited to, information on medical, housing, mental health, alcohol and other drug issues, relationships, and life skills. This information can be conveyed in various mediums but should be sensitive to the diversity of the client.

Likewise, the provider staff should facilitate referrals, linkages and coordination with other involved internal and external service providers (with appropriate consent) to maximize the benefit of the program. This can include, but not limited to, other programs within the provider's organization, other behavioral health providers, educational/vocational/housing providers, community service organizations, child welfare system, legal entities (juvenile justice, law enforcement, probation/parole, courts and corrections system). Linkages will be made, as needed on a client-by-client basis, to community support systems. This can include, but not limited to, peer services, local advocacy groups, consumer/survivor/former client groups, self-help groups, and any other viable avenue of support.

Policy 1-1: Client Financial Eligibility Determination

Effective Date: 8/26/13
Last Revised Date: 7/1/23
Lead Staff: Dustin Ratliff

Policy

The Patient Protection and Affordable Care Act, Subtitle F: Shared Responsibility for Health Care - Part I: Individual Responsibility - (Sec. 1501, as modified by section 10106) states: "Requires individuals to maintain minimal essential health care coverage beginning in 2014. Imposes a penalty for failure to maintain such coverage beginning in 2014, except for certain low-income individuals who cannot afford coverage, members of Indian tribes, and individuals who suffer hardship." While the Tax Cuts and Jobs Act of 2018 eliminated the penalty beginning in 2019, the mandate for coverage remains.

Therefore, individuals should first access all possible insurance coverage for which they are eligible, including private insurance, Medicare and Medicaid. It is the obligation of the Provider to bill all client insurances, even if out of network. MHRB is the payor of last resort.

Procedures

It is expected that the Provider will adhere to the following Best Practices for serving uninsured clients.

1. Assistance with Application: Uninsured individuals should be prompted to enroll in Medicaid and/or Health Exchange. The process should be as follows:

    a. Agency evaluates client's financial status and insurance status.

    b. If eligible for Medicaid, assist client with application for Medicaid. If ineligible for Medicaid and Health Exchange is open or there has been a Qualifying Event, assist client with completing enrollment on the Health Exchange.

    c. "Assist" means providing staff to help client to complete the application as determined by the needs of the client.

    d. Materials to be provided (as applicable for the individual):

        i. Information on Health Exchange
        ii. List of Qualifying Events for Health Exchange outside of open enrollment times
        iii. Medicaid Application
        iv. MHRB Benefits information

    e. Uninsured individuals should be prompted to enroll in Medicaid and/or Health Exchange:

i. At admission or prior to admission if possible.
ii. However, if the person is seen "in crisis" this can occur at the next contact.

2. Fee agreement

    a. For all individuals at admission, apply SFS and write Fee Agreement accordingly.

    b. If an individual fails to provide all information required to determine eligibility for the Sliding Fee Scale subsidy within 30 days from the date of service, the individual will automatically be disqualified for the subsidy and he/she will be considered 100% self-pay.

3. Chart Documentation for uninsured.

    Information to be documented in chart regarding applying for Medicaid and/or Health Exchange should include efforts made to assist individual and date. Such efforts could include, but not limited to, the following:

    - Provided written information to individual on how to apply for benefits
    - Verbally explained the application process for benefits
    - Accompanied individual to Job and Family Services to apply for benefits
    - Assisted individual with the completion of the application form for benefits
    - Assisted individual with completion of online application
    - Accompanied individual to Job and Family Services/Human Services for interview
    - Instructed/Assisted client in collecting necessary documentation for benefit application/interview
    - Followed up with client after interview on next steps

4. Re-opening of Health Exchange

    Uninsured clients (ineligible for Medicaid) should be prompted to enroll when the Health Exchange is about to re-open, including but not limited to, providing information about how to enroll. Depending upon the client's needs, assistance with the enrollment process may also be warranted.

5. Follow-up on Applicants for Medicaid/insurance

    a. The agency may consider doing the following as follow-up on application for Medicaid and/or Health Exchange:

        i. Checking JFS Portal – monthly after application
        ii. Contacting JFS for status update – monthly after application
        iii. Check with client regarding status – at each session

    b. Documentation in the chart should be present on all efforts to assist with application and follow-up.

6. If the uninsured client secures coverage, the following information shall be updated immediately:

a. SmartCare enrollment information
b. Fee Agreement

7. All services are subject to MHRB non-Medicaid caps as defined in the Benefit Rules.

8. Staff Training

   It is the duty of the Provider to train their staff in:

   a. Eligibility for MHRB funding for uninsured applicants/clients
   b. Basic Eligibility guidelines for Medicaid and Health Exchange
   c. Appropriate documentation of assistance and follow up with application for insurance

Policy 1-2: Sliding Fee Subsidy Program

Effective Date: 8/26/13
Last Revised Date: 7/1/25
Lead Staff: Dustin Ratliff

Policy

MHRB strives to make behavioral healthcare accessible and affordable to Warren and Clinton County residents. As resources are available, MHRB will contract with providers to supply behavioral health services on a sliding fee scale to adults and children who would otherwise be unable to afford them.

The Sliding Fee Subsidy program allows adults and children who are un-insured or under-insured to receive behavioral healthcare services free or at a reduced cost. Ability to pay is determined by a client's household income and family size according to the United States Health and Human Services (HHS) Federal Poverty Guideline (FPG). Clients with household income at or below 250% of the FPG may receive outpatient clinical services at no cost. Clients with household income between 250%-400% of the FPG may be eligible for a subsidy based on their monthly income and number of dependents.

The Sliding Fee Subsidy program is applicable to clients participating in clinical services under the Community Service Collaboration plan, including Mental Health Outpatient Program, SUD Outpatient, SPMI, and SED. However, the Sliding Fee Scale will be waived for individuals in the SPMI and SED Plans. See Policy 1-9 for any other exceptions. Under all service collaboration plans, individuals should first access all possible insurance coverage for which they are eligible, including private insurance, Medicare and Medicaid. **It is the obligation of the Provider to bill third party payors whether in or out of network and MHRB will remain the payor of last resort.**

To be eligible, the client must be a resident of Warren or Clinton counties as defined in the SmartCare residency guidelines and in Policy 1-4 Member Residency Determination. The MHRB Residency Verification Form shall be used to verify the county of residence in addition to obtaining other supporting documentation.

The availability of MHRB's subsidy for clients (including waiver of sliding fee scale) is contingent upon funding from state, federal and local sources and is limited to the provider's MHRB contract allocation for each designated service collaboration plan. The contract defines the amount of public funds administered through MHRB, which may be available to the provider for services billed for enrolled clients along with any other reimbursement stipulations.

Procedures

1. Annually, MHRB will update the sliding fee scale table based upon the most recently published HHS FPG. This fiscal year's table will be an attachment to the Sliding Fee Subsidy Program Policy & Procedure #1-2.

2. It is the provider's duty to make all reasonable efforts to obtain reimbursement from third party payors. These third-party payors shall be billed based on the full amount of fees and payments for such services without application of any discount or subsidy. The Sliding Fee Scale shall be applied after any other applicable payment adjustments. This includes 3rd party payments but also

uncovered adjustments (i.e., the difference between the billed rate and the contract rate if the billed rate is higher than the contract rate). As applicable, the billing order shall be as follows:

a. Third Party Payors

i. Medicare/Private Insurance
ii. Medicaid/SCHIP

b. Self-Pay (which shall include any Health Reimbursement Account or Health Spending Account)

c. MHRB subsidy

3. Clinical Providers shall adhere to the Billing Requirements section of Provider Contract for Services when serving an individual who meets the basic qualifications under Ohio Department of Job and Family Services for Ohio's Medicaid coverage.

4. If the client has no known source of income and is not eligible for Medicaid, the provider shall include in the client record a copy of the official ODJFS denial documentation and the source of basic living items (i.e., food, shelter, clothing). The provider shall make referrals to resources, as necessary.

5. A Health Reimbursement Account (HRA) and/or a Health Spending Account (HSA) could be used to cover charges not reimbursed by insurance (i.e., unmet deductible, co-pays, uncovered services).

6. The Provider will work with client and other community partners (Children Services, Court, etc.) to collect self-pay balances due by client after the sliding fee subsidy has been applied. Uncollected self-pay balances (bad debt) cannot be billed to MHRB.

8. The Provider will create a Sliding Fee Scale Application Form which documents client information for the purposes of determining eligibility for the subsidy. The application must include the items as noted on the attached "required components of application listing," however, the design of the form is to the discretion of the provider.

9. It is the duty of the Provider to document in the client chart eligibility for the Sliding Fee Scale Subsidy. To do so, an individual will be required to:

a. Complete a Sliding Fee Subsidy Application Form

b. Provide household income, defined as "gross income earned from all persons residing within the home as reported to IRS as exemptions on the most recent federal tax return" and may include:

- Wages
- Social Security, SSDI, SSI
- Annuities/pension payments
- Dividends, interest
- Veteran's Pension/Compensation

- Alimony
- Net income from Business/Farm
- Unemployment Compensation
- Rental Income
- Other sources of taxable income
- Worker's Compensation – Permanent Total Disability
- Gifts or inheritances in excess of $10,000 annually
- Child Support

Excluded from income shall be:

- Income earned by minors <18 years old
- Food stamps, Aid to Dependent Children (ADC)
- Bank withdrawals
- Student benefits
- Rebates
- Grants
- Loan disbursements (which require repayment)
- Utility allowance
- Workers Compensation – Temporary Total Compensation
- Training stipends
- Insurance proceeds
- Gifts/inheritances <$10,000 annually
- Military allowance

Proof of Income can include:

- Copies of payroll checks/stubs
- W-2
- Recent tax return
- Public assistance or social security check/stub or letter of award
- Medical assistance or social services certification letter
- Proof of government assistance
- Proof of zero or limited income

Dependents shall be determined by:

- The number of persons (dependents + self) whose primary support is provided by the gross income identified above in accordance with the Internal Revenue Code.
- In the case of a child client, use number of IRS exemptions claimed on most recent federal tax return for parents.
- Persons temporarily residing in the household that are not claimed as dependents (see above) are not considered part of the household.
- When there is a significant other in a household who is not recognized by the federal tax code (e.g., common-law spouse), determine if s/he and her/his income counts toward the calculation by asking if s/he contributes to the household income.

c. Provide Insurance billing information (if applicable)

10. If an individual fails to provide all information required to determine eligibility for the Sliding Fee Scale subsidy within 30 days from the date of service, the individual will automatically be disqualified for the subsidy and then will be considered 100% self-pay.

11. It is the provider's duty to complete client SmartCare enrollments reflecting the SFS percentage of responsibility based upon household income. This is applicable regardless of SFS Waiver status.

12. It is the provider's duty to update financial documentation for the sliding fee subsidy program every twelve (12) months and within 30 days of a significant change in income/dependents. This includes the Sliding Fee Scale Application/Fee Agreement and SmartCare enrollment.

13. The provider may request MHRB payment for services provided to non-Medicaid out of county resident(s) only with prior written authorization by the MHRB Executive Director or as required by law. In addition, the provider may contract directly with other county boards to provide services on behalf of that county. MHRB would not be responsible for payment of those services. Medicaid eligible clients receiving Medicaid eligible services or self-pay clients are excluded from pre-authorization.

14. Contract Providers will ensure their staff receives training on:

    a. Sliding Fee Subsidy Eligibility/Applicability
    b. Required Client Documentation
    c. Appropriate completion of the Sliding Fee Subsidy Application Form
    d. Required timelines for completion and re-certification
    e. SmartCare enrollment specifications regarding SFS percentage

15. MHRB may perform an audit up to twice annually on selected case charts of individuals enrolled in clinical services being billed to MHRB to ensure provider adherence to the Sliding Fee Subsidy Program. This selection will be on clients who received services during the current or previous fiscal year. Provider will be required to correct any errors discovered by MHRB during audit, including but not limited to obtaining additional documentation from client, reversing billing to MHRB, billing insurance, and/or billing client. An audit form will be available as an attachment to the policy. If problems are identified, this will trigger an additional sample for review.

16. The provider will maintain financial records in accordance with OAC 5122:1-5-01, Annual budget, financial reporting and independent financial audit requirements.

Policy 1-2 Attachment 1: Sliding Fee Scale (SFS)

Mental Health Recovery Board Serving Warren and Clinton Counties FY26 Board Funded Services - 250% Poverty			
FREE SERVICES (see also sliding fee scale for Fee Services) Gross Income (at or below)			
Family Size	**Monthly**	**Yearly**	**Hourly**
1	$ 3,260	$ 39,125	$ 18.81
2	$ 4,406	$ 52,875	$ 25.42
3	$ 5,552	$ 66,625	$ 32.03
4	$ 6,698	$ 80,375	$ 38.64
5	$ 7,844	$ 94,125	$ 45.25
6	$ 8,990	$ 107,875	$ 51.86
7	$ 10,135	$ 121,625	$ 58.47
8	$ 11,281	$ 135,375	$ 65.08
9	$ 12,427	$ 149,125	$ 71.69
10	$ 13,573	$ 162,875	$ 78.31

** add $13,750 annually per person

Poverty Data per 2025 HHS poverty guidelines released 1/17/25 per Federal Register

Free services are available to families whose incomes are at or below 250% of the federal poverty guideline (https://aspe.hhs.gov/poverty-guidelines)

Fee services are available to families whose incomes exceed 250% of the federal poverty guideline based on a sliding fee schedule - see attached policy & schedule

Sliding Fee Schedule for Mental Health Recovery Board Serving Warren & Clinton Co. Funded Services 1/17/25
Percent of Cost to be Paid by the Member Based on 250% - 400% Federal Poverty Guideline
FY26 (7/1/25-6/30/26)
Based on Monthly Income:

%	Rider	Family Size 1		Family Size 2		Family Size 3		Family Size 4		Family Size 5		Family Size 6		Family Size 7		Family Size 8		Family Size 9		Family Size 10	
0	Z	0	3,260	0	4,406	0	5,552	0	6,698	0	7,844	0	8,990	0	10,135	0	11,281	0	12,427	0	13,573
10	B	3,261	3,477	4,407	4,700	5,553	5,922	6,699	7,145	7,845	8,367	8,991	9,589	10,136	10,811	11,282	12,033	12,428	13,255	13,574	14,478
20	D	3,478	3,694	4,701	4,994	5,923	6,292	7,146	7,592	8,368	8,890	9,590	10,188	10,812	11,487	12,034	12,785	13,256	14,083	14,479	15,383
30	F	3,695	3,911	4,995	5,288	6,293	6,662	7,593	8,039	8,891	9,413	10,189	10,787	11,488	12,163	12,786	13,537	14,084	14,911	15,384	16,288
40	H	3,912	4,128	5,289	5,582	6,663	7,032	8,040	8,486	9,414	9,936	10,788	11,386	12,164	12,839	13,538	14,289	14,912	15,739	16,289	17,193
50	J	4,129	4,345	5,583	5,876	7,033	7,402	8,487	8,933	9,937	10,459	11,387	11,985	12,840	13,515	14,290	15,041	15,740	16,567	17,194	18,098
60	L	4,346	4,562	5,877	6,170	7,403	7,772	8,934	9,380	10,460	10,982	11,986	12,584	13,516	14,191	15,042	15,793	16,568	17,395	18,099	19,003
70	N	4,563	4,779	6,171	6,464	7,773	8,142	9,381	9,827	10,983	11,505	12,585	13,183	14,192	14,867	15,794	16,545	17,396	18,223	19,004	19,908
80	P	4,780	4,996	6,465	6,758	8,143	8,512	9,828	10,274	11,506	12,028	13,184	13,782	14,868	15,543	16,546	17,297	18,224	19,051	19,909	20,813
90	R	4,997	5,213	6,759	7,052	8,513	8,882	10,275	10,721	12,029	12,551	13,783	14,381	15,544	16,219	17,298	18,049	19,052	19,879	20,814	21,718
100	T	5,214	Up	7,053	Up	8,883	Up	10,722	Up	12,552	Up	14,382	Up	16,220	Up	18,050	Up	19,880	Up	21,719	Up

Service Sliding Fee Scale will be applied to:

MH/SUD Psychiatric Diagnostic Evaluation with & without Medical	90791, 90792
Medication Administration	96372
MH Behavioral Health Testing	96112-96121, 96130-96137
MH/SUD Individual and Group Psychotherapy (includes Family) Excludes Crisis	90832-90838; 90846, 90847; 90849, 90853
MH/SUD Prolonged Visit (for use with E&M codes only)	99415, 99416, 99417, G2212
MH/SUD Evaluation & Management (includes new, established, home visit)	99202-99350
Interactive Complexity	90785
MH Nursing Services (RN/LPN) (Individ/Group)	H2017, H2019/H2019HQ
SUD Assessment	H0001
SUD Nursing Services (RN/LPN) (Individ/Group)	T1002/T1002HQ, T1003
SUD Urine Drug Screen	H0048
SUD Individual and Group Counseling	H0004, H0005
SUD Intensive Outpatient, Group	H0015
SUD Vivitrol Injection	J2315
MHRB does not cover H0040-ACT bundled code	

Service Sliding Fee Scale will be Waived or NOT be applied to:

All services delivered to clients enrolled in the SED or SPMI population plans	**Various**
All grant funded positions &/or consultation codes billed non-client specific	**Various**
Crisis Services (incl mobile crisis, crisis consultation billed by designated Crisis Services Provider) CS Modifier	90832 KX, 90839, 90840
MH Housing, Residential, Transitional, Staff Support, Damage, (SPMI only) ***	M2200, M2261, M2270, M2290/M229X, M2292, M2210-M2212, M2215
SUD Recovery Housing *** ***Client benefit/rental payment to provider may apply	A2290/A229X, A2291
SUD Residential Treatment, Room & Board, Partial Hospitalization	H2036, A0740, H0015TG
MH Adult Education (SPMI only)	M1540
MH Therapeutic Mentoring (SED only) **(FY26 NEW CODE)**	M413T
MH Consultation & Support (Client Specific)	M4120, M412S
MH CPST, TBS, PSR (individual and group)	H0036, H0036/HQ, H2017, H2019, H2019/HQ
SUD Case Management	H0006
SUD Urine Pregnancy Test	81025
SUD Withdrawal Management-Hourly-ASAM2	H0014

Policy 1-2 Attachment 2: SFS Application Requirements

REQUIRED COMPONENTS OF APPLICATION FOR SLIDING FEE SCALE SUBSIDY PROGRAM
Component
Client Name
Client address
Admission Date
Form Completion Date
Name/Address of Responsible Party (if other than client)
of Exemptions (dependents + self) as reported to IRS on most recent federal tax return (in the case of a child client, use number of Exemptions from the parents most recent federal tax return)
Name/ Relationship of IRS defined dependents
Employer(s) of IRS defined dependents (18 years or older) Gross income from wages/employment/other income for each person in household (over age 18)
Sources of Household Income (other than employment) and Amount *Include: Social Security/SSDI/SSI, Annuities/pension payments, Dividends, Interest, Veteran's Pension/Compensation, Alimony, Net Income from Business/Farm, Unemployment Compensation, Rental Income, Other Sources of taxable income, Worker's Compensation – Permanent Total Disability, Gifts or inheritances (in excess of $10,000/year), Child Support* *Exclude: Income earned by minors (under age 18), Food Stamps/Aid to Dependent Children (ADC), Bank withdrawals, Student Benefits, Rebates, Grants, Loan Disbursements (which require repayment), Utility Allowance, Worker's Compensation – Temporary Total Compensation , Training Stipends, Insurance Proceeds, Gifts or Inheritances (less than $10,000/year), Military Allowance*
Insurance Information *Include: Insurance Company name, co-pay/co-insurance, deductible*
Statement: Discounts on service costs are offered to Warren and Clinton County residents based upon income and are subsidized by Mental Health Recovery Board Serving Warren & Clinton Counties
Statement that client is responsible for remaining cost of services after insurance payment has been received or denied
Statement regarding client obligation to notify provider of changes in income or dependents within 30 days of the change
Client Certification: I certify that the information given is true and accurate. I further certify that I understand giving false information could result in my losing reduced fee eligibility.
Signature of client (parent/guardian as applicable)
Provider Certification: I certify that documentation of income and insurance was reviewed and is accurately reflected above.
Signature of provider staff who performed Sliding Fee Scale assessment
Percentage of responsibility based upon current Sliding Fee Scale

Policy 1-2 Attachment 3: SFS Audit Form

SLIDING FEE SCALE (SFS) AUDIT FORM

Client Name:_____ **Date of Admission:**_____
SFS per SmartCare Enrollment:_____
Date of Review:_____ **Reviewer:**_____

Essential Components Recorded on SFS Subsidy Form	Present? Yes	No
Client Name		
Client Address		
Admission Date		
Form Completion Date		
Name/Address of Responsible Party (if other than client)		
# of Deductions (dependents + self) as reported to IRS on most recent federal tax return (in the case of a child client, use number of deductions from the parents most recent federal tax return)		
Name/Relationship of IRS defined dependents		
Employer(s) of IRS defined dependents (18 years or older) Gross income from employment for each		
Sources of Household Income (other than employment) and Amount *Include: Social Security/SSDI/SSI, Annuities/Pension Payments, Dividends, Interest, Veteran's Pension/Compensation, Alimony, Net Income from Business/Farm, Unemployment Compensation, Rental Income, Worker's Compensation – Permanent Total Disability, Gifts or inheritances (in excess of $10,000/year), Child Support, Other Sources of taxable income* *Exclude: Income earned by minors (under age 18), Food Stamps/Aid to Dependent Children (ADC), Bank Withdrawals, Student Benefits, Rebates, Grants, Loan Disbursements (which require repayment), Utility Allowance, Worker's Compensation – Temporary Total Compensation , Training Stipends, Insurance Proceeds, Gifts or Inheritances (less than $10,000/year), Military Allowance*		
Insurance Information *Include: Insurance Company Name, Co-Pay/Co-Insurance, Deductible*		
Signature of Client (parent/guardian as applicable)		
Signature of Provider Staff who performed Sliding Fee Scale assessment		
Percentage of responsibility based upon current Sliding Fee Scale documented on Form		
Standard Statements Required on all SFS Application Forms:	**Present? Yes**	**No**

Policy 1-3: Pre-Authorization for Service

Effective Date: 8/26/13
Last Revised Date: 7/1/25
Lead Staff: Amanda Peterson

Policy

MHRB is committed to provide a full continuum of care and strives to fund medically necessary behavioral health services in a sufficient quantity (as financially feasible). However, Benefit Rules/Billing to MHRB contract for Non-Medicaid clients (who have all or part of their behavioral healthcare funded by MHRB through a provider contract) will be consistent with benefit limits as established by Ohio Department of Medicaid through OAC 5160-27-02 Coverage and Limitations of Behavioral Health Services. Additional stipulations are noted in the Provider Contract Billing Requirements as well as Policy 1-9 Benefit Rules.

Clients may receive coverage for services beyond established limits when medically necessary and approved through the MHRB pre-authorization process.

The intent of this policy and procedure is to document guidelines for the submission of Pre-Authorization for continuation of services beyond established limits for Non-Medicaid (MHRB pay) clients. However, MHRB shall not make payment to a Provider for services delivered to an individual who is eligible for Medicaid and has earned the maximum Medicaid reimbursement available.

Procedure

1. It is the provider's duty to review and adhere to the current Mental Health and SUD annual limits documented in MHRB's Policy 1-9 Benefit Rules. When medically necessary to exceed these limits, the provider may proceed with the Pre-Authorization Process.

2. MHRB will provide a Pre-Authorization Request Form as an attachment to this policy and procedure (Attachment 1).

3. The Pre-Authorization Process begins with a Pre-Authorization (PA) Request Form being completed by the provider and submitted either via fax (513-695-1776), encrypted email, or hard copy to MHRB. An Ohio-licensed MHRB staff person will review the submitted Pre-Authorization Form for completeness and apply the following established and approved set of medical necessity criteria. "Medically necessary services" are defined as services that are necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. A medically necessary service must:

    a. Meet generally accepted standards of medical practice;
    b. Be appropriate to the illness or injury for which it is performed as to type of service and expected outcome;
    c. Be appropriate to the intensity of service and level of setting;
    d. Provide unique, essential, and appropriate information when used for diagnostic purposes;
    e. Be the lowest cost alternative that effectively addresses and treats the medical problem.

4. MHRB clinical reviewer will notify agency if additional supporting documentation needs to be submitted for adequate clinical review (i.e., assessment, past hospitalization records, etc.).

5. Providers will be notified by MHRB of the outcome of the PA request for continued service within 10 business days. The determination will be communicated to the provider in a confidential manner.

    a. If approved: This communication will contain the UCI#, hours/units authorized by service and effective date.

    b. If not approved: This communication will contain the UCI#, and clinical rationale for denial.

    c. If the provider does not agree with the decision rendered, an appeal may be filed. This appeal must be in writing and submitted to the MHRB clinical reviewer who made the initial determination. The request will be forwarded to the Board Chief Clinical Officer (BCCO) for review. All decisions made by the BCCO are final. The BCCO may:

        i. Approve the requested units (in full)
        ii. Deny the requested units (in full)
        iii. Approve a partial amount of the request
        iv. Reduce the amount approved by the initial reviewer
        v. Increase the amount approved by the initial reviewer

5. Quantity of Request: The provider may request any number of units of service. The number of units authorized are individualized and reviewed on a case-by-case basis. There is no minimum or maximum number of units that may be authorized. The provider is required to document the progress in treatment for on-going authorizations. All authorizations must include measurable benefits to the client for subsequent PA requests.

6. Retroactive Authorization: The provider is expected to monitor service provision on an on-going basis and submit a PA prior to need. However, in extenuating circumstances, a provider may request a retroactive authorization for services that were provided beyond the annual limits. Any retroactive approval will be at the discretion of the MHRB clinical reviewer and is not guaranteed. However, the provider should be aware that if the retroactive PA is not approved, no reimbursement will be made for any services already delivered beyond the limit.

7. The MHRB clinical reviewer will be responsible for notifying SmartCare of any approved services beyond the service limit so that billing will be allowed.

8. It is the duty of the Provider to train their staff on:

    a. Service limits as detailed in Policy 1-9 Benefit Rules
    b. Appropriate completion of the Pre-Authorization Form
    c. Required timelines for completion and submission of Pre-Authorization Forms

Policy 1-3 Attachment 1: Pre-Authorization for Services Form

Pre-Authorization for Services

Request Date _____ Client UCI # _____

Section I: Client Information

Name _____

Date of Birth _____ Gender _____

Address _____

_____

Section II: Provider Information

Agency _____

Site Location _____

Contact Person _____

Phone _____ Fax _____

Email _____

Section III: Units Requested

Service	Annual Limits (July 1 – June 30)	Total units of service which have been used	Total units requested beyond limit	Any units for retroactive purposes?	If yes, how many units are for retroactive services
Psychiatric Diagnostic Evaluation (90791, 90792)	1 encounter per code per billing agency			☐ Yes ☐ No	
Psychological Testing (96112, 96113, 96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137,)	Up to 20 hours/encounters combined			☐ Yes ☐ No	
Therapeutic Mentoring (M3140)	Max 832 units			☐ Yes ☐ No	
Parent Coaching	Max 24 units for families *not* involved with JFS			☐ Yes ☐ No	
Parent Coaching (JFS)	Max 48 units for families involved with JFS.			☐ Yes ☐ No	
SED Residential Placement	*FCFC pooled fund & OhioRISE ineligible			☐ Yes ☐ No	

Section III: Justification for Services

Please provide justification on the reason the client needs services (outside of the annual limits or residential placement). The justification should include why this is the most appropriate service for the client.

FOR MHRB USE ONLY

Service	Additional Units Approved	Retroactive Units Included?
Psychiatric Diagnostic Evaluation (90791, 90792)		☐ Yes ☐ No
Psychological Testing (96112, 96113, 96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137)		☐ Yes ☐ No
Therapeutic Mentoring (M3140)		☐ Yes ☐ No
Parent Coaching		☐ Yes ☐ No
Parent Coaching (JFS)		☐ Yes ☐ No
SED Residential Placement		☐ Yes ☐ No

MHRB Review By: _____

Approval Status ☐ Approved ☐ Denied

Date Effective _____

Date Notification Sent to Provider _____

Date SmartCare Notified _____

Date Appeal Received _____

Date Referred to BCCO _____

Policy 1-4: Member Residency Determination

Effective Date: 7/1/18
Last Revised Date: 7/1/24
Co-Lead Staff: Dustin Ratliff
Co-Lead Staff: Karen Robinson

Policy

Agencies must be able to validate member eligibility with supporting documentation that a client lives, or has the intent to remain, within the MHRB catchment area of Warren or Clinton counties. Any resident of Warren or Clinton County, as defined in O.R.C. 5122.01(S) or 5119.01(A)(19), shall be eligible for MHRB contracted covered services, unless otherwise noted in Provider Contract.

If a person is committed pursuant to section 2945.38, 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code, residence means the county where the criminal charges were filed.

"Intent to remain" is to be interpreted to mean a person's expressed or reasonably implied intent, together with actions which, taken as a whole, indicate a desire to remain permanently in the county. There can be no intent to remain when a person is visiting, transient or present in a county for only a time-limited specific purpose.

Procedure

1. Providers are expected to verify that clients being paid for by MHRB funding are residents of either Warren or Clinton Counties. Providers are free to serve whomever they wish with funds other than those provided pursuant to a contract with MHRB.

2. All clients receiving services being paid for either in whole or in part with public funds will be enrolled in the SmartCare system and the *SmartCare MCO Residency Verification Form* will be completed to document residency. This Form may be downloaded from the SmartCare website located at: https://partnersolutions.starkmhar.org/data-analytics/.

    a. The agency shall have the client sign the *SmartCareMCO Residency Verification Form* attesting to residency and keep this form in the client file. The Form shall have supporting documentation attached as required.

    b. If needed, the SmartCare Administrators (PartnerSolutions/Stark County Mental Health & Addiction Recovery) may ask for a copy of the residency form for verification when enrolling in SmartCare. Agency will provide all needed documentation as requested.

    c. The agency shall do all due diligence needed to verify that the client is truly a Warren or Clinton County resident prior to enrolling them in SmartCare.

    d. If the client moves out of MHRB catchment area, the client's residency shall be updated in the client record as well as in SmartCare and other payment arrangements shall be made.

3. Guidelines for Special populations/circumstances:

a. Minors: Residency for children is to be determined by the residency of the parents (or guardian) and should change when the parents move. When temporary or permanent legal custody of a child has been awarded to some other official entity (such as a CSB, ODYS, etc.), residency should remain with the Board of the county where the court which ruled maintains jurisdiction.

b. Incarcerated individuals: A person incarcerated in a jail facility shall remain a resident of the county from which s/he came. The person can receive services from MHRB contract providers while incarcerated in Warren/Clinton County Jails up to and including inpatient psychiatric care.

c. Individuals who are experiencing homelessness or are migrant workers: A person who is in the MHRB catchment area and declares to be homeless or is living in a homeless shelter in Warren or Clinton Counties can be enrolled in SmartCare and be eligible for MHRB funded services. Should the individual establish a home in Warren or Clinton Counties, his/her address shall be updated in SmartCare. Should the individual leave Warren/Clinton Counties, eligibility for MHRB funded services will cease. The provider may contact the board of the individual's new location to determine coverage.

d. College Students: If the individual is an IRS Tax Dependent of his/her parent(s)/guardians(s), the person will not be eligible for MHRB funded services if County of Residency is outside of Warren/Clinton Counties. However, if the student is NOT considered an IRS Tax Dependent, s/he has established residency or expressed the intent to remain AND has met any of the following criteria, the individual may be enrolled in SmartCare and be eligible for MHRB funded services:

    a) Emancipated
    b) Graduate level student
    c) Has dependent child(ren)

e. Individuals in Specialized residential programs or facilities:

    a) If an individual is placed in a specialized residential program or facility for the purposes of treatment, supervision/support, or other specialized services, residence will be determined as the county in which the person maintained his/her primary place of residence at the time of entering the facility.

    b) If a Warren or Clinton County resident is placed in an out-of-county facility for reasons having nothing to do with behavioral health needs and the individual develops such problems subsequent to placement, the individual will not be eligible for MHRB coverage.

    c) If a resident of another county is placed in a Specialized Placement located in Warren/Clinton Counties for reasons other than behavioral health, and the individual develops such subsequent to placement, the individual will be eligible for MHRB coverage.

f. Specialized Placements are defined as:

   a) A Program or facility subject to licensure (or comparable certification).

   b) These include hospitals, nursing homes, OhioMHAS-licensed certified residential facilities, ODJFS-licensed group homes and residential facilities, ODH-licensed Adult Care Facilities, developmental disabilities group homes, ICF rest homes, SUD residential programs, crisis shelters, foster-care homes, Recovery Housing, etc.

g. Strong Families Safe Communities grant clients: Eligible Out of County residents may be served under this OhioMHAS grant source, however, will NOT be enrolled in SmartCare. Rather, these individuals will be paid through manual invoices.

4. The following documentation is valid to verify an individual's county residency. Provider must copy any documentation the individual used to verify residency, that is consistent with the list below, and a copy must be part of the individual's record. In the case of a minor, documentation from parent/legal custodian shall be used. *DOCUMENTS MUST BE WITHIN THE LAST 60 DAYS.

   a. Current Ohio Driver's License with County Address same as Declared County Residence
   b. Current Ohio Personal Identification Card with County Address same as Declared County Residence
   c. Current Ohio Medicaid Care that shows County Address same as Declared County Residence
   d. Current SSI/SSDI Benefit Eligibility Statement with County Address same as Declared County Residence
   e. Current Pay Stub with Address same as Declared County in client's name*
   f. Current Utility Bill (gas, electric, water) with County Address same as Declared County Residence in clients' name*
   g. Current Voter Registration Card that shows County Address same as Declared County Residence
   h. Current Mortgage Statement or Payment with County Address same as Declared County Residence in client's name*
   i. Current Rent receipt with County Address same as Declared County in client's name*
   j. Student Information Screen from school

5. Contract Providers will ensure their staff will receive training on:

   a. MHRB Residency Eligibility
   b. Appropriate completion of the SmartCare MCO Residency Verification Form
   c. Required Client Documentation
   d. Required timelines for completion
   e. SmartCare enrollment specifications

Policy 1-5: Key Performance Indicator (KPI) Data, Outcome Data, and Audits

Effective Date: 7/1/18
Last Revised Date: 7/1/24
Co-Lead Staff: Dustin Ratliff
Co-Lead Staff: Amanda Peterson

Policy

To fulfill ORC 340.03 "Board of alcohol, drug addiction, and mental health services - powers and duties," MHRB will: "In accordance with criteria established under division (D) of section 5119.22 of the Revised Code, conduct program audits that review and evaluate the quality, effectiveness, and efficiency of addiction services, mental health services, and recovery supports provided by community addiction services providers and community mental health services providers under contract with the board and submit the board's findings and recommendations to the department of mental health and addiction services."

Additionally, MHRB will collect information as determined necessary by the Director of OhioMHAS. ORC 5119.22 - Director of mental health and addiction services; duties- specifies the OhioMHAS Director will: " Establish criteria by which each board of alcohol, drug addiction, and mental health services reviews and evaluates the quality, effectiveness, and efficiency of the facility services, addiction services, mental health services, and recovery supports for which it contracts under section 340.036 of the Revised Code. The criteria shall include requirements ensuring appropriate utilization of the services and supports. The department shall assess each board's evaluation of the services and supports and the compliance of each board with this section, Chapter 340. of the Revised Code, and other state or federal law and regulations. The department, in cooperation with the board, periodically shall review and evaluate the quality, effectiveness, and efficiency of the facility services, addiction services, mental health services, and recovery supports for which each board contracts under section 340.036 of the Revised Code and the facilities, addiction services, and mental health services that each board operates or provides under section 340.037 of the Revised Code. The department shall collect information that is necessary to perform these functions."

MHRB may select additional Key Performance Indicators and Outcomes to evaluate funded services. Through the use of these various selected outcomes tools, client engagement, satisfaction and progress will be evaluated on a consistent basis.

MHRB will require timely submission of Key Performance Indicators and Outcomes by providers as identified in the service collaboration plans. Subsequently, these indicators will be reviewed internally by MHRB staff and as deemed appropriate, with the Board of Directors for the purpose of planning, monitoring and evaluating the provider's performance.

Procedure

1. Key Performance Indicators:

a. MHRB will annually establish Key Performance Indicators for each service category and will be outlined in the applicable service collaboration plan along with report due dates. If necessary, MHRB will develop a form for the provider to report the results of the KPIs.

b. It is the provider's duty to collect, analyze, and report the results of the designated Key Performance Indicators and Outcomes Measurements to MHRB in a timely and accurate manner.

2. Outcomes administration:

a. MHRB will annually establish Outcomes Measurements for each service category and will be outlined in the applicable service collaboration plan along with report due dates.

b. It is the provider's duty to ask individuals served (seen individually or in a group) to participate in the administration of the outcomes tool. A client may refuse to participate, however a notation of such should appear in the clinical record. This does not absolve the clinician from completing any required worker tools.

c. The provider may use discretion when providing Family Therapy or Couples Therapy. Specifically, in terms of who completes form(s), this could be the identified client, a joint consensus on the responses on a single tool, or each participant completes separately.

d. In the event a new outcomes tool is selected at the beginning of a fiscal year, the provider will phase in implementation over time beginning with all individuals admitted to these service plans on or after the effective date. Clients admitted prior to the effective date may be offered the opportunity to participate at the discretion of the provider.

e. Outcomes tools should be administered at the following frequencies:

i. Admission
ii. Annually
iii. Termination

f. It is expected that a minimum of 50% of client population will complete the tool with data transmitted to MHRB as defined in the current Collaborative Plan.

g. The provider should review results and trends with the client as this is essential for the improvement of services and positive consumer outcomes.

h. The provider will train the applicable staff on the proper administration of tools, benefits, reporting and appropriate usage during sessions to enhance client engagement and focus on attainment of positive outcomes.

i. If necessary, MHRB will develop a form for the provider to report the results of the outcomes tools. This report form will be specific to the outcomes tool selected. Results will be reported in aggregate form and will include an Analysis of Findings as well as any necessary Performance Improvement plans. The report will be mandatory and will

be submitted electronically to MHRB by the provider at the frequency specified in the current Collaborative Plan.

j. Periodically, specific grants received by MHRB may have differing Outcomes reporting specifications. These shall be outlined accordingly in any contracts awarded to the provider.

3. Routine Clinical/Service Audits: MHRB reserves the right to perform an audit at least twice annually and as determined necessary of individual client records to ensure consumers are receiving timely service, to assess fidelity to best practices, as well as to determine the completeness and quality of documentation/service. This is applicable to consumers whose services are being billed/have been billed to MHRB only (i.e., excludes Medicaid/exclusively private insurance clients). A 5-business day notification of a planned audit will be provided. An audit tool will be shared with the provider in advance of the review.

4. Follow-up Clinical/Service Audits: Should it be determined upon Routine Clinical/Service Audit that a Plan of Correction is required, MHRB reserves the right to perform a follow-up audit to determine if the provider's services have come into acceptable compliance. Such Follow-up Audits will be in addition to the quantity listed in item 3 above. A 5-business day notification of a follow-up audit will be provided along with the planned focus of the review.

5. Clinical Audits for Cause: MHRB reserves the right to perform an audit and investigate:

   a. Any allegations of abuse/neglect made against a provider agency staff
   b. Reportable Incidents
   c. Any Client Rights violation allegation/grievance

   In the case of a Clinical Audit for Cause, immediate access to the record and provider site may be required if the health and safety of the client is in immediate danger or as dictated by the severity of the report/allegation.

6. If service delivery projections or goals outlined in the service collaboration plan or policy/procedures were not met during any reporting period throughout the contract time, the provider will provide a rationale for why service specifications were not achieved. If it is anticipated that without intervention, projections will not be met in the next consecutive reporting period, the provider will also develop a plan of correction. This shall be reported in a written narrative fashion following the close of the reporting period. Due dates are specified in the current fiscal year's service collaboration plan.

Policy 1-6: Reportable Incident Submission

Effective Date: 8/26/13
Last Revised Date: 7/1/25
Lead Staff: Amanda Peterson

Policy

The safety and well-being of consumers of MHRB contract providers is paramount. Consumers will be served in a safe environment, free of abuse and neglect. All providers will be required to submit reportable incidents to MHRB for monitoring and oversight purposes.

Providers will submit all reportable incidents which may impact consumer safety or well-being to state/federal entities as required by Administrative or Revised code. Providers will also report additional specified incidents to MHRB.

MHRB reporting requirements will encompass state/federal guidelines but in some incidents will be more stringent.

Providers will cooperate in any further investigations, including but not limited to chart audits and interviews with staff, deemed necessary by state/federal entities and/or MHRB.

This policy is applicable to all consumers funded through MHRB or Ohio Mental Health & Addiction Services (Medicaid) and receiving services from a MHRB provider.

Procedure

1. Providers will ensure their staff is trained in the reporting requirements, applicable time frames, and the appropriate completion of the Notification of Incident forms.

2. Reporting Requirements

    a. All Community Mental Health and Addiction Services Agencies certified by Ohio Department of Mental Health & Addiction Services, shall refer to and comply with OAC 5122-26-13. Attachment 1 outlines the incidents which require reporting to OhioMHAS.

    b. All Residential Facilities certified by Ohio Department of Mental Health & Addiction Services, shall refer to and comply with OAC 5122-30-16 requirements. Attachment 1 outlines the incidents which require reporting to OhioMHAS.

    c. OhioMHAS Certified Providers are required to submit Reportable Incidents via the Web Enabled Incident Reporting System (WEIRS) for all incidents which are specified in OAC 5122-26-13 and OAC 5122-30-16 . These reports are automatically forwarded by OhioMHAS to MHRB when the board name is appropriately indicated on the WEIRS submission.

    d. MHRB has identified select additional incidents which are deemed high risk or high profile but are not reportable to OhioMHAS. These incidents will be reportable to MHRB only via

email: incidentreports@mhrbwcc.org within 24 business hours of provider knowledge. Attachment 1 outlines the incidents which require reporting to MHRB. The Reporting Forms are available in Attachment 2 of this policy/procedure.

3. Attachment 3 provides a flowchart for the Reporting process.

4. Providers will adhere to Best Practice Processes with regards to reporting and oversight of Reportable Incidents including:

   a. Mandatory reporting laws
   b. Code of Ethics for applicable professions
   c. Monitoring for Trends and Assessment of need for Quality Improvement initiatives
   d. Applicable state and federal laws/statues

5. MHRB will monitor Notification of Incident forms submitted and will follow-up with inquires or requests for additional information, as necessary.

6. Clinical Audits for Cause: MHRB reserves the right to perform an audit and investigate Reportable Incidents. In this case, immediate access to the record and provider site may be required if the health and safety of the client is in immediate danger or as dictated by the severity of the report.

7. Any Notification of Incident forms in which the resolution is unknown at the time of submission will be required to have a follow-up report filed when further information is available.

8. Annually, MHRB will prepare a synopsis and analysis of Reportable Incidents which have been submitted. This analysis will be shared with providers to identify any trends and/or opportunities for improvement.

Policy 1-6 Attachment 1: Incident Reporting Crosswalk

*WEIRS report automatically forwarded to MHRB

Incident	Description	Community Mental Health or Addiction Services Agency		Class 2/3 MH Residential Facility		Class 1 MH Residential Facility	
		OhioMHAS	MHRB	OhioMHAS	MHRB	OhioMHAS	MHRB
DEATH							
Suicide Death	Intentional taking of one's own life by a client	yes	*	yes	*	yes	*
Homicide of Client	The alleged unlawful killing of a client by another person.	no	yes	no	yes	no	yes
Accidental Death	Death of a client resulting from an unusual and unexpected event that is not suicide, homicide or natural, and which happens on the ground of the agency or during the provisions of care or treatment, including during agency off-grounds events.	yes	*	yes	*	yes	*
Death of Resident due to "other" causes	Death of a resident due to any cause, specify cause of death	no	no	no	yes	no	yes
Death of Client by Drug Overdose	Death of active client which is reported as being due to the accidental consumption of excessive drugs or other substances (legal or illegal)	no	yes	see accidental death requirements		see accidental death requirements	
Seclusion/Restraint Related Death	Death of a client which occurs while a client is restrained or in seclusion, within twenty-four hours after the client is removed from seclusion or restraint, or it is reasonable to assume the client's death may be related to or is a result of seclusion or restraint. Subcategories include: 1. Death during seclusion or restraint; 2. Death within twenty-four hours of seclusion or restraint; 3. Death related to or result of seclusion or restraint	yes	*	no	yes	no	yes
Death of Client by Natural Causes	Community Provider: Death of active client which is reported as being due to a disease process or other malfunction of body (not externally caused by accident, suicide, homicide, etc.) MH Residential Facility: Death of a resident without the aid of inducement of any intervening instrumentality, i.e., homicide, suicide or accident	no	yes	yes	no	yes	no
Death of Resident due to Unknown Causes	Death of an active client when the cause in not readily known and is pending the determination of the coroner. Report these when preliminary cause of death is known.	no	no	no	no	no	no
CRIME							
Homicide/Suspected Homicide by Client	The alleged unlawful killing of a human being by a client	yes	*	yes	*	yes	*
ABUSE, NEGLECT, DEFRAUD, ASSAULT							
Physical Abuse	Allegation of STAFF action directed toward a client of hitting, slapping, pinching, kicking, or controlling behavior through corporal punishment or any other form of physical abuse as defined by applicable sections of the Revised or Administrative Code.	yes	*	yes	*	yes	*
Sexual Abuse	Allegation of STAFF action directed toward a client where there is sexual contact or sexual conduct with the client, any act where staff cause one or more other persons to have sexual contact or sexual conduct with the client, or sexual comments directed toward a client. Sexual conduct and sexual contact have the same meanings as in Section 2907.01 of the Revised Code	yes	*	yes	*	yes	*
Neglect	Allegation of a purposeful or negligent disregard of duty imposed on an employee by statute, rule, organizational policy, or professional standard and owed to a client by that STAFF member.	yes	*	yes	*	yes	*
Defraud	Allegation of STAFF action directed toward a client to knowingly obtain by deception or exploitation some benefit for oneself or another or to knowing cause, by deception or exploitation, some detriment to another.	yes	*	yes	*	yes	*

Incident	Description	Community Mental Health or Addiction Services Agency		Class 2/3 MH Residential Facility		Class 1 MH Residential Facility	
		OhioMHAS	MHRB	OhioMHAS	MHRB	OhioMHAS	MHRB
Sexual Assault by Non-staff, including a Visitor, Client or Other	Any allegation of one or more of the following sexual offenses as defined by Chapter 2907 of the Revised Code committed by a non-staff against another individual, including staff, and which happens on the grounds of the provider or during the provisions of care or treatment, including during provider off-grounds events: Rape, sexual battery, unlawful sexual conduct with a minor, gross sexual imposition, or sexual imposition.	yes	*	yes	*	yes	*
Physical Assault by Non-staff, Including Visitor, Client or Other	Knowingly causing physical harm or recklessly causing serious physical harm to another individual, including staff, by physical contact with that person, which results in an injury requiring emergency/unplanned medical intervention, hospitalization or death, and which happens on the grounds of the provider or during the provision of care or treatment, including during provider off-grounds events.	yes	*	yes	*	yes	*
INVOLUNTARY TERMINATION/DISCHARGE							
Involuntary Termination without appropriate client involvement	Discontinuing services to a client without providing reasonable advance notice to the client of the termination, providing a reason for the termination, and offering a referral to the client. This does not include situations when a client discontinues services without notification, and the provider documents it was unable to notify the client due to lack of address, returned mail, lack of or non-working phone number, etc.	yes	*	yes	*	yes	*
Involuntary Discharge	MH Residential Only: Involuntary discharge of a resident unless the facility is no longer able to meet the resident's care needs; the resident presents a documented danger to other residents, staff or visitors; or the monthly charges have not been paid for more than 30 days. Involuntary discharge includes discharging a resident after the resident unexpectedly vacates the facility for more than 48 hours without any notification to staff, and the monthly (or daily) charges for the days the resident is missing have been paid.			yes	*	yes	*
Inappropriate Discharge	MH Residential Only: Discharge of a resident without providing 30 days prior written notice for termination of residency except in an emergency when the resident presents a documented danger to other residents, staff or visitors			yes	*	no	yes
MEDICATION/DRUG ISSUES							
Medication Diversion	The Transfer of any legally prescribed controlled substances from the individual for whom it was prescribed to another person for any illicit use.	no	yes	no	yes	no	yes
Sale of Drugs on Premises	The sale of any medication or illicit drug on the premises of the provider not otherwise part of the provider's normal course of business.	no	yes	no	yes	no	yes
Missing/Unaccounted for Medication	Prescribed medication under the control of or stored by provider which is missing or unaccounted for, that is not believed to be a result of theft	no	yes	yes	no	yes	no
Medication Error	Any preventable Event while the medication was in the control of the health care professional or client, and which resulted in permanent client harm, hospitalization, or death. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication, product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.	yes	*	yes	*	yes	*
Adverse Drug Reaction	Unintended, undesirable or unexpected effect of a prescribed medication(s) that results in permanent client harm, hospitalization, or death.	yes	*	yes	*	yes	*
Employee Theft of Medication	Allegation of employee theft of prescribed medication under the control of/or stored by the provider.	yes	*	yes	*	yes	*

Incident	Description	Community Mental Health or Addiction Services Agency		Class 2/3 MH Residential Facility		Class 1 MH Residential Facility	
		OhioMHAS	MHRB	OhioMHAS	MHRB	OhioMHAS	MHRB
Theft of Medication	Allegation of theft of prescribed medication under the control of or stored by the facility. Subcategories: (1) Employee theft; (2) Resident/Client theft; (3) Other/Unknown theft	no (except subcategory 1 reported above – "Employee Theft")	yes (all subcategories)	yes	*	yes	*
CHANGES IN/CLOSURES OF OPERATIONS							
Medical Events Impacting Provider Operations	The presence or exposure of a contagious or infectious medical illness within an provider, whether brought by staff, client, visitor or unknown origin, that poses a significant health risk to other staff or clients in the provider, and that requires special precautions impacting operations. Special precautions impacting operations include medical testing of all individuals who may have been present in the provider, when isolation or quarantine is recommended or ordered by the health department, police or other government entity with authority to do so, and/or notification to individuals of potential exposure. Special precautions impacting operations does not include general isolation precautions, i.e., suggesting staff and/or clients avoid a sick individual or vice versa, or when a disease may have been transmitted via consensual sexual contact or sexual conduct.	yes	*	yes	*	yes	*
Temporary Closure of One or More Provider Sites	Community Provider: The provider ceases to provide services at one or more locations for a minimum period of more than seven consecutive calendar days due to: Fire, Disaster (flood, tornado, explosion, excluding snow/ice), Failure/Malfunction (gas leak, power outage, equipment failure, Other (specify)	yes	*				
In the case of OhioMHAS MH Residential Facilities, this is termed as Temporary Relocation of Residents	MH Residential Facility: Some or all of the residents must be moved to another unit, residential facility or community location for a minimum period of at least one night due to: 1. Fire, 2. (Disaster (flood, tornado, explosion, excluding snow/ice); 3. Failure/Malfunction (gas leak, power outage, equipment failure); 4. Other (specify).			yes	*	yes	*
SECLUSION/RESTRAINT							
Inappropriate Use of Seclusion or Restraint	Seclusion or restraint utilization that is not clinically justified, or mechanical restraint or seclusion employed without the authorization of staff permitted to initiate/order mechanical seclusion or restraint: Indicate: Seclusion, Mechanical restraint, Physical restraint, Transitional hold, and Total Minutes of the seclusion or restraint.	yes	*			no	yes
Use of Seclusion/Restraint by a Provider without Prior Notification that the Provider Permits the Use of Seclusion or Restraint	Use of seclusion or restraint without notification to the Department in accordance with paragraph (A)(1)(e) of rule 5122-25-03 or paragraph (A)(1)(e) of the OAC of a provider's intent to utilize seclusion or restraint. Subcategories include: 1. Seclusion; 2. Mechanical restraint; 3. Physical restraint, including transitional hold.	yes	*			yes	no
Inappropriate Restraint Techniques and other Use of Force	Staff utilize one or more of the following methods/interventions prohibited by paragraph (D)(2) of rule 5122-26-16 of the Administrative Code. Subcategories: 1. Behavior management interventions that employ unpleasant or aversive stimuli such as: the contingent loss of the regular meal, the contingent loss of bed, and the contingent use of unpleasant substances or stimuli such as bitter tastes, bad smells, splashing with cold water, and loud, annoying noises; 2. Any technique that restricts the client's ability to communicate; 3. Any technique that obstructs vision; 4.	yes	*			no	yes

Incident	Description	Community Mental Health or Addiction Services Agency		Class 2/3 MH Residential Facility		Class 1 MH Residential Facility	
		OhioMHAS	MHRB	OhioMHAS	MHRB	OhioMHAS	MHRB
	Any technique that obstructs the airways or impairs breathing, including placing a cloth or other item over an individual's mouth or nose; 5. Use of mechanical restraint on a client under age 18; 6. A drug or medication that is used as a restraint to control behavior or restrict the client's freedom of movement and is not a standard treatment or dosage for the client's medical or psychiatric condition or that reduces the client's ability to effectively or appropriately interact with the world around him/her; 7. The use of handcuffs or weapons such as pepper spray, mace, nightsticks, or electronic restraint devices such as stun guns and tasers.						
Unauthorized use of Restraint or Seclusion	MH Residential Facility (Class2/3): OAC 5122-30-17 prohibits the use of seclusion and restraint in a Class 2 and 3 residential facility. Subcategories: (1) Seclusion; (2) Mechanical restraint; (3) Physical restraint; (4) Transitional hold			yes	*		
Seclusion/Restraint Related Injury to Client	Injury to a client caused, or it is reasonable to believe the injury was caused by being placed in seclusion/restraint or while in seclusion/restraint, and first aid or emergency/unplanned medical intervention was provided or should have been provided to treat the injury, or medical hospitalization was required. It does not include injuries which are self-inflicted, e.g., a client banging his/her head, unless the provider determines that the seclusion/restraint was not properly performed by staff, or injuries caused by another client, e.g., a client hitting another client. Subcategories: 1. Injury requiring first aid; 2. Injury requiring unplanned/emergency medical intervention; 3. Injury requiring hospitalization	yes	*	no	yes	no	yes
Seclusion/Restraint Related Injury to Staff	Injury to staff caused, or it is reasonable to believe the injury was caused as a result of placing an individual in seclusion/restraint, and first aid or emergency/unplanned medical intervention was provided or should have been provided to treat the injury, or medical hospitalization was required. It does not include injuries which occur prior to, or are the rationale for, placing an individual in seclusion or restraint. Subcategories: 1. Injury requiring first aid; 2. Injury requiring emergency/ unplanned medical intervention; 3. Injury requiring hospitalization	no	yes	no	yes	no	yes
Report the use of any of the following interventions as a result of the reported incident:	Seclusion**:** A staff intervention that involves the involuntary confinement of a client alone in a room where the client is physically prevented from leaving. Mechanical Restraint: A staff intervention that involves any method of restricting a client's freedom of movement, physical activity, or normal use of his or her body, using an appliance or device manufactured for this purpose. Physical Restraint excluding Transitional Hold**:** A staff intervention that involves any method of physically (also known as manually) restricting a client's freedom of movement, physical activity, or normal use of his or her body without the use of mechanical restraint devices. Involuntary Emergency Medications**:** A staff intervention that involves the administration of emergency medications without the client's consent	yes	*	no	yes	no	no
CLIENT INJURY/MEDICAL EMERGENCY							
Suicide Attempt	Community Provider: Any and all attempts (post-intake, i.e., active client) when emergency/unplanned medical intervention/hospitalization is required (greater than minor first aid)	no	yes				
	MH Residential Facility: Intentional injury caused by a resident with the intent of taking one's own life, and is either a stated suicide attempt or clinically determined			yes	*	yes	*

Incident	Description	Community Mental Health or Addiction Services Agency		Class 2/3 MH Residential Facility		Class 1 MH Residential Facility	
		OhioMHAS	MHRB	OhioMHAS	MHRB	OhioMHAS	MHRB
	to be so, regardless of whether it results in medical treatment.						
Drug Overdoses requiring Medical Intervention	Any drug overdose (legal or illicit) on the premises requiring engagement of EMS, hospital, urgent care, or other medical service.	no	no	no	yes	no	yes
Self-Inflicted Injury by Client/Self-Injurious Behavior	Community Agencies: Self-inflicted harm (including drug overdoses) which results in serious bodily injury when emergency/ unplanned medical intervention/ hospitalization is required (greater than minor first aid)	no	yes				
	MH Residential Facilities: Intentional injury caused by a resident to oneself that is neither a stated suicide attempt, or clinically determined to be so, which requires emergency/unplanned medical intervention or hospitalization, and which happens on the grounds of the facility or during the provisions of care or treatment, including during facility off-grounds events.			yes	*	yes	*
Injury of Client on Provider Premises/During Provision of Care/ In Vehicle Operated by Provider Staff	Event which results in serious bodily injury when emergency/unplanned medical intervention/hospitalization is required (greater than minor first aid)	no	yes	no	yes	no	yes
Medical Emergency resulting from Resident Fall with Injury, Illness, or unknown cause	Event on premises which results in injury of resident requiring emergency medical care, specify illness	no	no	no	yes	no	yes

Policy 1-6 Attachment 2: Incident Notification Form

Mental Health Recovery Board
Serving Warren & Clinton Counties

Mental Health Recovery Board Serving Warren and Clinton Counties
Community MH/SUD Provider Notification of Incident

Provider Generated Incident #	Date Submitted to MHRB	Date of Discovery	Date of Incident	Time of Incident

Provider Name	Provider Number

Name of Person Completing Report

Other Notifications Made:

☐ **Other ADAMH Board(s) (list names):**

☐ **Children's Services** ☐ **Family/Guardian** ☐ **Other Protective Agency** ☐ **Other:**

Type of Incident (check all that apply)

Death of a Client:
☐ Homicide of Client ☐ Death of Client by Drug Overdose ☐ Death of Client by Natural Causes

Medication/Drug Issues:
☐ Medication Diversion ☐ Sale of Drugs on Premises ☐ Missing/Unaccounted for Medication
☐ Theft of Medication – Specify sub-category: ☐ Employee Theft ☐ Client Theft ☐ Other/Unknown Theft

Seclusion/Restraint:
☐ Seclusion/Restraint Related Injury to Staff –
Specify sub-category: ☐ Injury requiring first aid ☐ Injury requiring emergency/unplanned medical intervention ☐ Injury requiring hospitalization

Client Injury/Medical Emergency when emergency/unplanned medical intervention or medical hospitalization is required:
☐ Suicide Attempt ☐ Self-Inflicted Injury by Client (including drug overdoses) ☐ Client Injury on Provider Premises/in Vehicle operated by Provider

Persons Involved in the Incident

Race/Ethnicity Codes: A=Asian B=Black/African American H=Hispanic I=Alaskan Native M=Bi/Multiracial N=Native Am./Am. Indian P=Native Hawaiian/Other Pacific Islander W=White O=Other Race U=Unknown

Client(s) Involved - Use a HIPAA/42CFR Part 2 Compliant Identifiers (NO Client Names)	Program enrollment: SPMI, SED, SUD, MHOP	Age	Gender: M=Male; F=Female; O=Other identified	Race (see codes above)	P=Perpetrator V=Victim

Other(s) Involved (Initials/Provider Identifier – No names):	S = Staff V = Visitor O = Other	P=Perpetrator V=Victim

Explain incident. Include what action provider staff took, if any. Note if other entities (police, fire, etc.) were involved. No names

Please submit this form to MHRBWCC within 24 business hours of incident discovery via:
Email: IncidentReports@mhrbwcc.org OR Fax: 513-695-1776
This information is subject to a public record request

See MHRBWCC System Policy # 1-6 for definitions

Rev. 7/1/21

Mental Health Recovery Board
Serving Warren & Clinton Counties

Mental Health Recovery Board Serving Warren and Clinton Counties
Residential Facility (Classes 1, 2 and 3) - Provider Notification of Incident

Provider Generated Incident #	Date Submitted to MHRB	Date of Discovery	Date of Incident	Time of Incident

Provider Name	Facility Name	License Number

Name of Person Completing Report

Other Notifications Made:

☐ **Other ADAMH Board(s) (list names):**

☐ **Children's Services** ☐ **Family/Guardian** ☐ **Other Protective Agency** ☐ **Other:**

Type of Incident (check all that apply)

Death of a Resident:
☐ Homicide of Resident ☐ Death due to Other Causes ☐ Death related to Seclusion/Restraint

Involuntary Termination/Discharge: ☐ Inappropriate Discharge (MH Residential only)

Medication/Drug Issues:
☐ Medication Diversion ☐ Sale of Drugs on Premises

Seclusion/Restraint:
☐ Inappropriate Use of Seclusion or Restraint (Class 1 only)
☐ Inappropriate Restraint Techniques and other Use of Force (Class 1 only)
☐ Seclusion/Restraint Related Injury to RESIDENT – *Specify sub-category*:
☐ Injury requiring first aid ☐ Injury requiring emergency/unplanned medical intervention ☐ Injury requiring hospitalization
☐ Seclusion/Restraint Related Injury to STAFF – *Specify sub-category:*
☐ Injury requiring first aid ☐ Injury requiring emergency/unplanned medical intervention ☐ Injury requiring hospitalization
☐ Interventions Used as a result of the reported incident (Class 2/3 only)– *Specify sub-category:*
☐ Seclusion ☐ Mechanical Restraint ☐ Physical Restraint excluding Transitional Hold ☐ Involuntary Emergency Medications

Resident Injury/Medical Emergency when emergency/unplanned medical intervention or medical hospitalization is required:
☐ Drug Overdoses ☐ Resident Injury on Provider Premises/in Vehicle operated by Provider ☐ Injury from fall
☐ Medical Emergency resulting from Illness ☐ Medical Emergency due to unknown cause

Persons Involved in the Incident

Race/Ethnicity Codes: A=Asian B=Black/African American H=Hispanic I=Alaskan Native M=Bi/Multiracial N=Native Am./Am. Indian P=Native Hawaiian/Other Pacific Islander W=White O=Other Race U=Unknown

Resident(s) Involved - Use a HIPAA/42CFR Part 2 Compliant Identifiers (NO Resident Names)	Age	Gender: M=Male; F=Female; O=Other identified	Race (see codes above)	P=Perpetrator V=Victim

Other(s) Involved (Initials/Provider Identifier – No names):	S = Staff V = Visitor O = Other	P=Perpetrator V=Victim

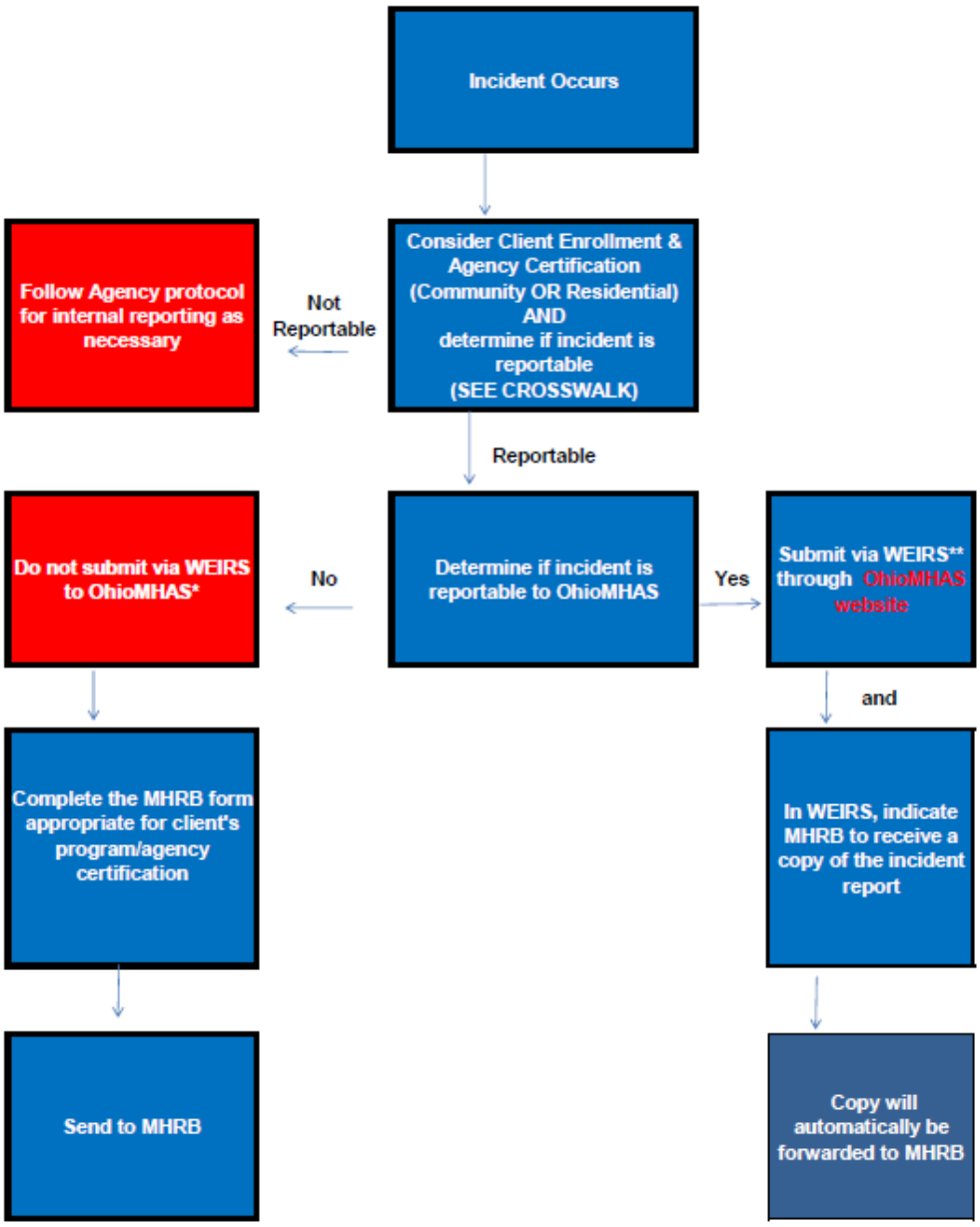
Explain incident. Include what action provider staff took, if any. Note if other entities (police, fire, etc.) were involved. No names

Please submit this form to MHRBWCC within 24 business hours of incident discovery via:
Email: IncidentReports@mhrbwcc.org OR Fax: 513-695-1776
This information is subject to a public record request
See MHRBWCC System Policy # 1-6 for definitions

Rev. 7/1/21

Policy 1-6 Attachment 3: Incident Reporting Flow Chart

Reportable Incident Flowchart:



MHRB Forms (Community or Residential) go to:

IncidentReports@MHRBwcc.org (E-Mail)
513-695-1776 (Fax)
MHRBWCC, 210 Reading Road, Mason, OH 45040 (Mail)

Policy 1-7: Waiting List and Referral Process

Effective Date: 8/26/13
Last Revised Date: 7/1/24
Lead Staff: Dustin Ratliff

Policy

Mental Health Recovery Board Serving Warren and Clinton Counties is committed to securing available Behavioral Health Services for the residents of our board area in a timely manner. All provider programs and/or services in the MHRB system will develop strategies to ensure accessibility and availability of services for clients.

The reasons for a system-wide waiting list policy are to:

- Improve the quality of care in the integrated behavioral health care system
- Promote system quality improvement and learning
- Develop knowledge of system trends and service gaps
- Promote inter-agency and intra-agency clinical collaboration and communication
- Recognize an increasing number of clients

For the purposes of this policy, while an individual may be referred by an outside entity (i.e. school, court, hospital, children services, etc.), the person may not be seen for service until after personally agreeing to or requesting care (or by parent/guardian as applicable) and has completed the initial provider paperwork. Therefore, this outside entity referral will not cause initiation of service or cause the individual to be placed on the waiting list as the individual (or parent/guardian) must also initiate contact with the provider and request services. However, after a referral, a provider may contact the individual to explain the admission and paperwork process to facilitate this.

Procedure

1. Wait Lists will be maintained by each provider. As indicated by the applicable service collaboration plan, reporting of this information may be required. If so, this will be done in an aggregate manner. The wait list data will be used in the analysis of trends and service gaps to reduce wait time and to assist providers in preventing the occurrence of future complaints.

2. The Provider shall have an efficient admission process which includes intake, clinical triage/screening, clinician assignment/scheduling for diagnostic assessment, and initiation of treatment services.

3. At the time the individual requests service, clinical staff will triage/screen the person's condition and determine if the individual meets eligibility criteria for a specific service population (see specific service collaboration plans for "target population").

    a. If so, the admission timeline for this specific population will be adhered to (see #4 below).

b. If it is unclear which population the individual would be eligible for, the default is to the Mental Health Outpatient Population guidelines (movement may occur to a different service population/service collaborative plan post-assessment as deemed appropriate).

4. MHRB has established the following admission priorities and timelines. Providers will offer individuals services based upon the following (also see Attachment 1 to this document for a process flowchart):

	Maximum Number of Calendar Days		
Population	From service request to First Offered Diagnostic Assessment appointment*	From Diagnostic Assessment to First treatment appointment	From Psychiatric Referral to First appointment with Prescriber**
Individuals discharged from inpatient psychiatric care	14***	7***	30
Individuals with Severe and Persistent Mental Illness (SPMI)	21	14	30
Individuals with Serious Emotional Disturbance (SED)	21	14	30
Mental Health Outpatient population (MHOP)	30	14	45
Individuals requesting treatment services for substance use disorders (SUD) must be offered appointments utilizing the following priority order: i. Pregnant women who inject drugs ii. Other pregnant clients iii. Others who inject drugs iv. Others NOTE: Pregnant women must be seen within 48 hours for interim services if they are not admitted into a program within that timeframe.	14	7	14

*if a recent compliant diagnostic assessment not otherwise available **as determined by the person's Individual Service Plan ***see #5 below

5. Should the Hospital Linkage Specialist secure/supply a diagnostic assessment from the inpatient hospital unit which incorporates all required components as defined in OAC 5122-29-03, the first treatment appointment should occur within 7 calendar days of service referral by the hospital.

6. An eligible and appropriate individual will be placed on a waiting list if s/he cannot be served for diagnostic assessment within the time frames established under # 4 above.

7. If the provider is unable to accommodate the specific service needs of the individual, the person will be immediately informed about services with another provider and/or outside of our system of care that may be of assistance. Individuals referred for services elsewhere shall receive a follow-up contact by the referring agency regarding engagement within 14 calendar days after referral.

8. If following diagnostic assessment and determination of appropriate services, the provider is unable to service the individual within the designated time (see #4 above), the individual:

   a. Is considered on the waiting list
   b. When placed on the waiting list, they will be informed about services with another provider and/or outside of our system of care that may be of assistance. Individuals referred for services elsewhere shall receive a follow-up contact by the referring agency regarding engagement within 14 calendar days after referral.

9. The provider will remove an individual from the waiting list when any of the following documented occurrences happen:

a. A telephone contact has been made with the individual to schedule an appointment (telephone or text messages do not meet this standard) and the individual declines offered appointment times.

b. An individual has been offered a minimum of 2 appointments and does not schedule with the provider.

c. An individual does not contact the provider following a written notice regarding an available appointment (letter needs to specify the time frame the appointment will remain open and the consequences if the individual neglects to schedule).

d. An individual does not attend the initial appointment, and a subsequent written notice is sent to the individual indicating s/he must contact the provider within 10 calendar days to re-schedule, to which the individual does not respond.

10. If an individual has been removed from the waiting list for any of the reasons noted in #9 above, and later requests services again, this will be viewed and treated as a new request (as opposed to a continuation of the prior request). However, the individual's previously completed intake paperwork may still be viewed as valid assuming there have been no changes to address, custody/guardianship, and income, and it is less than 12 months old. At the provider's discretion, a more stringent policy regarding paperwork may be established.

11. It is the provider's duty to train staff in the appropriate administration and documentation of the Wait List, to include

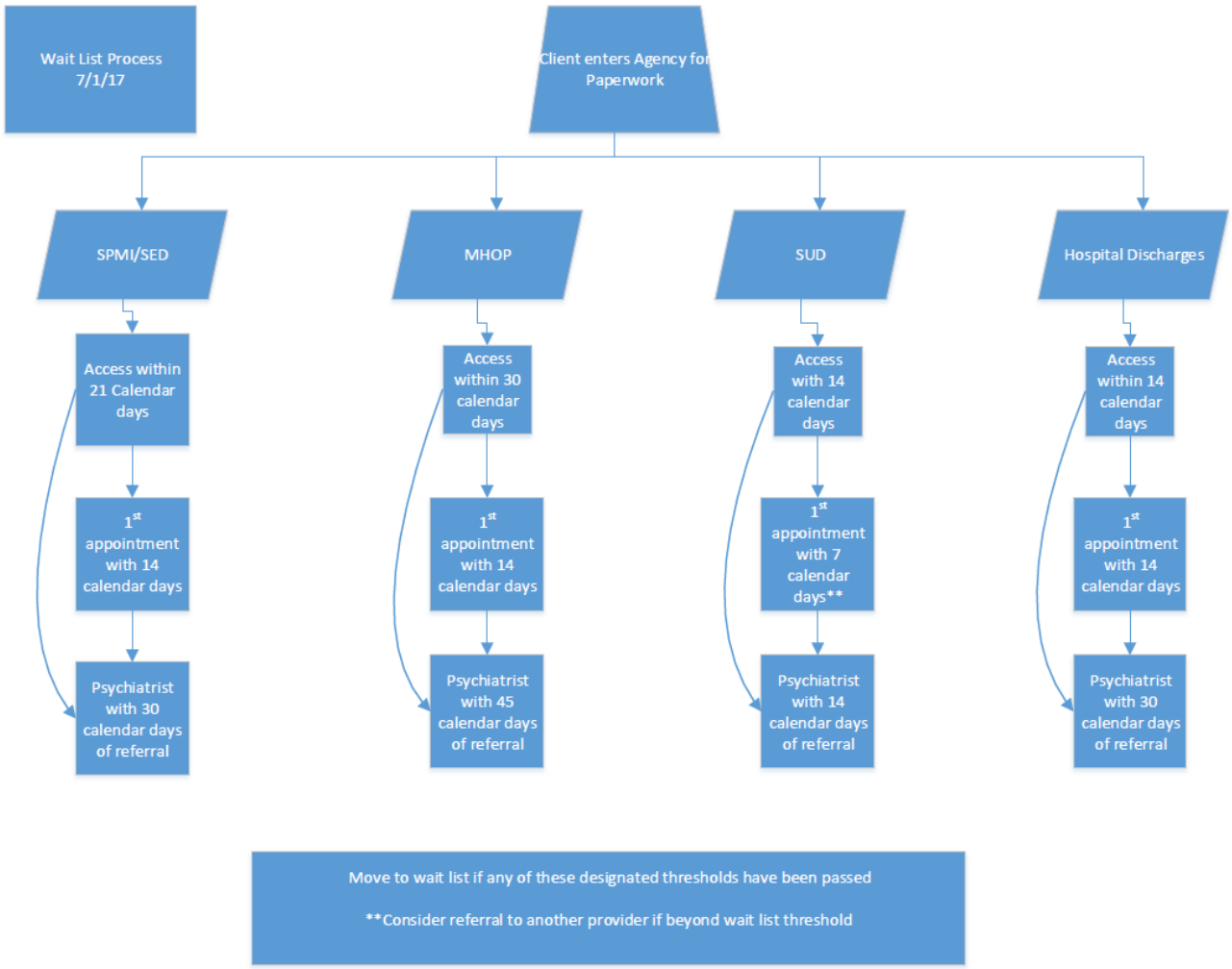
    a. Crisis assessment
    b. Clinical triage techniques
    c. Documentation of date of placement on waiting list
    d. Identified needs of individual
    e. Identified procedures for referral of persons in crisis to necessary care
    f. Procedure for ongoing review and updating of the list

12. MHRB will review at least annually the Waiting List Policy and data to ensure consistent application and compliance within the service areas.

13. Providers will comply with the guidelines set forth in OAC 5122-8-01 for collecting and reporting Wait List data for Alcohol and Drug Services.

14. If service delivery expectations outlined in this Waiting List Policy were not met during any quarter throughout the contract period, the provider will provide a rationale for why service specifications were not achieved. If it is anticipated that without intervention the same services will not be delivered in the next consecutive quarter, the provider will provide a plan of correction. This shall be reported as specified in the corresponding Service Collaborative Plans.

Policy 1-7 Attachment 1: Wait List Flow Chart



Policy 1-8: SmartCare Enrollment, Claims Processing, and Correction

Effective Date: 7/1/20
Last Revised Date: 7/1/25
Lead Staff: Karen Robinson

Policy

Persons who present to contract agencies for services who are deemed eligible for the Sliding Fee Scale Subsidy must be enrolled into the SmartCare system in order to receive claims paid in whole or in part by the Mental Health Recovery Board Serving Warren and Clinton Counties (MHRB).

Persons who are Medicaid eligible should be enrolled in SmartCare in case non-Medicaid eligible services are provided.

Only residents of Warren/Clinton Counties will be issued a Unique Client Identifier (UCI) number through SmartCare. See Policy/Procedure 1-4 Member Residency Determination Process and 1-10 Network of Benefits for more details and requirements.

Mental Health Recovery Board Serving Warren & Clinton Counties (MHRB) contracts with Partner Solutions at Mental Health and Recovery Services of Stark County to provide SmartCare enrollment and claims services. Specific agency questions about getting set up with SmartCare access as well as procedures should be directed to Partner Solutions.

Procedure

The most recently updated Provider Documents are available at https://partnersolutions.starkmhar.org/data-analytics/ is to be used as the procedure for claims testing, enrollment, claims processing, claims corrections, and any other activities regarding SmartCare.

Reference SmartCare Provider Resources located at:

https://partnersolutions.starkmhar.org/data-analytics/https://heartlandeast.starkmhar.org/smartcareresources/

These include:

- Claims Testing documents
- Enrollment Documents
- System Documents (including the Provider User Manual)
- User Account Documents
- Agency Documents
- Help Desk Ticket Documents

Items specific to Mental Health Recovery Board Serving Warren and Clinton Counties (MHRB) are not included in the Smart Care Provider User Manual and are identified below:

Enrollment Items of note

- Family size and income are required fields. Agency is required to enter all required data into SmartCare even if the client is considered SED or SPMI where the sliding fee scale is currently waived. The benefit rule will automatically waive the sliding fee scale in those cases.

- "In Crisis at Enrollment" Only the Crisis Services Team should identify that the client is being enrolled in crisis. If an agency enrolls a client and that client is later seen by the Crisis Services Team, when the Crisis Services Team enrolls and identifies the client as "in crisis at enrollment" then SmartCare staff will not replace the client demographics from the original enrollment with the new data.

- SED/SPMI clients should be marked as "Yes" during enrollment to identify them for specific benefit rules (see Benefit Rules policy 1-9)

Claim Modifiers

MHRB uses the modifier fields to identify claims for specific funding/processing. Modifier lists are set up specifically for each agency/service code. The list of available modifiers:

Funding Source Modifiers

- XX – Title XX client
- WD – Warren County Drug Court/ATP client
- CD – Clinton County Drug Court/ATP client
- SF – Strong Families Safe Communities client/services
- PG – Problem Gambling Treatment client

Population Identification Modifiers

- AC – Assertive Community Treatment (ACT) client
- CS – Crisis Service Team client/services
- JD – Juvenile Detention Center
- FA – Forensic ACT Team
- FE – First Episode Psychosis (FEP) Team

Providers should use the modifiers assigned to their agency to properly identify claims for various populations &/or funding sources. Claims submitted without the proper modifier may need to be reversed and rebilled. See offeror form in provider contract for specific modifiers.

Policy 1-9: Benefit Rules

Effective Date: 7/1/20
Last Revised Date: 7/1/25
Lead Staff: Karen Robinson

Policy

Annually, MHRB establishes Benefit Rules which outline key components of coverage including exclusions and limitations. SmartCare will apply these rules in claims adjudication.

Reimbursement is contingent upon providers maintaining complete and accurate documentation as required by all applicable Ohio Administrative Code, including but not limited to: OAC 5160-27, OAC 5160-8-05, and OAC 5122-29-31.

Procedure

1. MHRB will communicate the Benefit Rules for programming into the SmartCare billing system.
2. SmartCare will adjudicate claims according to the Benefit Rules provided.
3. Providers should adhere to these Benefit Rules when providing service and submitting claims to SmartCare.
4. Providers should train staff on these Benefit Rules so as not to encounter un-reimbursable claims.
5. The current Fiscal Year Benefit Rules will be in Attachment 1 to this Policy/Procedure.
6. Should Provider find a claim(s) which has not been adjudicated properly in accordance with the Benefit Rules, Provider should notify MHRB immediately for investigation.

Policy 1-9 Attachment 1: System Benefit Rules

System Benefit Rules – FY26

Fee Scale –The sliding fee scale will apply to clients considered SUD/MH Medicaid and Non-Medicaid general population (See Policy 1-2 Sliding Fee Subsidy Program). The sliding fee scale will be waived for clients considered Medicaid or Non-Medicaid SPMI or SED populations.

Agency is responsible to accurately collect and report client income information for all clients, regardless of population, for SmartCare enrollment demographics and update as needed based on client information. Agency is also responsible for collection of sliding fee scale payments for general population clients.

Medicaid Eligible Services - MHRB shall not make payment to a Provider for services delivered to an individual who is eligible for Medicaid and has earned the maximum Medicaid reimbursement available. Medicaid is considered payment in full for eligible services.

Crisis Team Services - Allow services provided by the MHRB Crisis Team to be delivered to all populations – sliding fee scale waived. Crisis Team services consist of:

- MH/SUD Psychotherapy in Crisis- 90832 KX (<30 min) 90839 (60 min) 90840 (add'l 30 min)
- MH Therapeutic Behavioral Services (TBS), Individual only - H2019 KX (Paid at community rate)
- MH Community Psychiatric Supportive Treatment (CPST), Individual only -H0036

Crisis Team provider should provide assessment in the jail to determine if client needs hospitalization – billed as normal crisis service code.

Services are identified with the "KX" modifier if needed. **All services provided by the Crisis Team will use the "CS" modifier.**

Note: General clinical codes that are delivered by non-crisis team staff "in crisis" (with KX modifier) are not considered Crisis Team services and therefore the sliding fee scale applies if applicable.

Case Management Services – Waive sliding fee scale for all populations for case management services defined as:

- MH-Community Psychiatric Supportive Services (CPST) H0036 (Individual and Group)
- MH-Therapeutic Behavioral Services (TBS) H2019 (Individual and Group)
- MH-Psychosocial Rehabilitation (PSR) H2017
- SUD-Case Management H0006

Youth < 18 Without Parental Consent - MHRB follows ORC 5122.04 and ORC 3719.012 regarding the provision of service for minors without knowledge or consent of parent or guardian. Any services that are provided to youth under 18 years of age must be provided in accordance with ORC 5122.04 and ORC 3719.012.

SmartCare will insert a 30-day payer span with the Z rider code (0% responsibility for client). After this time elapses, the rider code will automatically convert to T (100% responsibility to client). MHRB will

provide full coverage for enrollees during this 30-day period. (Note: Medicaid can be billed for enrollees this 30-day period per Ohio Department of Medicaid.)

State/Private Hospital Exclusion – Services provided to a client while they are residing in a State or Private Hospital psychiatric unit are excluded, except for the following:

1) Clients seen by current case manager while in hospital, allow

   - Individual Community Psychiatric Supportive Therapy-CPST (H0036) and Individual Therapeutic Behavioral Services-TBS (H2019).
   - These clients are identified using a "51" (Inpatient Psychiatric Facility) or "21" (Inpatient Hospital) CMS place of service code.
   - Applies to all populations, no sliding fee scale applies to these services.

2) Clients seen by the Hospital/Community Linkage Specialist will be paid as follows:

   - Individual Community Psychiatric Supportive Therapy (CPST H0036) should be billed to Medicaid when applicable (See OAC 5160-27-02)
   - Position is grant funded – no services should be billed to MHRB
   - These clients are identified using a "51" (Inpatient Psychiatric Facility) or "21" (Inpatient Hospital) CMS place of service code.

3) Allow Psychiatric Diagnostic Assessment (90791/90792) in a State or Private Hospital setting

   - These clients are identified using a "51" (Inpatient Psychiatric Facility) or "21" (Inpatient Hospital) CMS place of service code.
   - Applies to all populations, no sliding fee scale applies to these services.

4) Applies to Warren/Clinton Residents only

Adult Penal System Exclusion – Services provided to an adult client (18 years or older) while they are incarcerated in the penal system are excluded, except for the following:

- MH Individual Community Psychiatric Supportive Therapy-CPST (H0036) and Individual Therapeutic Behavioral Services-TBS (H2019) for ESTABLISHED Warren/Clinton CLIENTS ONLY
- Psychiatric Diagnostic Evaluation w/o medical – 90791 for Warren/Clinton Residents only.
- These clients are identified using a "09" (Jail) CMS place of service code.
- Applies to MHOP/SPMI populations, waive Sliding Fee Scale for all Warren/Clinton Residents.

Juvenile Penal System Exclusion – Services provided to a child/adolescent client (under 18 years) while they are incarcerated in the juvenile detention and Mary Haven are excluded, except for the following:

- MH Individual Psychotherapy in Crisis – 90832 KX (<30 min), 90839 (60min), +90840 (add'l 30 min) - for Warren/Clinton Residents only.
- MH Individual Community Psychiatric Supportive Therapy-CPST (H0036) and Individual Therapeutic Behavioral Services-TBS (H2019) for ESTABLISHED Warren/Clinton CLIENTS ONLY.
- Psychiatric Diagnostic Evaluation w/o medical –90791for Warren/Clinton Residents only.

- These clients are identified using a "09" CMS place of service code (includes juvenile detention and Mary Haven).
- Waive Sliding Fee Scale for all Warren/Clinton Residents.

Therapeutic Mentoring – Limit number of units allowed per client per SFY to 208 hours (832 units). Units billed in excess of 832 will be denied. Provider may request additional units prior to reaching the maximum number of units by utilizing the Pre-Authorization Process outlined in Policy 1-3.

Adult Education Limitation – Allow Adult Education (M1540) to clients in the SPMI population only. Limit adult education delivered to SPMI clients to no more than 96 units (24 hours) in a fiscal year. 1 unit = 15 minutes. (sliding fee scale waived for SPMI population)

MH Residential & Housing Exclusion – Exclude residential and housing services for clients in Medicaid and non-Medicaid general outpatient populations. (non SPMI/SED populations)

Exclude Client Specific – Unless an exception has been defined, exclude client specific services for services designated to be non-client specific services.

MH Assertive Community Treatment (ACT) (H0040) - Board pay clients will no longer be billed to H0040 for ACT Services. These services should be billed unbundled. Medicaid clients may be billed to ODM either using H0040 or unbundled.

Coverage, limitations and provision of behavioral health services by MHRB for non-Medicaid clients shall follow what has been established under OAC 5122-29-31, OAC 5160-27-02, OAC 5160-27-03, OAC 5160-8-05, Chapter OAC 5160-27, OAC 5160-1-18, and OAC 5122-29-31, of specific note:

- All client specific claims submitted to MHRB via SmartCare must include an ICD-10 diagnosis of mental illness or substance use disorder. Reimbursable behavioral health services are limited to medically necessary services defined in rule 5160-8-05 of the Administrative Code and Chapter 5160-27 of the Administrative Code.

- Non-Medicaid, non-clinical services do not need a diagnosis code (i.e., Consultation, Adult Education, Prevention Services, Housing Services, Room and Board Services, Therapeutic Mentoring, Other MH/SUD Services).

- Providers shall follow the above rules and Office of Medicaid (ODM) edits regarding services that cannot be billed in combination with other services.

- Behavioral Health services that are reimbursable by Medicare and/or a third-party health care insurer shall be billed first to that plan(s). Failure to do so may result in denial of claim.

The following services have limitations on the amount, scope or duration of the service that can be rendered to a recipient within a certain timeframe.

- Assertive Community Treatment (ACT) – Medicaid eligible clients must have prior authorization under OAC 5160-27-04.

- SUD Assessment (H0001) is limited to two assessments per recipient, per billing provider, per calendar year under 5160-27-09.

- SUD Urine Drug Screen (H0048) is limited to one per day, per recipient under 5160-27-09.

- Peer Recovery Support (H0038) is limited to four hours per day per recipient under 5160-27-09 and 5160-43-04.

- Substance use disorder residential level of care as described in rule 5160-27-09 of the Administrative Code is available for up to thirty consecutive days without prior authorization per recipient for the first and second admission, during the same calendar year. If the stay continues beyond thirty days of the first or second stay, prior authorization by MHRB's Deputy Director of Substance Use Disorders, Criminal Justice and Outpatient Mental Health is required to support the medical necessity of continued stay. If medical necessity is not substantiated and not approved by MHRB, only the initial thirty consecutive days will be reimbursed. Third and subsequent admissions during the same calendar year must be prior authorized by MHRB from the date of admission.

- SED residential placement requires pre-authorization as per Policy 1-3 for MHRB funding. MHRB is always the payor of last resort, therefore funding is only available (after any insurance or other benefits have been utilized) to clients not eligible for FCFC Service Coordination services or pooled funding, OhioRISE, or youth in custody of an agency. If the client does not have Medicaid, the parent/guardian will be responsible for 5% of the cost of Room and Board. The parent/guardian may choose to complete the Child Support payment assessment through the local Child Support Enforcement Agency. Then the lower of the two calculations would be used (5% vs. Child Support calculation). The financial obligations for MHRB and parent/guardian will be specified in any contracts with the residential facility.

- Psychiatric Diagnostic Evaluation with or without Medical (90791 and 90792) is limited to one of each service per provider per calendar year, not on the same date of service as a therapeutic visit.

- Psychological testing is limited to a maximum of twelve hours per recipient, per calendar year.

- Neuropsychological testing is limited to a maximum of eight hours per recipient, per calendar year.

- Certain Coordination & Support services – If more than six (6) units (90 minutes) of the following services are delivered on the same date of service by the same agency in place of service 11 &/or 53, subsequent units will be adjudicated at 50% of the standard rates:

    - Community psychiatric supportive treatment (CPST – H0036, H0036/HQ),
    - Therapeutic behavioral service (H2019, H2019/HQ),
    - Psychosocial rehabilitation (H2017),
    - SUD Targeted case management (H0006)

Telehealth Service Provision

Telehealth service and billing specifications are outlined in OAC 5160-1-18, OAC 5122-29-31, and any Ohio professional licensure board rules including but not limited to OAC 4757-5-13. **MHRB has implemented the same telehealth rules regarding services billed to MHRB.** Additionally, all telehealth services billed to MHRB shall use the location of service as "distant site" as defined in the rule - "Distant site means the site where the eligible provider is located at the time the service is furnished" (e.g. if provider is in the office or at home, the location of service shall be recorded as office for billing purposes).

The following services may be provided via telehealth:

- General services
- CPST
- TBS and PRS
- Peer Recovery services
- SUD case management service
- Crisis intervention service
- Assertive community treatment service
- Intensive home-based treatment service
- Mobile Response and Stabilization service

Provider shall adhere to all service provision and documentation stipulations outlined in OAC 5122-29-31 for the provision of telehealth. All providers must include the "GT" modifier for telehealth services.

Other General Rules

24 Hour Limit – Limit of 24 hours (units) of service per day whether billed as 1 hour unit (24 units) or 15-minute unit (96 units)

Day Services Limit – Limit of 1 service per day

- Intensive Outpatient-Group Counseling, H0015 must be provided to a client for a minimum length of 2 hours and 1 minute.
- Partial Hospitalization-Group Counseling H0015 must be provided to a client for a minimum length of 3 hours and 1 minute.
- SUD Residential Treatment (H2036) and Withdrawal Management (H0014)
- MH Residential & Housing

Prevention Services Exclusion – Unless an exception has been defined, exclude MH and SUD non-client specific prevention for services designated to be client specific services.

Policy 1-10: Network of Benefit Communication

Effective Date: 7/1/20
Last Revised Date: 7/1/24
Lead Staff: Dustin Ratliff

Policy

Mental Health Recovery Board Serving Warren and Clinton Counties (MHRB) strives to effectively and efficiently communicate benefits and coverage to individuals seeking services provided by contract agencies.

In order to do so, this requires the active participation and assistance of contract agencies.

Procedure

1. MHRB will provide agencies with an explanation of Network Benefits annually.

2. Agencies will be responsible for providing this document to individuals seeking MHRB-covered services. The current Network of Benefits document shall be in Attachment 1 to this Policy/Procedure.

3. In accordance with the Behavioral Health Provider Contract section 7.3.7, the agency shall ensure that persons seeking services under MHRB funding shall sign a disclosure statement which informs the individual of the following information in accordance with the requirements of Ohio's Personal Information Systems Act (ORC Chapter 1347):

    a. The purpose of the claims and information system utilized by the Board (SmartCare), and the personal information stored in the system;
    b. How the information is used by the Provider and the Board; and
    c. Whether the person is legally required to, or may refuse to, supply the information.

4. An overview of Ohio's Personal Information Systems Act can be found in Attachment 2.

5. The "Claims and Information System: Notice of Enrollment" client signature page can be found in Attachment 3.

6. Agencies shall train staff in this policy and procedure and ensure compliance.

Policy 1-10 Attachment 1: Network Benefit Plan

Mental Health Recovery Board Serving Warren & Clinton Counties (MHRBWCC) oversees and pays for behavioral health services for local citizens based upon need. The benefits that MHRBWCC provides are available to the residents of Clinton and Warren Counties through our network of provider agencies. MHRBWCC and its agency network work together to ensure quality services.

What is the Network Benefit Plan?

The Network Benefit Plan provides public funds to help pay for behavioral health services. These may include counseling, medication, case management, housing, job training, consultation with schools, social supports, and developing everyday living skills. The MHRBWCC network is designed to help individuals and families deal with the behavioral health crises that they sometimes face.

How is the MHRS Network funded?

The MHRBWCC network is funded by federal and state tax dollars (through the Ohio Department of Mental Health & Addiction Services) and a local levy..

What help does the Network Benefit Plan offer?

The Network Benefit Plan provides funding for quality behavioral health services, outpatient, and residential services to residents based on clinical and financial need.

What about more serious mental illnesses?

Serious mental illnesses, sometimes referred to as brain disorders, are conditions such as major depression, bipolar disorder, schizophrenia, and obsessive compulsive disorder. These conditions may range from mild to severe and are treated by qualified providers in the network. MHRBWCC encourages you to work with your provider to create and participate in your treatment plan, as this increases the likelihood of progress.

How can I receive these services?

Contact the agency from which you would like to receive services. You can check agency hours and locations at our website, mhrsonline.org. A staff person will ask you about your situation to make sure the services the agency provides are appropriate for your needs.

What if I can't afford to pay for services?

Your agency will ask you for some financial information. This will be used to determine the amount of financial help needed. You must be a resident of Warren or Clinton Counties to receive financial assistance.

How do I become part of the Network Benefit Plan?

Warren and Clinton County residents who request clinical services will be given the opportunity to enroll in the Network Benefit Plan.

What does enrollment in the Network Benefit Plan involve?

When you enroll you will be asked to sign a billing authorization statement. This form permits the provider to bill MHRBWCC, which accesses public funds. You will be asked during intake about your income, family size, whether you have private health insurance, or whether you are covered by Medicaid or Medicare. This information will be entered into a computerized billing system operated by MHRBWCC.

Will my private insurance cover my care?

Most agencies accept private insurance. Those agencies will work with you to determine if your treatment is covered under your private insurance plan. Keep in mind that you may be responsible for paying any applicable deductibles and co-pays.

Do I have to enroll in the Network Benefit Plan?

No. You may choose not to enroll. If you choose not to enroll, you will not be considered for public funds. You will need to make other arrangements for covering the cost of your treatment, and you may be billed for those services.

(over)

What if I receive a bill for my "in-network" benefit services?

If you are in the Network Benefit Plan and you receive a bill for services, please contact that agency and request that they review the billing for your services. Adjustments can be made if an error has been made.

How will I know I'm getting the best services?

MHRBWCC and the Ohio Department of Mental Health and Addiction Services review network agencies on a regular basis. Many agencies are also accredited by various professional organizations. Treatment staff must have specific educational degrees, certifications and trainings.

Can my family and I help decide on my treatment?

We encourage you to be involved in any decisions regarding your treatment. This is a right under state law. When there is no conflict with confidentiality, families are encouraged to be involved with the treatment being received. In most cases, the more a family is part of the individual's care, the more progress can be made.

What family supports are available?

Families dealing with a loved one's mental illness may wish to join the local chapter of the National Alliance on Mental Illness (NAMI) and other local support groups. Agencies also may have information available for alcohol and drug use support groups. In addition, support and education may be available for other mental health issues.

Can I help to make sure my treatment is successful?

Absolutely. In order for you and your family to receive the most benefit from services, you must think of yourself as part of the treatment team.

What If I seek services outside my network?

Enrollees are encouraged to use local county providers that are part of the network. If services are sought in another county or outside the network, and you are not Medicaid eligible, special requests can be considered but some benefits may not be available.

Is my information kept confidential?

Yes. MHRBWCC and each provider must comply with state and federal laws regarding confidentiality.

What if I'm not satisfied with my care?

The network aims to provide only quality services, but you are encouraged to discuss any concerns regarding treatment with your provider. If the problem continues, you can file a formal grievance. MHRBWCC and each provider have a plan for dealing with such complaints. To begin this process, ask to speak to the agency's Client's Rights Officer. Your rights are also fully explained in the Client's Rights Policy and Grievance Procedure. A copy is available on our website, or you can call us at 513-695-1695.

What if I have questions about MHRB's benefits or payments?

MHRB provides funding on a service continuum that covers most behavioral health needs. If you have questions about available services, or disagree with payment of your services, please call (513) 695-1695 and ask to speak with the MHRB Clients Rights Officer. We can assist you in understanding the Benefit Rules and funding that you have.

Primary Provider Network

Beech Acres Parenting Center • Butler Behavioral Health Services •
Greater Cincinnati Behavioral Health • New Housing Ohio • Sojourner Recovery Services •
Talbert House • Warren County Educational Service Center

For a complete list of provider agencies, visit our website at mhrbwcc.org

Mental Health Recovery Board
Serving Warren & Clinton Counties

Revised 07/1/2025

Policy 1-10 Attachment 2: Notice of Enrollment Form Overview

Overview of Claims and Information System Notice of Enrollment Form

Ohio's Personal Information Systems Act "PISA" (Ohio Revised Code (ORC) Chapter 1347) requires every state and local agency that maintains a "personal information system", such as the claims and information systems used by Boards, to comply with certain requirements in regards to that system and the information it contains. Many of the requirements of the Act are duplicative of what is required by HIPAA such as breach reporting, protecting the information against unauthorized use or disclosure and providing individuals with access to their own information upon request. Boards comply with those requirements through their compliance with the HIPAA Privacy and Security Rules. There are some requirements of the Act, however, that are not duplicative of HIPAA's requirements.

PISA requires that when persons are asked to supply personal information to a governmental system, they are informed whether they are required to, or may refuse to, supply that information. ORC 1347.05(E). It also requires that when personal information is placed into a system that is connected to or combined with that of another organization, individuals must be provided with "information relevant to the system, including the identity of other agencies or organizations that have access to the information in the system". ORC 1347.071(C).

For Boards, this means that Boards must inform persons that if they wish to receive any publicly-funded services, their personal information is required to be entered into the system used by the Board. Other information relevant to the system must also be provided to the individual, including the names of other entities that have access to the information in the system.

The law does not require these notices to be signed by the individual, although it is a good practice to do so in order to show that the Board has complied with the Act. It also does not require any specific statements or information to be included in the notice beyond what is required by ORC 1347.071(C). The attached *Claims and Information System Notice of Enrollment* is a sample notice that can be used to comply with the Act.

Since the Act does not require the notice to be signed by the individual, it is acceptable to attempt to have a client experiencing a crisis or lacking capacity sign the form at a later date, such as when on-going services commence.

Some Boards have asked whether they can comply with the Personal Information Systems Act by including the required information in their HIPAA-required Privacy Notice. It is important to note that the Act requires that an individual receive information about the system before it is entered into that system. Since Boards typically do not provide their Notice of Privacy Practices to individuals until after they are entered into the system, a separate notice containing the information required by the Act must be provided to individuals at the time they are asked by the provider to supply the information.

Please note that this is not an authorization to disclose information under the confidentiality laws. Providers are responsible for ensuring that any required authorizations are obtained from the client prior to disclosing information to Boards. Boards are responsible for ensuring that individuals receive the information required by the Personal Information Systems Act prior to being entered into the billing management system used by Boards.

Policy 1-10 Attachment 3: Notice of Enrollment Form

CLAIMS AND INFORMATION SYSTEM NOTICE OF ENROLLMENT

To be eligible to receive public funds to help pay for the cost of your mental health and/or addiction services, your personal information must be entered into the claims and information system used by Mental Health Recovery Board Serving Warren and Clinton Counties (MHRB). The billing system "SmartCare" is administered on behalf of MHRB by the Stark County Mental Health & Addiction Recovery Board.

This information will be used by the Board to:

- Enroll you in the Board's Benefit Plans
- Determine your eligibility for publicly-funded services
- Pay the provider for those services
- Fulfill the Board's legal responsibilities

If applicable law requires you to consent to the disclosure of this information to the Board, your information will not be entered into the system without your written consent. Once in the system, your information will only be used or disclosed by the Board as authorized by you or as permitted by applicable law.

Other County Behavioral Health Boards that pay for your services may utilize the same billing management information system as the Board but will only access your personal information as authorized by you or as permitted by applicable law.

Name of Client: _____

Signature of Client: _____Date _____

I have read and explained this information to the above-named individual.

_____

Provider Agency Staff Date

Client has refused or is unable to sign this form but has been informed of its contents.

(Check if applicable) ☐

If Refusal, note reason: _____

* This form must be completed for every client seeking publicly funded services. This form must be kept with the client's record.

Policy 1-11: Provider Marketing – Inclusion of MHRB Logo

Effective Date: 7/1/20
Last Revised Date: 7/1/23
Lead Staff: John Cummings

Policy

All Contract providers are required to publicize their funding from Mental Health Recovery Board Serving Warren & Clinton Counties (MHRBWCC), as well as include MHRBWCC logo and funding recognition in marketing and communications materials when appropriate.

Procedure

General Requirements

- Include news of your funding in any publications or digital media you produce for internal or external audiences, such as newsletters, brochures, annual reports, lists of supporters, board minutes, or e-Newsletters, website, and social media.
- Contact local media, including special interest publications, as appropriate.
- Where financially feasible, include the MHRBWCC logo on brochures, digital media, signs, or plaques that recognize funders at events or on facilities.

Website Linking

- Please use the following URL to link to MHRBWCC's site: www.mhrbwcc.org

MHRBWCC Logo Formatting Guidelines

- You may resize, but do not crop the logo.
- Use the Encapsulated Postscript (EPS) format for printing professionally.
- Use the Joint Photographic Experts Group (JPEG) format for using Microsoft Word or Publisher
- Use the RGB format for online (web) usage.

Logo Formats

Provided by MHRBWCC upon request. Please send logo requests to jcummings@mhrbwcc.org.

Policy 1-12: Client Abuse or Neglect Investigations

Effective Date: 7/1/23
Last Revised Date: 7/1/25
Lead Staff: Amanda Peterson

Policy

It is the policy of Mental Health Recovery Board Serving Warren and Clinton Counties (MHRB) that all complaints alleging abuse or neglect of persons served will be investigated in a timely manner and corrective action taken, if necessary. This policy and procedure is applicable to persons who are:

- Receiving services from a provider under contract with MHRB
- Residing in an Ohio Department of Mental Health and Addiction Services (OMHAS) licensed residential facility provider located in Warren or Clinton Counites
- Residing in an Ohio Department of Mental Health and Addiction Services (OMHAS) licensed residential facility provider located out-of-county but providing service to a Warren or Clinton County resident

Authority

In accordance with ORC 340.03(A)(2), MHRB shall investigate, or request another agency to investigate, any complaint alleging abuse or neglect of any person receiving addiction services, mental health services, or recovery supports from a community addiction services provider or community mental health services provider or alleging abuse or neglect of a resident receiving addiction services or with mental illness or severe mental disability residing in a residential facility licensed under section 5119.34 of the Revised Code. If the investigation substantiates the charge of abuse or neglect, MHRB shall take whatever action it determines is necessary to correct the situation, including notification of the appropriate authorities. Upon request, MHRB shall provide information about such investigations to OMHAS.

Definitions

Definitions applicable to Contract Service Providers pursuant to OAC 5122-24-01 or to MHRB:

1. “Abuse” means any act or absence of action inconsistent with human rights which results or could result in physical injury to a person served, unless the act is done in self-defense or occurs by accident; any act which constitutes sexual activity, as defined under Chapter 2907 of the Revised Code, where such activity would constitute an offense against a person served under that chapter; insulting or coarse language or gestures directed toward a person served which subjects the person served to humiliation or degradation; or depriving a person served of real or personal property by fraudulent or illegal means. For children, the definition of abuse is the same as in sections 2919.22 and 2151.031 of the Revised Code.

2. "Client" means a person admitted by a provider for mental health or addiction services or who receives mental health or addiction services from a provider. "Persons," "Persons Receiving Services," "Persons Being Served," "Persons Served", or "Consumer" has the same meaning as client. The terms include all categories of persons of all ages, unless specified.

3. "Neglect" means a purposeful or negligent disregard of duty by an employee or staff member. Such duty is one that is imposed on an employee or staff member by statute, rule, or professional standards and which is owed to the person served by that employee or staff member.

4. "Provider" means

    a. Any community addiction services provider or community mental health services provider certified by OMHAS to provide services pursuant to section 5119.36 of the Revised Code.

    b. Any board of alcohol, drug addiction, and mental health services approved by OMHAS in accordance with section 340.037 of the Revised Code to provide any of the mental health or addiction services listed in section 340.09 of the Revised Code, or any board of alcohol, drug addiction, and mental health services determined by OMHAS to be providing a service subject to department approval; or,

    c. Any residential facility licensed according to section 5119.34 of the Revised Code that provides any of the mental health services listed in Chapter 5122-29 of the Administrative Code.

Definitions applicable to Licensed Residential Care Facilities pursuant to OAC 5122-30-03:

1. "Abuse" means any act or absence of action inconsistent with human rights which results or could result in physical injury to a resident unless the act is done in self-defense or occurs by accident; any act which constitutes sexual activity, as defined under Chapter 2907 of the Revised Code, when such activity would constitute an offense against a resident under Chapter 2907 of the Revised Code; insulting or coarse language or gestures directed toward a resident which subjects the resident to humiliation or degradation; or depriving a resident of real or personal property by fraudulent or illegal means. For children, in addition to the above, the definition of abuse is the same as in sections 2919.22 and 2151.031 of the Revised Code.

2. "License" means the signed, numbered, dated document issued by OMHAS to the facility which specifies the term of licensure (full, probationary, or interim), the category of facility as defined in division (B) of section 5119.34 of the Revised Code, and the resident limitations imposed by the facility category.

3. "Neglect" means a purposeful negligent disregard of duty by an employee or staff member. Such duty is one that is imposed on an employee or staff member by statute, rule, or professional standards and which is owed to the person served by that employee or staff member.

4. "Residential facility" means a publicly or privately operated home or facility as defined in division (B) of section 5119.34 of the Revised Code. The categories of facility are:

    a) Class one facilities provide accommodations, supervision, personal care services, and mental health services for one or more unrelated adults with mental illness or one or more unrelated children or adolescents with severe emotional disturbances.

    b) Class two facilities provide accommodations, supervision, and personal care services to any of the following:

a. One or two unrelated persons with mental illness;
b. One or two unrelated adults who are receiving residential state supplement payments; or,
c. Three to sixteen unrelated adults.
d. Class three facilities provide room and board for five or more unrelated adults with mental illness.

5. "Staff" means any person or persons participating in the physical operation of the facility, the provision of mental health services, personal care, room and board, and/or supervision of residents, whether or not that person is compensated for that assistance. Staff should be understood to include the operator of the facility when the operator is a participant in the performance of those activities.

Procedure

1. Contract providers and residential facilities shall maintain written procedures for investigating alleged cases of neglect/abuse of clients in accordance with the Ohio Administrative Code, professional licensing boards' regulatory standards, and legal obligations to report.

2. Contract providers and residential facilities shall report any allegation of staff neglect, abuse, or exploitation to the proper authorities immediately upon discovery and to MHRB in writing within twenty-four hours of the event discovery. Subsequently, contract providers and residential facilities shall communicate the results of the investigation to MHRB in writing when completed.

3. Per ORC 340.05, a contract community addiction and/or mental health services provider that receives a complaint alleging abuse or neglect of an individual with mental illness or severe mental disability, or an individual receiving addiction services, who resides in a residential facility licensed under section 5119.34 of the Revised Code, shall immediately report the complaint to MHRB if the facility is located in Warren or Clinton Counties. Allegations of abuse or neglect of out-of-county adult care facilities shall be made to the alcohol, drug addictions and mental health services board in which the adult care facility is located. Should the residential facility be located outside the MHRB catchment area, but a Warren or Clinton County resident is the alleged victim, MHRB will also be notified immediately.

    a. The responding board that receives such a report from a provider shall report the complaint to the director of OMHAS for the purpose of the director conducting an investigation under section 5119.34 of the Revised Code.

    b. The board may enter the facility with or without the OMHAS director and, if the health and safety of a resident is in immediate danger, take any necessary action to protect the resident.

    c. The board's action shall not violate any resident's rights specific in rules adopted by OMHAS under section 5119.34 of the Revised Code.

    d. The board shall immediately report to the OMHAS director regarding the board's actions.

    e. As deemed appropriate, the directors of the Ohio departments of health, and aging and the Ohio Disability Rights service may also be notified.

f. If such actions taken involve relocating a residential state supplement recipient, MHRB shall immediately notify the passport administrative agency for the area.

g. Per ORC 5119.34(L)(2), employees of the board may enter a residential facility at any time under either of the following circumstances:

   i. When a resident of the facility is receiving services from a community mental health services provider under contract with that MHRB or another ADAMHS board

   ii. When authorized by section 340.05 of the Revised Code.

h. Per ORC 5119.34(L), employees of the board shall be afforded access to examine and copy all records, accounts, and any other documents relating to the operation of the residential facility, including records pertaining to residents.

i. Provider shall cooperate with Board investigations of alleged abuse or neglect of persons receiving services from the Provider in accordance with the requirements of ORC 340.03(A)(2).

4. Anyone may call MHRB to make an abuse/neglect complaint. If an allegation concerns someone receiving services from a certified contract provider (regardless of payor source) or from someone residing in a residential facility licensed by Ohio Department of Mental Health and Addiction Services, MHRB shall require the provider to complete the appropriate Notification of Incident form that is sent to OMHAS (within 24 hours of discovery of the incident) and copied to MHRB.

5. Allegations of abuse or neglect shall also be reported to:

   a. Child: The respective county Children's Services.

   b. Nursing home residents who are adults over the age of 60 or individuals aged 16-60 who are developmentally delayed: Ohio Department of Health and the local board of developmental disabilities.

   c. Adults over the age of 60: The respective county department of Job and Family Services' Adult Protective Services Division.

   d. Individuals aged 16-60 who are developmentally delayed: The respective county department of Job and Family Services' Adult Protective Services Division and the local board of developmental disabilities.

   e. A report may be made to the appropriate law enforcement authorities having jurisdiction over the location where the alleged abuse or neglect occurred, including when immediate protection of the victim is necessary.

   f. A report may also be made as deemed appropriate to the licensing entities.

6. Upon receipt of a provider or facility report alleging client abuse or neglect, MHRB will ensure that the report has been made to the appropriate authorities. If not, MHRB will make such a report.

7. Allegations of client abuse or neglect will be accepted, and the process overseen by the MHRB client rights officer (CRO) under the direction of the executive director. The investigation will be conducted by the program director for the service population in which the alleged victim is enrolled. This investigation may include contact with the reporting provider, other agencies involved, investigating entities, as well as an interview with the client and other individuals who may have information relevant to the allegations of abuse or neglect.

8. Investigations will be delegated to those authorities legally responsible for such as outlined in Procedure E listed above and results documented by MHRB staff. Only when such delegation of authority is not deemed feasible will MHRB be the lead investigating entity.

9. The identity of any person reporting allegations of abuse or neglect shall not be disclosed to the alleged perpetrator except through appropriate legal action or if the person agrees in writing to such disclosure.

10. If the investigation substantiates the charge of abuse or neglect, MHRB shall take whatever action determined necessary to correct the situation, including notification of the appropriate authorities and licensing entities.

11. A written report of the investigation into an allegation of client abuse or neglect will be reviewed by the MHRB executive director. MHRB shall keep documentation of any reports of client abuse or neglect on the Incident Form accompanied with any follow-up action taken by MHRB staff, findings of the investigation, as well as actions taken or recommended as a result of the investigation.

12. Upon request, MHRB shall provide information about the investigation to OMHAS.

13. Any data provided to persons requesting it pursuant to Ohio Public Records Acts will be in system-wide aggregate nature only which conforms to provisions in law regarding client confidentiality.

14. This policy and procedure is for abuse and neglect complaints only and does not replace MHRB's policies/procedures for client rights and grievances or incident reporting.

Policy 1-13: Clients Rights and Grievance Investigations

Effective Date: 7/1/23
Last Revised Date: 7/1/25
Lead Staff: Amanda Peterson

Policy

The purpose of this policy is to protect and promote the rights of all persons receiving or applying for services provided or funded by the Mental Health Recovery Board Serving Warren and Clinton Counties (MHRB), to insure the opportunity for a timely and impartial hearing and fair resolution of grievances, and to insure compliance with all applicable federal, state and local laws and regulations regarding client rights. MHRB shall have a procedure for addressing client rights complaints, including complaints initiated by or on behalf of a resident of a residential facility licensed by the Ohio Department of Mental Health and Addiction Services which is a contracted provider in the MHRB system of care.

Definitions

"Abuse" means any act or absence of action inconsistent with human rights which results or could result in physical injury to a person served, unless the act is done in self-defense or occurs by accident; any act which constitutes sexual activity, as defined under Chapter 2907. of the Revised Code, where such activity would constitute an offense against a person served under that chapter; insulting or coarse language or gestures directed toward a person served which subjects the person served to humiliation or degradation; or depriving a person served of real or personal property by fraudulent or illegal means. For children, the definition of abuse is the same as in sections 2919.22 and 2151.031 of the Revised Code.

“Board” means Mental Health Recovery Board Serving Warren and Clinton Counties, a board of alcohol, drug addiction, and mental health services constituted according to section 340.02 of the Revised Code.

“Client” means an individual applying for or receiving mental health or addiction services from the Board or contract provider of the Board. This also incorporates residents who live in Residential Facilities Class One, Two and Three licensed by the Ohio Department of Mental Health and Addiction Services which is also a contracted provider in the MHRB system of care.

“Client Rights Officer" (CRO) means the individual designated by a community mental health or addiction services provider or Board with responsibility for assuring compliance with the client rights and grievance procedure rule as implemented within each provider or board. For these purposes, the title of Client Rights Officer has the same meaning as client advocate or client rights specialist.

“Contract provider” means a public or private service provider with which a Board enters into a contract for the delivery of behavioral health services. A board which is itself providing behavioral health services is subject to the same requirements and standards which are applicable to contract providers as specified in rule 5122:2-1-05 of the Ohio Administrative Code.

"Grievance" means a written complaint initiated either verbally or in writing by a client or by any other person or provider on behalf of a client regarding denial or abuse of any client's rights.

"Neglect" means a purposeful or negligent disregard of duty by an employee or staff member. Such duty is one that is imposed on an employee or staff member by statute, rule, or professional standards and which is owed to the person served by that employee or staff member.

"Services" means the complete array of professional interventions designed to help a person achieve improvements in mental health or addiction such as counseling, individual or group therapy, education, community psychiatric supportive treatment, assessment, diagnosis, treatment planning and goal setting, clinical review, psychopharmacology, discharge planning, professionally led support, etc.

"Reasonable" means a standard for what is fair and appropriate under usual and ordinary circumstances."

"Residential Facility" means a publicly or privately operated home or facility as defined in division (B) of section 5119.34 of the Revised Code. The categories of facility are:

a. Class one facilities provide accommodations, supervision, personal care services, and mental health services for one or more unrelated adults with mental illness or one or more unrelated children or adolescents with severe emotional disturbances.

b. Class two facilities provide accommodations, supervision, and personal care services to any of the following:

    i. One or two unrelated persons with mental illness;
    ii. One or two unrelated adults who are receiving residential state supplement payments; or,
    iii. Three to sixteen unrelated adults.

c. Class three facilities provide room and board for five or more unrelated adults with mental illness.

"Resident rights advocate" means the residential facility staff, or a representative of the state long-term care ombudsman program, with responsibility for implementing the grievance procedure in Residential Facilities Class One, Two and Three.

Client Rights are defined in rules 5122-26-18, 5122-30-22 and 5122-30-22.1 of the Ohio Administrative Code (OAC) and endorsed by the Board. These are as follows:

Client Rights – General – OAC 5122-26-18

All persons applying for or receiving services from the Board or funded by or through the Board except for clients receiving forensic evaluation services through a State Certified Forensic Agency shall be entitled to the following rights in accordance with Ohio Department of Mental Health and Addiction Services' Administrative Rule 5122-26-18 and all other applicable sections of the Ohio Revised Code:

1. The right to be treated with consideration and respect for personal dignity, autonomy, and privacy;
2. The right to reasonable protection from physical, sexual or emotional abuse, neglect, and inhumane treatment;
3. The right to receive services in the least restrictive, feasible environment;
4. The right to participate in any appropriate and available service that is consistent with an individual service plan (ISP), regardless of the refusal of any other service, unless that service is a necessity to clear treatment reasons and requires the person's participation;
5. The right to give informed consent to or refuse any service, treatment or therapy, including medication absent an emergency;
6. The right to participate in the development, review, and revision of one's own individualized treatment plan and receive a copy of it;
7. The right to freedom from unnecessary or excessive medication, and to be free from restraint or seclusion unless there is immediate risk of physical harm to self or others;
8. The right to be informed of and refuse any unusual or hazardous treatment procedures;
9. The right to be advised of and refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, televisions, movies, photographs or other audio and visual technology. This right does not prohibit an agency from using closed-circuit monitoring and observe seclusion rooms or common areas, which does not include bathrooms or sleeping areas;
10. The right to confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of client information under state and federal laws and regulations;
11. The right to access one's own client record unless access to certain information is restricted for clear treatment reasons. If access is restricted, the treatment plan shall include the reason for the restriction, a goal to remove the restriction, and the treatment being offered to remove the restriction;
12. The right to be informed a reasonable amount of time in advance of the reason for terminating participation in a service, and to be provided a referral, unless the service is unavailable or not necessary;
13. The right to be informed of the reason for denial of a service;
14. The right not to be discriminated against for receiving services on the basis of religion, race, ethnicity, color, gender, sexual orientation, national origin, age, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws;
15. The right to know the cost of services;
16. The right to be verbally informed of all client rights, and to receive a written copy upon request;
17. The right to exercise one's own rights without reprisal, except that no right extends so far as to supersede health and safety considerations;
18. The right to file a grievance;
19. The right to have oral and written instructions concerning the procedure for filing a grievance, and to receive assistance in filing a grievance if requested;
20. The right to be informed of one's own condition; and,
21. The right to consult with independent treatment specialists or legal counsel at one's own expense.

Client Rights – Forensic - OAC 5122-26-18

Each client receiving a forensic evaluation service from a Certified Forensic Center has the following rights:

1. The right to be treated with consideration and respect for personal dignity;
2. The right to be evaluated in a physical environment affording as much privacy as possible;
3. The right to service in a humane setting which is the least restrictive feasible if such setting is under the control of the forensic center;
4. The right to be informed of the purpose and procedures of the evaluation service;
5. The right to consent to or refuse the forensic evaluation services and to be informed of the probable consequences of refusal;
6. The right to freedom from unnecessary restraint or seclusion if such restraint or seclusion is within the control of the forensic center;
7. The right to be advised of and refuse observation by techniques such as one-way vision mirrors, tape recordings, televisions, movies, or photographs, or other audio and visual technology, unless ordered by the court, in which case the client must be informed of such technique. This right does not prohibit an agency from using closed-circuit monitoring to observe seclusion rooms or common areas, which does not include bathrooms;
8. The right not to be discriminated against in the provision of service on the basis of religion, race, ethnicity, color, gender, national origin, sexual orientation, age, genetic information, physical or mental handicap, developmental disability, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws;
9. The right to be fully informed of all rights;
10. The right to exercise any and all rights without reprisal in any form;
11. The right to file a grievance;
12. The right to have oral and written instructions for filing a grievance including an explanation that the filing of a grievance is exclusively an administrative proceeding within the mental health system and will not affect or delay the outcome of the criminal charges.

Client Rights – Class One Residential Facilities: OAC 5122-30-22

1. The right to be verbally informed of all resident rights in language and terms appropriate for the resident's understanding, prior to or at the time of residency, absent a crisis or emergency.
2. The right to request a written copy of all resident rights and the grievance procedure.
3. The right to exercise one's own rights without reprisal, except that no right extends so far as to supersede health and safety considerations.
4. The right to file a grievance.
5. The right to be treated all times with courtesy and respect, and with consideration for personal dignity, autonomy and privacy.
6. The right to receive services in the least restrictive, feasible environment.
7. The right to receive humane services in a clean, safe, comfortable, welcoming, stable and supportive environment.
8. The right to reasonable protection from physical, sexual and emotional abuse, neglect, and exploitation.
9. The right to freedom from unnecessary or excessive medication, and the right to decline medication, except a class one facility which employs staff authorized by the Ohio Revised Code to administer medication and when there is imminent risk of physical harm to self or others.

10. The right to be free from restraint or seclusion unless there is imminent risk of physical harm to self or others.
11. The right to be advised and the right to refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, television, movies, photographs or other audio and visual technology. This right does not prohibit a facility from using closed-circuit monitoring to observe seclusion rooms or other areas in the facility, other than bathrooms or sleeping areas, or other areas where privacy is reasonably expected, e.g., a medical examination room.
12. The right to confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of resident information under state and federal laws and regulations.
13. The right to have access to one's own record unless access to certain information is restricted for clear treatment reasons. If access is restricted, a treatment/service plan shall include the reason for the restriction, a goal to remove the restriction, and the treatment/service being offered to remove the restriction.
14. The right to be informed of one's own condition.
15. The right not to be discriminated against on the basis of race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental disability, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws.
16. The right to practice a religion of his or her choice or to abstain from the practice of religion.
17. The right to be informed in writing of the rates charged by the facility as well as any additional charges, and to receive thirty days' notice in writing of any change in the rates and charges.
18. The right to reside in a class one residential facility, as available and appropriate to the type of care or services that the facility is licensed to provide, regardless of previous residency, unless there is a valid and specific necessity which precludes such residency. This necessity shall be documented and explained to the prospective resident.
19. The right to continued residency unless the facility is no longer able to meet the resident's care needs; the resident presents a documented danger to other residents, staff or visitors; or the monthly charges have not been paid for more than thirty days.
20. The right not to be locked out of the facility at any time.
21. The right of adult residents not to be locked in the facility at any time for any reason.
22. The right to consent to or refuse treatment or services, or if the resident has a legal custodian, the right to have the legal custodian make decisions about treatment and services for the resident.
23. The right to consult with an independent treatment specialist or legal counsel at one's own expense.
24. The right to communicate freely with and be visited without staff present at reasonable times by private counsel and, unless prior court restriction has been obtained, to communicate freely with and be visited at reasonable times by a personal physician, psychologist or other health care providers, except that employees of a board, a provider, personnel of the Ohio protection and advocacy system, or representatives of the state long-term-ombudsman program may visit at any time when permitted by the Revised Code.
25. The right to communicate includes receiving written communications, which may be opened and inspected by facility staff in the presence of the resident recipient so long as the communication is then not read by the staff and given immediately to the resident.
26. The right to meet with staff from the Ohio department of mental health and addiction services in private.
27. The right not to be deprived of any legal rights solely by reason of residence in the facility.

28. The right to personal property and possessions:
    a. The right of an adult resident to retain personal property and possessions.
    b. The right of a child resident to personal property and possessions in accordance with one's health and safety considerations, and developmental age, and as permitted by his/her parent or guardian.
29. The right of an adult resident to manage his/her own financial affairs, and to possess a reasonable sum of money.
30. The right to use the common areas of the facility.
    a. Adult residents shall have right of access to common areas at all times.
    b. Children and adolescent residents shall have the right of access to common areas in accordance with the facility's program schedule.
31. The right to engage in or refrain from engaging in activities:
    a. The right of an adult to engage in or refrain from engaging in cultural, social or community activities of the resident's own choosing in the facility and in the community.
    b. The right of a child or adolescent to access cultural and social activities.
32. The right to meet or communicate with family or guardians, and visitors and guests:
    a. The right of an adult:
        i. To reasonable privacy and the freedom to meet with visitors and guests at reasonable hours.
        ii. To make and/or receive confidential phone calls, including free local calls.
        iii. To write or receive uncensored, unopened correspondence subject to the facility's rules regarding contraband.
    b. The right of a minor:
        i. To visitors and to communicate with family, guardian, custodian, friends and significant others outside the facility in accordance with instructions from the minor's parent or legal guardian.
        ii. To write or receive mail subject to the facility's rules regarding contraband and directives from the parent or legal guardian, when such rules and directives do not conflict with federal postal regulations.
33. The right to be free from conflicts of interest; no residential facility employee may be a resident's guardian, custodian, or representative with the exception of an employee that has a previously established legal relationship to a resident, e.g. parent, spouse or child if permitted by facility policy.

Client Rights – Class Two and Three Residential Facilities: OAC 5122-30-22.1

1. The right to be verbally informed of all resident rights in language and terms appropriate for the resident's understanding, prior to or at the time of residency, absent a crisis or emergency.
2. The right to request a written copy of all resident rights and the grievance procedure.
3. The right to exercise one's own rights without reprisal, except that no right extends so far as to supersede health and safety considerations.
4. The right to file a grievance.
5. The right to be treated at all times with courtesy and respect, and with consideration for personal dignity, autonomy and privacy.
6. The right to receive services in the least restrictive, feasible environment.
7. The right to receive humane services in a clean, safe, comfortable, welcoming, stable and supportive environment.

8. The right to reasonable protection from physical, sexual and emotional abuse, neglect, and exploitation.
9. The right to freedom from unnecessary or excessive medication and the right to decline medication.
10. The right to be free from restraint or seclusion.
11. The right to be advised and the right to refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, television, movies, photographs or other audio and visual technology. This right does not prohibit a facility from using closed-circuit monitoring to observe areas in the facility other than bathrooms or sleeping areas, or other areas where privacy is reasonably expected.
12. The right to confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of resident information under state and federal laws and regulations.
13. The right to have access to one's own record.
14. The right to be informed of one's own condition.
15. The right not to be discriminated against on the basis of race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental disability, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws.
16. The right to practice a religion of his or her choice or to abstain from the practice of religion.
17. The right to visit the facility alone or with individuals of the prospective resident's choosing.
18. The right to be informed in writing of the rates charged by the facility as well as any additional charges, and to receive thirty days' notice in writing of any change in the rates and charges.
19. The right to continued residency unless the facility is no longer able to meet the resident's care needs, the resident presents a documented danger to other residents, staff or visitors, or the monthly charges have not been paid for more than thirty days.
20. The right to receive thirty days prior written notice for termination of residency except in an emergency when the resident presents a documented danger to other residents, staff or visitors.
21. The right not to be locked out of the facility at any time.
22. The right not to be locked in the facility at any time for any reason.
23. The right to consent to or refuse services in a class two facility, or if the resident has a legal custodian, the right to have the legal custodian make decisions about services for the resident.
24. The right to consult with an independent treatment specialist or legal counsel at one's own expense.
25. The right to communicate freely with and be visited at reasonable times by private counsel and, unless prior court restriction has been obtained, to communicate freely with and be visited at reasonable times by a personal physician, psychologist or other health care providers, except that employees of a board, a provider, personnel of the Ohio protection and advocacy system, or representatives of the state long-term-ombudsman program may visit at any time when permitted by the Revised Code. The right to communicate includes receiving written communications, which may be opened and inspected by facility staff in the presence of the resident recipient so long as the communication is then not read by the staff and given immediately to the resident.
26. The right to meet with staff from the Ohio department of mental health and addiction services in private.
27. The right not to be deprived of any legal rights solely by reason of residence in the facility.
28. The right to personal property and possessions:
    a. The right of an adult resident to retain personal property and possessions.

b. The right of a child resident to personal property and possessions in accordance with one's health and safety considerations, and developmental age, and as permitted by his/her parent or guardian.

29. The right of an adult resident to manage his/her own financial affairs, and to possess a reasonable sum of money.
30. The right to use the common areas of the facility.
    a. Adult residents shall have right of access to common areas at all times.
    b. Children and adolescent residents shall have the right of access to common areas during routine non-sleeping hours in accordance with facility expectations, e.g., school attendance, homework, implementation of natural and logical consequences, etc.
31. The right to engage in or refrain from engaging in activities:
    a. The right of an adult to engage in or refrain from engaging in cultural, social or community activities of the resident's own choosing in the facility and in the community.
    b. The right of a child or adolescent to access cultural and social activities.
32. The right to meet or communicate with family or guardians, and visitors and guests:
    a. The right of an adult:
        i. To reasonable privacy and the freedom to meet with visitors and guests at reasonable hours.
        ii. To make and/or receive confidential phone calls, including free local calls.
        iii. To write or receive uncensored, unopened correspondence subject to the facility's rules regarding contraband.
    b. The right of a minor:
        i. To visitors and to communicate with family, guardian, custodian, friends and significant others outside the facility in accordance with instructions from the minor's parent or legal guardian.
        ii. To write or receive mail subject to the facility's rules regarding contraband and directives from the parent or legal guardian, when such rules and directives do not conflict with federal postal regulations.
33. The right to be free from conflicts of interest; no residential facility employee may be a resident's guardian, custodian, or representative.

Procedure

A. Availability of Client Rights Policy and Grievance Procedure:

1. The client rights policy and grievance procedure shall be posted at the Board office in a conspicuous location that is accessible to persons served, their family or significant others and the public.
2. A written copy of the Board's Client Rights Policy and Grievance Procedure shall be available to any individual upon request.

B. Monitoring, Oversight, and Reporting Procedure:

1. The Board shall assure that each contract provider has a written Clients Rights and Grievance Policy/Procedure which meets the Ohio Administrative Code 5122:26-18. This shall be accomplished by each contract provider supplying a current copy of their Client Rights and Grievance Policy/Procedure to the Board, as well as any changes subsequently made, for review. The Board shall recognize that, for a provider accredited and granted deemed status by Ohio Department of Mental Health and Addiction Services in accordance with rule 5122-25-02 of the

Administrative Code, the requirements of rule 5122-26-18 of the Administrative Code are met by provider conformance to its accrediting body standards.

The Board will review the implementation of the client rights policy and grievance procedures for each of its contract agencies by receiving annually from each provider the client rights officer's summary of the number of grievances received, type of grievances, and resolution state of grievances.

The Board Client Rights Officer shall also keep records of grievances it receives, the subject of the grievance, and the resolution of each, and shall assure the availability of these records for review by the Ohio Department of Mental Health and Addiction Services upon request.

The Board Client Rights Officer shall summarize annually the Board's records to include the number of grievances received, types of grievances, and resolution status. This annual summary report of Provider and Board grievances will be provided to the Board Executive Director.

Per Ohio Revised Code 340.08, the Board Client Rights Officer will annually submit to the Ohio Department of Mental Health and Addiction Services a report summarizing the following:

a. Complaints and grievances received by the board concerning the rights of persons seeking or receiving addiction services, mental health services, or recovery supports;
b. Investigations of the complaints and grievances;
c. Outcomes of the investigations.

As the Ohio Department of Mental Health and Addiction Services may periodically review the implementation of this policy and procedure, the Board shall make all related materials available upon request.

The Board will submit any subsequent substantive changes to this written policy and procedure to Ohio Department of Mental Health and Addiction Services for approval prior to enactment.

C. Grievance Procedure:

1. A Board staff member shall serve as the Board Clients Rights Officer (CRO) through appointment by the Executive Director. Additionally, the Executive Director shall appoint a back-up CRO to perform the duties in the absence of the Board CRO or in the event the Board CRO is the subject of the complaint.

2. It is the CRO's responsibility to accept and oversee the process of a grievance which is filed. This staff person shall be available during regular business hours to clients wishing to discuss client rights issues.

3. Any client, parent/guardian of a minor client, or any other person or provider on behalf of a client (with client's permission) (hereafter referred to as "complainant") of a contracting provider may initiate a grievance regarding a violation of any client rights as set forth in this policy/procedure. A person who applied for services from a contracting provider may also file a grievance if it is on the basis of denial of service or discrimination.

4. The grievance should be filed within a reasonable period of time from the date the grievance occurred.

5. A written copy of the Board's grievance procedure shall be available upon request. Additionally, Board staff will explain any and all aspects of the Client Rights and Grievance Procedure upon request.

6. Upon receiving a complaint, the Board CRO shall determine if an attempt for resolution has been made at the provider level. If it has not, the CRO will assist the complainant in making contact with the Provider's Client Rights Officer (PCRO) and, if requested, assist the complainant in filing a grievance. However, if the subject of the grievance is the Provider Executive Director or related to policies/procedures of the provider which allegedly violate client rights, the Board CRO has the discretion to accept the grievance at the board level prior to any provider level filing.

7. In the event the complainant has exhausted all administrative remedies available at the provider level, the Board CRO shall:

    1. Accept a written grievance from the complainant. The Board CRO can assist the complainant in writing the grievance upon request. The grievance must:
        i. Be dated and signed by the client, the individual filing the grievance on behalf of the client or have an attestation by the Board CRO that the written grievance is a true and accurate representation of the client's grievance.
        ii. Include, if available, the date, approximate time, description of the incident and names of individuals involved in the incident or situation being grieved.
    2. Within three business days from receipt of the grievance, a written acknowledgment of receipt will be provided to each complainant. This document will include, but not be limited to, the following:
        i. Date grievance was received;
        ii. Summary of grievance;
        iii. Overview of grievance investigation process;
        iv. Timetable for completion of investigation and notification or resolution; and,
        v. Treatment provider contact name, address and telephone number.
    3. Obtain written permission from the complainant to receive copies of his or her grievance at the provider level, provider research/documentation, provider response to the grievance and any necessary information relevant to investigating the complaint.

    Pursue an investigation to the extent necessary to verify the contents of the documentation.

    Attempt to negotiate resolution between the provider and the complainant.

    Upon resolution, the Board CRO shall:
    1. Ensure the complainant and provider has a written copy of the resolution.

2. Ensure the complainant and provider has a thorough understanding of the contents of the resolution.

3. Ensure the complainant has an understanding of the remaining options to pursue, in the event of continued dissatisfaction.

8. In the event of an impasse between the Board Client Rights Officer and the provider, the Board CRO shall enlist the involvement of the Board Executive Director to serve as an impartial decision-maker. The Executive Director will have the discretion to determine an appropriate resolution or enlist the involvement of the Board Chairperson as the final local step in the administrative review process.

9. In the event the Board CRO determines that a client rights violation has not occurred or that the provider has acted properly in attempting to resolve the grievance, the Board CRO shall review this finding with the Board Executive Director.

    a. If the Executive Director concurs, this decision will be communicated verbally and in writing to the complainant along with an explanation as to other administrative remedies and resources for further appeal.

    b. If the Executive Director does not concur, the Executive Director will make a determination as to the appropriate resolution, and this will be communicated to the complainant and provider both verbally and in writing.

10. The entire process, from receiving the written grievance through resolution, shall not exceed twenty-one (21) business days. Should extenuating circumstances occur indicating that this time period will need to be extended, verbal or written authorization from the complainant shall be obtained. This must be documented in the grievance file and written notification given to the client/complainant.

11. The Client Rights Officer shall maintain a file of client grievances for at least two years from resolution. The file shall consist of the following:

    a. Copy of grievance including:
        i. Complainant Name/Relationship to client
        ii. Name of client
        iii. Date
        iv. Nature of complaint
    b. Documentation reflecting process used and resolution/remedy of the grievance
    c. Documentation of all contacts made with or on behalf of clients including:
        i. Information obtained
        ii. Investigative action taken
    d. Documentation, if applicable of extenuating circumstances for extending the time period for resolving the grievance beyond twenty business days.
    e. Copy of notification to complainant of resolution if written grievance filed.

12. Any client may file a grievance with outside organizations which includes but is not limited to Ohio Department of Mental Health and Addiction Services, the Ohio protection and

advocacy system (Disability Rights Ohio), the U.S. Department of Health and Human Services, and appropriate professional licensing or regulatory associations (see section C(2) for list and contact information).

13. Upon written request of the client, all relevant information about the grievance will be provided by the Board to one or more of the outside organizations to which the complainant has initiated a complaint.

D. Resources

1. The current Client Rights Officer (CRO) for the Board is:

Amanda Peterson, Deputy Director of Youth and Prevention
Mental Health Recovery Board Serving Warren and Clinton Counties
201 Reading Road
Mason, Ohio 45040
(513) 695-1695
www.mhrbwcc.org
Available Hours: 8:30 A.M. - 4:30 P.M. Weekdays; Evening Hours by Appointment

2. Outside organizations to which complaints may be directed:

Disability Rights Ohio
200 Civic Center Drive, Suite 300
Columbus, OH 43215
(614) 466-7264; (800) 282-9181
(614) 644-1888 (fax)
www.disabilityrightsohio.org

Ohio Department of Mental Health and Addiction Services
30 East Broad Street, 36th Floor
Columbus, Ohio 43215-3430
(614) 466-2596; (877) 275-6364
1-888-636-4889 (TTY) https://mha.ohio.gov

U.S. Department of Health and Human Services
Office for Civil Rights, Region V
233 N. Michigan Ave., STE 240
Chicago, Illinois 60601
(800) 368-1019
(202) 619-3818 (fax)
(800) 537-7697 (TDD)
www.hhs.gov

Ohio Counselor, Social Worker and Marriage and Family Therapist Board
77 S. High St., 24th Floor, Room 2468
Columbus, OH 43215-6171
(614) 466-0912
(614) 728-7790 (fax) https://cswmft.ohio.gov

State of Ohio, Board of Psychology
77 S. High St., Suite 1830
Columbus, OH 43215-6108
(614) 466-8808; (877) 779-7446
(614) 728-7081 (fax)
www.psychology.ohio.gov

State of Ohio, Medical Board
30 E. Broad ST, 3rd Floor
Columbus, OH 43215-6127 (614) 466-3934
(614) 728-5946 (fax) www.med.ohio.gov

Ohio Board of Nursing
17 S. High St., Suite 660 Columbus, OH 43215-3466
(614) 466-3947
(614) 466-0388 (fax) https://nursing.ohio.gov

Citations:

- ORC 340.08 (E) 1-3 Duties of boards of alcohol, drug addiction, and mental health services
- OAC 5122:2-1-02 Board client rights and grievance procedure
- OAC 5122-26-18 Client rights and grievance procedure
- OAC 5122-30-22 Resident rights and grievance procedure for class one facilities
- OAC 5122-30-22.1 Resident rights and grievance procedure for class two and class three facilities

Policy 1-14: Contract Change Orders

Effective Date: 7/1/25
Last Revised Date: 7/1/25
Lead Staff: Dustin Ratliff

Policy

The purpose of this policy is to provide a clear and concise process for implementing contract change orders for all contracts with the Mental Health Recovery Board Serving Warren and Clinton Counties.

A change order is a mutually agreed upon document that addresses any change in the scope of a project, details the specific changes that need to occur, what the cost of the change will be, and when the changes will be in effect. Considering a change order may adjust the budget and service delivery of a contract, they cannot be acted upon until both MHRB and the contract agency agree on terms and conditions.

Procedure

For any proposed change to the scope of a contract, the process is as follows:

1. Contract Agency completes the Change Order Request Form (CORF).

2. Contract Agency submits the CORF to the appropriate MHRB clinical staff via email to review the clinical impacts of the change.

3. MHRB clinical staff will either recommend approval or recommend denial of the CORF.

    a. If the request is denied, the MHRB clinical staff member will notify the Contract Agency of the denial and the reason for the denial.

    b. If the request is recommended for approval, the CORF will be forwarded to the MHRB finance staff for review.

4. MHRB finance staff will review the CORF and identify if the change will result in additional costs to the contract exceeding the contract maximums for the project as approved by the MHRB Board of Directors. If the proposed changes will result in an increase to the approved project cost that exceeds $25,000, the contract change will need to be submitted for approval by the MHRB Board of Directors at the next scheduled Board of Directors meeting and will need a formal Contract Amendment before the change may go into effect.

    The MHRB finance staff will either recommend approval or recommend denial of the request.

    a. If the CORF is denied, they will send the reason for denial to the MHRB clinical staff to notify the Contract Agency of the denial.

    b. If the request is approved, the request will be submitted to the MHRB Executive Director for review.

5. The MHRB Executive Director will review the CORF and the associated feedback from both the MHRB clinical and finance staff.

    a. If the CORF is denied, the MHRB Executive Director will send the reason for denial to the MHRB clinical staff to notify the Contract Agency of the denial.

    b. If the request results in a project cost increase that is $25,000 or less, the MHRB Executive Director may approve the CORF and will notify the Board of Directors of the approval of the CORF at the next regularly scheduled MHRB Board of Directors Meeting.

    c. If the request will result in a project cost increase that exceeds $25,000, the MHRB Executive Director may recommend the approval of the CORF to the MHRB Board of Directors at the next regularly scheduled MHRB Board of Directors meeting.

6. The MHRB Board of Directors may review CORFs that have been recommended for approval by the MHRB Executive Director.

    a. If the request is denied, the contract agency will be notified of the denial.

    b. If the request is approved, a contract amendment will be provided to the Contract Agency to be executed.

Policy 2-1: Recovery Housing Level of Care

Effective Date: 8/26/13
Last Revised Date: 7/1/25
Lead Staff: Jeff Rhein

Policy

In accordance with ORC [340.032, 340.033 & 340.034], each client receiving MHRB subsidy for recovery housing will be placed in the least restrictive level of care available within the system. Evaluation of level of care will be completed semi-annually for each client receiving MHRB subsidy to evaluate whether client is still in need of recovery housing, has the desire to maintain housing in that environment and is not yet able to move out into the community.

Intensity	Minimum On-Site Supervision or Service
Level 3	Staff in a manner sufficient with Level 3 recovery housing according to ORH

Procedure

1. If receiving MHRB funding, a recovery house must be ORH certified, or in the process of obtaining certification.
2. Recovery Housing referral is made (treatment provider, probation officer, court, Hopeline, navigator, self, family)
3. Meet with client and/or guardian. When warranted, meet with families when consent and release have been obtained to share information.
4. Complete discussion with each resident about the individual's current need, desire to maintain housing in sober environment and any obstacles to move out into the community.
5. Establish plan for moving beyond recovery housing.
6. Follow ORH outcomes standards by using tool on each resident at admission, 6 months and discharge. Any current resident that may not have completed admission data, must have one completed at next interval (6 months or discharge). For clients that leave and are unable to complete at discharge, staff can indicate they are completing the discharge data on behalf of the resident and agency.
7. Have written documentation files for each resident and maintain these files at discharge for those residents that move out.
8. Document regular meetings with resident, and if applicable, involve clean and sober family members to share information (with required consents and releases of information).
9. Notify Board of identified changes to recovery housing programming or staffing.
10. Provider will maintain a waiting list specific to opiate use disorder for clients that are referred or seek services on their own according to ORC 5122-9-01, refer also to MHRB Policy 1-6.

Policy 2-2: Housing Level of Care

Effective Date: 8/26/13
Last Revised Date: 7/1/25
Lead Staff: Reija Huculak

Policy

Each client receiving MHRB subsidy for housing will be placed in the least restrictive level of care available within the system. Evaluation of level of care (DLA-20 housing scale) will be completed semi-annually for each client receiving MHRB subsidy.

Intensity (Level of Care)	Minimum On-Site Supervision or Service
Level 3b	24 hours per day (Residential Care)
Level 3a	Transitional (16 hours per day) Homeless Shelter (24 hours per day)
Level 2	8-12 hours per day
Level 2a	20 hours per week
Level 1	8-40 hours per week (hours vary based on the size of the property)
Level 0	0 hours per week

Procedure

1. Complete DLA-20 housing score on each client.
2. Norm score against established baselines.
3. Have written documentation with recommendations for Level of Care based on clinical observation, current functioning and ability to wrap appropriate services around client at a lower level of care.
    a. Case manager
    b. Case manager supervisor
    c. Treating psychiatrist
4. Meet with client and/or guardian to share information.
5. Notify Board of identified changes.
6. Collaborate with Board representative to meet with client/guardian as needed.
7. Notify NHO of any anticipated changes and needs for a 30-day letter to client.

Policy 2-3: Housing Retention for Clients on Temporary Leave

Effective Date: 8/26/13
Last Revised Date: 7/1/24
Lead Staff: Reija Huculak

Policy

Mental Health Recovery Board Serving Warren and Clinton County (MHRB) provides subsidy to Warren and Clinton County residents who are active clients in the treatment system. The purpose of this agreement is to assist clients with decent, safe and affordable housing.

In the event of unexpected absence (i.e. hospitalization, arrest, AWOL) from MHRB funded housing placement, MHRB will continue to fund the housing placement for a period up to 30 days.

Procedure

Any requests for extensions beyond this period of time must be submitted to MHRB in writing by the client, guardian, family member, case manager or other authorized professional prior to the expiration of the initial retention period. The request may be submitted via fax (513-695-1776), encrypted email (rhuculak@mhrbwcc.org), or hard copy to MHRB.

MHRB response will be made within 3 working days. If the response is delayed and approved, the approval will be retroactive to the first day past the initial retention period. If it is delayed and denied, the payment will be approved through the date of denial.

Policy 2-4: Housing Subsidy

Effective Date: 8/26/13
Last Revised Date: 7/1/25
Lead Staff: Reija Huculak

Policy

Mental Health and Recovery Board Serving Warren and Clinton Counties (MHRB) provides subsidy to Warren and Clinton County residents who are active clients in the MHRB treatment system. The purpose of this agreement is to assist clients with decent, safe, and affordable housing.

Procedure

The Housing Subsidy Agreement is to be completed by the client and the housing provider upon initial admission into MHRB funded housing and renewed every six (6) months hereafter until the client no longer receives housing subsidy from MHRB (see attached agreement).

Policy 2-3 Attachment 1: Housing Subsidy Rules

Housing Subsidy Rules

Mental Health Recovery Board Serving of Warren and Clinton County (MHRB) provides subsidy to Warren and Clinton County residents who are active clients in the treatment system. The purpose of this agreement is to assist clients with decent, safe, and affordable housing for a duration of 18 months. This Housing Subsidy agreement is entered in between _____ (client) and MHRB. This subsidy is based on compliance with the New Housing Ohio's (NHO) lease/tenant agreement and any addendums to such as well as engagement in services through MHRB providers.

The housing subsidy that you receive is $_____ per month and will be reviewed every six (6) months. Your subsidy is based on the cost of the rent minus your portion of the rent. Your portion of the rent is based on your income. If you have no income, you are required to apply/sign up for income benefit(s) within 30 days from the subsidy start date and provide documentation to NHO of this action. If you do not apply/sign up for income benefit(s), your subsidy will be terminated.

If your income should change at any time or you receive a back payment, it is your responsibility to report it to New Housing Ohio within 30 days. Housing Subsidy calculation completed by NHO:

Current Income; verified ❑Yes ❑No	$
30% of Monthly Income	$
Fair Market Rent	$
Total Subsidy amount	$
Total Tenant Payment	$

It is important to understand that your subsidy is provided while you are engaged in treatment services through an MHRB provider and based on your commitment to follow the rules of your lease/tenant agreement. Should either of these not be followed, then any action or inaction on your part may be reason for terminating your MHRB subsidy. MHRB will not require you to move, but MHRB will no longer pay money to your landlord to supplement your rent payment. The full amount of the rent will become your responsibility. If you do not follow the rules or pay your full rent if subsidy is terminated, then you may be subject to eviction by your landlord.

The rule violations include, but are not limited to:

1. Refusing inspections of property for cleanliness and damage
2. Failure to follow drug free housing requirements
3. Failure to follow house rules
4. Non-prescribed, Illegal use of prescription medication, use of other illegal drug or misuse of alcohol that results in related EMT calls, emergency room visits, or hospitalizations. Police calls related to drug use, or illegal behavior resulting in charges being filed or multiple needs for police intervention.
6. Failure to sign up for Section 8 housing when the list is open
7. Refusal to accept Section 8 subsidy.

You will be required to sign up for the Section 8 housing list when it is open. If you do not sign up, this may be seen as a violation of your subsidy agreement. If you become eligible for Section 8, refusal to accept Section 8 may also be cause for termination of your rental subsidy.

If your subsidy is terminated, you will be given 30-Day Notice of the Intent to Terminate. At the end of the 30 days, you will no longer receive money to pay for the difference between your portion of the rent and the actual cost.

Your signature to this document acknowledges that you have been given this information and understand that your subsidy depends on following the rules in your lease and other conditions/requirements noted above.
Failure to sign will not be sufficient to keep the Housing Subsidy rules from going into effect on _____, 20____.

_____ _____
Client Signature Date

_____ _____
NHO Staff Signature Date

Policy 2-5: Personal Allowance

Effective Date: 8/26/13
Last Revised Date: 7/1/25
Lead Staff: Reija Huculak

Policy

Definition-Personal Needs Allowance (PNA): (excerpted from the Ohio Administrative Code 5160-3-1-16.5) The PNA is an amount which is set aside from the individual's gross income before determining how much income is available to pay the subsidized housing facility (or off-set MHRB costs). The PNA is allowed in the client liability calculation. The PNA amount is set aside to be used for payee services, clothing, medical expenses and other personal needs of the resident.

Definition- Subsidized Housing: residential facilities directly contracted with MHRB or it's designee for provision of residential and supportive care services.

Residential State Supplement (RSS) amounts should be considered as applicable.

Procedure

SPMI clients utilizing contracted MHRB subsidized housing beds who receive confirmed monthly income or a combination of benefits (SSI, SS, SSDI, RSS, etc.) are eligible to retain a monthly MHRB approved PNA. The contract provider is responsible for recalculating the PNA whenever there is a change in monthly income or benefits received by the client or at least annually.

If a client receives backpay from any income source, covering any days the client was utilizing an MHRB subsidized housing bed, the client is responsible to pay MHRB.

SPMI clients utilizing contracted MHRB subsidy for housing are responsible for appropriate financial contribution to their cost of care and housing. Based on confirmed client monthly income, or benefits, they shall contribute 85% of their monthly income (in the case of RSS, the amount is $200). The 15% PNA is an amount set aside to be used for clothing and other personal needs of the residential client.

Policy 2-6: Residential Service Authorization

Effective Date: 8/26/13
Last Revised Date: 7/1/25
Lead Staff: Reija Huculak

Policy

To utilize the system's residential and housing resources effectively and efficiently to facilitate individual consumers with housing that is based on options available to them.

Subsidy is available for financially eligible clients who reside in the appropriate Level of Care (LOC).

Role	Description
Deputy Director of Adult Mental Health and Recovery Services or Designee	Reviews and authorizes Board payment and/or utilization of Board resources per Residential Service Authorization (RSA) requests.
Case Manager Supervisor or SPMI Director	Approves any and all Residential Service Authorization (RSA) requests prior to submission to MHRB.
Case Manager	Individual currently listed as client Case Manager and developer of most current ISP.

Procedure

This RSA procedure will cover any and all residential service provided when the Board pays subsidy.

1. Fill out the most recent RSA completely per instructions on form (Flowchart attached). Completion of DLA-20 must be within 6 months of the requested date.

2. Submit to Supervisor for Approval signature.

3. Fax completed form to Board 513-695-1776. RSA must be submitted 24 hours prior to placement. Retrospective payment for delinquent requests may be denied.

Policy 2-6 Attachment 1: Housing RSA Form

RESIDENTIAL SERVICE AUTHORIZATION (RSA)

Instructions:

- Case Manager/Supervisor: fill out RSA (below)
- Fax RSA to MHRB Confidential Fax: 513-695-1776 Attn: Reija Huculak at least 24 hours prior to admission
- MHRB will fax Request Status to originating fax within 48 hours or next business morning by Noon if weekend/holiday request.

Client Name:	DOB:	Client UCI:
Form Completed by: (CM Name)	CM Contact Phone Number:	CM Fax Number:
Resident's County of eligibility:	Date Faxed:	Client Primary Diagnosis

CURRENT FACILITY: _____ **FACILITY REQUESTED:** _____

HOUSING ASSESSMENT RESULTS: DLA Housing Score: _____ Date of DLA:_____

Access to Wellness Eligibility ❑Yes ❑No If yes, identify YTD ATW utilization $_____

VERIFICATION REQUESTED BED IS AVAILABLE ❑Yes ❑No If yes, list name: _____

LENGTH OF STAY PROJECTED OR REQUESTED (check one) ❑ 30 Days or Less ❑3 Months
Initial step down/transition may be approved max 30 days

PLAN AFTER 30 DAY STEP DOWN PLACEMENT: _____

START DATE: _____

IS THIS A CONTINUED STAY REQUEST? ❑Yes ❑No If yes, why? _____

_____

CLIENT FINANCIAL STATUS: (circle all that apply) SSI $____ SSDI $____VA $____ RSS $__ Other ___
TOTAL MONTHLY INCOME: ☐

PAYEE: ❑Yes ❑No If yes, list name, address: _____
Has Payee been notified of the change in Residence? ❑Yes ❑No If no, when will notice
Has Payee been notified of any change in PNA amount? ❑Yes ❑No be given? _____

REASONS FOR TRANSFER/PLACEMENT: (brief narrative requested) _____

IF CHANGE OF HOUSING, HAS PREVIOUS HOUSING BEEN RELEASED? ❑Yes ❑No
If no, why?_____

Case Manager Signature _____ **Supervisor Signature** _____

DO NOT WRITE BELOW THIS LINE – FOR MHRB USE ONLY

☐ MHRB authorizes Residential Services funding reimbursement for services effective from: _____ to: _____

☐ Client added to Residential Services waiting only at this time. Update required by: _____ or will be removed from list.

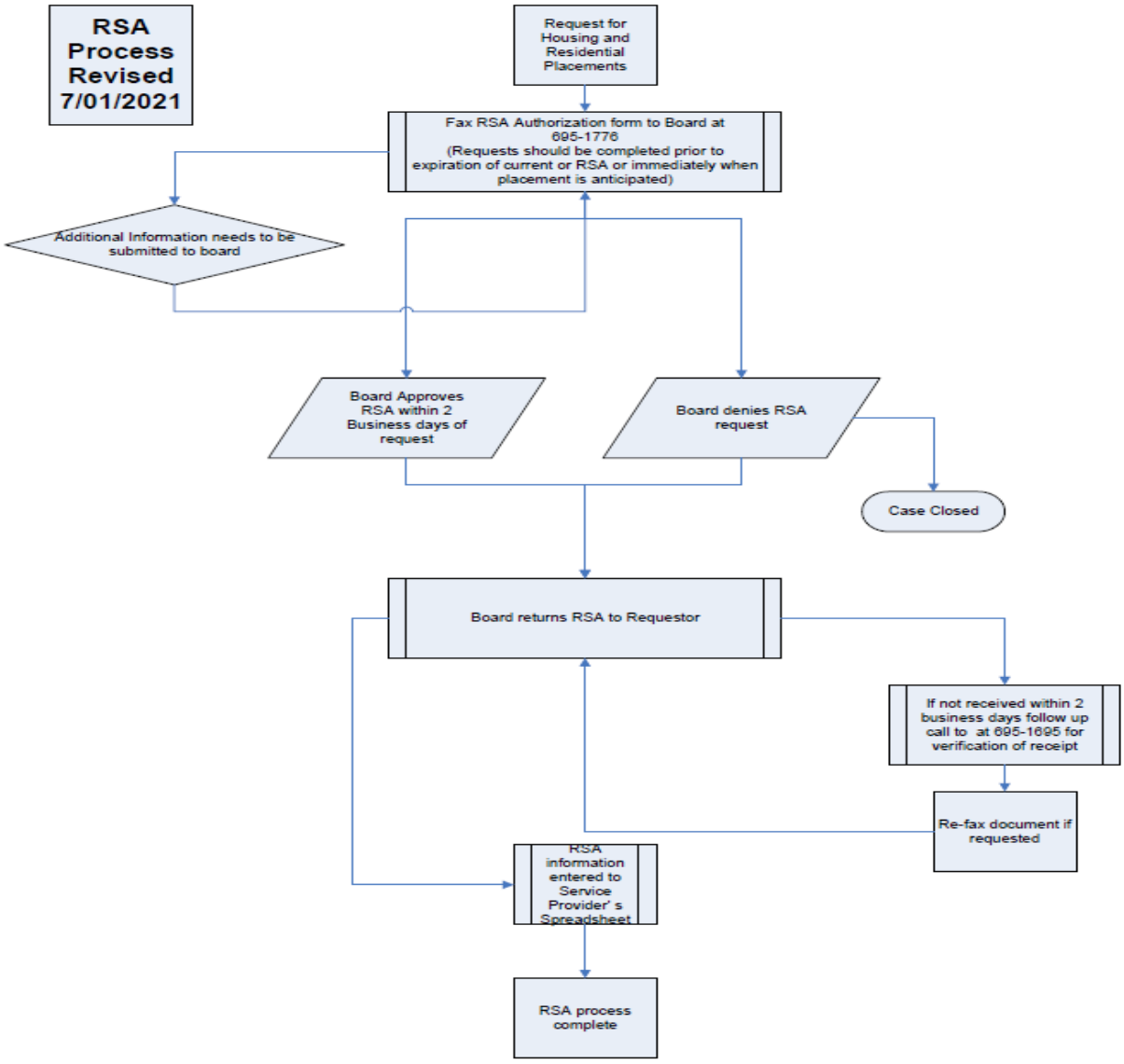
☐ MHRB does not authorize Residential Services funding reimbursement.

Reason:

_____

R. Huculak / MHRB Designated Staff Date

Policy 2-6 Attachment 2: RSA Process Flowchart



Policy 2-6 Attachment 3: Recovery Housing RSA Form

Recovery House
RESIDENTIAL SERVICE NOTIFICATION (RH-RSN)
Instructions:

- Fax RSN to MHRB Confidential Fax: 513-695-1776 Attn: Jeff Rhein

Client Name:	DOB:	Client UCI:
Form Completed by: (Therapist Name)	Therapist Contact Phone Number:	Therapist Fax Number:
Resident's County of eligibility:	Date Faxed:	Client Primary Diagnosis

CURRENT ADDRESS: _____

VERIFICATION REQUESTED BED IS AVAILABLE ❑Yes ❑No

LENGTH OF STAY PROJECTED OR REQUESTED ❑ 3-6 MONTHS ❑ >6 MONTHS

Legal Charges _____

Current Medications _____

TOTAL MONTHLY INCOME: ☐

REASONS FOR TRANSFER/PLACEMENT: (brief narrative requested) _____

_____

_____

DO NOT WRITE BELOW THIS LINE – FOR MHRB USE ONLY

Client will be responsible for working with the RH staff on payment of required fees and moving into the facility, once there the client can still receive any necessary SUD treatment services at the nearest provider location.

Policy 2-7: Levels of SPMI Case Management

Effective Date: 8/26/13
Last Revised Date: 7/1/25
Lead Staff: Reija Huculak

Policy

Mental Health Recovery Board Serving Warren and Clinton Counties (MHRB) is committed to provide various levels of SPMI case management services to the residents of our service area. As funds allow the levels of SPMI Case Management may include: Standard (SCM), Intensive (ICM), Assertive Community Treatment (ACT), and Forensic Assertive Community Treatment (FACT).

Case management aims to strengthen outcomes for the person through individualized and coordinated service delivery. In general terms, as noted by SAMHSA, case management is a coordinated individualized approach that links individuals with appropriate services to address their specific needs and help them to achieve their stated goals. One important function of case management services is providing sufficient monitoring and support for a person's recovery.

Target Population

Residents of Warren and Clinton County who meet the criteria listed below:

A. Severe and persistent mental illness or "SPMI" means a documented primary mental health disorder diagnosed by a mental health professional that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning inclusive of social, personal, family, educational or vocational roles. The individual has a degree of impairment arising from a psychiatric disorder such that:

   - The individual does not have the resources or skills necessary to maintain function in the home or community environment without assistance or support;
   - The individual's judgment, impulse control, or cognitive perceptual abilities are compromised;
   - The individual exhibits significant impairment in social, interpersonal, or familial functioning; AND
   - The individual has a documented mental health diagnosis.

   For this purpose, a "mental health diagnosis" means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding neurodevelopmental disorders, substance use disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention.

B. Those who have a combination of item A of this policy major mental illness and substance use diagnoses

Selection of case management level should align with needs and goals identified in the ITP.

Levels of Case Management:

1. **Assertive Community Treatment (ACT and FACT)** clients seen an average of three times per calendar week. Must meet fidelity model of staffing. OAC 5122-29-29

2. **Intensive Case Management (ICM)** clients must be seen at least once (face-to-face or telehealth) every calendar week and can be seen up to five times per calendar week. This adult population has symptoms which are at least partially controlled. The individual shows skills and resource deficits which somewhat impair the person's ability to achieve personal goals independently.

3. **Standard Case Management (SCM)** clients must have a monthly face-to-face or telehealth contact with a staff member responsible for case coordination. This adult population is mostly able to self-manage much of their progress with occasional assistance.

Procedure

1. It is the provider's duty to assess and determine if case management service is needed and to apply established and approved set of medical necessity criteria. "Medically necessary services" are defined as services that are necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. A medically necessary service must:

    a. Meet generally accepted standards of medical practice;
    b. Be appropriate to the illness or injury for which it is performed as to type of service and expected outcome;
    c. Be appropriate to the intensity of service and level of setting;
    d. Provide unique, essential, and appropriate information when used for diagnostic purposes;
    e. Be the lowest cost alternative that effectively addresses and treats the medical problem.

2. Once it has been determined an individual would benefit from case management service, the agency will enter all required data into SmartCare (Policy#1-8).

3. It is the duty of the Provider to train their staff on service limits as detailed in Policy 1-9 Benefit Rules.

4. Provider organizations are expected to provide timely treatment access. If the provider is unable to accommodate the case management service needs of the individual, the person will be immediately informed about services with another provider and/or outside of our system of care that may be of assistance. In cases involving a transfer to another provider, utilization of "a warm handoff" strategy is to be implemented. Individuals referred to services elsewhere shall receive a follow-up contact by the referring agency regarding engagement within 14 calendar days after referral.

Policy 3-1: Crisis Services

Effective Date: 8/26/13
Last Revised Date: 7/1/25
Lead Staff: Jeff Rhein

Policy

Durning FY25 MHRBWCC undertook and extensive look at current crisis services, at the time of this policy adoption, recommendations are currently being considered that may impact updates to this policy throughout FY26.

In accordance with 340.03 Board of alcohol, drug addiction, and mental health services - powers and duties.

Establish, to the extent resources are available, a community support system, which provides for treatment, support, and rehabilitation services and opportunities. The essential elements of the system include, but are not limited to, the following components in accordance with section ORC 340.032 of the Revised Code:

Mental health care, including, but not limited to, outpatient, partial hospitalization, and, where appropriate, inpatient care;

Emergency services and crisis intervention;

Background: Mental Health Recovery Board Serving Warren & Clinton Counties is required by the State to contract for an Emergency & Crisis Response System. Primarily this service array serves as:

1. The 24/7 safety net for current clients and community members currently in or experiencing an emerging crisis, AND
2. A pre-screening and authorization agent designated to act on behalf of the Board for inpatient hospitalizations of indigent residents of Warren & Clinton Counties.

The Board contracts with one agency for face-to-face crisis services and one agency for Hotline services to manage and maintain the Emergency Services Network.

1. The hotline services are operated by Sojourner (doing business as TCN) and perform 24-Hour Dispatch for Crisis and MRSS responders. In addition, information and referrals are part of the hotline responsibility. This is the state contracted 988 provider.

2. **Butler Behavioral Health Services (BBHS)** operates Crisis Connections and MRSS, mobile crisis responders available for 24 Hour Crisis and Pre-Hospitalization screening service.

Talbert House will provide a Hospital Specialist to coordinate discharge planning and referral back to community services.

Another primary component of the Emergency & Crisis Service Network is response to the designated Emergency Departments (ED's) located in each County. These ED's act as triage sites and assessment staging areas prior to any decision for hospitalization or other referral. BBHS personnel conduct pre-

screening and hospitalization pre-authorization activities at these designated ED's and in community settings. Callers to the Crisis Hotline, police/sheriff pickups, and the general public may be directed to the closest emergency department, if mobile crisis response is not applicable. Crisis Counseling and Pre-Screening response may occur in the community or at Bethesda Arrow Springs in Warren County and Clinton Memorial Hospital in Clinton County, and if warranted, the jails and the juvenile detention center. The designated ED's are:

1. **Warren County:** Bethesda Arrow Springs in Warren County, Ohio, off I-71, just one exit north of the King's Island exit (513-282-7000), and
2. **Clinton County:** Clinton Memorial Hospital located at 610 W. Main St. Wilmington, Ohio **(937-382-6611)**

Payor Distinction

Mental Health Recovery Board Serving Warren & Clinton Counties is the payor of last resort for crisis services in both Counties. Per Ohio Statute, the Board does not provide direct care. Rather the Board contracts for the services of the above- named agency to meet the crisis mental health needs of residents in Warren & Clinton Counties.

Procedure

1. Most crisis situations start with the hotline/ 988 but could be a provider response, or from a connection to local law enforcement or EMS

2. When a crisis starts with the hotline/988, hotline staff will work with the individual (s) on the line to determine the outcome which may include:

    a. Telephonic response only
    b. Scheduling of in-office follow up, next day
    c. Scheduling follow up to the community (not office based) for next day
    d. Setting mobile crisis response in motion
    e. Recommendation of ER visit

3. If the crisis has escalated to the point of an emergency room visit, potential clients may be referred many ways to the staging ED contact points in each County.

    Typically, clients will arrive at the ED contact point by:

    a. Walk up on their own or family encouragement,
    b. Directed by contact with the 24-Hour Crisis Hotline,
    c. Directed by contact with Case Manager or other service provider,
    d. Transported by Police/Sheriff or EMS squad, and/or
    e. Assessment completed by Mobile Crisis Personnel

4. All clients admitted to the above-named ED Contact points are, until discharged from the ER, patients of Clinton Memorial Hospital or Bethesda Arrow Springs. The Crisis Provider, BBHS, plays a **consultative** role in providing level of care assessments for behavioral health clients and in helping arrange inpatient care or outpatient referral as indicated.

5. The ED, as directed by the attending physician, will screen all behavioral health clients for acute medical/somatic problems and will provide treatment for such problems. A drug and alcohol screen will be ordered by the attending physician. The attending physician will make the medical diagnosis that the patient is coherent and medically stable. (Coherent means that the patient is **awake, alert, and responsive to questions**. Medically stable means ready for discharge home aside from psychiatric symptoms.) Once all the above procedures have been completed, the attending physician will order ED staff to call BBHS for a pre-hospital screen in the event a 72-hour hold has not been signed by the ED physician. When ED staff contacts BBHS the following information is given:

    a. The patient name
    b. Presenting issue or reason for screen
    c. County of residence
    d. That the physician has medically cleared the patient
    e. A drug and alcohol screen has been drawn and forwarded to the lab for analysis. Results must be with BAL ↓ .08 or under.

6. **BBHS** staff will inform the ED staff of an estimated time of arrival for the Crisis Therapist. Time of arrival will vary depending on whether the pre-screener is at another facility at the time of the call. BBHS will arrive as soon as possible in all cases. (Routinely the timeframe is within 1 hour.)

7. All BBHS Crisis Therapists who perform services in the ED will be identified with a BBHS name badge. A list of Health Officers appointed is updated at least annually.

8. **The Crisis Therapist** will consult with the attending physician and nurse, review toxicology results and interview the patient to recommend level of care and to develop a discharge plan. BBHS does not admit patients to a hospital on a voluntary basis. Emergency hospitalization criteria must be met to hospitalize:

    Criteria defined in ORC chapter 5122.02. Psychiatric facilities are not permitted to admit patients whose primary diagnosis is substance use/abuse.

    If the person meets hold criteria (involuntary commitment) and is intoxicated, he/she will need to remain in observation in the ER until the alcohol level is below a .08 and not in active withdrawal. It is not clinically appropriate to conduct an assessment with a patient who is intoxicated or under the influence of other substances. An observation may be necessary if the alcohol level is below a .08 but other drugs are also detected (i.e., marijuana, cocaine, opiates).

    The ER may discharge a patient to home at the attending physician's discretion. If the client is not discharged after 24 hours, the ER physician may order a call to BBHS to re-evaluate the client for hospitalization.

9. For all Warren & Clinton County patients (only) who are indigent, only BBHS Crisis Service employees and the MHRB chief clinical officer/designee have the authority to admit clients. Payment is guaranteed only for clients who meet the hospital in-patient contract criteria for indigent clients. ED staff is to contact the receiving psychiatric facility only to give a nursing report or for a doctor-to-doctor consultation in accordance with EMTALA regulations. The

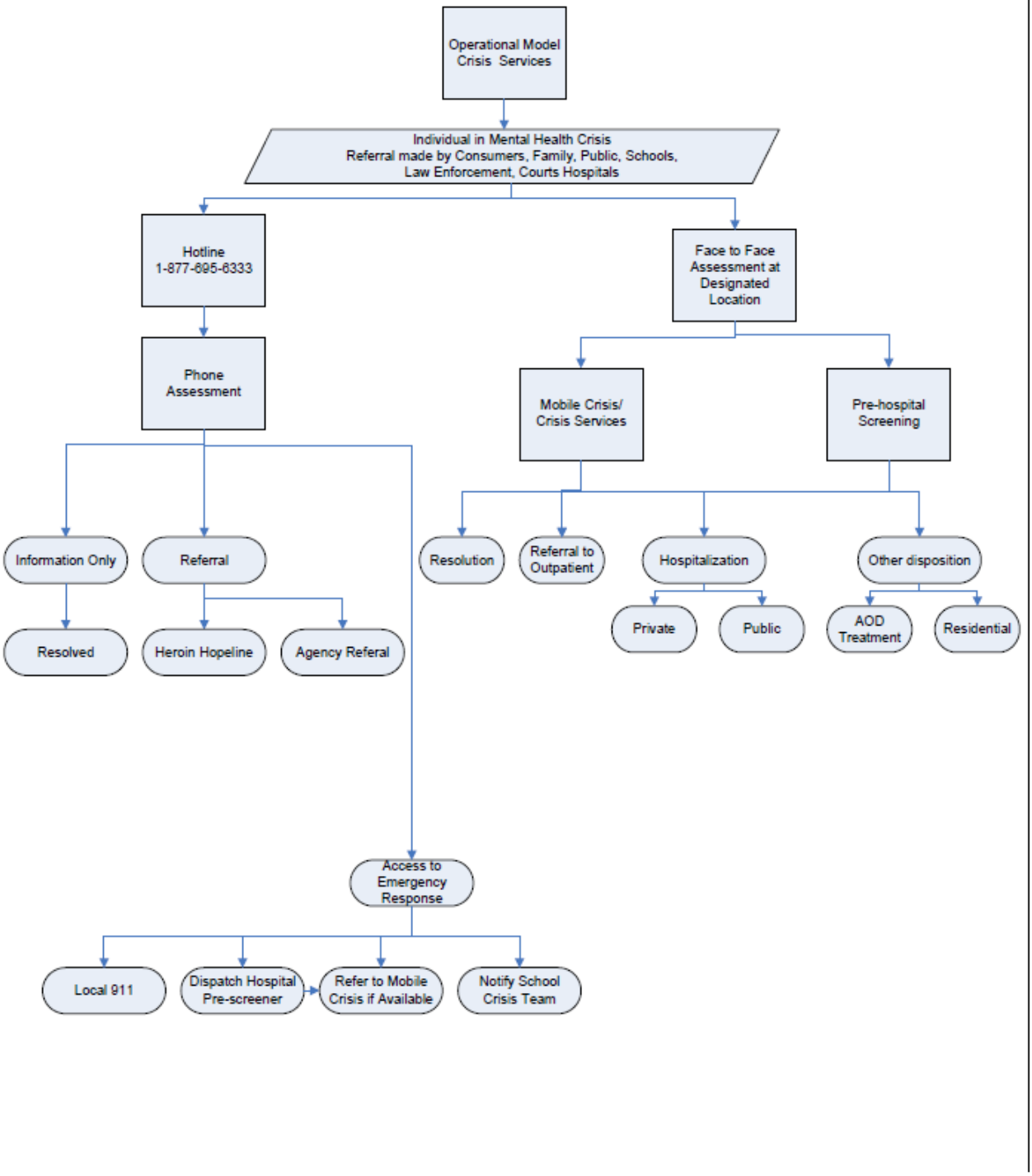
board is in no way responsible for medical costs or for any psychiatric admission made without the pre-screening agency's authorization.

Insurance patients and those who have Medicaid, Medicare or who are already determined by the ED staff to need hospitalization through the completion of a 72 hour hold form, may be admitted to psychiatric facilities by ED staff without BBHS assistance unless the state designated Behavioral Health Organization is the only option. In most exceptional cases, the ED Contact person requests consultation with the BBHS Crisis staff to facilitate admission. BBHS is not authorized to consent for payment of patients who have 3rd party coverage and will not authorize use of any public funds for patients not screened and hospitalized by BBHS **or who do not meet the residency criteria**.

10. **BBHS** is not responsible for transportation for any patient.

11. If the ED physician disagrees with the discharge plan of the BBHS Crisis Therapist, the physician can consult the BBHS supervisor by calling the 24- Hour Triage Crisis Hotline (1-877-695-6333). The Hotline personnel will route the call to the designated Supervisor on-call for a call back at that time. Ultimately, the dispositional decision is that of the physician.

Policy 3-1 Attachment 1



Policy 3-2: Hospitalization

Effective Date: 8/26/13
Last Revised Date: 7/1/23
Co-Lead Staff: Reija Huculak
Co-Lead Staff: Jeff Rhein

Policy

Hospitalization is sometimes necessary as the least restrictive setting when the client's safety, community safety or psychiatric stability cannot be ensured. In this event, MHRB will provide for client hospitalization using the following protocols and authorizations.

Procedure

1. Potential clients are referred many ways to the staging ED contact points in each County. Typically, clients will be funneled to the ED contact point by:

    a. Walk up on their own or family encouragement,
    b. Directed by contact with the 24-Hour Triage Crisis Hotline,
    c. Directed by contact with Case Manager or other service provider,
    d. Transported by Police/Sheriff or EMS squad
    e. Assessed by Mobile crisis personnel

2. All clients admitted to the above-named ED Contact points are, until discharged from the ED, patients of the hospital. The Crisis Provider, BBHS, plays a consultative role in providing level of care assessments for behavioral health clients and in helping arrange inpatient care or outpatient referral as indicated.

    The ED, as directed by the attending physician, will screen all behavioral health clients for acute medical/somatic problems and will provide treatment for such problems. A drug and alcohol screen will be ordered by the attending physician. The attending physician will make the medical diagnosis and determine that the patient is coherent and medically stable. (Coherent means that the patient is awake, alert, and responsive to questions. Medically stable means ready for discharge home aside from psychiatric symptoms.)

    BBHS crisis staff will inform the ED staff of an estimated time of arrival for the Crisis Therapist. Time of Arrival will vary depending on whether the pre-screener is at another facility at the time of the call. BBHS will arrive as soon as possible in all cases. (Routinely the timeframe is 1 hour.)

3. All BBHS Crisis Therapists who perform services in the ED will be identified with a BBHS name badge. The list of Health Officers appointed by the MHRB is on file with MHRB.

4. **The Crisis Therapist** will consult with the attending physician and nurse, review toxicology results and interview the patient to determine needed level of care and to develop a discharge plan. BBHS does not admit patients to a hospital on a voluntary basis. Emergency hospitalization criteria must be met to hospitalize (as defined in ORC 5122.01):

It is not permissible to admit a drug or alcohol patient to a hospital against their will. Psychiatric facilities are not permitted to admit patients whose primary diagnosis is substance use/abuse.

If the person meets hold (involuntary commitment) criteria and is intoxicated, he/she will need to remain in observation in the ED until the alcohol level is below a .08. It is not clinically appropriate to conduct an assessment with a patient who is intoxicated. A 24-hour observation may be necessary if the alcohol level is below a .08 but other drugs are also detected (i.e., marijuana, cocaine, opiates).

The ED may discharge a patient home at the attending physician's discretion. If the client is not discharged after 24 hours, the ER physician may order a call to BBHS to reevaluate the client for hospitalization.

5. For all Warren & Clinton County patients (only) who are indigent, only BBHS Crisis Service employees and the MHRB chief clinical officer and designee have the authority to admit clients. ED staff are to contact the receiving psychiatric facility only to give a nursing report or for a doctor-to-doctor consultation in accordance with EMTALA regulations. MHRB is in no way responsible for medical costs or for any psychiatric admission made to a private hospital apart from #6 below.

6. For Warren & Clinton County indigent patients who are under the age of 18:

    a. All aspects of the Hospitalizations Policy/Procedure in the MHRB Services Policy/Procedure Manual shall pertain to the hospitalization of youth as it does with adults.

    b. If an uninsured youth presents to the hospital ED and meets the criteria for hospitalization as determined by BBHS, and a hospital is unwilling to accept the youth without guarantee of payment:

        i. BBHS should complete and send to MHRB the "Initial Hospital Authorization Form for Youth." This form should include the parent/guardian's name and contact information.

        ii. During business hours, BBHS should contact MHRB for authorization for payment. At which time, the hospital will be sent the Ad Hoc Inpatient Service Agreement for completion.

        iii. During after hours, weekend, holiday, BBHS may send them the Ad Hoc Inpatient Service Agreement. If they are agreeable to the terms, BBHS is authorized to agree to no more than $1,000/day for placement of the youth for up to 7 days. On the first business day after admission, or as soon as possible, MHRB will provide a signed contract for the hospital.

        iv. If the youth is not currently a client of the system, the parent/guardian must also agree to the terms of the contract in relation to instituting system services upon discharge from the hospital for the hospitalization costs to be covered.

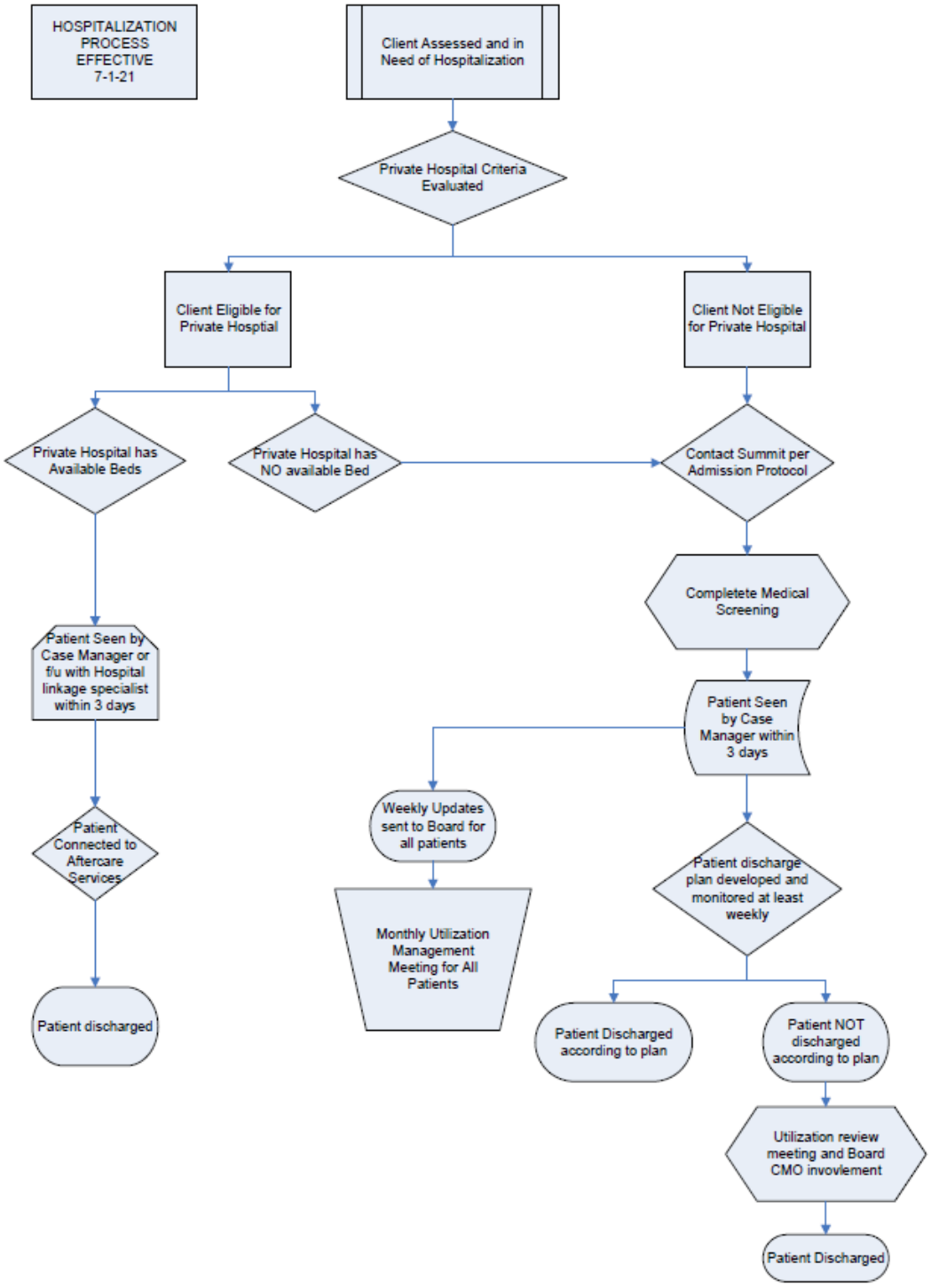
        v. In all cases, the hospital must be in the state of Ohio and licensed by OhioMHAS.

7. Insurance patients may be admitted to psychiatric facilities by ED with BBHS assistance. However, in most cases the ED Contact points request consultation with the BBHS Crisis staff to facilitate admission BBHS is not authorized to consent for payment of patients who have 3rd party coverage and will not authorize use of any public funds for patients not screened and hospitalized by BBHS **or who do not meet the residency criteria of a Warren/Clinton County resident**.

8. **BBHS** is not responsible for transportation for any patient. If there is an exception, BBHS will notify the Board and will request payment.

9. If the ED physician disagrees with the discharge plan of the BBHS Crisis Therapist, the physician can consult the BBHS supervisor by calling the 24-Hour Triage Crisis Hotline (1-877-695-6333). The Hotline personnel will route the call to the designated Supervisor on-call for a call back at that time. Ultimately, the dispositional decision is that of the ED physician.

Policy 3-2 Attachment 1: Hospitalization Flow Chart



Policy 3-2 Attachment 2: Youth Inpatient Agreement

YOUTH INPATIENT SERVICE AGREEMENT

This Agreement made and entered into by and between Mental Health Recovery Board Serving Warren and Clinton Counties (hereinafter "MHRBWCC") and _____ (hereinafter "HOSPITAL").

WHEREAS, MHRBWCC is charged with the responsibility for assessing, planning and assuring the provision of appropriate services for persons with mental illness in accordance with federal, state, and local statutes and regulations governing these services; and

WHEREAS, one of the responsibilities of MHRBWCC as described in ORC Section 340.03 is to ensure that persons who are of hospitalization, and who reside in Warren or Clinton Counties will have the ability to obtain comprehensive mental health services; and

WHEREAS, MHRBWCC desires to purchase inpatient psychiatric services for such persons, and provide continuity of care within the community; and

WHEREAS, MHRBWCC and HOSPITAL recognize Butler Behavioral Health Services as the sole and primary agent to work on behalf of MHRBWCC to assess, authorize admission, and Talbert House/Hospital Linkage Specialist to provide discharge planning in conjunction with the HOSPITAL; and

WHEREAS, HOSPITAL is duly licensed and certified by the Ohio Department of Mental Health and Addiction Services to provide inpatient psychiatric services and accredited by TJC.

WHEREAS, MHRBWCC desires to purchase youth inpatient psychiatric services from HOSPITAL.

NOW, THEREFORE, in consideration of the mutual promises contained herein MHRBWCC and HOSPITAL agree as follows:

1.0 DEFINITIONS

The following definitions shall apply as used herein:

1.1. "Board Chief Clinical Officer (BCCO) " shall mean the psychiatric physician or clinical psychologist duly licensed by the State of Ohio and appointed by MHRBWCC pursuant to the Ohio Revised Code Chapter '5122.01(K) to provide consultation, evaluation, monitoring and other mental health services on behalf of MHRBWCC.

1.2. "Medical Director or Designee " shall mean the "Chief of Medical Staff" who is the physician designated by the Hospital to represent the Hospital in the dispute resolution process under this Agreement.

1.3. "Client" shall mean a mentally ill or seriously emotionally disturbed person who is a resident of Warren or Clinton Counties, and who is approved by MHRBWCC for mental health services as described in this Agreement. This person must be a resident of Warren or Clinton County and must be or has been a client of MHRBWCC within six months of date of hospitalization. Retrospectively, if a person who has not been a client of MHRBWCC, is hospitalized and initiates services beyond one appointment with an MHRB contracted agency upon discharge from the hospital, the person may be reclassified at the end of the fiscal year as a client of MHRBWCC if all other requirements are met.

1.4. "Guardian" shall mean any person or agency to which a court has granted temporary or permanent custody, or shelter care, or who is in actual possession, or entitled to physical custody or possession by statute.

1.5. TJC shall mean The Joint Commission, an independent not for profit organization for accreditation and certification of health care organizations.

1.6. "Treatment Provider" shall mean the public or private agency, which has provided or is currently providing the client with mental health treatment in the community.

1.7. "Utilization Review" shall mean those activities (retrospective, concurrent and prospective) undertaken individually or collectively by MHRBWCC or HOSPITAL to ensure the appropriate utilization of hospital, psychiatric and social services provided to MHRBWCC clients under this Agreement.

1.8. "Indigent" shall mean the client has no third party payment source such as private insurance, Medicaid, Medicare, or is without resources such as personal income earnings or assets to assume financial responsibility.

2.0 TERMS AND TERMINATION

2.1. The term of this Agreement shall commence on _____ and end on _____.

3.0 HOSPITAL SERVICES

3.1. HOSPITAL shall provide Covered psychiatric inpatient services and/or available services provided by the Hospital for MHRBWCC's client admitted to the HOSPITAL in compliance with TJC Standards. Treatment delivered covers the biopsychosocial issues pertinent to the patient's diagnosis and reasons for hospitalization. Active psychosocial treatment is offered every day not less than 6 hours/day in group and/or individual format. Failure to deliver this treatment without proper documentation may disqualify reimbursement claims for that specified day.

3.2. Non-Psychiatric Medical Treatment /Services. The sole interest of MHRBWCC is to provide acute psychiatric inpatient services for its clients through a contractual arrangement with

HOSPITAL. In no circumstances shall MHRBWCC be financially responsible for treatment and/or services provided for concurrent non-psychiatric medical problems of MHRBWCC's clients.

4.0 PRE-AUTHORIZATION FOR ADMISSION

4.1. HOSPITAL agrees to use its best efforts to accept all funded MHRBWCC's clients who meet admission criteria, Appendix A, and are referred for admission to the HOSPITAL according to the client's health status and mental health needs and provided that those needs do not exceed the abilities of the hospital to provide such services to such clients as defined in Paragraph 3.1.

4.2. Covered admissions for which MHRBWCC will accept financial responsibility under Paragraph 8.3 are subject to meeting criteria for admission and facility reporting using the form, MHRBWCC-Provider Inpatient Authorization Form. After obtaining the authorization for initial hospitalization by contacting our crisis therapist designated by MHRBWCC, admissions shall be authorized initially for up to five (5) days, each additional inpatient day subject to the prior approval of MHRBWCC's BCCO or designee, upon MHRBWCC's receipt of the Continued Authorization Form (Exhibit "B") from Hospital. The form requesting authorization for continued hospitalization must be received at the MHRBWCC's office prior to the last approved day of hospitalization and on Friday if that day is a weekend or a holiday. The decision for approval or denial shall be faxed back to the Hospital's Behavioral Health Unit. The approval for continued hospitalization will be valid for up to 3 days only. The process needs to be repeated if more hospital days are needed.

The BCCO/designee shall work in full collaboration with the Admitting/ Attending Physician/ Psychiatrist regarding the clinical care of patient. It is further understood that the Admitting/ Attending Physician is in full control of the patient clinical care.

4.3. Should a patient be admitted and is believed not to have commercial insurance/Medicaid and discovered later to have insurance, MHRBWCC will pay a maximum of 1 day's services (i.e., 24 hours) if the admission has been authorized through the Hospital Pre-Screening Agent and only if the insurance company/Medicaid denies the admission for medical necessity purposes. The Hospital will not bill MHRBWCC for any days denied by the insurance company/Medicaid based on medical necessity. Insurance/Medicaid denials for non-coverage will be billed to MHRBWCC.

5.0 CASE MANAGEMENT

MHRBWCC's Mental Health Crisis Services designee or designate provider shall make its' best efforts to coordinate the admission, treatment, and discharge of clients with HOSPITAL, the legal guardian or custodian, and the MHRBWCC system case management provider.

5.1. HOSPITAL shall make its best efforts to obtain all consents for treatment necessary for admission, treatment, and discharge.

5.2. MHRBWCC's Mental Health Crisis Services or designated provider shall make its best efforts to provide HOSPITAL with all known information regarding the client such as legal guardian, guardian's employer, payer responsibility, Medicaid/Medicare case numbers, clinical information as outlined in the Mental Health Unit's Inquiry Form, etc., which would assist HOSPITAL in obtaining appropriate consents for treatment and in determining financial responsibility to enable HOSPITAL to bill and collect services not payable by MHRBWCC.

5.3. MHRBWCC's Mental Health Crisis Services or designated provider shall be entitled to full participation in all HOSPITAL treatment team meetings regarding MHRBWCC system clients. HOSPITAL will make its' best efforts to provide to MHRBWCC's Mental Health Crisis Services designee the dates and times when the treatment team will regularly meet to discuss MHRBWCC clients.

5.4 HOSPITAL shall make its best efforts to notify MHRBWCC's designated agency at least twenty-four (24) hours in advance of regularly scheduled treatment team meeting. If unforeseen circumstances should occur, the HOSPITAL will make an effort to notify changes in treatment team meetings. In the event an emergency treatment team meeting is necessary, the HOSPITAL shall make its best efforts to immediately notify MHRBWCC's Mental Health Crisis Services designee. The HOSPITAL shall make its best efforts to provide access for MHRBWCC's Mental Health Crisis Services designee staff to meet with the client, attend treatment team meetings, and review the client's HOSPITAL records.

5.5 MHRBWCC has designated Hospital Linkage Specialist as follows:

5.5.1. To ensure continuity of care for all of its clients, MHRBWCC will require that a Hospital Linkage Specialist be assigned by the designated agency to each client admitted to the HOSPITAL. The Hospital Linkage Specialist will have contact with the client within forty-eight (48) hours of admission.

5.5.2. The Hospital Linkage Specialist will provide services solely as an adjunct to services provided by the social service department of the HOSPITAL, and not as a replacement for such services.

6.0 ACCESS TO HOSPITAL MEDICAL RECORDS AND CONFIDENTIALITY

HOSPITAL agrees to provide MHRBWCC with access during normal business hours, to the extent allowable by State and Federal law, upon reasonable request, to all information and records requested by MHRBWCC for their Covered Clients for the purpose of evaluating the quality, effectiveness, and efficiency of services and determining whether services meet the standards required by this Agreement, including, but not limited to, information pertaining to admission of Covered Clients; provision of services related to re-hospitalization within 4 weeks of discharge, length of stay, medical necessity, quality assurance, utilization management information and all financial information relating to Covered Clients' medical and billing records per month containing information referred to in this paragraph necessary for auditing the HOSPITAL'S compliance with the terms of this Agreement. The access

required by this paragraph shall include access to Clients' records, whether maintained by the HOSPITAL, one of the component hospitals, or another entity. In recognition of the confidentiality rights of patient, all information obtained by MHRBWCC pursuant to this paragraph shall not be retained with the name of any patient, as required by O.R.C. 5122.31 (K). MHRBWCC shall indemnify and hold harmless the Hospital for any action arising from the compliance with a request for release of a Covered Client's medical and financial records to MHRBWCC or any other party.

6.1 MHRBWCC's representatives and system provider personnel will display and provide proper identification to HOSPITAL security personnel at all times when onsite, to the extent permitted by State and Federal law. MHRBWCC's representatives will have the authority to review client charts and discuss treatment related concerns with the hospital treatment team without obtaining clinical privilege or obtaining consent forms from the clients. The MHRBWCC Chief Clinical Officer, and/or their designee, will be granted Courtesy Privileges at the Hospital upon the CCO's successful completion of the Hospital's physician privileging process.

6.2 Adverse Events: limited to: a) Death; b) Serious Injury; c) Abuse: Physical or Sexual; and d) Attempted Suicide, which may occur to MHRBWCC's clients must be reported to the MHRBWCC BCCO within 24 hours, or as soon as is reasonably possible. The MHRBWCC expects an investigation to be initiated within 24 hours of the event with a written report including the recommendations to minimize or prevent future occurrences delivered to the MHRBWCC within 30 working days, or as soon as is reasonably possible.

6.3 Confidential Information/HIPAA. Neither party to this Agreement nor its employees or agents shall disclose to any unauthorized person any confidential information received during the course of this Agreement. MHRBWCC acknowledges that Hospital is bound by law to have written agreements with its business partners who may have access to patient information requiring compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules and regulations promulgated hereunder. Accordingly, MHRBWCC warrants and represents that it is or will be in compliance with HIPAA and all relevant federal and state statutes, rules, regulations and requirements effective at future dates according to the applicable timetables and will execute any appropriate addendum to this Agreement to enable Hospital to be compliance with HIPAA. Failure by MHRBWCC to comply with this provision shall result in immediate and automatic termination of the Agreement without penalty or cost to Hospital.

6.4 Utilization Review will be overseen by MHRBWCC for the management of inpatient services. MHRBWCC, as part of its on-going quality assurance processes, will monitor at least annually the admissions, treatment, length of stay, readmissions, financial documentation, and other issues as necessary.

7.0 COMPENSATION AND COORDINATION OF BENEFITS

7.1. MHRBWCC agrees to pay HOSPITAL a daily rate of $_____ which includes room and board, and all HOSPITAL inpatient psychiatric services as provided in Paragraph 3.1, HOSPITAL SERVICES herein. Such inclusive rate covers all HOSPITAL inpatient psychiatric services as

provided in Paragraph 3.1 herein whether such services are provided directly by the HOSPITAL, or indirectly by the HOSPITAL pursuant to a contractual arrangement for the provision of such services by a person or entity other than the HOSPITAL. For the purpose of this Agreement, MHRBWCC shall be charged the herein agreed upon inclusive rate beginning on the day the client is admitted. MHRBWCC shall not, however, be charged for a room on the day the client is discharged, unless admission and discharge occur on the same day.

7.2 MHRBWCC agrees to accept financial responsibility as the **payor of last resort** (excluding HCAP), in accordance with the terms of this Paragraph 8, only for a MHRBWCC's client (as "client" is defined in Paragraph 1.3 herein) referred to the HOSPITAL for admission who:

7.2.1 Has no third party payment source for the services provided, such as private insurance, Medicaid, Medicare, or is without resources such as personal income or earnings to assume financial responsibility, as determined at the time of admission or during hospitalization; AND

7.2.2 MHRBWCC agrees to accept financial responsibility, in accordance with the terms of this paragraph, for one (1) inpatient day for individuals understood to meet the criteria 8.2 above at the time of admission but later during the hospitalization are found to have a third party payment source or personal earnings to assume financial responsibility. If a client is admitted on referral from MHRBWCC's system providers and through MHRBWCC's provider error or omission is subsequently discovered not to have third party insurance coverage, payment for inpatient services will be assumed by MHRBWCC according to terms for indigent care in this contract and pursuant to Paragraph 4.3. The only circumstance in which payment would be denied by MHRBWCC is when denial by the third party payer is for insufficient documentation of need to meet Medical Necessity Criteria. The Hospital shall notify MHRBWCC of any MHRBWCC paid client that subsequently receives a third party payer retroactively. At the end of the fiscal year, the Hospital will refund any such payments directly to the MHRBWCC.

7.3 The HOSPITAL shall submit a billing statement per diem rate agreed to in 8.1 to MHRBWCC for services rendered to clients meeting the criteria in 8.2 above. See Contract Appendix C for details on billing statement.

MHRBWCC shall be responsible only for payment of the per diem rate as agreed upon in paragraph 8.1 herein.

7.4 Denial of Benefits. In the event that within 180 days, after discharge, the HOSPITAL receives a denial from the third-party payor and has met the residency and treatment affiliation requirements as defined by the Client definition and in 8.2, HOSPITAL shall provide MHRBWCC with documentation of denials as received from the third-party payor prior to payment by MHRBWCC pursuant to 7.1 and 7.2 above. MHRBWCC shall not be responsible for billings submitted more than 120 days after discharge (exceptions would be third-party payer bills still in the billing process per Section 7.5. If no documented denial of eligibility has been received from

the third party, HOSPITAL agrees to continue to review the case at least every thirty (30) days until proof of denial of eligibility can be provided to MHRBWCC. Should HOSPITAL receive payment from the client's third-party payer, HOSPITAL shall notify MHRBWCC, in writing, and the HOSPITAL stay shall be credited to MHRBWCC within thirty (30) days.

7.5 The HOSPITAL shall exercise all due diligence in collecting first and third-party payments. Due diligence may include, but not be limited to, an interview with the client to determine 1st and 3rd party payers, working with client to complete Medicaid or Medicare paperwork, working with client to complete charity care or other financial paperwork. Billing to 1st or 3rd party payers should take place before billing MHRBWCC as per 8.4 above. The hospital should notify MHRBWCC within 90 days of discharge for any client(s) still in the billing process. MHRBWCC through its agencies and case managers agrees to work with the Hospital to effectively support clients follow through and effort to obtain Medicaid services when identified as eligible.

7.6 The HOSPITAL shall not, under any circumstances, bill a MHRBWCC's client as defined in paragraph 3.1 and 7.4 herein, unless found to have resources to pay as per 7.2.1.

8.0 DISPUTE RESOLUTION

8.1 Treatment Issues. In any case where a dispute occurs concerning the treatment or discharge of a client, a case conference shall be scheduled within one (1) working day (Monday through Friday, legal holidays excluded) at the request of either the HOSPITAL or MHRBWCC. MHRBWCC shall pay the per diem rate for the client in dispute until the required conference. The Medical Director or Designee and the Board Chief Clinical Officer of MHRBWCC involved shall attend the conference either in person or by conference call. A written statement of the conference shall be prepared. If an agreement cannot be reached through this means, the judgment of the Board Chief Clinical Officer of MHRBWCC shall prevail. If the issue is not resolved to the HOSPITAL's satisfaction, HOSPITAL may appeal the decision (refer to the dispute resolution process as defined in Section 9.2, "System Issues"). It is expressly understood that MHRBWCC shall not under any circumstances be financially responsible for such continued hospitalization. MHRBWCC reserves the right for the Board Chief Clinical Officer of MHRBWCC to examine a client to determine discharge readiness should a dispute occur between MHRBWCC, Hospital Psychiatrist and/or the HOSPITAL.

9.2 System Issues. In the case of a dispute concerning the HOSPITAL's implementation of this Agreement, general patient care, billing, or other matters related to a specific client, MHRBWCC's Executive Director or his/her designee and the HOSPITAL's Designated Representative will attempt to resolve the issue(s) in dispute. A written summary of the meeting shall be prepared which shall describe any agreement reached and/or the issue(s) not resolved at the meeting. If the issue is not resolved, then the HOSPITAL Designated Representative and MHRBWCC's Executive Director may pursue mediation with an independent mediator, the cost of which shall be borne equally by MHRBWCC and the Hospital. If the issue is not resolved through mediation, then the dispute may be submitted to arbitration for final resolution. In the event the dispute is

referred to arbitration, the sole venue and jurisdiction for the dispute shall be in a court of competent jurisdiction located in Warren County, Ohio.

9. LIABILITY INSURANCE

Each party at its sole cost and expense shall procure and maintain such policies of general liability and professional liability insurance and other insurance as shall be necessary to insure it and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of any services provided hereunder, the use of any property or services and the activities performed in connection with this Agreement. The HOSPITAL may self-insure through a captive insurance company funded by prudent actuarial principles. Each Party's professional liability insurance shall provide for limits of not less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the aggregate. If such insurance is "claims made," an extended reporting endorsement insurance shall be purchased in the event of the termination of MHRBWCC's services, and MHRBWCC shall be responsible for and shall pay any such Tail insurance premium. Hospital shall provide MHRBWCC a copy of proof of such insurance as Exhibit A to this contract.

10. INDEMNIFICATION

10.1. HOSPITAL will indemnify and hold harmless MHRBWCC and its respective trustees, officers, employees and agents from all claims, actions, awards, judgments, settlements, damages, liabilities and expenses, including reasonable attorney's fees and witness' fees, to the extent caused by the negligence or willful acts or omissions of HOSPITAL'S or any of HOSPITAL'S employees or agents.

10.2. MHRBWCC will indemnify and hold harmless the HOSPITAL and its respective trustees, directors, officers, employees and agents from all claims, actions, awards, judgments, settlements, damages, liabilities and expenses, including reasonable attorney's fees and witness' fees, to the extent caused by the negligence or willful acts or omissions of MHRBWCC or any of MHRBWCC's employees or agents.

11. ASSIGNMENT

This Agreement is personal between MHRBWCC and HOSPITAL and neither may assign nor delegate any rights, duties or interests created hereunder without prior written consent of the other party. Any such assignment or delegation of either party hereunder without such consent shall be null and void.

12. NOTICE

12.1. Any notice to be given under this Agreement by any party to the others shall be sufficient if made in writing and sent by certified mail, return receipt requested to:

MHRBWCC:

Amy Fornshell – Executive Director
201 Reading Road; Mason, OH 45040

HOSPITAL:
(complete with contact name/hospital name/address)

13. NON-DISCRIMINATION

HOSPITAL shall not discriminate on the basis of race, sex, color, national origin, religion, age, disability, or ability to pay in the provision of services under this Agreement.

14. MODIFICATIONS AND AMENDMENT

This Agreement may be modified or amended only by a written document, signed by both parties.

15. SEVERABILITY

The provisions of this Agreement shall be severable. The unenforceability of any provision in this Agreement shall not affect the validity of the remaining provisions.

15.1. Any provision of law that invalidates, or otherwise is inconsistent with, the terms or conditions of this Agreement, or that would cause one or both of the parties to be in violation of the law shall be deemed to have superseded the terms of this Agreement, provided, however, that the parties shall exercise their best efforts to accommodate the terms and intent of this Agreement to the greatest extent possible consistent with the requirements of law. However, if the invalid provision is material to the overall purpose and operation of this Agreement, then this Agreement shall terminate upon severance of such provision.

16. GOVERNING LAW & VENUE

This Agreement shall be construed in accordance with the laws of the State of Ohio. The parties agree that the sole venue and jurisdiction for any dispute arising under this Agreement shall be in the Federal, State or Municipal Courts located within Warren or Clinton County, Ohio.

17. EXCLUDED PROVIDER

If applicable, MHRBWCC hereby represents and warrants that it is not and has at no time been excluded from participation in any federal or state funded healthcare program, including but not limited to, Medicare and Medicaid. MHRBWCC hereby agrees to notify Hospital immediately of any threatened, proposed, or actual exclusion of MHRBWCC from any federal or state funded healthcare program, including but not limited to, Medicare and Medicaid. In the event that MHRBWCC is excluded from participation in any federal or state funded healthcare program during the term of this Agreement, or if at any time after the effective date of this Agreement it is determined that MHRBWCC is in breach of this Section, this Agreement shall, as of the effective date of such exclusion or breach, automatically

terminate. MHRBWCC shall indemnify and hold harmless Hospital against any and all actions, claims, demands and liabilities, and against all loss, damages, cost and expenses, including reasonable attorney's fees, arising directly or indirectly, out of any violation of this section of this Agreement by MHRBWCC, or due to exclusion of the MHRBWCC from a federally funded healthcare program including but not limited to Medicare or Medicaid.

18. CERTIFICATION OF DEBARMENT AND SUSPENSION

The HOSPITAL certifies by signature to this contract that it is not suspended, debarred, or ineligible from entering into contracts with any department or other agency of the Federal Government, or in receipt of a notice of proposed debarment or suspension.

18.1 The HOSPITAL shall provide immediate notice to MHRBWCC in the event of being suspended, debarred, or declared ineligible by any department or other agency of the Federal Government, or upon notice of a proposed debarment or suspension, either prior to or after execution of this agreement.

18.2 The HOSPITAL agrees to secure from its Sub-Grantees or Participants in transactions expected to equal or exceed the small purchase threshold, certification that such participants are not suspended, debarred, or declared ineligible from entering into contracts with any department or agency of the Federal Government, or in receipt of a notice of proposed debarment or suspension.

IN WITNESS WHEREOF, the parties as hereto have executed this Agreement as of the dates written below.

Mental Health Recovery Board Serving Warren and Clinton Counties

Dayton Children's Hospital

By:_____ By: _____
Amy Fornshell, Executive Director Date

Date

ATTACHMENTS:
APPENDIX-"A" MHRBWCC's Admission Criteria
APPENDIX-"B" Discharge Planning Procedures
APPENDIX - "C" Billing Procedures with Invoice Example & Instructions
EXHIBIT - "A" HOSPITAL's Certification of Insurance (Hospital Provides)
EXHIBIT - "B" Initial Hospital Authorization Form and Authorization for Continued Stay

APPENDIX - "A"

CRITERIA FOR ADMISSION TO INPATIENT CARE

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A and B and either C, D or E must be met to satisfy the criteria for severity of need.

A. The client has a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV codes on all applicable axes (I-V).

B. The client requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment including but not limited to medication monitoring and administration, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions.

C. The client demonstrates a clear and reasonable inference of imminent serious harm to self. This is evidenced by having any one of the following:
    1. a current plan or intent to harm self with an available and lethal means, or
    2. a recent lethal attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety, or
    3. an imminently dangerous inability to care adequately for his/her own physical needs or to participate in such care due to disordered, disorganized or bizarre behavior, or
    4. other similarly clear and reasonable evidence of imminent serious harm to self.

D. The client demonstrates a clear and reasonable inference of imminent serious harm to others. This is evidenced by having any one of the following:
    1. a current plan or intent to harm others with an available and lethal means, or
    2. a recent lethal attempt to harm others with continued imminent risk as demonstrated by poor impulse control and an inability to plan reliably for safety, or
    3. violent unpredictable or uncontrolled behavior that represents an imminent risk of serious harm to the body or property of others, or
    4. other similarly clear and reasonable evidence of imminent serious harm to others.

E. The client's condition requires an acute psychiatric assessment technique or intervention that unless managed in an inpatient setting, would have a high probability of leading to serious, imminent and dangerous deterioration of the client's general medical or mental health.

APPENDIX - "B"

MHRBWCC's SYSTEM DISCHARGE PLANNING PROCEDURES

1. Callers to Talbert House – Hospital Linkage Specialist: 1-513-932-4337- should identify themselves as Hospital personnel with a Warren or Clinton County system client who is scheduled to be discharged, they will be requested to provide:
    a. Hospital Contact Name & Number (for follow-up contact)
    a. Identify Client Name
    b. Current Client Address
    c. Client Date of Birth
    d. Client Social Security Number
    e. Clarify if client has known current Case Manager in MHRBWCC system.

2. If client in question is a known client, the appropriate representative will be contacted by the Hospital Linkage Specialist to notify of discharge.

3. If client in question is *previously unknown* to system, the Hospital Linkage Specialist will contact the parent/guardian to ensure discharge coordination and arrangement for services post-discharge.

4. The Hospital should contact the Talbert House number again if they have not received a call from the appropriate representative within 1 business day of the initial call.

APPENDIX - "C"

BILLING PROCEDURES

Following the 1st of each month, provide a single invoice detailing client, number of days in occupancy (per client), facility location/name, and per diem daily rate plus monthly total by client for the previously unbilled services to the MHRBWCC office for payment. Said invoice should also include name and phone number of a contact person to whom any billing questions should be directed. Lastly, the Hospital's Federal Employment Identification Number (FEIN) should appear on the monthly invoice. (Example of invoice and instructions are included on following pages)

All invoices for Warren & Clinton County indigent admissions should be sent to:

Mental Health Recovery Board Serving Warren & Clinton Counties
Attn: Karen Robinson, CFO
invoices@mhrbwcc.org
201 Reading Road, Mason, OH 45040)
(o) 513-695-1694, (f) 513-695-1776 (confidential)

Policy 3-2 Attachment 2: Invoice for Hospital Services

Invoice for Hospital Services

Date of Invoice: _____

Services Provided To:	**Remit Payment To:**
Mental Health Recovery Board Serving Warren & Clinton Counties 201 Reading Road Mason, OH 45040 invoices@mhrbwcc.org	**FEIN:**

Rate per Day per contract: _____

Contact Person for Invoice Questions (name & phone #): _____

Patient Name	Admission Date	Discharge Date	Days	Rate Per Day	Total
					0.00
					0.00
					0.00
					0.00
					0.00
					0.00
					0.00
					0.00
					0.00
					0.00
					0.00
					0.00
					0.00
					0.00
					0.00
				Invoice Total	**0.00**
Pending Insurance Etc...					
					0.00
					0.00
					0.00
				Pending Total	**0.00**

Payment for date of admission, but not for date of discharge based on all inclusive perdeim rate

The Hospital shall exercise all due diligence in collecting first & third party payments. Due diligence may include, but not be limited to interviews with client to determine first & third party payers, working with client to complete Medicaid/Medicare paperwork, working with client to complete charity care or other financial paperwork.

I certify, that the hospital has performed the due diligence above and have found the client to not have other insurance or resources, not be Medicaid/Medicare eligible and therefore be eligible for charity care and MHRB funding.

_____ _____
Name/Title Date

https://mhrswcc.sharepoint.com/sites/CompanySharedFolders/Shared Documents/AHTING/U-Z/Youth Hospitalization/IP Hospital Invoice Blank

Instruction for Inpatient Hospital Billing Invoice

1 Enter date of Invoice

2 Enter Hospital payment information. List name check should be made payable to and address check should be sent to. This information should match the W-9 information sent for accounts payable verification.
Insert hospital Federal Employment Identification Number (FEIN)

3 Enter the rate per day (perdiem rate) per the contract

4 Enter the name & phone number of the person to contact with billing questions

5 Enter client name, admission date, discharge date, # days and perdiem rate for billing purposes. Please see the contract specifications for client eligibility and payment requirements. Note that Mental Health Recovery Board Serving Warren & Clinton Counties is payor of last resort and all other payors should be billed prior to MHRB.

6 Sign & date the invoice noting that hospital has performed all due diligence for the clients listed above and there is no other funding source available for payment.

7 Send invoice to Mental Health Recovery Board Serving Warren & Clinton Counties for paymer

8 If hospital later receives payment from another source on a client that was billed to MHRB, hospital will issue a refund to MHRB.

Hospital should invoice monthly for all clients that have met the eligibility requirements per the contract.

EXHIBIT - "A"

Attached: HOSPITAL Certificate of Insurance (Hospital Provides)

EXHIBIT - "B" Initial Hospital Authorization Form and Authorization for Continued Stay

Mental Health Recovery Board
Serving Warren & Clinton Counties

Initial Hospitalization Authorization Form for Youth (under age 18 year)

Form must be faxed to MHRB: (513) 695-1776
Questions? Call Amanda Peterson, Deputy Director at 513-695-1695

****

Date: _____ Location of Crisis Service: _____

Patient's name: _____

Address: _____

SS#: _____ DOB: _____

Name and Contact information of Parent/Guardian: _____

_____

Is the patient uninsured? ☐ Yes ☐ No

Has the patient been receiving outpatient behavioral health services? ☐ Yes ☐ No

If yes, the last date services were received: _____

Name of agency, case manager and psychiatrist:

_____

Reason for admission to hospital? (include dates, identifying data, pertinent past history - med, psych & CD):

_____

Current condition/MSE:

_____

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Mental Health Recovery Board
Serving Warren & Clinton Counties

DSM-5 Diagnosis(es):

Name of Hospital:

Name of Hospital or Crisis Staff: Signature :

Email Address: Phone #:

*Documentation can be sent as attachments as well

FOR COMPLETION BY HOSPITAL:

Date patient will see a financial counselor?

Though uninsured, does client qualify for hospital assistance/and or Medicaid? ☐ Yes ☐ No

If yes, at what percentage of coverage?

Per Diem Cost:

FOR COMPLETION BY MHRB:

*Admission Date: *Approved through date: Denied ☐

Recommended alternative level of care (if denied):

Other comments/notes:

Name of MHRB Staff: Signature :

Page 2; v. 7/1/2024

Policy 3-3: Involuntary Commitments

Effective Date: 8/26/13
Last Revised Date: 7/1/23
Co-Lead Staff: Reija Huculak
Co-Lead Staff: Jeff Rhein

Policy

5122.11 Judicial hospitalization.

Proceedings for the hospitalization of a person pursuant to sections 5122.11 to 5122.15 of the Revised Code shall be commenced by the filing of an affidavit in the manner and form prescribed by the department of mental health, by any person or persons with the court, either on reliable information or actual knowledge, whichever is determined to be proper by the court. This section does not apply to the hospitalization of a person pursuant to section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code.

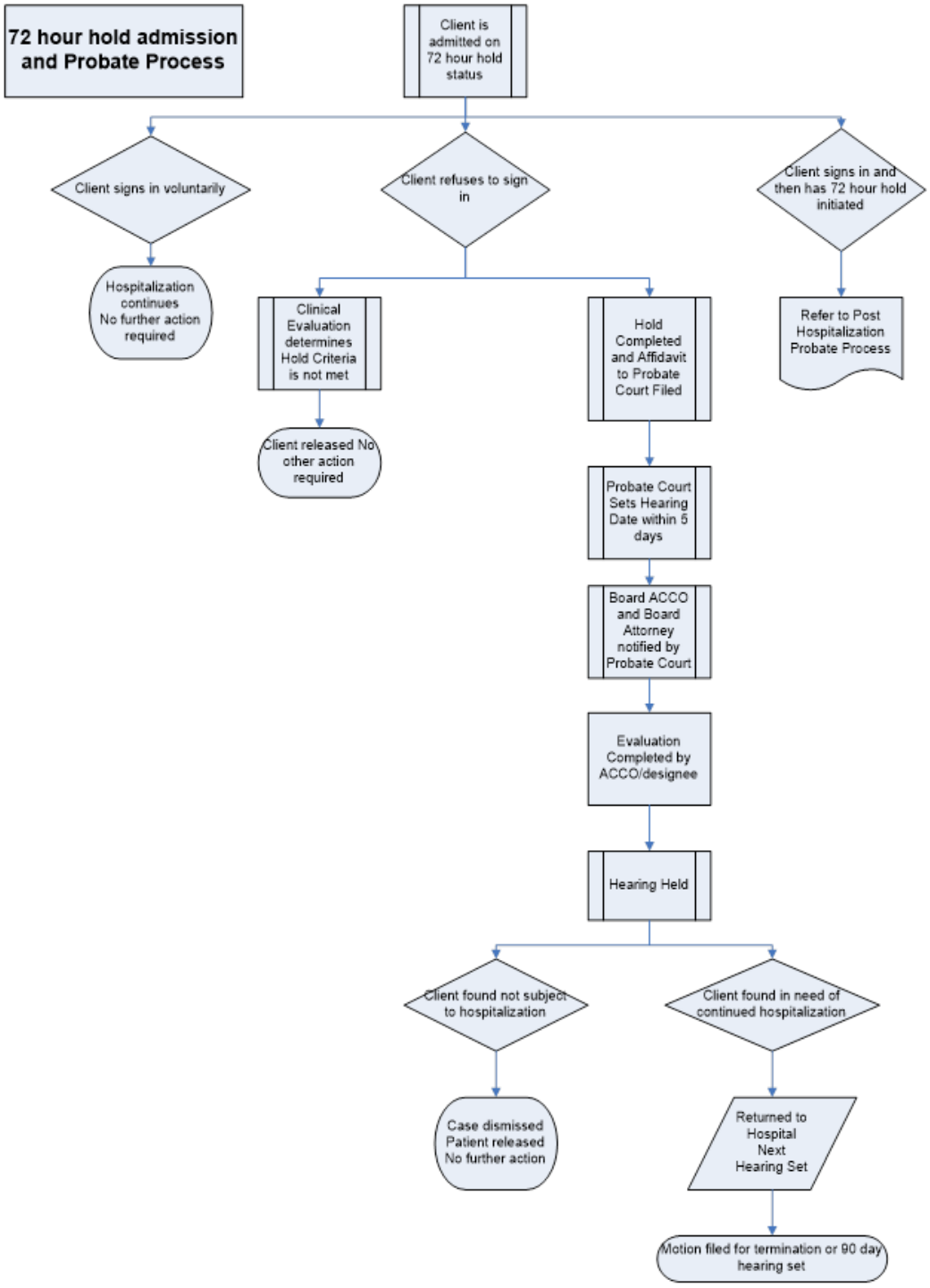
The affidavit shall contain an allegation setting for the specific category or categories under division (B) of section 5122.01 of the Revised Code upon which the jurisdiction of the court is based and a statement of alleged facts sufficient to indicate probable cause to believe that the person is a mentally ill person subject to hospitalization by court order. The affidavit may be accompanied, or the court may require that the affidavit be accompanied, by a certificate of a psychiatrist, or a certificate signed by a licensed clinical psychologist and a certificate signed by a licensed physician stating that the person who issued the certificate has examined the person and is of the opinion that the person is a mentally ill person subject to hospitalization by court order, or shall be accompanied by a written statement by the applicant, under oath, that the person has refused to submit to an examination by a psychiatrist, or by a licensed clinical psychologist and licensed physician.

Upon receipt of the affidavit, if a judge of the court or a magistrate who is an attorney at law appointed by the court has probable cause to believe that the person named in the affidavit is a mentally ill person subject to hospitalization by court order, the judge or referee may issue a temporary order of detention ordering any health or police officer or sheriff to take into custody and transport the person to a hospital or other place designated in section 5122.17 of the Revised Code, or may set the matter for further hearing.

The person may be observed and treated until the hearing provided for in section 5122.141 of the Revised Code. If no such hearing is held, the person may be observed and treated until the hearing provided for in section 5122.15 of the Revised Code.

Hospitalization is not permitted under Senate Bill 43 Application for Emergency Admission criteria 5. If hospitalization is indicated, a crisis services evaluation would be required.

Policy 3-3 Attachment 1: Involuntary Commitment Flow Chart



Policy 3-4: Private Hospital Request for Transfer to Summit Behavioral Health Care

Effective Date: 8/26/13
Last Revised Date: 7/1/23
Co-Lead Staff: Reija Huculak
Co-Lead Staff: Jeff Rhein

Policy

Provide appropriate authorized transfer to Regional Psychiatric Hospital (Summit Behavioral Healthcare) as needed to maximize patient care.

Procedure

1. Private Hospital completes a Request for Transfer to Summit Form and submits it along with 10 days of clinical notes to MHRB via fax (513-695-1776), encrypted email, or hard copy.

2. MHRB completes a review of the clinical notes.

3. If MHRB approves the request for a transfer, MHRB contacts Summit Behavioral Healthcare (SBH) and authorizes admission. Private Hospital completes all required SBH transfer forms and submits those to SBH for their review. If the transfer is denied, SBH notifies MHRB and the requesting hospital. If probate proceedings have been initiated, follow attached flow chart.

Policy 3-4 Attachment 1: Private Hospital Transfer Request Form

Private Hospital Request for Transfer to RPH/Summit

Request Date: _____

Client Name: _____

Private Hospital Information

Requesting Hospital Name: _____

Clinical Contact Person: _____ Treating Physician: _____

Contact Information:

Phone: _____ Email: _____ Fax:_____

For Private Hospital completion

Client Service Information

Date of Admission:

Insurance Name: _____ Behavioral Health Coverage: _____

If no insurance, explain why:

Diagnosis:

Psychological Testing Info: ☐ Yes ☐ No ☐ N/A
If yes, provide details:

Compliant with psychotropic medications: ☐ Yes ☐ No ☐ N/A
Psychotropic medication(s) prescribed at this time: ☐ None

Drug Name	Dosage	Frequency	Therapeutic Level
			☐ Yes ☐ No ☐ N/A
			☐ Yes ☐ No ☐ N/A
			☐ Yes ☐ No ☐ N/A
			☐ Yes ☐ No ☐ N/A
			☐ Yes ☐ No ☐ N/A

Number of previous admissions within the past year: _____

Month	Year	Facility	Length of Stay

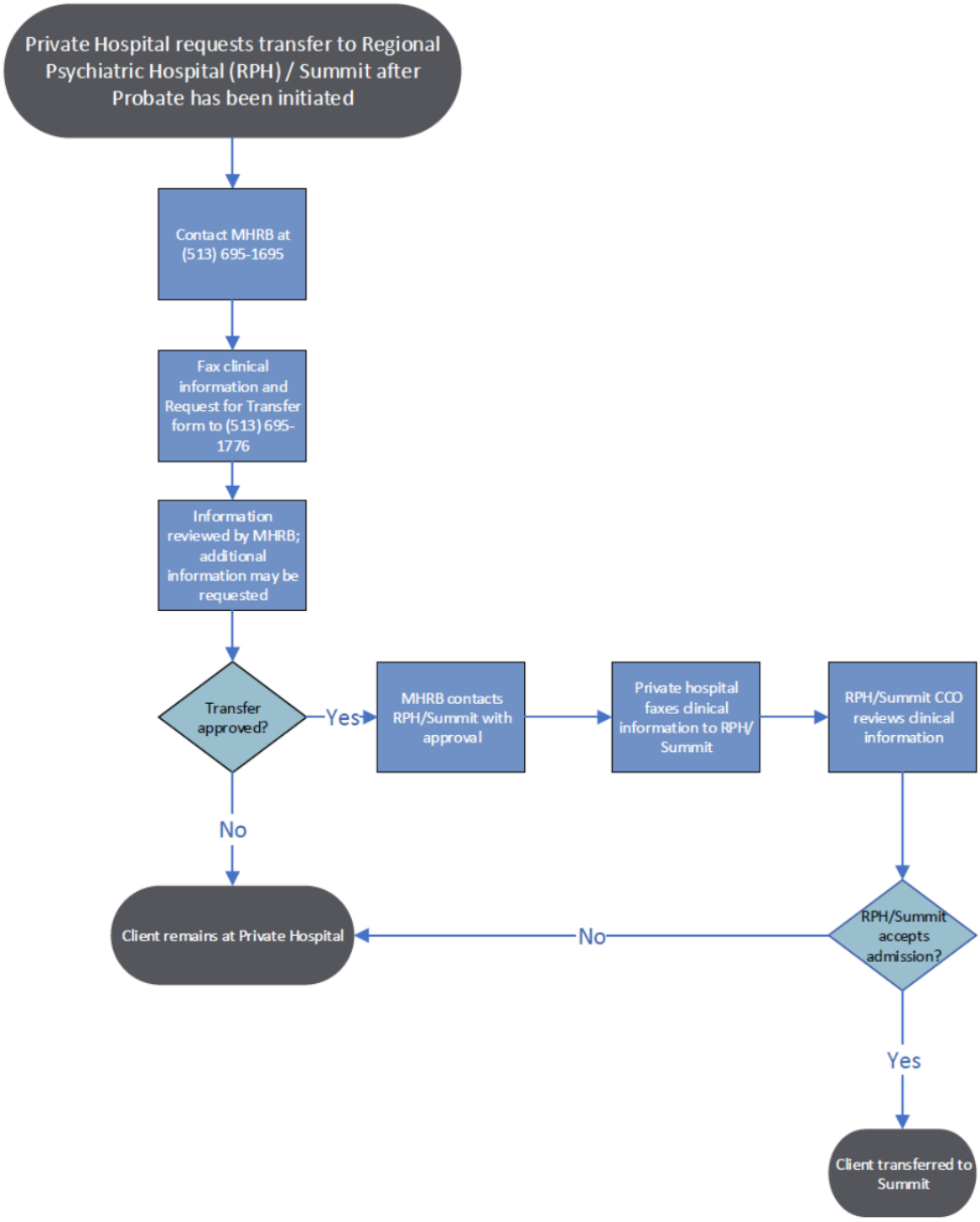
Current Active Outpatient Treatment Provider Information:

Name: _____ Type of Treatment: _____ Name: _____ Type of Treatment: _____	
Other Information:	

For MHRB Completion

MHRB Review by: _____
Date Clinical Data Received:_____
Review of Data Comments: _____
Date Notification sent to Provider:_____
Admission Approval Decision /Comments*: _____
Date of RPH/ Summit Contacted if admission approved: _____
**If request is denied, an explanation will accompany this sheet*
Signature of MHRB Staff: _____ **Date:** _____

Policy 3-4 Attachment 2: Private Hospital Request for Transfer Flow Chart



Policy 3-5: Probate Services

Effective Date: 7/1/16
Last Revised Date: 7/1/25
Lead Staff: Reija Huculak

Policy

Probate services shall be provided in accordance with the requirements of ORC 5122 and Chapter 340.09.

Procedure

1. Monitoring

    a. Monthly updates
    b. Update evaluations for the Probate court as prescribed by Court entry
    c. Notification to the Court of status changes
    d. Request for dismissal as indicated by clinical assessment

2. Attend Monthly Risk Management meeting with updates

3. Attend monthly Probate Status meetings with behavioral health providers

4. Reporting and Testimony
    a. Evaluation of new probate clients
    b. Evaluation of current probate clients who have been hospitalized
        i. Three court day response
        ii. Report to be filed with Probate court one day prior to scheduled hearing, if feasible.

5. Coordination

    a. Responsiveness to Probate in scheduling hearings, locating clients, affecting dismissals and transfers
    b. Communication and coordination with Board counsel regarding findings, hearings, dismissals and transfers
    c. Monitoring client clinical treatment with provider agencies
        i. Initiate and complete hospital discharge follow-up letter
        ii. Facilitate the treatment agency's follow-up with the client within seven days of discharge from a hospital or release from jail.
        iii. If the client's whereabouts are unknown or the client cannot be located, the Probate Monitor shall advise and coordinate with the treatment agency when necessary to initiate appropriate notice, correspondence and/or wellness check to the last known address.
        iv. If, after diligent efforts to locate the client, they cannot be located within five days, then the court will be contacted. In these cases, a request for an earlier review hearing is made.

6. Maintain confidentiality in accordance with HIPAA requirements
7. Use MHRB' electronic record system
8. Develop cooperative working relationships with Counsel, Courts, Agency, Hospital and Board Personnel
9. Maintain Data as required for MHRB reporting

Policy 3-6: Forensic Services

Effective Date: 7/1/16
Last Revised Date: 7/1/25
Lead Staff: Reija Huculak

Policy

Forensic Services shall be provided in accordance with the procedures defined below.

Procedure

Forensic Monitoring

Monthly reporting to MHRB regarding the status of those under forensic order, inpatient and outpatient, shall be submitted in written form. All changes of status regarding those being monitored will be reported immediately to the Deputy Director Adult Mental Health & Recovery Services and the Prosecutor's office. Adherence to the guidelines of the Manual of Forensic Services published by Ohio Department of Mental Health and Addiction Services is required.

Timely updating, at least monthly, of MHRB's electronic record is required. FTAMS reports submitted quarterly and BCI validations as requested.

Policy 3-7: Health Officer Appointments

Effective Date: 7/1/16
Last Revised Date: 7/1/25
Lead Staff: Jeff Rhein

Policy

5122.01 Hospitalization of mentally ill definitions

"Health officer" means any public health physician; public health nurse; or other person authorized by or designated by a city health district; a general health district; or a board of alcohol, drug addiction, and mental health services to perform the duties of a health officer under this chapter.

5122.10 Emergency hospitalization

Any psychiatrist, licensed clinical psychologist, licensed physician, health officer, parole officer, police officer, or sheriff may take a person into custody, or the chief of the adult parole authority or a parole or probation officer with the approval of the chief of the authority may take a parolee, an offender under a community control sanction or a post-release control sanction, or an offender under transitional control into custody and may immediately transport the parolee, offender on community control or post-release control, or offender under transitional control to a hospital or, notwithstanding section 5119.33 of the Revised Code, to a general hospital not licensed by the department of mental health and addiction services where the parolee, offender on community control or post-release control, or offender under transitional control may be held for the period prescribed in this section, if the psychiatrist, licensed clinical psychologist, licensed physician, health officer, parole officer, police officer, or sheriff has reason to believe that the person is a mentally ill person subject to court order under division (B) of section 5122.01 of the Revised Code, and represents a substantial risk of physical harm to self or others if allowed to remain at liberty pending examination.

A written statement shall be given to such hospital by the transporting psychiatrist, licensed clinical psychologist, licensed physician, health officer, parole officer, police officer, chief of the adult parole authority, parole or probation officer, or sheriff stating the circumstances under which such person was taken into custody and the reasons for the psychiatrist's, licensed clinical psychologist's, licensed physician's, health officer's, parole officer's, police officer's, chief of the adult parole authority's, parole or probation officer's, or sheriff's belief. This statement shall be made available to the respondent or the respondent's attorney upon request of either.

Procedure

In compliance with the Ohio Revised Code (ORC) referenced above, the policy and practice of MHRB is to appoint Health Officers that are employed or contracted by designated agencies that provide crisis and/ or behavioral health services for MHRB.

Health officers must receive annual training approved by MHRB. It should include, but is not limited to, the continuity of care agreement with the Regional Psychiatric Hospital, pink slip criteria, and

procedural components. Each Health Officer must be at a minimum dependently licensed with independent license supervision from their employing MHRB contracted provider agency.

Other hospitals, agencies and organizations may complete health officer and/or "pink slip" training; however, unless designated in the ORC, MHRB will not extend the status of Health officer to these trained individuals unless a written request is made to MHRB and the clinical staff deems the exception necessary.

All referrals to Summit Behavioral Healthcare must be approved through MHRB's Deputy Director of Adult Mental Health & Recovery Services or designee, or the Chief Clinical Officer of MHRB. **When a referral is made to Summit Behavioral (or any state hospital), MHRB staff must be notified ASAP through fax notification at 513-695-1776. Fax should be made at time of referral to the hospital, but if on a weekend or holiday, should be filed with MHRB staff at the latest next business day.**

Date:

Notification of referral to Summit Behavioral (or other state hospital)

If other hospital: _____ (this would need prior approval from MHRB staff)

Name of individual referred to hospital:

DOB:

Reason for referral:

Name of health officer making referral:

Heath Officer signature and date:

Name of supervisor:

Policy 4-1: Inpatient Alcohol and Drug Treatment

Effective Date: 8/26/13
Last Revised Date: 7/1/22
Lead Staff: Jeff Rhein

Policy

Mental Health Recovery Board Serving Warren and Clinton Counties is committed to provide a full continuum of care to the residents of our service area. This includes services to treat the abuse or dependence on alcohol and other drugs. As funds allow, the Levels of Care may include: Non-Intensive Outpatient, Intensive Outpatient, and Residential Care.

The abuse of alcohol and drugs is a major concern of the residents of Warren and Clinton Counties. Problems associated with alcohol and drug abuse also affect the community in terms of economic costs (e.g., sick leave, accidents, public safety and related health conditions). Alcoholism and other drug addiction are progressive medical illnesses, and treatment approaches must be consistent with a disease-recovery model.

Women who have become dependent on alcohol and other drugs have unique needs that must be addressed to achieve sobriety and long-term recovery. Gender specific treatment in a safe, empowering environment is essential. Other needs include specialized health care, maintaining ties with children and families, educational and vocational development and coordination of care with criminal justice, family violence, mental health, pre-natal care, child protective services and related community service systems.

Long-term residential services are appropriate for individuals who need a structured environment that provides intensive treatment and supports their continued sobriety. Individuals who are referred to residential services typically have long histories of substance abuse, have multiple relapses after attempting outpatient treatment and are functioning poorly in multiple life domains.

Procedure

Target Population

The target population for Substance Use Disorder SUD Community Residential includes:

1. Women who meet criteria for Community Residential using ASAM Levels of Care

   Priority includes:
   a. Pregnant (and postpartum) injecting and intravenous drug users (IDVU)
   b. Other pregnant (and postpartum) substance abusers/ use disorders (SUD)
   c. All other women

2. Men who meet criteria for Community Residential using ASAM Levels of Care

Facility Requirements

1. Facility and program shall meet all applicable standards for licensure as required by law, including fire, health, safety, staffing, and services. Additionally, residential treatment facilities must meet all applicable standards for mental health or alcohol/drug programs.

2. Housing and residential care providers shall maintain admission criteria approved by Mental Health Recovery Board which clearly defines who is to be served.

3. Facilities shall be maintained to promote the individual's self-reliance in a safe environment. Grounds and facilities should be maintained in a clean and sanitary manner, with reasonable privacy and personal space, and the maintenance of heating, ventilating, and air conditioning as appropriate with outside conditions.

4. The facility will compile an assessment and maintain a clinical record. The assessment will address the medical, emotional, behavioral, social recreational, vocational, legal, and nutritional needs and resources. From this assessment, the facility will jointly develop a service plan with the assigned case manager and client. Family members and other significant caregiver involvement will be encouraged unless expressly denied by the client.

5. Discharge planning and targeted length of stay will be established and documented in the service plan within 5 (five) days of admission. Continued involvement must be thoroughly documented in the case record and service plan review(s).

6. The assigned case manager, client, family members, other significant caregivers and a licensed representative of the facility will review the assessment and service plan, at least monthly. The case manager and facility representative will document this in the case record, at least monthly.

7. The facility will offer daily programming that is scheduled and consistent with the treatment goals and objectives of the residential client.

8. Facility staff will assist the client in maintaining participation in services provided outside of the facility.

9. The facility will provide adjunctive therapeutic activities consistent with the service plan. They may include such activities as cooking, budgeting, personal hygiene, recreation and other social activities designed to incorporate family involvement.

10. The client will be discharged for the following reasons:

11. The client's clinical condition has improved as evidenced by symptom reduction that warrants a less intensive level of care;

12. The client is able to return to increased levels of independence; or,

13. The client's clinical condition has deteriorated to the extent that a higher level of care is required.

14. The facility shall maintain a Board approved quality improvement plan.

15. Adequate staff shall be provided to meet the stated goals and purposes of the residential care facility.

16. Services are to be provided from the Women's Recovery Center located at 515 Martin Drive Xenia, Ohio and Sojourner, LLC located at 235 Industrial Park Dr, Franklin, OH and Sojourner locations in Hamilton, OH and Preble County for women as needed

17. Provider will notify the referring agency immediately by phone and in writing if the client does not show for admission.

18. Provider will notify the referring agency of any problems during treatment that may result in non-compliant discharge.

19. Provider shall notify the referring agency with the discharge date and will arrange for transition and discharge.

20. Provider will maintain a waiting list specific to opiate use disorder for clients that are referred to or seek services on their own according to ORC 5122-9-01, refer also to MHRB Policy 1-7

Policy 4-2: Outpatient and Intensive Outpatient Substance Use and Addictive Disorders Treatment

Effective Date: 8/26/13
Last Revised Date: 7/1/22
Lead Staff: Jeff Rhein

Policy

Mental Health Recovery Board Serving Warren and Clinton Counties is committed to provide a full continuum of care to the residents of our service area as fiscally possible. This includes services to treat the misuse of alcohol, drugs, and/or other addictive behaviors. This policy is specific to outpatient and intensive outpatient treatment.

Procedure

It is expected that the primary goal of abstinence from the use of alcohol and other drugs of abuse be evident in the treatment program(s). Additionally, treatment goals include:

- Increase the number of customers who are abstinent at the completion of the program.
- Increase the number of customers who are gainfully employed at the completion of the program.
- Increase the number of customers who incur no new arrests at the completion of the program.
- Increase the number of customers who live in safe, stable, permanent housing at the completion of the program.
- Increase the number of customers who participate in self-help and social support groups at the completion of the program.

Treatment services must be provided by credentialed staff and supervised by appropriate licensed individuals according to scope of practice standards.

Provider organizations are expected to provide timely treatment access. Specific timelines are outlined in the MHRB Waitlist Policy. Additionally, the current SFY Board Assurances outlines the following priority populations:

Preference to treatment should be given in the following order:

a) Pregnant (and postpartum) injecting and intravenous drug users (IDVU).
b) Other pregnant (and postpartum) substance abusers (SUD).
c) Other injecting and intravenous drug users (IDVU).
d) All others.

Provider Organizations must refer pregnant women to another organization when the program has insufficient capacity to provide services to any such pregnant women who seek the services of the program. Interim services must be available within 48 hours to pregnant women who cannot be admitted because of lack of capacity.

Provider Organizations must not only screen for pregnant women, but they must also screen for IVDU.

When a client screens positive for IVDU in the past 90 days, it is expected they be admitted to treatment services within 14 days after making the request for admission to the program.

Screening must take place for intravenous drug abuse, sexually transmitted diseases, HIV, tuberculosis (TB), and Hepatitis C (Hep C). When the screening is positive for TB it is expected the treatment provider will make available tuberculosis services that include education, testing and treatment when indicated. Treatment providers should send MHRB an annual report indicating the number of clients referred to TB services. This report shall be sent to MHRB no later than July 15.

Provider Organizations shall offer education regarding STD, HIV, TB, and Hep C to all persons seeking services. This information should include how and where to be screened. Additional information may include:

a) Counseling and education about HIV and TB, the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that,
b) HIV and TB transmission does not occur,
c) Referrals for HIV or TB treatment services are provided, if necessary, and
d) Counseling pregnant women on the effects of alcohol and other drug use on the fetus and referrals for prenatal care for pregnant women

Provider will maintain a waiting list specific to opiate use disorder for clients that are referred to or seek services on their own according to ORC 5122-8-01, refer also to MHRB Policy on Waiting List/Referral Process #1-7.

Outpatient and Intensive Outpatient Substance Use Treatment Services are outlined in the current Service Plan.

These services include the following:

- Assessment
- Case Management
- Family Counseling
- Crisis Management
- Group Counseling
- Individual Counseling
- Intensive Outpatient Treatment
- Medication Assisted Treatment

Intensive outpatient services (IOP) should include the following services:

a) Assessment.
b) Individual counseling.
c) Group counseling.
d) Crisis intervention as needed
e) DA CPST as needed

Screening and Treatment for High-Risk Gambling Behavior

Provider organizations are expected to screen all individuals entering treatment services for high-risk gambling problems. Individuals who screen at high-risk must meet with a qualified counselor to address the high-risk gambling behavior. The number of individuals who screen and receive services for gambling shall be reported based on Ohio MHAS guidelines.

Key Performance Indicators and Outcomes Measures will be selected by MHRB each fiscal year. Prior to the beginning of each fiscal year, the provider will be asked to make projections as to their performance on each measure (based upon past performance, contracted amount, etc.). Subsequently, data for each indicator/measure will be reported as indicated in the Service Plan.

If service delivery projections outlined in this Service Plan were not met during any quarter throughout the contract period, the provider will provide a rationale for why service specifications were not achieved. If it is anticipated that without intervention, projections will not be met in the next consecutive quarter, the provider will also provide a plan of correction using the QBS Model, or its equivalent, for Systems Improvement. This shall be reported on a Quarterly Basis in a written narrative following the close of the quarter. Due dates are specified in the current year's service plan.

Provider organizations are required to complete admission/discharge information (Behavioral Health Module) as stated in the current SFY Board Assurances that meet Ohio MHAS specification.

Policy 5-1: SED Respite Funds

Effective Date: 10/12/16
Last Revised Date: 7/1/25
Lead Staff: Amanda Peterson

Policy

Families who care for children with behavioral health disorders often are overwhelmed by the responsibility. At times, this obligation exceeds the emotional resources of the caregivers, leads to extreme distress and subsequent requests for out-of-home placement for the youth.

As a means to supply adequate recovery support to families with children who meet SED criteria and are in active treatment, MHRB will provide funds for participation in respite opportunities at Camp Joy, Pause for Parents, or other respite opportunities. MHRB will contract directly with these vendors for these services. This policy and procedure outlines the process in which provider agencies may select and send youth to these respite opportunities.

The purpose of these funds is to provide short-term, temporary relief to the informal, unpaid caregiver of a youth to support and preserve the primary caregiving relationship. The service should provide general supervision of the child, meal preparation and recreational activities during the period of the respite service. If overnight, this will include adequate and safe lodging facilities. This respite will be provided on a planned basis.

Procedure

Eligibility

1. Meets enrollment criteria, including age, from the respite vendor
2. A Warren or Clinton County resident OR, Out of County Resident (if served by Strong Families/Safe Communities grant and a student at Warren County Learning Center or Southern Ohio Learning Center)
3. Must have a mental health diagnosis
4. Must be involved in MHRB funded behavioral health services
5. Preference should be given to (but is not limited to):
    a. Youth whose families are struggling with the stressors of caring for a child with behavioral health needs
    b. Youth who are being cared for by kin
    c. Youth who are involved in multiple services
    d. These funds may not be used for children in foster care placement or when alternative funding is already available.

e. There are no limitations as to the number of times a youth attends these respite opportunities. This should be determined on a case-by-case basis after evaluating the needs of the family/youth.

Requirements:

1. Youth is agreeable to attend respite opportunity

2. Parent/Guardian completes/signs:

    a. Vendor Registration forms (provided at the time of registration)
    b. Release of Information so Agency can communicate with Vendor and can provide name to MHRB for tracking purposes
    c. Parent/Guardian transports to/from respite opportunity

Process:

1. No later than one week prior to the start of the respite opportunity, Referring Agency will:

    a. Recruit youth to refer for respite opportunities
    b. Document the youth's information on the tracking sheet in SharePoint (or other mechanism developed by MHRB/Vendor to track registered youth)
    c. Obtain completed forms from parent/guardian
    d. Submit completed forms to:
        i. Respite Vendor (contact information provided with registration forms)
        ii. MHRB (FAX # 513-695-1776 or via encrypted email to apeterson@mhrbwcc.org)

2. Vendor shall notify MHRB if youth attended the respite opportunity or not.

3. MHRB will receive an invoice from the vendor and will vet the billing numbers in relation to actual attendance and submitted forms from referring agencies. MHRB will pay the vendor directly.

Allocated Slots

After negotiating a final contract with vendors, each agency will be notified of the total number of slots available to our system of care.

Notifications

Due to the after-hours and/or weekend nature of the service, essential contacts should be noted on the submitted registration forms.

Resources

Information about vendors will be supplied to agencies with registration forms to be shared with parents/guardians/youth. Most vendors are willing to provide a tour to a client/family prior to the respite opportunity to ensure comfort with the respite arrangement.

Policy 6-1: Prevention Services

Effective Date: 7/1/17
Last Revised Date: 7/1/25
Lead Staff: Amanda Peterson

Policy

Prevention in Ohio is grounded in the Public Health Model. The focus of the Public Health Model is on the health, safety, and well-being of entire populations, rather than individual persons. A unique aspect of both the field and the model is that it strives to provide the maximum benefit for the largest number of people. Public health also draws on a science base that is multi-disciplinary, relying on knowledge from a broad range of disciplines including medicine, epidemiology, sociology, psychology, criminology, education, and economics. This broad knowledge base allows the field of public health to respond to a range of conditions across populations.

Prevention aims to reduce the underlying risk factors that increase the likelihood of mental, emotional, and behavioral health disorders (MEB) and simultaneously promote protective factors to decrease MEB health disorders. MEB health disorders include, but are not limited to, substance use disorders, mental illness, suicide, problem gambling, etc.

Procedure

1. Prevention services must be provided and supervised in accordance with standards set forth in the Ohio Administrative Code 5122-29-20 (C)(5) and in accordance with provider responsibilities detailed in MHRBWCC FY26 Prevention Plan. Prevention Staff must meet all necessary and applicable legal, licensing, credentialing, certification and/or registration criteria. Documentation of this will be present and maintained in each staff member's personnel files.

2. Prevention Services will be targeted at one or more of three distinct populations:

    a. ***Universal***: targeted at the general public or a whole population group that has not been identified on the basis of individual risk.
    b. ***Selective:*** targeted to individuals or a subgroup of the population whose risk of developing mental, emotional, or behavioral disorders is significantly higher than average.
    c. ***Indicated***: targeted to high-risk individuals who are identified as having minimal but detectable signs or symptoms that foreshadow an MEB disorder, as well as biological markers that indicate a predisposition in a person for such disorder prior to a clinical diagnosis.

3. **Education**, **Environmental**, and **Community-Based Process** strategies are the three main prevention strategies, because they have the intervention strength to influence attitude, behavior, and status. *Therefore, conducting* **prevention education**, **environmental strategies,** or **community-based process** *alone is considered prevention.*

    a. **Education:** This strategy increases knowledge and skills, as well as influences attitude or behavior. This strategy does not include education provided as a component of treatment services.

b. **Environmental:** This strategy seeks to establish or change standards or policies that will reduce the incidence and prevalence of behavioral health problems in a population.
c. **Community-based process:** This strategy focuses on enhancing the ability of the community to provide prevention services through organizing, training, planning, interagency collaboration, coalition building, or networking. This strategy is essential to effectively implementing environmental strategies that will impact social determinants of health.

4. The following four supplemental strategies support the implementation of the three main strategies. *These strategies used individually do not constitute prevention.*

   a. **Alternatives:** This strategy focuses on providing opportunities for positive behavioral support that reduce risk taking behavior and reinforce protective factors achieved through attachment and bonding to families, schools, communities, and peers. The opportunities are to be provided as part of a larger comprehensive prevention effort.
   b. **Information Dissemination:** This strategy builds knowledge and awareness of the nature and extent of risk and protective factors related to MEB disorders and their effects on individuals, families, and communities.
   c. **Problem Identification & Referral:** This strategy focuses on identifying individuals who exhibit behavior or risk indicators and referring them for prevention interventions, clinical assessment, or services. An example of this strategy is universal screening in a school.

5. Services will consider all of the following when implementing interventions:

   a. Conceptual fit addressing identified risk and protective factor priorities
   b. Cultural relevance and support from key prevention stakeholders
   c. Adverse childhood experiences and trauma-informed implications
   d. Age and gender appropriateness

6. Referrals, linkages, and coordination will be facilitated with other involved internal and external service providers (with appropriate consent) to maximize the benefit of the program. This can include, but not limited to, other programs within the provider's organization, other behavioral health providers, educational/vocational/housing providers, community service organizations, child welfare system, legal entities (juvenile justice, law enforcement, probation/parole, courts and corrections system).

7. Contract providers are expected to identify and provide evidence-based or evidence-informed prevention strategies. This can be demonstrated by one of the following:

   a. A theory of change that is documented in a logic or conceptual model
   b. A description of the intervention in a national registry or peer-reviewed journal
   c. Documentation that the intervention has been implemented showing a consistent pattern of positive results
   d. Documentation that the intervention has been reviewed and found appropriate by a panel of informed prevention experts or key community leaders that includes a description of each reviewer's qualifications

8. Key Performance Indicators and Outcomes Measures will be reported on as indicated in the Service Plan. These Indicators and Measures will be selected by MHRB each fiscal year.

9. Prevention Staff will receive training and demonstrate proficiency in:

    a. Prevention methods and evidence-based models utilized in the program
    b. The specific needs of the persons served
    c. The requirements of the job and clinical skills that are appropriate for the position
    d. Cultural competency
    e. Collaboration with outside entities

10. Documentation of competency in these areas will be maintained in the staff members' personnel files.

11. When applicable, ongoing supervision of direct service personnel should include:

    a. Accuracy of prevention programming provision (adherence to fidelity of model as applicable)
    b. Evaluation/Outcomes measurement techniques
    c. Service effectiveness as measured by the persons served meeting anticipated outcomes
    d. Instruction/feedback to improve the skills of a direct service provider
    e. Ethical and legal aspects of clinical practice as well as professional standards
    f. Clinical documentation issues identified through compliance review
    g. Cultural competency issues