Multi-System Youth Program Application – Signature Pages

Multi-System Youth Program Requestor and Legal Guardian Attestation

Requestor Information		
Organization Type: ○ Family and Children First Council	◉ OhioRISE Care Management Entity	
Agency / Organization Name Move Forward CME	Requestor Name Susan Slide	
Child/Youth and Legal Guardian Information		
Child/Youth Name John Jump	Social Security Number 333-33-3333	Date of Birth 5/6/11
Legal Guardian Name Laura Jump	Date of Application 6/21/24	

By signing below, the requestor and the child/youth's legal guardian certify that the information submitted with this application, including any attachments, is true and accurate to the best of their knowledge and belief.

The requestor and legal guardian acknowledge (**requestor and legal guardian initials required**):

Requestor	Legal Guardian	
SS	LJ	The Multi System Youth Custody Relinquishment Prevention Program (Program) is intended to prevent custody relinquishment or support children/youth who have recently been relinquished solely to access care so they can quickly return to family custody. For children who have recently been relinquished to access care, Program funding cannot be authorized until receipt of verification of custody return to the legal guardian.
SS	LJ	Program funding is only available when appropriated by the Ohio General Assembly. Funding is provided through grants and is limited. The receipt of funding is not guaranteed. There is no right to funding beyond 30 days of initial authorization. Funding can be rescinded at any time.
SS	LJ	Complete applications will be reviewed by a team of individuals from multiple state agencies and determinations will be made using objective criteria. Incomplete applications will not be reviewed. Funding determinations are final and not subject to appeal.
SS	LJ	Children/youth receiving funding from the Program must receive care in the least restrictive setting that is documented as clinically appropriate to meet their needs. If funding for out-of-home treatment is requested, the child/youth must have already received and exhausted intensive services in a lesser restrictive setting, and now services in a more restrictive setting are clinically indicated.
SS	LJ	A local multi-system team must be actively engaged in supporting the child/youth and their caregivers prior to application submission and must remain engaged for the duration of receipt of Program funding.
SS	LJ	Program funding is intended to meet acute short-term needs to prevent custody relinquishment. When longer-term funding is needed to support the child or youth's

care, the requestor and legal guardian commit to work together to secure sustainable longer-term funding for care.

SS LJ All information submitted within the application will be shared for purposes of determining grant eligibility consistent with the terms of the attached information release.

If funding is authorized, the requestor commits to (**requestor initials required**):

SS Facilitate family-centered care coordination, including discharge and transition planning, to meet the child/youth's clinical needs. If funding is authorized to support out-of-home treatment, the requestor commits to immediately facilitate detailed discharge planning upon admission to an out-of-home treatment setting; if the child/youth is already receiving out-of-home treatment at the time of application, discharge planning must have started prior to application and the requestor commits to continue this work for the duration of funding.

SS Provide the state MSY review team timely updates regarding the use of funding for services and supports. Updates are required at least every 90 days and prior to requesting continued or shifted funding. If services and supports for the child/youth and family become disrupted, the applicant commits to provide an update within 14 days of the disruption or change.

If funding is authorized, the legal guardian commits to (**legal guardian initials required**):

LJ Maintain or obtain custody of the child/youth. If the child/youth is in the custody of the child protection system at the time of application, funding will only be authorized for dates of service after custody is returned to the legal guardian.

LJ Actively participate in care coordination activities to support the child/youth.

LJ Maintain active involvement in implementing the child/youth's plan of care for all treatments and services as clinically indicated, including but not limited to active participation in family therapy, learning skills, discharge planning, and implementing coping behaviors, as appropriate.

LJ Assure the child/youth is integrated into the family environment. If funding is authorized to support out-of-home treatment, the legal guardian commits to immediately begin working toward reintegrating the youth into the family setting, to fully participate in discharge planning, and to allow the child/youth to return to their home as soon as deemed clinically appropriate.

I have read or have had this document read to me and I understand its content.

Susan Slide 6/21/24

Signature of Requestor (FCFC Director/Coordinator or OhioRISE CME Supervisor) Date

Laura Jump 6/21/24

Signature of Legal Guardian Date

LEGIBLE SIGNATURES ARE REQUIRED ABOVE.

 Not Required - ROI On File

Child/Youth and Legal Guardian Information		
Child/Youth Name	Social Security Number	Date of Birth
Legal Guardian Name		

I, _____, authorize the release of all information pertaining to the above-named Child/Youth, including substance use disorder information if applicable, required for service coordination, funding reviews and program evaluation of the Multi-System Youth Program process to be exchanged between and among the following organizations:

All member agencies of the Ohio Family and Children First (OFCF) Governor's Children's Cabinet per section 121.37 of the Ohio Revised Code, including the Ohio Department of Medicaid and its contractors, the Ohio Department of Children and Youth and/or its designee(s), and staff from the Office of the Ohio Governor.

All of the following _____county and local organizations

- Board of Developmental Disabilities (DD)
- Juvenile Court
- Department of Job and Family Services
- Public Children's Services Agency
- Alcohol Drug and Mental Health (ADAMH) Board
- Family and Children First Council
- OhioRISE Care Management Entity

And all the following organizations (please name applicable organizations below):

Educational Service Center
Residential/Inpatient Facility
School District of Residence & Attendance
Behavioral Health Provider(s)
In-home service provider(s)
Medicaid Managed Care Entity or Entities
Other
Any exceptions or exclusions for information released

Please initial <u>one</u> of the following statements:

_____ I understand and acknowledge that this authorization extends to all or any parts of the information described above, which may include treatment for mental illness, and/or alcohol/drug abuse/dependency, AIDS/HIV, and/or educational records. I understand that this information will be released only to the person(s)/organization(s) named above and that any information released to such person(s)/organization(s) may not be further disclosed or shared with any person(s)/organization(s) not specifically listed on this form without my written, prior authorization, unless required or permitted to do so by federal and/or state law or regulation.

_____ I do not consent to the disclosure of any information *(will prevent proceeding with the Multi-System Youth Program and Funding)*

1. This authorization will remain effective as long as the MSY program is active, unless an earlier date or condition/event is specified here _____. This consent is subject to revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it.

2. However, I understand that I *HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION, IN WRITING*, by sending/providing such written notification to ATTN: Multi-System Youth (MSY) Administrator; 50 West Town Street, Suite 400; Columbus, Ohio 43215.

3. I understand that I have the right to refuse to sign this authorization; however, should I refuse to sign the authorization, the child or youth listed above will not be eligible for financial assistance from the Multi- System Youth Program.

4. I have the right to inspect or copy the protected health information and protected educational information to be used of disclosed as permitted under law.

I have read or have had this document read to me and I understand its content.

_____

Signature of Legal Guardian Date

_____

Relationship to Child or Youth

_____

Signature of Child or Youth if information regarding SUD is involved Date

<u>A copy of this signed authorization shall have the same force and effect as the original.</u>**

LEGIBLE SIGNATURES ARE REQUIRED ABOVE.