Family Support Program Guidelines

The Division of Behavioral Health

The Family Support Program is designed to assist in meeting the unique challenges of children, youth and their families who are involved or at risk of involvement with the juvenile justice system. The program will assist by financially supporting efforts needed to improve the child, youth and family's overall mental well-being, decrease the risk for involvement in the juvenile justice system and aid in other related needs as identified.

The Division of Behavioral Health (DBH) establishes eligibility for the program through an application form. The application is completed by the care coordinator or clinician who oversees services.

The care coordinator or clinician shall assess requests to ensure each is tied to the client's service and/or treatment plan and will improve the child, youth and family's overall mental well-being, decrease the risk for involvement in the juvenile justice system and aid in other related needs as identified.

Eligibility criteria are as follows:

- Resident of South Dakota
- Be receiving services through the Systems of Care model and/or from a mental health provider and meet the required financial eligibility requirements

All other sources of payment shall be exhausted before financial assistance is requested, including other community resources. The care coordinator or clinician will need to submit documentation that no other funding sources are available as part of the request.

Purchases cannot be made prior to the approval.

Upon approval, the DBH will provide written notice to the care coordinator or clinician. The care coordinator or clinician is responsible for notifying the client/family of the decision. Once approved, the request and/or total cannot be modified.

The care coordinator or clinician will work with the client/family to coordinate the purchase of the approved services and/or supports within 45 days. If the purchase of services and/or supports does not occur within 45 days of the notice of approval, those dollars will be reallocated to other individuals in need.

The mental health provider will submit to the designated service coordinator itemized receipts for all approved services/supports within 30 days of purchase. The designated

service coordinator will reimburse the mental health provider upon submission of receipts. Reimbursement will not be directly paid to the client/family.

The DBH will be requesting the completion of surveys by the clinician in order to gather outcomes data on all approved services/supports.

If no other funding sources are available, some examples of things that may be supported include:

- Sensory integration equipment – i.e. weighted blankets
- STEM learning toys
- Transit tickets/gas cards
- Tracfone/prepaid minute cards
- Rent/rental deposit and/or utilities
- Client and family wellness opportunities
- Vehicle repairs – repairs must be less than what the vehicle is worth and guarantee no other major repairs are needed. Also dependent upon the rurality and need of client.
- Dental work – related to psychotropic medications, beyond coverage through Medicare, Medicaid and private insurance.
- Eye exam and/or glasses
- After school programs
- Clothing and shoes
- Other basic needs

Some examples of things not supported include:

- Personal vacations
- Purchase of vehicles
- Laptops/computers and iPads/iPods
- Televisions and gaming systems i.e. Wii, X-box, PS3 Player
- Legal fees – i.e. consultation fees, outstanding warrants, past due fines, garnishment of wages.
- Loan debt – i.e. payday loans, bank loans, or loans from friends/family

The DBH will evaluate requests in order to assure funding is evenly accessed across the state and that clients across the state are afforded the opportunity to access the program.

FAMILY SUPPORT PROGRAM APPLICATION

Division of Behavioral Health

CLINICAL INFORMATION

Mental Health Provider: Clinician's Name:
Address: Email Address: Work Phone:

CLIENT INFORMATION

Client's Name: ☐Male ☐Female DOB:

Race: ☐White ☐Black ☐Hispanic ☐American Indian ☐Alaskan Native ☐Asian ☐Pacific Islander ☐Other

Service Program: ☐Children, Youth & Family (CYF) ☐Functional Family Therapy (FFT) ☐Aggression Replacement Therapy (ART) ☐Moral Reconation Therapy (MRT) ☐System of Care (SoC)

Is the client a South Dakota resident? ☐Yes ☐No

REQUESTED SUPPORT INFORMATION

With the application, submit the following information:

1. Description of the request;
2. Itemized estimate of cost;
3. Documentation showing the request is tied to the client's treatment plan;
4. Explanation of how the request will support the child/youth and family's overall mental well-being, decrease the risk for involvement with the juvenile justice system and assist with other related needs as identified in the treatment plan; and
5. Documentation of what other funding sources have been pursued and the result.

Does the client meet financial eligibility requirements? ☐Yes ☐No *(Submit a copy of the client's Means Financial Eligibility 101 form)*

If financial eligibility requirements are NOT met, explain why paying for this request would be an undue financial burden for the client?

INTENDED OUTCOMES

Check only those that apply to this request.

Hospitalizations *(check only one)*

☐The client has gone to the emergency room or has been hospitalized within the last 30 days due to declining mental health issues.

☐The client has experienced a decline in mental health within the last 30 days and as a result, is at imminent risk of hospitalization due to those mental health issues. *(Imminent risk is the*

Updated: 07/20/2017

expectation that hospitalization will occur in the immediate future without intervention or assistance.)

Child Protective Services (CPS) *(check only one)*

☐The client has experienced a decline in mental health and as a result, has been reported to or investigated by CPS within the last 30 days.

☐The client has experienced a decline in mental health within the last 30 days and as a result, is at imminent risk of having involvement with CPS. *(Imminent risk is the expectation that CPS involvement will occur in the immediate future without intervention or assistance.)*

Housing *(check only one)*

☐The client has been actively seeking housing within the last 30 days.

☐The client has experienced a decline in mental health within the last 30 days and as a result, is at imminent risk of losing their housing and/or utilities. *(Imminent risk is the expectation that homelessness will occur in the immediate future without intervention or assistance.)*

Basic Needs

☐The client has experienced a decline in mental health within the last 30 days and as a result, has not been able to provide or afford basic needs and all other resources have been exhausted. Basic needs include personal hygiene products, household cleaning supplies and products; furnishings, bedding, cooking utensils and appliances.

Continuing Education

☐The client has been actively attempting to further their education within the last 30 days and their mental health service plan has a treatment goal to support this.

Educational Supports

☐The client has experienced a decline in mental health within the last 30 days resulting in significant school absences, declining grades and/or relational problems with peers and teachers and their treatment plan has a goal to address this.

Specialized Equipment

☐The client has been experiencing a decline in mental health within the last 30 days and it has been identified through their treatment plan that their mental health would benefit from sensory integration equipment, STEM learning toys and/or other adaptive equipment. The family/client cannot otherwise afford this and all other funding sources have been exhausted.

Community Involvement

☐The client has been struggling with isolation, peer relationships and/or lack of community involvement that has affected their mental health within the last 30 days and their treatment plan has a goal to address this.

Health *(check only one)*

☐The client has experienced a decline in mental and physical health within the last 30 days and is in need of opportunities to increase their level of activity and their treatment plan has a goal to address this.

☐The client has experienced a decline in mental and physical health within the last 30 days due to lack of dental and/or eye care that the client otherwise cannot afford and is beyond coverage through Medicare, Medicaid or private insurance and their treatment plan has a goal to address this.

Self-Harm

☐The client has experienced incidences of self-harm and/or has attempted suicide within the last 30 days and has an active crisis intervention plan to address this.

Family Involvement

☐The client has experienced significant family relational problems within the last 30 days which has affected their mental health and their treatment plan has a goal to address this.

CLINICIAN'S SIGNATURE________________________________**DATE**_______________

I understand for individuals and/or families/children to be eligible for the Mental Health Support Program they must be a South Dakota resident, receiving services through a mental health provider and meet the required financial eligibility requirements. I hereby attest that this information is true and correct and that the individual and/or family/child meet the eligibility requirements for the Mental Health Support Program.

Submit the completed application, Means Financial Eligibility 101 form and other supporting documentation to:

Department of Social Services
Division of Behavioral Health
Mental Health Support Program
Kneip Building
700 Governors Drive
Pierre, SD 57501-5070
Phone Toll-Free 855-878-6057 or 605-773-3123
FAX 605-773-7076