pennsylvania
DEPARTMENT OF HUMAN SERVICES

DHS BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
April 6, 2021	April 6, 2021	14-Bul-110

SUBJECT	BY
Complex Case Planning for Children and Youth Under Age 21	Teresa D. Miller, Secretary Department of Human Services

SCOPE:

County Chief Juvenile Probation Officers
County Children and Youth Social Service Agencies
Private Children and Youth Social Service Agencies
County Mental Health/Intellectual Disabilities Agencies
County Child and Adolescent Services System Program (CASSP) Coordinators
County System of Care (SOC) Coordinators
Human Services Administrators
Juvenile Court Judges' Commission
Administrative Office of Pennsylvania Courts
Office of Developmental Programs Supports Coordination Organizations/Targeted Support Management
Behavioral Health Managed Care Organizations (BHMCOS)
Physical Health Managed Care Organizations (PHMCOS)
Family and Youth Advocacy Organizations
Early Intervention Service Coordination Entities
Early Learning Resource Centers

PURPOSE:

The purpose of this bulletin is to provide guidance to all child-serving state and county agencies, family and youth advocacy organizations, and both physical and behavioral managed care organizations that are involved in case planning for children and youth with complex needs up to age 21.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:
The appropriate DHS program office, or Licensing Representative or Supervisor in your regional office
Visit the Department of Human Services website at https://www.dhs.pa.gov/contact/DHS-Offices/Pages/default.aspx

BACKGROUND:

The Department of Human Services (department) seeks to provide a comprehensive approach to serving children and youth, birth to 21 years of age, through programs that focus on early intervention, long-term prevention, and services that support family stability, safety, community protection, and the child/youth's healthy development and permanent connections. In order to meet the needs of children, youth, and families with complex challenges, clear structures are necessary at the county, regional, and state levels so that resources, expertise, and collaboration can be maximized.

A comprehensive and effective system of care recognizes that children and youth with developmental, social, cultural, emotional, behavioral, and/or physical health needs often require services from more than one child-serving system. For example, a child that has a behavioral health need that is being addressed in a school setting may also be receiving services from the child welfare, juvenile justice, or health care system due to emotional, social, and/or physical needs. Effective planning takes into account the strengths of the child and family, the multitude of needs, and engages the various human service agencies responsible for assisting the child and family.

At the state level, departments and agencies with programs serving children and youth collaborate on children's issues. These include program offices in the department (Office of Child Development and Early Learning (OCDEL); Office of Children, Youth and Families (OCYF); Office of Developmental Programs (ODP); Office of Medical Assistance Programs (OMAP); Office of Mental Health and Substance Abuse Services (OMHSAS); Office of Long Term Living (OLTL)), the Juvenile Court Judges' Commission, the Office of Health Promotion and Disease Prevention in the Department of Health (maternal and child health), the Office of Elementary and Secondary Education in the Department of Education, the Bureau of Vocational Rehabilitation in the Department of Labor and Industry, the Department of Drug and Alcohol Programs, and the Office of Advocacy and Reform. In addition, there is collaboration at the state level with the judicial branch through the Administrative Office of the Pennsylvania's Courts' Office of the Children and Families in the Courts.

At the county level there are diverse structures for serving the needs of children and youth. Each county agency has a local process for developing plans and delivering services based on the child/youth's needs identified by the individual agency. Many counties have developed a cross-agency process to support children and youth when the needs identified require the expertise of multiple systems. Counties have also created ways to engage systems outside of the county human services system, including for example the education and physical health systems, in this cross-agency planning process. Counties continue to revise these local cross-agency planning processes as they strive to more efficiently serve children and youth with complex needs in the least restrictive, most appropriate setting. Counties are encouraged to establish ongoing reviews of their cross-agency partnerships and processes for strengths and areas for improvement to ensure continued enhancement of planning and services for children and youth with complex needs.

To make certain that children and youth are receiving comprehensive coordinated services at the county level, the department implemented the Integrated Children's Services Planning process in 2004. Integrated planning calls for all child-serving systems within a county to plan together as one system in which appropriate services can be accessed regardless of what "door" a child or youth may initially enter. This planning process is an integral first step toward building a holistic approach to serving the individual child/youth and family.

When a viable solution that addresses all of the child/youth's needs cannot be reached for a child/youth with multi-system needs who is receiving services from more than one county agency or organization, the department will work with counties to address these complex situations either at the regional or state level. This bulletin, which updates the process and phases of complex case planning for children and youth up to age 21, replaces Bulletin #14-Bul-109, entitled "Complex Case Planning for Children and Youth Under Age 21," which was issued on October 2, 2020.

DISCUSSION:

Service Planning:

Service planning for all children and youth should start where the family and child/youth are located, at the local level. Whenever possible, services should be delivered in the child/youth's home and community, drawing on formal and informal resources and supports to promote their successful participation in a community setting. Services must take place in settings that are the most appropriate and natural for the child/youth and family, and services should be the least restrictive and intrusive level available to meet their needs.

Services should be planned to meet the child/youth and family's individual needs, rather than to fit them into an existing service. Services should be developmentally appropriate and child/youth specific. There should be consideration of the child/youth's family and community structure and build on the strengths of the child/youth and family to meet their developmental, social, cultural, emotional, behavioral, and physical health needs. The approach to services should be a trauma-informed approach and take into account the child/youth and family's history. Services should be planned in collaboration with all the child-serving systems involved in the child/youth's life. If during the planning it is found that the child/youth could benefit from another service system that is not already involved, a referral to that agency should be made if the child/youth and family are interested.

Representatives from all the systems should collaborate with the family or guardian and involve the child/youth as much as developmentally appropriate when defining the goals for the child/youth, developing a service plan, developing the necessary resources to implement the plan, and evaluating progress. The child/youth and family should be provided the appropriate support through this process and through on-going service provision. Additional services and supports necessary to ensure the child/youth's and family's success

should also be considered, such as transportation and child care. Moreover, planning is not a static “once and done” activity; rather it is an ongoing process from the moment a child/youth and family enter a service door that ends only when they no longer need services or when the child/youth transitions out of child-serving systems. It is critical to establish a trusting and supportive relationship with the child/youth and family in order to promote complete and open communication that supports inclusion of all parties and comprehensive, appropriate service planning.

Pennsylvania has a wide array of resources, services, and supports for children, youth, and their families that can be accessed at the county level. These resources, services, and supports include not only emotional, behavioral, developmental, and physical health professionals and provider agencies, but also social, religious, and cultural organizations and other natural community support networks. Below are examples of services that may benefit the child/youth or family, which are generally listed in order from least restrictive to most restrictive (please note that although all of these services can be offered in Pennsylvania, not every county offers each service, and some may have eligibility requirements):

Case Management/Prevention/Intervention Services

- Mental Health Case Management to include: Intensive, resource coordination, blended or administrative
- Resource/Service Coordination
    - Child and Adolescent Social Service Program (CASSP)
    - Systems of Care (SOC) Coordinator
- Drug and Alcohol Case Management and Case Coordination
- Supports Coordination/Targeted Support Management
- Respite – services provided in the home or facility allowing caregivers to take a break
- Individual, group and family interventions, practices and services
    - Youth Directed Transition Planning
    - Family Finding
    - Family Group Conferencing/Decision Making
    - Hi Fidelity Wraparound (Youth and Family Teams)
    - Family Engagement in Case Planning
    - Transitional Living/Independent Living
    - Peer Support
    - Homemaker Services
    - Home Visiting Programs (Parents as Teachers, Nurse Family Partnership, Early Head Start, etc.)
    - Family Centers
- Screening and Assessment
- Early Intervention
- Child Protective Services (CPS)
- Prevention/Intervention Services (Drug and Alcohol)
- Early Childhood Mental Health Consultation
- Student Assistance Program
- School-to-Work Transition Services

- Career and Technical Training
- Home and community-based waiver services for children birth through age 9 with a developmental disability, and any age for intellectual disability or autism

Outpatient Therapy or In Home/Community-Based Services

- Individual, Family and/or Group Outpatient (Mental Health) Services
- Speech and Language Therapy
- Intensive Outpatient (Drug and Alcohol)
- School-based Behavioral Health Services
- Intensive Behavioral Health Services (IBHS), provided through Individual Services, Applied Behavior Analysis (ABA) Services, Group Services, and Evidence-Based Treatment (EBT),
- Behavioral Health Evaluations by a Licensed Professional
- Family-Based Mental Health Services
- Certified Peer Support
- Day Treatment Programs
- Crisis Intervention Services
- Evidence Based Practices, including Multisystemic Therapy (MST), and Functional Family Therapy (FFT)
- Assertive Community Treatment (ACT)
- Partial Hospitalization Programs
- Psychiatric Rehabilitation

Residential Programs

- Adoption Services
- Therapeutic Foster Care
- Foster/Kinship Care
- Lifesharing for children birth through age 9 with a developmental disability, and any age for individuals with an intellectual disability or autism
- Respite
- Community Residential Rehabilitation Services
- Community Living Arrangements
- Transitional Living
- Emergency Services
- Group Homes
- Residential Facilities
- Psychiatric Residential Treatment Facilities
- Residential Treatment Facilities (some also provide Drug and Alcohol services)
- Non-hospital Residential (Drug and Alcohol detoxification, Rehabilitation, “halfway house”)
- Inpatient Hospitalization (Mental Health, also Drug and Alcohol detoxification or rehabilitation based on medical necessity)

Complex Services Planning – County Level

In most instances, the child/youth and family needs can be most appropriately served through the county planning process outlined above. However, there are some situations where a child/youth's needs require more intricate planning at a broader level than just the individual efforts of involved agencies. In these complex cases, the department recommends that in addition to the minimum requirement of the necessary agencies coming together to develop the child-specific plan, all human services agencies/providers that serve children and youth in the county should come together with the child/youth's family or guardian to serve as one team to address all of the child/youth's needs. The department expects that a joint county team approach that treats each child/youth with complex needs as a member of the community, rather than as a child/youth served by specific agencies, will enable the county to resolve the many challenging issues at that level. To ensure a comprehensive system for service planning for children and youth with complex needs, each county should:

1. Identify the core system partners and members of their complex planning team or identify an existing planning team to fulfill this function;
2. Develop policies and procedures for the formation and functioning of the team, including how the meetings will be scheduled, how the lead agency will be identified, how follow-up will be ensured, and how children, youth, and families will be included in the process; and
3. Provide public awareness of service planning processes for stakeholders, including children, youth, and families.

Child-serving systems must leverage existing resources, programs, and expertise to ensure inclusive, individualized, and coordinated plans and supports for children and youth with complex needs and their families. Children and youth should receive timely, coordinated, and appropriate services in their communities whenever possible. Only when deemed necessary should congregate care be considered as a treatment option. Prior to considering a congregate care setting, the following should be documented in the child/youth's case record:

I. That all possible supports have been provided to the child/youth and family to maintain the child/youth in their home and community.
II. That the child/youth has been offered all medically necessary services they are eligible for pursuant to Early and Periodic Screening, Diagnostic and Treatment (EPSDT).
III. That less restrictive settings have been tried and no family-based setting is able to meet the child/youth's needs, including the use of Home and Community Based Medicaid Waivers to facilitate community-based settings.
IV. The specific needs of the child/youth that require a congregate care setting and how specifically the proposed setting will meet those needs.
V. That the child/youth has had the opportunity to give input into the placement decision about his or her preferences, as age appropriate.
VI. That the child/youth's family members have provided input on the type of placement that best suits the child/youth.
VII. That family visitation and contact, education, and participation in activities during the placement are included in the child/youth's plan.

VIII. That a plan for discharge and family reunification is being completed (beginning at intake and reevaluated regularly).

In those instances when congregate care is temporarily deemed appropriate, the child/youth's team should make reasonable efforts to immediately identify a provider that offers programming that meets the needs of the child/youth to ensure timely and effective delivery of services. The appropriateness of the placement and progress should be reviewed regularly by the child/youth's team until the child/youth transitions to a less restrictive setting.

The child/youth's team should include the following participants in the planning process as applicable and documentation should be maintained regarding who was part of the teaming and decision-making process:

- The child/youth (if age appropriate) and the child/youth's family;
- Individuals identified by the child/youth and family as part of their support network;
- County-level agencies and providers currently involved with or identified to be involved with the child/youth and family;
- Caseworkers or Service/Support Coordinators from Mental Health/Intellectual Disabilities, Children and Youth Services, Juvenile Justice, and/or Early Intervention;
- Behavioral Health Managed Care Organizations care managers, Physical Health Managed Care Organizations special needs coordinators, and/or a representative from the child/youth's insurance coverage organization;
- The CASSP or SOC Coordinator;
- The child/youth's guardian ad litem;
- A court appointed special advocate (CASA);
- Advocates (as determined by the family);
- A representative from the child/youth's school; and/or
- Others with pertinent information regarding the child/youth.

Effective planning at a county level requires the county's complex planning team to take a collaborative, innovative and flexible approach to meeting the needs of the child/youth and family. Additionally, effective planning requires county complex planning teams to be proactive as opposed to reactive, e.g., planning should begin as soon as the child/youth's needs are identified, not at the time of a crisis or when a youth is preparing to transition from the child-serving system(s).

Complex Services Planning – Regional Level

The department recognizes that, in spite of best efforts at the county level, there are situations where the needs of the child/youth are so complex that they cannot be resolved by county complex planning teams and therefore require additional support or intervention at a higher level. When the county complex planning team has exhausted all local/county options, solutions, and/or resources and still are not able to address all needs, the case should then be referred for assistance from the appropriate department regional office. The referral and submission instructions can be found in Appendix A. Any individual or local agency can refer a case for regional office assistance. Although the county is expected to

continue its efforts to resolve the issues, it is imperative that a referral be submitted for regional office assistance in a timely manner. The department regional office lead will be identified during an internal department meeting scheduled within one week of receipt of the referral. A planning meeting should be scheduled with the county complex planning team as quickly as possible, but no later than two weeks from date of the internal department meeting. The department's regional staff will identify and coordinate with other applicable regional offices based on the individual child/youth's needs. The applicable regional offices will assist the county complex planning team with securing provision of necessary services, as well as on-going case coordination efforts through the child/youth's insurance coverage organization and/or county or private case management agencies.

Regional complex planning teams should include all members of the child/youth's county complex planning team and staff from the applicable regional offices who are knowledgeable of resources and services necessary to address the identified challenge(s).

Following the occurrence of the regional complex planning team meeting, the regional office lead will provide a summary of the results of the meeting, including any follow up actions and timelines, to all individuals invited to the meeting. Summaries should be maintained in the child/youth's case record(s) to ensure system collaboration. If a resolution was not able to be identified, the team will determine if follow-up meetings will be scheduled or if it is necessary for the county to submit a referral to the DHS Complex Case Planning Team.

Complex Services Planning – State Level

In the event that a complex case cannot be resolved with the assistance of the appropriate regional office(s), the complex case can be referred for review by the county agency to the DHS Complex Case Planning Team. The DHS Complex Case Planning Team reviews any case that cannot be resolved at the county or regional levels and which meets the review criteria set forth below. The DHS Complex Case Planning Team is structured to handle issues involving children and youth with multi-system, complex funding, developmental, behavioral and/or physical health related needs.

Based on the needs of each individual, the DHS Complex Case Planning Team will include cross-functional team members from the department's program offices, managed care organizations, county agencies, providers, advocates, family members, and the child/youth. Upon receipt of a referral, the appropriate members will be identified with a program office lead responsible for the timely scheduling of a coordination meeting to discuss, strategize, and achieve resolution for these most complex situations. The referral and submission instructions can be found in Appendix A. Members and a program office lead will be identified and an internal department meeting scheduled within one week of receipt of a referral. A planning meeting with all participants will be scheduled no later than two weeks from the internal meeting. The scheduling and facilitation of the planning meetings will be coordinated by the identified program office lead and county agency. For example, if there are behavioral health, child welfare, and developmental disability service or support challenges, OMHSAS, ODP, or OCYF will coordinate the scheduling of a meeting with local authorities to resolve the issue. If there are identified physical health

needs that are covered under Medical Assistance, the referral will be sent to OMAP to ensure service needs are met. Additionally, the department works with OLTL and the Department of Health when the child/youth's complex needs arise from a traumatic brain injury.

At times, the identified solution requires a Deputy Secretary level review and joint commitment of department program staff and/or resources. The process assumes a shared responsibility and common sense of urgency among the different programs for individuals that have cross-system needs. With this in mind, the recommended solution may require financial commitments from multiple entities and flexibility across programs as the DHS Complex Case Planning Team works to identify services that best meet the needs of the child/youth.

For the referral to be reviewed by the DHS Complex Case Planning Team, the child/youth's particular situation must meet at least one of the following:

- The clinically appropriate solution requires support from multiple program offices/agencies or stakeholders at the county level who together cannot agree on a solution.
- The funding solution comes from multiple sources, which may include external entities.
- The case involves complexities that render it un-resolvable through the established county or regional office processes.
- The child/youth is currently in an inappropriate placement due to an inability to identify or implement the least restrictive treatment option.

All state-level planning meetings should include the following participants:

- The child/youth;
- The child/youth's family;
- Individuals identified by the child/youth and family as part of their support network;
- County-level agencies and providers currently involved with or identified to be involved with the child/youth and family;
- Caseworkers or Services/Support Coordinators from Mental Health/Intellectual Disabilities, Children and Youth Services, Juvenile Justice, and/or Early Intervention;
- Behavioral Health Managed Care Organizations care managers, Physical Health Managed Care Organizations special needs coordinators, and/or a representative from the child/youth's insurance coverage organization;
- The CASSP or SOC Coordinator;
- The child/youth's guardian ad litem;
- A court appointed special advocate;
- Advocates (as determined by the family);
- A representative from the child/youth's school;
- Regional offices and other state level representatives; and/or
- Others with pertinent information regarding the child/youth.

Following the occurrence of the DHS Complex Case Planning Team meeting, the program office lead will provide a summary of the results of the meeting, including any follow up actions and timelines, to all individuals invited to the meeting. Summaries should be

maintained in the child/youth's case record(s) to ensure system collaboration. If a resolution was not able to be identified, follow-up meetings will be scheduled until an appropriate resolution is determined.

All referrals will be monitored within the department to ensure timely resolution as well as to track strengths, challenges, and potential gaps in service provision. Statewide aggregated trend data will be reviewed by a multi-system Steering Team to continually assess and improve service delivery for children and youth with complex needs.

Expedited Review

Though the department expects that most case planning will progress smoothly through the county and regional planning levels, the department recognizes that at times, case planning does not occur sequentially, and it may be necessary for regional offices to be invited to the county complex planning team meetings for an expedited review and service planning. Additionally, under emergency situations or to prevent an imminent placement, a referral can be sent requesting assistance from the DHS Complex Case Planning Team directly following the county complex case planning process.

Complex Case Service Planning – Checklist

The department created the following checklist as a guide to ensure efficient and effective facilitation of the various steps involved in complex case planning. This checklist is to be used as a guide in requesting assistance from the regional office or DHS Complex Case Planning Team regarding complex case issues. This checklist can also be found in Appendix B for convenience purposes.

County Level

___ County complex planning team meeting(s) held on _____.
___ Family and child/youth received contact information for family advocacy organizations available to them. Information provided includes_____.
___ An appropriate assessment was completed as deemed necessary based on the child/youth's needs to determine the appropriate level and type of service(s) recommended. The type of assessment completed: _____ on _____.

Result of County Complex Planning Team Meeting:
(check any that apply)
__ Resources were discussed, and next steps cannot be identified.
__ Services and/or placement options cannot be identified.
__ The team, family, and child/youth cannot reach an agreement on services or placement options.
__ Funding sources cannot be identified and/or resolved in a blended, braided or shared manner.

If a county complex planning team meeting has been held with **all** agencies/individuals involved in the child/youth's case and one or more of the conditions

above are keeping the case from being resolved, then an individual or county agency should contact the appropriate regional office for assistance.

Regional Level

If regional office assistance is needed, a referral can be made via submission to the Complex Case Resource Acct (RA-PWCMPLXCASEREFS@pa.gov). In order to refer a complex case for regional office assistance around funding and appropriate services/placement options, the county agency should include the following information and documentation:

___ If a county is requesting funding assistance, the county should provide a list of the current funding source(s), funding sources that have been explored, and the specific barriers(s) to obtaining funding from existing funding sources/systems.
___ If a county is requesting assistance locating appropriate community-based services that would allow a family or community-based placement (non-group setting), the county should include a list of the services or supports that it thinks would make a community or family-based placement possible.
___ If a county is requesting assistance with locating appropriate community or congregate care services, the county should include a list of services/placements already explored and outcomes related to those service/placement referrals.
___ All assessments, screenings, evaluations, and recommendations.

___ Regional complex planning team meeting(s) held on _____.

State Level

If the county and regional teams were unable to come to an agreeable resolution, a referral can be made to the DHS Complex Case Planning Team via submission to the Complex Case Resource Acct (RA-PWCMPLXCASEREFS@pa.gov). Only cases meeting one of the following criteria are appropriate for referral to the DHS Complex Case Planning Team:

___ The resolution involves a clinically appropriate solution that requires support from multiple program offices or agencies.
___ The funding solution comes from multiple sources, which may include external entities.
___ The case involves complexities that render them un-resolvable through the established county or regional offices processes.
___ The child/youth is currently in an inappropriate placement due to an inability to identify or implement the least restrictive treatment option.

Question regarding this bulletin should be directed to the appropriate department regional office or program office. Cases requiring escalation to a regional complex planning team or the DHS Complex Case Planning Team should have a referral (Appendix A) completed and submitted to (RA-PWCMPLXCASEREFS@pa.gov).

Office of Children, Youth and Families:
Western Region: 412-565-5728
Central Region: 717-772-7702
Northeast Region: 570-963-4376
Southeast Region: 215-560-2249

Office of Mental Health and Substance Abuse Services:
Western Region: 412-565-5226
Central Region: 717-705-8395
Northeast Region: 570-963-4335
Southeast Region: 610-313-5844

Office of Developmental Programs:
Western Region: 412-565-5144
Central Region: 717-772-6507
Northeast Region: 570-963-4749
Southeast Region: 215-560-2245

Office of Child Development and Early Learning:
717-346-9320

Appendix A

Complex Case Referral Form

After all efforts are exhausted to coordinate care for the child/youth at the county level and no solution is identified, please complete the following referral and submit to the Complex Case Resource Acct (RA-PWCMPLXCASEREFS@pa.gov)

☐ Regional Complex Planning Referral ☐ DHS Complex Case Planning Team Referral

Child/youth's Name *(Last, First, MI)*:	Date of Birth *(mm/dd/yyyy):*	Social Security #:	MAID:
If the Child/youth is Currently in Out-of-Home Care, Provider Name and Address:			
Parent/Caregiver(s) Name (*Last, First*), Email Address and Phone Number:			
County of Residence:	Home County:		
Agencies Involved:			
Reason for Referral *(Include Full Summary as Additional Attachment)*: ☐ The resolution involves a clinically appropriate solution that requires support from multiple program offices or agencies. ☐ The funding solution comes from multiple sources; which may include external entities. ☐ The case involves complexities that render them un-resolvable through the established county or regional offices processes. ☐ The child/youth is currently in an inappropriate placement due to an inability to identify or implement the least restrictive treatment option. ☐ Other*: (Provide explanation)*			
Child/Youth Strengths:			
Services Previously Received and the Effectiveness:			

Specific Needs/Services Currently Identified and Recommended, including specific mental and behavioral health recommendations (attach all supporting assessments, screenings, and evaluations):

Recommendation	Source of recommendation	Approvals and/or medical necessity determination obtained (Y/N)	Is the recommended support/ service being received (Y/N)

If a Congregate Care Setting is Recommended, has the following occurred:

☐ All possible supports have been provided to the child/youth and family to maintain the child/youth in their family home.

☐ The child/youth has been offered all medically necessary services they are eligible for pursuant to EPSDT.

☐ Less restrictive settings have been tried and no family-based setting is able to meet the child/youth's needs, including the use of Home and Community Based Medicaid Waivers to facilitate community-based settings.

☐ The specific needs of the child/youth that require a congregate care setting have been identified and how specifically the proposed setting will meet those needs.

☐ The child/youth has had the opportunity to give input into the placement decision about his or her preferences, as age appropriate.

☐ The child/youth's family members have provided input on the type of placement that best suits the child/youth.

☐ Family visitation and contact, education, and participation in activities during the placement are included in the child/youth's plan.

☐ A plan for discharge and family reunification is being completed (beginning at intake and reevaluated regularly).

If any of the above boxes are checked, provide explanation:

Challenges Obtaining Services:

Additional Information (please attach):

- If funding assistance is being requested, provide a list of current funding source(s), funding sources that have been explored, and the specific barriers(s) to obtaining funding from existing funding sources/systems.
- If assistance is being requested to locate appropriate community-based services that would allow a family or community-based placement (non-group setting), include a list of the services or supports that would make a community or family-based placement possible.
- If assistance is being requested with locating appropriate community or congregate care services, the county should include a list of services/placements already explored and outcomes related to those service/placement referrals, including any denial reasons received for each referral.
- Provide all child/youth and family assessments, screenings, and evaluations, including relevant historical information and traumas, Individualized Family Service Plan (IFSP), the Individualized Education Program (IEP), etc.

Referral Contact Information

Contact Name*:*	Referral Source: *(Agency Office Name)*
Contact Phone #:	Email Address:

Completed Coordination Efforts at the County Level

Participants (name, and agency, if applicable):	
Date of Last Contact:	Type of Contact:
Description of Coordination efforts, including if lead Managed Care Organization (MCO) or Fee-for-Service (FFS) was contacted to discuss all possible options:	

Completed Coordination Efforts with DHS Program Offices at the Regional Level, if Referring to the DHS Complex Case Planning Team

ODP: Yes ☐ No ☐ N/A ☐		OMHSAS: Yes ☐ No ☐ N/A ☐	
County: Yes ☐ No ☐ N/A ☐	Contact Name:	County: Yes ☐ No ☐ N/A ☐	Contact Name:
Date of Last Contact:		Date of Last Contact:	
Regional Field Office: Yes ☐ No ☐ N/A ☐	Contact Name:	Regional Field Office: Yes ☐ No ☐ N/A ☐	Contact Name:
Date of Last Contact:		Date of Last Contact:	
State Level: Yes ☐ No ☐ N/A ☐	Contact Name:	State Level: Yes ☐ No ☐ N/A ☐	Contact Name:
Date of Last Contact:		Date of Last Contact:	

OCYF: Yes ☐ No ☐ N/A ☐		OMAP: Yes ☐ No ☐ N/A ☐
County: Yes ☐ No ☐ N/A ☐	Contact Name:	Contact Name:
Date of Last Contact:		Date of Last Contact:
Regional Field Office: Yes ☐ No ☐ N/A ☐	Contact Name:	
Date of Last Contact:		
State Level: Yes ☐ No ☐ N/A ☐	Contact Name:	
Date of Last Contact:		

OLTL: Yes ☐ No ☐ N/A ☐	OCDEL: Yes ☐ No ☐ N/A ☐
Contact Name:	Contact Name:
Date of Last Contact:	Date of Last Contact:

Invitees for the Regional Complex Planning Team or DHS Complex Case Planning Team Meeting(s)

Name	Agency Name, if applicable	Relationship to Child/youth	Email Address

Notes:

Coverage

Physical Health Plans	Has Currently:	Applied for:
Aetna Better Health	☐	☐
AmeriHealth Caritas	☐	☐
Gateway	☐	☐
Geisinger Health Plan	☐	☐
Health Partners	☐	☐
Keystone First	☐	☐
UPMC *for You*	☐	☐
United Health Care	☐	☐
Fee-for-Service	☐	☐
Medicare	☐	☐

Behavioral Health Plans	Has Currently:	Applied for:
Community Behavioral Health	☐	☐
Community Care Behavioral Health	☐	☐
Magellan Behavioral Health	☐	☐
PerformCare	☐	☐
Beacon Health Options of PA	☐	☐
Fee-for-Service	☐	☐
Medicare	☐	☐

Waivers	Has Currently:	Applied for:
Adult Autism	☐	☐
Attendant Care & Act 150	☐	☐
Community Health Choices	☐	☐
Community Living	☐	☐
Consolidated	☐	☐
Independence	☐	☐
Infants, Toddlers & Families	☐	☐
Living Independence for the Elderly	☐	☐
OBRA	☐	☐
PA Dept. of Aging 60+ (PDA)	☐	☐
Person/Family Directed Support (P/FDS)	☐	☐

Physical Health (PH) Diagnosis (DX)

PH DX:
Primary DX:
Secondary DX:
Tertiary DX:
Has contact been made with PH-MCO: Yes ☐ No ☐ PH-MCO Contact Name:
Please provide details:

Behavioral Health (BH) Diagnosis (DX)

BH DX:
Primary DX:
Secondary DX:
Tertiary DX:
Has contact been made with BH-MCO: Yes ☐ No ☐ BH-MCO Contact Name:
Please provide details:

Medications (RX)

Current Medications:

Appendix B

Complex Case Service Planning - Checklist

The following checklist is to be used as a guide in requesting assistance from the regional office or DHS Complex Case Planning Team regarding complex case issues.

County Level

___ County complex planning team meeting(s) held on _____.
___ Family and child/youth received contact information for family advocacy organizations available to them. Information provided includes_____.
___ An appropriate assessment was completed as deemed necessary based on the child/youth's needs to determine the appropriate level and type of services recommended. The type of assessment completed: _____ on _____.

Result of County Complex Planning Team Meeting:
(check any that apply)
___ Resources were discussed, and next steps cannot be identified.
___ Services and/or placement options cannot be identified.
___ The team, family, and child/youth cannot reach an agreement on services or placement options.
___ Funding sources cannot be identified and/or resolved in a blended, braided or shared manner.

If a county complex planning team meeting has been held with **all** agencies/individuals involved in the child/youth's case and one or more of the conditions above are keeping the case from being resolved, then an individual or county agency should contact the appropriate regional office for assistance.

Regional Level

If regional office assistance is needed, a referral can be made via submission to the Complex Case Resource Acct (RA-PWCMPLXCASEREFS@pa.gov). In order to refer a complex case for regional office assistance around funding and appropriate services/placement options, the county agency should include the following information and documentation:

___ If a county is requesting funding assistance, the county should provide a list of the current funding source(s), funding sources that have been explored, and the specific barriers(s) to obtaining funding from existing funding sources/systems.
___ If a county is requesting assistance locating appropriate community-based services that would allow a family or community-based placement (non-group setting), the county should include a list of the services or supports that it thinks would make a community or family based placement possible.

___ If a county is requesting assistance with locating appropriate community or congregate care services, the county should include a list of services/placements already explored and outcomes related to those service/placement referrals.
___ All assessments, screenings, evaluations, and recommendations.

___ Regional complex planning team meeting(s) held on _____.

State Level

If the county and regional teams were unable to come to an agreeable resolution, a referral can be made to the DHS Complex Case Planning Team via submission to the Complex Case Resource Acct (RA-PWCMPLXCASEREFS@pa.gov). Only cases meeting one of the following criteria are appropriate for referral to the DHS Complex Case Planning Team:

___ The resolution involves a clinically appropriate solution that requires support from multiple program offices or agencies.
___ The funding solution comes from multiple sources, which may include external entities.
___ The case involves complexities that render them un-resolvable through the established county or regional offices processes.
___ The child/youth is currently in an inappropriate placement due to an inability to identify or implement the least restrictive treatment option.