

Status **Pending** PolicyStat ID **18655144**



Origination	07/2017	Owner	monica Hampton: Clinical Specialist
Last Approved	N/A	Policy Area	Children Services
Effective	Upon Approval	Applicability	Detroit Wayne Integrated Health Network
Last Revised	03/2026		
Next Review	1 year after approval		

Children Diagnostic Treatment Services Program Policy

POLICY

It is the policy of Detroit Wayne Integrated Health Network (DWIHN) that the Provider Network and any subcontractors, and direct contractors that provide services to children, adolescents, and their families will meet the standards for the Children's Diagnostic Treatment Services Program Policy.

PURPOSE

The purpose of this policy is to provide direction to DWIHN contractors, subcontractors, and direct contractors in assuring that a comprehensive array of services is available for children and their families.

APPLICATION

1. The following groups are required to implement and adhere to this policy:
 - a. DWIHN Board,
 - b. DWIHN Staff including the following
 1. DWIHN PIHP Staff
 2. DWIHN Community Care Clinic Staff (Direct Care Staff)
 3. DWIHN Community Care Clinic Staff (**DWIHN staff operating as a CCBHC**)
 4. Crisis Services
 - c. Contractual Staff
 - d. Clinically Responsible Service Provider (CRSP) and their subcontractors

- e. Specialty Providers
2. This policy serves the following populations
- a. Children
 - b. Individuals with Intellectual and/or Developmental Disabilities (I/DD)
 - c. Serious Mental Illness (SMI),
 - d. Serious Emotional Disturbance (SED),
 - e. Substance Use Disorder (SUD)
 - f. Autism
 - g. Mild/Moderate levels of care
3. This policy impacts the following **contracts/service lines**:
- a. Autism
 - b. Certified Community Behavioral Health Clinics
 - c. General Fund
 - d. Grants
 - e. Medicaid
 - f. SUD

KEYWORDS

- 1. Additional Mental Health Services (B3S)
- 2. Applied Behavioral Analysis (ABA)
- 3. Best Practice
- 4. Central Registry Clearance
- 5. Certified Community Behavioral Health Clinic (CCBHC)
- 6. Child Mental Health Professional (CMHP)
- 7. Coordination of Care
- 8. Devereux Early Childhood Assessment (DECA)
- 9. Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT):
- 10. Evidence-Based Practice (EBP)
- 11. Family Member
- 12. Home Based Services
- 13. Individual Plan of Service (IPOS)
- 14. Maintenance of Certification (MOC)
- 15. MichiCANS Michigan Department of Health and Human Services (MDHHS) developed the MichiCANS screener and comprehensive assessment for children and youth ages 0 to 21st birthday. This tool is used to support Family Driven, Youth Guided care planning and level of

care decisions, facilitate quality improvement initiatives, and monitor outcomes of services.

16. Medical Necessity
17. Prevention Services
18. Promising Practice
19. Referral
20. Respite
21. Serious Emotional Disturbance (SED)
22. System of Care (SOC)
23. Waiver Support Application (WSA)
24. Intensive Care Coordination with Wraparound (ICCW)

STANDARDS

Responsibilities of the DWIHN staff

1. Promote practices that use a strength-based ecological orientation that emphasizes the assets, coping skills and unique history of a minor child and family members, as well as noting developmental problems, unmet needs and caregiver limitations.
2. Provide leadership to system of care efforts that support a mental health service system for children that is responsive to the unique and complex needs of children who are served by and across multiple child service entities.
3. Provide the philosophical framework for outreach efforts and services for minors and families that considers the support for the larger ecosystem.
4. Ensure uniform access throughout the DWIHN's network for increased coordination among systems that influences the everyday lives of minors and their family members.
5. Ensure that policies are developed to guide services and programs for minors and families that are family-focused, strength-based and encourage and support efforts to provide the least restrictive environment so that minors remain in the home, school and community.
6. Ensure the inclusion of youth and family voice and involvement in the design and implementation of the service system, including specific emphasis on the voice of fathers/ male caregivers.
7. Ensure that person and family-centered planning is active and evident in each minor's Individual Plan of Service and Plan of Care involving the child and family in every aspect of the minor's treatment program. The plan must be developmentally appropriate to ensure that treatment is delivered in the most normative environment as clinically appropriate.
8. Engage public entities in the partnerships and collaborative activities that promotes a quality and responsive system of care for children.

Responsibilities of DWIHN Provider Network

DWIHN Provider Network and their subcontractors must ensure that, at a minimum, the following occurs:

1. Develop and implement policies, procedures, practices and monitoring activities that comply with the Department of Community Health Administrative Rules (subpart 6), and DWIHN policies and procedures for Children's Diagnostic Treatment Service Program Policy.
2. Provide initial screening, intake evaluations, and emergency evaluations to ascertain the mental health needs of minors.
3. Provide referrals to the appropriate Authority to meet immediate needs, protection and security for those minor's located in Wayne County who are residents of another county. Describe how services not directly provided can be accessed.
4. Have written agreements/arrangements that clarify the respective responsibilities for coordination and provision of services with public and private human service agencies which provide for the educational, judicial and child welfare and other health services agencies.
5. Maintain a resource listing that identifies programs to which the minors and their families are referred. The listing indicates the types of services provided, eligibility criteria and names and location of the referral sources.
6. Provide an array of services specifically oriented to meet the needs of minors and their families that include:
 - a. Diagnostic Services sufficient to develop a Plan of Service; including Screening, Evaluation, Emergency services, Emergency evaluations and Referrals.
 - b. Case management for the development, coordination, implementation, and monitoring of the plan of service.
 - c. Crisis Stabilization and responses that reduce acute emotional disabilities and their physical and social manifestation to ensure safety of the minor, his or her family and others.
 - d. Out of home treatment includes both inpatient treatment and community residential treatment.
 - e. Traditional outpatient mental health treatments for children and their families.
 - f. Clinical therapies that are provided for individuals, groups and families.
 - g. Prevention services and other treatments that provide opportunities to learn, improve and demonstrate specific skills that are appropriate to the child's needs, which may include problem-solving skills, communication skills and acceptable social skills.
 - h. Home-based services that can be provided in the minor's home and/or other community settings.
 - i. Respite services providing temporary relief to the caregiver supporting the goal of maintaining the minor in the home and community.
 - j. Applied Behavioral Analysis (ABA) services for children from birth to age 21 with an autism spectrum disorder diagnosis.
 - k. Aftercare services including follow-up services to assist individuals/families after discharge from a hospital, residential facility, or who have received community mental health services.
 - l. Provide 1915 (i)SPA services:

1. 1915 (i)SPA services include; Community Living Supports, Enhanced Pharmacy, Environmental Modifications, Family Support and Training, Financial Management Services/Fiscal Intermediary, Housing Assistance, Respite, Skill Building, Specialized Medical Equipment and Supplies, Supported/ Integrated Employment and Vehicle Modification (Assistive Technology).
 2. That are applicable to the following designations: Serious Emotional Disturbance, Serious Mental Illness, and Intellectual/Developmental Disability.
7. Provide services in locations that are to be accessible through publicly available transportation and in a barrier-free environment.
 8. Adherence to this policy, including development, implementation and monitoring of any policies and procedures relevant to this policy, is carried out with regard to the cultural, ethnic, gender and community values of the minors and families.
 9. Person and family-centered planning is active and evident in each minor's Individual Plan of Service and Plan of Care involving the child and family in every aspect of the minor's treatment program. The plan must be developmentally appropriate to ensure that treatment is delivered in the least restrictive environment as clinically indicated.
 10. Collaborate with systems that are likely to affect the lives of minors and their families with an effort toward influencing an outcome that supports minors living with their families, including ensuring that the coordination of services and programs occurs within the community to better support improved functioning in the home, school and community of the minors.
 11. Demonstrate and document activities that engage families in collaborative partnerships and community support systems, including specific emphasis on the voice of fathers/ male caregivers, so services are sufficiently comprehensive to support minors living with their families and support improved functioning in their home, school and community.
 12. Develop, administer, provide and coordinate services which are family focused within the context of the person and family centered planning model.
 13. Ensure that services and supports are provided within the framework of and in support of the System of Care to encourage ongoing development and sustainability.
 - a. Services and supports must encompass the System of Care values:
 1. Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
 2. Community based, with the locus of services, as well as system management, resting within a supportive, adaptive infrastructure of structures, processes, and relationships.
 3. Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports.

Eligibility Criteria for Children's Community Mental Health Services

To be eligible the individual must meet the needs-based criteria for either Serious Emotional Disturbance (SED) or Intellectual Developmental Disability (I/DD).

1. **Serious Emotional Disturbance (SED):** A diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year and has resulted in functional impairment that substantially interferes or limits the minors role in functioning in the family, school, or community.
2. **Intellectual Developmental Disability (I/DD):** A severe chronic condition that is attributable to a mental or physical impairment or both, and is manifested before the age of 22 years; is likely to continue indefinitely; and results in substantial functional limitations in three or more areas of the following major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment or other services that are of lifelong or extended duration.
3. **MichiCANS:** The Child and Adolescent Needs and Strengths (CANS) is a comprehensive information integration tool designed to summarize and organize information gathered from multiple sources and assessments. The Michigan Department of Health and Human Services (MDHHS) as implemented a Michigan-specific version of the tool, known as the MichiCANS. Prepaid Inpatient Health Plans (PIHP), Community Mental Health Services Programs (CMHSP), and Certified Community Behavioral Health Clinics (CCBHC) are required to use the MichiCANS to support potential eligibility for services, assist with initial determination of needs and strengths, and provide information for appropriate referrals for behavioral health services.
 - a. The **MichiCANS Screener** is the required tool at the point of access for all infants, toddlers, children, youth, and young adults ages birth to 21. The results of the MichiCANS Screener provide one of the following recommendations for level of need: Crisis Continuum of Care Services Need, Severe/Serious Level of Need, or Mild/Moderate Level of Need. *Refer to attached MDHHS MichiCANS Behavioral Health Services Bulletin 24-38.*
 - b. Depending on the results of the **MichiCANS Screener**, the **MichiCANS Comprehensive** will be used at initial intake, annually thereafter, and at the time of exit for infants, toddlers, young children, youth, and young adults ages birth through 20 to guide treatment service planning. In addition, relevant sections of the MichiCANS Comprehensive will be updated when there is a significant change in life circumstances and/or a behavioral health event. The MichiCANS Comprehensive is used to provide recommendations for eligibility for the Michigan Intensive Child and Adolescent Services (MICAS), which include Home-Based Services, Intensive Crisis Stabilization Services, Respite Services, ICCW, Youth Peer Support Services and Parent Support Partners. The MichiCANS also provides eligibility recommendations for the Serious Emotional Disturbance Waiver (SEDW).

- c. Child and Adolescent Functional Assessment Scale (CAFAS) and the Preschool and Early Childhood Functional Assessment Scale (PECFAS) are ONLY required to administer to children, youth, and families ages 0 to 21st birthday receiving 1915i SPA services or are in the Serious Emotional Disturbance Waiver (SEDW). (Refer to the CAFAS/PECFAS/DECA procedure for more information). The PIHPs are required to use the Devereux Early Childhood Assessment at intake and during treatment planning, based on the results of the MichiCANS screener, for infants, toddlers, and children ages one month up to age six who have (1) a Serious Emotional Disturbance (SED) or (2) SED and Intellectual/Developmental Disabilities (IDD). The results of the MichiCANS Comprehensive will also be used to identify areas of strengths and needs which will be used to assist with the planning process. The Devereux Early Childhood Assessment (DECA) is administered as an assessment tool for ages 0 to 5 for both SED and IDD children.

Home Based Services

1. **Home Based Services:** Services are provided in the family home or community. Any contacts that do not occur in the home or community must be clearly explained in case record documentation. The case record must also speak to the expected duration of how long the services won't be provided in the home and/or community as well as the plan to address issues that are preventing the services from being provided in the home and community. Treatment is based on the child's needs, with the focus on the family unit. The service style must support a family-driven and youth-guided approach, emphasizing strength-based, culturally relevant interventions, parent/youth and professional teamwork, and connection with community resources and supports. The organizational structure through which the mental health home-based services program shall be delivered must be specified. The following requirements must be met:
 2. Enrolled home-based service providers are available and sufficient to ensure home-based services meet the need across the community.
 3. Responsibility for directing, coordinating, and supervising the staff/program must be assigned to a specific staff position. The supervisor of the staff/program must be a child mental health professional with three years of clinical experience. For home-based services programs serving children with developmental disabilities, the child mental health professional must meet the qualifications to also be a Qualified Intellectual Disability Professional (QIDP).
 4. Home-based services programs are designed to provide intensive services to children and families in their home and community. The degree of intensity will vary to meet the needs of families.
 5. The maximum full-time home-based services worker-to-family ratio is 1:12. This can be adjusted to accommodate families transitioning out of home-based services. The maximum worker-to-family ratio in those circumstances is 1:15 (12 active/3 transitioning).
 6. If providers wish to utilize clinicians who have more than one role in the agency (home-based services plus other services, e.g., outpatient, case management, etc.), the percentage of each position dedicated to home-based services must be specified. The number of home-based services families assigned to each partial position cannot exceed the same percentage of the maximum active home-based services families. For example, a 50% home-based position

could serve no more than 6 home-based families. The total maximum number of families, including home-based and other services families, for a full-time clinician with multiple roles is 20 families.

7. The initial training curriculum and 24 hours of annual child-specific training for home-based services staff should be relevant to the age groups served and the needs of the children and families receiving home-based services.
8. Home-based services must be provided in accordance with a plan of service that focuses on the child and his family. The plan of service is a comprehensive plan that identifies child and family strengths and individual needs, determines appropriate interventions, and identifies support and resources.
9. Home-based services programs combine services to restore or enhance social, psychological, or biophysical functioning of individuals, couples, or families and/or individual therapy, family therapy, group therapy, crisis intervention, case management, and collateral contacts. The family is defined as immediate or extended family or individual(s) acting in the role of family.
10. Services provided in a home-based services program range from assisting beneficiaries to link to other resources that might provide food, housing, and medical care, as well as providing more therapeutic interventions such as family therapy or individual therapy, or services to restore or enhance functioning for individuals, couples, or families.
11. Home-based services staff must receive weekly clinical supervision (one-on-one and/or group) to help them navigate the intense needs of the families receiving home-based services. Evidence of the provision of this clinical supervision must be recorded via supervision logs, sign-in sheets, or other methods of documentation.
12. The organization must have a policy or policies in place that support providing a comprehensive crisis/safety training curriculum that is required for all homebased services staff that includes de-escalation skills among other relevant trainings.
13. Home-based providers shall participate in local meetings and adhere to DWIHN reporting protocol.
14. There must be an internal mechanism for coordinating and integrating the home-based services with other mental health services, as well as general community services relevant to the needs of the child and family.
15. A minimum of four hours of individual and/or family face-to-face home-based services per month will be provided by the primary home-based services worker or, if appropriate, the evidence-based practice therapist. In addition, it is expected that adequate collateral contacts, including non-face-to-face collateral contacts, with school, caregivers, child welfare, court, psychiatrist, etc., will be provided to implement the plan of service.
16. The amount and scope of home-based services to families as they transition out of home-based services into a less intensive service or to closure can be determined by family-driven and youth-guided decision making to maintain continuity of treatment and ensure stability. Variation from the required intensity of services for families transitioning out of home-based services must be documented in the plan of service. This transition period is not to exceed three months.
17. Crisis intervention services must be available 24 hours a day, 7 days a week, via availability of home-based services staff, agency on-call staff or DWIHN Crisis Care Center. If after-hours

crisis intervention services are provided to a family by staff other than the primary home-based services worker, procedures must be in place which provide the on-call staff access to information about any impending crisis situations and the family's crisis and safety plans.

18. **Criteria:** The following MichiCANS Comprehensive Decision Support Model criteria will be used to determine eligibility for home based services for children, youth, and young adults ages 6-20 years old (day prior to 21st birthday) and will be recommended for home-based services if criteria is met. *Refer to attached MDHHS MichiCANS Behavioral Health Services Bulletin 24-38.*

Infant and Early Childhood Mental Health (IECMH):

A Home-Based Services that is a best practice model that focuses on the caregiver-child dyad. The target population served ages 0 to 5 years old:

1. Women exhibiting perinatal or postpartum symptoms.
2. Support pregnant women, infant, toddlers and young children and families.
3. Adolescent parents and their infants, toddlers, preschoolers, or young children.
4. Parents/legal guardian engaged with the child welfare system for possible signs of risk and neglect.
5. Medically sensitive infants with fragile medical conditions and their parents/legal guardian.
6. Infants, toddlers, preschoolers, or young children with suspected developmental delays or
7. Infants, toddlers, preschoolers, or young children who have a diagnosable behavioral or emotional disorder.
8. Infant, toddlers, preschoolers, or young children who may be at risk of reduced academic functioning due to behavioral or emotional impairment(s).
 - a. Characteristics of intervention occur through the modality of home, school/ childcare observations and clinical assessments and referrals as needed. Home visits are a necessary component of all Infant and Early Childhood Services. All Infant and Early Childhood mental health services have the following components:
 1. The focus of assessment and intervention is the attachment of the parent-infant relationship (or toddler, preschooler, or young child) dyad in the context of the family system.
 2. Intervention is designed to support and nurture the parent as the primary caregiver, including attention to parental needs; increasing parental self-esteem; and reinforcement of appropriate parent-infant, toddler, preschooler, or young child interactions; and parental capacity to empathize with the child's needs of attachment.
 3. Provision of developmental assessments and information about infant, toddler, preschooler or young child behavior and corresponding child caring practices.
 4. Facilitate and promote management of real-life problems including crisis resolution, linkage to community resources, advocacy, facilitation of

problem-solving skills, and linkage to informal support systems.

5. Problem solving techniques for reduction of social determinate of health.

b. Infant and Early Childhood Mental Health clinicians must:

1. Meet the qualifications of a child mental health professional, AND
2. Must have, at a minimum, a MI-AIMH Endorsement, OR
3. Must request a Provisional Endorsement (*IMH Waiver*), and be in the process of applying for Endorsement through the Michigan Association for Infant Mental Health (MI-AIMH)
4. Receive their Endorsement within two years of requesting a Provisional Endorsement
5. Attend any relevant training courses specific to this age group.

9. **Criteria:** The following MichiCANS Comprehensive Decision Support Model criteria will be used to determine eligibility for home-based services for children, youth, and young adults ages 0 to 5 and will be recommended for home-based services if meet criteria. *Refer to attached MDHHS MichiCANS Behavioral Health Services Bulletin 24-38.*

Intensive Care Coordination Wraparound (ICCW):

Children, youth, or young adults ages birth through 20 years (day prior to 21) are eligible for ICCW if they meet the following criteria:

1. Serious Emotional Disturbance, Serious Mental Illness, and/or Intellectual/Developmental Disability.
2. Presenting with complex behavioral needs; and • Have an identified community AND two or more of the following criteria:
3. Involved in two or more child, youth, or young adult-serving systems, including but not limited to: Mental/Behavioral Health, Juvenile or Adult Criminal Justice, Child Welfare, Adult Protective Services, Education (special education or other school support services).
4. Has received other case management or case management-like services, and higher intensity is required to meet needs.
5. Lack of an identified support system.
6. Presenting with complex medical needs and stabilization has not been reached.
7. Has a functional impairment related to school activities, attendance, or performance. This includes, but is not limited to, experiencing multiple suspensions and/or expulsions.
8. Displays significant physical and/or emotional distress after experiencing a traumatic event. Traumatic events may include, but are not limited to, natural disasters, acts of violence, abuse, neglect.
9. The following MichiCANS Comprehensive Decision Support Model criteria will be used to determine eligibility for Intensive Care Coordination with Wraparound for beneficiaries ages 0 to 5 and or 6 through 20 years (day prior to 21) and will be recommended for ICCW services if

meet criteria. Refer to attached MDHHS MichiCANS Behavioral Health Services Bulletin 24-38.

Serious Emotional Disturbance Waiver (SEDW)

The Children with Serious Emotional Disturbances Home and Community-Based Services Waiver (SEDW) provides services that are enhancements or additions to Medicaid State Plan coverage for beneficiaries up to age 21 with serious emotional disturbance (SED) who are enrolled in the SEDW.

Criteria:

To be eligible for this waiver, the beneficiary must meet all the following criteria.

1. Reside with the birth or adoptive family or have a plan to return to the birth or adoptive home;
OR
2. Reside with a legal guardian; OR ? Reside in a foster home with a permanency plan; OR
3. Be age 18, 19 or 20 and live independently with supports; AND
4. Meet current MDHHS criteria for the State psychiatric hospital for children or is at risk of hospitalization without waiver services; AND
5. Meet Medicaid eligibility criteria and become a Medicaid beneficiary; AND
6. Demonstrate serious functional limitations that impair their ability to function in the community. As appropriate for age, functional limitation will be identified using the Child and Adolescent Functional Assessment Scale (CAFAS®), the Preschool and Early Childhood Functional Assessment Scale (PECFAS®), or the Devereux Early Childhood Assessment (DECA) Clinical Version scales:
 - a. CAFAS® score of 90 or greater for beneficiaries ages 7 to 12; OR
 - b. CAFAS® score of 120 or greater for beneficiaries ages 13 to 18; OR
 - c. For beneficiaries ages 3 to 7, elevated PECFAS® subscale scores in at least one of these areas: self-harmful behaviors, mood/emotions, thinking/communicating or behavior towards others; OR
 - d. For beneficiaries ages 2 to 4, scores in the concern range across DECA Clinical Version scales:
 1. Protective factor scales (initiative, self-control, and attachment) that are in the Concern Range with a Total Protective Factor T-score of 40 or below; and/or
 2. Elevated scores on one or more of the behavioral concerns 32 scales (attention problems, aggression, withdrawal/depression, emotional control problems) with a T score of 60 or above; AND
 - e. Be under the age of 18 when approved for the waiver. If a beneficiary on the SEDW turns 18, continues to meet all non-age-related eligibility criteria, and continues to need waiver services, they can remain on the waiver up to their 21st birthday.
 - f. The Michigan Department of Health and Human Services (MDHHS) must use the Decision Support Model criteria from the Michigan Child and Adolescent Needs and Strengths (MichiCANS) Comprehensive Decision Support Model tool to measure

functional limitations for the purposes of determining eligibility for SEDW.

- g. The Child and Adolescent Functional Assessment Scale (CAFAS), Preschool and Early Childhood Functional Assessment Scale (PECFAS), and Devereaux Early Childhood Assessment (DECA) are required tools through state spending and CMS notification of close-out of American Rescue Plan Act Section 9817 funding as listed below:
 1. For new applicants, MDHHS must use either the CAFAS, PECFAS, or DECA and the MichiCANS. If the results are different and one tool indicates eligibility, MDHHS must apply the results that establish the applicant is eligible.
 2. For children, youth, or young adults receiving a re-evaluation of eligibility, MDHHS must use the MichiCANS. If the results indicate that a participant is no longer eligible, MDHHS must verify ineligibility with either the CAFAS, PECFAS or DECA.
 3. CAFAS/PECFAS should be completed at initial and annually if pursuing another year in the SEDW.
7. Referrals are coordinated by the DWIHN Children's Initiative Coordinator along with Child Welfare, MDHHS, other counties, parents/guardians and service providers.
8. The DWIHN Coordinator shall:
 - a. Review all referrals for appropriateness in collaboration with the referral source and the SEDW provider.
 - b. Provide oversight to the application process, ensuring all documentation is compiled and complete for submission to MDHHS.
 - c. Provide technical assistance and case consultation when appropriate.
 - d. Provide ongoing SEDW training to all SEDW providers
 - e. Track all referrals and youth that are active in the SEDW.
 - f. Coordinate the SEDW for all eligible children residing in Wayne County.
 - g. Assist with coordinating transfers when a youth moves out of Wayne County or into Wayne County.
 - h. Review all documentation that has been submitted by the SEDW provider into the Waiver Support Application (WSA).
 - i. Review and approve all SEDW packets submitted by the provider and send to MDHHS via the Waiver Support Application (WSA).
9. Service providers shall:
 - a. Submit billing through CHAMPS (via MH-WIN).
 - b. Submit all SEDW renewals into the WSA, one month prior to the due date.
 - c. Submit all initial SEDW packets into the WSA for DWIHN Coordinator to review and approve.
 - d. Participate in monthly meetings with DWIHN Coordinator to review each youth that

is currently active in the SEDW or pursuing the SEDW.

- e. Send SEDW Informational Letter to youth and family once a referral is received.
- f. Send SEDW Transitional Letter to the family three (3) months prior to the youth's renewal/termination date from the SEDW.
- g. Complete the ICCW capacity google doc. every Friday, indicating whether the service provider has capacity to accept a new SEDW referral or not.

Intensive Crisis Stabilization Services (ICSS): These services are for children or youth ages 0 to 21 with SED and/or I/DD, including autism or co-occurring SED and SUD, and their parents/caregivers who are currently residing in the catchment area of the approved program, and are in need of intensive crisis stabilization services in the home or community as defined in this section. The child and family define the crisis, and eligibility for receiving children's ICSS will be based on the child and family requesting this service. The MichiCANS DSM may identify beneficiaries who may benefit from crisis services, and if this is a recommendation from the MichiCANS, the treatment team should incorporate this into the family-driven youth-guided planning process. The following MichiCANS Comprehensive Decision Support Model criteria will be used to determine eligibility for Intensive Crisis Stabilization Services for beneficiaries ages 0 to 5 and or 6 to 21st birthday and will be recommended if meet criteria. *Refer to attached MDHHS MichiCANS Behavioral Health Services Bulletin 24-38.*

Respite Care: The MichiCANS will be used to support eligibility determinations for respite for children and youth enrolled in the 1915(i), Children's Waiver Program, Serious Emotional Disturbance Waiver, and Habilitation Supports Waiver. The following MichiCANS Comprehensive Decisions Support Model criteria will be used to determine eligibility for Respite Care for beneficiaries ages 0-5 and 6 to 21st birthday and will be recommended for respite care services if meet criteria. *Refer to attached MDHHS MichiCANS Behavioral Health Services Bulletin 24-38.*

Youth Peer Support: Youth Peer Support Services is a peer-delivered service for youth and young adults who are middle school to 26 years of age. It is designed to support youth and young adults with a serious emotional disturbance/serious mental illness (SED/SMI) through shared activities and interventions in the form of nonjudgmental support, connection through lived experience and supporting self-advocacy. The following MichiCANS Comprehensive Decision Support Model criteria will be used to determine eligibility for Youth Peer Support ages 11 to 26 and will be recommended for Youth Peer Support services if meet criteria. *Refer to attached MDHHS MichiCANS Behavioral Health Services Bulletin 24-38.*

Parent Support Partner (PSP): Parent-to-Parent Support aims to support families whose children receive services through a community mental health service provider. The purpose of the service is to increase family involvement, voice and engagement within the mental health treatment process and to equip parents with the skills necessary to address the challenges of raising a youth with special needs thus improving outcomes for youth with serious emotional disturbance and/or intellectual/developmental disabilities, including autism involved with the public mental health system. The following MichiCANS Comprehensive Decision Support Model criteria will be used to determine eligibility for Parent Support Partners ages 0 to 5 and or 6 to 21st birthday and will be recommended for PSP if meet criteria. *Refer to attached MDHHS MichiCANS Behavioral Health Services Bulletin 24-38.*

Additional Array of Services

The Autism Benefit is a benefit under the Behavioral Health Treatment Services (BHT) which provides access to evidence-based Applied Behavior Analysis (ABA) Services to eligible individuals covered by Medicaid ages birth to 21 with an autism spectrum disorder (ASD) diagnosis. The Medicaid Autism Benefit covers Comprehensive Diagnostic Evaluations, Psychological Testing, Adaptive Testing, Behavior Assessments, Behavior Plans of Care, ABA Direct Services, Technician Direction and Observation (Supervision), group training and Parent/Guardian Training. Individuals receiving the Autism Benefit have access to other services deemed medically necessary that are covered by Medicaid and provided by DWIHN.

DWIHN is the initial point of access for members who have been referred and require a screening to be completed for a comprehensive diagnostic evaluation and behavioral assessment of ASD. To access the BHT services, a validated and standardized ASD screening tool must be administered before the individual is referred for further evaluation. The ASD screening tool may be administered through a variety of means (i.e., PCP, DWIHN Access Department, other medical professionals, etc.).

1. The DWIHN Access Department will review the ASD screening results or physician referral form to determine if further evaluation may be needed. If the ASD screening is positive, then the family is offered a choice of three Diagnostic Evaluators to receive a Comprehensive Diagnostic Evaluation to determine diagnosis. The Diagnostic Evaluator in receipt of the referral receives an automatic authorization for the evaluation, cognitive, and adaptive testing. The practitioner provides a comprehensive review of evaluation results, feedback, recommendations for behavioral management, and medical necessity for behavioral health service eligibility.
2. The comprehensive diagnostic evaluation must be performed before the individual receives the BHT services array of applied behavior analysis (ABA) services, occupational therapy (OT), and speech language therapy (SLT).
3. In cases of transfer between PIHPs or CMHSPs for individuals who were deemed to meet medical necessity criteria for ABA, the initial diagnostic evaluation from the transferring region should be deemed valid and accepted unless there are clearly extenuating and clinically relevant circumstances (e.g., caregiver or provider recommending/seeking re-evaluation). DWIHN will accept these evaluations completed outside of DWIHN contracted provider network which meet requirement of MDHHS Autism Policy. The procedure steps of submission are detailed in the Comprehensive ASD Evaluations Procedure.

Youth in Transition: Services for youth supportive to the specific needs of young people ages 15-21 transitioning to adulthood. Youth in Transition services include:

1. Group curriculum focused on development and mastery of practical life skills.
2. Inclusion of Youth Peer Support Services in treatment plan
3. Community-based learning opportunities
4. Individual therapy services with a therapist trained in transitional age youth service models.
 - a. For youth transitioning to adulthood focus on transition planning to adult services as applicable and according to medical necessity.

Evidence Based Practices

1. The use of evidence based practices (EBP) and programs are encouraged in the provision of mental health services to children and their families in the Community Mental Health Services Programs and their provider network. The use of evidence based practices, programs or promising practices are supported to ensure better outcomes for the services provided.
<https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/childrenandfamilies/eb-pp-offered>
2. **Trauma Focused Cognitive Behavior Therapy (TF-CBT):** TF-CBT is an evidence-based treatment for children and adolescents impacted by trauma and their parents or caregivers. Research shows that TF-CBT successfully resolves a broad array of emotional and behavioral difficulties associated with single, multiple and complex trauma experiences. TF-CBT addresses the multiple domains of trauma impact including but not limited to Posttraumatic Stress Disorder (PTSD), depression, anxiety, externalizing behavioral problems, relationship and attachment problems, school problems and cognitive problems. TF-CBT includes skills for regulating affect, behavior, thoughts and relationships, trauma processing, and enhancing safety, trust, parenting skills and family communication. For information on the model, go to http://www.nctsn.org/sites/default/files/assets/pdfs/tfcbt_general.pdf or www.tfcbt.org
TF-CBT is an evidence-based treatment for children and adolescents impacted by trauma and their parents or caregivers. It is a components-based treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles and techniques. TF-CBT has proved successful with children and adolescents who have significant emotional problems (e.g., symptoms of posttraumatic stress disorder, fear, anxiety, or depression) related to traumatic life events. It can be used with children and adolescents who have experienced a single trauma or multiple traumas in their lives.
 - a. **Targeted Populations:** individuals ages 3-21st birthday; with Posttraumatic Stress Disorder (PTSD) or other traumatic life experiences, and their parents or primary caregivers
 - b. **Modality:** Individual therapy, group therapy, family therapy
 - c. **Trauma Screening:** Administer a culturally competent, standardized and validated screening tool appropriate for children during the intake process and other points as clinically appropriate.
 - d. **Trauma Assessment:** Administer standardized assessment (Trauma Symptom Checklist for Young Children, UCLA-PTSD 5) instruments to assess children with serious emotional disturbance for trauma symptomology during Pre Treatment, Mid Treatment, and Post Treatment.
 - e. **Key Components:**
 - Establishing a therapeutic relationship with youth and parent
 - Use of gradual exposure throughout treatment
 - f. **PRACTICE components:**
 1. Psycho-education about child trauma and trauma reminders
 2. Parenting component including parenting skills

3. Relaxation skills individualized to youth and parent
 4. Affective modulation skills tailored to youth, family and culture
 5. Cognitive coping: connecting thoughts, feelings and behaviors
 6. Trauma narrative and processing
 7. In vivo mastery of trauma reminders
 8. Conjoint youth-parent sessions
 9. Enhancing safety and future developmental trajectory
 10. Traumatic grief components
- g. **Guidance for Materials Related to Trauma Focused- Cognitive Behavioral Therapy (TF-CBT):** To provide guidance to the Provider network and any subcontractors, and direct contractors, regarding all materials developed during the course of delivering the Trauma Focused- Cognitive Behavioral Therapy (TF-CBT) model with children, youth and their families. <https://dwmha.policystat.com/policy/14553319/latest>
- h. **Training Requirements:** Providers must complete training requirements and successfully complete the TF-CBT cohort prior to using the approved billing modifier. Training opportunities and requirements are provided from Michigan Department of Health and Human Services (MDHHS) and DWIHN Children Initiative Department to review, approve, and submit applications to MDHHS as the Implementation Coordinator.
3. **Parent Management Training - Oregon model (PMTO):** PMTO is an evidence-based structured intervention to help parents and caregivers manage the behavior of their children. The PMTO method is designed to promote prosocial skills and cooperation and to prevent, reduce and reverse the development and maintenance of mild to moderate to severe conduct problems in children age 3 - 18. PMTO empowers parents as primary treatment agents to promote and sustain positive change in families. PMTO emphasizes, identifies, and builds upon strengths already present in parents, children, and their environment. <https://michiganpmt.com/>
- a. **PMTO Core Parenting Practices:**
1. Encouragement: Parents encourage their children to demonstrate positive behaviors.
 2. Limit Setting: Parents remain consistent in their delivery of effective consequences in order to promote pro-social behavior.
 3. Problem Solving: The family system works together in setting goals, brainstorming, evaluating solutions and carrying out plans.
 4. Monitoring: Parents track children's whereabouts and ensure adult supervision for activities
 5. Positive involvement: Parents show love and concern for their children by providing positive attention and participating in activities with children.
- b. **PMTO Supporting Parenting Practices:**
1. Directions: Promotes children's cooperation and helps parents stay

focused on the positive.

2. Tracking: Notes progress of what is working and what may need to be adjusted for success.
 3. Emotional Regulation: Learning ways to maintain a well-regulated emotional state to cope with everyday stress and be available for learning and interactions.
 4. Communication: The best parent-child relationships are characterized by lots of positive communication and interaction.
- c. **PMTO Intervention Model:** In order to assist specialists with learning, and staying certified in PMTO, sessions are videotaped. These videos primarily focus upon the efforts of the specialist, however the family is included in the video taping. Videos are seen by trainers and coaches in order to provide coaching regarding the implementation and sustainability of PMTO. Specialists are encouraged to participate in individual and group coaching sessions, which provide praise and support as well as the opportunity to problem solve various situations they may encounter. These videos are also utilized to ensure the fidelity of the PMTO model is upheld, and families are receiving the best possible service.
4. **Parenting Through Change (PTC):** The goal of PTC is to build skills, give hope and to enhance parenting tools via a group model. This is an engaging, hands-on group for parents and other caregivers who have children with difficult behavior, ages 3-18. PTC is an evidence-based program based on years of research and development of proven skills that help families and children during challenging transitions. The world tugs at parents and children in so many ways. Providing parents with tools to help their children enhances the relationship.
- a. PTC can be applied to families with multiple problems:
 1. Parents with mental health challenges (depression, anxiety, antisocial)
 2. Adverse contextual problems (poverty, poor neighborhoods, health problems)
 3. Family transitions (divorce, re-parenting, moves, new births, deaths)
 4. Martial Conflict
 - b. PTC is tailored for serious behavior problems for youth from preschool through adolescence.
 1. Overt antisocial behavior (noncompliance, aggression, defiance, hyperactivity, fighting)
 2. Covert antisocial behavior (lying, stealing, truancy, fire setting)
 3. Internalizing problems (depressed mood, peer problems, deviant peer association)
 4. Delinquency
 5. Substance Abuse
 6. School Failure

5. **Parenting Through Change-Reunification:** The goal of PTC-R is to build skills, give hope and to reunify the family via a group model. This is an engaging, hands-on group for parents and other caregivers who have children in foster care and are seeking reunification. PTC-R is an evidence-based program based on years of research and development of proven skills that help families and children during challenging transitions. The world tugs at parents and children in so many ways, including the trials and tribulations of reunification.
 - a. PTC-R Intervention Model: PTC-R is a two part program that includes PTC-R (Parenting Through Change Reunification) and PTC-RH (Parenting Through Change Return Home).
 - b. PTC-R: Parents learn new skills to increase effective parenting while the child is not in the home. Through participation in a 10-week group, parents practice skills during group and during parenting time. Group facilitators provide a welcoming and safe environment for parents as they rebuild their families. Topics are presented in a step-by-step approach integrating and revisiting topics discussed throughout the 10 weekly sessions.
 - c. PTC-RH: 6 individual sessions are provided to parents as reunification approaches or upon the child's return home. The family is seen individually for at least six weeks and the worker reviews relevant strategies and materials. Families learn additional skills to support and assist them in dealing with the changes and challenges that arise during the time of reunification. These skills focus on the strength of the parents and rebuilding the family.
6. **Training Requirements:**
 - a. Providers must complete training requirements and successfully complete the EBP cohort prior to using the approved billing modifier. Training opportunities and requirements are provided from MDHHS. Applications are to be reviewed, approved by respective agency leadership and must be submitted to the PMTO State Office..
 - b. Providers to complete document relevant EBP with the appropriate billing code and modifier according to the Evidenced Based Practice Bulletin (refer to attached document)
 - c. Providers to complete the EBP availability spreadsheet monthly (refer to the attached memo)

Plan of Care Development Case Management Requirements

1. Develop a **Family-Centered Plan** that addresses the expressed desires and needs of the identified consumer and their family after they have participated in a pre-planning process and a comprehensive evaluation/assessment has been developed. Ensure that the actual provision of each service is documented on an individual basis in the case record according to Person/Family Centered Planning process. Each plan must include the amount, scope and duration of services. The plans will be reviewed according to services provided, as requested by the consumers, but no less than annually.
2. The **Family Centered Plan (or IPOS)** is the fundamental document in the individual's record

and must be authenticated by the dated legible signatures of the recipient/authorized representative and the person chosen by the recipient, and named in the plan to be responsible for its implementation. The IPOS consists of a treatment plan and/or a support plan, and may be further characterized as follows:

- a. It must satisfy MDHHS guidelines demonstrating adherence to the Person-Centered Planning (PCP) process and principles.
 - b. It includes pertinent information from assessments necessary to address the expressed desires and needs prioritized by the recipient, and may include general physical, psychiatric (i.e., mental/psychological, emotional and behavioral) and social examinations. For persons under 26 years of age who have developmental disabilities, the mental examination includes psychometric and educational evaluations as well as assessment of adaptive behavior.
 - c. It addresses as either desired or required by the consumer/family, his or her need for housing, clothing, health care, employment opportunities, legal services, transportation, and recreation.
 - d. It is reviewed and updated at intervals specified in the plan which reflect the level of care and intensity of service needs and when requested by the consumer or required as a result of identified health and safety conditions, but no less than annually. The documented reviews shall contain an analysis of progress regarding objectives and goals that were developed using the PCP process. Updates and the indicated changes are authenticated by the signature of the consumer/authorized representative and the dated legible signature of the person named in the plan as responsible for managing it.
 - e. It includes any Behavioral Treatment Committee that approved restrictions or limitations of rights placed on the recipient only when these limitations or restrictions are essential to safeguarding the health and safety needs of the individual. All clinically appropriate attempts shall be made to limit or avoid such restrictions or limitations. Actions taken as part of the plan to ameliorate or eliminate the need for the restrictions in the future shall be documented and include specific intermediate and long-range goals, developed with the individual/authorized representative, that specifies the manner in which the facility can improve the consumer's condition and the projected timetable for attainment of such goals.
 - f. The person/authorized representative shall receive a copy within 15-business days of the IPOS meeting. Includes, but is not limited to, core demographic and clinical elements.
3. Ensure that families are provided information about accessing respite services and community living supports (CLS) during the Person/Family Centered Planning process as deemed medically necessary. It should be documented on the pre-planning form, dated and initialed by the families, that they have been offered these services.
 4. Shall ensure that all families of children and youth that are Medicaid eligible have information regarding their right to Early Periodic Screening, Diagnostic and Treatment Services (EPSDT). There must be documentation in the case record that is signed by family/guardians that they have been informed of this service, and if requested, assist with accessing this service. If families have accessed this service, clinicians should request copies to be included in the case

record.

5. Standardized assessments tools will be utilized to determine level of function and level of care. All Child Mental Health Professionals who provide direct clinical services or supervise clinical Child Mental Health Professionals must be certified to administer the assessment tools specific to their service population. All tools must be administered baseline (14 days of intake), quarterly and discharge.
 - a. The Level of Care Utilization Services (LOCUS) is a required assessment tool for all individuals in the Community Mental Health Service Programs (CMHSP) system over the age of 18. The LOCUS is to be completed at intake and at reassessment intervals for individuals over the age of 18 receiving adult services.
 1. The LOCUS is not required for youth ages 18-21 receiving SED services. If youth transitions to adult services, the LOCUS is required.
 - b. The Child Adolescent Functional Assessment Scale (CAFAS) is a required assessment tool for all children in the CMHSP system, ages 7 through 21 years.
 1. 1915i SPA Services: The CAFAS is to be completed at intake, quarterly thereafter and at exit for children in this age range receiving behavioral health services.
 2. SEDW Services: The CAFAS is to be completed at intake, annual certification, and at exit for children in this age range receiving behavioral health services.
 - c. 1915i SPA services, the Pre School and Early Childhood Functional Assessment Scale (PECFAS) is a required assessment tool for all children in the CMHSP system ages 4 up until the 7th birthday. The PECFAS is to be completed at intake, quarterly thereafter and at exit for children in this age range receiving behavioral health.
 1. 1915i SPA Services: The PECFAS is to be completed at intake, quarterly thereafter and at exit for children in this age range receiving behavioral health services.
 2. SEDW Services: The PECFAS is to be completed at intake, annual certification, and at exit for children in this age range receiving behavioral health services.
 - d. Devereaux Early Childhood Assessment (DECA): DECA-I, DECA-T, DECA-C; is used for assessing the social and emotional needs of infants, toddlers and children ages 0 - 47 months.
 1. Infants (DECA I) 0 to 18 months of age
 2. Toddlers: (DECA-T) 18 to 36 months of age
 3. Children: (DECA-C) 37 to 47 months of age.
 4. The DECA is to be completed at intake, quarterly thereafter and at exit for children in this age range receiving behavioral health.
6. **Modified Checklist for Autism in Toddler-Revised (M-Chat-R)** is a questionnaire for individuals 16 months to 30 months of age. The Social Communication Questionnaire (SCQ) is an autism spectrum disorder screening instrument for individuals ages 4 years and up, with a

mental age over 2 years.

- a. Coordinate with other entities that serve the youth and their families, i.e., primary care physicians, schools, child welfare, public health, substance use providers, and the juvenile justice system once a signed release has been obtained and placed in the case record. There should also be documentation in progress notes indicating when coordination and attempts have occurred to get information from other human service entities including primary care physicians.
- b. Maintain formalized workforce development program that assures professional development and training in identifying and treating the needs of minors and their families. Regular review of training requirements and recommendations will occur to ensure special emphasis is made on new and emerging material and practices and outdated material is removed.
- c. Certified programs shall be clinically supervised by a Child Mental Health Professional who has at least a master's degree in a mental health related field with 3 years of clinical experience working with minors and their families.
- d. Employ clinicians that are qualified by certified training and have supervised experience to diagnose and treat children with serious emotional disturbance and/or intellectual/developmental disabilities, and who meet the requirements for Child Mental Health Professional Credentials, Criminal Background Check and Central Registry. Clearance of the applicants shall be reviewed and verified by the service provider prior to the Clinician providing services to children and their families.
- e. Ensure that Child Mental Health Professionals (CMHP) must meet DWIHN Credentialing standards. Please refer to the [CREDENTIALING/RE-CREDENTIALING](#) policy and the [Organizational Credentialing/Re-Credentialing](#) policy and [Organizational Credentialing/Recredentialing Procedure](#).
- f. Have maintenance of certification and licensure documentation in the credentialed employees' files of Board Certified Behavior Analyst.
- g. Include toll free, TTY, and TDD telephone numbers on all publicly distributed publications that are distributed to the public.

QUALITY ASSURANCE/IMPROVEMENT

DWPHN shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives.

The quality improvement programs of DWPHN network of providers and their subcontractors must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

COMPLIANCE WITH ALL APPLICABLE LAWS

DWPHN network of providers and their subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY

All of the following Authority policies refer to the most recent policy:

1. [Department of Community Health, Mental Health and Substance Abuse, Administrative Rules Subpart 6, R 330.1205 – 330.2135 Children's Diagnostic and Treatment Services.](#)
2. Michigan Compiled Laws, Mental Health Code Act 258 of 1974: Sec.330.1206. Sec. 330.1208
3. Department of Human Services Central (Perpetrator) Registry.
4. MDHHS Family Driven-Youth Guide Policy (March 2021)
5. SED WAIVER (A Home and Community-based Services Waiver for Children with Serious Emotional Disturbance) TECHNICAL ASSISTANCE MANUAL
6. PECFAS - CAFAS Guidance (March 2021)

RELATED POLICIES

1. Assessment Policy
2. [CAFAS-PECFAS-DECA Procedure](#)
3. Clinical Practice Guidelines
4. Coordination of Care
5. Quality Assurance Performance Improvement Plan (QAPIP)
6. Credentialing/Re-Credentialing.
7. Individualized Plan of Service.
8. Early Childhood Mental Health Services
9. Services to Minor Children
10. Parent Management Training Oregon Model
11. Respite
12. Intensive Care Coordination Wrap Around (ICCW)

CLINICAL POLICY

Yes

Attachments

[Bulletin 24-001 v2 - Childrens Evidenced Based Services October 2024 \(2\).pdf](#)

[CAFAS.PECFAStransition2024 \(1\).pdf](#)

- [Children Services 1915iSPA memo Feb 2025.pdf](#)
- [Children Services Evidenced Based Practices Memo 12.29.25.pdf](#)
- [Children Services Transition Procedure April 2025 \(002\).docx](#)
- [DCH MH Admin R330 2105.pdf](#)
- [DHHS 17 Family-Driven_and_Youth-Guided_Policy_and_Practice_Guideline - Clean \(1\).docx](#)
- [Final Bulletin MMP 24-38-MichiCANS-final.pdf](#)
- [Final Bulletin MMP 24-41-BCCHPS.pdf](#)
- [FY26 Children Services Annex.docx](#)
- [MDHHS 12 TECHNICAL REQUIREMENT FOR SED CHILDREN.docx](#)
- [MichiCANS Overview 2024.pdf](#)
- [Michigan Department of Health and Human Services Devereux Early Childhood Assessment \(Infant, Toddler, Clinical Versions\) March 2018](#)
- [PECFAS-CAFAS Guidance March 2021 \(1\).doc](#)
- [Technical_Requirement_for_Behavioral_Treatment_Plans Sep 2024.pdf](#)

Approval Signatures

Step Description	Approver	Date
Clinical Review Committee	Jacquelyn Davis: Associate Vice President - Access and Strateg	Pending
Clinical Review Committee	Shama Faheem: Chief Medical Officer	Pending
Clinical Review Committee	Marlena Hampton: Director of Utilization Management	Pending
Clinical Review Committee	Stacey Sharp: Associate Vice President of Clinical Operatio	Pending
Clinical Review Committee	April Siebert: Director of Quality Improvement	Pending
Clinical Review Committee	Erik Hutchison: Vice President of Clinical Operations	Pending
Clinical Review Committee	Matthew Yascolt: Director of Substance Use Disorder	03/2026

NCQA Committee	Margaret Keyes: Strategic Planning Administrator	03/2026
NCQA Committee	Tania Greason: Quality Administrator	03/2026
NCQA Committee	Allison Smith: Director of Strategic Operations	03/2026
NCQA Committee	Justin Zeller: Project Manager	03/2026
Director Review	Cassandra Phipps: Director of Childrens Initiatives	03/2026
Unit Review and Approval	monica Hampton: Clinical Specialist	02/2026

Applicability

Detroit Wayne Integrated Health Network

Standards

Standard Body: 2.1206.2

Chapter: COUNTY COMMUNITY MENTAL HEALTH PROGRAMS

Standard Body: 2.1206.1

Chapter: COUNTY COMMUNITY MENTAL HEALTH PROGRAMS