



**Office of
Mental Health**

**Children's Crisis Residence
Program Guidance
January 2021**

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Children's Crisis Residence

I. Introduction

As a part of the Children's Medicaid Transformation, the services provided by Crisis Residence programs serving children became an expanded resource for Medicaid enrolled children and are now available under both Medicaid managed care and fee-for-service. As a result, children and their families who are in need of immediate interventions and supports for a child's psychiatric crisis can more easily access this program. The programs described in this manual include those available under the Crisis Stabilization/Residential Supports component of Crisis Intervention services authorized under the Medicaid State Plan.

Crisis Residence options include Children's Crisis Residences, which are available to all children up to age 21, and two Adult Residential Crisis programs; Intensive Crisis Residence and Residential Crisis Support, which are available for young people ages 18-20 years old. Both children and adult crisis residence programs are similar, providing a level of short-term support with the goal of having the child or individual return to their home and to prevent the need for a more intensive level of care. Program Guidance, as well as, Benefit and Billing Guidance, for the adult crisis residential programs can be found at:

<https://omh.ny.gov/omhweb/bho/crisis-intervention.html>.

Services provided by Children's Crisis Residence programs are one component of a comprehensive continuum of crisis services, intended to help avert extended emergency room visits and inpatient hospitalizations. Community-based crisis services available within the continuum include crisis hotlines, mobile crisis intervention, and other crisis service components under Children and Family Treatment Supports and Services (CFTSS), as well as Comprehensive Psychiatric Emergency Programs (CPEPs). For children in crisis who are identified as needing a short-term higher level of care, the expanded benefit of a Children's Crisis Residence can now offer children and their families the greater level of service and support needed to help ensure a more successful return home.

II. Purpose

The purpose of a Children's Crisis Residence Program is to stabilize a child's psychiatric crisis symptoms and restore the child to a level of functioning and stability that supports their transition back to community-based services and supports to prevent or reduce future psychiatric crises. The Crisis Residence program will work to transition the child and ensure the receipt of adequate community-based services and supports to prevent or reduce future psychiatric crises. The crisis residence program provides 24/7 monitoring and supervision, as

well as intensive crisis treatment and support for the child, family, and caregivers to facilitate the child's successful return home and/or to the community. Children under the age of 21 are eligible to receive services in a Children's Crisis Residence. While children under the age of five years old may be eligible for the Crisis Residence, they are unlikely to meet the medical necessity criteria required for an overnight residential service and may be more appropriately served through community-based emergency services, such as mobile crisis intervention.

Children in need of Crisis Residence services may require this level of care after having been diverted from inpatient hospitalization or after presenting at other emergency services, such as a CPEP or an Emergency Department. In addition, children in the community who may have required mobile crisis intervention services or other community-based behavioral health services, may be determined appropriate for additional services through a crisis residence program, until such time as they can return home or to the community safely and with ample supports.

The intended goals of the program are to:

- stabilize the child's psychiatric crisis symptoms and prevent unnecessary inpatient admission;
- restore the child to a level of functioning and stability and developing coping mechanisms that supports the child's transition to community-based services, supports and resources;
- mobilize the resources of the family and community to support the child's on-going treatment and recovery needs and connecting an individual with identified supports and linkages to community services in order to prevent future crises, or to reduce the intensity and duration of crises that may arise; and,
- provide a safe and therapeutic environment where services are delivered through a trauma-informed approach and are consistent with the child's conditions and needs.

III. Guiding Principles

Child/Family Centered: The program should be focused around the needs of each child and/or their family. While all children are eligible to receive services in the Crisis Residence once enrolled, the determination of services delivered, discharge planning and outreach efforts and the connections with alternate providers should be based upon the needs of each particular child/family.

Community Integrated: It is expected that the crisis residence program will maintain a strong connection to their local community, including both with mental health providers and alternate community connections such as the local library, school district, recreational providers, etc. For

those children who reside in the same community as the Crisis Residence, this opportunity will assist them in building their own connections.

Culturally Competent: Every step of the program should operate in a culturally competent manner, from receipt of a referral to the child's discharge. Program policies and procedures as well as staff interactions/behaviors need to be respectful of the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies, and practices characteristic of all participants.

Developmentally Appropriate: Services and interventions in the program are provided in a manner that is not only appropriate for a child/youth's age, but anchored to their developmental, social and emotional stage, and attuned to the relationship between the child/youth and family/caregiver. Based on the child/youth's developmental needs, the approach of services and interventions should foster the family/caregiver's active involvement and are reflected in the service plan.

Trauma Informed: A trauma informed program integrates the understanding that the experience of traumatic events impacts all people involved, whether directly or indirectly. Staff in every part of the organization take into consideration the experiences of trauma among child participants and their families, as well as among staff providing the services. Programs incorporate principles of trauma informed care to reflect safety; trustworthiness and transparency; empowerment and choice; collaboration; and respect for cultural and gender differences.

IV. Certification

Providers of Children's Crisis Residence Programs must be licensed by the Office of Mental Health to provide children's crisis residential services. All Children's Crisis Residence programs are governed by Part 589 of Title 14 NYCRR. This regulation governs both adult and children's crisis residence programs. In order to provide this service, agencies must have a valid Operating Certificate from the Office of Mental Health which outlines their ability to deliver residential services. Providers shall abide by this regulation and any forthcoming guidance related to Children's Crisis Residences.

Licensed Crisis Residence Providers will also be designated by the State to verify their authorization to serve children under 21, in accordance with the Medicaid State Plan. Such designation will apply to all Crisis Residence programs, including Children's Crisis Residences and both Adult Crisis Residences (Intensive Crisis Residence and Residential Crisis Support) for individuals 18-20 years old.

V. Services

A Children's Crisis Residence program provides the following required components by qualified staff in accordance with their scope of practice:

- (A) Mental Health Assessment
- (B) Service Planning
- (C) Family Support
- (D) Individual and Family Counseling
- (E) Care Coordination

Each component reflects a variety of services and activities to be provided within the program to ensure children and families receive adequate care in preparation for a successful discharge. These treatment and support services are provided in a trauma-sensitive, safe and therapeutic living environment consistent with the recipient's condition and needs.

(A) Mental Health Assessment

A Mental Health Assessment involves the completion of a comprehensive intake assessment, which includes a risk assessment, development of a crisis plan, and health screening.

Comprehensive Intake Assessment: An intake assessment is conducted for each child by a professional or QMHP (qualified mental health staff person) upon admission to the program and includes, at a minimum:

- *description of the current symptoms and/or behaviors* which demonstrate eligibility for admission; including the onset/duration of crisis related/mental health symptoms;
- *presenting problem*, including factors contributing to the psychiatric crisis or risk; current stressors or precipitants impacting symptoms/behaviors;
- *description of the child's current needs* (which may include psychiatric, physical/medical, social and/or rehabilitative) *and strengths* (which may include current supports/family strengths); and,
- *description of the skills needed to transition to the home* or community.

Additional intake information may include, but is not limited to developmental and family history, social relationships and functioning; other available supports; trauma experiences; behavioral health (mental health and substance use) service history/outcomes; prescribed medications; current providers, services or agency involvement (e.g. legal involvement, CPS); and, school performance/educational or vocational plan.

1. **Risk Assessment:** conducted upon admission, preferably using a standardized risk assessment tool(s), using collateral sources for additional information; to assist in the

development of a crisis plan. The assessment should include risk factors and level of severity (minimally including risk of self-harm, both suicidal and self-injurious behaviors, and risk of violence), current and recent history of substance use, if applicable, and perception of own risks and safety. Areas identified during the risk assessment are to be addressed in the crisis plan.

2. **Crisis planning:** a collaborative process between provider and the child/family to develop a crisis plan (or “safety plan”). A crisis plan is a tool utilized by the child/family and provider to assist in reducing or managing crisis-related symptoms; promoting healthy behaviors; addressing safety measures; and/or preventing or reducing the risk of harm or diffusion of dangerous situations. This plan is created upon admission and refined during the course of treatment and in preparation for discharge.

With the family’s consent, the crisis plan may be shared with other providers and identified collaterals outside of the crisis residence program who may provide treatment, support or intervention upon discharge. Sharing the crisis plan helps promote the awareness of, and ability to support, the strategies identified and implemented by the child and family.

3. **Health screening:** conducted by a licensed registered nurse as part of the comprehensive intake assessment process. Screening for physical health conditions is comprised of the initial gathering of and assessing information concerning the child’s medical history, and current physical health status (including physical examination and determination of substance use), to inform an assessment and determination of its potential impact on the child’s mental health diagnosis and treatment, and the need for additional health services or referrals.

(B) Service Planning

Service Planning: An individualized, child centered, and family focused approach to service planning and implementation should be utilized to address the unique needs, preferences and strengths of the child and family/caregiver. While service planning and implementation is centered around the developmentally appropriate needs of the child, it takes into consideration the family/caregiver’s integral role in the care and recovery of the child. It emphasizes shared decision-making approaches to empower the child and family/ caregiver, provide choice, minimize stigma, and establish youth and family driven goals. The family participates as a full partner to the extent possible and appropriate, in all stages of planning and decision-making, including treatment implementation, monitoring and discharge.

Children's Crisis Residence programs are required to develop plans to assure continuity and integration of care within the mental health system and other systems of care. The crisis residence program is encouraged to facilitate a child's participation in their established services within the community of the residence or in their home community, to the extent possible, which do not duplicate the services being provided by the crisis residence program. When a child's condition and needs indicate the capacity for community participation, a flexible approach by the crisis residence that promotes continuity of care with the child's providers will help to seamlessly transition the child back to the home/community,

If the QMHP (qualified mental health staff person) developing the plan does not possess a license, the plan must be approved and signed by a professional staff. Additional detail on requirements for the development of Preliminary and Individual Service Plans can be found below.

(C) Family Support

Engagement and support for families includes activities to maintain or facilitate positive relationships with family members and promote skills needed for success in the discharge living environment. Engagement and support for families is comprised of activities to assist families in supporting the child's return to the community. Actions may include the support and facilitation of home visiting, facilitating linkages for the family with local community services such as peer support, or facilitating support groups for parents of children who have accessed the crisis residence.

Crisis residence programs should provide regular opportunities for the involvement of families and caregivers in supportive services to assist in reinforcing the child's treatment and readiness for discharge. Family engagement and supportive activities can involve family members, caregivers and natural supports. It may also include training in skills needed for success in the discharge living environment, such as implementation of a safety plan, and skills for eliciting positive interactions among family members. Opportunities should be provided to practice and develop skills that promote and reinforce techniques introduced in treatment, as well as promote and assist with ongoing linkage to treatment, rehabilitative, and support services during the crisis and in the discharge living environment, including the child's natural supports.

Although engagement and support for families may resemble activities that fall within the State Plan Family Peer Support Services (FPSS) through the Children and Family Treatment and Support Services array, it is not required that Children's Crisis Residence programs provide FPSS nor employ a credentialed Family Peer Advocate. Rather, it is expected that programs assist in coordinating and linking children and families to Family Peer Support Services within

their home communities to facilitate ongoing support upon discharge from the crisis residence to the home and community environment.

(D) Individual and Family Counseling

Individual and family counseling: Counseling services provided in a crisis program are the use of therapeutic communication and interaction to alleviate the child's psychiatric crisis symptoms, address the acute distress and associated behaviors related to the child's crisis situation, symptoms or dysfunction associated with their diagnosed mental illness or emotional disturbance, while resolving conflict, de-escalating crises and monitoring high-risk behavior. Crisis-oriented counseling is provided for each child admitted to the crisis residence program by a professional staff and may be provided via individual, family or group modalities. It should address the crisis at hand, promote community re-integration, and encompass interventions to facilitate readiness for re-engagement of the child with family, school, and other providers of service. This should also include consultation with psychiatric prescribers and urgent psychopharmacology intervention, as needed.

The frequency of the crisis counseling services to be delivered by the professional staff should be determined by the needs and preferences of each child and family and may be adjusted in accordance with the child's reduction of symptoms and risk, progress toward goals, and readiness for discharge. Crisis counseling provided through the crisis residence program is distinct from ongoing psychotherapy services a child and family may be receiving from community providers. As crisis/risk symptoms alleviate, reengagement with existing providers should be encouraged and facilitated.

Crisis Residences are also required to provide the following services outlined below are provided by qualified staff, as appropriate to meet the needs of each child.

Medication monitoring: means activities performed by staff which relate to storage, monitoring, recordkeeping, and supervision associated with the use of medication. Such activities include reviewing the appropriateness of an existing regimen by staff with the prescribing physician. Prescribing medication is not an activity included under this service. Programs will develop policies and procedures for the storage and oversight of medication consistent with applicable Federal and State laws and regulations.

Medication management and training: means activities conducted by a registered nurse to provide information to ensure appropriate management of medication through understanding the role and effects of medication in treatment, identification of side effects of medication, and discussion of potential dangers of consuming other substances while on medication. Training

in self-medication skills is also an appropriate activity when developmentally and clinically indicated.

(E) Coordination of Care

Coordination of services emphasizes discharge planning conducted by the program including collaboration with existing providers, identified family and friends, and community supports as well as referral and access to behavioral health services (including pharmacological evaluation and management), and community supports.

Ongoing communication between the child, family/caregiver, crisis residence staff and the child's established primary care and behavioral health providers, SPOA where applicable, and care manager is necessary to manage the crisis, facilitate continuity of care, and ensure effective community reintegration. This includes communication of the developed crisis plan with appropriate providers. Upon the identification of the services and supports needed at discharge, the professional staff or QMHP (qualified mental health staff person) are expected to immediately begin the process of coordinating and linking the child and/or family/caregiver to community providers to assure the needed services and supports are in place upon discharge.

If it is appropriate and beneficial to the child's process of stabilization or crisis resolution to facilitate their continued participation in outside services during their period of admission, those outside services should not duplicate the services being provided by the crisis residence program; rather, services should be distinct and complementary. This may include, but not limited to, community based behavioral health services/psychiatry, medical care, care management/care coordination, educational services, or other significant supportive services. Programs must follow-up with the individual and the individual's family/support network to ensure their needs are being met, such as enrollment in and receipt of care coordination, outpatient treatment, or other community services.

(F) Daily Program Management Activities

Children's Crisis Residence programs are also expected to provide the following activities in the milieu, as appropriate to meet the needs of each child.

One-to-one monitoring: includes the capacity for ongoing observation and assessment of one individual child by one trained para-professional staff member, (for a prescribed period of time, of actions or activities that could result in physical and/or mental harm to themselves and/or others. One-to-one monitoring may be a necessary service for any child admitted to the crisis residence to ensure safety for a period of time when they are exhibiting high risk

behaviors/symptoms or are admitted to the crisis residence as a diversion from an inpatient hospital admission. High risk behaviors may include a wide array of symptoms and the need for one-to-one monitoring is determined by the needs of each individual child. Implementation of appropriate crisis/safety plan strategies and interventions should occur during this period. Staff should document their observations and the child's response to interventions, to help determine and demonstrate when a sufficient reduction in high risk symptoms has occurred to discontinue this level of monitoring.

Behavior support: includes skill building for managing behavior and regulating emotional responses. Behavior support is a broad term used to encompass a variety of activities, interventions and modalities that staff (both para-professional, professional and QMHP (qualified mental health staff person) utilize to create a milieu that is therapeutic, recovery-oriented and trauma-informed. Behavior support includes activities which provide guidance and training in behavior intervention techniques and practice of skills to increase the child's capacity to manage their behavior from everyday life situations to acute emotional stress. Such activities focus on interventions that assist in identifying internal or external stressors and developing coping strategies to address them. Behavior support can also promote and reinforce the implementation of skills introduced in treatment.

Respite: Children's Crisis Residences provide a respite for the child and their family as a result of the crisis situation that led to admission into the crisis residence program. Respite is a service provided in the course of admission to a crisis residence in conjunction with ongoing treatment and support services. Respite provides an opportunity for a child to separate from their immediate stressor(s), and de-stress as they work through the crisis in a safe environment. It also provides the short-term relief for a child or family/primary caregiver needed to enhance the family/primary caregiver's ability to support the child's functional and behavioral health care needs and prepare for a successful return home

Note: Respite as a separate standalone service is only billable to Medicaid for children who have been determined eligible for the Children's Home and Community Based Services (HCBS) Waiver. Children enrolled in HCBS who have been determined in need of respite on their plan of care, can receive HCBS respite (planned or crisis) from a Children's Crisis Residence only if it has been designated by the State as a HCBS respite service provider.

VI. Admission Criteria for Medicaid-Enrolled Children

Admission Criteria

Programs must clearly define their admission criteria in accordance with the following medical necessity criteria:

- The child is under the age of 21; AND
- The child/youth is experiencing acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved (e.g. collateral, provider, community member) to effectively resolve it; AND
- The child/youth demonstrates at least one of the following:
 - Impairment in mood/thought/behavior disruptive to home, school, or the community, OR
 - Behavior escalating to the extent that higher intensity services will likely be required; AND
- The intervention is necessary to further evaluate, resolve, and/or stabilize the child/youth, AND
- The child/youth is not at imminent risk of harm to self or others.

Admission Policies

The Children's Crisis Residence must establish a process to determine eligibility of children referred to the program in accordance with the program's admission criteria, based on a recommendation by professional staff of the agency, qualifying as a Licensed Practitioner of the Healing Arts (LPHA), acting within their scope of practice.

The referral source and/or parent/guardian should be notified by the Children's Crisis Residence of eligibility/non-eligibility upon determination within 24 hours of initial contact. For children enrolled in managed care, notification of admission must also be issued to the Medicaid managed care plan within two (2) business days, outlined in the Utilization Management for Children Enrolled in Medicaid Managed Care section of this document. Documentation that parent/guardian and referral source were notified of the determination, and the manner in which they were notified, should be maintained by the program and/or included in the child's record.

If the child is determined by the provider to be ineligible for admission to the Children's Crisis Residence, the provider shall also send a notice of the eligibility determination to the child's parent/guardian and the referral source to assist with linkages to alternative services. Notification should be accompanied by an explanation of the determination and suggestion for alternative treatment options or identified resources (e.g. Single Point of Access (SPOA), primary care, or behavioral health provider, Health Home care manager, etc.). Children's Crisis Residence programs should develop policy and procedures related to the storage of referral information should a child be denied for admission.

VII. Discharges

Discharge Criteria

Programs must clearly define their discharge criteria in accordance with the following medical necessity criteria:

- The child no longer meets admission criteria - demonstrates symptom reduction, stabilization, and restoration, or development of the coping mechanisms to pre-crisis levels of functioning.
- The child's symptoms have escalated to a level of severity where they can only be safely treated in a higher level of care, such as an inpatient setting.
- The parent/guardian and/or child (as appropriate) withdraws consent for the service.

Discharge Policies

Each provider shall develop a discharge policy which includes its discharge criteria. The policy should: describe the development of the discharge plan to be initiated upon admission; include the participation of the child and/or family; identify the caregiver(s) and living situation upon discharge; identify the services and supports needed to enable the child to return to the community; and, the goal areas to be addressed to strengthen the child and family's success upon discharge. The provider shall ensure that each child and family, with proper consent, is linked with the appropriate behavioral health, educational-vocational support, and community services needed to successfully transition into the community or other appropriate alternative.

Children's Crisis Residences shall provide follow-up contacts for the child and family, as needed, for up to 30 days after discharge. Follow-up contacts should include but not be limited to ensuring aftercare linkages have been made and the child, family/caregiver has actively engaged in community-based services.

Discharge Planning

Discharge planning is an important element of service provision and a critical component of continuity of care. Discharge planning begins upon the child's admission and continues to be updated throughout the course of service provision. At admission, the discharge criteria are identified, the plan for discharge is developed, and the service plan further refined in conjunction with the child's family/guardian. For children enrolled in Medicaid Managed Care, it is also important to ensure communication with the Plan to ensure a successful discharge for the enrollee.

Providers are encouraged to connect families to community-based services and support, such as Health Homes Serving Children (HHSC) or Child and Family Treatment Supports and Services (CFTSS) and help to initiate services in the child's home and community if they are

not already connected. The implementation of additional supports for the child and family may help prevent the need for future admission to the crisis residence or escalation of care.

In order to make referrals, designated treatment providers can be found on the DOH website at: [Designated HCBS and Child and Family Treatment Supports and Services \(CFTSS\) Providers](#). Children's Health Home care managers can help to determine if the child may be eligible for additional services, such as Home and Community Based Services (HCBS). For children enrolled in Medicaid managed care, providers can also find available providers by contacting the Medicaid Managed Care Plan (MMCP) or viewing the MMCP's provider directory to verify provider participation in the MMCP's network.

VIII. Setting Standards

Children's Crisis Residence Programs will:

- utilize a community-based site offering a therapeutic, supportive, home-like environment;
- be staffed and open 24 hours a day, seven days a week;
- have the ability to accept referrals 24 hours a day, seven days a week;
- provide a safe physical environment, as evidenced by compliance with relevant building safety standards;
- provide a smoke-free environment;
- allow the child to have visitors and maintain contact with the parent/guardian, family members, or other identified collaterals considered to be supportive to their care. Visitation is allowed at any time convenient and practical for the child, as well as the operations of the crisis residence program;
- provide services in a culturally and linguistically competent, person-centered, trauma informed manner; and,
- minimally provide three meals a day, personal care items and clean bedding.

The expected length of the child's stay is less than 21 days. For children enrolled in a MMCP, the provider must obtain authorization from the MMCP for a length of stay that exceeds 28 days. For children enrolled in Medicaid fee-for-service (FFS), the provider must obtain authorization from the OMH Regional Field Office for a length of stay that exceeds 28 days.

IX. Staffing

Each Children's Crisis Residence will have a staffing plan based on the number of approved beds, projected volume of participants and services, and should include the categories of

professional and para-professional staff listed below. The plan must also include the provision of on-call staff for emergency situations and adhere to the following:

- A children's crisis residence program with six beds or fewer shall have at least two full-time equivalent para-professional staff assigned to direct supervision of recipients during "peak times." For purposes of this Part, "peak times" include early mornings, after school, early evenings, weekends and holidays. For eight bed programs, at least three full time equivalent para-professional staff shall be assigned to direct supervision of recipients during "peak times" if more than six beds are occupied.
- A Children's Crisis Residence program shall assign at least two para-professional staff for overnight coverage. At least one staff must be awake and providing direct supervision during this time.
- A Children's Crisis Residence shall have an adequate volume of registered nursing staff on duty to ensure the continuous provision of treatment services in accordance with their scope of practice.
- A Children's Crisis Residence shall have an adequate volume of professional staff and QMHP (qualified mental health staff) in addition to professional nursing staff, to ensure the continuous provision of the program's required treatment services in accordance with their scope of practice.
- A Children's Crisis Residence shall have a continuous provision of sufficient ongoing and emergency supervision. Supervisory staff of crisis residence programs shall be available to assist on at least an on-call basis when not on site, as set forth in the staffing plan. Qualified mental health staff may be considered supervisory staff as set forth in the staffing plan.
 - On-call staff may need to respond in-person when the needs of a child, or a group of children, exceed the capacity of the staff present on site. Individual determinations regarding the need for an in-person response by on-call staff will be left to the discretion of each program.
- For co-located programs, staff may only be assigned and work in one program during a shift.

All staff must be cleared through the Child Abuse Registry and criminal background checks completed in accordance with 14 NYCRR Part 550 regarding criminal background checks, and NYS Social Services Law Section 424 regarding the child abuse and neglect registry.

Staff Orientation and Training

Each licensed Children's Crisis Residence program shall develop an orientation and ongoing training program for program staff, which address the following areas of training targeted to appropriate staff based on their roles and responsibilities within the program.

Required trainings for staff include:

- 1) Crisis De-escalation, Resolution and Debriefing Techniques
- 2) Suicide Prevention (Suicidal and Self-Harming Behaviors)
- 3) Crisis Plan Development (Risk Assessment, Crisis Management, and Safety Planning)
- 4) Mandated Reporter
- 5) First Aid
- 6) CPR
- 7) Narcan training
- 8) Trauma Informed Care
- 9) Culturally and Linguistically Appropriate Service Delivery

Additional recommended training topics, include, but are not limited to the following:

- 10) Developmental Stages of Children and Adolescents
- 11) Symptoms of Mental Illnesses in Children and Adolescents

X. Program Procedures

Intake Assessment

Within 24 hours of admission of a child to a children's crisis residence program, an intake assessment must be completed by a QMHP (qualified mental health staff person) within their scope of practice and, at a minimum, a preliminary individual service plan developed.

The intake assessment includes, at minimum, a description of the current symptoms and/or behaviors which demonstrate eligibility for the program; the presenting problem including factors contributing to the psychiatric crisis or risk; an assessment of risk; a description of the child's current needs and strengths; and, a description of the skills needed to transition to the home or community. (See *Services* section for additional information regarding the intake assessment).

Individual Service Plan

Preliminary Service Plan: A preliminary individual service plan must also be completed within 24 hours of admission. This should include at a minimum, a description of the immediate need(s) to be addressed, the initial goal(s), service(s), intervention(s) and crisis plan to address the need(s) during the initial period after admission.

As a result of the crisis situation or family circumstance that may be impacting the child's crisis presentation, it is possible that only the most immediate need of the child may be identified and agreed upon at the time of admission. This is likely to result if the child's family/caregiver or significant collateral support(s) are unable to fully or effectively engage in a service planning process immediately upon admission. Thus, a preliminary service plan may be established that includes only the most prioritized goal(s), objective(s) and intervention(s) for the child.

Individual Service Plan: Within 72 hours of the child's admission however, the Individual Service Plan must be completed and include the following participants, as appropriate: the child, the child's parent/guardian, or other identified collaterals. The parent/guardian, or other collaterals participating in the development of the plan, must be specifically identified in the plan.

Because of the family/caregiver's significance in the child's stabilization, recovery or readiness for step down to a lesser restrictive level of treatment, a 72-hour time period is allotted (*if needed*) for the crisis residence to identify, engage and accommodate the participation of the parent(s)/guardian, family members, or other collaterals to complete a substantive service and discharge plan.

Note: *If the QMHP (qualified mental health staff person) developing the plan does not possess a license, the plan must be approved and signed by a professional staff.*

The completion of the Individual Service Plan must include, at a minimum, the following components, reflecting the services provided by the residence:

- a) The treatment goal(s) and objectives including the services, interventions, projected time periods to accomplish the goal(s);
- b) The parent/guardian, family members, or other identified collaterals participating in treatment and discharge planning;
- c) The criteria for discharge and a description of the services and supports needed at the time of transition to the home or community;
- d) Signatures of the child, participating family, or collaterals indicating their agreement. If the child, family, or identified collateral(s) are unable to participate, reason for non-participation should be documented; and,
- e) The plan for facilitating the provision of additional service(s) outside of the crisis residence program to further support and prepare the child for discharge while in the program.

Service Plan Reviews

The individual service plan should be reviewed as needed and must be revised if there is a change to the child's goals or plan for discharge, such as a change in caregiver, living situation, hospitalization, etc. Reviews must include the appropriate staff involved in the provision of services, the child, family/guardian and any other identified collaterals requested by and/or agreed to by the child/family. Reviews should be scheduled according to the convenience of the family, and arrangements should be made for phone/video conferencing, if requested. Collaborative providers with whom the child/family are expected to engage with upon the child's transition to home or community should be included to the extent possible in order to facilitate an effective, seamless transition.

Reviews should include, at a minimum:

- a) assessment of the child's progress regarding the treatment goals and objectives;
- b) recommendations for adjustment of goals, objectives or time periods for achievement; or plan for discharge (including service needs, living environment); and,
- c) signature of the QMHP (qualified mental health staff person) who completed the review. If the QMHP (qualified mental health staff person) conducting the service plan review does not possess a license, the plan must be approved and signed by a professional staff.

Case Records

There shall be a complete case record maintained electronically or at one location for each recipient. The case record shall be confidential, and access shall be governed by the requirements of sections 33.13 of the Mental Hygiene Law.

Each case record shall include:

- identifying information about the child and the child/families support system;
- a note upon admission indicating source of referral, date of admission, rationale for admission, the date service commenced, presenting problem, and initial treatment needs;
- summary of psychiatric, medical, emotional, and social needs;
- summary of reports of all mental and physical diagnostic examinations and assessments, including findings and conclusions, if available;
- summary of reports of all special studies performed, including but not limited to X-rays, clinical laboratory tests, psychological tests, if available;
- an individual service plan;
- daily progress notes which relate to the goals and objectives of the service plan including:
 - date of the progress note
 - signature of staff member who provided the service

- any significant event(s) that affects, or potentially affects the child's progress towards achieving goals of the treatment plan or discharge;
- recommendations for changes to the goals and objectives of the treatment plan, if appropriate, dated and signed orders which indicate commencement and termination dates for all medications for applicable programs, if applicable; and,
- a discharge summary, which includes the reasons for discharge and, if appropriate, the provision for alternative services which the child or family may require, should be available on day of discharge.

Records must be retained for a minimum period of six years from the date of the last service provided to a patient or, in the case of a minor, for at least six years after the last date of service or three years after he/she reaches majority, whichever time period is longer.

XI. Reporting Requirements for Children's Crisis Residences

Background Checks

OMH Licensed providers must adhere to the criminal background check requirements under the Justice Center in accordance with Mental Hygiene Law (MHL) Section 31.35 and 14 NYCRR 550 (see OMH Justice Center website for more information:

<https://www.omh.ny.gov/omhweb/dqm/jc/> and clearance requirements under NYS Social Services Law Section 424 regarding the child abuse and neglect registry.

(Please note that in instances where a Children's Crisis Residence provider is providing crisis residence under both State Plan authority outlined herein, as well as respite (planned or crisis) Home and Community Based Services (HCBS) under the authority of the 1915c Children's Waiver, the provider must also adhere to the statutorily required background checks, as outlined in the Children's HCBS Provider Manual:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/hcbs_manual.pdf

Incident Reporting

OMH Licensed Children's Crisis Residence providers are required to adhere to the incident reporting requirements under the Justice Center in accordance with MHL Section 31.35 and 14 NYCRR 550. See OMH Justice Center website for more information:

<https://www.omh.ny.gov/omhweb/dqm/jc/>.

Mandated Reporting

All Children's Crisis Residence programs shall comply with the provisions governing the reporting of suspected child abuse or maltreatment, as set forth in sections 413-416 and 418 of the Social Services Law.

Consolidated Fiscal Reporting

Agencies with Children's Crisis Residences must complete an annual Consolidated Fiscal Report (CFR) as a licensed program under the Office of Mental Health. More information can be found at: <https://omh.ny.gov/omhweb/finance/main.htm>

XII. Utilization Management for Children Enrolled in Medicaid Managed Care

Pursuant to Section 10.21(a) of the Medicaid Managed Care Model Contract, MMCPs must adhere to utilization management and level of care guidelines for making initial and ongoing mental health level of care decisions and with utilization management criteria approved by the Office of Mental Health. In addition, MMCPs must utilize evidence-based, peer reviewed, and age-appropriate medical necessity criteria that has been reviewed and approved by the Office of Mental Health, in consultation with the Department of Health, as required by NYS Public Health Law §4902. When developing medical necessity criteria MMCPs must ensure alignment with service criteria outlined above and utilization management guidance in the [*OMH Guiding Principles for the Review and Approval of Clinical Review Criteria for Mental Health Services.*](#)

Prior authorization for Medicaid Managed Care enrollees to access Crisis Residence Services is prohibited.¹ Crisis Residence providers must notify the plans within two business days of admission. OMH has developed a [*Crisis Residence Admission Notification Form*](#) that contains the necessary information providers must submit to a MMCP within two business days of the individual's admission. MMCPs may use this form or develop their own but can only require providers to submit the information contained in the Crisis Residence Admission Notification Form.

MMCPs are required to work collaboratively with the Crisis Residence provider to share relevant information that supports the child's treatment, care coordination and discharge planning. If there are barriers to discharge, a discussion between MMCP and the Crisis Residence provider must identify strategies to resolve them. The frequency of communication should reasonably reflect the complexity of the child's treatment and care coordination needs.

¹ *Medicaid Managed Care Model Contract*, Emergency Services- Section 10.13(e), and Mental Health Services- Section 10.21(i).

Lengths of stay must not exceed 28 days *unless* the OMH Regional Field Office (for children who are billed fee-for-service) or the Managed Care Organization (for children enrolled in managed care) provides authorization for an extension upon review of submitted documentation to demonstrate clinical appropriateness for continued stay.

When determined, Crisis Residence providers must notify the MMCP of the individual's discharge date. Individuals admitted to Crisis Residence programs may still receive previously authorized community-based outpatient services or new outpatient services identified as part of the child's Crisis Residence service plan. MMCP authorization of these services cannot be restricted because of an individual's Crisis Residence admission.

XIII. Medicaid Provider Requirements and Billing

Only Crisis Residence providers licensed by NYS OMH and designated by the State are permitted to bill Medicaid fee-for-service or MMCPs for services provided. In order for licensed Children's Crisis Residence providers to be eligible to receive Medicaid payment, they must be enrolled as a Medicaid provider. Information on Medicaid enrollment and billing can be found in the [Children's Crisis Residential Benefit and Billing MMCP Guidance](#). Medicaid reimbursement cannot be used for room and board and funding for these components of the program must be secured elsewhere.

XIV. Glossary of Terms

Clinical staff: means professional, para-professional and non-professional staff members who provide residential crisis services directly to recipients.

Family: means those members of the recipient's natural family, family of choice, or household who interact with the recipient and are directly affected by, or have the capability of affecting, the recipient's condition.

Individual Service Plan: means a written plan based on the assessment of the mental health status and needs of a recipient, establishing their treatment and rehabilitative goals and determining what services may be provided to assist the recipient in accomplishing these goals.

Para-professional staff: individuals 18 years of age or older with a High School diploma or equivalent and 1-3 years of relevant experience or a bachelor's degree employed or under contract with a provider of services.

Professional staff: practitioners possessing a license or a permit from the New York State Education Department who are qualified by credentials, training, and experience to provide direct services related to the treatment of mental illness.

Qualified Mental Health Staff Person:

1. A physician who is currently licensed as a physician by the New York State Education Department
2. A psychiatrist is an individual who is currently licensed as a physician by the New York State Education Department, and is a diplomat of the American Board of Psychiatry and Neurology or is eligible to be certified by that board; or is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that board.
3. A psychologist who is currently licensed as a psychologist by the New York State Education Department
4. A social worker who is either currently licensed as a master social worker or as a licensed clinical social worker by the New York State Education Department or has a master's degree in social work from a program approved by the New York State Education Department
5. A registered nurse who is currently licensed as a registered professional nurse by the New York State Education Department; including Clinical Nurse Specialist.
6. A creative arts therapist who is currently licensed as a creative arts therapist by the New York State Education Department.
7. A marriage and family therapist who is currently licensed as a marriage and family therapist by the New York State Education Department.
8. A mental health counselor who is currently licensed as a mental health counselor by the New York State Education Department.
9. A psychoanalyst who is currently licensed as a psychoanalyst by the New York State Education Department.
10. A nurse practitioner who is currently certified as a nurse practitioner by the New York State Education Department.
11. An individual having education, experience and demonstrated competence, as defined below:
 - a. A master's or bachelor's degree in a human services related field.
12. A certified rehabilitation counselor currently certified by The Commission on Rehabilitation Counselor Certification (CRCC); or

13. Other professional disciplines which receive the written approval of the Office of Mental Health.