The Bridge Program: Care Coordination for Children with Developmental Disabilities Guidelines

2009

State of Vermont
Agency of Human Services
Department of Disabilities, Aging and Independent Living
Division of Disability and Aging Services
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I. INTRODUCTION

The Bridge Program: Care Coordination for Children with Developmental Disabilities offers families assistance with accessing needed medical, educational, social or other services to address their children's needs. The program can also help families coordinate multiple community-based services and develop a coordinated plan to address assessed needs. The Bridge Program will be provided by the ten Designated Agencies for Developmental Disability Services. Funding and oversight of the program is provided by the Department of Disabilities, Aging and Independent Living, Division of Disability and Aging Services. These guidelines outline the rules, procedures, documentation and reporting requirements, and forms related to operation of the program.

II. COVERED SERVICES

Below are the procedures outlined in the Developmental Disability Services Medicaid Manual.

5.1 THE BRIDGE PROGRAM: CARE COORDINATION FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES

The Bridge Program offers care coordination to assist families of Medicaid eligible children under 22 with developmental disabilities. The Bridge Program provides a goal-driven service which will:

- Help families determine what supports or services are needed,
- Help families access needed medical, educational, social or other services to address their child's needs,
- Help families coordinate multiple community-based services and develop a coordinated plan to address assessed needs.

Reimbursable activities include assessment, care plan development, referral and monitoring as defined below:

5.1.1 Assessment of an individual to determine the need for any medical, educational, social or other services. These assessment activities include:

- Taking client history;
- Identifying the individual's needs and completing related documentation;
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

5.1.2 Development of a specific care plan that:

- Is based on the information collected through the assessment;
- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the

individual's authorized health care decision maker) and others to develop those goals; and

- Identifies a course of action to respond to the assessed needs of the eligible individual.

5.1.3 Referral and related activities:

- To help an eligible individual obtain needed services including activities that help link an individual with:
  - Medical, social, educational providers; or
  - Other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

5.1.4 Monitoring and follow-up activities:

- Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. These activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:
  - Services are being furnished in accordance with the individual's care plan;
  - Services in the care plan are adequate; and
  - If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers.

5.1.5 <u>For billing purposes:</u>

5.1.5a Services are billed on a monthly per child case rate. The case rate is the individually determined rate for the designated agency. Billing may occur for a child as long as services were provided for at least 15 minutes during the month. A service is billable if it involves addressing any goal identified in the Bridge Program Care Coordination Plan or any of the activities noted in 5.1.1- 5.1.4 above.

5.1.5b Bridge Program Care Coordination may <u>not</u> be billed for children who are receiving <u>care coordination, case management or service coordination</u> from another Agency of Human Services funded source including:

- Home and Community-based Developmental Disability Services (DDS) or DDS Targeted Case Management
- Children's Mental Health Home and Community-based waiver or Targeted Case Management Services
- Adult Mental Health – CRT or case management services

- Traumatic Brain Injury Home and Community-based Waiver services
- Choices for Care Services
- Department for Children and Family Services, Family Services Division (children in custody) or Intensive Family-based Services
- Post-adoption case management
- Children living in residential placements such as nursing homes, ICF-MR, hospitals, rehabilitation facilities, residential schools, psychiatric hospitals or crisis facilities (except 90 days prior to discharge)
- Children's Integrated Services team (Family, Infant and Toddler Program, Part C Early Intervention/Healthy Babies, Kids and Families/Children's Upstream Services)
- Purchased through Children's Creative Connection in Children's Personal Care Services

(not including special education case management for school services).

5.1.5c Bridge Program Care Coordination may be billed for persons receiving other clinic services including individual psychotherapy, group therapy, emergency care and chemotherapy.

5.1.5d Bridge Program Care Coordination may be billed for an individual residing in a nursing home, ICF-MR, hospital, rehabilitation facility, residential school, psychiatric facility, or crisis facility only for the purposes of discharge planning when the service does not duplicate the facility's services and when provided ninety (90) calendar days or less prior to discharge.

5.1.5e The cost of conducting assessments for eligibility for this service are included in the monthly case rate and may not be billed separately by the agency for those receiving Bridge Program Care Coordination.

5.1.6 Required Documentation for Bridge Program Care Coordination:

5.1.6a A psychological and an adaptive behavior assessment documenting eligibility consistent with criteria outlined in the *Regulations Implementing the Developmental Disabilities Act of 1996* (see exception on page 11) or subsequent revisions.

5.1.6b Bridge Program Care Coordination Plan (CCP). (See form on pages 19-22.) Because of the more limited nature of this service, a care plan known as a Bridge Program Care Coordination Plan will be used rather than the Individual Service Agreement format used for

all other Developmental Disability Services. The CCP must include:

- Designated Agency
- Beginning and end dates of the CCP term, not to exceed one year
- Service goals
- Linkage plan describing what activities the care coordinator will engage in to reach the service goal
- Anticipated timeframe for completion (extension if needed)
- Description of outcome achieved and date achieved
- Frequency of review of CCP (minimum once per term)
- Documentation of CCP review
- Approval of individual (not required for those under 18), parent or guardian, Care Coordinator and Qualified Developmental Disability Professional (QDDP)

5.1.6c Service Documentation: A contact note is needed each time a service is provided. The note should include the date; a description of the activity; amount of time spent; the service location; and staff signature. (Only one note would be needed for a period of continuous service, e.g. 2 hours, even if multiple activities were being completed.)

III. THE BRIDGE PROGRAM AND REGULATIONS IMPLEMENTING THE DEVELOPMENTAL DISABILITIES ACT

The Regulations Implementing the Developmental Disabilities Act of 1996 – July, 2007 will apply to provision of services under the Bridge Program: Care Coordination for Children with Developmental Disabilities with the following exceptions:

Part 1: The criteria for eligibility is same as for other developmental disability services except in the case of the Bridge Program, the person must also be under age 22 and the exception noted on page 11.

Part 2.02 (2): This section does apply, but it is important to ensure that primary beneficiary of the service is the child. Services should not be directed to assisting the parents or non-eligible siblings with their needs that are unrelated to the eligible child/youth. For example, it would be appropriate to link a non-eligible sibling to a sibshop, but not to help the family find him/her a summer camp. It would be appropriate to link a parent to support to address stress related to parenting a child with a disability, but not to try to locate medical specialists to address a parent's own medical problems.

Part 2.03 (2): This section would apply as long as the person maintained his/her eligibility for Medicaid.

Part 5.06: The agency will not specify an authorized amount of funding or hours. Rather the person will be assigned a care coordinator. The amount of service provided will be flexible depending upon the needs targeted to be addressed in the Care Coordination Plan. The agency should explain to families that the service is not unlimited and they need to balance the needs of all the individuals on care coordinator's caseload.

Part 5.09: The Bridge Program will only be provided by the Designated Agency for the area where the person lives. Families and individuals will not have the option of selecting other providers or self-managing this service.

Part 6.01: The agency should review the continued need for the Bridge Program at least annually. However, this may occur sooner if the agency perceives that the person no longer needs the service. It is expected that the agency will keep close track of the needs of people on the caseload, so those who no longer need the service are moved off the program to allow the agency to add people from the waiting list.

Part 6.02: The Bridge Program is not transferrable between Designated Agencies. If a person moves out of the Designated Agency's catchment area, his/her services will be terminated and he/she can apply for this service at the new DA. The person would need to be placed on the waiting list of the new DA if the new DA had no openings on their agency's caseload for the Bridge Program. The determination of whether the person had a developmental disability would not need to be redone, but a new needs assessment and Care Coordination Plan reflecting the new circumstances should be completed.

Part 8: This section does not apply as the Bridge Program does not entail the provision of direct care assistance.

Part 9: A family may appeal a determination that their child is not eligible for the service. When a child is deemed eligible, a specific number of hours of service are not being awarded. Therefore the quantity of service is not appealable. The family can file a grievance if they do not feel the agency is providing a sufficient amount of service to meet the needs of the child.

IV. THE BRIDGE PROGRAM APPLICANT AND WAITING LIST INSTRUCTIONS

Applicant List Instructions

Effective: July 1, 2009

Definition:

All people who **meet eligibility criteria 1 – 4** on the Bridge Program Care Coordination Needs Assessment and Eligibility Determination form, but **who do not meet criteria 5**.

Criteria:

1. Child is under age 22
2. Child is Medicaid eligible
3. Child has a developmental disability according to DD services regulations
4. Child does not receive case management/care coordination/service coordination from another Agency of Human Services source
5. Child/family demonstrates the need for assistance to access or coordinate needed medical, educational, social or other services

Process:

- **The DA will include people on the list using the "Service Planning and Coordination" column. To indicate the services is wanted, mark the column with a "1" and write "Bridge Program" in the comments section.**

Data for Applicant List:

- Name of DA/SSA
- Submission month
- Last name of person
- First name of person
- Date of birth
- Dates person went on/off list
- Reason person went off applicant list:
  1. Received Bridge Program funding
  2. No longer needs or wants funding/services
  3. No longer meets Bridge Program criteria
  4. Moved
  5. Deceased
- Service Area Funding Requested - Mark column with a "1":
  - Service Planning & Coordination
- Comments – note "*Bridge Program*"

Waiting List Instructions

Effective: July 1, 2009

Definition:

All people who **meet all five (5) eligibility criteria** on the Bridge Program Care Coordination Needs Assessment and Eligibility Determination form, but **there is no opening because the Bridge Care coordinators caseloads are full**[1].

Criteria:

1. Child is under age 22
2. Child is Medicaid eligible
3. Child has a developmental disability according to DD services regulations
4. Child does not receive case management/care coordination/service coordination from another Agency of Human Services source
5. Child/family demonstrates the need for assistance to access or coordinate needed medical, educational, social or other services

Process:

- **The DA will include people on the list using the "Service Planning and Coordination" column to indicate waiting for Bridge Program Care Coordination. To get the "Annual Cost", take the DA case rate at the time the person is placed on the waiting list times 12 months (e.g., $296.79 x 12 = $3,561.48). Write "Bridge Program" in the comments section.**

Data for Waiting List:

- Name of DA/SSA
- Submission month
- Last name of person
- First name of person
- Date of birth
- Dates person went on/off list
- Reason person went off waiting list:
  1. Received Bridge Program funding
  2. No longer needs or wants funding/services
  3. No longer meets Bridge Program eligibility criteria
  4. Moved
  5. Deceased
- Annual Cost (estimated) of Funding Needed:
  - Service Planning & Coordination
- Total Annual Cost (formula)
- Comments – note "*Bridge Program*"

[1] Agency has met full expected caseload as stipulated in contract.

V. EXCEPTION TO ELIGIBILITY REQUIREMENTS

MEMORANDUM

To: Developmental Services Directors
From: Ellen Malone, Director, Developmental Disabilities and Children's Services Unit
Re: Change in requirements for eligibility determinations for children with PDD funded for limited services.
Date: June 16, 2009

With the addition of the Bridge Program Care Coordination for children with developmental disabilities, your agencies have to do many more eligibility determinations and assessments for children. We have been made aware of a problem related to the need for re-assessment for children who were first diagnosed prior to entering first grade. The DD Act of 1996 Regulations requires a full re-assessment of these children when they enter first grade. This continues to make sense for children who had a condition with a high probability of resulting in mental retardation or significant delays in cognitive development and adaptive behavior. Standardized IQ and adaptive behavior assessments are not required for young children prior to entering first grade. Confirming a mental retardation diagnosis using standardized assessments at that point is needed and continues to be required.

However, the requirement to reconfirm a diagnosis of a pervasive developmental disorder when a child enters first grade is creating challenges for our system. There are a limited number of evaluators with expertise in diagnosing PDD in VT. Even prior to the creation of the Bridge program, there were waiting lists for PDD evaluations resulting in delays in access to services for individuals looking to either establish or reconfirm a diagnosis. The situation has been exacerbated by the need for additional eligibility determinations for the Bridge Program. Also, the cost of completing these evaluations is significant. It is not cost effective to require this assessment for children who will be receiving limited services such as Flexible Family Funding, Targeted Case Management or the Bridge Program. Therefore, for children applying for or enrolled in FFF, TCM and/or the Bridge Program, we are waiving the need to have a new assessment to confirm a diagnosis of PDD when a child enters first grade. An adaptive behavior assessment will continue to be required at this time and the child would need to have substantial deficits in adaptive behavior as defined in the DD Act Regulations. The agency should do a full re-assessment if, at any time, they have reason to believe that the child does not have a PDD diagnosis. A full re-assessment is required when a child is transitioning to adulthood or if they are applying for Developmental Disability Home and Community-based Services. Families should be made aware that the eligibility requirements for limited services are less stringent and that their child's eligibility for developmental disability services is not guaranteed in the future.

This change will be incorporated into the DD Act Regulations when they are next revised.

VI. REPORTING AND PERFORMANCE REQUIREMENTS

The Bridge Program will be provided by Designated Agencies for Developmental Disability Services under a grant agreement with the Department of Disability, Aging and Independent Living. The grant requirements, including reporting and performance expectations, will be outlined in the Designated Agencies' Master Grant Agreements. Budgets and work specifications will be renegotiated at the end of each fiscal year.

VII. DESIGNATED AGENCIES BILLING CODES WHICH CAN AND CANNOT BE BILLED WITH THE BRIDGE PROGRAM (T2022)

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Bridges Care Coordina

VIII. FORMS

State of Vermont
Bridge Program: Care Coordination for children with Developmental Disabilities
Application Form

Designated Agency _____
Date: _____
Care Coordination Services Requested for: _____
Address: _____ Phone Number: (___) ___-_____
_____
_____
Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____
Applicant's Name: _____
Address: _____ Phone Number: (___) ___-_____
_____
_____
Relationship of Applicant to Individual: _____ Self _____Parent ___Guardian
Insurance:
Medicaid _____
Other _____
Legal Guardian (for individuals over age 18): _____Private _____Public ___ None
Guardian's Name: _____
Address: _____ Phone Number: (___) ___-_____
_____
_____
Do you believe the child/youth has a developmental disability (diagnosis of mental retardation or pervasive developmental disorder)? _____YES _____NO

Signature of Person &/or Parent/Guardian _____ Date_____
_____
Signature of Applicant (if different) _____Date _____

- **Is the child/youth who is in need of Care Coordination experiencing a crisis right now? _____YES_____NO**

- **Are you or the person you are applying for a resident of Vermont ?**

Lived in Vermont since _____(date)

- **If not, please explain on the back of the application why you are applying now.**

State of Vermont Department of Disabilities, Aging & Independent Living
Division of Disability and Aging Services

Bridge Program Care Coordination Needs Assessment & Eligibility Determination

Date of Needs Assessment_____Provider Agency_____

Intake Worker/Care Coordinator completing this needs assessment
name_____

Name of Child/Youth_____DOB_____Age_____
Date Youth will turn 22_____
Current Medicaid Status_____

Date determined eligible for developmental services per State of VT regulations _____

Documents demonstrating developmental disability:
Psychological evaluation date:_____DX:_____MR_____PDD/ASD
Adaptive behavior assessment date:_____Score:_____

Does the child/youth receive **case management** from an Agency of Human Services source?

Developmental Services waiver or Targeted Case Management_____
DMH Children's or Adult Mental Health (waiver, CRT or Targeted Case Management)_____
Traumatic Brain Injury waiver_____
Choices for Care waiver_____
DCF Family Services (children in custody)_____
Children living in residential placements such as nursing home, correctional facilities, hospitals, residential schools, psychiatric hospitals, (except 30 days prior to discharge)_____
Post-adoption case management_____
Children's Integrated Service team (Family, Infant, Toddler Program/ Healthy Babies Kids and Families/Children's Upstream Services) _____
Children's Personal Care Services C3 Project_____

If YES to any of the above, he/she is not eligible for the Bridge Program.

High Technology Nursing case management_____
Children with Special Health Needs/Dept. of Health_____

Are there additional non-medical care coordination needs beyond the scope of these 2 services above?_____YES_____NO

SERVICES	Currently Receiving	Needs Service	Needs Assistance to Coordinate
Flexible Family Funding			
Children's Personal Care Services____Allocation			
High Technology Nursing Services_____Allocation			
Other Home Health or Nursing Services			
Medical Home: Primary Care_____Dental care_____			
Children with Special Health Needs: Clinic _____ Social Work Respite			
Use of the statewide respite homes			
Special Education (IEP)			
School 504 Plan			
Early Essential Education (EEE)			
Children's Integrated Services team, age 0 – 6 (FITP____ HBKF_____ CUPS_____)			
Physical Therapy_____School_____Home			
Occupational Therapy_____School_____Home			
Speech/Language Therapy_____School_____Home			
Assistive Technology_____School_____Home			
Behavioral Services/Consultation_____School____Home			
Counseling/Psychological Services___School___Home			
Psychiatric Services			
Other Specialized Supports/Therapies/Medical Services			
Crisis Services			
Child Care/Day Care/Afterschool Program			
Other Recreational Programs			
Summer and/or school vacation camps			
IEP Transition Plan			
Vocational Rehabilitation services			
Does the child/youth receive Social Security Income (SSI)?			
Does/Is the family receive/in need of economic services? Housing Food Fuel			
Home Modifications Previously Accessed or Needed			
Family access to local and statewide support groups			
Vermont Family Network			
Federation of Families for Children's Mental Health			
Autism Support Daily			
Brain Injury Association			
Other Miscellaneous Supports and Services			

Describe the specific Care Coordination assistance needed by the child/youth/family.

Assistance/support to access appropriate school services_____

_____

_____

Assistance accessing and maintaining Medicaid insurance_____

_____

_____

Assistance with linking to mental health services, e.g. psychiatrist, psychologist, counseling, behavioral or crisis services_____

_____

_____

Assistance with linking to needed medical services, e.g. dentist, doctors, specialists, OT,PT Speech, home health or high tech services, etc.

_____

_____

_____

Assistance linking to Children's Integrated Services teams (Family, Infant and Toddler Program, Healthy Babies Kids and Families, Children's Upstream Services)_____

_____

_____

Assistance with linking to economic services, e.g. housing, food, fuel assistance, etc._____

_____

_____

Assistance accessing Children's Personal Care Services, including directing families to resources to find workers_____

_____

_____

Assistance with linking to child care_____

_____

_____

Assistance with linking to assistive technology resources and home accessibility modifications_____

_____

_____

Assistance with linking to recreational resources, including summer camps_____

_____

_____

Assistance with linking to adult services providers and other resources at high school transition_____

_____

_____

Assistance with linking to family support resources, e.g. Vermont Family Network, support groups_____

_____

_____

Support to track and coordinate multiple services and supports_____

_____

_____

Support to prepare for meetings with school personnel and/or other professionals_____

_____

_____

Other assistance:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Eligibility Criteria:

1) **Child is under age 22 _____**
2) **Medicaid eligible_____**
3) **Has a developmental disability according to Developmental Disability Services regulations ____**
4) **Does not receive case management/care coordination/service coordination from another Agency of Human Services source____**
5) **Child/Family demonstrates the need for assistance to access or coordinate needed medical, educational, social or other services ____**

All of the above must be checked to be eligible.

Eligible for Bridge Program Care Coordination? _____YES_____NO

The Bridge Program Care Coordination Plan

CLIENT NAME: _____

BEGIN DATE: _____**END DATE**: _____

DESIGNATED AGENCY: _____

CARE COORDINATOR: _____

1) SERVICE GOAL (see possible options attached)**:**

_____
_____
_____
_____

LINKAGE PLAN: _____
_____
_____
_____
_____

ANTICIPATED TIMEFRAME FOR COMPLETION: _____

EXTENSION: _____

FREQUENCY OF REVIEW OF PROGESS ON THIS GOAL (e.g. monthly, quarterly, annually)
_____

OUTCOME ACHIEVED:

_____
_____
_____
_____
_____

DATE: _____

2) SERVICE GOAL (see possible options attached)**:**

_____
_____
_____
_____

LINKAGE PLAN: _____
_____

_____
_____
_____

ANTICIPATED TIMEFRAME FOR COMPLETION: _____

EXTENSION: _____

FREQUENCY OF REVIEW OF PROGESS ON THIS GOAL (e.g. monthly, quarterly, annually)
_____

OUTCOME ACHIEVED:
_____
_____
_____
_____
_____

DATE: _____

3) SERVICE GOAL (see possible options attached)**:**
_____
_____
_____
_____

LINKAGE PLAN: _____
_____
_____
_____
_____

ANTICIPATED TIMEFRAME FOR COMPLETION: _____

EXTENSION: _____

FREQUENCY OF REVIEW OF PROGESS ON THIS GOAL (e.g. monthly, quarterly, annually)
_____

OUTCOME ACHIEVED:
_____
_____
_____
_____
_____

DATE: _____

4) SERVICE GOAL (see possible options attached)**:**

_____
_____
_____
_____

LINKAGE PLAN: _____

_____
_____
_____
_____

ANTICIPATED TIMEFRAME FOR COMPLETION: _____

EXTENSION: _____

FREQUENCY OF REVIEW OF PROGESS ON THIS GOAL (e.g. monthly, quarterly, annually)

_____

OUTCOME ACHIEVED:

_____
_____
_____
_____
_____

DATE: _____

SIGNED:

_____

CLIENT (suggested but not required if under 18)

_____

GUARDIAN

_____

CARE COORDINATOR/QDDP

Bridge Program Care Coordination activities for families/children may include, but are not limited to:

- Support to access appropriate school services
- Assistance accessing or maintaining Medicaid insurance
- Assistance with linking to mental health services, e.g. psychiatrists, psychologists, counselors, behavioral and crisis services
- Assistance with linking to medical services, e.g. dentist, doctors, specialists, OT, PT, Speech, home health or high tech services, etc
- Assistance linking to Children's Integrated Services teams (Family, Infant and Toddler Program, Healthy Babies Kids and Families, Children's Upstream Services)
- Assistance with linking to economic services, e.g. housing, food, fuel assistance, etc
- Assistance accessing Children's Personal Care Services including completing assessments/re-assessments and directing families to resources to find workers
- Assistance with linking to child care
- Assistance with linking to assistive technology resources and home accessibility modifications
- Assistance with linking to recreational resources, including summer camps
- Assistance with linking to adult services providers and other resources at transition from high school
- Assistance with linking to family support resources, e.g. Vermont Family Network, support groups
- Support to track and coordinate multiple services and supports
- Support to prepare for meetings with school personnel and/or other professionals

The Bridge Program Care Coordination Plan (CCP) Review Form

Client Name**:** _____

CCP Begin date**:** _____End date: _____

Date of Review:_____

Care Coordinator /QDDP Completing this form**:**_____
_____

What is the status of each service goal?
Goal 1:_____
_____
_____
_____
Goal 2:_____
_____
_____
_____
Goal 3:_____
_____
_____
_____
Goal 4:_____
_____
_____
_____

What are the individual's comments about his/her or satisfaction with the Bridge Program services? (not required for those under 18)_____
_____
_____
_____

What are the family's/guardian's comments about satisfaction with the Bridge Program services?_____
_____
_____
_____

What are the provider's comments?_____
_____
_____

Note: Complete a CCP change form if service goals are changed, dropped or added.

The Bridge Program Care Coordination Plan (CCP) Change Form

Client Name**:** _____

CCP Begin date**:** _____End date: _____

Effective Date of Change:_____

Care Coordinator/QDDP:_____

A. Goals dropped:_____
_____
_____

Reason dropped:_____

B. Goals added or modified:
S**ERVICE GOAL # ____**
_____
_____
_____
_____

LINKAGE PLAN: _____
_____
_____
_____
_____

ANTICIPATED TIMEFRAME FOR COMPLETION: _____

EXTENSION: _____

FREQUENCY OF REVIEW OF PROGESS ON THIS GOAL (e.g. monthly, quarterly, annually) _____

OUTCOME ACHIEVED:
_____
_____
_____

DATE ACHIEVED: _____

S**ERVICE GOAL # ____**
_____
_____
_____
_____

LINKAGE PLAN: _____
_____
_____
_____
_____
ANTICIPATED TIMEFRAME FOR COMPLETION: _____

EXTENSION: _____

FREQUENCY OF REVIEW OF PROGESS ON THIS GOAL (e.g. monthly, quarterly, annually) _____

OUTCOME ACHIEVED:
_____
_____
_____

DATE ACHIEVED: _____

C. Approval may be documented by signature or by noting date of approval via phone contact.

SIGNATURE OR DATEOF APPROVAL VIA PHONE

_____ _____
GUARDIAN

_____ _____
CLIENT (not required in under 18)

Frequently Asked Questions Regarding the Bridge Program

1. *Can a family receiving IFBS (Intensive Family Based Services) access the Bridge Program?*
   No, IFBS includes a case management component so a family cannot have IFBS and Bridge simultaneously. However, typically IFBS is a time-limited service, so if a child has been in Bridge and the family starts receiving IFBS, you can suspend Bridge and re-start it (if the child/family still have care coordination needs) once IFBS is no longer in place.

2. *What is the correct provider number to use for billing for the Bridge Program?*
   The Bridge Program is billed under the DA's current developmental disabilities services provider number. Your provider numbers all begin with 1001.

3. *What is the correct procedure code for Bridge Program services?*
   The procedure code for billing for Bridge services is T2022, modifier HW.

4. *Are only children with a specific type of Medicaid eligible for the Bridge Program?*
   No, children enrolled in either Medicaid Managed Care (PC+) or traditional fee-for-service Medicaid are eligible for Bridge.

5. *Can a child receive mental health clinic services and medication checks from the agency psychiatrist and still receive Bridge Program services?*
   Yes, children receiving therapeutic and psychiatric services from the mental health side of your DA may also be enrolled in Bridge. The therapist and/or psychiatrist should understand that they cannot bill for case management if the child has a Bridge care coordinator.

6. *What if the child is receiving Success Beyond Six (SBS) mental health/school services?*
   Success Beyond Six community skills work, family, group and individual therapy, transportation and crisis intervention services may all be billed concurrently with Bridge Program services. If the child has a home/school based clinician or SBS case manager who bills for case management and is providing that type of service to the child and family, you will not be able to bill Bridge concurrently.

7. *Can we enroll more individuals in Bridge than our contract stipulates, and not bill for every person each month?*
   Yes, this is acceptable practice since we recognize that some children/families may not require service every month. You may submit claims for more than the agreed upon number of individuals in your contract in a given month; however, you may not submit claims exceeding the total amount of your annual allocation. This should allow you flexibility in service delivery and billing each month.

8. *What should we do if a claim is submitted and denied by EDS?*
   Your billing manager should send an email to your DAIL Bridge Program contact (HC, LCC, NKHS, NCSS, WCMH to Clare, CA, CAP, HCRS, UCS, UVS to Amy) with as much information as possible about the claim, and we will research the problem with our EDS contact and get back to you.