Minnesota Health Care Programs

Children’s Mental Health
Crisis Response Services

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Minnesota Department of Human Services
Chemical and Mental Health Administration
Children’s Mental Health Division
PO Box 64985
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This information is available in alternative formats to individuals with disabilities by calling your agency at 651-431-2321. TTY users can call through Minnesota Relay at 800-627-3529. For Speech-to-Speech, call 877-627-3848. For additional assistance with legal rights and protections for equal access to human services benefits, contact your agency’s ADA coordinator.
To become a certified Crisis Response Service (CRS) agency, the agency must meet all applicable administrative and clinical infrastructure standards noted in Minnesota Statutes, section 256B.0944 and Medicaid related rules and laws. The agency demonstrates meeting administrative and clinical infrastructure and service delivery standards by submitting a CRS application that is approved by DHS.

Information submitted for review will vary depending upon the applicant’s organizational structure and written policies and procedures. Materials to be reviewed and submitted for primary application Part I and II minimally include:
- A completed and electronically signed application (including agreed to assurances and attachments) and
- A model CRS clinical case, including a Crisis Assessment, Crisis Plan, Progress Notes, and Crisis Plan Review.

If DHS is unable to determine that portions of the application meet requirements, applicants will receive a request for additional information. Applicant must respond within 60 days or a new application will be required.

Once Part I is approved applicants will be invited to submit the Model Clinical Case for Part II.

Agencies are asked to make responses either in the application or by including attachments. **All attachments must be labeled with the appropriate element name.** If more than one attachment per element is submitted, identify the attachment with a number. If an attachment is longer than one page, add page numbers at the bottom of each page.

The information included in this guide is intended to provide additional clarity or guidance for completing select sections in the CRS Primary Certification Application.

Read Children's Mental Health Crisis Response Services PRIOR to reading these instructions and completing the application.

Only sections that require more information are included in this document. The application and instructions should provide all of the information necessary to complete this certification process. However, if you have remaining questions, please contact John Kowalczyk at John.Kowalczyk@state.mn.us or 651-431-2335.

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**General Tools and Tips**

**General Information**
The application contains data fields that must be completed in order for the applicant to continue advancing through the application. Pop up boxes will contain instructions on how to complete the fields.

**Hyperlinks**
For your convenience there are hyperlinks throughout the application that will connect you to the relevant section of these instructions if additional guidance is provided. Simply click on the underlined text to view the information.

**Filling out fields**
A **radio button** is a type of graphical user interface element that allows the user to choose only one of a predefined set of options. These will appear as circles to the left of the text.

A **checkbox** is a graphical user interface element that permits the user to make multiple selections from a number of options. These will appear as square boxes to the left of the text.

For sections that have the option to **add and remove rows**, the button to add a row is and the button to remove a row is .

**Definitions and acronyms**
There is a list of [definitions](#) and [acronyms](#) that you might need to reference. It might be helpful to print this section of the guide for easy reference while completing the application.
**Section A. Agency Information**

**Name of agency**
Provide the legal name and business address of agency that will submit claims to Minnesota Health Care Programs (MHCP) for CRS. If an agency does business under a different name indicate the name.

**Name of contact person**
While many people will likely contribute to this application, identify the person primarily responsible for completing the application and his/her contact information. This is the person that can facilitate questions that DHS may have about the application.

**Accreditation or certification**
Agencies are not required to meet one of these certifications to be accredited for CRS certification.
Organizations may be able to demonstrate meeting some CRS administrative requirements if they are accredited or certified.

Check appropriate box and insert date of current accreditation or certification from:
- Joint Commission on the Accreditation of Health Organization (JCAHO)
- DHS Licensing as a Community Mental Health Center as defined by Minnesota Statutes 256B.0625, Subdivision 5, or as a Mental Health Clinic as defined by Minnesota Rules, parts 9520.0750 to 9520.0870
- DHS certification as a CTSS provider.

**Section B. Practice Site Information**

**Practice sites**
A practice location is a specific site or physical plant, where the agency provides CRS services. The main practice location should function as the agency’s record and documentation storage area and house most of the administrative functions for the agency. There is an expectation that the majority of CRS will be conducted at locations other than the main site.

Services delivered in the community should meet the same administrative and clinical standards as those in the main location.

A child’s home is a place of service but is not a practice site because other clients should not be receiving services in another child’s home.

A therapist’s vehicle is not a practice site or place of service.

**Community Based Services**
Agencies need to provide:
- Crisis Assessment
- Crisis Intervention
- Crisis Stabilization
Section C. Community Based Services

Identify each county where community based CRS will be delivered and check which services will be delivered in that county.

Administrative Infrastructure

While Minnesota Statutes 256B.0944 requires CRS policies and procedures to be pertinent to the delivery of CRS it mandates providers follow administrative and clinical infrastructure requirements defined in Children’s Therapeutic Services and Supports (CTSS). Minnesota Statutes 256B.0943, subd. 5 requires agencies to have an administrative infrastructure that includes critically important aspects of a business.

DHS expects agencies to have an administrative infrastructure that exceeds CRS certification requirements as the agency is only being asked to provide minimal information about basic policies that must be in place to be a provider under MHCP.

CRS Requirements

Written material must support descriptions of how the agency meets each requirement. Application responses must have enough information to demonstrate the agency has thought through various administrative functions and activities in enough detail to support the delivery of medically necessary, crisis services for the most common mental health needs.

Minnesota Statutes 256B.0943 states the provider’s written policies and procedures must be reviewed at a minimum of every three years. Any changes to policy and procedures must be distributed to staff and must be communicated to other affected parties in a consistent manner.

Policies are the principles, rules and guidelines adopted by an agency to reach it’s long-term goals. They are designed to determine all major decisions and activities within a defined area. Procedures are the specific methods or steps taken in an agency’s day-to-day operations. Policies and procedures need to stand apart from your CRS application, even if you develop them because you are applying to be a CRS provider. When Department staff ask to review your policies and procedures in future site visits, it will not be acceptable to identify the application materials as your policies and procedures for CRS.

Section D. Staff

Organizational chart

Develop an organizational chart that clearly outlines individuals responsible to deliver, supervise, or administer CRS. Indicate whether individual is employed full-time or part-time at agency. State how your organization defines part time and full time status.

For each mental health professional, mental health practitioner, and administrative staff identified in the chart, include the:

- Person’s name
- Title
- Show reporting relationships.

Depending on the size of the agency, there may be multiple pages needed for the organizational chart.
Mental Health Professionals (MHP)

**Mental Health Professional’s name**
Enter the full name of each MHP who is employed by or under contract with the agency.

**Licensure**
Indicate the MHP’s current licensure.

**MHCP Enrolled**
If MHP is not enrolled, go to the [provider enrollment](#) page on the DHS website.

**Sites**
Refer to Practice Sites table for the list of sites. Indicate the site(s) from that list, where the MHP provides services. For example, if a person works at three sites, find those locations on the Practice Sites table and list the name for each of those site(s).

**Clinical supervisor**
Is the MHP identified responsible to provide clinical supervision for any mental health practitioners? If yes, list the total number of mental health practitioners that the person supervises from all sites combined. This should include both part and full time staff.

Mental Health Practitioner

**Mental Health Practitioner’s name**
Enter the full name of each practitioner who is employed by or under contract with the agency.

**Sites**
Refer to Practice Sites table for the list of sites.

**Clinical Supervisor’s name**
Enter full name of MHP who provides the majority of clinical supervision.

Mobile Crisis Response Teams

Identify the number of crisis teams that will operate under this certification. A team includes at least two staff, at least one professional and one practitioner, who regularly work together to provide CRS in a given area. For example, if you have a different professional and practitioner serving specified areas, such as separate counties, each would be a different team.

Volunteers/Interns

If the applicant uses volunteers and/or interns to respond to crisis calls or provide services, the applicant needs to identify how they use volunteers and/or interns, the training provided, limitations on duties, and how the applicants insure that such persons complete a criminal background check.

Criminal background study

Submit applicant’s criminal background study policy and procedures.

There are many ways for an agency to be compliant with this requirement. For an agency to be approved they must have a standard procedure for all employees and must have disqualification standards that wouldn’t knowingly put other staff or clients at risk.

- Does the agency use the same standards for all employees, or are there different standards for different types of employee?
- Does the procedure identify the roles and responsibilities of those who carry out each procedure?
- Does the procedure identify criteria for disqualification from employment?

Disqualification standards may be different depending upon the population served by the agency. One set of standards used by DHS for the protection of children is for foster care providers under [Minnesota Statutes, section 245A.04](#), subdivision
3d. Agencies may choose to use these same standards or may decide to use a similar set of standards to meet the needs of their agency while still protecting the health and safety of the children they serve.

A typical background study might include, but is not limited to:
- Current and prior addresses for the past seven years
- Academic/education verification
- Driving history record
- Employment history in the last five years
- Professional licenses held (if applicable), county records for maltreatment reports and
- A sexual misconduct employer report with employers within the last five years, as outlined in Minnesota Statutes, sections 604.20 to 604.205 and criminal conviction record.

**Ethical conduct**

The term “ethics” has several definitions. They include: “the moral principles which determines the rightness or wrongness of particular acts or activities” and “the rules or standards governing the conduct of the members of a profession.” A Code of Ethics is defined as formal codes providing general prescriptive guidelines based on ethical principles that include sets of rules for behavior of individuals or groups. The code govern duties, responsibilities and the quality of the relationship between the client and the provider.

Submit procedure(s) for investigating, reporting and acting on violations of ethical conduct standards. Ethical conduct standards are not limited to licensing board or professional organization codes of ethics.

Agencies must have standard policy and procedure for all employees. The policy must be implemented in a timely manner in response to the magnitude of the violation. Procedure must address the following questions:
- Does the process explain and identify the steps involved in each of these activities?
- Using the submitted procedure can you answer the following:
  - How are violations reported?
  - Who are violations reported to?
  - What actions must be taken by the individual notified of the violations?
  - Who is responsible for the final resolution on violation?
  - What are the time frames for the activities in this process?

**Data privacy**

Submit procedure(s) for investigating, reporting and acting on violations of data privacy policies.

The time lines associated with these procedures must show implementation in a timely manner in response to the magnitude of the violation. Procedures must address the following questions:
- Does the process explain and identify the steps involved in each of these activities?
- Using the submitted procedure can you answer the following:
  - How are violations reported?
  - Who are violations reported to?
  - What actions must be taken by the individual notified of the violations?
  - Who is responsible for the final resolution on violation?
  - What are the time frames for the activities in this process?

The provider may want to view the Minnesota Data Practices Act when writing their procedures in addition to the Health Insurance Portability and Accountability Act of 1996. Providers who are not familiar with either of these should become familiar with them. An important link for provider research is the Center for Medicare and Medicaid Services (CMS) at www.cms.gov.
Overview
Describe the agency’s history of providing mental health services to children who meet the criteria of an emotional disturbance (ED), severe emotional disturbance (SED), mental illness (MI), or severe and persistent mental illness (SPMI). ED and SED criteria apply to children ages 0-17 while MI and SPMI criteria applies to youth ages 18-20. If the agency has a vision for expanding services or building relationships within the community, include that here. Include information about what kinds of mental health services the agency has provided previously and if CRS is an expansion of the services. If the agency has a mission specific to its CRS, include that in this section.

Discuss:
- The agency’s experience in planning and delivering mental health services
- How CRS services fit with the current set of mental health programs and services available now and in the future
- Areas for future improvements and/or possible service changes.

If the agency has not previously provided CRS, identify what steps the agency has taken to begin providing these services. Discuss why the agency is interested in offering these services now. Discuss the qualifications of the mental health staff who will provide CRS services for the agency, etcetera.

Family education
The response should identify what families are told about:
- Available services
- Service delivery
- Accessing services
- Addressing concerns about services received.

Family involvement
This question is about how parents influence the larger administrative planning process not the individual treatment planning process. Some examples might include a parent advisory committee, an annual parent survey about mental health services, focus groups before developing services, or parent opportunities for recommendations.

Cultural competency
Providing culturally competent services usually means an agency takes concrete steps to improve its ability to serve people from different backgrounds. It is not limited to English proficiency and those individuals requiring a language interpreter. The department developed Cultural Competence Guidelines identifying specific steps to achieve a culturally competent organization. All agencies are in various stages of cultural competency. See Cultural Competence Guidelines

This question is also referring to the larger administrative planning and implementation process. Some examples might include:
- Mental health staff have received training in: how cultures differ in how they understand mental illness
- Cultural differences in perceptions of “normal” behavior
- Cultural variance in the non-English language proficiency among mental health staff
- Ensuring that individuals representing cultures of children served are participants in advisory committees and focus groups
- Partnering with culturally based organizations.

The application requires an incremental plan that includes:
- evidence of community assessment
- agency self assessment
- goals and objectives for increasing cultural competency
- time frame for implementation
- responsible parties.
**Section F. Population**

**Count**
Please do not use census data for these questions, rather use data on the children receiving crisis services from the agency. If the agency did not provide crisis services previously or did not bill for any services to MHCP enter N/A in the box.

Children served through CRS through age 17, must at least meet the criteria for ED to qualify for MHCP reimbursement. Children age 18-21 must at least meet the criteria for MI to qualify for MHCP reimbursement.

**Current capacity**
DHS is attempting to gauge the total number of children who could receive CRS services during the next 12 months. This is simply an estimate based on whatever data or information the agency has available. DHS will not hold the agency accountable to an exact number, rather is looking at the capacity to provide crisis services to its clients.

**Section G. Partnerships**

**Formal contracted partners**
DHS needs to ensure that persons or organizations the agency contracts with are qualified and able to meet the statutory requirements for CRS services.

Agencies that contract CRS from another CRS certified provider must enter the agency or individual’s name. DHS will check the CRS application to ensure the agency(s) and available services are accurately reflected in each provider’s CRS application. If the other CRS certified provider did not include your agency and all services identified in the application, your application will be pended until the certified provider submits an addendum and receives approval.

Formal documentation may include written agreements or contracts specifying both the relationship and responsibilities of each party as it relates to the administrative and clinical infrastructure of the applicant. It is not necessary to submit contracts for contracted administrative service such as a CPA, attorney or billing agent.

**Section H. Billing Minnesota Health Care Programs**

Requirements for fiscal procedures ([Minnesota Statutes 256B.0943](https://www.leg.state.mn.us/statutes/chapter-256b.html)) include both internal fiscal control practices and a process for collecting revenue that is compliant with federal and state laws.

**Billing MHCP**
Agencies serving youth on MA fee-for-service (FFS) must enroll with MHCP in order to be reimbursed. Billing MHCP FFS requires electronic claim submission through MN–ITS. Many children with coverage from MA or MinnesotaCare receive their health care from a managed care organization (MCO). Mental health services for those families must be billed to the MCO not to DHS. Thus, for the agency to bill for covered services for these youth, the agency must become a provider for the health plan and/or receive authorization from the health plan MCO for these services.

**Insurance Verification**
Describe your medical insurance billing and collection process. The description must show how medical insurance (or claims for medical costs through auto insurance or worker compensation) information is collected, the kind of information collected, when the provider determines payment funding for services, how payment sources are verified and billed, follow up on unpaid claims, and revenue collection. The medical billing and collection process should be applied across the board (with limited exceptions).
Section 1. Communications

External Coordination

Service coordination is an important aspect of mental health treatment which supports consistency and improved treatment outcomes. Agencies may serve children who receive services from multiple providers such as:

- CTSS providers
- Mental health case managers
- Collaborative staff
- MHCP waivered service providers
- Child welfare case managers

The description must include:

- How data is collected, maintained and used. The process should describe: completion of form(s) by client, copying health insurance information, verifying third party payment eligibility (for MHCP client information may be verified through the Eligibility Verification System [EVS]), collecting payment (from Medicare, Medicaid, health plan, insurance company, county or another payer source)
- Who is responsible and accountable for the different parts of the process?
- Who is responsible for submitting actual claim and doing reconciliation?
- What is the process to ensure delivered service are accurately billed?
- Do identified billing activities clearly show who is accountable for collecting data so that an applicant is able to bill (multiple payers) for provided service?
- What is the billing and collection process for clients who cannot pay? (e.g. reduced fee, pro bono, or a referral to appropriate agency for health insurance coverage such as Minnesota Health Care Programs)

Providers should read Provider Basics, Billing Policy and Mental Health Services of the Minnesota Health Care Programs Provider Manual to gain an understanding of requirements for billing medical services (such as CTSS). Additionally, the provider should view the Provider Section of the DHS website to learn about the Minnesota Information Transfer System (MN–ITS) and provider training workshops.

MA Payment as Payment in Full

42 CFR 447.15. § 447.15 Acceptance of State payment as payment in full.

Federal law requires states to limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid to the agency plus any deductible, coinsurance or co-payment to be paid by the individual. However, the provider may not deny services to any eligible individual on account of the individual’s inability to pay the cost-sharing amount imposed by the managed care plan in accordance with §431.55(g) or §447.53. The previous sentence does not apply to an individual who is able to pay. An individual’s inability to pay does not eliminate his or her liability for the cost-sharing charge.

Agencies cannot seek additional payment from children, families, counties or others for MHCP covered services while the child was eligible. This includes but is not limited to:

- Staff supervision
- Meetings
- Staff training and education
- Building expenses
- Collateral contact, etc.

Minnesota Information Transfer System

Information about the MN–ITS and training workshops is available in the Provider Section of the DHS website.
Mental health staff should identify these types of connections and ensure services and goals are coordinated as necessary. A release of information form must be signed before communication between providers can be established.

Service coordination is also supported by developing knowledge of the local mental health service system and forming relationships with both formal and informal supports for children. This is important from a treatment perspective, as the agency will have a greater pool of knowledge to draw upon when developing the crisis plan and working with the child and family.

All providers are required to collaborate with local children’s mental health or family services collaboratives (if one exists). However, DHS strongly encourages all providers to collaborate with other mental health providers to the extent possible.

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**Section J. Mental Health Records**

**Forms**

Forms may include:
- Release of information/consent
- Data privacy
- Referrals
- Crisis
- Individualized crisis plan
- Progress notes/contact charting

**Security**

The response should include information about:
- Record storage
- Transporting records to off-site locations
- Staff positions with access to records
- Forms that document access and transporting of files.

It is critically important for DHS to ensure that private medical records are secure. Records must be stored in a safe place in case of a natural disaster or fire and protected from unauthorized access. Legally, CRS providers must meet both Minnesota Data Practices Act (Select Medical Data) and Health Insurance Portability and Accountability Act (HIPAA) requirements. Overall, this means that agencies providing CRS services must limit access to protected health information to those who need access to the records based on individual roles in the agency and also have written authorization that grants such access.

For more information about data privacy go to the DHS Data Practices Manual. The manual provides useful information and examples of public, private, and confidential data. There is also a very useful online training that DHS has made available regarding data privacy practices. To use the online training go to [https://hipaacourses.dhs.state.mn.us](https://hipaacourses.dhs.state.mn.us) and register as a guest (not an employee).

Adhering to the above data privacy laws may mean the agency has to make adjustments to mental health record procedures, storage, and computer access. Employees with certain responsibilities may need limited access to mental health records, while others will need access to the entire file.

Mobile crisis team members may bill for mental health provider travel time. MHCP Provider Manual – MH Provider Travel Time.
Section K. Quality Assurance

Quality Assurance
Describe quality assurance plan development, review and updating procedures. The information should include how the agency will integrate cultural and linguistic competence measures into ongoing performance measurement programs.

The submitted information must include:
- Existence of cultural and linguistic competency measures in performance improvement programs, satisfaction surveys, and client outcome evaluations.
- Demonstration that the provider agency collects the following data elements:
  - Race/ethnicity/tribe
  - Nation of origin
  - Length of time in U.S.
  - Preferred language
  - Client request for a culturally or linguistically specific provider.

Client Satisfaction
Describe the agency’s process for collecting information about client and family satisfaction with services. The description should include how often client satisfaction measures are administered and how the agency analyzes such data to improve agency practices and policy.

Client Outcomes
Describe how the agency collects data about client outcomes, including how the agency uses standardized measures such as the Strengths and Difficulties Questionnaire (SDQ) and Child and Adolescent Service Intensity Instrument (CASII) or Early Childhood Service Intensity Instrument (ECSII) information to improve clinical practices and policy.

Section L. Clinical Infrastructure

To verify the agency has a satisfactory clinical infrastructure, there is a two-part review process. First, the agency submits clinical policies and procedures in the Part I Application. After DHS approves Part I, instructions for Part II Model Case File will be e-mailed to the agency.

Agencies must meet all requirements and expectations in both Part I and Part II to receive certification for a one year period.

Prior to the end of the one year certification DHS will conduct a site visit to evaluate whether the agency continues to meet CRS standards.

The mental health professional should review this section carefully.

Crisis Assessment
Include or attach the applicant’s policies and procedures for complete a crisis assessment (CA) for a child or adolescent. See MHCP Provider Manual – CRS. Submitted information should describe standards for completing the CA and approval by the supervising mental health professional.

Functional Assessment Tools
If the applicant agency has the MHP use formal functional assessment tools (e.g., Child and Adolescent Service Intensity Instrument, Strengths and Difficulties Questionnaire) as part of the assessment of functioning for the CA, please list those in this section.
**Crisis Plan**

The plan identifies goals and objectives of treatment, treatment strategies, schedules for accomplishing treatment goals and objectives, the individuals responsible to provide treatment and how often the services will be provided. The plan must also target discharge date from the inception. It is generally expected that a crisis plan will cover crisis intervention for a period of 48 hours or less. If crisis stabilization services are offered, a crisis plan may cover a longer period.

The mobile crisis response team must develop a written crisis intervention plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The MHP must be consulted in person or via telephone within the first three hours when a mental health practitioner provides on site services.

The crisis plan must be approved by and signed-off by a MHP. The plan must include a signature line for both the child and parent(s) or other person(s) authorized to approve treatment, and indicate that the child/family has received a copy.

The crisis plan must:
- Be based on the information and outcome of the child’s crisis assessment
- Be developed through a child-centered, family-driven planning process
- Identify service needs which are individualized, planned and culturally appropriate
- Identify interventions which contain specific treatment goals and objectives for the child and the child’s family or foster family to resolve the crisis
- Signed by the child (as appropriate), the child’s parent, primary caregiver, or other person authorized by statute (Minnesota Statutes 256B.0943 and Minnesota Statutes 245.4871 subd. 16), to consent to mental health services for the child.

The submission must answer the following:
- How does the agency insure that the family is actively involved in the development of the crisis plan and possible follow-up services?
- How is the family’s culture and beliefs included and addressed in the crisis plan?
- Does the plan address specific individual treatment needs and services necessary for the child to function in the least restrictive home and community environment?
- Does the plan contain goals and objectives that are measurable?
- Do the goals and objectives realistically support the crisis resolution plan?
- Does the plan identify what coordination with other providers or agencies will take place?

**Progress notes/contact charting**

Documentation is critically important for several reasons. Documentation is important for staff supervision and evaluation, to transition new staff, to track and monitor clients’ actual progress, to evaluate treatment methods, and to request additional service hours for a client if necessary. Agencies and individual providers may be legally liable for mental health documentation in the event of an audit or lawsuit. Questionable or nonexistent documentation may have serious implications for the agency and individual’s reputation. For all of these reasons, documentation must be given ample care and attention.

The description should include required contents, allowable timeframe for completing documentation, signature requirements for each individual provider (licensure/job/title/etc.), procedures for mental health professional review and other documentation policies. The description should also include methods and frequency for training staff on these policies.

There may be other things to consider when developing documentation policies and procedures. Information in mental health records must be legible and readable (no cryptic notes). Record entries cannot be blacked out or otherwise eliminated from the record. Information in a record should not be changed unless the change is acknowledged in the record. White out should not be used in a record. This information is important for billing and especially important if the provider is involved in a civil or criminal matter.

CRS criteria also requires agencies to maintain progress notes for each face-to-face contact with children. Clinical supervision must also be documented.
Progress note documentation must include:
- Date on which entry is made
- Date on which the service was provided
- Actual time spent delivering service (start and stop time) it took to deliver service
- Travel time to provide the documented service
- Place of service
- Summary of the service and how it links to goals identified in the crisis plan
- Child’s response to the service
- Measurement of progress toward goals in the crisis plan
- Signature of the individual writing the note, including his/her title and credentials
- Specific service rendered date on which the entry is made.

Contact charting is used whenever the provider has contact regarding the child’s mental health status either directly or in phone consultation with others.

Note that while not all documented services are MHCP billable, it is important that all services provided be documented.

Crisis Plan review
Provide the applicant’s policy and procedure for reviewing the crisis plan, including determination of:
- The extent to which goals have been met or unmet and why
- If additional services remain necessary and documentation of referrals to services
- If the child is being discharged from crisis services.

Clinical supervision
Clinical supervision is the process of control and direction of a child’s crisis services by which a MHP accepts full professional responsibility for the supervisee’s actions and decisions, instructs the supervisee in his/her work, and oversees or directs the work of the supervisee. A clinical supervisor must be available for urgent consultation as required by the individual child’s needs or the situation.

The MHP who provides clinical supervision to mental health practitioners must also provide documentation by cosigning crisis plans and by making entries in the child’s mental health record about supervisory activities.

Clinical supervision:
- Does not include authority to make or terminate court-ordered placements
- May occur individually or in a small group
- Should be focused on the child’s treatment and review of progress toward goals.

The response should be a thorough description of clinical supervision practices. Discuss how the clinical supervisor provides oversight for assessment, service planning, and delivery of medically necessary services. Specify the supervisee’s role in supervision. Identify the frequency of clinical supervision for practitioners, how often child progress is reviewed in clinical supervision, the format used and/or what is typically discussed. Include information about how and who determines if a supervisee has adequate training to perform services. Include in the description how supervisee’s access supervisors if they provide services outside the agency’s normal hours of operation. Also, discuss how supervisors are involved in the development and implementation of aftercare planning.

Assurance Statements

Read each assurance statement and select the appropriate response. The response default is “No”; choose “Yes” for all assurance statements to which the agency agrees. Keep in mind that the policies and procedures required under the assurance statements must be immediately available upon request by DHS. If any assurance statements are not agreed to without adequate explanation, CRS certification will be denied.
Definitions

DHS
Minnesota Department of Human Services Children’s Mental Health Division, Children’s Crisis Response Services (CRS) certification team.

Emotional disturbance
An organic disorder, of the brain or clinically significant disorder of thought, mood, perception, orientation, memory or behavior that:
- Is listed in the clinical manual of the International Classification of Diseases (ICD-9 CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0 or the corresponding code in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III
- Seriously limits a child’s capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation.

Emotional disturbance is a general term and is intended to reflect all categories of disorder described in the DSM-MD as usually first evident in childhood or adolescence.

Medical necessity or medically necessary
A health service is consistent with the child’s diagnosis and:
- Is recognized as the prevailing standard or current practice by the provider’s peer group
- Is rendered in response to a life threatening condition or pain
- To treat an injury, illness or infection
- To treat a condition that could result in physical or mental disability
- To achieve a level of physical or mental function.

Mental health practitioner
Mental health practitioners providing services for the treatment of mental illness, who are not eligible for enrollment, must be under clinical supervision of a mental health professional and must be qualified in at least one of the following ways:
- Bachelor’s degree in a behavioral science/related field, from accredited college/university and
  - Completed 2000 hours of supervised clinical experience delivering clinical services to treat mental illness or children with emotional disturbances.

OR
- Bachelor’s degree in a behavioral science/related field, from accredited college/university and
  - Fluent in the dominant, non-English language of at least 50% of clients
  - Complete 40 hours of training and delivering services to clients with mental illness or children with emotional disturbances
  - Minimum of once-a-week clinical supervision
- Completed 6000 hours of supervised clinical services experience delivering mental illness treatment
- Enrolled graduate student in behavioral science/related field formally assigned to the center for clinical training by accredited college/university
- Obtained a Master’s degree/doctorate in a behavioral science/related field from accredited college/university and has less than 4,000 hour post-master’s experience in the treatment of emotional disturbance.

These MHCP practitioner level requirements apply to all crisis services.

Mental health professional
Each mental health professional must submit evidence of being licensed in one of the following ways:
- Licensed Psychologist (LP) – licensed under Minnesota Statutes 148.88 to 148.98, who has stated to the Board of Psychology competencies in the diagnosis and treatment of mental illness.
Psychiatrist – a physician licensed under Minnesota Statutes 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry.

Clinical Nurse Specialist – a registered nurse who is licensed to practice in accordance with the Minnesota Board of Nursing under Minnesota Statutes 148.171 to 148.285 and certified as a clinical nurse specialist in psychiatric or mental health nursing by a national nurse certification organization.

Nurse Practitioner (NP) – a registered nurse who is licensed to practice in accordance with the Minnesota Board of Nursing under Minnesota Statutes 148.171 to 148.285 and certified as a nurse practitioner in adult or family psychiatric nursing by a national nurse certification organization or

Licensed Marriage and Family Therapist (LMFT) – licensed under Minnesota Statutes 148B.29 to 148B.39 with at least two-years of post-master’s, supervised experience in the delivery of clinical services in the treatment of mental illness.

Licensed Professional Clinical Counselor (LPCC) under Minnesota Statutes 148B.50 to 148B.54.

Mental Illness (MI)
An organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory or behavior that is listed in the current edition of the ICD-9 CM, code range 290.0 to 302.99 or 306.0 to 316.0.

Severe Emotional Disturbance (SED)
A child who has an emotional disturbance and who meets one of the following criteria:

- Admitted or at risk of inpatient or residential treatment within the last three (3) years
- Minnesota resident and receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact
- A mental health professional has determined the child has one of the following:
  - Psychosis or clinical depression
  - Risk of harming self or others as a result of emotional disturbance
  - Psychopathological symptoms as a result of being a victim of physical/sexual abuse or psychic trauma within the past year

Severe and Persistent Mental Illness (SPMI)
The condition of an adult or child (at least 18 years of age) has a mental illness diagnosis and meets at least one of the following criteria:

- Undergone two or more episodes of inpatient care for mental illness within the preceding 24 months
- Experienced a continuous psychiatric hospitalization or residential treatment exceeding six (6) months duration within the preceding 12 months
- Diagnosis of schizophrenia, bipolar disorder, major depression or borderline personality disorder, evidences a significant impairment in functioning, and has a written opinion from a mental health professional stating he/she is likely to have future episodes requiring inpatient or residential treatment, unless community support program services are provided
- Committed by a court as a mentally ill person within the last three-years under Minnesota statutes or the adult’s commitment as a mentally ill person has been stayed or continued
- Was eligible under one of the above criteria, but the specified time period has expired
- Was eligible as a child with severe emotional disturbance, and has a written opinion from a mental health professional in the last three (3) years, stating that he/she is reasonably likely to have future episodes requiring inpatient or residential treatment of a frequency described in the above criteria, unless ongoing case management or community-support services are provided.

Acronyms

<table>
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<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>CTSS</td>
<td>Children’s Therapeutic Services and Supports</td>
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<td>CRS</td>
<td>Crisis Response Services</td>
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<td>DA</td>
<td>Diagnostic Assessment</td>
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<tr>
<td>DHS</td>
<td>Minnesota Department of Human Services</td>
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<td>ED</td>
<td>Emotional Disturbance</td>
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<td>IEP</td>
<td>Individual Education Plan</td>
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<td>MA</td>
<td>Medical Assistance</td>
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<td>MCO</td>
<td>Managed Care Organization</td>
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<td>MHP</td>
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