County: _____ **Date:** _____

☐ May 1st Submission (September 1st through February 28th Reporting Period)

☐ October 1st Submission (March 1st through August 31st Reporting Period)

Name and Contact Information County Child Welfare Department Representative					
Name:					
Title:					
Agency Name:					
Address:					
City:		State:		Zip Code:	
Phone:		E-mail:			

Name and Contact Information County Mental Health Department Representative					
Name:					
Title:					
Agency Name:					
Address:					
City:		State:		Zip Code	
Phone:		E-mail:			

County: _____ **Date: _____**

If your answer below is blank or zero, please provide an explanation.

PART A: Potential Subclass Members Identified During the Reporting Period			
Item #	**Information Requested**	**Column 1 Beneficiary Count**	**Column 2 Next Steps/Timelines**
1	Potential Subclass Members		
2	Potential Subclass Members who received a mental health assessment and do not meet medical necessity criteria for SMHS.		
3	Potential Subclass Members who have been referred to MHP for a full mental health assessment to determine medical necessity criteria for SMHS, and have not yet been assessed.		
4	Potential subclass members who were unknown to the MHP during the reporting period.		

County: _____ **Date: _____**

If your answer below is blank or zero, please provide an explanation.

PART B: Services Provided to Identified Subclass Members at Any Time During the Reporting Period			
Item #	**Information Requested**	**Column 1 Beneficiary Count**	**Column 2 Timelines**
1	Subclass Members		
2	Receiving Intensive Care Coordination (ICC).		
3	Receiving Intensive Home Based Services (IHBS).		
4	Receiving intensive Specialty Mental Health Services (SMHS) through a Wraparound Program or Full Service Partnership Program consistent with the Core Practice Model (CPM), but not claimed as ICC and IHBS. *Do not include youth already counted in 2 or 3 above.*		
5	Receiving other intensive SMHS, but not receiving ICC or IHBS. Examples of intensive SMHS may include: Therapeutic Behavioral Services (TBS), Intensive Treatment Foster Care (ITFC), or Multidimensional Treatment Foster Care (MTFC). *Do not include youth already counted in 2, 3, or 4*		
6	Receiving mental health services not reported in 2, 3, 4, & 5 above (include children who are receiving mental health services outside of the Medi-Cal mental health system, i.e. services paid for by private insurance or other sources).		
7	Not receiving mental health services (neither through Medi-Cal nor through any other program or funding source).		
8	Declined to receive ICC or IHBS.		

County: _____ **Date: _____**

If your answer below is blank or zero, please provide an explanation.

PART C: Projected Services			
Item #	**Service**	**Projected number of subclass members to be receiving services by August 31st**	**Strategy/Timeline Description** Provide County action steps and timelines to be used to provide (and claim for) ICC and IHBS to subclass members.
1 (a)	ICC		
1 (b)	IHBS		

Is your county experiencing the following implementation barriers?

Hiring	Yes	No
Training	Yes	No
Service Availability	Yes	No
County Contracting Process	Yes	No

Please provide an explanation for any Yes responses above. Are there other barriers not listed above? Explain and add pages, as needed.