

ATTACHMENT 2

I. ANNUAL COUNTY PROPOSAL *

Counties choosing to submit a proposal describing their proposed EPSDT expansion for the next fiscal year should submit the following information by **May 1, 1998** for Fiscal Year (FY) **1998/99** and by the first of May in future years. (This proposal would not be submitted once the fixed funding amount for this program is determined.)

Claims Estimate

Provide an estimate of the Medi-Cal claims for all nonhospital inpatient services for full scope Medi-Cal beneficiaries ages 0 to 21 for the new fiscal year. If the implementation of these services is expected to be phased in, provide estimates of expenditures for these services on a quarterly basis.

Service/Program Description

If the costs have increased significantly **from** the prior year, briefly describe any new services and the estimated number of new clients to be served.

- For those counties where there are city mental health programs, the county is expected to include any proposed increases in the city mental health programs in their proposals.

Other Funding Sources for Medi-Cal Matching Funds

Provide a description of any funds other than realignment or state managed care funds that will be used as local/state match for EPSDT services which are in excess of such amounts used in FY 1994/95. Such sources could include grants, state system of care funds, funds received from other county agencies, schools, etc. which were used to provide the local/state match for Medi-Cal services to EPSDT eligibles. Funds used for administrative/overhead costs, for services for beneficiaries other than full scope Medi-Cal eligible children, for **non-Medi-Cal** services for full scope Medi-Cal eligible children **and/or** where the revenue is used to reduce the cost of mental health services should not be included.

If a county had grant funds in FY **1994/95** that were used for local/state match for EPSDT services that have been reduced, the county should report that change and the base line will be adjusted accordingly. There will be no adjustments in the base line for reductions in funding **from** county agencies or the schools.

Signature and Contact Person

The **proposal shall be signed by a representative of the director** of the county mental health program. A person who should be contacted if further information or clarification is needed should be designated.

2. DMH REVIEW

DMH will review each proposal to determine reasonableness. Some of the factors DMH will take into consideration may include penetration rates (the percentage of beneficiaries who are eligible for services who actually receive services), cost per client, and other relevant factors. DMH will notify counties within one month of receiving the proposal of the results of the review and may follow up with the county to discuss local needs.

Sample EPSDT Proposal

XYZ County

FY 1998/99

1. Program Description

Claims Estimate

EPSDT claims are anticipated to be \$100,000 For FY 1998/99. Since services will be delivered in already existing programs with one exception, we do not anticipate much variation on a quarterly basis. The new program, therapeutic in-home support **services** For children in Foster care, will begin September 1, 1998.

Service Program Description

We have added a half-time social worker to provide therapeutic in-home supports for children in foster care. The estimated cost of the new service is \$25,000.

Other Funding Sources

In FY **1998/99**, it is anticipated **that the county** social services department will increase the county funds transferred to the county mental health department for Medi-Cal covered mental health services for **full** scope Medi-Cal beneficiaries who are in foster care from the FY **1994/95** level of \$5,000 to \$ 10,000.

Signature and Contact Person

John Z. Administrator 4/1/98

Contact: Joan Smith, Social Worker, **555-12 12**.