SECTION 5 – MEMORANDA OF UNDERSTANDING AND INTER/INTRA-AGENCY AGREEMENTS

General Instructions 2

California Children's Services (CCS) 2

Healthy Families Program: 2

Medi-Cal Managed Care Plans: 2

Special Education/Local Education Agency: 2

Other Programs: 2

Child Health and Disability Prevention Program (CHDP) 3

Department of Social Services: 3

Health Care Program for Children in Foster Care (HCPCFC): 3

Medi-Cal Managed Care Plans: 3

Other Programs: 3

Memorandum of Understanding California Children's Services Program/Healthy Families Program Plan 4

Delineation of Responsibilities for Children's Medical Services Branch, Regional Offices, and Dependent Counties as They Relate to the Healthy Families Memorandum of Understanding 7

County/City CHDP Program Model Interagency Agreement 10

Model HCPCFC Memorandum of Understanding 25

General Instructions

Please complete the Memoranda of Understanding (MOU)/Inter/Intra-Agency Agreements (IAA) listing to summarize all the MOUs and IAAs in your county/city program (see Section 2, page 14). MOUs and IAAs that are new, have been renewed, or have been changed should be submitted. If you are unsure, please check with your Regional Nurse Consultant.

California Children's Services (CCS)

Healthy Families Program:

Independent County Responsibilities: MOUs and procedures for implementation of MOUs between the county CCS program and the Healthy Families plan(s) must be on file at the county CCS office. Anytime a HF plan initially enters or re-enters a county, a signed MOU is required and procedures must be developed with the HF plan for implementing the MOU. **MOUs that have already been signed with the existing plans should remain the same.** It is appropriate that all staff who coordinate with the plans are aware of this document and periodically review it.

Dependent County Responsibilities: MOUs and procedures for implementation of MOUs between the county CCS program, the CMS Branch and Regional Offices, and the HF plan(s) must be on file at the county CCS office. Anytime a HF plan initially enters or re-enters a county, a signed MOU is required and the procedures that were developed by the CMS Branch must be shared with the HF plan(s) for implementing the MOU. MOUs that have already been signed with the existing plans should remain the same. It is appropriate that all staff who coordinate with the plans are aware of this document and periodically review it.

Counties that use one MOU for both Medi-Cal and Healthy Families may revise the MOUs as necessary.

Medi-Cal Managed Care Plans:

MOUs between the plans in the 12 two-plan model and the Geographic Managed Care (GMC) counties must have an approved MOU on file. The approval comes from the Medi-Cal Managed Care Division. If the MOU is not yet approved, the county should develop and submit a workplan to complete the MOU.

Counties with County Organized Health Systems (COHS) are strongly encouraged to negotiate a MOU with the Medi-Cal Managed Care Plan(s) in their jurisdiction.

Special Education/Local Education Agency:

An IAA is required between the county CCS Medical Therapy Program and the Local Education Agency (LEA) or Special Education Local Planning Area (SELPA). The IAA delineates responsibilities such as, but not limited to, appointment of liaison positions, referral and exchange of information, participation in Individual Education Planning Meetings, and Medical Therapy Unit requirements for space, operations, and supplies.

Other Programs:

Include other agreements such as Regional Centers, Early Start, etc.

Child Health and Disability Prevention Program (CHDP)

Department of Social Services:

An IAA between the local Child Health and Disability Prevention (CHDP) program and the Department of Social Services (DSS) is required every two fiscal years. A model format is provided in this section that reflects the minimum requirements (see page 10). *Please describe local needs and policies where words appear in Italics.*

Sample forms referenced in the IAA specific to the CHDP Program and used by the DSS, such as the CHDP Referral Form (PM 357), can be found in Section 9 - References. The name of the local health jurisdiction and the effective dates of agreement are to be listed on each page of the IAA and must correspond to the signature page.

Health Care Program for Children in Foster Care (HCPCFC):

A MOU among health, welfare, and probation departments in each county is required for the continued operation of the HCPCFC at least biennially. The MOU delineates the roles and responsibilities of the PHN, Social Worker, and Probation Officer in the HCPCFC.

The HCPCFC MOU may be referred to in the IAA between the CHDP Program and the DSS. A model MOU for the HCPCFC is located in this section beginning on page 25. The name of the local health jurisdiction and the effective dates of agreement are to be listed on each page of the MOU and must correspond to the signature page.

Medi-Cal Managed Care Plans:

Local CHDP programs in the 12 Managed Care Expansion Counties must have in place a **current** negotiated MOU with each of the Medi-Cal Managed Care Plans in their jurisdiction.

Local CHDP programs in other counties implementing Medi-Cal Managed Care are strongly encouraged to have in place a negotiated MOU with the Medi-Cal Managed Care Plan(s) in their jurisdiction.

Other Programs:

Any revised interagency/interprogram agreements with the Women, Infants, and Children (WIC) Supplemental Nutrition Program, the Childhood Lead Poisoning Prevention Program (CLPPP), the Adolescent Family Life Program (AFLP), Head Start, or any other program, should also be attached to the Plan.

Memorandum of Understanding California Children's Services Program/Healthy Families Program Plan

County/City: Effective Dates:

Service	Health Plan Responsibilities	CCS Program Responsibilities
Liaison	• Designate a liaison to CCS and/or require plan networks to designate a liaison to coordinate and track referrals. • Meet, at a minimum, quarterly to ensure ongoing communication; resolve operational and administrative problems; and identify policy issues needing resolution at the management level.	• Designate a liaison to the plan who will be the program's point of contact for the health plan and its networks to coordinate all related activities. • Meet, at a minimum, quarterly, to ensure ongoing communication; resolve operational and administrative problems; and identify policy issues needing resolution at the management level.
Provider Training	• Develop policies and procedures that will ensure that providers are informed of CCS eligibility requirements and the need to identify potentially eligible children and refer to the CCS program. • Provide multiple initial training opportunities, in conjunction with the local CCS program, for primary care providers, including organized provider groups and support staff, in order to ensure awareness and understanding of the CCS program and eligibility requirements. • Collaborate with CCS to develop training materials that will assure that primary care providers, specialty providers, and hospitals understand the respective responsibilities of the health plan and the CCS program in authorizing services for subscribers with CCS-eligible conditions. • Maintain training opportunities on, at least, an annual basis.	• Collaborate with plan to assist with the development of CCS related policies and procedures, as needed by health plan and CCS. • Collaborate with health plan to provide multiple initial training opportunities that will give providers an understanding of the CCS program and eligibility requirements. • Provide availability of local program medical consultant or designee to consult with primary care providers and/or specialty providers on a case-by-case basis. • Support ongoing training opportunities as needed.
CCS Provider Network	• Develop a process to review plan providers for qualifications for CCS provider panel participation and encourage those qualified to become paneled. • Identify in training to providers and in the provider manual those facilities that are CCS approved, including hospitals and Special Care Centers. • Ensure access for diagnostic services to appropriate specialty care within the network or medical group. When appropriate specialist not available within network or medical group, ensure access to appropriate plan specialist.	• Provide plans with CCS provider applications to expedite the paneling or approval of specialty and primary care network providers. • Coordinate with the CMS Branch to assure identification of local CCS provider network to health plan. • Coordinate with plan to refer to an appropriate CCS paneled specialty provider to complete diagnostic services and treatment as needed.

County/City: Effective Dates:

Service	Health Plan Responsibilities	CCS Program Responsibilities
Case Identification and Referral	• Develop procedures, in conjunction with the local CCS program, for plan or provider to submit the necessary documentation to determine medical eligibility at the time of referral. • Develop procedures to specify that providers are to refer a subscriber to the CCS program within two days of a suspicion of the presence of a CCS eligible condition. (Referral date will identify the earliest possible date from which medically necessary services may be approved.) • Inform families of subscribers of referral to the CCS program and the need to have care under the direction of an appropriate CCS paneled physician once program eligibility has been determined. • Arrange for medically necessary care during the period after referral and prior to the CCS eligibility determination. (Medically necessary services provided by a CCS paneled provider during the interim may be authorized by the CCS program for a condition determined to be CCS eligible.) • Develop with network designees, where applicable, a monthly tracking list to include: name of referred subscriber; address and telephone number; birth date; social security number (if known); plan eligibility status; primary care provider name, address, and telephone number; and plan number and enrollment /disenrollment dates to be used for coordination and follow-up with the local CCS program.	• Provide technical assistance to plans for the development of plan policies, procedures, and protocols for making referrals to the program, including necessary medical documentation. • Determine medical eligibility within five working days of receiving adequate medical documentation of the suspicion of a CCS eligible condition. • Ensure that provider, designated plan personnel, and subscriber family are informed of either program eligibility or denial upon eligibility determination. Provide medical consultation as appropriate during the time period from referral to medical eligibility determination. • Authorize from referral date medically necessary CCS benefits required to treat a subscriber's CCS eligible condition and be responsible for the reimbursement of care to authorized providers when CCS eligibility is established. • Coordinate with plan liaison and network designees to share a tracking list of CCS eligibles who are known to the plans. The list will include name, CCS case number, birth date, social security number (if known), CCS eligible diagnoses, date of eligibility and status; in case of denial or closure, reason for ineligibility and date closed; referral source and primary care provider on file, if known.
Case Management/Tracking and Follow-Up	• Utilize tracking system to coordinate health care services for members receiving services authorized by the CCS program. • Develop policies and procedures that specify providers' responsibility for coordination of specialty and primary care services and ensure that CCS eligible children receive all medically necessary pediatric preventive services, including immunizations. • Develop policies and procedures that specify coordination activities among primary care providers, specialty providers, and hospitals and communication with CCS program case managers.	• Assist plan in assessing, and alleviating barriers to accessing primary and specialty care related to the CCS eligible condition. Assist subscriber/subscriber family to complete enrollment into the CCS program. • Provide case management services in order to coordinate the delivery of health care services to subscribers with CCS eligible conditions, including services provided by other agencies and programs, such as Local Education Agencies and Regional Centers. • Develop systems that result in transmission of medical reports of services provided by CCS authorized providers to the appropriate plan primary care providers.

County/City: Effective Dates:

Service	Health Plan Responsibilities	CCS Program Responsibilities
Quality Assurance and Monitoring	• Conduct jointly with the CCS program, regular reviews of policies and procedures related to this agreement. • Participate, at a minimum, in quarterly meetings with the CCS program to update policies and procedures as appropriate. • Review and update protocols annually in conjunction with the CCS program. • Develop work plan, in conjunction with CCS, that will monitor the effectiveness of the MOU and the plan/CCS interface.	• Conduct jointly with the plans, regular reviews of policies and procedures related to this agreement. • Participate, at a minimum, in quarterly meetings with the plan to update policies and procedures as appropriate. • Review and update protocol on an annual basis in conjunction with the health plan. • Develop work plan, in conjunction with the plan, to monitor the effectiveness of the MOU and the plan/CCS interface.
Problem Resolution	• Assign appropriate health plan management/liaison staff to participate with the local CCS program management and professional staff in the resolution of individual subscriber issues as they are identified. • Assign appropriate health plan management/liaison staff to participate in, at a minimum, quarterly meetings to identify and resolve operational and administrative issues, including coordination, communication, referral, training, billing, provision of appropriate services, and authorization of services. • Refer issue to the appropriate CMS Regional Office if problem cannot be resolved locally.	• Assign appropriate CCS program management and professional/liaison staff to participate with health plan management staff in the resolution of individual subscriber issues as they are identified. • Assign appropriate CCS program/liaison staff to participate in, at a minimum, quarterly meetings with health plan management/liaison staff to identify and resolve operational and administrative issues, including coordination, communication, referral, training, billing, provision of appropriate services, and authorization of services. • Refer issue to CMS Regional Office if problem cannot be resolved locally.

Signatures of the undersigned indicate intent to develop policies and procedures that will successfully develop the local CCS and Healthy Families Program interface.

County CCS Administrator — Date

Plan Designee — Date

Luis Rico — Date
Children's Medical Services Acting Branch Chief

Delineation of Responsibilities for Children's Medical Services Branch, Regional Offices, and Dependent Counties as They Relate to the Healthy Families Memorandum of Understanding

County/City: Effective Dates:

Service	CCS Program Responsibilities	CMS Branch, Regional Offices, and Dependent County CCS Program Responsibilities
Liaison	• Designate a liaison to the plan, who will be the program's point of contact for the health plan and its networks to coordinate all related activities.	• Regional Office will designate a liaison as lead for their responsibilities as identified in the CCS case management procedure manual. Each dependent county will also designate a liaison to work with the plan.
	• Meet, at a minimum, quarterly, to ensure ongoing communication; to resolve operational and administrative problems; and identify policy issues needing resolution at the management level.	• CMS Branch staff, one representative from Regional Office and designated dependent county representative(s).
Provider Training	• Collaborate with plan to assist in the development of CCS related policies and procedures as needed by health plan and CCS.	• Regional Office and dependent county CCS program (joint)
	• Collaborate with health plan to provide multiple initial training opportunities that will give providers an understanding of the CCS program and eligibility requirements.	• Regional Office and dependent county CCS program (joint)
	• Provide availability of local program medical consultant or designee to consult with primary care providers and/or specialty providers on a case-by-case basis.	• Regional Office
	• Support ongoing training opportunities as needed.	• Regional Office and dependent county CCS program (joint)
CCS Provider Network	• Provide plans with CCS provider applications to expedite the paneling or approval of specialty and primary care network providers.	• Dependent county CCS program
	• Coordinate with the State office to assure identification of local CCS provider network to health plan.	• Dependent county CCS program
	• Coordinate with plan to refer to an appropriate CCS-paneled specialty provider to complete diagnostic services and treatment as needed.	• Regional Office and dependent county CCS program (joint)

County/City: Effective Dates:

Service	CCS Program Responsibilities	CMS Branch, Regional Offices, and Dependent County CCS Program Responsibilities
Case Identification and Referral	• Provide technical assistance to plans for the development of plan policies, procedures, and protocols for making referrals to the program including necessary medical documentation.	• Regional Office
	• Determine medical eligibility within five working days of receiving adequate medical documentation of the suspicion of a CCS-eligible condition.	• Regional Office
	• Ensure that provider, designated plan personnel, and subscriber family are informed of either program eligibility or denial upon eligibility determination.	• Regional Office and dependent county CCS program (joint), as per CCS Case Management Procedure manual
	• Provide medical consultation as appropriate during the time period from referral to medical eligibility determination.	• Regional Office
	• Authorize, from referral date, medically necessary CCS benefits required to treat a subscriber's CCS-eligible condition and be responsible for the reimbursement of care to authorized providers when CCS eligibility is established.	• Regional Office
	• Coordinate with plan liaison and network designees to share a tracking list of CCS eligibles who are known to the plans. The list will include name, CCS case number, DOB, SSN (if known), CCS eligible diagnoses, date of eligibility, and status; in case of denial or closure, reason for ineligibility and date closed; referral source and primary care provider on file, if known.	• CMS Branch
Case Management/Tracking and Follow-Up	• Assist plan in assessing and alleviating barriers to accessing primary and specialty care related to the CCS-eligible condition. Assist subscriber/subscriber family to complete enrollment into the CCS program.	• Regional Office and dependent county CCS program (joint)
	• Provide case management services in order to coordinate the delivery of health care services to subscribers with CCS-eligible conditions, including services provided by other agencies and programs, such as Local Education Agencies and Regional Centers.	• Regional Office and dependent county CCS program (joint)
	• Develop systems that will result in transmission of medical reports of services provided by CCS-authorized providers to the appropriate plan primary care providers.	• Regional Office

County/City: Effective Dates:

Service	CCS Program Responsibilities	CMS Branch, Regional Offices, and Dependent County CCS Program Responsibilities
Quality Assurance and Monitoring	• Conduct, jointly with the plans, regular reviews of policies and procedures related to this agreement.	• CMS Branch and designated dependent county representative (joint) with CMS Branch as lead
	• Participate, at a minimum, in quarterly meetings with the plans to update policies and procedures as appropriate	• CMS Branch and designated dependent county representative (joint) with CMS Branch as lead.
	• Review and update protocol on an annual basis in conjunction with the health plan.	• CMS Branch and designated dependent county representative (joint) with CMS Branch as lead.
	• Develop work plan in conjunction with the plans that will monitor the effectiveness of the MOU and the plan/CCS interface.	• CMS Branch and designated dependent county representative (joint) with CMS Branch as lead.
Problem Resolution	• Assign appropriate CCS program management and professional/liaison staff to participate with health plan management staff in the resolution of individual subscriber issues, as they are identified.	• Regional Office
	• Assign appropriate CCS program/liaison staff to participate in, at minimum, quarterly meetings with health plan management/liaison staff to identify and resolve operational and administrative issues, including coordination, communication, referral, training, billing, provision of appropriate services and authorization of services.	• Regional Office will refer to CMS Branch, Program Standards, and Quality Assurance Section if issue cannot be resolved.
	• Refer issue to CMS Regional Office if problem cannot be resolved locally.	• Regional Office will refer to CMS Branch, Program Standards, and Quality Assurance Section if issue cannot be resolved.

Signatures of the undersigned indicate intent to develop policies and procedures that will successfully develop the local CCS and Healthy Families Program interface.

County CCS Administrator — Date

Plan Designee — Date

Luis Rico — Date
Children's Medical Services Acting Branch Chief

County/City CHDP Program Model Interagency Agreement

Fiscal Years ____ to ____

(Please describe local needs and procedures where words appear in *Italics*.)

I. Statement of Agreement

This statement of agreement is entered into between *(Name of Health Department)* and *(Name of Social Services Department)* to assure compliance with Federal and State regulations and the appropriate expenditure of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) funds in the implementation of the Child Health and Disability Prevention (CHDP) Program.

II. Statement of Need

The following specific needs in (*County/City*) have been identified by the Health and Social Services departments as a focus for FY ____-____.

Specify, for example:

A. *Need for increasing the number of referrals for CHDP services using a variety of modalities including continuing staff education for the purposes of increasing referrals and identifying children's health conditions for which to seek consultation and coordination by trained health professionals*.

B. Need for increasing the number of children ages 0 to 21 years receiving health assessments.

C. Need for increasing coordinated, comprehensive, and culturally competent services for children living in foster care (relative/kinship, foster family homes, group homes, etc.) including CHDP health assessment services and necessary diagnostic and treatment services.

D. Gaps in existing program.

E. Objectives for the year(s) of the agreement that represent joint activities of the health and social services departments.

F. Need for consultation and information about CHDP resources and general public health services in child care settings.

G. Need for involvement of other community organizations in the program, e.g., advocacy groups.

H. Need for evaluation of reporting systems in health and social services departments.

I. Need for coordination with local Medi-Cal Managed Care Plans, where appropriate.

County/City: _____ Effective Dates: _____ to _____

J. Other, such as changes in State or Federal regulations.

III. Organizational and Functional Relationships

A. The exchange of information about persons applying for or receiving Medi-Cal, with or without linkages to other social services programs as outlined in this document, is permitted by State and Federal law and regulations, and is to be maintained in a confidential manner.

B. *Attach organizational charts* to display important points of interface between CHDP and Social Services programs and personnel.

1. *The relationship between administrative staff of the CHDP Program and the DSS*.

2. *Health system interrelationships*.

3. *Social services system interrelationships*.

4. *Social services system relationship to probation departments, licensed adoption agencies, and placement agencies*.

5. *Relation of EPSDT unit(s) to departments named in number "4"*.

6. *Reporting relationship of EPSDT unit to CHDP Director*.

7. *Designation, by name, title, and location (address) of liaison personnel from Departments of Social Services and Health Care Services*.

8. *Health Care Program for Children in Foster Care*.

C. *Attach flow charts to depict the CHDP process of informing from availability of health care, preventive care, through diagnosis and treatment for the following*:

1. California Work Opportunity and Responsibility to Kids (CalWORKs) Families, In-person Application/Annual Re-determination.

2. Medi-Cal

   a. In-person Application/Annual Re-determination (if requested)

   b. Mail-in Application/Re-determination

3. Children Placed in Foster Care

Indicate departmental responsibility for each step.

IV. Social Services Department Responsibilities and Activities

A. Basic Informing and Documentation of Informing for CalWORKs or Medi-Cal.

Following are the requirements for Basic Informing and Documentation of Informing by Eligibility Determination staff for persons applying for, or receiving, CalWORKs or Medi-Cal.

Describe procedures for informing the responsible adult who is blind, deaf, illiterate, or does not understand the English language. Include one or more specific methods for informing each identified group with special communication needs.

1. In-person Application/Annual Re-determination

   a. In the requested face-to-face eligibility intake interview or at the time of the annual re-determination, the appropriate adult(s) responsible for Medi-Cal eligible persons, including unborn, and persons under 21 years of age will be:

      1) Given a State-approved brochure about the CHDP Program.

      2) Given an oral explanation about CHDP including:

         a) The value of preventive health services and the differences between episodic and wellness care;

         b) Availability of health assessments;

         c) Availability of dental services;

         d) The need for prompt diagnosis and treatment of suspected conditions to prevent disabilities and that all medically necessary diagnosis and treatment services will be paid for by Medi-Cal; and

         e) The nature, scope, and benefits of the CHDP Program.

      3) Asked questions to determine whether:

         a) More information about CHDP Program services is wanted;

         b) CHDP Program services - medical and/or dental - are wanted; and

         c) If appointment scheduling and/or transportation assistance are needed to obtain requested CHDP medical and/or dental services.

   b. The Eligibility Determination staff will document on the *designated form and/or the case narrative, as appropriate, (please specify,*

e.g., JA2, SAWS2, MC 210, MC 210 RV) using automated or non-automated systems (please specify) that **face-to-face** informing occurred:

1) Explanation and brochure given;

2) Date of the explanation and giving of the brochure; and,

3) The individual responses to the CHDP service questions.

NOTE: The JA2 form is obsolete but if still in use by the county the requirements in this section still apply.

2. Mail-in Application/Annual Re-determination - Medi-Cal

a. Responsible adult(s) for Medi-Cal eligible persons under 21 years of age who apply by mail will do so through completion of a State-approved Medi-Cal Application/Annual Re-determination form. The Application/Annual Re-determination process includes the mailing of a State-approved brochure about the CHDP Program to the applicant. The State-approved brochure about the CHDP Program, entitled "Medical and Dental Health Check-Ups," informs the family of where to call or write if:

1) More information about CHDP Program services is wanted; or

2) Help with getting an appointment and transportation to medical care is needed.

b. Eligibility Determination staff will document on the *designated form and/or the case narrative, as appropriate, (please specify, e.g., MC 321 HFP or Healthy Families Annual Eligibility Review (AER) Form; MC 210 RV or in the case record if any follow-up action is required)*.

NOTE: Any "Yes" response to the CHDP questions or offer of services through face-to-face encounters or mail-in applications requires a referral on the CHDP Referral Form (PM 357), or State-approved alternate referral form. *If using an alternate referral form, indicate name and number and date of approval.* See CHDP Program Letter No. 81-5/DSS All County Letter No. 81-43. *Cite the form title and number of your county's State-approved, alternate form*.

B. Basic Informing and Documentation of Informing for Children in Foster Care Program Placement

Following are the requirements for Basic Informing and Documentation of Informing by staff responsible for placement of children in foster care, including

placements controlled by the Probation Department, Licensed Adoption Agency, and/or Placement Agencies.

1. Within 30 days of placement, the staff responsible for placing the child (i.e., social worker, probation officer) will document the need for any known health, medical, or dental care and ensure that information is given to the payee, hereafter referred to as the substitute care provider, about the needs of the eligible person and the availability of CHDP services through the CHDP Program. In the case of an out-of-state placement, the social worker shall ensure information is given to the substitute care provider about the Federal EPSDT services. The substitute care provider and/or child will be:

    a. Given a State-approved brochure about CHDP services and information about the child's need of preventive health care; and

    b. Given a face-to-face oral explanation about CHDP, including:

        1) The value of preventive health services and the differences between episodic and wellness care;

        2) The availability of health assessments according to the CHDP periodicity schedule, and how to obtain health assessments at more frequent intervals if no health assessment history is documented or the child has entered a new foster care placement;

        3) The availability of annual dental exams for children one year of age and older;

        4) The need for prompt diagnosis and treatment of suspected conditions to prevent disabilities and that all medically necessary diagnosis and treatment services will be paid for by Medi-Cal; and

        5) The nature, scope, and benefits of the CHDP Program.

    c. Asked questions to determine whether:

        1) More information about the CHDP Program is wanted;

        2) CHDP Program services - medical and/or dental - are wanted; and

        3) If appointment scheduling and/or transportation assistance is needed to obtain CHDP medical and/or dental services.

2. The Child Welfare Services staff responsible for placement will document the substitute care provider's response to the questions in the CHDP Program area of the Identification Page in the Placement Notebook in the

Placement Management Section in the Client Services Application on the Child Welfare Services/Case Management System (CWS/CMS):

a. Date care provider was informed of the CHDP Program and brochure given; and

b. Care provider's request for CHDP services.

3. The Probation Department, Licensed Adoption Agency, or other Placement Agency staff responsible for placement will document the substitute care provider and/or child's response to the CHDP questions on the CHDP Referral Form (PM 357) and maintain a copy in the case record.

NOTE: Any "Yes" response to the CHDP questions or offer of services requires a referral on the CHDP Referral Form (PM 357). See CHDP Program Letter No. 81-5/DSS All County Letter No. 81-43. A copy of the Referral Form is to be maintained in the child's case record.

4. A "payee," referred to as the "out-of-home care provider" or "substitute care provider," is defined as the foster parent(s) in a foster home, the officially designated representative of the payee when the child is in the foster care program, or a Medi-Cal eligible child residing in a group home, residential treatment center, or other out-of-home care facility.

5. Child Welfare Services staff responsible for the child in a foster care placement will complete annual informing of the care provider/child. They will include information about CHDP preventive health services, unmet health care needs requiring follow up, and a review of the child's access to a primary care provider according to the process outlined for initial informing in B.1. a – B.1.c; and will document the results of informing in the case plan update.

6. The Probation Department, Licensed Adoption Agency, or other Placement Agency staff responsible for placement will complete annual informing and the documentation of that informing according to the outline in B.1 and B.3.

7. Describe the procedures used by the DSS for ensuring satisfactory initial and annual informing on behalf of children in the Foster Care program or Medi-Cal eligible children when the placement responsibility is controlled by the probation department or any other social agency such as licensed adoption agencies, and/or placement agencies. Include any interagency agreements developed for this assurance if they are available.

8. Describe procedures for ensuring that informing about the need for a CHDP exam and the health status of children in the Foster Care program and/or Medi-Cal eligible children is provided at the time of out-of-home placement with a relative, *or upon return of the child to the parent(s)*.

County/City: _____ Effective Dates: _____ to _____

9. Describe procedures for assuring that substitute care providers/payees responsible for children placed in foster care out-of-county are properly informed about CHDP services.

C. Referral to the EPSDT Unit of the CHDP Program

1. All "Yes" responses to the offers of more information about CHDP, CHDP medical/dental services, and appointment scheduling/ transportation assistance will be documented on a CHDP Referral Form (PM 357), or a State-approved alternate referral form. The Referral Form will be sent to the *EPSDT Unit of the CHDP Program*. This action is required to ensure these services are received and that any necessary diagnostic and/or treatment services are initiated within 120 days of the date of eligibility determination for persons receiving assistance through CalWORKs or Medi-Cal, and within 120 days of the date of request for children in foster care placement.

2. *Describe the process for referrals indicated by "Yes" responses from persons, children, or care providers to the offers of more information about CHDP, CHDP medical/dental services and appointment scheduling/ transportation assistance when the child is a member of a Medi-Cal Managed Care Plan*.

3. *Describe procedures for assuring that children in foster care placed out-of-county are properly referred for CHDP services*.

4. Referral requirements described in C.1 and C.2 above also apply to children in foster care placement controlled by the probation department, licensed adoption agency, and/or a placement agency. *Describe the procedures used by the DSS to assure that proper referrals are made by the probation department, licensed adoption agencies, and/or placement agencies. Include any interagency agreements developed for this assurance if they are available*.

D. Information Provided by Social Services Staff on the CHDP Referral Form (PM 357) or State-Approved Alternate Referral Form

The following will be included on the referral form when any "Yes" response is given, written or verbal, to the offer of services:

1. Case Name and Medi-Cal Identification Number.

2. Type of services requested:

   a. Additional information

   b. Medical services

   c. Dental services

d. Transportation assistance

e. Appointment scheduling assistance

3. Source of referral:

a. New application

b. Re-determination

c. Self-referral

4. Case type:

a. CalWORKs (on existing form as AFDC)

b. Foster Care

c. Medi-Cal Only (Full Scope, Limited Scope with or without a Share-of-Cost)

5. Complete listing of members in case with birth dates including unborn and the expected date of confinement (EDC)

6. Listing of the payee/substitute care provider and child in foster care

7. Residence address and telephone number

8. Eligibility Worker signature

9. Date of eligibility determination for CalWORKs and Medi-Cal only cases or date of request for children in Foster Care and self-referrals

E. Care Coordination for Children in Foster Care

1. The staff responsible for placement of the child will ensure that the child receives medical and dental care that places attention on preventive health services through the CHDP Program, or equivalent health services in accordance with the CHDP Program's schedule for periodic health and dental assessments. More frequent health assessments may be obtained for a child when the child enters a new placement. Another health assessment may be claimed through CHDP by entering "New Foster Care Placement" in the Comments/Problems are of the Confidential Screening/Billing Report (PM 160). (For example: if there is no record documenting a health assessment during the child's previous placement, if the child is not performing age-expected developmental skills, or if he/she has been moved to an area with a new provider.)

2. The staff responsible for placement of the child will ensure that arrangements are made for necessary diagnosis and treatment of health conditions suspected or identified.

3. Medical records including, but not limited to, copies of the CHDP Confidential Screening/Billing Reports (PM 160) or results of an equivalent preventive health screen for any child in foster care will be kept in the child's case record. Case records for children age one and over must also contain the result(s) of dental visit(s).

4. The case record will contain a plan which ensures that the child receives medical and dental care which places attention on preventive health services through CHDP or equivalent preventive health services in accordance with the CHDP Program's schedule for periodic health and dental assessments.

V. EPSDT Unit of the CHDP Program Responsibilities and Activities for Referrals

A. *Describe where the EPDST unit is administratively located and physically stationed (i.e., Health and/or Social Services Department(s))*.

B. *Attach duty statements of unit personnel*.

C. *Describe provision for (1) overall medical supervision, (2) administrative supervision, and (3) day-to-day supervision*.

D. The EPSDT Unit will accept and take appropriate action on all referrals of Medi-Cal eligible persons under 21 years of age, including unborn, and will:

1. Intensively inform those requesting more information, and offer scheduling and transportation assistance to those who request CHDP medical and/or dental services.

2. Provide all requested scheduling and/or transportation assistance so that medical and/or dental services can be received from a managed care plan or provider of the requester's choice. These services will be provided and diagnosis and treatment initiated within 120 days of the child's date of eligibility determination or re-determination, and within 120 days of a request if by self referral or for children in foster care unless:

   a. Eligibility is lost; or,

   b. Child is lost to contact and a good faith effort was made to locate the child as defined in Section VII; or,

   c. Failure to receive services was due to an action or decision of the family or child.

   Describe the procedure for new and established members in Medi-Cal managed care plans.

3. Assure that families asking for health assessment procedures not furnished by their provider are referred to another provider for those

procedures so that all requested CHDP services are received within 120 days of the initial request.

Describe the procedure for new and established members in Medi-Cal Managed Care Plans.

4. Follow up on families requesting appointment scheduling and transportation assistance to:

   a. Re-offer scheduling and transportation assistance to those persons whose failure to keep appointments was not due to an action or decision of the family or child.

   b. Offer and provide requested assistance to those for whom further diagnosis and treatment is indicated.

   Describe the procedure for new and established members in Medi-Cal Managed Care Plans.

E. Health Assessment reminder cards with current addresses will be generated and mailed by the State CHDP Program for all children twenty-seven months of age and younger who are receiving Medi-Cal through the Fee-for-Service system.

F. The following will be documented on the CHDP Referral Form (PM 357) or an alternate, State-approved referral form for each eligible person listed:

   1. Type of transportation assistance and date given

   2. Appointment scheduling assistance and date given

   3. Date(s) of appointment(s) and name(s) of provider(s)

   4. Confirmation of CHDP services:

      a. Health assessment requires a PM 160 on file or provider certification of provision of service.

      b. Dental services require family, provider, or child verification.

   5. Follow up to needed diagnosis and treatment:

      a. Response to offer of appointment scheduling and transportation assistance

      b. Type of transportation assistance and date given

      c. Date(s) of appointment(s) and name(s) of provider(s)

      d. Confirmation of care - PM 161 or similar form of certification by provider

6. Date appointment scheduling and/or transportation assistance was declined and by whom.

7. Disposition of case: appointment kept or not kept, eligibility lost, family declined further services, or family/person lost to contact and Good Faith Effort was made to locate the person as defined in Section VII.

G. A quarterly report will be prepared by the 15th day following the end of each quarter showing the number of CalWORKs and Medi-Cal Only persons requesting CHDP services. This report will be used to verify information submitted annually on the Case Management Data Flow sheet as part of the county's Plan and Budget for the following fiscal year.

VI. CHDP Program Responsibilities and Activities

A. An adequate number of medical providers will be available to meet county needs and Federal regulations in regard to allowable time frames.

B. The local CHDP Program will make all possible attempts to assure an adequate number of dental providers are available to meet local needs and Federal regulations.

C. An adequate supply of the following materials will be available to meet Social Services Department and other county needs:

1. State-approved informing brochure with the address and phone number of the local CHDP Program

2. Current list of CHDP medical and dental providers

3. Other informational material, e.g., CHDP poster

D. When eligible persons still needing CHDP services move to another county, the new county will be notified and appropriate information sent. *Describe this process.*

E. Copies of Screening/Billing Reports (PM 160) for services given to children in foster care will be sent to the responsible DSS. *Describe this process.*

F. All persons eligible for Title V services (California's women of reproductive age, infants, children, adolescents, and their families) will be informed of availability of these services and referred as requested.

G. Referrals for Public Health Nursing services for intensive informing and follow up to health assessment and diagnosis and treatment will be accepted, and such services will be provided.

NOTE: Item G is required only when EPSDT funds are requested for Public Health Nursing through a county/federal match.

County/City: _____ Effective Dates: _____ to _____

VII. Joint Social Services/CHDP Responsibilities

A "Good Faith Effort" will be made to locate all persons lost to contact. The EPSDT Unit/CHDP Program will query the DSS for current addresses, telephone numbers, and Medi-Cal status of these persons. Upon request, the DSS will share this information. The exchange of this confidential information is based on Federal and State regulations. (*A "Good Faith Effort" includes at least one documented attempt to trace the person through local welfare departments by obtaining a current address and telephone number and to contact the family at their current address/telephone number.*

VIII. Staff Education

A. Within 90 days of employment by the DSS, all new staff with responsibility for placement or eligibility determination will have completed orientation regarding the CHDP Program and their role and responsibilities for informing persons about CHDP and referring for services. *Identify staff person(s) from the Health Department CHDP Program responsible for conducting this training*.

B. Within 90 days of employment by the Probation Department or licensed adoption agency, staff responsible for placement will have completed orientation regarding the CHDP Program and their roles and responsibilities for informing persons about CHDP and referring for services. *Identify staff person(s) responsible for conducting this training*.

C. Upon licensure and at renewal, foster parent(s) and group care home, residential treatment center, and other out-of-home care facility staff will complete orientation regarding nature, scope, benefits, and availability of CHDP Program services. *Identify staff person(s) responsible for conducting this training*.

D. All appropriate health department staff will receive orientation and an annual update regarding the CHDP Program.

E. The local CHDP Program will provide an annual update to all placement and eligibility determination staff regarding the CHDP Program.

F. *Describe how additional staff in-service education needs will be identified. Specify, for example*:

1. *Need due to regulatory changes*.
2. *Need revealed through program evaluation/reports*.
3. *Need revealed through task force/problem solving meetings*.
4. *Use of formalized education needs assessment tools*.

IX. Management Information and Program Evaluation

County/City: _____ Effective Dates: _____ to _____

A. The following information will be compiled and shared between departments. *Describe mechanism of reporting this information to management and program staff, e.g., eligibility and placement workers. Specify, for example*:

1. *Numbers of*:

   a. *Eligibles - intake/re-determination. Break out number of children in foster care placement*.

   b. *Requests for CHDP services*.

   c. *Requests for more information*.

   d. *Requests for scheduling and/or transportation assistance*.

   e. *Medical assessment services requested and received*.

   f. *Dental services requested and received*.

   g. *Referrals to diagnosis and treatment*.

2. *At a minimum, a quarterly newsletter focusing on the aforementioned information from "1"and "2" is to be sent to program/agency staff*.

B. Conduct and describe methods of program evaluation. *Specify, for example*:

1. *Description of internal process for monitoring, improving, and evaluating compliance with the program as outlined in the agreement*.

2. *Review in the DSS and EPSDT units in the Departments of Health and/or Social Services*.

3. *Review of program procedures - e.g., periodic notification*.

4. *Special studies in each department*.

5. *Care coordination reviews of CHDP process/system within each department*.

6. *Review of status of plan/interagency agreement objectives on a systematic basis*.

County/City: _____ Effective Dates: _____ to _____

X. Compliance Certification

In signing this agreement, we hereby certify that the CHDP Program in our community will meet the compliance requirements and standards pertaining to our respective departments contained in the following:

A. Enabling legislation of the CHDP Program

Reference: Health and Safety Code Sections 124025 through 124110 and Section 104395.

B. CHDP Program regulations that implement, interpret, or make specific the enabling legislation.

Reference: California Code of Regulations, Title 17, Section 6800 through 6874.

C. Medi-Cal regulations pertaining to the availability and reimbursement of EPSDT services through the CHDP Program.

Reference: California Code of Regulations, Title 22, Sections 51340(c), 51340 and 51532.

D. Regulations defining county DSS responsibilities for meeting CHDP/EPSDT Program requirements.

1. Social Services Regulations

Reference:

a. Staff Development and Training Standards - Manual of Policies and Procedures (MPP) Sections: 14-530, 14-610.

b. Civil Rights - MPP Section 21-101, 21-107, 21.115.

c. Eligibility and Assistance Standards - MPP Sections: 40-107.61, 40-131.3(k), 40-181.211, 45-201.5.

d. Child Welfare Services Program Standards - MPP Sections: 31-002(c)(8), 31-075.3(h)(1), 31-075.3(h)(2), 31-205.1(h), 31-206.35, 31-206.351, 31-206.352, 31-206.36, 31-206.361, 31-206.362, 31-206.42, 31-206.421, 31-206.422, 31-330.111, 31-401.4, 31-401.41, 31-401.412, 31-401.413, 31-405.1(f), 31-405.1(g), 31-405.1(g)(1).

e. Intra and interagency relations and agreements Chapter 29-405 and Chapter 29-410.

County/City: _____ Effective Dates: _____ to _____

2. Medi-Cal Regulations

Reference:

a. California Code of Regulations, Title 22, Sections: 50031; 50157(a), (d), (e), (f), and 50184(b).

b. Other Title 22 regulations governing DSS programs regarding adoptions and referring parents to community services, including CHDP Pre-placement Advisement, California Code of Regulations, Title 22, Section 35094.2 and Advisement of Parents Whose Child has not been Removed from Parent's Care, Section 35129.1

E. Current interpretive releases by State Departments of Health Care Services and Social Services.

1. Children's Medical Services (CMS) Branch /CHDP Program Letters and Information Notices - Health Care Services.

2. All County Letters - Social Services.

3. Joint Letters - Health Care Services and Social Services

4. CMS Branch/CCS Numbered Letters pertaining to the CHDP Program - Health Care Services.

This interagency agreement is in effect from *July 1, 20__ through June 30, 20__* unless revised by mutual agreement.

NOTE: In the event that changes in Federal or State legislation impact the current Interagency Agreement, the Health Department and Social Services Department agree to renegotiate the pertinent section within 90 days of receiving new language or instructions from the State.

Child Health and Disability Prevention Program Director	Date
County Social Services Department Director	Date
County Probation Department	Date

County/City: _____ Effective Dates: _____ to _____

Model HCPCFC Memorandum of Understanding

Suggested Areas of Responsibility for Child Health and Disability Prevention (CHDP) Public Health Nurses (PHNs) and Child Welfare Service (CWS) Agency Social Workers and Probation Officers in the Health Care Program For Children In Foster Care (HCPCFC)

County/City: Effective Dates:

Service Provided	Local CHDP Responsibilities Foster Care PHN	Local Child Welfare Service Agency Responsibilities Social Worker/Probation Officer
Location	• PHN will be located in the CWS agency with accessibility to all team members	• PHN will be located in the CWS agency with accessibility to all team members servicing children in foster care, including any PHNs currently working in CWS.
Supervision	• PHN will be supervised by supervising PHN in the local CHDP Program with input from CWS agency staff.	• CWS agency/Supervising Probation Officer will provide input to the supervising PHN.
Accessing Resources	• PHN will identify health care providers in the community. • PHN will evaluate the adequacy, accessibility and availability of the referral network for health care services and collaborate with CHDP staff to identify and recruit additional qualified providers. • PHN will serve as a resource to facilitate (e.g., assist in scheduling appointments, arranging transportation, etc.) referrals to early intervention providers, specialty providers, dentists, mental health providers, CCS and other community programs. • PHN will assist PHNs in the child's county of residence to identify and access resources to address the health care needs of children placed out of county.	• CWS agency Social Worker/Probation Officer will work with PHN to ensure that all children in foster care are referred for health services appropriate to age and health status on a timely basis. • CWS agency Social Worker/Probation Officer will work with the substitute care provider (Foster Parent) and the PHN to identify an appropriate health care provider for the child. • CWS agency Social Worker/Probation Officer will work with the PHN to ensure that children placed out of county have access to health services appropriate to age and health status.

County/City: Effective Dates:

Service Provided	Local CHDP Responsibilities Foster Care PHN	Local Child Welfare Service Agency Responsibilities Social Worker/Probation Officer
Health Care Planning and Coordination	• PHN will interpret health care reports for social worker/probation officers and others as needed. • PHN will develop a health plan for each child expected to remain in foster care. • PHN will work with substitute care provider to ensure that the child's Health and Education Passport or its equivalent is updated. • PHN will assist substitute care provider s in obtaining timely comprehensive assessments. • PHN will expedite timely referrals for medical, dental, developmental, and mental health services. • PHN will assist social worker/probation officer in obtaining additional services necessary to educate and/or support the foster caregiver in providing for the special health care needs, including but not limited to Early and Periodic Screening, Diagnosis, and Treatment Supplemental Services (EPSDT-SS). • PHN will obtain and provide health care documentation when necessary to support the request for health care services. • PHN will collaborate with social worker/probation officer, biological parent when possible and substitute care provider to ensure that necessary medical/health care information is available to those persons responsible for providing healthcare for the child, including a copy of the Health Education Passport (HEP) to the substitute care provider. • PHN will assist social worker/probation officer to assess the suitability of the foster care placement in light of the health care needs of the child. • PHN will collaborate with the social worker/probation officer and substitute care provider to develop a system of tracking and follow-up on changes in the health care status of the child, service needs, effectiveness of services provided, etc. • PHN will review child's health plan with social worker/probation officer as needed and at least every six months.	• Child's Social Worker/Probation Officer will collaborate with PHN to develop a health plan which identifies the health care needs and service priorities for each child expected to remain in foster care for 6 months or longer. • Social Worker/Probation Officer or designee will incorporate health plan into child's case record. • Social Worker/Probation Officer will assemble and provide health care documentation to the court when necessary to support the request for health care services. • Social Worker/Probation Officer will collaborate to complete and keep current the child's Health and Education Passport or its equivalent and provide a copy of the HEP to the substitute care provider. • Social Worker/Probation Officer will consult with the PHN to assess the suitability of the foster care placement in light of the health care needs of the child. • Social Worker/Probation Officer will collaborate with the PHN and substitute care provider to develop a system of tracking and follow-up on changes in the health care status of the child, service needs, effectiveness of services provided, etc. • Social Worker/Probation Officer will review child's health plan with PHN at least every six months and before every court hearing relevant information will be incorporated into the HEP and court report.

County/City: Effective Dates:

Service Provided	Local CHDP Responsibilities Foster Care PHN	Local Child Welfare Service Agency Responsibilities Social Worker/Probation Officer
Training/Orientation	• PHN will participate in developing and providing educational programs for health care providers to increase community awareness of and interest in the special health care needs of children in foster care. • PHN will educate social workers, juvenile court staff, substitute care provider s, school nurses and others about the health care needs of children in foster care.	• CWS agency staff/Probation Officers will provide input to PHN in developing curriculum for training others about health care needs of children in foster care. • CWS agency staff/Probation Officers will collaborate with PHNs in educating juvenile court staff, substitute care providers, and others about the health care needs of children in foster care. • CWS agency personnel will arrange for PHN access to the Child Welfare Services/Case Management System (CWS /CMS) system and provide training in its use.
Policy/Procedure Development	• PHN will provide program consultation to DSS/ Probation Departments in the development and implementation of the EPSDT/CHDP Program policies related to the Health Care Program for Children in Foster Care. • PHN will participate in multi-disciplinary meetings for review of health-related issues.	• CWS agency staff/Probation Officers will include the PHN in team meetings and provide orientation to social services and consultation on CWS/CMS.
Transition from Foster Care	• PHN will provide assistance to the Social Worker/Probation Officer and youths leaving foster care on the availability of options of health care coverage as well as community resources to meet the health care needs upon emancipation.	• CWS agency staff/Probation Officers will collaborate with PHN to assure youths leaving foster care supervision are aware and connected to resources for independent living.

County/City: Effective Dates:

Service Provided	Local CHDP Responsibilities Foster Care PHN	Local Child Welfare Service Agency Responsibilities Social Worker/Probation Officer
Quality Improvement	• PHN will conduct joint reviews of case records for documentation of health care services with CWS agency/Probation Department. • PHN will work with CWS agency/Probation Department to develop a plan for evaluating the process and impact of the addition of the PHN component to the foster care team. • PHN will establish baseline data for evaluating health care services provided to children in foster care.	• CWS agency staff/Probation Officers will conduct joint reviews of case records for documentation of health care services • CWS agency/Probation Department will work with PHN to develop a plan for evaluating the process and impact of the addition of the PHN component to the foster care team. • CWS agency/Probation Officers will collaborate and assist PHN in gathering data.

This Memorandum of Understanding in effect from July 1, 20__ through June 30, 20__ unless revised by mutual agreement. In the event that changes in Federal or State requirements impact the current Memorandum of Understanding, the local health department, social services department, and probation department agree to renegotiate the pertinent section within 90 days of receiving new instructions from the State.

Public Health Director or Child Health and Disability Prevention Program Director — Date

County Social Services Director or County Child Welfare Service Agency Director — Date

Chief Probation Officer — Date