CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: August 11, 2026

Behavioral Health Information Notice No: 26-0XX

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Program
California Association of Mental Health Peer Run Organizations
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professional
California Behavioral Health Association
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: Medi-Cal Coverage of Parent-Child Interaction Therapy (PCIT), Multisystemic Therapy (MST), and Functional Family Therapy (FFT) for Children and Youth

PURPOSE: To provide standards for required Medi-Cal coverage of PCIT, MST, and FFT pursuant to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mandate.

REFERENCE: California Welfare and Institutions (W&I) Code §14184.102(d) and 14184.400; W&I Code Sections 14059.5

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State of California
Gavin Newsom, Governor

California Health and Human Services Agency

BACKGROUND:

OVERVIEW OF BH-CONNECT

The Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) initiative is designed to increase access to and strengthen the continuum of community-based behavioral health services for Medi-Cal members living with significant behavioral health needs. BH-CONNECT is comprised of a five-year Medicaid Section 1115 demonstration and State Plan Amendments (SPAs) to expand coverage of evidence-based practices (EBPs) available under Medi-Cal, as well as complementary guidance and policies to strengthen behavioral health services statewide that are implemented under other existing state authority.

Under BH-CONNECT, DHCS is updating and clarifying existing Medi-Cal coverage of EBPs focused on children and youth, including PCIT, MST, and FFT.[1] This BHIN provides the minimum requirements all behavioral health plans (BHPs), inclusive of mental health plans and plans that also provide substance use disorder (SUD) services through an integrated contract,[2] must meet related to scope of coverage, medical necessity and evidence-based service criteria, care delivery settings, provider qualifications, and claiming and payment for providing PCIT, MST, and FFT under Medi-Cal. The BHIN also includes instructions for BHPs to request alternative access standards (AAS) for MST and/or FFT when BHPs have limited local demand and are unable to meet the certification requirements for one or both EBPs.

Operational guidance to support BHPs and county-operated and county-contracted behavioral health providers in implementing and administering PCIT, MST, and FFT under Medi-Cal is included in Enclosure 1.

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[1] As defined by the Agency for Healthcare Research and Quality, an EBP is a way of providing health care that is guided by a thoughtful integration of the best available scientific knowledge with clinical expertise. This approach allows the practitioner to critically assess research data, clinical guidelines, and other information resources to correctly identify the clinical problem, apply the most high-quality intervention, and re-evaluate the outcome for future improvement.

[2] Only mental health plans are required to provide PCIT, MST, and FFT. For purposes of this BHIN, Drug Medi-Cal Organized Delivery System (DMC-ODS) plans that are not operating under an integrated plan contract are not referenced in the definition of BHPs. The Drug Medi-Cal program is also not included in the definition of BHP.

MEDICAID EPSDT MANDATE

The EPSDT mandate requires comprehensive screening, diagnostic, treatment, and preventive health care services for individuals under the age of 21 who are enrolled in full-scope Medi-Cal.[3] Under EPSDT, states are required to provide all Medicaid-coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not such services are covered under a state's Medicaid State Plan. Furthermore, the Centers for Medicare & Medicaid Services has clarified that mental health services need not be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition and are therefore medically necessary and covered under the EPSDT mandate. Nothing in this BHIN limits or modifies the scope of the EPSDT mandate.

MST AND FFT CERTIFICATION REQUIREMENTS AND ALTERNATIVE ACCESS STANDARDS (AAS)

Under the EPSDT mandate, all BHPs must cover PCIT, MST and FFT. MST and FFT are team-based services with specific staffing and caseload requirements to achieve certification. Both MST and FFT require a team of at least three Licensed Mental Health Practitioners (LMHPs) or Clinical Trainees.[4] In addition, each LMHP or Clinical Trainee on a MST or FFT team must maintain approximately five cases at any given time. Achieving and maintaining certification consistent with these requirements may not be feasible in very rural areas. BHPs that have limited local demand and are therefore unable to meet certification requirements for MST and/or FFT may submit AAS requests to DHCS for one or both EBPs.[5] Federal authority permits DHCS to establish AAS when a standard network adequacy metric (e.g., time/distance, provider-to-enrollee ratio, or appointment wait time) is not appropriate or feasible for a particular service, provider type, population, or geographic area.[6] DHCS will use a similar process for BHPs to request AAS for MST and/or FFT, as described

[3] 42 C.F.R. Part 441, Subpart B; 42 U.S.C. §§1396a(a)(43) and 1396d(r)
[4] One LMHP on a MST team must serve as a supervisor, and one LMHP on a FFT team must become a supervisor in the team's second year of operation.
[5] BHPs must use the AAS Request Form in Enclosure 2 to submit all AAS requests to DHCS.
[6] 42 C.F.R. §438.68(d) effective July 9, 2024; see also BHIN 26-015 or subsequent DHCS network certification guidance.

in this BHIN. BHPs that do not receive DHCS approval for AAS must provide MST and FFT.

POLICY:

OVERVIEW OF CHILDREN & YOUTH EBPs

BHPs shall ensure Medi-Cal members under the age of 21 receive the following EBPs if determined medically necessary and clinically appropriate:

- **Parent-Child Interaction Therapy (PCIT).** PCIT is a specialized behavior management intervention for children and their caregivers. PCIT is appropriate for young children with oppositional or defiant behavior, aggression, frequent or severe tantrums, or symptoms related to behavioral health conditions such as attention-deficit/hyperactivity disorder, anxiety, and trauma.
- **Multisystemic Therapy (MST).** MST is an intensive, family-based intervention for youth at risk of severe negative consequences within their family, school or community due to serious externalizing, anti-social, and/or challenging behaviors. For example, MST may be appropriate for youth who are involved in the juvenile justice system and/or at risk of out-of-home placement due to a history of criminogenic behavior.
- **Functional Family Therapy (FFT).** FFT is an intensive, short-term, family-based counseling service designed for youth from early to late adolescence who are at risk of developing, or who are already experiencing, moderate to severe behavioral or emotional challenges, such as conduct disorder, violent acting-out, substance use, and criminogenic behavior.

PCIT IMPLEMENTATION

Description

Through PCIT, caregivers are taught therapeutic strategies to reduce challenging behaviors by a PCIT therapist. PCIT focuses on decreasing child behavior challenges (e.g., dysregulation, externalizing behaviors,
difficulty maintaining engagement or complying with prompts from primary caregivers), increasing positive parenting skills (e.g., therapeutic play, effective prompts),
and enhancing the caregiver-child relationship through structured interactions.

Evidence-Based Service Criteria

PCIT is medically necessary when a child who meets the access criteria for SMHS undergoes assessment in accordance with BHIN 23-068 and the service is recommended as an appropriate treatment intervention by a Licensed Mental Health Professional (LMHP) acting within the scope of their license and training.[7]

PCIT may be appropriate for Medi-Cal members who:

- Are 2 to 7 years of age, or an appropriate developmental age to receive the service;[8]
- Exhibit dysregulation or behavior challenges that may be helped by PCIT;
- Reside with their caregiver and not within a residential facility.[9]

Provider Qualifications

PCIT shall be provided by LMHPs (including waivered or registered professionals) or Clinical Trainees acting within the scope of their license and training who have been trained and are certified to provide PCIT by an approved certifying entity.[10] For the purposes of this BHIN, approved certifying entity means PCIT International or another entity approved by the BHP to provide PCIT training and certification. BHPs shall only approve certifying entities that meet the following criteria:

- Training is based on the recognized PCIT evidence-based model; and
- Certification indicates the provider has necessary skills to deliver PCIT with fidelity to the recognized evidence-based model.

DHCS has contracted with PCIT International to provide training, technical assistance, and certification support for PCIT free of charge. BHPs can access support from PCIT

[7] For the purposes of this BHIN, a LMHP is defined on page 2l of Supplement 3 to Attachment 3.1-A of the California Medicaid State Plan.
[8] The LMHP must determine the child is of an appropriate developmental age during the assessment process.
[9] A child's caregiver may include, but is not limited to, a biological parent, adoptive parent, foster parent, kinship carer, legal guardian, or non-residential caregiver (e.g., a non-custodial parent) who shares caregiving responsibilities for the child.
[10] For the purposes of this BHIN, LMHP and Clinical Trainee are defined on page 2l of Supplement 3 to Attachment 3.1-A of the California Medicaid State Plan.

International by submitting an Engagement Initiation Form (EIF) on the DHCS COE Resource Hub website.

Medi-Cal Claiming For PCIT

To claim Medi-Cal for PCIT, BHPs shall administer PCIT in accordance with the standards set forth above and all other applicable Medi-Cal requirements. BHPs must use the procedure codes listed in Table 1 below to claim for PCIT delivered as a SMHS.

Modifier 22 accounts for the additional expenses of administering PCIT, including the in-person facility space (for parent and child play and therapist observation through a one-way mirror), sound system, and audio equipment used by the therapist to provide coaching to the caregiver.

PCIT may be provided via telehealth at member and caregiver choice, consistent with BHIN 23-018 or subsequent DHCS guidance.

Claiming the procedure codes listed for PCIT does not preclude BHPs from claiming concurrently for other SMHS.[11] However, PCIT is intended to be a standalone therapeutic service. It should not be combined with other therapeutic approaches unless determined to be clinically appropriate by the treating LMHP.

Table 1. PCIT Claiming Details

Service	Rate Structure	CPT/HCPCS Code	Code Description
Therapy	Outpatient rate plus session add-on	90832 (Modifier 22)	Psychotherapy with patient, 30 minutes
Therapy	Outpatient rate plus session add-on	90833 (Modifier 22)	Add-on for psychotherapy with patient when performed with an evaluation and management service, 30 minutes

[11] BHPs should consult the applicable Short-Doyle Medi-Cal billing manual for detailed claiming requirements for PCIT.

Service	Rate Structure	CPT/HCPCS Code	Code Description
Therapy	Outpatient rate plus session add-on	90834 (Modifier 22)	Psychotherapy with patient, 45 minutes
Therapy	Outpatient rate plus session add-on	90836 (Modifier 22)	Add-on for psychotherapy with patient when performed with an evaluation and management service, 45 minutes
Therapy	Outpatient rate plus session add-on	90837 (Modifier 22)	Psychotherapy with patient, 60 minutes
Therapy	Outpatient rate plus session add-on	90838 (Modifier 22)	Add-on for psychotherapy with patient and/or family member when performed with an evaluation and management service, 60 minutes
Therapy	Outpatient rate plus session add-on	90846[12] (Modifier 22)	Family psychotherapy (without patient present), 50 minutes
Therapy	Outpatient rate plus session add-on	90847 (Modifier 22)	Family psychotherapy (with patient present), 50 minutes

[12] BHPs shall not submit claims for 90846 until DHCS confirms systems updates are in place to claim for this service. BHPs should consult the applicable Short-Doyle Medi-Cal billing manual for claiming requirements once systems updates are complete.

Service	Rate Structure	CPT/HCPCS Code	Code Description
Therapy	Outpatient rate plus session add-on	T2021 (Modifier 22)	Therapy substitute, 15 minutes

MST IMPLEMENTATION

Description

MST is a time-limited, intensive family- and community-based treatment. It uses therapy sessions to address emerging high-risk behaviors including criminogenic behavior, anti-social activities, substance use, and other behaviors that may lead to juvenile justice involvement, out-of-home placement, or other severe system consequences within the family, school, or community. For parents/caregivers, the goal is to learn skills to independently address difficulties in raising children and adolescents as well as skills to cope with other family, peer, and neighborhood problems.

Evidence-Based Service Criteria

MST is medically necessary when a youth who meets the access criteria for SMHS undergoes assessment in accordance with BHIN 23-068 and the service is recommended as an appropriate treatment intervention by a LMHP acting within the scope of their license and training.

MST may be appropriate for Medi-Cal members who:

- Are 12 to 17 years of age or of an appropriate developmental age to receive the service;[13]
- Exhibit serious externalizing, anti-social, aggressive, and/or criminogenic behaviors that may place the youth at risk of out-of-home placement;
- Reside in a family, community or home-like setting that is conducive to a family-focused treatment model.

[13] The LMHP must determine the child is of an appropriate developmental age during the assessment process.

Provider Qualifications

MST shall be provided by a team of eligible mental health providers who have been trained and certified to provide MST by MST Services. LMHPs (including waivered or registered professionals) and Clinical Trainees acting within the scope of their license and training may provide MST.

DHCS has contracted with MST Services to provide training, technical assistance, and fidelity monitoring support for MST free of charge. BHPs can access support from MST Services by submitting an Engagement Initiation Form (EIF) on the DHCS COE Resource Hub website.

Medi-Cal Claiming For MST

To claim Medi-Cal for MST, BHPs shall administer MST in accordance with the standards set forth above and all other applicable Medi-Cal requirements. BHPs must use the procedure code listed in Table 2 below to claim for MST delivered as a SMHS.

To be paid the full monthly rate for MST, the team must deliver a service on at least six different days that month, of which at least four of the services are face-to-face with the member.[14] To be paid the partial monthly rate for MST, teams must provide at least four services on four different days that month, of which at least three services are face-to-face with the member. Other services may be face-to-face or using telehealth with either the member or collateral.

Claiming the procedure code listed for MST does not preclude BHPs from claiming concurrently for other SMHS.[15] However, MST is intended to be a standalone therapeutic service. It should not be combined with other therapeutic approaches unless determined to be clinically appropriate by the treating LMHP.

[14] Face-to-face services must be in-person or by synchronous interaction through a mode of telehealth that utilizes both audio and visual components. Services that include both the member and the member's parent/caregiver may count towards fulfilling the minimum face-to-face contact requirement.

[15] BHPs should consult the applicable Short-Doyle Medi-Cal billing manual for detailed claiming requirements for MST, including claiming requirements for MST while a member is in an inpatient or residential setting.

Table 2. MST Claiming Details

Service	Rate Structure	CPT/HCPCS Code	Code Description
MST	Monthly Rate	H2033	Multisystemic therapy (MST) for juveniles

FFT IMPLEMENTATION

Description

FFT is a systemic, family-based intervention designed for youth at risk for out-of-home placement due to externalizing behaviors (e.g., physical aggression, oppositional behavior, substance use) that require the engagement of the youth or family members' social system (e.g., family, teachers, health care providers). The service aims to reduce adolescent behavioral problems, conduct disorder, substance use, and recidivism while improving parenting practices. A critical component of FFT is active involvement of the family, caregivers, foster family, or other key home-based influences.

Evidence-Based Service Criteria

FFT is medically necessary when a youth who meets the access criteria for SMHS undergoes assessment in accordance with BHIN 23-068 and the service is recommended as an appropriate treatment intervention by a LMHP acting within their scope of their license and training.

FFT may be appropriate for Medi-Cal members who:

- Are 11 to 18 years of age or of an appropriate developmental age to receive the service;[16]
- Are at-risk of or have moderate to severe behavioral or emotional challenges, such as conduct disorder, violent acting-out, substance use disorder, or criminogenic behavior.

[16] The LMHP must determine the child is of an appropriate developmental age during the assessment process.

Provider Qualifications

FFT shall be provided by a team of eligible mental health providers who have been trained and certified to provide FFT by FFT LLC or FFT Partners. LMHPs (including waivered or registered professionals) and Clinical Trainees acting within the scope of their license and training may provide FFT.

DHCS has contracted with FFT LLC to provide training, technical assistance, and certification support for FFT free of charge. BHPs can access support from FFT LLC by submitting an Engagement Initiation Form (EIF) on the DHCS COE Resource Hub website.

Medi-Cal Claiming for FFT

To claim Medi-Cal for FFT, BHPs shall administer FFT in accordance with the standards set forth above and all other applicable Medi-Cal requirements. BHPs must use the procedure code listed in Table 3 below to claim for FFT delivered as a SMHS.

FFT may be provided via telehealth at member and caregiver choice, consistent with BHIN 23-018 or subsequent DHCS guidance.

Claiming the procedure code listed for FFT does not preclude BHPs from claiming concurrently for other SMHS.[17]

Table 3. FFT Claiming Details

Service	Rate Structure	CPT/HCPCS Code	Code Description
FFT	Outpatient Rate	H0036	Community psychiatric supportive treatment (face-to-face), 15 minutes

[17] BHPs should consult the applicable Short-Doyle Medi-Cal billing manual for detailed claiming requirements for FFT.

AAS FOR MST AND/OR FFT IMPLEMENTATION

DHCS recognizes that some BHPs will have limited local demand for MST and/or FFT and will therefore be unable to meet certification requirements for one or both EBPs.

BHPs that are unable to meet the certification requirements for MST and/or FFT described above in the "MST and FFT Certification Requirements and AAS" section of this BHIN due to limited local demand may submit requests for DHCS approval of AAS for one or both EBPs. **Initial AAS requests for MST and FFT must be submitted no later than October 30, 2026, and must be re-submitted every three years thereafter.**

BHPs that have DHCS-approved AAS for MST and/or FFT are required to provide High-Fidelity Wraparound (HFW) and one or more of the following evidence-based therapy approaches:

1. Attachment Therapy Focused Approaches
2. Cognitive Behavioral Therapy (CBT) Focused Approaches
3. Dialectical Behavioral Therapy (DBT) Focused Approaches
4. Eye Movement Desensitization and Reprocessing (EMDR)
5. Somatic Approaches

BHPs must submit separate AAS requests for MST and FFT.[18] DHCS will review and individually approve each AAS request.

For each AAS request, BHPs must:

1. Engage with the applicable COE (MST Services or FFT LLC) to understand implementation requirements and assess local demand and capacity;[19]
2. Provide data demonstrating limited local demand for the EBP and resulting inability to achieve and maintain certification from the applicable COE;[20] and

[18] AAS requests for MST and FFT are separate and distinct processes from AAS requests for DHCS' time and distance standards described in BHIN 26-015 or subsequent guidance.
[19] BHPs that submit AAS requests for both EBPs must engage with both COEs. BHPs that submit an AAS request for just one EBP must engage with the applicable COE.
[20] There typically must be 30 children and youth with a clinical need for MST or FFT to be able to staff and certify a MST or FFT team.

3. Indicate how the BHP will ensure children and youth with complex behavioral health needs receive evidence-based, clinically appropriate care, including through delivery of HFW and one or more other evidence-based therapy approaches, as indicated above.

The MST/FFT AAS request form and submission instructions are available in Enclosure 2 and will be available on the DHCS website.

DOCUMENTATION

Providers shall comply with Medi-Cal SMHS documentation requirements set forth in BHIN 23-068 for PCIT, MST, and FFT.

PRIOR AUTHORIZATION

BHPs shall not require prior authorization for PCIT, MST or FFT. BHPs may refer to BHIN 22-016 or subsequent guidance for additional guidance on service authorization.

COMPLIANCE MONITORING

BHPs are responsible for conducting monitoring of contracted providers for compliance with the terms of the BHP's contract with DHCS, including with policies outlined in this BHIN. DHCS monitors and oversees BHPs and their operations as required by state and federal law. DHCS will monitor BHPs for compliance with the requirements outlined above, and deviations from the requirements may require corrective action plans. This oversight may include, but is not limited to, verifying that services provided to Medi-Cal members are medically necessary, and that documentation complies with the applicable state and federal laws, regulations, and the BHP's contract with DHCS. Recoupment shall be focused on identified overpayments and fraud, waste, and abuse.

Please contact BH-CONNECT@dhcs.ca.gov for questions regarding this BHIN.

Sincerely,

Original signed by

Ivan Bhardwaj, Chief

Medi-Cal Behavioral Health – Policy Division

Enclosures (2)

ENCLOSURE 1: OPERATIONAL GUIDANCE FOR PCIT, MST AND FFT

This Enclosure provides operational guidance to support BHPs and county-operated and county-contracted behavioral health providers in implementing PCIT, MST, and FFT under Medi-Cal. [21]

PCIT:

TREATMENT DURATION

PCIT typically consists of weekly, hour-long sessions over approximately 14 to 20 weeks, in the presence of both the caregiver and child. PCIT is implemented in two phases:

- Child-Directed Interaction (CDI), which focuses on increasing positive child behavior and reducing negative attention-seeking behaviors through positive parent-child interactions; and
- Parent-Directed Interaction (PDI), which teaches parents effective strategies for being consistent and managing disruptive child behaviors like non-compliance with directions and rules.

CARE DELIVERY SETTING

The PCIT therapist provides caregivers in-the-moment coaching via a wireless headset while they engage in therapeutic play with their child, helping caregivers apply the most effective strategies with their child.

PCIT is delivered in the context of the family unit. Services should ideally be provided in an outpatient clinic or in a community-based treatment setting with a space that includes a childproofed playroom where the caregiver will engage in therapeutic play with their child. The space should also include a separate observation room with a one-way mirror and live video or audio feed for the LMHP to observe interactions between the child and caregiver and provide coaching through a transmitter to the caregiver wearing an earpiece. Alternatively, PCIT may be provided via telehealth using secure video-conference software or through in-room coaching.[22]

[21] DHCS has contracted with designated Centers of Excellence (COEs) for MST, FFT, and PCIT to provide training for BHPs to provide each service to fidelity.
[22] In-room coaching is allowed but not preferred.

MST:

TREATMENT DURATION

Treatment intensity varies based on youth and family needs (i.e., sessions may range from brief check-ins to 2-hours or more sessions on a daily to weekly basis) generally over the course of 3-5 months.

CARE DELIVERY SETTING

MST is delivered in the context of the family unit, but services may take place within the youth's home, community, or anywhere where a youth needs support. MST is typically conducted in an adoptive home, birth family home, foster/kinship care home, and/or school setting.

TREATMENT TEAM AND CASELOAD

Teams are typically comprised of one clinical supervisor with a minimum of two and a maximum of four therapists. Teams also have at least one team member available 24 hours a day, 7 days a week to provide crisis management. The supervisor is responsible for facilitating one group supervision meeting per week and providing individual supervision clinician meetings and additional trainings as needed. The supervisor may also have primary or shared responsibility for program management tasks as part of their administrative responsibility for the MST team. The MST supervisor may be part-time if only supervising one MST team, but may be full-time if they supervise two MST teams or carry two MST cases and have additional MST responsibilities. Each team typically has a caseload of approximately 30-60 families per year and each therapist typically oversees a maximum caseload of six families.

FFT:

TREATMENT DURATION

The service is offered on average through 12 to 14 therapy sessions (though this may range from 8 to 30 depending on the severity of the case) generally spread over a three to five month period. FFT consists of five phases with steps that build upon each other. The five phases are: Engagement, Motivation, Relational Assessment, Behavior Change, and Generalization.

CARE DELIVERY SETTING

FFT is delivered in the context of the family unit but services may be provided in any community-based setting where the family and/or caregiver(s)[23] can be involved, including clinic-, home-, and school-based settings.

TREATMENT TEAM AND CASELOAD

FFT may be provided by a team of eligible mental health practitioners consisting of a minimum of three and a maximum of eight LMHPs and one clinical supervisor.

Each full-time FFT therapist typically has a caseload of approximately ten to twelve families. The supervisor is considered a team member of the team and will see families accordingly. Supervisors may reduce their caseload to meet the requirements of the position but typically carry a caseload of a minimum of five families.

[23] Caregivers may include foster or kinship caregivers.

ENCLOSURE 2: ALTERNATIVE ACCESS STANDARDS (AAS) REQUEST FORM

OVERVIEW

BHPs that have limited local demand for Multisystemic Therapy (MST) and/or Functional Family Therapy (FFT) and are unable to meet the certification requirements may request AAS for one or both EBPs. BHPs must submit separate AAS requests for MST and FFT using the forms below. DHCS will review and individually approve each AAS request. Initial AAS requests for MST and FFT must be submitted no later than October 31, 2026, and must be re-submitted every three years thereafter.

For questions on this form or the EBPs for children and youth, please reach out to BH-CONNECT@dhcs.ca.gov.

BACKGROUND INFORMATION

1. Date of Submission [Choose date]
2. County Name [Drop down]
3. Name of Individual Completing Form [Free text]
4. E-mail Address [Free text]

AAS REQUEST: MST

5. Has your county engaged with MST Services to understand the implementation requirements and assess local demand and capacity for MST? [Drop down]
    a. Yes
    b. No

6. Please list the date of first engagement with MST Services. [Choose date]

7. Please describe your county's engagement with MST Services, including how your county worked with MST Services to determine there may be limited local demand for MST and AAS are appropriate.
8. Please send documentation demonstrating your county's limited local demand for MST (preferred format: csv or xlsx; pdf or docx also acceptable) to BH-CONNECT@dhcs.ca.gov after completing this form.

    a. Acknowledgement [choice]

9. In addition to High Fidelity Wraparound, what services does your county provide to ensure children and youth with complex behavioral health needs receive evidence-based, clinically appropriate care? [Select all that apply; multiple checkboxes]

   Note: To receive approval for an AAS request for MST, a county must provide High Fidelity Wraparound and one or more evidence-based therapy approaches from the list below.

   a. Attachment Therapy Focused Approaches (e.g., Attachment-Based Family Therapy)
   b. Cognitive Behavioral Therapy (CBT) Focused Approaches (e.g., Trauma-Focused CBT)
   c. Dialectical Behavioral Therapy (DBT) Focused Approaches (e.g., Dialectical Behavioral Therapy for Adolescents DBT-A))
   d. Eye Movement Desensitization and Reprocessing (EMDR)
   e. Somatic Approaches (e.g., Occupational Therapy)

10. In response to Question #9, please describe the approach for each evidence-based therapy selected from the list above.

<u>AAS REQUEST: FFT</u>

11. Has your county engaged with FFT, LLC to understand the implementation requirements and assess local demand and capacity? [Drop down]
    a. Yes
    b. No

12. Please list the date of first engagement with FFT, LLC. [Choose date]

13. Please describe your county's engagement with FFT, LLC, including how your county worked with FFT, LLC to determine there may be limited local demand for FFT and AAS are appropriate.

14. Please send documentation demonstrating your county's limited local demand for FFT (preferred format: csv or xlsx; pdf or docx also acceptable) to BH-CONNECT@dhcs.ca.gov after completing this form.

    a. Acknowledgement [choice]

15. In addition to High Fidelity Wraparound, what services does your county provide to ensure children and youth with complex behavioral health needs receive evidence-based, clinically appropriate care? [Select all that apply; multiple checkboxes]

    Note: To receive approval for an AAS request for FFT, a county must provide High Fidelity Wraparound and one or more evidence-based therapy approaches from the list below.

    a. Attachment Therapy Focused Approaches (e.g., Attachment-Based Family Therapy)
    b. Cognitive Behavioral Therapy (CBT) Focused Approaches (e.g., Trauma-Focused CBT)
    c. Dialectical Behavioral Therapy Focused Approaches (e.g., Dialectical Behavioral Therapy for Adolescents (DBT-A))
    d. Eye Movement Desensitization and Reprocessing
    e. Somatic Approaches (e.g., Occupational Therapy)

16. In response to Question #15, please describe the approach for each evidence-based therapy selected from the list above.