Saginaw County Community Mental Health Authority (SCCMHA)

Network Services Provider Manual

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October Update
Fiscal Year 2025

Provider Manual Update - October 2024

Included are the updated policies and procedures since the FY24 July Provider Manual Update

Page	Policy Number	Policy/Procedure Name	What Was Added / Updated	Date Revised	Licensed Residential/Crisis Residential	Enhanced Health Services/Autism (speech, behavioral, ot)	Inpatient	Crisis/CAI/MUTT	Primary Providers (Supports Coordination/Case Management/Primary/ACT/Autism/ Wraparound/Integrated Care)	Community Living Supports/ CLS Per Diem/Respite Services Skill Build/Supported Employment/Clubhouse/Drop-In	Fiscal Intermediaries/Pharmacy/LEP
N/A	**Tab 1 Introdution to SCCMHA - No Updates**										
5	**Tab 2 Eligibility & Care Management**										
6	09.06.00.13	Case Transfer	Review only.	5/10/2024				X	X		
N/A	**Tab 3 Services & Protocols - No Updates**										
31	**Tab 4 Service Delivery**										
32	02.03.09.26	Beyond Trauma: A Healing Journey for Women	New to Provider Manual.	8/29/2024	X	X	X	X	X	X	X	X
35	02.03.24	Suicide Prevention	Complete overhaul of the policy to incorporate all aspects needed for Zero Suicide implementation. Revised procedure. Updated exhibit for Social and Ecological Model of Risk and Protective factors, updated C-SSRS with SAFE-T protocol exhibit, added exhibit of Zero Suicide Workflow (Pathway) for Suicide Risk, added exhibit of Zero Suicide Training Plan, added exhibit for C-SSRS Completion Guidelines, several updated references.	10/1/2024	X	X	X	X	X	X	X	
54	06.03.01	Pest Prevention, Identification and Management	Updated exhibits.	10/8/2024	X	X		X	X	X	X	X
74	09.06.05.09	Training of Adaptive Equipment for Community Ties & Residential Staff	Review only.	3/5/2024	X	X				X	X	
77	09.06.10.01	Autism School and ABA	Review only.	3/15/2024		X						
80	09.06.10.02	Autism Program Entry to Services	Review only.	3/15/2024		X						
84	09.06.10.03	Autism Expectations Regarding Treatment Plans	Review only.	3/15/2024		X						
91	09.06.10.04	Autism Program Mission and Vision Statement	Review only.	3/15/2024		X						
92	09.06.10.05	Autism Program Introduction	Review only.	3/15/2024		X						
94	09.06.10.06	Autism Discharge Planning	Review only.	3/15/2024		X						
97	09.06.10.07	Autism Supports Coordinator Responsibilities	Review only.	3/15/2024		X						
103	09.06.10.08	Autism Eligibility Determination & Re-Evaluation	Review only.	3/15/2024		X						

Page	Policy Number	Policy/Procedure Name	What Was Added / Updated	Date Revised								
111	09.06.10.09	Autism Program Orientation Meeting	Review only.	4/1/2024		X						
114	09.06.10.10	Referrals for ASD Eligibility Determination Evaluations for ABA	Review only.	4/1/2024		X						
122	09.06.12.09	Referral-Application, Screening and Eligibility Determinaiton	Review only.	3/19/2024					X			
146	09.06.12.11	Housing Assessment & Plan	Review only.	3/19/2024					X			
148	09.06.12.13	Housing Search and Placement for TRA Programs	Review only.	3/19/2024					X			
152	09.06.12.18	Medicaid Housing Assistance Benefit	Review only.	3/19/2024					X			
155	09.06.12.21	Support Services	Review only.	3/20/2024					X			
157	09.06.12.22	Case Manager Agreement	Review only.	3/20/2024					X			
160	09.06.12.23	Annual Recertification	Review only.	3/20/2024					X			
183	09.06.12.28	Housing Appeals & Grievance	Review only.	3/21/2024					X			
185	**Tab 5 Regulatory Management/HIPAA Compliance**											
186	05.07.02	SCCMHA Network HIPAA Compliance	Review only.	9/9/2024	X	X	X	X	X	X	X	X
191	08.06.00.01	IT Definitions	Added definitions.	9/9/2024	X	X	X	X	X	X	X	X
197	08.06.04	HIPAA Security – Security Sanctions	Large update. Please review policy	9/9/2024	X	X	X	X	X	X	X	X
201	08.06.08.01	HIPAA Security – Security Management Process	Large update. Please review policy	9/9/2024	X	X	X	X	X	X	X	X
207	08.06.08.02	HIPAA Security – Assigned Security Responsibility	Large update. Please review policy	9/9/2024	X	X	X	X	X	X	X	X
211	08.06.08.03	HIPAA Security – Workforce Security	Large update. Please review policy	9/9/2024	X	X	X	X	X	X	X	X
217	08.06.08.04	HIPAA Security – Information Access Management	Large update. Please review policy	9/9/2024	X	X	X	X	X	X	X	X
221	08.06.08.05	HIPAA Security – Security Awareness & Training	Large update. Please review policy	9/9/2024	X	X	X	X	X	X	X	X
226	08.06.08.06	HIPAA Security – Security Incident Procedures	Large update. Please review policy	9/9/2024	X	X	X	X	X	X	X	X
230	08.06.08.07	HIPAA Security – Contingency Plan	Large update. Please review policy	9/9/2024	X	X	X	X	X	X	X	X
236	08.06.08.08	HIPAA Security – Evaluation	Large update. Please review policy	9/9/2024	X	X	X	X	X	X	X	X
241	08.06.08.09	HIPAA Security – BAA & Other Arrangements	Large update. Please review policy	9/9/2024	X	X	X	X	X	X	X	X
246	08.06.10.01	HIPAA Security – Facility Access Controls	Large update. Please review policy	9/9/2024	X	X	X	X	X	X	X	X
252	08.06.10.04	HIPAA Security – Device & Media Controls	Large update. Please review policy	9/9/2024	X	X	X	X	X	X	X	X
257	08.06.12.02	HIPAA Security – Audit Controls	Large update. Please review policy	9/9/2024	X	X	X	X	X	X	X	X

Page	Policy Number	Policy/Procedure Name	What Was Added / Updated	Date Revised								
261	08.06.12.03	HIPAA Security – Integrity	Large update. Please review policy	9/9/2024	X	X	X	X	X	X	X	X
266	08.06.12.04	HIPAA Security – Person or Entity Authentication	Large update. Please review policy	9/9/2024	X	X	X	X	X	X	X	X
271	08.06.12.05	HIPAA Security – Transmission Security	Large update. Please review policy	9/9/2024	X	X	X	X	X	X	X	X
275	08.06.16.01	HIPAA Security – Policies, Procedures, & Documentation	Large update. Please review policy	9/9/2024	X	X	X	X	X	X	X	X
280	08.06.40	HIPAA Security – Data Backup & Storage	Large update. Please review policy	9/9/2024	X	X	X	X	X	X	X	X
N/A	**Tab 6 Recipient Rights - Customer Service - Appeals & Grievance - No Updates**											
N/A	**Tab 7 Claims Processing - No Updates**											
284	**Tab 8 Network Services**											
285	09.08.01.03	Agency Naming Convention Standardization	New to Provider Manual	7/30/2024	X	X	X	X	X	X	X	X
N/A	**Booklets and Brochures - No Updates**											

Tab 2

Eligibility & Care Management

<table>
<tr><td colspan="3">Clinical Services Procedure Manual
Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Case Transfer</td><td>Chapter: 09.06.00 - Clinical Services</td><td>Subject No: 09.06.00.13</td></tr>
<tr><td colspan="3">Clinical Services</td></tr>
<tr><td>Effective Date:
1/1/2015</td><td>Date of Review/Revision:
1/1/15, 5/2/16, 3/17/17, 3/1/18, 3/21/19, 2/10/20, 3/17/21, 10/24/22, 5/10/24
Supersedes:</td><td>Approved By:
Kristie Wolbert, Executive Director of Clinical Services

Authored By:
Executive Director of Clinical Services

Reviewed By:
Clinical Directors, Director of NSPP & CE</td></tr>
</table>

Purpose:
To ensure continuity of care when a case is transferred from one staff to another and to set standards to assure that all the informational and document requirements for the transferring and receiving of cases are completed.

Application:
All SCCMHA contracted and board operated clinical staff

Policy:
It is the policy of Saginaw County Community Mental Health Authority (SCCMHA) that the transfer of persons receiving services cases from one case holder to another shall occur in a manner that is trauma informed and results in minimal distress for the person.

Standards:
The transfer of cases between units or providers is through Care Management.

The transfer of cases between staff within a unit or provider will be done through the Supervisor.

When a transfer of a case occurs, the primary concern is the impact of the transfer on the person receiving services, with the person receiving services well-being of utmost priority.

The transfer of cases will be done in a trauma-informed manner with the goal of causing minimal distress for the person receiving services.

The transfer of cases will be done in a professional, collaborative, and cooperative manner by all staff involved.

When a case is being transferred between units or providers, the transfer will include a discussion between the supervisors of those teams. The supervisor transferring the case will initiate the transfer by completing a "Level of Care Change" form and submitting it to the teams assigned Care Management Specialist.

A person receiving services will continually be assigned a staff to contact during the transfer process.

It is the responsibility of the transferring staff to have all necessary information and documents current and complete prior to the transfer, and when feasible, to communicate with the receiving staff any additional pertinent information regarding the case. This includes the minimum quality data set and ability to pay assessment. Please see Member Enrollment, Transfer/Discharge, Quality Data and Case Service Status policy number 05.04.02.

In situations where a staff member leaves an organization, the supervisor will work to update any missing documentation prior to transferring to another organization.

It is the responsibility of the receiving staff person to review the case and understand the care that has been provided to the person as soon as possible. The review should include the following:

1) Current psychosocial assessment.
2) Current therapy assessment if applicable.
3) Current individual plan of service (IPOS)
4) Assure all releases of information and consents are in the Sentri electronic health record.
5) Last several months of progress notes and chart notes.
6) Last three medication reviews if applicable.
7) Assure any follow up has occurred as noted in any of the above documents.

Once the case has been transferred it is important to meet with the person receiving services and review the IPOS and get to know the person within 10 days of the transfer. This is important to build a rapport with the person as well as to understand the strengths and needs of the person receiving services.

When a person receiving services is transferring to a higher level of care, the case holder is required to complete a new psychosocial assessment, and IPOS. These circumstances could include the following:

1) From case management to Assertive Community Treatment or ACT services.
2) From a home setting to a general Adult Foster Care (AFC) setting.

3) From a general AFC setting to a specialized AFC setting.

When a person receiving services moves to a lower level of care, the case holder is required to complete a new psychosocial assessment and IPOS that reflects the needs and desires of the person receiving services. A few examples of when this might occur are:

1) Person receiving services moves from AFC to their own apartment or in with family.
2) Person moves from ACT to case management.
3) Person moves from Specialized AFC to general AFC.
4) Person moves from case management to outpatient therapy.

Definitions:

Case Transfer: The transfer of person receiving care from one case holder to another.

Case Holder: This is a term that refers to the primary record holder or the person assigned to the care of the case in Sentri. This can be a case manager, supports coordinator, or therapist - whoever is assigned as the primary staff person to oversee the person receiving services care and coordination.

Supervisor: This is a term that refers to the Supervisor or the person that oversees the Case Holder.

Initial Assessment: the assessment located in sentri used to determine eligibility and probable services that a new person receiving services will require.

Annual Psychosocial Assessment: the assessment located in sentri based off the Initial Assessment and used as part of the process for developing the Individual Plan of Service as part of the Person-Centered Planning.

Therapy Assessment: the assessment located in sentri used as part of the determination of the course of treatment for a person served receiving individual or group therapy.

Transferring Case Holder: The team where the Case Holder for the person receiving services is handing over the person receiving services care and coordination to another Case Holder.

Receiving Case Holder: The team where the Case Holder will take over monitoring and care and coordination for the person receiving services.

Same Level of Service Transfer: Refers to the circumstance where a person receiving services is moving from a Case Holder by one team of providers to another team of providers with out the need for increased or decreased level of care. *Examples are Community Support Services to Community Support Services, Community Support Services to TTI case management, TTI case management to Saginaw Psychological Services Inc., Support Coordination Services to Disability Network.*

Different Level of Service Transfer: Refers to the circumstance where a person receiving services is moving from one level of service to another level of service. *Examples are Family Services Unit Home Based to Family Services Unit Case Management, Community Support Services to Assertive Community Treatment, Family Services Unit to Community Support Services, Family Services Unit to Wraparound Services, Wraparound Services to Westlund or Family Services Unit, Family Services Unit to Autism, Family Services Unit to Westlund, Caro Regional Center or Forensic Center to Community Residential Treatment.*

General Adult Foster Care (AFC)- is typically a home licensed by the state of Michigan as an adult foster care home to provide shelter, three meals a day, and assure medications are given to persons receiving services. The homes may have people referred from the Department of Health and Human Services or from SCCMHA and network providers.

Specialized Residential Adult Foster Care (AFC)- is typically a home licensed by the state of Michigan as an adult foster care home to provide shelter, three meals a day, and assure medications are given to persons receiving services. These homes also have a certification by the State of Michigan to provide specialized care and have a contract with a Community Mental Health Specialty Program (CMHSP). This specialized contract pays for the additional staffing required to provide the extra care that is required for the people receiving services. These AFC homes must abide by HCBS rules in order to pay the providers. These homes are required to have 24-hour awake staff and at least two staff on shift unless otherwise noted in the contract with the CMHSP. Please refer to SCCMHA Policy on Residential Services 03.02.07 and related policies 03.02.07.01-03.02.07.11 for more information about requirements.

References:
SCCMHA Policy on Transition/Discharge Services 03.02.13
SCCMHA Procedure on Care Management Procedure on Continuing Stay Reviews 09.03.01.04
SCCMHA Policy on Member Enrollment, Transfer/Discharge, Quality Data and Case Service Status 05.04.02
SCCMHA Policy on Residential Services 03.02.07

Exhibits:
Exhibit A - Intake Process
Exhibit B - Intake Steps Chart
Exhibit C - Case Transfer Checklist
Exhibit D - Care Management Specialist Disposition form
Exhibit E - SCCMHA Care Management Continuing Stay Review/Level of Care Review
Exhibit F – Level of Care Change Form – Adult Version
Exhibit G – Level of Care Change Form – Child Version

Procedure:

ACTION	RESPONSIBILITY
Case transfer from Central Access and	

Intake (CAI):	
a. Will complete Intake Assessment to determine Eligibility for SCCMHA services.	CAI Specialist
b. Will complete checklist of forms and have them scanned into Sentri.	CAI Specialist
c. Will assign to a team in Sentri for orientation.	Care Management Specialist
d. Will review *Case Transfer Checklist attached*, to make sure all documents are in the person receiving services file.	Receiving Case Holder
e. Care management Specialist will provide authorization for orientation.	Care Management Specialist
f. Will schedule orientation in Case Holder Supervisor; Sentri scheduler.	CAI Specialist
g. Will give proper status in Sentri scheduler of orientation appointment met.	Receiving Case Holder Supervisor/designated staff
h. Will transfer case to Case Holder within five (5) working days.	Receiving Case Holder Supervisor
i. Will schedule face to face meeting with person receiving services within five (5) working days of assignment.	Receiving Case Holder
j. Will complete an update to the Initial Assessment (this will convert the Initial Assessment to an Annual Psychosocial Assessment) of strengths and needs and record in Sentri within 45 days. This update should also include the necessity for any additional services identified within the 45 days' timeframe. *If person receiving services is also receiving therapy from the record holder then a Therapy Assessment is needed in addition to the updated psychosocial assessment.*	Receiving Case Holder
k. Initiates Person-Centered Planning process including completing a Pre-Plan to set the planning meeting with person receiving services and/or family.	Receiving Case Holder

l. Will obtain any items missing at first visit with person receiving services/family. *See Case Transfer Checklist attached.*	Receiving Case Holder
m. The receiving Case Holder will add any needed authorization for assessments of needed services and supports.	Receiving Case Holder
Case Transfer with Same Level of Service:	
Transferring Case Holder:	
a. Will discuss with person receiving services the need for the person to be transferred to new Case Holder and document in the person receiving services electronic medical record (Sentri).	Transferring Case Holder
b. Will assure all mandatory documents are in the person receiving services file. *See Case Transfer Checklist attached.*	Transferring Case Holder/Supervisor
c. Will complete update psychosocial assessment and update person receiving services /family plan if plan and psychosocial assessment does not contain current information about the person receiving services /family or/is 326 days old or older.	Transferring Case Holder/Supervisor
d. Completes the Care Management continuing stay or level of care form to request transfer. *Refer to Continuing Stay procedure 09.03.01.04.*	Transferring Case Holder
e. Review request and documents in sentri the disposition of review.	Care Management Specialist
f. Assures all mandatory documents are in the person receiving services file. *See Case Transfer Checklist attached.*	Transferring Case Holder
g. Discusses with receiving team supervisor the need to transfer the person receiving services to a new	Transferring Case Holder Supervisor

team.	
h. Notifies both receiving and transferring Case Holder and both Supervisors of the decision via Care Management disposition form. *Refer to Continuing Stay procedure 09.03.01.04.*	Care Management Specialist
i. Care Management Specialist sets the time and day of orientation in the supervisor Sentri scheduler and enters authorization for orientation. Notifies transferring supervisor of orientation appointment.	Care Management Specialist
j. Transferring Case Holder notifies person receiving services of orientation for new case manager. ***Please note: Transferring Case Holder maintains case until orientation appointment has been met.***	Transferring Case Holder
k. Will give proper status in sentri scheduler of orientation appointment met.	Receiving Case Holder Supervisor
l. Transfers the person receiving services case in Sentri to appropriate team and Case Holder once orientation appointment has been met and notifies the transferring team and Case Holder of transfer.	Care Management Specialist
m. Will transfer case to Case Holder within five (5) working days.	Receiving Case Holder Supervisor
n. Will assure receiving Case Holder is aware of any upcoming appointments or other relevant information needed by receiving case holder.	Transferring Case Holder
o. Reviews consumer information including those items noted in policy section of this document. Will assure the assessment and plan, are not older than 326 days prior to official transfer of case in Sentri.	Care Management Specialist
p. Will make sure all progress notes are up to date from transferring case	Transferring Case Holder,

manager.	
q. Will make sure appropriate authorization(s) is/are in place for receiving Case Holder for residential, CLS, Respite, MiAIMS/Adult Community Placement, Occupational Therapy, Physical Therapy, Speech Therapy, Psychologist, Psychiatrist, Supported Employment, Clubhouse, Drop-In Center, Medication Drop, etc. services.	Transferring Case Holder Supervisor and Care Management Specialist
r. Will notify Case Holder Supervisor of Case Holder receiving the person receiving services case.	Transferring Case Holder Care Management Specialist
Receiving Case Holder:	
a. Completes the orientation, gives proper status of orientation in sentri scheduler, and notifies care management specialist of met orientation appointment.	Receiving Case Holder Supervisor
b. Assigns Case Holder within five (5) working days of the receipt of notice of transfer.	Receiving Case Holder Supervisor
c. Will assure all mandatory documents are in person receiving services file. Including health care coordination notifying primary care physician of change in service and new case holder. *See Case Transfer Checklist attached.*	Receiving Case Holder
d. Will meet with person receiving services within ten (10) working days of assignment.	Receiving Case Holder
e. Will obtain new notice of privacy practices if needed (different agency from transferring case holder).	Receiving Case Holder
f. Will review psychosocial assessment and person receiving services/family plan.	Receiving Case Holder
g. Will review plan with person receiving services/family to assure plan is relevant and still what	Receiving Case Holder

person receiving services wants in the plan.	
h. Will ensure that goals and objectives noted in plan are still relevant for the person receiving services/family. If not, new psychosocial assessment and plan should be developed.	Receiving Case Holder
i. Will submit authorization request for any additional services or supports noted during contacts.	Receiving Case Holder
Case Transfer to Different Level of Service:	
Transferring Case Holder:	
a. Will discuss with person receiving services the transfer of the care and coordination to a new Case Holder and document in person receiving services chart (sentri).	Transferring Case Holder
b. Will assure all mandatory documents are in the person receiving services file (sentri). *See Case Transfer Checklist attached.*	Transferring Case Holder
c. Will complete SCCMHA Care Management Continuing Stay Review/Level of Care Review form (*see attached*)	Transferring Case Holder
d. Will complete updated psychosocial assessment and update plan if plan and psychosocial assessment do not contain current information about the person receiving services/family or are 326 days old or older.	Transferring Case Holder
e. Discusses with receiving team supervisor the need to transfer the person receiving services to a new team.	Transferring Case Holder Supervisor
f. Will complete and adequate notice for appeal.	Transferring Case Holder
g. Will assure all progress notes are up to date.	Transferring Case Holder
h. Will assure all authorizations and consents are in place prior to	Transferring Case Holder

transfer. Assure authorizations will not expire in the next 15 days.	
i. Assures all mandatory documents are in the person receiving services file. *See Case Transfer Checklist attached.*	Transferring Case Holder Supervisor
j. Discusses with receiving team supervisor the need to transfer the person receiving services to a new team.	Care Management Specialist
k. Notifies both receiving and transferring Case Holder of the decision via Care Management disposition form. *Refer to Continuing Stay procedure 09.03.01.04.*	Care Management Specialist
l. Care Management Specialist sets the time and day of orientation in the supervisor sentri scheduler and enters authorization for orientation. Notifies transferring team of orientation appointment.	Care Management Specialist
m. Transferring Case Holder notifies person receiving services of orientation for new case manager. ***Please note: Transferring Case Holder maintains case until orientation appointment has been met.***	Transferring Case Holder
n. Receiving Case Holder Supervisor will give proper status in sentri scheduler of orientation appointment met.	Receiving Case Holder Supervisor
o. Transfers the person receiving services case in sentri to appropriate team and Case Holder once orientation appointment has been met and notifies the transferring team and Case Holder of transfer.	Care Management Specialist
p. Will transfer case to Case Holder within five (5) working days.	Receiving Case Holder Supervisor
q. Will assure receiving Case Holder is aware of any upcoming appointments or other relevant information needed by receiving case holder.	Transferring Case Holder

r. Care Management Specialist will assure the assessment and plan, are not older than 326 days prior to official transfer of case in sentri.	Care Management Specialist
s. Will make sure all progress notes are up to date from transferring case holder.	Transferring Case Holder and Transferring Case Holder Supervisor
t. Will make sure appropriate authorization(s) is/are in place for receiving Case Holder for residential, CLS, Respite, Model Payments (ASAP), Occupational Therapy, Physical Therapy, Speech Therapy, Psychologist, Psychiatrist, Supported Employment, Clubhouse, Drop-In Center, Medication Drop, etc. services.	Transferring Case Holder
u. Will notify receiving Case Holder Supervisor of Case Holder receiving the person receiving services case.	Care Management Specialist
Receiving Case Holder:	
a. Completes the orientation and notifies care management specialist of met orientation appointment.	Receiving Case Holder Supervisor
b. Assigns Case Holder within five (5) working days of the receipt of notice of transfer.	Receiving Case Holder Supervisor
c. Make sure all mandatory information is in the person receiving services chart in sentri. *See Case Transfer Checklist attached.*	Receiving Case Holder
d. Will meet with person receiving services within ten (10) working days of assignment.	Receiving Case Holder
e. Will obtain any new releases of information including health care coordination notifying primary care physician of change in service and new case holder.	Receiving Case Holder
f. Will obtain new notices of privacy notices (if different agency from transferring case holder.)	Receiving Case Holder
g. Will have a 30-day authorization to	Care Management Specialist &

	complete an Will complete new assessment and plan as level of care has changed. If Case Holder has need of additional time to complete, please document reason for delay in person receiving services electronic medical record and contact Care Management Specialist to discuss the circumstances. *If person receiving services is also receiving therapy from the record holder, then a Therapy Assessment is needed in addition to the updated assessment.*	Receiving Case Holder
h.	Will request authorization for services and supports needed as part of new person receiving services plan.	Receiving Case Holder
i.	Will complete an adequate notice for appeal.	Receiving Case Holder
j.	Will give/send copy of updated plan to person receiving services/family.	Receiving Case Holder
k.	Will note date plan given/sent to person receiving services/family in sentri.	Receiving Case Holder
l.	Will monitor services and supports noted in the plan including additional services such as residential, CLS, Respite, MiAIMS for Adult Community Placement payments, Occupational Therapy, Physical Therapy, Speech Therapy, Psychologist, Psychiatrist, etc.	Receiving Case Holder
m.	Will make changes to person receiving services plan as necessary.	Receiving Case Holder

Exhibit A

INTAKE PROCESS

Step (in order)	**Staff**	**Time Standard**	**Actions/Description/Note**

Access Screening Contact /Intake Eligibility	CAI Intake Specialist	Point of service	• Potential Consumer calls/walks in for assistance
			  ○ Coordinates with CIS for Access Call Back
			• Creates Eligibility Screening (signs using code H0002)
			• Determines if meets intake eligibility
			  ○ If no, do linking
			  ○ If yes:
			• Creates Admission with CAI as Team
			• Makes Intake Appointment
			• Determines any proof document needs and requests consumer to bring to Appointment
			  ○ MI Consumer requests code H0031
			  ○ DD Consumer requests code 90887
			• Letter sent, to Consumer Re: expectations
			• Documents actions on Progress Note

Intake Appointment	CAI Intake Specialist	2 days from Access Screening Contact /Intake Eligibility	• Places name as "Case Holder" on Admission form
			• Creates Initial Intake assessment (date is start for Timeliness Standards)
			  ○ Marks Eligibility field as "Pending"
			  ○ Does not sign document
			• Obtains any needed proof documents
			  ○ Documents delays daily on Progress Note
			• Completes items on the Initial Orientation form
			• Sends notification to Care Management for Eligibility Determination
			• Documents action in a Progress Note (non-billable)

Eligibility Determination	Care Management Specialist	1 day from Notification	• Coordinates with CAI Intake Specialist to make a determination for Eligibility and Medical Necessity
			• Notifies CAI worker of eligibility determination
			  ○ If ineligible, notifies CAI worker to do linking
			  ▪ Sends Adequate Notice
			  ○ If eligible, notifies CAI regarding the Team
			  ○ Changes Team name on Admission from CAI to assigned Team
			• Documents actions on Progress Note (non-billable)
			• Creates Authorization for initial services (T1016/T1017)

Completion of Initial Intake Assessment	CAI Intake Specialist	1 day from Notification	• Completes Preliminary Plan fields on Initial Intake
			• Coordinates with Consumer and Team Supervisor's Sentri Calendar to set Orientation appointment date
			  ○ Email notification to Team Supervisor
			• Adds to Intake Assessment, Orientation appointment (14 days from Intake Assessment)
			  ○ Documents reason of deviation from 14 days on both Progress Note and Intake Assessment
			• Signs Initial Intake with Code H0031
			• Documents actions on Progress Note (non-billable)

Orientation Appointment	Team Supervisor or designee	5 days from Completion of Initial Intake Assessment	• Documents on Scheduler and on Progress Note any changes in appointment date
			• Meets consumer
			• Completes items on the Team Orientation Form
			• Introduces new Case Holder
			• Changes Admission Form Case Manager field to assigned Case Holder
			  ○ Sets meeting date for Pre-plan or initiates Pre-plan
			• Documents actions on Face/Face Progress Note using code T1016/T1017
			• Request Authorization for services based on the Preliminary Plan to expire 60 days from Orientation Appointment
			  ○ Requests Authorization for additional needed services (not indicated in the Preliminary Plan)
			  ○ Documents in a Progress Note

Pre-planning	Assigned Case Holder	5 days from Orientation Appointment	• Meets with consumer • Does Annual Assessment update from Intake Assessment • Starts Pre-planning • Documents in Face/Face Progress Note using apropos code

Exhibit B

INTAKE STEPS CHART

Deadline	**Point of service** →	**2 days** →	**1 day** →	**1 day** →	**5 days**
Step	Access Screening Contact /Intake Eligibility	Intake Appointment	Eligibility Determination	Completion of Initial Intake Assessment	Orientation Appointment
Who	CAI Intake Specialist	CAI Intake Specialist	Care Management Specialist	CAI Intake Specialist	Team Supervisor or designee

Does What	• Takes potential Consumer calls/walk ins for assistance
	  ○ Coordinates with CIS for Access Call Back
	• Determines if meets intake eligibility
	  ○ If no, completes linking
	  ○ If yes
	• Creates Admission with CAI as Team
	• Schedules Intake Appointment
	• Determines any proof document needs and requests consumer to bring to Appointment
	  ○ CM generates code H0031
	• Letter sent, to Consumer Re: expectations
	• Documents actions in Chart Note
		• Places name as "Case Manager" on Admission form
		• Creates Initial Intake assessment (date is start for Timeliness Standards)
		  ○ Marks Eligibility field as "Pending"
		  ○ Does not sign document
		• Obtains any needed proof documents
		  ○ Documents delays daily in chart Note
		• Completes items on the Initial Orientation form
		  ○ DD Consumers may need a second appointment made to discuss/review findings.
		• Sends notification to Care Management for Eligibility Determination
		• Documents actions in chart note
			• Coordinates with CAI Intake Specialist to make a determination for Eligibility and Medical Necessity
			• Notifies CAI worker of eligibility determination
			  ○ If ineligible, notifies CAI worker to do linking
			  ▪ Sends Adequate Notice
			  ○ If eligible, notifies CAI regarding the Team
			  ○ Changes Team name on Admission from CAI to assigned Team
			• CM generates code S9445 if eligible for service
			• Documents actions on Progress Note
			• Creates Authorization for initial services (T1017 or T1016)
				• Completes Preliminary Plan fields on Initial Intake
				• Coordinates with Consumer and Team Supervisor's Sentri Calendar to set Orientation appointment date
				  ○ Email notification to Team Supervisor
				• Adds to Intake Assessment, Orientation appointment (14 days from Intake Assessment)
				  ○ Documents reason of deviation from 14 days on both Chart Note and Intake Assessment
				• Signs Initial Intake with Code H0031
				• Documents actions in Chart Note
				•
					• Documents on Scheduler and on Progress Note any changes in appointment date
					• Meets consumer
					• Completes items on the Team Orientation Form
					• Introduces new Case Worker
					• Changes Admission Form Case Manager field to assigned Case Worker
					  ○ Sets meeting date for Pre-plan or initiates Pre-plan
					• Documents actions on Face/Face Progress Note using code T1016/1017
					• Request Authorization for services based on the Preliminary Plan to expire 60 days from Orientation Appointment
					  ○ Requests Authorization for additional needed services (not indicated in the Preliminary Plan)
					• Documents actions on Progress Note

Forms Screen	Eligibility Screening Admission Sentri Scheduler Chart Note	Admission Form Initial Intake Initial Orientation Form Email Chart Note	Admission Form Adequate Notice Email Progress Note	Initial Intake Sentri Scheduler Email Authorization Chart Note	Sentri Scheduler Admission Progress Note Team Orientation Form Progress Note
Tracking	**Chart Note**	**Initial Intake** **Chart Note**	**Progress Note**	**Initial Intake** **Chart Note**	**Progress Note**

03-27-12 revised 11-26-13; KW 5-2-16

Exhibit C

Case Transfer Checklist

From Central Access and Intake (CAI):

Case Manager to do the following:

☐ What Authorizations are in place?

☐ Proof of Notice of Privacy for your agency (i.e. SCCMHA, TTI, Westlund, Disability Network, Saginaw Psychological, Case Management of Michigan) in the file?

☐ Consent to Treatment form signed?

☐ Consumer notified of recipient rights and given brochure?

☐ Does person need to sign the Consent for Substance Abuse and receive the recipient rights booklet for Substance abuse treatment (any person receiving COD, IDDT, or Co-occurring Services)?

☐ Ability to Pay information is current in Sentri?

☐ Release of information to consumer primary care physician?

☐ Release of information for others as applicable: Payee, family other than guardian, other doctors or specialists, school, DHHS, Social Security Administration, etc.

☐ Health Care coordination notice sent to primary care physician noting services to be provided to consumer, notice of the primary record holder, psychiatrist if one is assigned, and any medications that are prescribed by psychiatrist.

☐ Assure all demographic fields are completed.

- Primary care physician (should match releases of information to primary care and should match health care coordination notice).
- Residential Living Arrangement
- Consumer people are filled in including guardian, payee, and other emergency contacts.
- Health Conditions are accurate

☐ If guardian involved a copy of guardianship papers are in the consumer file?

☐ Complete consumer psychosocial assessment of strengths and needs to determine services and reason for continuing treatment/services.

☐ Complete pre planning meeting and enter into Sentri.

☐ Complete planning meeting and enter into Sentri.

☐ Plan should address scope of services for all internal services, community resources, and any assistance the natural supports will give to assist the consumer.

☐ Make sure consumer receives or has copy of the following and these are explained to the consumer/family:

- Recipient Rights Booklet
- Recipient Rights Booklet for Substance Abuse *if* receiving services for Substance Use as well as Mental Health Services (any person receiving COD, IDDT, or Co-occurring Services)
- Copy of Independent Facilitation Brochure
- Copy of Appeals and Grievance Brochure

☐ Obtain signature on the consumer plan after development. Be sure appropriate boxes are checked on the form including consent to treatment.

☐ Send copy of signed signature page to Medical Records, or other staff that scan information into consumer electronic medical record; to scan into consumer electronic medical record.

☐ Enter date plan given/sent to consumer.

☐ All outstanding documentation will be completed prior to transfer, including Progress Notes, Case Notes, and scanned documents

Case Transfer Checklist

☐ If psychiatrist prescribes medications make sure consumer has signed medication consent for each medication and this is scanned into Sentri.
☐ Make sure if medications are initiated by the psychiatrist or changed, a new health care coordination notice is sent to the consumer primary care physician.

Same Level of Service:

Case Manager to check the following:

☐ Notify consumer/family of new primary case holder and new primary case holder contact information including supervisor name and contact information if unable to contact case worker.
☐ What Authorizations are in place?
☐ Make sure consumer receives copy of your agency (i.e. SCCMHA, TTI, Westlund, Disability Network, Saginaw Psychological, Case Management of Michigan, SVRC, New Hope) privacy practices. Notice of Privacy Practices.
☐ Does person need to sign the Consent for Substance Abuse and receive the recipient rights booklet for Substance abuse treatment? (any person receiving COD, IDDT, or Co-occurring Treatment)
☐ Ability to Pay information is current in Sentri?
☐ Release of information to consumer primary care physician?
☐ Release of information for others as applicable: Payee, family other than guardian, other doctors or specialists, school, DHHS, Social Security Administration, etc.
☐ Health Care coordination notice sent to primary care physician noting services to be provided to consumer and notice of the primary record holder, psychiatrist if one is assigned, and any medications that are prescribed by psychiatrist.
☐ Assure all demographic fields are completed.

- Primary care physician (should match releases of information to primary care and should match health care coordination notice.
- Health Care Conditions are correct and have not changed
- Residential Living Arrangement
- Consumer people are filled in including guardian, payee, and other emergency contacts.
- Correct team and primary case holder identified in the consumer chart?

☐ If guardian involved a copy of guardianship papers are in the consumer file?
☐ Date of next appointments such as with psychiatrist?
☐ Review consumer assessment of strengths and needs update if needed.
☐ Does consumer/family have current plan? If not develop.
☐ Is there a signature of the consumer/family on the consumer plan?
☐ Review plan with consumer/family to assure plan is reflective of consumer/family wants and needs.
☐ Develop new plan if goals/outcomes are different than the plan states.
☐ Make sure consumer receives copy of the following if they would like a new copy and these are explained to the consumer/family:

- Recipient Rights Booklet

- Recipient Rights Booklet for Substance Abuse *if* receiving services for Substance Use as well as Mental Health Services (any person receiving COD, IDDT, or Co-occurring Treatment)
- Copy of Independent Facilitation Brochure
- Copy of Appeals and Grievance Brochure

☐ Obtain signature on the consumer plan after development. Be sure appropriate boxes are checked on the form including consent to treatment.
☐ Send copy of signed signature page to Medical Records, or other staff that scan information into consumer electronic medical record, to scan into consumer electronic medical record.
☐ Enter date plan given/sent to consumer into sentri
☐ All outstanding documentation will be completed prior to transfer, including Progress Notes, Case Notes, and scanned documents
☐ If psychiatrist prescribes medications make sure consumer has signed medication consent for each medication and this is scanned into Sentri.
☐ Make sure if medications are initiated by the psychiatrist or changed, a new health care coordination notice is sent to the consumer primary care physician.

Different Level of Service Transfer:

Case Manager to check the following:

☐ Discuss with consumer/family the need to transfer to different level of service and why.
☐ What Authorizations are in place?
☐ Make sure consumer receives copy of your agency (i.e. SCCMHA, TTI, Westlund, Disability Network, Saginaw Psychological, Case Management of Michigan, SVRC, New Hope) privacy practices. Notice of Privacy Practices.
☐ Does person need to sign the Consent for Substance Abuse and receive the recipient rights booklet for Substance abuse treatment? (anyone receiving COD, IDDT, or Co-occurring services)
☐ Ability to Pay information is current in Sentri?
☐ Release of information to consumer primary care physician?
☐ Release of information for others as applicable: Payee, family other than guardian, other doctors or specialists, school, DHHS, Social Security Administration, etc.
☐ Health Care coordination notice sent to primary care physician noting services to be provided to consumer and notice of the primary record holder, psychiatrist if one is assigned, and any medications that are prescribed by psychiatrist.
☐ Assure all demographic fields are completed.

- Primary care physician (should match releases of information to primary care and should match health care coordination notice).
- Health Care Conditions are current and reflect consumer current conditions
- Residential Living Arrangement
- Consumer people are filled in including guardian, payee, and other emergency contacts.
- Correct team and primary case holder identified in the consumer chart in sentri?

☐ If guardian involved a copy of guardianship papers are in the consumer file in sentri?
☐ Date of next appointments such as with psychiatrist?

Case Transfer Checklist

☐ Complete new consumer psychosocial assessment as needs are probably different if consumer is changing level of service.
☐ Complete new plan of service to reflect the needed changes in services by consumer/family.
☐ Plan should address scope of services for all internal services, community resources, and any assistance the natural supports will give to assist the consumer.
☐ Make sure consumer receives copy of the following and these are explained to the consumer/family:

- Recipient Rights Booklet
- Recipient Rights Booklet for Substance Abuse if receiving services for Substance Use as well as Mental Health Services (anyone receiving COD, IDDT, and Co-occurring services)
- Copy of Independent Facilitation Brochure
- Copy of Appeals and Grievance Brochure

☐ Obtain signature on the consumer plan after development.
☐ Send copy of signed signature page to Medical Records, or other staff that scan information into consumer electronic medical record; to scan into consumer electronic medical record (sentri).
☐ Update Sentri with date plan was sent to consumer/guardian.
☐ Provide services and at the frequency noted in the plan and assure team members via monitoring are completing services at the frequency noted in the plan.
☐ Update goals as needed.
☐ All outstanding documentation will be completed prior to transfer, including Progress Notes, Case Notes, and scanned documents
☐ If psychiatrist prescribes medications make sure consumer has signed medication consent for each medication and this is scanned into Sentri.
☐ Make sure if medications are initiated by the psychiatrist or changed, a new health care coordination notice is sent to the consumer primary care physician.

FOR ALL TYPES OF TRANSFERS
☐ All outstanding documentation will be completed prior to transfer, including Progress Notes, Case Notes, and scanned documents

Exhibit D

Care Management

Care Management Specialist Disposition

Consumers Name: **Case Managers Name:**

Consumers Sentri ID: **Supervisors Name:**

Medical Necessity (please check one):

☐ Medical Necessity Criteria Met
Comments:

Diagnosis	

Medications:
Utilizations history

☐ Medical Necessity Criteria Not Met
Specify Reason:

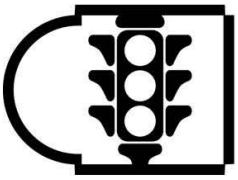
☐ Medical Necessity Criteria Met, but Service Array Modification Requested
Specify Change Requested and Reason:

Actions Taken/Date:

_____ _____
Care Management Specialist Date

_____ _____
Care Management Supervisor Date

Exhibit E



Care Management

SCCMHA Care Management Continuing Stay Review

Consumer Name:	**Sentri ID:**
Case Manager Name/Team:	**Supervisor:**
Current PCP Date:	

Information required will be used the SCCMHA Care Management Department to determine if a consumer currently enrolled in services continues to meet the required medical necessity criteria for continuing authorization of services.

Please complete this form electronically, print, sign, and forward to the Care Management Specialist assigned to your team. Complete as thoroughly as possible.

PROVIDER REPORT (To be completed by the Case Manager)	**CARE MANAGEMENT REVIEW (To be completed by Care Management Specialist)**
I. Diagnosis Date of Diagnosis: Diagnosis Given By: Axis I: Axis II: Axis III: Axis IV: Axis V: LOCUS Co-morbidity Score ( )	Is this diagnosis current and valid and is it a service eligible diagnosis according to Service Selection Guidelines? ☐ Yes ☐ No
II. Severity of Illness **Psychiatric Signs/Symptoms:** LOCUS Dangerousness/Risk Score ( )	Does the provider describe a severity of illness/functional impairments requiring access to the SCCMHA specialty array of supports and services? ☐ Yes

Functional Impairments List all functional impairments currently presenting: LOCUS Functional Status Score ( )	☐ No
III. Medications Please list consumers current medications:	Do the medications listed support medical necessity based on the diagnosis? ☐ Yes ☐ No
IV. Intensity of Services Start date of this episode of care: List services used in the last 12 months, including those provided by the primary care physician: List hospitalizations in the last 12 months: LOCUS Treatment and Recovery Score ( ) LOCUS Attitude and Engagement Score ( )	Has this consumer's utilization of services shown a need for access to the SCCMHA specialty array of supports and services? ☐ Yes ☐ No Has this consumer shown progress in treatment resulting in improvement in signs/symptoms/level of functioning as a result of services provided? ☐ Yes ☐ No
V. Proposed Continued Services Specify services requested for authorizations: Anticipated discharge date: Notes/Additional Comments:	Do the proposed continued services demonstrate that the consumer needs access to the SCCMHA array of specialty supports and services? ☐ Yes ☐ No

Exhibit F

Level of Care Change Form – Adult Version

SCCMHA Level of Care Change for Adults

Consumer Name:	Sentri ID:
CSM/SC Name/Team:	Supervisor:
Date:	Current PCP Date:

Diagnosis Review	
Diagnosis Import from Sentri	**Supported in Record**
Axis I	
Axis II	
Axis III	
Axis IV	
Axis V	

General Information

Review Purpose

☐ Initial ☐ Ongoing ☐ Discharge ☐ Acute Crisis

Did you discuss this change with consumer/parent/guardian: Yes ☐ No ☐

Supported in record (progress note/periodic review date):

1. Risk of Harm within last year & history of attempts, ideations, and self-harm behaviors.

Supported in record (progress note/periodic review date):

2. Current level of function to include psychiatric symptoms and medications used.

Supported in record (progress note/periodic review date):

3. Medical risk

Supported in record (progress note/periodic review date):

4. Substance abuse risk

Supported in record (progress note/periodic review date):

5. Treatment and Recovery History

Supported in record (progress note/periodic review date):

6. Benefits: adherence/non-adherence to current services.
Supported in record (progress note/periodic review date):

Utilization Summary	
Services over the last six months	
Entitlement Status	Hospital Episodes: Date/Number of Days
Reason for level of care change.	

Recommendations
Next Step in Recovery Plan
Disposition: ☐ Transfer to ☐ MI ☐ DD ☐ Increase Level of Care to ☐ Case Management ☐ ACT ☐ Maintain Level of Care; transfer to _____ ☐ Reduce Level of Care to ☐ Therapy only ☐ Case Management ☐ Prepare for Discharge to ☐ Outside Provider* ☐ Primary Care *agencies that accept consumer's Qualified Health Plan
Discharge Recommendations

CSM/SC Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Exhibit G

Level of Care Change Form – Child Version

SCCMHA Level of Care Change for Children

Consumer Name:	Sentri ID:
CSM/SC Name:	Supervisor:
Date:	Current PCP Date:

Diagnosis Review

Diagnosis Import from Sentri	Supported in Record
Axis I	
Axis II	
Axis III	
Axis IV	
Axis V	

General Information

Review Purpose
☐ Initial ☐ Ongoing ☐ Discharge ☐ Acute Crisis
Did you discuss this change with consumer/parent/guardian: ☐ Yes ☐ No
Supported in record (progress note/periodic review date):

CAFAS/PECFAS Total

1. Schoolwork	CAFAS/PECFAS Score	
Supported in record (progress note/periodic review date):		
2. Home	CAFAS/PECFAS Score	
Supported in record (progress note/periodic review date):		
3. Community	CAFAS/PECFAS Score	
Supported in record (progress note/periodic review date):		
4. Behavior towards others	CAFASPECFAS Score	
Supported in record (progress note/periodic review date):		
5. Moods and emotions	CAFAS/PECFAS Score	
Supported in record (progress note/periodic review date):		
6. Self-harm behavior	CAFASPECFAS Score	
Supported in record (progress note/periodic review date):		

7. Substance Abuse	CAFAS/PECFAS Score	
Supported in record (progress note/periodic review date):		
8. Thinking; symptoms and medications	CAFAS/PECFAS Score	
Supported in record (progress note/periodic review date):		
9. Adherence/non-adherence to current service (child and parent).		
Supported in record (progress note/periodic review date):		
DECA: If child is between 1 month and 47 months old please summarized your DECA results.		

Utilization Summary	
Services over the last six months	
Entitlement Status	Hospital Episodes: Date/Number of Days
Reason for level of care change.	

Recommendations
Next Step in Recovery Plan
Disposition: ☐ Transfer to ☐ MI ☐ DD ☐ Increase Level of Care to ☐ Wraparound ☐ Home Based Service ☐Autism ☐ Adult Services ☐Child Case Management ☐ Reduce Level of Care to ☐ Therapy only ☐ Maintain Level of Care; transfer to _____ ☐ Prepare for Discharge to ☐ Outside Provider* ☐ Primary Care *Agency that accepts consumer's Qualified Health Plan
Discharge Recommendations

CSM/SC/Therapist Signature: _____ Date: _____

Supervisors Signature: _____ Date: _____

Tab 4

Service Delivery

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Beyond Trauma: A Healing Journey for Women	**Chapter**: 02 – Customer Services & Recipient Rights	**Subject No**: 02.03.09.26
Effective Date: 8/29/2024	**Date of Review/Revision**: **Supersedes**:	**Approved By**: Sandra M. Lindsey, CEO
		Responsible Director: Director of Network Services, Public Policy, & Continuing Education **Authored By**: Mary Baukus **Additional Reviewers**: Brittany Burton, Sara Anani, EBP Leadership Team

Purpose:
The purpose of this policy is to specify the use of Beyond Trauma: A Healing Journey for Women.

Policy:
A. SCCMHA recognizes that the experience of trauma is the rule rather than the exception among persons served by the public mental health system.
B. Persons served who have been found to have experienced trauma shall be offered opportunities to participate in trauma-specific, evidence-based interventions.
C. SCCMHA shall, resources permitting, offer Beyond Trauma: A Healing Journey for Women for women or nonbinary individuals who have experienced trauma and are being served by SCCMHA-funded providers.
D. Beyond Trauma: A Healing Journey for Women can be delivered face-to-face, in-person, or via telehealth technology.

Application:
This policy applies to the SCCMHA-funded provider network.

Standards:
A. Beyond Trauma: A Healing Journey for Women groups shall be offered to women or nonbinary person served 18+ who have a history of sexual, physical, and/or emotional abuse.

B. Beyond Trauma shall be provided by female clinical members of the SCCMHA provider network who have completed SCCMHA-approved training and have been privileged to provide Beyond Trauma in accordance with SCCMHA policy.

C. Beyond Trauma shall be delivered by one or more facilitators who meet the following qualifications:
    a. A master's degree or higher in the mental health field
    b. Professional licensure (limited or full licensure)
    c. One two-day training of in-person Beyond Trauma: A Healing Journey for Women (or the live virtual equivalent).
    d. Annual clinical training on topics such as a specific *Beyond Trauma* refresher, or more general clinical training in trauma, cognitive behavioral therapy, relational therapy, and/or mindfulness of at least six hours in total.

D. Beyond Trauma: A Healing Journey for Women shall be delivered in accordance with fidelity to the model.

E. SCCMHA's quality improvement activities shall include fidelity monitoring to ensure adherence to the evidence-based practice model using the GOI (Global Organization Index) as a guide.
    1. The Evidence-Based Practice and Trauma-Informed Care Coordinator and the Director of Network Services, Public Policy, & Continuing Education will facilitate quarterly meetings for Supervisors of EBP Teams, including Beyond Trauma: A Healing Journey for Women when appropriate, to discuss fidelity monitoring.

F. When Beyond Trauma: A Healing Journey for Women is actively being offered, the Adult Strengths and Needs Assessment (ANSA) will be used as a tool to examine outcomes with reports reviewed at least twice per year (or as is appropriate for how frequently Beyond Trauma: A Healing Journey for Women is occurring) for Beyond Trauma: A Healing Journey for Women participants.

G. Beyond Trauma: A Healing Journey for Women is conducted in the following manner:
    1. Beyond Trauma: A Healing Journey for Women shall be conducted by one female leader or two female co-leaders, in once weekly 90-minute group sessions for twelve weeks.
    2. It is manual based with a facilitator's guide and participant workbook.
    3. The group consists of the following session topics:
        a) Introduction to the program
        b) The Connections between violence, abuse, and trauma
        c) Power and abuse
        d) The process of trauma and reactions to trauma
        e) How trauma affects our lives
        f) Abuse and the family
        g) The connection between trauma and addiction: Spirals of Recovery and healing
        h) Grounding and self-soothing
        i) The mind and the body connection
        j) Our feelings
        k) Healthy relationships
        l) Endings and beginnings

Definitions

Trauma: A psychologically distressing event that is outside the range of usual human experience, often involving a sense of intense fear, terror or helplessness that creates significant and lasting damage to a person's mental, physical, and emotional growth. According to SAMHSA (2014), trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

Beyond Trauma: A Healing Journey for Women: An evidence-based treatment for women who have experienced trauma. It consists of twelve sessions using cognitive-behavioral techniques, mindfulness, body-focused exercises, expressive arts, and the principles of relational therapy which are integrated in this strengths-based approach. The curriculum also has a psychoeducation component that teaches women what trauma is, its process, and its impact on both the inner self (thoughts, beliefs, values) and the outer self (behavior and relationships, including parenting). (*Stephanie S. Covington, PhD, 2024*)

References:

A. Covington, S. S. (2016). Beyond Trauma Facilitator Guide. Hazelden Information & Educational Services.
B. SCCMHA Policy 02.03.09 – Evidence-Based Practices (EPBs)
C. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports
D. SCCMHA Policy 04.01.04 – Trauma Screening, Assessment, and Treatment Services

Exhibits:

None

Procedure:

Refer to Evidence-Based Practices procedure.

<table>
<tr><td colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Suicide Prevention</td><td>Chapter: 02 – Customer Services & Recipient Rights</td><td>Subject No: 02.03.24</td></tr>
<tr><td rowspan="2">Effective Date:
8/1/16</td><td>Date of Review/Revision:
6/13/17, 5/11/18, 4/9/19, 7/29/20, 4/13/21, 5/10/22, 4/11/23, 10/01/24</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
Executive Director of Clinical Services

Authored By:
Mary Baukus

Additional Reviewers:
Jennifer Keilitz, Kristie Wolbert, Zero Suicide Implementation Committee</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:

This policy outlines guidelines and practices for the screening and assessment of suicidal ideation, determination of-frequency of assessment, subsequent planning, and continuity of service. It also includes all work standards related to documentation and communication across assessment, treatment, monitoring, and transfer of care.

Policy:

A. Within all the SCCMHA delivery system, safety to all persons served is of primary importance. Our programs incorporate trauma informed principles and evidenced based practices with an emphasis on safety, trustworthiness, opportunity for choice, collaboration, and connection, with strengths-based and skill building approaches to care. Suicide prevention is a complex social issue that cannot be addressed one dimensionally. SCCMHA aims to reduce death by suicide by acknowledging that suicide prevention requires assisting individuals in building lives worth living, by recognizing that suicide prevention is everyone's responsibility, and that SCCMHA will provide appropriate training and support in order for workforce members to feel comfortable and empowered to ask about thoughts of suicide.
B. SCCMHA is committed to preventing suicide and dedicating resources to support education and training as well as functioning as a catalyst to energize and mobilize key stakeholders to promote community awareness and support interventions that are targeted to eliminating suicidality. SCCMHA shall promote

an integrated, multi-tiered approach to suicide prevention in a comprehensive and collaborative manner to increase protective factors and mitigate risk factors (see Exhibit A) at both the community and individual served levels.

Application:
The policy applies to the entire SCCMHA service delivery system and is a foundational element of the system.

Standards:
A. SCCMHA shall adopt a "zero suicide" goal for all populations served as part of following the Zero Suicide Evidence-Based Practice.
B. Screening of Referrals
    a. Screening is required for all referred persons to any of SCCMHA's programs using the Columbia Suicide Severity Rating Scale (C-SSRS) at initial contact.
    b. The C-SSRS will help with clinical judgement to determine if the referred person meets criteria for services or another level of service and the need for frequency of suicide screening assessment.
    c. For persons served that are identified as needing low, moderate, or high frequency of screening for suicide prevention using the Columbia Suicide Severity Rating Scale (C-SSRS), the appropriate clinical staff member will conduct the following.
        i. Clinical staff member will complete the following for low risk:
            1. Outpatient referral.
            2. Develop (or review/update) collaborative safety plan.
            3. Next day follow-up with assigned staff or MRSS, with increased monitoring.
            4. See workflow (Exhibit C)
        ii. Clinical staff member will complete the following for moderate risk:
            1. Use clinical judgment to determine if further evaluation is necessary.
            2. Outpatient referral.
            3. Develop (or review/update) collaborative safety plan.
            4. Next day follow-up with assigned staff or MRSS, with increased monitoring.
            5. See workflow (Exhibit C)
        iii. Clinical staff member will complete the following for high risk or when further evaluation is deemed necessary:
            1. Escort person served to Crisis Intervention Services for possible inpatient evaluation.
                a. Follow recommendations of Zero Suicide Workflow
            2. Stay with patient until transfer to higher level of care is complete.
            3. Follow-up and document outcome of Crisis Intervention Services evaluation.
            4. If not going inpatient- develop (or review/update) a collaborative safety (crisis) plan.

5. Next day follow-up with assigned staff or MRSS, with increased monitoring.
6. See workflow (Exhibit C)

C. Job Role

a. SCCMHA believes that suicide prevention is everyone's responsibility. For the sake of clarity, job roles and expected role within the assessment, screening, and treatment planning will be outlined below.

1. Case Management/Case Holder/Therapist: It is appropriate for the case manager, case holder, secondary case holders, or therapist to screen using the C-SSRS to complete appropriate risk assessments including safety planning. Follow up tasks including enrollment into the Suicide Prevention Pathway and documentation should also be completed by the case manager/case holder/therapist as appropriate.
2. Prescribers: If there is no case manager available, the medical provider is responsible for screening using the C-SSRS and for immediate referral to crisis services for the completion of the risk assessment and safety plan if appropriate. Transferring to case management may be appropriate but risk must be assessed, and safety planning must be completed even if there are no case managers available.
3. Nursing and Enhanced Health Staff*: Nurses and Enhanced Health Staff should administer the C-SSRS and complete all required documentation including risk assessment and safety planning if needed. It is appropriate for nursing to consult with case management and supervisor.
4. Program Leadership: Leadership is an important part of suicide prevention. Program leadership is responsible for holding staff accountable to policies and best practices, providing consultation and support, answering questions related to the screening process, and providing guidance on the Suicide Prevention Pathway. Program leadership should also feel empowered to ask persons served about thoughts of suicide and utilize the C-SSRS if appropriate.
5. Support Staff: Support Staff should consult with clinical staff, including but not limited to case managers, social workers, or medical providers regarding any concerns with a presenting person served around suicide.

D. Suicide Care Planning and Treatment

a. Suicide care planning and treatment are based on C-SSRS Screening,

C-SSRS Assessment and Suicide Prevention Clinical Pathway.

b. Treatment planning accounts for potential for suicide, and capacity to form a treatment alliance. Treatment will include but not limited to
c. Individual therapy
d. Ongoing assessment
e. Case Management
f. Evaluation to determine need for Psychopharmacological Intervention

E. For persons served identified as struggling with suicidal ideations, therapeutic interventions will focus on the least restrictive level of care that is clinically appropriate in regard to warning signs, precipitating factors, risk factors, and protective factors.
F. Additional assessments and screenings including the PHQ-9 may be required by some services lines and programs. Refer to specific program guidelines for all required screenings.
    a. Ongoing Monitoring
G. Perform a C-SSRS Screening for all encounters with individuals served.
H. There will be the need for clinical judgement to be made for some situations regarding the use of the C-SSRS. For example, when working with individuals with an Autism Spectrum Disorder Dx who have demonstrated a strong and recent history of ruminating on the questions it would be appropriate to document in the sessions' progress note why the screen was not completed. However, even with these few types of exceptions we need clinical staff to remain in tune with the person served and to complete the screener when warranted. These types of exceptions should be minimal.
I. Clinical staff will review the current C-SSRS, Risk Assessment, and the Collaborative Safety Plan for persons served that are on the Suicide Prevention Clinical Pathway at all subsequent appointments.
J. Document review of C-SSRS tools and Collaborative Safety Plan in EHR.
K. Continue following Suicide Prevention Clinical Pathway until person served meets criteria to exit pathway.
    a. Discharge and Continuity of Care
    b. At Discharge, the following are required to be reviewed and assessed with the person served:
L. C-SSRS Screening
M. Collaborative Safety Plan
N. Appropriate resources and information on how to access future support and emergency services.
    a. Addressing a Missed Appointment
O. Clinical Professional to call person served during missed appointment time and at least one additional attempt the same day to contact and reschedule appointment.
P. Attempts to call the person served will continue within 24 hours of missed appointment to reschedule the appointment or verify the appointment scheduled by therapist.
Q. Send a caring Postcard, Letter, E-mail, or Text Message after missed appointment call.
R. A wellness check will be initiated by the treating clinical professional based on

clinical judgement, clinical consultations, and attempts to contact the person served.

S. Individuals who are served by SCCMHA shall be educated about crisis management services and how to access crisis services, including suicide or crisis hotlines and warm lines, at the time of the initial evaluation in accordance with the appropriate methods, language(s), and literacy levels of persons served.

T. The SCCMHA *Customer Services Handbook* (which describes how to access crisis management services, advance directives, and psychiatric advance directives) shall be distributed to all persons served during the initial meeting.

U. Psychiatric Advance Directives shall be documented in the person served's electronic health record.

V. Collaborative safety planning shall be offered to persons served and shall be deemed a formal component of the Person-Centered Plan.

   a. Safety plans shall be developed for at-risk persons served and documented in the electronic health record and shall include the components enumerated below.

      i. Identification of warning signs (e.g., feelings of hopelessness or irritability; thoughts like, "I'll always be alone"; behaviors like arguing with a parent; and/or physiological sensations such as intense pain from a chronic medical condition; or events, such as the anniversary of the death of a loved one) that risk for suicide is increasing in order to help persons served gain awareness of when they need to access and use their safety plan.

      ii. Identification of various categories of coping strategies persons served will use once they have recognized that they are at heightened risk for suicide.

      iii. Safety plans start with internal coping strategies (e.g., experiences that distract from suicidal thoughts, emotional distress, or urges by diverting attention to other activities, stimuli, or sensations) persons served can use without assistance from others and progress through incrementally more intensive strategies that can be used if the initial strategies prove ineffective.

      iv. Identification of individuals and social settings that can serve as a distraction during a suicidal crisis.

      v. Identification of individuals that can be contacted to request support.

      vi. Mental health providers or facilities (e.g., the treating clinician, hotline services including SCCMHA Crisis Services, Mobile Response and Stabilization Services, and 988 that can provide professional help if the person served is still in suicidal crisis after using the previous coping strategies.

      vii. Reduce the person served's access to their identified means for suicide.

W. SCCMHA shall conduct and/or sponsor training to support Zero Suicide. (See exhibit D.)

   a. Training shall be conducted and/or sponsored for mental health and substance use disorder treatment providers on the recognition, assessment, and

management of at-risk behavior as well as the delivery of effective clinical care for individuals who are at risk for suicide.

i. This level of training applies to master's degree & case holder bachelor's degree clinical providers.
ii. This staff shall receive initial and annual training on suicide prevention.
1. Mandatory initial and annual training requirements shall include suicide risk and assessment knowledge and roles of families and peers.

b. All SCCMHA staff and network providers who have contact with recipients of services shall be required to receive suicide prevention and suicide response training which shall include the Columbia-Suicide Severity Rating Scale (C-SSRS).
i. Non-clinical and secondary case holder staff shall renew training every three years.

X. SCCMHA shall promote the use of evidence-based suicide prevention and intervention practices.

Y. SCCMHA shall promote public awareness and resources to improve recognition of the signs and symptoms of mental disorders and risks for suicide and where to get help.

Z. SCCMHA shall promote and support community-wide efforts to reduce access to lethal means and methods of suicide.

AA. SCCMHA shall promote and support responsible media reporting of mental illness and suicide to reduce prejudice and stigma as well as prevent contagion.

BB. SCCMHA shall maintain authorship and make available the *Saginaw County First Responder's Guide for Behavioral Interventions* which is a written instruction tool for all local collaborating partners in dealing with any type of behavioral health crisis response, including the role of law enforcement in responding to a psychiatric crisis.

a. This document shall provide guidance and define all local collaborating partners' roles with SCCMHA, including the SCCMHA provider network, in urgent psychiatric and substance use disorder responses in the community.
1. NOTE: The *Saginaw County First Responders Guide for Behavioral Interventions* has been signed by all sixteen law enforcement jurisdictions in the county and by the Sheriff representing the County Jail and is actively used and referred to by officers in their collaborations with SCCMHA to meet urgent needs.

CC. SCCMHA shall publish a suicide hotline on its website.

DD. SCCMHA shall disseminate information to the community on suicide risk and prevention.

EE. The SCCMHA website shall describe available mental health crisis services and how to access them.

FF. The SCCMHA website shall offer a resource section on suicide awareness and prevention including links to the Saginaw County Suicide Awareness and Prevention

Service and other prevention resources including the Trevor Project for LGBTQ youth and the National Suicide Prevention Hot Line.

GG. SCCMHA shall participate in the regional suicide prevention or awareness initiative, the Great Lakes Bay Regional Suicide Prevention Coalition.

HH. SCCMHA shall support and promulgate its nationally recognized, award-winning anti-stigma campaign in an effort to reduce prejudice about mental disorders and suicide in an effort to enhance help-seeking behaviors (The One in Five Campaign).

II. SCCMHA shall offer Mental Health First Aid (MHFA) and Youth Mental Health First Aid (YMFA) to the community free of charge in order to promote improved knowledge and awareness and expand the capacity of the community to identify persons who are at-risk and increase referrals for treatment.

JJ. SCCMHA shall provide county-wide (and beyond as applicable to CCBHC [Certified Behavioral Health Clinic] persons served) crisis intervention services.

KK. SCCMHA shall provide 24/7 crisis services for adults and youth including suicide prevention and response, a mobile crisis team response (Mobile Response and Stabilization Services [MRSS]), emergency crisis intervention service and crisis stabilization and post intervention services.

LL. SCCMHA's Crisis Intervention Services (CIS) unit shall maintain a key responsibility to respond appropriately to any and all suicide related crises and emergencies.

MM. SCCMHA shall continue to promote trauma-informed policies and practices in order to ensure that persons served are treated with respect and in a manner that promotes healing and recovery.

i. Resources shall be made available to offer social support, resiliency training, problem-solving skills, and other protective factors to persons served and their families and/or support network.

ii. SCCMHA shall offer and/or link survivors with postvention services.

NN. SCCMHA shall ensure that systems are in place to evaluate the effectiveness and efficiency of the interventions provided (Quality Improvement).

OO. The SCCMHA Critical Incident Review Committee (CIRC) shall review all incidences of person served death by suicide and reported suicide attempts.

PP. Each attempt and successful suicide shall represent an opportunity for the system and provider to evaluate care delivered and to consider opportunities for improvement.

QQ. A root cause analysis of suicide attempts and deaths shall be conducted when recommended by the CIRC.

RR. Findings shall be used to continuously improve the quality of services and supports provided to persons served.

SS. Impacted staff shall be supported through a debriefing and EAP services are available.

Definitions:

Collaborative Safety Plan: A written list of warning signs, coping responses, and support sources that an individual can avail themselves of to avert or manage a suicide crisis.

Enhanced Health Staff: Includes dietary, speech, occupational therapy, physical therapy, and OBRA staff.

Potential Lethal Means: Any items that may be used by the person served to harm or injure self. Examples include shoestrings, belts, fingernail files, mirrors, all types of razors, knives, firearms. (List not inclusive of all lethal means.)
Postvention: Activities following a suicide to help alleviate the suffering and emotional distress of the survivors and prevent additional trauma and contagion; response to and care for individuals affected in the aftermath of a suicide attempt or suicide death.
Prevention: A strategy or approach that reduces the likelihood of risk of onset or delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviors; activities implemented prior to the onset of an adverse health outcome (e.g., dying by suicide) and designed to reduce the potential that the adverse health outcome will take place.
Protective Factors: Attributes, characteristics, or environmental exposures that reduce the likelihood of suicidal behaviors; conditions that promote strength and resilience and ensure that vulnerable individuals are supported and connected with others during challenging times that make suicidal behaviors less likely to occur. Protective factors may encompass biological, psychological, or social factors in the individual, family, and environment. For example, connectedness to others, including family members, teachers, coworkers, community organizations, and social institutions help increase an individual's sense of belonging, foster a sense of personal worth, and provide access to sources of support help to protect against suicide.
Resilience: Capacities within a person that promote positive outcomes (e.g., mental health and well-being) and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.
Risk factors: Personal or environmental characteristics that increase the likelihood that an individual will think about suicide or engage in suicidal behaviors. Risk factors may encompass biological, psychological, and/or social factors in the individual, family, and environment. For example, mental and/or substance use disorders can greatly increase the risk for suicidal behaviors. Suicide risk tends to be highest when someone has several risk factors at the same time.
Root Cause Analysis (RCA): A step-by-step method that leads to the discovery of a fault's first or root cause using a systematic approach to identify the progression of actions and consequences that led to an undesired event. Within the context of suicide prevention, an RCA investigation entails tracing the cause-and-effect path from a suicide attempt or death back to the root cause.
Screening: A procedure in which a standardized tool, instrument, or protocol is used to identify individuals who may be at risk for suicide.
Suicide: Death caused by self-directed injurious behavior with intent to die as a result of the behavior.
Suicide Attempt: A non-fatal, self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt may or may not result in injury.
Suicidal Behavior: A spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide as well as preparatory behavior such as buying a gun, hoarding pills, writing a suicide note, etc.
Suicide Contagion: Suicide risk associated with the knowledge of another person's suicidal behavior, either firsthand or through the media. Suicides that may be at least partially caused by contagion are sometimes called "copycat suicides." Contagion can

contribute to a suicide cluster. Community and media education is vitally important to reduce this risk.

Suicidal Ideation: Thoughts or fantasies about engaging in suicide-related behavior.

Suicide Risk: All aspects of suicidal thoughts, behaviors, and attempts or actions with the intent of killing oneself, regardless of lethality. The person served presenting with non-suicidal self-injury, involving intentional destruction to self, are also included.

Support Staff: Includes all clerical, peers, drivers, aids, Supported Employment, CLS workers, Respite Workers, Drop-In, Housing, Clubhouse, Residential/Direct Care Workers.

Warning Signs: Behaviors and symptoms that may indicate that a person is at immediate or serious risk for suicide or a suicide attempt.

Wellness Check: Contact family members and/or identified contact on Collaborative Safety Plan (authorization needed) or call Police (Non-Emergency Number) to check on person served.

References:

A. CDC National Vital Statistics System (Mortality Data).
B. Hope Network & Affiliates Network Policy, Suicide Prevention Policy, Revised 01/22/24.
C. Hope Network & Affiliates Network Policy, Suicide Prevention Procedure, Revised 01/22/24.
D. Michigan Suicide Prevention Plan: A Systems Level Approach to Preventing Suicide, 2024-2027. PowerPoint Presentation (govdelivery.com)
E. Saginaw County's First Responders Guide for Behavioral Health Interventions: https://www.sccmha.org/userfiles/filemanager/12403/
F. SCCMHA Policy 02.03.09.12– Mobile Response and Stabilization Services (MRSS)
G. SCCMHA Policy 02.03.09.17 – Mental Health First Aid (MHFA)
H. SCCMHA Policy 02.03.14 – Trauma-Informed Services and Supports
I. SCCMHA Policy 03.02.46 – Whole-Person Care
J. Suicide Prevention Resource Center Suicide Prevention Resource Center (sprc.org)
K. Zero Suicide Homepage | Zero Suicide (edc.org)

Exhibits:

A. Social Ecological Model of Risk and Protective Factors
B. Columbia-Suicide Severity Rating Scale (C-SSRS) and SAFE-T protocol (modified for SCCMHA SENTRI use).
C. Zero Suicide Workflow (Pathway) for Suicide Risk
D. Zero Suicide Training Plan
E. C-SSRS Completion Guidelines

Procedure:

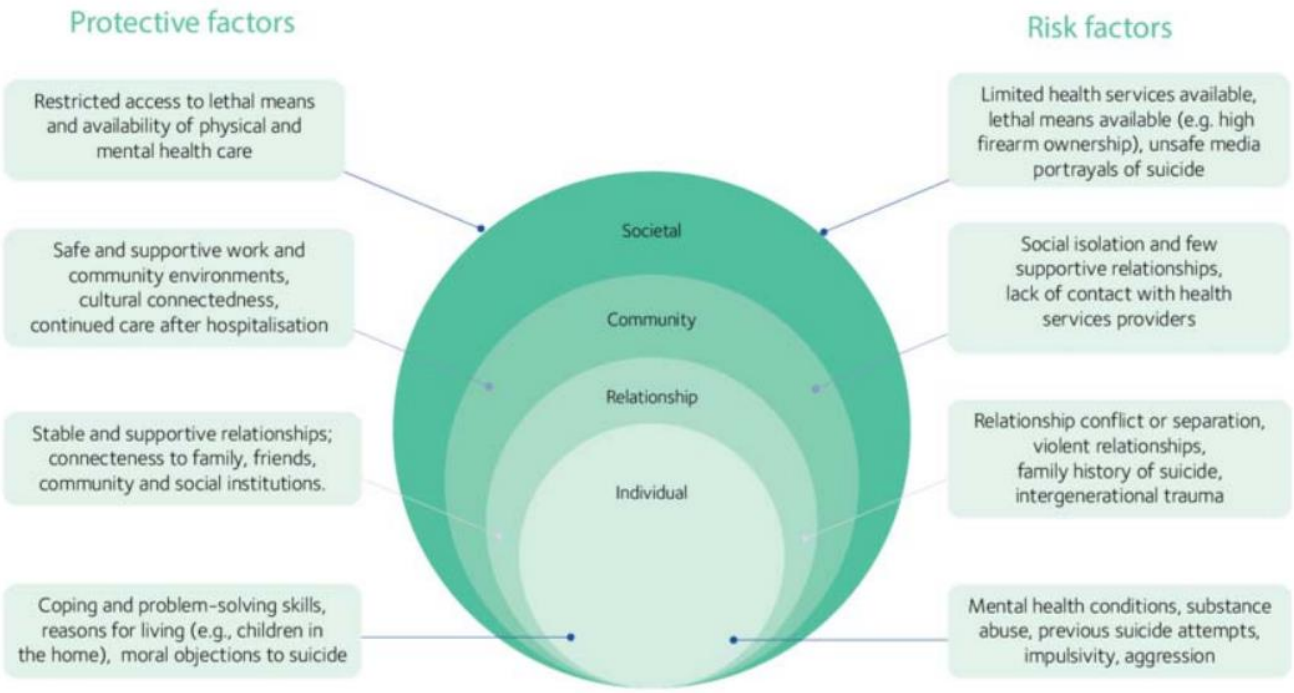
ACTION	RESPONSIBILITY
1. SCCMHA has a Zero Suicide Implementation Committee made up	1. Committee members

of a diverse group of workforce members. This committee is working to implement all aspects of the Zero Suicide practice.	
2. Conducts suicide risk screening using the PHQ-9 and the questions in the C-SSRS, during the initial assessment in addition to taking relevant measures in the ANSA or MichiCANS into consideration.	2. CAI/CIS/Case Holder
3. If the person served screens positive for suicide risk (i.e., a danger to self, others, or property as documented in SENTRI), follow the SAFE-T protocol for the risk level.	3. CAI/CIS/Case Holder
4. Conducts a CSS-R Suicide risk assessment.	4. CAI/CIS/Case Holder/assigned master's level clinician.
5. Works with at-risk persons served (and families as appropriate) to develop and/or revise and review a collaborative safety plan in the SCCMHA EHR.	5. CAI/CIS/Case Holder/assigned master's level clinician.
6. Works with the person served and family (as appropriate) as well as the treatment team to ensure the safety plan is incorporated into the person-centered plan and adhered to.	6. Case Holder
7. Screens persons served with the CSSR-S during each encounter.	7. CAI/CIS/Case Holder/assigned master's level clinician/secondary case holder/prescriber/nurse/enhanced health staff.
8. Follows SAFE-T protocol workflow for identified risk level.	8. Case Holder
9. Seeks consultation with supervisor and/or clinical leadership for all persons served with identified risk.	9. Case Holder

10. Conducts routine, ongoing screening of persons served with a history of suicide risk as well as persons served who are currently at risk using the SCCMHA EHR, ANSA, and/or MichiCANS in accordance with planned periodic reviews of the person-centered plan.	10. Case Holder
11. Provides consultation and guidance to staff.	11. Clinical supervisory staff/leadership

Exhibit A

Examples of Risk and Protective Factors in a Social Ecological Model



Suicide in Queensland Annual Report 2020 Suicide in Queensland: Annual Report 2020 National Library of Australia Cataloguing-in- Publication entry Title: Suicide in Queensland: Annual Report 2020

Exhibit B

Columbia-Suicide Severity Rating Scale (C-SSRS) and SAFE-T protocol

Step 1: Identify Risk Factors	
C-SSRS Suicidal Ideation Severity (If question 2 is "no" you may skip 3, 4 and 5)	**Month**
1) Wish to be dead *Have you wished you were dead or wished you could go to sleep and not wake up?*	*Yes No* ○ ○
2) Current suicidal thoughts *Have you actually had any thoughts of killing yourself?*	*Yes No* ○ ○
3) Suicidal thoughts w/ Method (w/no specific Plan or Intent or act) *Have you been thinking about how you might do this?* *E.g. "I thought about taking an overdose, but I never made a specific plan as to when where or how I would actually do it... and I would never go through with it."*	*Yes No* ○ ○
4) Suicidal Intent without Specific Plan *Have you had these thoughts and had some intention of acting on them?* *As opposed to "I have the thoughts, but I definitely will not do anything about them."*	*Yes No* ○ ○
5) Intent with Plan *Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*	*Yes No* ○ ○
6) **C-SSRS Suicidal Behavior:** *"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If "YES" Was it within the past 3 months?**	**Lifetime** *Yes No* ○ ○ **Past 3 Months** *Yes No* ○ ○
Risk Level	

RISK STRATIFICATION	TRIAGE
High Suicide Risk □ Suicidal ideation with intent or intent with plan **in past month** (C-SSRS Suicidal Ideation #4 or #5) **Or** □ Suicidal behavior **within past 3 months** (C-SSRS Suicidal Behavior)	□ **Escort person served to Crisis Intervention Services for possible inpatient evaluation** □ **Stay with patient until transfer to higher level of care is complete** □ **Follow-up and document outcome of Crisis Intervention Services evaluation** □ **If not going inpatient- develop (or review/update) a collaborative safety (crisis) plan** □ **Next day follow-up with assigned staff or MRSS, with increased monitoring.**
Moderate Suicide Risk □ Suicidal ideation with method, **WITHOUT plan, intent, or behavior in past month** (C-SSRS Suicidal Ideation #3) **Or** □ Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime)	□ **Use clinical judgement to determine if further evaluation is necessary** □ **Outpatient Referral** □ **Develop (or review/update) a collaborative safety (crisis) plan** □ **Next day follow-up with assigned staff or MRSS, with increased monitoring**
Low Suicide Risk □ Wish to die or Suicidal Ideation **WITHOUT method, intent, plan or behavior** (C-SSRS Suicidal Ideation #1 or #2) **Or** □ No reported history of Suicidal Ideation or Behavior	□ **Outpatient Referral** □ **Develop (or review/update) collaborative safety (crisis) plan** □ **Next day follow-up with assigned staff or MRSS, with increased monitoring**

Exhibit C

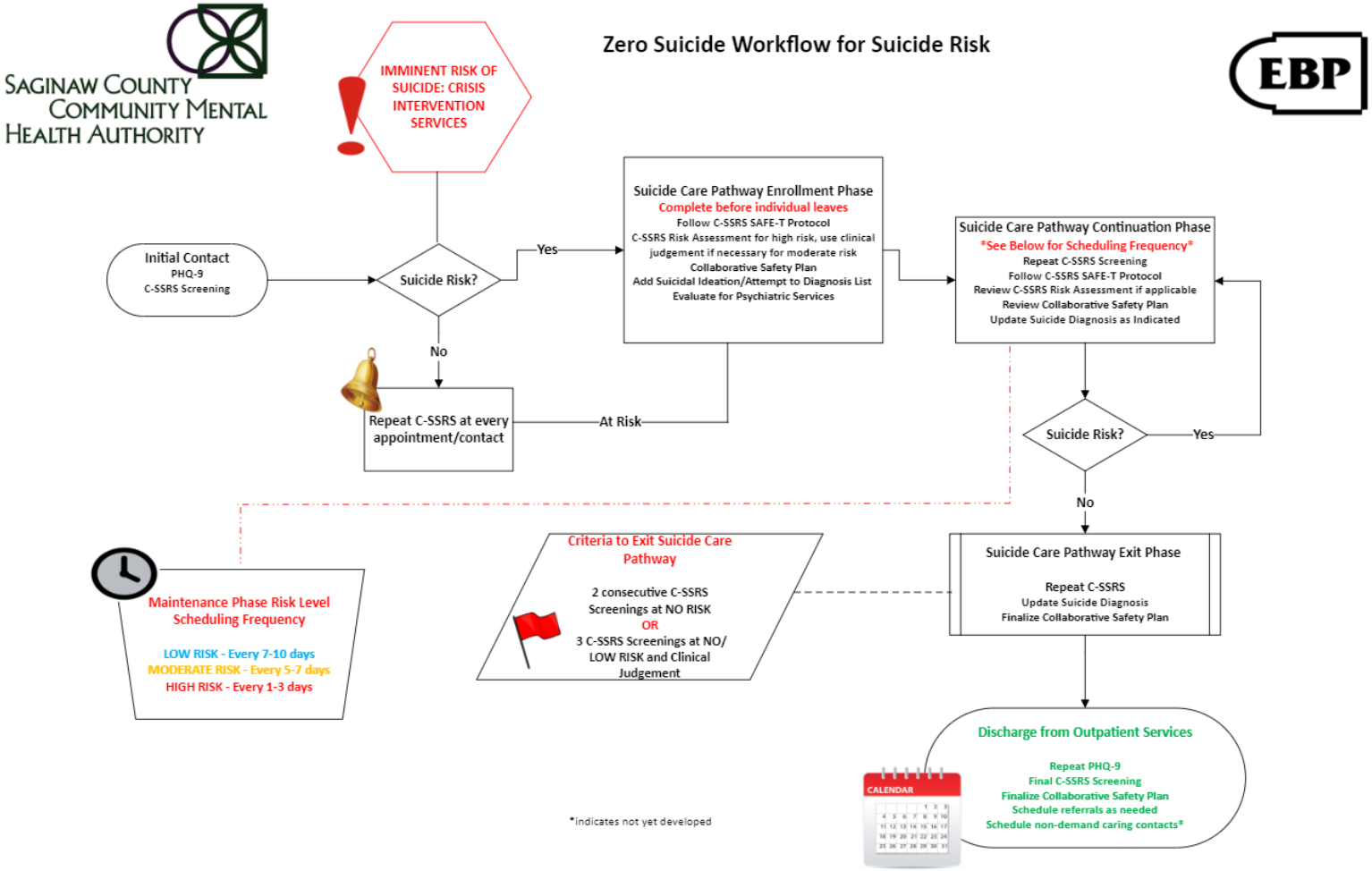

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY
Zero Suicide Workflow for Suicide Risk
EBP
IMMINENT RISK OF SUICIDE: CRISIS INTERVENTION SERVICES
Initial Contact
PHQ-9
C-SSRS Screening
Suicide Risk?
Yes
No
Suicide Care Pathway Enrollment Phase
Complete before individual leaves
Follow C-SSRS SAFE-T Protocol
C-SSRS Risk Assessment for high risk, use clinical judgement if necessary for moderate risk
Collaborative Safety Plan
Add Suicidal Ideation/Attempt to Diagnosis List
Evaluate for Psychiatric Services
Repeat C-SSRS at every appointment/contact
At Risk
Suicide Care Pathway Continuation Phase
See Below for Scheduling Frequency
Repeat C-SSRS Screening
Follow C-SSRS SAFE-T Protocol
Review C-SSRS Risk Assessment if applicable
Review Collaborative Safety Plan
Update Suicide Diagnosis as Indicated
Suicide Risk?
Yes
No
Suicide Care Pathway Exit Phase
Repeat C-SSRS
Update Suicide Diagnosis
Finalize Collaborative Safety Plan
Criteria to Exit Suicide Care Pathway
2 consecutive C-SSRS Screenings at NO RISK
OR
3 C-SSRS Screenings at NO/ LOW RISK and Clinical Judgement
Maintenance Phase Risk Level Scheduling Frequency
LOW RISK - Every 7-10 days
MODERATE RISK - Every 5-7 days
HIGH RISK - Every 1-3 days
Discharge from Outpatient Services
Repeat PHQ-9
Final C-SSRS Screening
Finalize Collaborative Safety Plan
Schedule referrals as needed
Schedule non-demand caring contacts*
CALENDAR
*indicates not yet developed

Exhibit D

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Zero Suicide Initiative Trainings Overview and Expectations

For a list of required training for your specific job role, please contact your supervisor.

Training Requirement for Non-clinical Staff & Secondary Case Holder Bachelor Level Staff			**Training Requirement(s) for Master & Bachelor *(Case Holder only)* Level Clinical Staff**		
Initial and Renewal Training must address cultural competence; person-centered and family-centered, recovery-oriented, evidence-based and trauma-informed care; and primary care/behavioral health integration.					
NON-CLINICAL & Secondary Case Holder Bachelor Level SCCMHA Network Staff - *Choose 1 training to meet suicide awareness & prevention requirement*					
Course Title	**Sponsor**	**Description**	**Required**	**Length**	**Compliance Date**
Suicide Awareness Training – Full Version *FREE*	Zero Suicide Free online training from Zero Suicide Alliance	A self-led, online suicide awareness training to gain skills and confidence to help someone who may be considering suicide. Will learn the skills and confidence to have a potentially life-saving conversation with someone you're worried about, how to spot suicide warning signs and where to go for further support.	Choice 1 of 5 / All non-clinical staff & PSS/PSP	20 Minutes	Within 90 days of hire and every 3 years. *Renewal from 1 of these 5 sources*
QPR Question, Persuade and Refer **Hope Network is providing online training at no charge.* ***They are also offering private training for up to 30 ppl for a minimal fee*	QPR Institute	The Gatekeeper course is self-led, online and takes approximately one hour to complete. KEY COMPONENTS COVERED IN TRAINING: The common causes of suicidal behavior, the warning signs of suicide and how to get help for someone in crisis. How to Question, Persuade and Refer someone who may be suicidal.	Choice 2 of 5 / All non-clinical staff	1-2 Hours	Within 90 days of hire and every 3 years. *Renewal from 1 of these 5 sources*
Connect Suicide Prevention/Intervention Training **$19-$49 pp fee*	www.theconnectproject.org	Connect is self-led, online training to prevent suicide by recognizing and responding to individuals at risk. Participants will learn to identify risk and protective factors and respond to warning signs for suicide. Intervening with individuals at risk and connecting the individual with appropriate resources.	Choice 3 of 5 / All non-clinical staff	2-4 hours	Within 90 days of hire and every 3 years. *Renewal from 1 of these 5 sources*
Mental Health First Aid FREE	National Council for Mental Wellbeing / SCCMHA	Skills-based training course that teaches participants about mental health and substance-use issues and basic suicide prevention. *3-year certification acquired*	Choice 4 of 5 / **Encouraged for nonclinical staff supplemental / not required*	8 hours, 2 hours self-led pre-work and 6-7 hours virtual, instructor led	Within 90 days of hire and every 3 years. *Renewal from 1 of these 5 sources* or Supplemental if requested
SafeTALK **possible no cost or $20-?$ fee – see website*	LivingWorks LivingWorks safeTALK - LivingWorks	Equips people to be more alert to someone thinking of suicide and better able to connect them with further help Document was last saved: Just now	Choice 5 of 5 / All non-clinical staff	4 hours	Within 90 days of hire and every 3 years. *Renewal from 1 of these 5 sources*
PSS/PSP Staff ONLY: Crisis Through a Peer Support Len Or	https://mipeers.org/	***Can complete one of the above or one of these MIPeers trainings*** This training provides information, skills, and practical applications that peer workers can use in various crisis settings. *Eligible for 19.5 MDHHS Continuing Education credits.*	Peer Support Staff and Parent Support Partners *Only*	In-Person / 3 days	Within 6 mos of hire and 1 hour annually *from any accredited/ CCBHC / mipeers*

Emotional CPR Two Day Training		Emotional CPR (eCPR) is a public health educational program designed to teach people to assist others through an emotional crisis in three simple steps: Connecting, Empowering and Revitalizing. *Eligible for 13 MDHHS Continuing Education credits*		In-Person / 3 days	*approved Suicide Intervention Education source*
Master & Bachelor (Case Holder only) Level Clinical staff training should include training related to suicide care. • Screening and Assessment (C-SSRS or AMSR as an EBP) • Safety Planning (Stanley Brown Safety Plan as an EBP) • Means Reduction (CALM or Talking About Lethal Means Course Training *or* will be completed through ASIST training)					
MASTER & Bachelor *(Case Holder only)* Level Clinical Staff *see below for options to meet training requirement*					
Course Title	**Sponsor**	**Description**	**Required**	**Length**	**Compliance Date**
Applied Suicide Intervention Skills Training (ASIST) Suicide Intervention Training	Living Works/ SCCMHA	Two-day interactive workshop in suicide first-aid. ASIST teaches participants to recognize when someone may be at risk of suicide, work with them to create a plan that will support their immediate safety and how to reduce access to the methods people use to kills themselves. ***14 CEs provided***	All master level clinical staff	16 Hours	Within 6 mos of hire and 1 hour annually *from any accredited/CCBHC approved Suicide Intervention Education source*
Counseling on Access to Lethal Means (CALM) *FREE* CHOOSE ONE – THIS OR *Talking About Lethal Means*	Zero Suicide https://zerosuicide.edc.org/resources/trainings-courses/CALM-course	Self-led, online – Focuses on how to reduce access to the methods people use to kills themselves. Will be able to: Explain that reducing access to lethal means is an evidence-based strategy for suicide prevention. Explain how reducing access to lethal means can prevent suicide. Identify clients for whom lethal means counseling is appropriate. Describe strategies for raising the topic of lethal means and feel more comfortable and competent applying these strategies with clients. Advise clients on specific off-site and in-home secure storage options for firearms and strategies to limit access to dangerous medications. Work with clients and their families to develop a specific plan to reduce access to lethal means and follow up on the plan over time.	All master level clinical staff	1.25-2 Hours	Within 6 mos of hire and 1 hour annually *from any accredited/CCBHC approved Suicide Intervention Education source*
Talking About Lethal Means *FREE* CHOOSE ONE – THIS OR *Counseling on Access to Lethal Means (CALM)*	HealtheKnowledge Talking About Lethal Means: A Course for Crisis Counselors	Self-led, online - Participants will learn how to collaborate with individuals in crisis to reduce their access to lethal means during a crisis conversation. The course includes actionable strategies for talking about lethal means, assessing and reducing a person's access to them, and building rapport. Participants will also learn how lethal means conversations can help decrease the need to involve emergency services.	All master level clinical Staff	2 Hours	Within 6 mos of hire and 1 hour annually *from any accredited/CCBHC approved Suicide Intervention Education source*
Assessing and Managing Suicide Risk (AMSR) **possibly free through SAMHSA* ***$50 pp through Hope Network*	AMSR	***MUST COMPLETE A SUICIDE INTERVENTION TRAINING PRIOR***How to provide effective treatment for patients and clients who are at risk of suicide. AMSR's research-informed risk formulation model helps health and behavioral health professionals feel confident navigating challenging conversations and offers key strategies for providing compassionate care to people at risk for suicide	All master level clinical staff	Virtual/live 8 hours	Within 6 mos of hire and 1 hour annually *from any accredited/CCBHC approved Suicide Intervention Education source*
QPR Question, Persuade and Refer **Hope Network is providing online training at no charge.* ***They are also offering private training for up to 30 ppl for a minimal fee*	QPR Institute	The Gatekeeper course is self-led, online and takes approximately one hour to complete. KEY COMPONENTS COVERED IN TRAINING: The common causes of suicidal behavior, the warning signs of suicide and how to get help for someone in crisis. How to Question, Persuade and Refer someone who may be suicidal.	All master level clinical staff	1-2 Hours	Within 6 mos of hire and 1 hour annually *from any accredited/CCBHC approved Suicide Intervention Education source*

Master & Bachelor (Case Holder Only) Level Clinical Training: 3 Steps to complete initial training requirement:
Suicide Intervention Training; Access to Lethal Means Training; and Managing Risk Training.

SCCMHA Zero Suicide Vetted Options to meet initial training requirement
Completion of these **3**: Question, Persuade and Refer Training, Access to Lethal Means Training and Managing Risk Training
OR
Completion of these **2**: ASIST Training and AMSR Training

1-hour annual renewal *from any accredited/CCBHC approved Suicide Intervention Education source*

CLINICAL STAFF Bachelor (Case Holder)/Master Level: ASSESSEMENTS

Course Title	Sponsor	Description	Required	Length	Compliance Date
PHQ-9 FREE	Relias	This brief course will provide an introduction to the PHQ-9, a brief screening instrument designed to detect symptoms of depression. The benefits of screening with the PHQ-9 will be discussed, as well as scoring and interpretation of the instrument.	All staff who conduct screening	15 minutes	Within 30 days of hire
Assessing Suicide Risk Using the C-SSRS FREE	Relias	The Columbia-Suicide Severity Rating Scale (C-SSRS) is a questionnaire used for suicide assessment. This microlearning will present a brief overview of the instrument, including proper administration and scoring procedures, and information about how to proceed with the results of the C-SSRS.	All staff who conduct assessments	15 minutes	Within 30 days of hire

C-SSRS Completion Guidelines
July 2024

All persons served over the age of 6 are eligible for the C-SSRS screening regardless of diagnosis. The expectation is that the screening will be completed by staff with persons served at the time of providing services.

- The C-SSRS can be completed however services are being provided: in-person/face to face, audio-only, or audio-visual.
- All staff are eligible to complete the screening – it does not require any specific credentials to use.
    - This means that case holders, therapists, peer supports (adult and youth), nurses, occupational therapists, physical therapists, dieticians, etc. are all able to complete the screening when providing services to the people they serve.
- As an exemption, staff who do not work directly with a person served to complete their role (i.e. a Parent Support Partner) should not be completing the C-SSRS for time spent providing services to a parent or guardian. If services are provided to someone other than the person served, the C-SSRS is not eligible to be completed.

There are some instances where completing the screening would not be appropriate, in which case staff should choose "No" for the "Qualifies for suicide risk assessment?" question. Please see examples/reasons below why it would be acceptable for staff to **not** complete the C-SSRS with a person served at the time of providing services.

- The person served is non-verbal and not able to communicate answers to the yes/no questions being asked.
- The person served is cognitively unable to understand the yes/no questions being asked.
- The person served will perseverate on questions asked leading to possible decline in mental status.
- The person served is not present at the time of providing services. For example:
    - Staff is working with a parent/guardian/AFC staff/etc. and did not interact with the person receiving services.
    - Staff is completing care coordination tasks and did not directly contact the person receiving services.
- The purpose of contact with a person-served is to provide follow up care coordination. For example:
    - Calling a person served to schedule a future appointment.

Whatever the reason staff are not completing the C-SSRS, please ensure there is a clear reason why documented within the available text box. N/A is not an acceptable response as staff should be indicating *why* the screening is not applicable for that person served. A quick summary of their reason for not completing the screening should be documented for all instances of "No" being chosen. This summary should include what services were being provided that resulted in the screening not being appropriate at the time of services.

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Pest Prevention, Identification and Management</td><td>Chapter: 06 – Management of Health & Safety</td><td>Subject No: 06.03.01</td></tr>
<tr><td rowspan="2">Effective Date:
4/3/17</td><td>Date of Review/Revision:
10/10/23, 10/8/24</td><td rowspan="2">Approved By:
Sandra M. Lindsey, CEO</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td><td>Responsible Director:
Fred Stahl, Director of Human Resources

Authored By:
EOC Sub-Committee

Additional Reviewers:
Environment of Care Committee</td></tr>
</table>

Purpose:
The purpose of the Pest Prevention, Identification and Management Policy & Procedure is to provide and maintain, at all service site locations operated by SCCMHA, a safe, clean, pest-free environment.

Policy:
It is the policy of SCCMHA to seek to prevent and mitigate all identified insect/pest infestations to protect the health of customers, employees, contractors, vendors and other visitors to SCCMHA service site locations operated by SCCMHA. All employees and various program site locations must follow the reporting procedures contained in this policy. It will be the responsibility of the SCCMHA Facilities & Custodial Services Department to provide appropriate follow up to address any and all areas of concern at SCCMHA sites. Other SCCMHA network sites are responsible to promptly report, coordinate, and treat as noted in this policy. Upon suspicion of pest/insect reporting, appropriate referral for professional consultation is to take place.

Application:
This policy and procedure applies to all customers, employees, contractors, vendors and other visitors.

Standards:

I. To reduce any potential health hazard.
II. Prevent pests from spreading to the community or properties beyond the suspected/confirmed area of identification.

III. To provide a safe, clean, pest free environment in which individuals may render and/or receive health services.
IV. SCCMHA will provide training to staff on pest prevention and appropriate response.
V. Staff are required to report potential pest concerns to the appropriate parties.

References:
MDCH Michigan Manual for Prevention and Control of Bed Bugs
SCCMHA Employee Handbook

Definition: Use of the term *pest* is intended to include the following: Bed Bugs and Fleas. Other insects, as defined per Professional Exterminator/Pest Control Vendor, are addressed elsewhere in policy, procedure and/or protocol.

Exhibits:
Exhibit A: SCCMHA Pest Response Flow Chart per work locations
Exhibit B: MDCH Don't let Bed Bugs Bite
Exhibit C: University of Minnesota Extension *Let's Beat the Bed Bug* Campaign-Resource

- Have I Found a Bed Bug?
- What Not to do When You have Bed Bugs
- Understanding Bed Bug Treatments
- Bed Bug Control in Residences
- Prevention Tips for Employee's

Procedure:

ACTION	RESPONSIBILITY
1. SCCMHA will provide educational in-services, trainings, updates, and any additional necessary information concerning pest prevention and response to all staff.	1. Continuing Education Unit, General Utilities and Custodial Supervisor, Professional Exterminator vendor
2. These educational sessions are to be offered periodically and required annually.	2. Continuing Education Unit, Environment of Care Committee
3. A standard for staff response and reporting is located on the Pest Response Flow Chart for the designated work location (Refer to the SCCMHA Employee Handbook #622). All staff is expected to implement the procedures outlined in this policy.	3. All Staff

4. Standards for Supervisors will include education and adherence to policy standards.	4. All Supervisors
5. Standards for facilities and custodial response will be initiated per the Facilities policy and procedure.	5. General Utilities and Custodial Supervisor and Custodial staff
6. Quarterly updates will be provided to the Environment of Care Committee regarding Facilities response actions, outcomes, trends and/or patterns.	6. General Utilities and Custodial Supervisor Supervisor, Environment of Care Committee, Contract Management Supervisor
7. Random, routine preventative inspections are done by the Custodial Services Department. Locations include: Hancock, A&W, CTN, CTS, FSU, TWL, Salter Place, and Supported Employment.	7. Professional Extermination vendor, Contract Management Supervisor
8. Discontinuation of individual services may be determined on a case by case analysis and only under the direction of the Clinical Services Director and Office of Recipient Rights.	8. Clinical Services Director and/or Office of Recipient Rights
9. Because an infestation can be transmitted via clothing, bags, or other personal items between SCCMHA operated or contracted program/office sites, all providers are expected to be alert for potential infestation. Supervisors of sites where infestation has been transferred or suspected of being transferred must communicate risk between programs where found. Although contractors are responsible for the cost of addressing infestation at their own sites, SCCMHA will make bed bug information and initial treatment kits available to all contracted programs (or partners) immediately upon request as issued	9. All network Supervisors will coordinate containment and treatment efforts within and between program sites. Contracted programs are expected to identify a lead person who is responsible to ensure the infestation is promptly and thoroughly addressed, as well as ensure ongoing prevention and monitoring for such at their program sites. This includes communication with SCCMHA and other community resource sites if an infestation is identified at their program and before there is any interfacing with these resource sites.

by the SCCMHA Contracts & Properties Unit. In certain situations when landlords may not be responsible, housing assistance benefits can be used for fumigation.

Exhibit A

A & W

Pest Management Response

SCCMHA Department becomes aware of a pest problem by either observation or notification.

Immediate Response

Do Not Panic

Notify your supervisor and discreetly move the individual from a public space to the lounge behind security.

Provide educational counseling & support to the individual.

Report to Case Holder (CM/SC).

Identify other potential locations at risk of exposure and notify as appropriate, (ie) CTS, CTN, Transportation, FRC and other SCCMHA owned properties.

The affected department should complete and file an Incident Report

Environmental Response

Contact the General Utilities and Custodial Supervisor at 989-928-8172

Location of exposure needed.

Custodial Team alerted.

-Assist the individual in securing personal items in designated receptical

A&W 2nd Floor

CTN

Pest Management Response

SCCMHA Department becomes aware of a pest problem by either observation or notification.

Immediate Response

Do Not Panic

Notify your supervisor and discreetly move individual from a public space to the Gym.

Provide educational counseling & support to the individual.

Report to Case Holder (CM/SC).

Identify other potential locations at risk of exposure and notify as appropriate, (ie) CTS, CTN, Transportation, FRC and other SCCMHA owned properties.

The affected department should complete and file an Incident Report

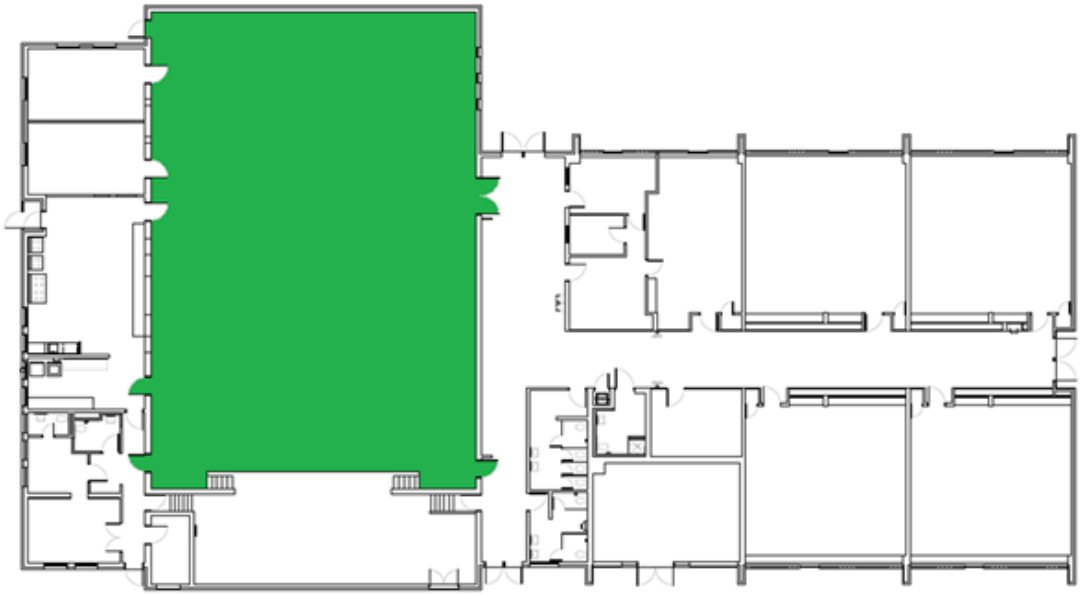
Environmental Response

Contact the General Utilities and Custodial Supervisor at 989-928-8172

Location of exposure needed.

Custodial Team alerted.

-Assist the individual in securing personal items in designated receptical



CTS

Pest Management Response

SCCMHA Department becomes aware of a pest problem by either observation or notification.

Immediate Response

Do Not Panic

Notify your supervisor and discreetly move the individual from a public space to the Gym.

Provide educational counseling & support to the individual.

Report to Case Holder (CM/SC).

Identify other potential locations at risk of exposure and notify as appropriate, (ie) CTS, CTN, Transportation, FRC and other SCCMHA owned properties.

The affected department should complete and file an Incident Report

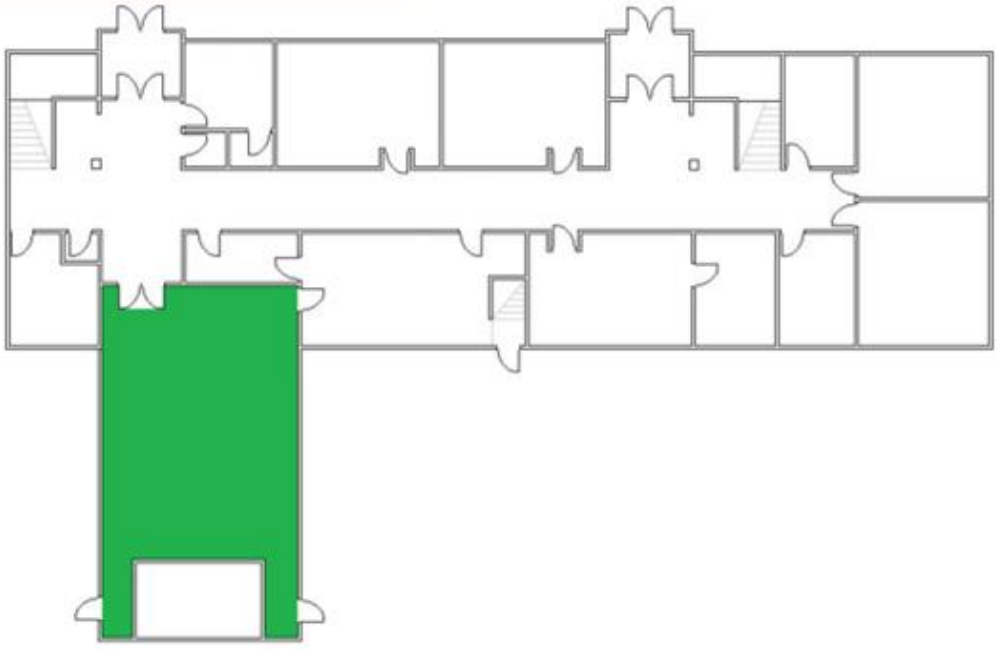
Environmental Response

Contact the General Utilities and Custodial Supervisor at 989-928-8172

Location of exposure needed.

Custodial Team alerted.

-Assist the individual in securing personal items in designated receptical



Supported Employment

Pest Management Response

SCCMHA Department becomes aware of a pest problem by either observation or notification.

Immediate Response
Do Not Panic
Notify your supervisor and keep the individual in place.

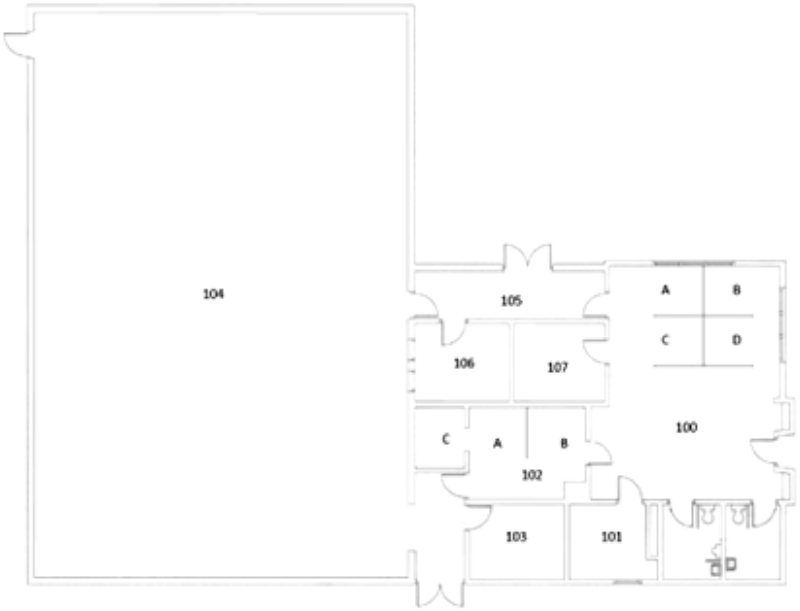
Environmental Response
Contact the General Utilities and Custodial Supervisor at 989-928-8172
Location of exposure needed.

Custodial Team alerted.
-Assist the individual in securing personal items in designated receptical

Provide educational counseling & support to the individual.
Report to Case Holder (CM/SC).

Identify other potential locations at risk of exposure and notify as appropriate, (ie) CTS, CTN, Transportation, FRC and other SCCMHA owned properties.

The affected department should complete and file an Incident Report



FSU

Pest Management Response

SCCMHA Department becomes aware of a pest problem by either observation or notification.

Immediate Response
Do Not Panic
Notify your supervisor and keep the individual in place.

Environmental Response
Contact the General Utilities and Custodial Supervisor at 989-928-8172
Location of exposure needed.

Provide educational counseling & support to the individual.
Report to Case Holder (CM/SC).

Custodial Team alerted.
-Assist the individual in securing personal items in designated receptical

Identify other potential locations at risk of exposure and notify as appropriate, (ie) CTS, CTN, Transportation, FRC and other SCCMHA owned properties.

The affected department should complete and file an Incident Report

Hancock

Pest Management Response

SCCMHA Department becomes aware of a pest problem by either observation or notification.

Immediate Response

Do Not Panic

Notify your supervisor and discreetly move the individual from a public space to a Crisis or Diversion room in CAI/CIS..

Environmental Response

Contact the General Utilities and Custodial Supervisor at 989-928-8172

Location of exposure needed.

Provide educational counseling & support to the individual.

Report to Case Holder (CM/SC).

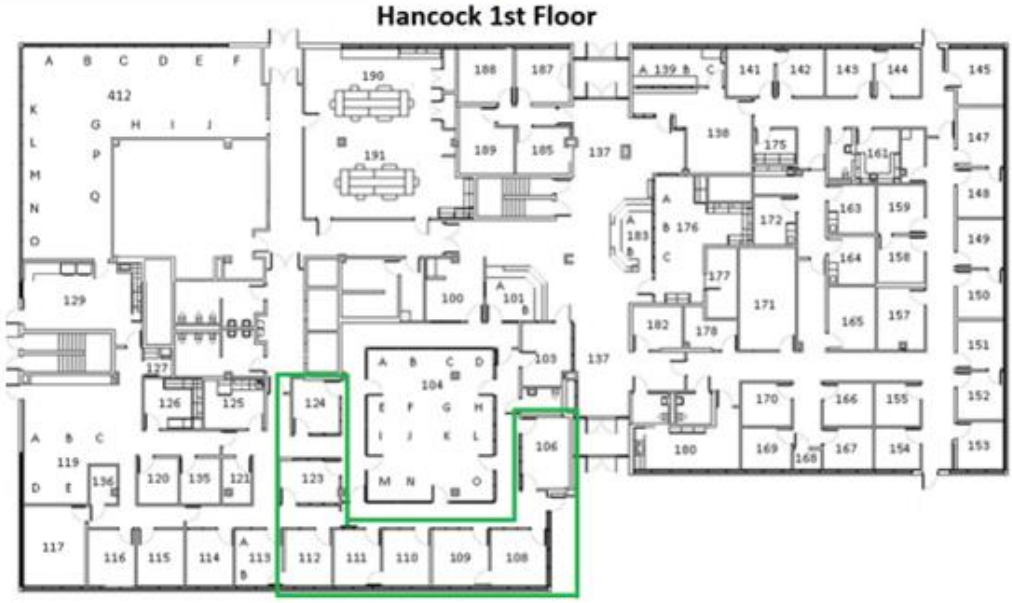
Custodial Team alerted.

-Assist the individual in securing personal items in designated receptical

Identify other potential locations at risk of exposure and notify as appropriate, (ie) CTS, CTN, Transportation, FRC and other SCCMHA owned properties.

The affected department should complete and file an Incident Report

Hancock 1st Floor



Salter Place

Pest Management Response

SCCMHA Department becomes aware of a pest problem by either observation or notification.

Immediate Response

Do Not Panic

Notify your supervisor and discreetly move the Individual from a public space to room 102.

Provide educational counseling & support to the individual.

Report to Case Holder (CM/SC).

Identify other potential locations at risk of exposure and notify as appropriate, (ie) CTS, CTN, Transportation, FRC and other SCCMHA owned properties.

The affected department should complete and file an Incident Report

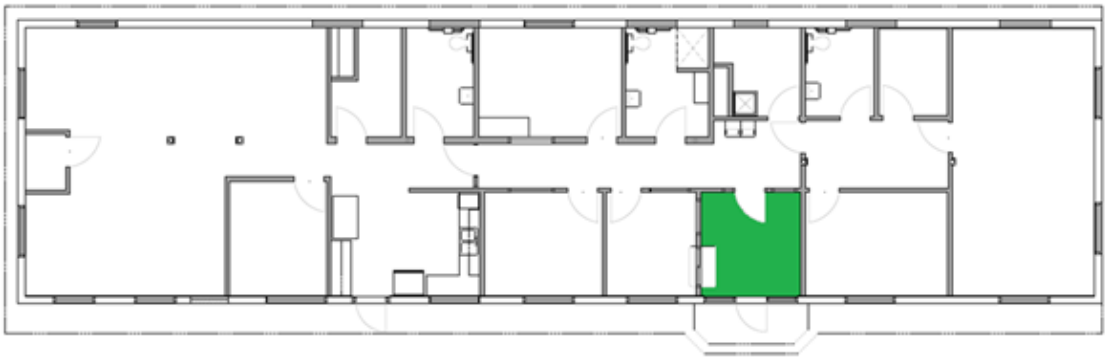
Environmental Response

Contact the General Utilities and Custodial Supervisor at 989-928-8172

Location of exposure needed.

Custodial Team alerted.

-Assist the individual in securing personal items in designated receptical



Towerline

Pest Management Response

SCCMHA Department becomes aware of a pest problem by either observation or notification.

Immediate Response

Do Not Panic

Notify your supervisor and discreetly move the Individual from a public space to room 102.

Environmental Response

Contact the General Utilities and Custodial Supervisor at 989-928-8172

Location of exposure needed.

Provide educational counseling & support to the individual.

Report to Case Holder (CM/SC).

Custodial Team alerted.

-Assist the individual in securing personal items in designated receptical

Identify other potential locations at risk of exposure and notify as appropriate, (ie) CTS, CTN, Transportation, FRC and other SCCMHA owned properties.

The affected department should complete and file an Incident Report

Transportation
Pest Management Response

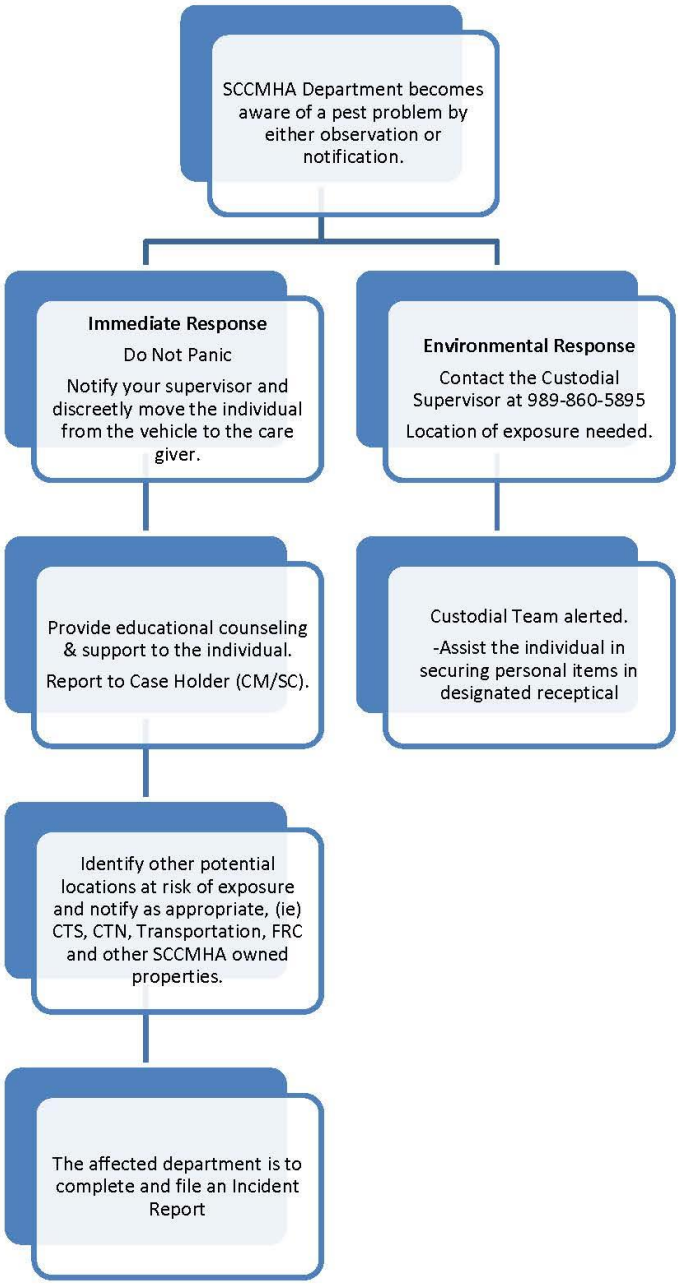


Exhibit B

- Consult a pest management professional before disposing of furniture.
- After washing store all clothing in tightly closed plastic bags until all insects have been eliminated. Normally after two or more treatments.

Important
Place bed bug infested clothing in washer or dryer directly from sealed bag to prevent an infestation of the laundry facility. Wash and/or dry on the high heat setting.

Tenant's Responsibility

- The faster you act, the better the results will be. When you spot bed bugs, immediately call your landlord.
- If your landlord doesn't take action, contact your local housing code authority.
- Don't try to solve the problem yourself.
- Keep your home clean and clutter-free.
- Carefully follow the pest management professional's recommendations.

Landlord's Responsibility

- When notified about bed bugs, landlords should immediately make efforts to correct the problem. Avoiding or ignoring the issue will only lead to a more severe infestation.
- To determine the extent of the infestation and better control the problem, landlords should enable the pest manager to inspect every room and apartment.
- Landlords should utilize an experienced professional pest manager or a certified staff.

Pest Management Professional's Responsibility

- Pest management professionals must make every effort to detect bed bugs throughout each room and all apartments in a building.
- Pest management professionals must make sure to destroy bed bugs at all stages of development (including eggs). This may require them to return at least twice to apply insecticides and check whether the first treatment worked.
- Pest management professionals must use insecticides according to label use directions. Effective Iternatives to pesticide treatment may be available such as by using heat or steam treatments.

CAUTION
Total release foggers (bug bombs) are not effective against bed bugs and may harm your health or your family's health. Before you chose to use over the counter pesticides, consult with a qualified pest management professional. Always read and follow the label-use directions before using such product(s).

For more information visit:
www.michigan.gov/bedbugs
or
www.epa.gov/bedbugs

Don't let

Bed Bugs

Bite

Guidelines to help you solve bed bug problems

WARNING!
Bed bugs are back with a vengeance! Any house, apartment or building can be a haven for bed bugs.

Produced by the
Michigan Bed Bug Working Group

MDHHS
Michigan Department of Health & Human Services

Bed bugs

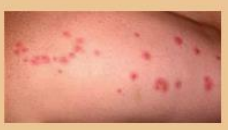
Bed bugs are small brownish insects. They're about 4 mm long (1/8 in.) and visible to the naked eye. They're active at night and can usually be seen along the seams of mattresses. They feed on human blood.

Bed Bug Life Stages

Bed bug infestations may cause irritating, itchy bite reactions, and anxiety.
Over the past few years, bed bugs have been spreading in large cities worldwide.

How to detect them

Itchy skin and insect bites are clues that you may have bed bugs in your home. You'll usually see three or four bites in a straight line or grouped together. Exposed areas of your arms, legs and back are more susceptible to bites. Also look for small black stains "blood spots" on your sheets, pillows, or mattress seams. Bed bugs may also be hiding in cracks and crevices in your furniture.



How they spread

Bed bugs are usually brought into your home in suitcases and handbags and on clothing and furniture, especially previously used mattresses and other items.

They can also travel between apartments in a building. There's no need to be embarrassed if these bugs end up moving in with you. Bed bugs are not necessarily associated with dirty environments, but they flourish in clutter.

How To Prevent Them

Vacuum your home regularly. If you do have bed bugs, make sure you close the vacuum bag tightly and dispose of it outside your home.

Avoid picking up used mattresses or second-hand upholstered furniture because it's hard to see whether they harbor bed bugs.

Other used furniture must be carefully inspected and cleaned before you bring it home. Scrub furniture with soapy water or a household cleaning product to remove any possible bed bugs or their eggs.

Second-hand clothing should be placed in a sealed, plastic bag and emptied directly into the washing machine. Wash in hot water and dry on hot setting to kill bed bugs and their eggs.

When visiting hotels inspect the room for signs of bed bugs prior to unpacking luggage.

Important
Avoid bringing home discarded furniture, it may be infested with bed bugs. Also inspect any used item for bed bugs before bringing it into your home.

Pest Management

To ensure successful treatment, your cooperation and that of your landlord and the pest management professional are key.

The important thing is to act fast. As soon as you see these bugs, call your landlord, who will then contact a qualified, licensed pest management professional.

Preparing your home for the pest management professional

This step is extremely important. Closely follow the pest management professional's guidelines. Below are a few tips to keep in mind.

- Remove clutter as it provides hiding places for bed bugs.
- Place all bedding (sheets, mattress covers, bedspreads) in a sealed, plastic bag. Wash and/or dry bedding on high heat setting.
- Vacuum and dispose of the vacuum bag (outside the home). If a bagless vacuum is used, deposit all contents of the container into a plastic bag, seal and dispose of outside. Rinse collection container outside before re-attaching to vacuum.
- Empty dresser drawers and closets and place contents in a sealed, plastic bag. Wash and/or dry clothes on high heat setting.
- Don't bring home new furniture until bed bugs are eliminated.

Exhibit C

Let's Beat the Bug!

Have I Found a Bed Bug?

In Short:

- Bed bugs may have different shapes and sizes
- Bed bugs are small insects, about the size of an apple seed.
- Look for bed bugs , fecal spots and skins
- Bed bugs are night feeders, but sometimes feed during the day
- How can I tell that I found a bed bug
- What to do if I find a bed bug

For more information contact the Bed Bug *InformationLine* at 612-624-2200, 1-855-644-2200, bedbugs@umn.edu, or visit www.bedbugs.umn.edu

Bed bugs can be difficult to identify as they are similar to many other small insects. Also, their appearance will change depending on their age and if they have recently eaten.

Adult bed bugs are reddish brown in color and approximately ¼ to 3/8 inch long; they are nearly as wide as they are long. They are about the size of an apple seed. Juvenile bed bugs can be very small and very hard to see.

Bed bugs do not have wings, and cannot fly. Bed Bugs can move very quickly on both horizontal and vertical surfaces

If a bed bug has not recently eaten it is flat and oval shaped. Once a bed bug has bitten someone it swells in size, becoming longer and redder in color; frequently compared to the shape of a cigar.

If you have a bed bug infestation you may also notice cast skins. The cast skin of a bed bug is an empty shell that is left behind when a bed bug grows. This skin will be in the shape of a bed bug but it will be transparent.

Bed bugs are active mainly at night, so it is unlikely that you will see one during the day. They can become accustomed to feeding during the day if they become aware that people are resting or sleeping during the day. Bed bugs may be seen during the day if there is a big infestation, or if the insect you have found is actually a bat bug. Bat Bugs are very similar to bed bugs and are often found in places with bats or birds. Bugs should be sent to a professional for identification.

If you think you have found a bed bug, try to catch it on a piece of tape or put it in a plastic bag, you can then have this bug identified by a pest management professional (exterminator).

If an exterminator cannot verify it is a bed bug, send a sample on sticky tape to:

Bed Bug *InformationLine*
Rm 219 Hodson Hall
1980 Folwell Ave
St. Paul, MN 55108

If you find bed bugs, make a note of when and where you saw them. This will help the pest management professional in the inspection of your home and will increase the likeliness that treatment will be effective.

By Amelia Shindelar and Dr. Stephen Kells, 2011
Funding for "Let's Beat the Bug" Campaign provided by the United States Environmental Protection Agency and MDA. Additional assistance from the Minnesota Department of Health was greatly appreciated.

Updated on May 27, 2014

MINNESOTA DEPARTMENT OF AGRICULTURE
www.mda.state.mn.us

UNIVERSITY OF MINNESOTA EXTENSION

Let's Beat the Bug!

Bed Bug Basics

- Bed bugs are small insects, about the size of an apple seed. Adult bed bugs are flat, oval and reddish-brown in color. Juvenile bed bugs can be very small and hard to see.
- Bed bugs feed on human blood and can live for over a year without a meal.
- Bed bugs usually hide during the day near where people rest or sleep and then come out at night to feed. Bed bugs do not live on our bodies.
- Some people do not react when bitten by a bed bug.
- Most bed bugs are found within 8 feet of a person's resting place. As the infestation grows, bed bugs will spread further. You can find bed bugs in any of the following places:
  - In mattresses, box springs, bed frames, and bedding
  - In the cracks and crevices of furniture
  - Behind peeling wall paper
  - Behind pictures and clocks
  - In curtains
  - In cracks in hardwood floors
  - Under carpeting
  - Behind electrical outlets or switch plates

For more information contact the Bed Bug *InformationLine* at 612-624-2200, 1-855-644-2200 bedbugs@umn.edu, or visit www.bedbugs.umn.edu

What NOT to Do When You have Bed Bugs

- ⊗ Do not Panic. You can control bed bugs with careful inspection and by using proper control methods.
- ⊗ Do not try to kill bed bugs by using agricultural or garden pesticides. Using outdoor pesticides to control bed bugs can make you or your family very sick.
- ⊗ Do not use products that appear to be "homemade" or "custom formulated." Homemade products could be dangerous and they might make the problem worse.
- ⊗ Do not use products that have labels in a language other than English.
- ⊗ Do not apply pesticides directly to your body. This could make you very sick.
- ⊗ Do not use rubbing alcohol, kerosene or gasoline. These chemicals may cause fires.
- ⊗ Do not throw away your furniture. Beds and other furniture can be treated for bed bugs. Throwing away your furniture can spread the bugs and you have to buy new furniture.
- ⊗ Do not store things under the bed. Storing stuff under the bed gives bed bugs many new places to hide. This makes it more difficult to get rid of bed bugs.
- ⊗ Do not move things from room to room. Moving your things from the room with bed bugs to another room in your house may spread the bed bugs.
- ⊗ Do not wrap items in black plastic and place in the sun. It will not get hot enough to kill all the bugs.

Things you can do if you think you have bed bugs:

- ☑ Make sure it is a bedbug; see the factsheet *"Have I found a Bed Bug?"* at www.bedbugs.umn.edu/have-i-found-a-bed-bug
- ☑ Contact a Pest Management Professional or your landlord.
- ☑ Take steps to control the infestation; see the factsheet *"Bed Bug Control in Residences"* at www.bedbugs.umn.edu/bed-bug-control-in-residences

Updated on March 6, 2015

By Amelia Shindelar and Dr. Stephen Kells, 2011
Funding for "Let's Beat the Bug" Campaign provided by the United States Environmental Protection Agency and MDA. Additional assistance from the Minnesota Department of Health was greatly appreciated.

Let's Beat the Bug!

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  - Behind electrical outlets or switch plates

For more information contact the Bed Bug *InformationLine* at 612-624-2200, 1-855-644-2200 bedbugs@umn.edu, or visit www.bedbugs.umn.edu

Understanding Bed Bug Treatments

There are a number of options to effectively get rid of bed bugs, but sometimes it can get confusing when trying to decide which option would be best for your situation. Here is some basic information regarding the two most common methods used by pest management companies to kill bed bugs.

Whole Room Heat Treatments

Whole room heat treatments involve a Pest Management Professional (PMP) bringing in specially designed equipment to raise the temperature in your home to kill the bed bugs. Bed bugs and eggs die within 90 minutes at 118°F (48°C) or immediately at 122°F (50°C). During a heat treatment, the air temperature in the room is typically between 135°F (57.2°C) and 145°F (62.7 °C). The PMP will place remote thermometers throughout the home, to make sure the right temperatures are reached. The PMP watches the thermometers closely to ensure that it gets hot enough to kill bedbugs. A heat treatment typically takes between six and eight hours, depending on the condition of the area being treated.

During the heat treatment pets and any heat sensitive items that may melt or be damaged at temperatures up to 150°F degrees should be removed from the area being treated. Make sure you discuss this with your PMP as anything not treated with heat will need to be treated in another way.

Heat treatments do not offer any residual effects and your home could quickly become reinfested after a heat treatment if prevention steps are not taken.

Often, a residual insecticide will be applied to the border of the home/room being treated for bed bugs as a prevention step.

Insecticide Treatments

Insecticide treatments that are conducted thoroughly and correctly by a licensed PMP can be a very effective way of controlling bed bugs. Three different types of insecticides should be used in order to achieve the best result. There are many different brands of insecticides but one of each of the following broad categories should be used.

- A fast-acting, contact insecticide for use on surfaces that we frequently touch, i.e. sofas.
- A residual insecticide for inside furniture, cracks and crevices and the underside of surfaces we touch.
- A dust insecticide for cracks, crevices and voids, such as electrical outlets and baseboards.

Your PMP may offer other services such as container heat treatments, steam applications, or freezing infested items. Usually, items treated with these optional controls do not require an insecticide treatment and therefore fewer insecticides are needed.

A thorough insecticide treatment should involve 2-3 visits from the PMP, as it is unlikely all the bed bugs will be killed in the initial treatment. An insecticide treatment typically takes about 30 minutes to 2 hours per room depending on size and condition of the room. Once the treatment is complete you should wait until all the insecticides have dried before reentering your home, or until the PMP says it is safe to re-enter.

Before any treatment the PMP should provide you with a detailed list of instructions for how to prepare your home. It is very important to follow these directions closely as properly preparing the home is a very important step in any treatment process. Improper preparation is one of the main reasons that treatment for bed bugs fail.

We strongly recommend against trying to conduct an insecticide treatment for bed bugs by yourself. Controlling bed bugs with insecticides is a challenging and time consuming process which requires expertise and in many states a license is required to apply the insecticides which kill bed bugs. The insecticides that can be purchased in a hardware store, such as foggers, are not effective in controlling bed bugs and we strongly recommend against their use.

Updated on May 28, 2014

By Amelia Shindelar and Dr. Stephen Kells, 2013
Funding for "Let's Beat the Bug" Campaign provided by the United States Environmental Protection Agency and MDA. Additional assistance from the Minnesota Department of Health was greatly appreciated.

Let's Beat the Bug!

Bed Bug Basics

- Bed bugs are small insects, about the size of an apple seed. Adult bed bugs are flat, oval and reddish-brown in color. Juvenile bed bugs can be very small and hard to see.
- Bed bugs feed on human blood and can live for over a year without a meal.
- Bed bugs usually hide during the day near where people rest or sleep and then come out at night to feed. Bed bugs do not live on our bodies.
- Some people do not react when bitten by a bed bug.
- Most bed bugs are found within 8 feet of a person's resting place. As the infestation grows, bed bugs will spread further. You can find bed bugs in any of the following places:
  - In mattresses, box springs, bed frames, and bedding
  - In the cracks and crevices of furniture
  - Behind peeling wall paper
  - Behind pictures and clocks
  - In curtains
  - In cracks in hardwood floors
  - Under carpeting
  - Behind electrical outlets or switch plates

For more information contact the Bed Bug *InformationLine* at 612-624-2200, 1-855-644-2200 bedbugs@umn.edu, or visit www.bedbugs.umn.edu

Bed Bug Control in Residences

When trying to control bed bugs in your home:

- ***DO NOT*** use pesticides meant for garden or agricultural use.
- ***DO NOT*** use products that appear to be "homemade" or "custom formulated" or products purchased from someone without a license.

The most effective way to control bed bugs in your home is through a combination of chemical measures and heat treatments applied by a Pest Management Professional (PMP). Unfortunately, the service of a PMP can be costly. So we are providing information on how to control a bed bug infestation on your own.

Controlling bed bugs by yourself is very difficult and time consuming. It involves moving furniture, household goods and personal items. Plan how you want to treat each room. Set up a "clean zone".

How to set up a "Clean Zone"?

- ✓ Start with corners and edges of an open wall, dig things out of cracks and crevices with a plastic card.
- ✓ Inspect and clean along all cracks and crevices
- ✓ You can use a damp cloth or mop to clean if you have bare tile or wood floors, otherwise vacuum thoroughly
- ✓ Don't forget to clean pictures and other wall hangings
- ✓ Inspect other items and put them into the clean zone
- ✓ Sort clothes, bedding, and other items that can be laundered into plastic bags for future laundering, as this can be very effective to treat infested items.
- ✓ See http://www.bedbugs.umn.edu/bed-bug-control-in-residences/controlling-bed-bugs-by-hand/ for more details on setting up a clean zone.

Killing bed bugs by hand is not 100% effective but will help you reduce the number of bugs in your home. You can capture and squash them or capture them on sticky tape and throw away the tape.

Tools for hunting and destroying bed bugs: Flashlight, old credit card (or similar) clear tape, plastic bags, a cloth and hot soapy water.

Steps: Use the flashlight and a credit card to search out bed bugs by moving the card along cracks and crevices to push out the bugs. Use the sticky tape to trap the bugs. Use the hot soapy water to wipe up infestations, the bugs, blood stains, droppings, eggs and shed skins.

Vacuuming helps to quickly capture and contain bed bugs. Vacuum crevices around baseboards, electronic items (such as TVs and stereos) and any other likely hiding places, such as beds, couches, bedframes, and dressers. If using a canister vacuum, immediately empty the contents into a plastic bag, seal and throw away. Clean the

Pest Prevention Tips for SCCMHA Employee's

All SCCMHA Employee's are encouraged to follow the recommendations below in an effort to reduce the risk of transmission during work assignments and tasks.

1. Know or ask ahead of a visit/entering the home if the space has a pest problem
2. Protective foot covering will be available for all staff whose daily assignments/tasks are required to provide services in customer homes. Foot coverings are to be applied upon entering the home, not in staff vehicle. Remove and dispose of immediately upon exit.
3. It is recommended staff wear light colored clothing as this will enhance visual inspection prior to entering your vehicle.
4. You may choose to have a hand mirror in your vehicle to aid with visual inspection of your clothing prior to entering your vehicle.
5. It is recommended you take into the home only those supplies you absolutely need to complete your job duties.
6. Do not place bags, brief cases, totes, or other personal items in the floor of a residence of other building. Many pests are hitch-hikers and may travel on your mishandled items.
7. Do not sit on upholstered furniture. Recommendation in to stand whenever possible if you need to sit, do so on hard surface only after a quick visual inspection.
8. You may choose to keep a change of clothing available if needed.
9. For additional prevention tips/recommendations, please refer to the exhibits attached to this policy.

<table>
<tr><th colspan="3">Skill Building Services Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Training of Adaptive Equipment for Community Ties & Residential Staff</td><td>Chapter: 09.06.05 – Skill Building Services</td><td>Subject No: 09.06.05.09</td></tr>
<tr><td colspan="3">Skill Building Services</td></tr>
<tr><td rowspan="2">Effective Date:
August 1, 2011</td><td>Date of Review/Revision:
4/19/16, 2/11/13, 1/30/17, 3/1/18, 2/25/19, 5/31/19, 2/25/20, 5/31/20, 4/23/21, 3/2/23, 3/5/24</td><td rowspan="2">Approved By:
Kristie Wolbert, Executive Director of Clinical Services

Authored By:
Director of Services for Persons with IDD

Reviewed By:
Julie Bitterman,
Jennifer Rieck-Martin</td></tr>
<tr><td>Supersedes:</td></tr>
</table>

Purpose:
SCCMHA is dedicated to ensure all program and specialized residential staff are trained on the use of adaptive equipment.

Application:
During orientation with program coordinator and/or supervisor, all Community Ties North and South staff and specialized residential staff will be trained on the use of adaptive equipment by the Occupational Therapist on site.

Policy:
Upon hire, Community Ties and specialized residential staff will be trained on the use of adaptive equipment per individual plan of service. Regular in-services are provided annually or as needed. Additional training will be provided as needed or upon request.

Standards:
- All Community Ties staff and specialized residential staff will be in serviced on the use of adaptive equipment for any individuals who attend the Community Ties programs or live in the home and require use of adaptive equipment.
- Staff will be trained by a licensed, registered occupational therapist (OTRL) in conjunction with the Community Ties program Service Coordinator. The specialized residential supervisor and/or home supervisor will be responsible for training staff with assistance from the OTRL as needed.

- Staff will be trained upon hire, annually, and as needed or requested.
- Staff will be trained on site at the Community Ties day program or the specialized residential site for which they have been hired.
- Training will be to ensure the safety of the individuals who use the adaptive equipment and the staff assisting them.
- Staff who has not been trained to use the adaptive equipment will not assist a consumer with their adaptive equipment. This includes training on assisting a person in a wheelchair on and off the lift bus.

Definitions:
Adaptive equipment**:**

- Gait Belt – a device used to transfer people from one position to another or from one thing to another. The gait belt is worn around the waist. The purpose is to put less strain on the back of the care giver and to provide support for the individual. A gait belt should never be used as a restraint.
- Walker/cane – a tool for an individual who needs additional support to maintain balance or stability while walking. Walkers and canes come in many variations such as single, two or four-footed frames.
- Wheelchair – a chair with wheels, designed to be a replacement for walking. Wheelchairs come in many variations such as manual and motorized.
- Splints/orthoses – a device used for support or immobilization of limbs or spine. Splints come in many variations such as a hand, elbow, ankle foot orthosis (AFO) or back brace.
- Mechanical lifts – a lift is used to move a person from one surface to another who is unable to bear weight safely. A sling is needed as an accessory to the lift. Slings and lifts come in a wide variety to meet all transfer needs.

References:
1. Wikipedia.org
2. SpinLife.com

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Training on the use of adaptive equipment per individual plan of service. Regular in-services are provided every three years and as needed. Additional training will be provided as needed or upon request.	OTRL, Community Ties Program Coordinator and supervisor; specialized residential supervisor
The Community Ties and specialized residential supervisors of staff working with individuals will ensure that staff	Supervisors of the Community Ties programs, specialized residential supervisor

are aware of this policy and their responsibilities and competence when using the adaptive equipment.	
The Community Ties and specialized residential supervisors will ensure that adaptive equipment is safe and in good condition. Guardians and/or homes may be contacted if repair is needed.	Supervisors of the Community Ties programs, specialized residential supervisor

<table>
<tr><th colspan="3">Autism Program Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: School and Applied Behavior Analysis (ABA)</td><td>Chapter: 09.06.10 – Autism Program</td><td>Subject No: 09.06.10.01</td></tr>
<tr><td colspan="3">Autism Program</td></tr>
<tr><td rowspan="2">Effective Date:
3/1/18</td><td>Date of Review/Revision:
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Kristie Wolbert, Executive Director of Clinical Services

Authored By:
Director of Children’s Services

Reviewed By:
Autism Program Support Coordinators, Amanda Elliott</td></tr>
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Purpose:
The purpose of this procedure is to outline expectations regarding children’s (who are over age 5 or under age 5 receiving Special Education services) school attendance and Adaptive Behavior Analysis (ABA) schedule.

Application:
This procedure applies to ABA contracted providers, Supports Coordinators, and children/families receiving ABA intervention.

Policy:
It is the policy of Saginaw County Community Mental Health Authority to provide ABA services in cooperation with the schools and contracted ABA Providers in order to provide coordinated services to persons with Autism.

Standards:
ABA intervention is not currently an approved school-based service under the State plan. These services may serve to reinforce skills or lessons taught in school but are not intended to supplant services or to be provided when the child would typically be in school but for the care givers choice to home-school their child. When SC’s are documenting home school schedule, it must include that all core areas of academics are being provided including but not limited to mathematics, social studies, and English. Each child’s Individual Plan of Service (IPOS) must document that these services do not include special

education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) that are available to the child through a local education agency. Support Coordinators will communicate with the Michigan Department of Health and Human Services (MDHHS) that the child's school schedule is not interfering with ABA in the IPOS. Providers are to document that the child's school schedule is not interfering with ABA through the the Request for Revision in Treatment Hours/ABA Authorization forms. Please note that if the child is being home-schooled, this schedule still needs to be reflected in the fore-mentioned documents. The team involved in the child's care is expected to coordinate and collaborate on services.

Additional notes regarding school and ABA:

- Medicaid funded ABA can only be provided outside of the school schedule as identified in the Individualized Educational Plan.
- In the event that a child is receiving a reduced school day through their Individualized Education Program (IEP) and the family and treatment team wish to receive ABA during typical school hours the IEP must be reviewed and approved by SCCMHA to ensure all domains in the IEP are met for the State Plan to cover ABA services during typical school hours prior to the ABA provider providing ABA during typical school hours.
- The goal should always be for a school to provide Free and Appropriate Education (FAPE) and for the Autism benefit to provide ABA services outside of typical school hours.
- Caregivers still have a choice about their ABA schedule, as long as it is outside of typical school hours.
- If a school does not support the need for a shortened school day in the IEP, but it is the impression of the team that the child's educational needs are not being met, then the SC should work the family to advocate for appropriate educational supports.
- A school, who determines that ABA is the necessary treatment for an individual, should work to include ABA into the child's educational plan, as part of IDEA and FAPE. This might include: a school hiring a Qualified Professional, contracting with an outside ABA provider for consultation, etc.
- ABA providers should be prepared to work outside of typical school hours, including evenings and weekends, in an effort to meet programming/consumer needs while maintaining compliance with this procedure.
- A provider should not be billing for services that occur during typical school hours (typical school's hours as defined in the child's IEP.)
- If a child is suspended from school, SC's should explore whether there has been a manifestation hearing and reasoning for the suspension prior to implementing ABA during the time the child is out of school.

There are a number of required documents. These have not been attached to this procedure as they change and are modified frequently. These documents can be obtained through either the Autism Program Supervisor or Autism Program Administrative Coordinator. Pertinent documents relevant to this procedure include:

- Autism Program Request for Revision in Treatment Hours/ABA Authorization

Definitions:
MSHN-Mid State Health Network (pre-paid inpatient mental health plan)
MDHHS-Michigan Department of Health and Human Services

References:

A. IDEA 2004
B. Michigan Association of Special Education (MAASE), Individualized Family Service Plan and Individualized Education Program Considerations for Students with ASD Receiving Insurance-Based Treatment/Intervention
C. Michigan Medicaid Program Applied Behavior Analysis FAQ
D. Memo from Mid-State Health Network dated 2/26/18
E. MSA 15-59
F. Mid-State Health Network Policy, Autism Benefit Compliance Monitoring Procedure
G. Michigan Department of Education Office of Special Education Guidance on Shortened School days 9-2022

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Reduced school day written into the child's IEP not for the purposes of attendance at ABA.	School Personnel
Prior to ABA being provided during typical school hours, IEP is reviewed by SCCMHA to ensure it meets criteria	Supports Coordinator and Autism Program Supervisor
Document the ABA and school schedule within the IPOS.	Supports Coordinator

<table>
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<tr><td>Subject: Autism Program Entry to Services</td><td>Chapter: 09.06.10 – Autism Program</td><td>Subject No: 09.06.10.02</td></tr>
<tr><td colspan="3">Autism Program</td></tr>
<tr><td rowspan="2">Effective Date:
5/20/15</td><td>Date of Review/Revision:
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Kristie Wolbert, Executive Director of Clinical Services

Authored By:
Director of Children’s Services

Reviewed By:
Autism Program Support Coordinators, Amanda Elliott</td></tr>
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</table>

Purpose:
The purpose of this policy is to define the procedures for the Consumer when they become an active participant in the Autism Program.

Application:
This procedure applies to children and adults with the diagnosis of Autism and Autism Spectrum Disorder, served by SCCMHA, between the ages of 0 through the day before their 21st birthday.

Policy:
It is the policy of the Autism Program to provide each consumer who participates in the Autism benefit with a high quality, value-based experience that provides a person-first approach from entry to discharge.

Standards:
None

Definitions:
CAI – Central Access/Intake
SC – Support Coordinator
MSHN- Mid-State Health Network
ADOS-Autism Diagnostic Observation Schedule
ABA- Applied Behavioral Analysis

References:

A. 09.06.10.03, Autism Program Expectations Regarding Treatment Plans
B. 02.03.21, Autism Spectrum Disorder (ASD) Program
C. 09.06.10.08, Eligibility Determination and Re-Evaluation Eligibility

Exhibits:

None

Procedure:

Following is a detailed procedure for the Autism Program Entry to Services after they have been found determined to have been diagnosed with Autism Spectrum Disorder and would benefit from Applied Behavior Analysis (ABA).

Pertinent documents relevant to this procedure include:

Referral Packets
What is ABA?

These documents can be obtained either through the Autism Program Supervisor or Autism Program Administrative Coordinator.

ACTION	RESPONSIBILITY
If eligible for Autism benefit:	
• Sends encrypted email of the MSHN Evaluation Form to MSHN	Autism Program Administrative Coordinator
• Adds population type for Autism Program in Consumer Demographics	Autism Program Administrative Coordinator
• Assigns Support Coordinator	Autism Program Supervisor
• If a transfer from another SCCMHA/Provider then schedules orientation meeting (OTM) with the Autism Program Supervisor or designee (no additional OTM needed if not a transfer).	Record Holder of current provider Autism Program Administrative Coordinator
If child is not eligible for Autism benefit:	Care Management
• Notifies the Autism Supervisor, Care Management Staff, CAI Administrative Coordinator, and Assigned CAI worker and Supervisor regarding eligibility and request for services	
• Sends encrypted email MSHN Evaluation Form	CAI worker
• Determines eligibility for SCCMHA related services, assigns to treatment provider and informs CAI and Autism Supervisor.	
• Requests Orientation Meeting with appropriate provider	Support Coordinator

Once Consumer is officially a beneficiary of the program:	Support Coordinator
• Initial Meeting and psychosocial assessment completed. • Preplan Meeting held with family and consumer. • Individual Plan of Service (IPOS) completed with the family, consumer and another natural and community supports identified by the family.	Support Coordinator
• Family identifies preferred Contract Provider of their choice for services. If person has commercial insurance, referral letter without authorization is sent to choice provider to obtain authorization through commercial insurance payor to submit to SCCMHA Care Management Department for a mirrored authorization from the commercial insurance.	Care Management and Contracted Provider
• Requests authorization for ABA Initial Assessment if person has Medicaid only	Support Coordinator
• Provider contacts caregiver and schedule initial assessment within 3 days of referral. All efforts will be made to accommodate the caregiver to schedule the assessment within 14 days.	Contracted Provider
• Completes <u>ABA Initial Assessment</u> document within 5 days of last visit.	Contracted Provider
• Schedules visit with caregiver within 7 days of completion of documentation to conduct in-service NOTE: this visit is to include the Supports Coordinator and the primary Behavioral Technician, if available.	Contracted Provider & Support Coordinator
• Complete separate in-service (<u>Autism Program Staff In-Service</u>) with the primary Behavioral Technician.	Contracted Provider, Behavior Consultant, Behavior Technician, Support Coordinator
• Requests authorization for Direct ABA service, ABA supervision and Family Guidance as outlined in the IPOS for Medicaid only consumers. For persons with commercial insurance and Medicaid, ABA Provider will need to obtain authorization from the commercial insurance for services and submit that to Care Management to receive a mirror authorization and Supports	Supports Coordinator, Care Management, Contracted Provider

Coordinator to update IPOS based on the commercial insurance authorization. At Initial authorization (when a person is first receiving ABA during their treatment episode) an authorization will be provided for 60 days time for 10 hours of ABA, 10% supervision and agreed upon Family Guidance with family and the provider.	
• Begin intervention. (For every 10 hours of direct intervention being provided, 1 hour of supervision must occur.)	Contracted Provider
• ABA Assessment is required to be completed at day 45 and submitted for review.	Behavior Consultant, Contracted Provider
• ABA Assessment is reviewed, collaboration between Behavior Consultant and Contracted Agency regarding the assessment will occur.	Behavior Consultant, Contracted Provider
• After ABA Assessment approval, Supports Coordinator notified to update the IPOS as necessary and request ongoing authorizations.	Supports Coordinator
• Every 6 months of intervention beginning, completes ABA 6 Month Review and appropriate behavioral outcome measurement tool such as the VB-MAPP, ABLLS-R, AFLS, Vineland.	Contracted Provider
• Schedules visit with caregiver, Supports Coordinator, and primary Behavioral Technician, if available, to review.	Contracted Provider
• Every three years re-evaluation conducted to determine whether child continues to qualify for the benefit.	Supports Coordinator, Autism Program Administrative Coordinator
• Three months prior to discharge, begins transitioning/discharge planning with primary caregiver when possible.	Contracted Provider
• Shortly before discharge, schedules visit with caregiver, Supports Coordinator, and primary Behavioral Technician, if available, to review Autism Program Discharge/Transition Plan.	Contracted Provider, Supports Coordinator

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<tr><td>Subject: Autism Expectations Regarding Treatment Plans</td><td>Chapter: 09.06.10 - Autism Program</td><td>Subject No: 09.06.10.03</td></tr>
<tr><td colspan="3">Autism Program</td></tr>
<tr><td rowspan="2">Effective Date:
9/22/15</td><td>Date of Review/Revision:
1/16/18, 3/1/18, 6/29/18, 2/10/19, 3/27/19, 8/22/19, 4/20/20, 5/3/21, 3/3/22, 3/6/23, 3/15/24</td><td rowspan="2">Approved By:
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Authored By:
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Reviewed By:
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Purpose:
To specify how phases in treatment plan development should occur and provides a standardized expectation on how Applied Behavior Analysis (ABA) plans are to be submitted to Saginaw County Community Mental Health Authority’s (SCCMHA) Autism Program. Further included are standards that ABA providers are to use when providing intervention to consumers.

Application:
The procedure applies to Behavior Consultants and ABA providers developing treatment plans for children and adults involved in SCCMHA’s Autism Program.

Policy:
None

Standards:
SCCMHA shall provide ABA services in accordance with Michigan Department of Health and Human Services (MDHHS) Guidelines and ensure children are receiving high quality intervention. Parents are to be fully engaged and knowledgeable about the process. It is the requirement of SCCMHA that treatment interventions will follow the Behavior Analyst Certification Board Professional and Ethical Code for Behavior Analysts. This document is not to supplant SCCMHA’s policies and procedures, rather outlines specific requirements for documents within the Autism Program.

Documentation of important aspects of intervention is to be conducted via the following forms and must be maintained in accordance with the most recent Scanned Document Summary Responsibility and Delegation Grid:

- Autism Program Assessment

    - Requires the administration of the Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP) or the Assessment of Basic Language and Learning Skills-Revised (ABBLS-R) or any other behavior outcome measurement tool required by MDHHS.
    - Trauma and/or medical complexities that may impact treatment must be included in background information.
    - If restrictive/intrusive techniques as defined by the MDHHS are to be used, SCCMHA requires approval by the Behavior Treatment Committee prior to implementation.
    - Information regarding risk factors, discharge criteria, and language that provides a clear linkage regarding intervention and the goals the caregiver has as outlined in the Individual Plan of Service.
    - When transferring from another Provider, it is SCCMHA's expectation that a new Assessment will be completed.

- Autism Program Staff In-Service

    It is the requirement of SCCMHA that each staff member (Behavior Technician) providing services to a child will be in-serviced on the ABA treatment plan and the consumer's Individual Plan of Service prior to beginning implementation. Each staff member needs to be provided the opportunity to ask questions and receive clarification on the programs. In addition, the treatment plan writer will ensure staff have been modeled the intervention and taught the intervention. The evaluator will further certify that staff have met the minimum training requirements per MDHHS.

    ABA Assessments
    It is the requirement of SCCMHA that caregivers are fully involved in the treatment of their child and are in-serviced on their child's assessment and behavior intervention plans.

    During the in-service with caregivers:

    - The assigned Supports Coordinator (SC) and primary Behavior Technician are to be present when possible. A determination of the schedule and hours of treatment will be decided. Behavior Consultants are to recommend hours based on their clinical decision. If the team would like to request a change in treatment hours after intervention has begun, this will be done by completing a Request for Revision in Treatment Hours form and should be done through a treatment team process. Although SCCMHA has no requirement in regards to how programs are documented, it is the

expectation that these are written in an easy to understand format and that caregivers have a full understanding of what intervention their child is to receive. This must include, if the child is of school age, the child's school and ABA schedule.

- Autism Program Request for Initial/Revision in Treatment Hours/ABA Authorization Form

  This form is to be completed immediately upon start of ABA services and any requested change in hours or schedule or other service array and forwarded to the primary SC for approval ***prior to initiation***. The SC will amend the Individual Plan of Services (IPOS) with the updated number of hours of intervention/service array. Reductions in hours can't be due to lack of provider staffing. Any individual on the team can complete this form, however, it must be signed by the person who spoke to the parent/consumer/guardian about the changes. Supports Coordinator fills out the MSHN Autism Benefit ABA Authorization Form for any change in ABA related services and submits to the Autism Program Administrative Coordinator for submission to MSHN.

- Autism Program 6 Month Progress Report (Semi-Annual Review of Progress)

  It is the requirement that each child receiving active intervention will be re-assessed every 6 months from the date of initial assessment, regardless of when he/she began active intervention, for skill acquisition and behavior decrease. Providers are responsible maintaining a tracking system to ensure assessments are completed a timely manner. This will include progress towards goals and a VB-MAPP or ABBLS-R or other required behavior outcome measurement tool per MDHHS. It is the expectation that a team meeting is held with the caregiver, primary SC, and primary Behavioral Technician (if available) to review the report. If contact with caregiver is unable to be made, it is SCCMHA's expectation that at a minimum 3 attempts be made and documented on the report. 6 Month Progress Reports need to include the recommended hours of intervention by the Behavior Consultant at that time. Please note color grids must always be included in the report. In addition, information regarding risk factors, discharge criteria, and language that provides a clear linkage regarding intervention and the goals the caregiver has as outlined in the Individual Plan of Service must be included.

- Autism Program Discharge/Transition Plan

  It is the requirement that the treatment plan writer will begin preparing the caregiver and child for discharge about 3 months prior to discharge when possible. During the last month of active intervention, a closing meeting will occur with primary treatment team members present, including primary SC. Caregivers will be provided recommendations and community resources to access. If providers are unable to review discharge plans with consumers, that is to be noted on the report and reasoning why.

- Autism Program Monthly Report

  This form (located electronically in Sentri) is to be completed monthly (due signed by the 5th business day of the month) on children referred for ABA intervention. Providers are expected to complete these for all children who may or may not be receiving active intervention, however, are considered assigned to that provider. For example, if a child was referred to a provider, but active intervention hasn't begun, please complete the form to the best of your ability. Please note that Supervision Ratio is based on the total number of hours the child attends, not on the number of reported hours of intervention. The monthly average needs to be at least 10% and providers are responsible for maintaining a tracking system for such. If there are cancellations due to weather, building closures, holidays, etc. those are to be noted as part of the percentage attended. Caregivers are to be offered make up hours to ensure the treatment hours are being met. Family Guidance notes for the reporting month should be uploaded as an attachment to the Autism Provider Monthly Reports

- Autism Program Medical Necessity Request-Time Limited Supervision

  All providers who are requesting increased supervision (above 10% ratio) are to complete this document in its' entirety. This will provide the SC the medical necessity to request the noted change.

- **Behavior Intervention Plan**

  If provider is wanting to develop and implement intervention(s) that is intrusive or restrictive based on the MSHN definitions from the MDHHS Standards for Behavior Treatment Plan Review Committees, the provider will need to complete a Behavior Intervention Plan and submission to the Behavior Treatment Plan Review Committee (BTPRC) prior to implementation of the intervention. The BTPRC would require the provider to attend the BTPRC meeting to present your Behavior Intervention Plan. If the intrusive or restrictive technique is approved, parent consent will need to be obtained on a special consent form and Behavior Technician staff trained on the interventions prior to implementation of the intervention.
- FY 20 Attachment B: Scanned Document Summary and Responsibility Delegation Grid

  Per Provider's contract with SCCMHA, this is to be followed for uploading all documents to SENTRI II and whether those documents are to be uploaded by Providers or by Autism Staff. No documents are to be uploaded without signatures from provider staff and parent/consumer as applicable.

- Autism Program Consumer Flow

This sheet is a reference sheet for use by Providers outlining the timeframe expectations for how consumers are to be served through the Autism Program. Please note that SCs are to be invited to 6 month progress report meetings, and discharge/transition meetings.

Important Additional Notes:

- The role of the SC is to be the primary contact person for the consumer and he/she is responsible for ensuring compliance with program requirements. The SC is the primary contact for authorizations and concerns. They are expected to be involved in the treatment and monitoring the effectiveness of the plan. SCs are to be notified of all changes with consumers, including, but not limited to, when a consumer's schedule changes (times/days), changes in Behavior Consultant and/or Behavioral Technician, and location of where they are being served. Providers are expected to allow SCs into their facility to monitor intervention. In addition, the must allow access to all documentation of intervention to the SC. Providers will communicate with the SC primarily through the SENTRI II system.
- When children are napping, SCCMHA is not to be billed. Snack/meal time is not to exceed 20 minutes.
- Use of telepractice is outlined in SCCMHA Policy, Autism Spectrum Disorder (ASD) Program.
- Absolutely no restrictive and/or intrusive techniques can be implemented without approval from the Behavior Treatment Committee.
- Providers are responsible for maintaining contingency plans to reduce risk factors and address staffing issues. In addition, providers are responsible for maintaining and following cancellation procedures.

- <u>Family Guidance</u>
  The use of Family Guidance is to be encouraged and expected from families in order to generalize skills. Providers are expected to offer family guidance at a frequency and location written in the IPOS. Family Guidance does not include discussions regarding hour/schedule changes, cancellations, barriers to receiving intervention, behavioral concerns during ABA, etc. Instead should include, at a minimum, the following and be clearly documented:
  - Basics of ABA
  - Planning and setting goals for their child in the home related to ABA
  - Skills to support their child and instilling confidence to use them. If there are behavioral concerns, a clearly outlined home program should be instituted.
  - Assisting parents with generalizing skills the child is learning into the home.
- Family Guidance notes should be uploaded to the Autism Provider Monthly Reports.

Pertinent documents relevant to this procedure include:

Autism Program Assessment
Autism Program Staff In-Service
Autism Program Caregiver Statement of Understanding

Autism Program Request for Revision in Treatment Hours
Autism Program 6 Month Progress Report
Autism Program Discharge/Transition Plan
Autism Program Individual Plan of Service Statement of Understanding
Autism Program Monthly Summary Report
Autism Program Medical Necessity Request-Time Limited Supervision or 2:1 Staffing
FY 20 Attachment B: Scanned Document Summary and Responsibility Delegation Grid
Autism Program Consumer Flow

These documents can be obtained either through the Autism Program Supervisor or Autism Program Administrative Coordinator.

Definitions:
None

References:

A. 03.02.27, SCCMHA Policy and Procedure Manual, Behavioral Plans
B. 02.03.21, Autism Spectrum Disorder (ASD) Program,
C. 09.06.10, Autism Program Supports Coordinator Responsibilities
D. 09.06.10.09, Orientation Meeting
E. 09.06.10.08, Eligibility and Re-Evaluation Eligibility
F. 09.06.10.06, Autism Discharge Planning
G. 09.06.10.01, School and Applied Behavior Analysis (ABA)
H. Michigan Department of Community Health Mental Health and Substance Abuse Administration Technical Requirement for Behavior Treatment Plan Review Committees
I. Board Analyst Certification Board, Professional and Ethical Compliance Code for Behavior Analysts
J. 1915(i) State Plan Home and Community-Based Services Administration and Operation
K. Michigan Department of Health and Human Services Bulletin (MSA 15-59)
L. MSHN Definitions from the MDHHS Standards for Behavior Treatment Plan Review Committees Revision FY17 application

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Assure ABA services are provided in accordance with Michigan Department of Health and Human Services (MDHHS) Guidelines and ensure children are receiving high quality intervention.	Autism Supervisor Support Coordinator ABA Providers Support Coordinator

Assure Parents are to be fully engaged and knowledgeable about the process.	ABA Providers
Assure that treatment interventions follow the Behavior Analyst Certification Board Professional and Ethical Code for Behavior Analysts.	ABA Providers

<table>
<tr><th colspan="3">Autism Program Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Autism Program Mission and Vision Statement</td><td>Chapter: 09.06.10 - Autism Program</td><td>Subject No: 09.06.10.04</td></tr>
<tr><td colspan="3">Autism Program</td></tr>
<tr><td rowspan="2">Effective Date:
7/21/16</td><td>Date of Review/Revision:
3/30/17, 3/1/18, 3/27/19, 4/20/20, 5/3/21, 3/3/22, 3/6/23, 3/15/24</td><td rowspan="2">Approved By:
Kristie Wolbert, Executive Director of Clinical Services

Authored By:
Director of Children’s Services

Reviewed By:
Autism Program Support Coordinators, Amanda Elliott</td></tr>
<tr><td>Supersedes:</td></tr>
</table>

Mission Statement

It is the mission of the Autism Program to recognize the strengths of and provide opportunities for success in individuals with Autism Spectrum Disorder. Opening new doors of hope and independence to create a life full of limitless possibilities.

Vision: The Autism Program works to ensure individuals served in the program will have reached their fullest potential and will have a quality of life specific to each one.

Application:
Autism Program

This manual represents policies and procedures specific to Autism Program Unit Manual but Autism Program staff are bound to SCCMHA Policy and Procedure Manual.

<table>
<tr><th colspan="3">Autism Program Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Autism Program Introduction</td><td>Chapter: 09.06.10 - Autism Program</td><td>Subject No: 09.06.10.05</td></tr>
<tr><td colspan="3">Autism Program</td></tr>
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The Autism Program Unit Manual provides case managers with operational information to provide service and supports to children and adults up to the day before their 21st birthday diagnosed with Autism Spectrum Disorder in Saginaw County.

The Saginaw County Community Mental Health Authority Policy and Procedure Manual specifies the directives of the Board to the Chief Executive Officer in the form of policy, and the directives of the Chief Executive Officer in the form of procedures. The General Service Delivery Procedure of the SCCMHA Policy and Procedure Manual specifies each program will develop and maintain a program operations manual which elaborates on agency procedures as they are applied in each program. The manual is also required to address procedures which are unique to that program. The Autism Program Unit Manual is designed to meet this requirement.

Since this manual expands upon rather than supplants the SCCMHA Policy and Procedure Manual, it is important to be familiar with and adhere to the requirements outlined in both documents to ensure compliance with agency expectations for service delivery.

In addition to the SCCMHA Policy and Procedure Manual, there are a variety of regulations, directives and guidelines which apply to specific services and supports. It is also important to be aware of and familiar with these documents. Copies are not included with this manual but can be obtained from program supervisors for reference. Information from these

documents has been incorporated into this manual as much as possible. The primary documents which were considered in the development of this manual are as follows:

1. CARF Behavioral Health Standards Manual: July 1, 2009 – June 30, 2010.
2. Michigan Mental Health Code, ACT 258 of 1974 and revisions.
3. Medicaid Chapter III;
4. Mental Health Alternative Services Definitions
5. Interpretive Guidelines for Intermediate Care Facilities for Persons with Mental Retardation;
6. Michigan Department of Community Health Rules for Certification of Specialized Programs Offered in Licensed Foster Care Homes;

Application:
Autism Program

Autism Program Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Autism Discharge Planning	**Chapter**: 09.06.10 - Autism Program	**Subject No:** 09.06.10.06
Autism Program		
Effective Date: 3/1/18	**Date of Review/Revision**: 6/29/18, 3/27/19, 2/25/20, 5/3/21, 3/3/22, 3/6/23, 3/15/24 **Supersedes**:	**Approved By**: Kristie Wolbert, Executive Director of Clinical Services **Authored By**: Director of Children's Services **Reviewed By**: Autism Program Support Coordinators, Amanda Elliott

Purpose:
The purpose of this procedure is to highlight ways consumers may be discharged from Applied Behavior Analysis (ABA) in the Autism Program. Saginaw County Community Mental Health Authority (SCCMHA) wants to ensure that children involved in the (ABA) intervention will have a transition plan highlighting goals, progress made, and resources recommended for future treatment.

Application:
This applies to SCCMHA staff and contracted providers offering ABA services.

Policy:
Discharge from ABA is determined by a qualified professional for children who meet any of the below criteria:

1. The child has achieved treatment goals and less intensive modes of services are medically necessary and appropriate.
2. The child is either no longer eligible for Medicaid or is no longer a State of Michigan resident.
3. The child has not demonstrated measurable improvement and progress towards goals, and the predicted outcomes as evidenced by a lack of generalization of adaptive behaviors across different settings where the benefits of interventions are not able to be maintained or they are not replicable beyond the treatment session through a 6-month period.

4. Targeted behaviors and symptoms are becoming persistently worse with treatment over time or with successive authorizations.
5. The child no longer meets the eligibility criteria as evidences by use of valid evaluation tools administered by the qualified licensed practitioner. This evaluation is conducted on a yearly basis. The primary Support Coordinator is to notify the provider of upcoming re-evaluation. The provider should begin planning for potential discharge in the event the child is found no longer eligible.
6. The child and/or parent/guardian are not able to meaningfully participate in services, and does not follow through with treatment recommendations to a degree that compromises the potential effectiveness and outcome of the service. ABA Providers are to follow a Cancellation Procedure and review with caregivers upon entry to the program.
7. SCCMHA has only so many providers available to children. If a provider dismisses a family due to attendance issues, there may be no additional availability.

Please note:

- All discharges from ABA services require the completion of the Autism Program Discharge/Transition Plan by the ABA provider.

- When a consumer is aggressive and/or displaying unusual behavior where discharge is being considered, all providers of ABA services are required to follow SCCMHA's policy regarding, referenced in "References."

- If they child continues to qualify for Saginaw County Community Mental Health Authority's other supports and services, he/she will be transferred to a different department pending Care Management's approval and if appropriate.

Pertinent documents relevant to this procedure include:

Autism Program Discharge/Transition Plan

These documents can be obtained either through the Autism Program Supervisor or Autism Program Administrative Coordinator.

Standards:

None

Definitions:

None

References:

- 09.06.10.08, Autism Program Eligibility Determination and Re-Evaluation Eligibility
- 02.03.21, Autism Spectrum Disorder (ASD) Program
- 09.06.10.03, Autism Program Expectations Regarding Treatment Plans
- Mid-State Network (MHSN) Policy, Service Delivery System, Autism Spectrum Disorder Benefit

- MSHN Policy, Autism Benefit Compliance Monitoring Procedure, Autism Spectrum Disorder Benefit
- 03.02.16, Discharges for Assaultive, Aggressive, or Other Types Disruptive Behavior

Exhibits:
None

Procedure:
None

<table>
<tr><th colspan="3">Autism Program Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Autism Supports Coordinator Responsibilities</td><td>Chapter: 09.06.10 - Autism Program</td><td>Subject No: 09.06.10.07</td></tr>
<tr><td colspan="3">Autism Program</td></tr>
<tr><td rowspan="2">Effective Date:
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Purpose:
The purpose of this procedure is to outline Supports Coordinator (SC) responsibilities within the Autism Program due to the many reporting and Mid-State Health Network (MSHN) requirements. In no way does this policy supplant Saginaw County Community Mental Health Authority’s requirements regarding case management duties; rather it outlines specific additional duties staff working in the Autism Program must perform.

Policy:
None

Application:
This applies to all SC’s and the Administrative Coordinator employed in the Autism Program.

Standards:
None

Definitions:
MSHN-Mid State Health Network (pre-paid inpatient mental health plan)
MDHHS-Michigan Department of Health and Human Services

References:
A. 02.03.01, Autism Spectrum Disorder (ASD) Program,
B. 09.06.10.09, Orientation Meeting
C. 09.06.10.08, Eligibility and Re-Evaluation Eligibility

D. 09.06.10.03, Expectations Regarding Treatment Plans
E. 09.06.10.06, Discharge Planning
F. 09.06.10.01, School and Applied Behavior Analysis

Exhibits:
None

Procedure:
(Outlining SC responsibilities in each of the below areas)

Health Care Coordination:

Ensures children and adults referred for the benefit either have or will receive a screening by his/her Primary Care Physician to review the individual's overall medical and physical health, hearing, speech, vision, behavioral and developmental status. A full medical and physical examination must be performed and documented, including possible inclusion in the Individual Plan of Service (IPOS) if not completed.

Re-Evaluation:

After the Autism Program Administrative Coordinator assigns an Assessor for re-evaluations, the SC is responsible for forwarding the Autism Program Re-Evaluation Feedback Form prior to the appointment time for Assessor review. Autism Program Administrative Coordinator will notify the SC and provider of the results of the re-evaluation.

ABA Providers:

- All Family Guidance notes are to be attached to Autism Provider Monthly Reports for staff review. SC's to review notes to ensure what is documented is reflective of appropriate use of Family Guidance and return to the provider for revision if not adequate.
- SC's to monitor information provided in Autism Provider Monthly Reports to ensure what is documented on the form is giving good clinical detail. If not, communication to the provider regarding the need for more clinical detail is required.
- When possible during observation visits, SCs to review progress note documentation, including Behavior Technician notes and Observation notes for anything out of the ordinary, plateau in progress, and behavior issues and document that in their progress note
- If concerns are brought forth regarding potential billings for non-ABA-rendered services, Supervisor is to be made aware so that review can occur during the Autism Revenue Management Meeting and/or passed to auditing for an ad-hoc audit of provider

a. SC are to document in a chart note when referrals to ABA providers are made.

b. If caregivers want to switch providers, the current provider is to be given 30-day notice unless the current provider waives that and agrees to a transfer sooner. SC to coordinate transition.
c. When completing ABA 6 Month Assessments, it must be documented in the assessment the child's current progress and/or lack of progress and whether ABA intervention is recommended to continue. Six (6) Month Progress Reports due dates are organized and reported to the SC monthly. It is then the responsibility of the SC to coordinate with the providers to ensure that the 6 Month Progress Reports are completed timely and submitted into the Sentri record.
d. SC are responsible for ensuring providers are using SCCMHA approved documentation and following the IPOS as written.

Monitoring:

Visits are to occur in a variety of settings including home, school, ABA providers/centers, and other authorized services to ensure what SCCMHA is paying for is occurring. SCs need to attend school Individualized Education Plan meetings and document when they are unable to attend or whether they were unaware. School documentation is to be uploaded to the record. It is expected that SC conduct at a minimum 3 home visits per year at the time of periodic reviews. Whenever possible, home visits are to occur and caregivers are to be informed of this expectation. If a caregiver requests that home visits not occur, this must clearly be documented in the IPOS and the reasoning why. When an individual will no longer be accessing the benefit, disenrollment should occur by notifying Autism Program Administrative Coordinator and sending an Appeal Notice. In addition, SC to complete addendum to plan with reasoning why, that caregiver was notified and in agreement, and what team is recommended transfer to occur to if transferring. If transfer to any other team requested besides general Support Coordination, a Level of Care Change form must be completed and forwarded to Care Management for approval.

IPOS Information:

a. SC must complete quarterly reviews by the date indicated in the IPOS which must be completed every 90 days from the effective date of the IPOS. If past this date, the review should include the statement, "This periodic review is overdue according to Medicaid guidelines and is being retroactively completed." Staff would use the current date when completing overdue periodic reviews, yet reference the date it was due in the body of the review.
b. IPOS are to be updated within 365 days of their last IPOS. If due to caregiver request and/or the SC is unable to reach the caregiver to complete, an addendum to the old plan is to be made extending that plan to the date the new plan is to be completed.
c. Providers are to be notified of upcoming renewal IPOS and caregivers are to be strongly encouraged to invite Behavior Consultants (BC) and Behavior Technicians (BT) to the meeting, along with any other provider (internal or external) involved in the consumer's care. The request for attendance is to be clearly documented in the pre-plan.

d. SC is responsible for notifying all providers involved in the consumers care once the IPOS completed so they can review the plan and sign off.
e. Each beneficiary's IPOS must document that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) that are available to the beneficiary through the local education agency.
    1. SC must follow the procedure regarding school and ABA. ABA can't be provided during typical school hours unless the caregiver homeschools their child or it is written into the IEP that the child is on a reduced school day, not for the purposes of ABA attendance. The SC should obtain a copy of the IEP to ensure the Michigan Department of Education Guidance on Shortened School Days criteria is met within the IEP prior to ABA being provided during typical school days if the family and treatment team are requesting ABA during typical school days. SC are to document the consumers school and ABA schedule. If there is a small gap in between start time, documentation needs to notate the travel distance.
f. Using the person-centered planning process, the IPOS shall be developed based on findings of all assessments and input from the child and the family and includes, but is not limited to:
    1. Identification of outcomes based on the child's stated goals
    2. Determination of the amount, scope, and duration of all medically-necessary services, including ABA
    3. Any revisions (including related amount, scope, and duration relative to caregiver circumstances) to the IPOS at the request of the family or as changing circumstances may warrant.
g. The IPOS shall identify how ABA will be part of a comprehensive plan of non-duplicative supports and services.
h. The IPOS shall be a dynamic document that is revised based on changing needs, newly-identified, or developed strengths, and/or the result of periodic review (every three months), and/or assessments.
i. The IPOS shall be kept current (i.e. annually at a minimum) and modified when needed (reflecting changes in the intensity of the beneficiary's health and welfare needs or changes in the beneficiary's preferences for support).
j. The hours of intervention the child is receiving needs to be clearly documented and how the team came to the decision.
k. If indicated, the IPOS shall reflect service intensity adjustment and setting to meet the child's changing needs.
l. Revisions to the IPOS may come at the request of the family or authorized representative as changing circumstances may warrant.
m. DD-CANS will be completed by the SC with the consumer and family every 90 days. Outcomes from the DD-CANS will be shared and discussed with the family as a tool to support the IPOS.
n. The average number of hours ABA services utilized within a quarter shall fall within the suggested range of the intensity of the service to a variance of no greater (or lesser) than .25%.

1. If the suggested range falls outside of this accepted variance, the SC shall determine the reasons for the variance in service provision and document that in the quarterly periodic review.
2. If the fluctuation in service provision is not temporary, this shall result in a review of the plan and recommendation to addend the plan to an appropriate range. Since the (BC) reviews and monitors data and makes programmatic changes based on the data, the BC shall be involved in the review and suggestion of any changes to the number of hours to ensure proper treatment plan recommendation.
3. The person-centered planning process shall be used to address changes to the IPOS and families who have a dispute about the process have a right to appeals and grievance.
4. The SC shall reflect the potential for changes to the IPOS by documenting attempts to engage the family, with the additional reasoning for why the change to ABA service hours occurred.
5. Upon receiving Request for Revision in Treatment Hours forms, SC are to review within 24 hours and notify the provider whether the change is agreed upon and can proceed.

Other Primary Teams:

a. If a child is transferred from the general Support Coordination department, the Autism Program SC does not have to complete a new psychosocial or IPOS, however, it is expected that the IPOS and psychosocial would be reviewed with the caregiver. If needed, the psychosocial is to be updated. An addendum to the IPOS will be completed indicating that it was reviewed with the caregiver. If the child is transferred from any other program besides general Support Coordination, the expectation is that a new psychosocial and IPOS would be completed within 45 days of case assignment.
b. At times, consumers are receiving services through the Wraparound Program. In these circumstances the consumer can continue to receive ABA with the SC being "ancillary." Per Medicaid guidelines, consumers can only have one case manager. The case manager in these circumstances is considered the Wraparound worker and changes to the plan related to ABA need to be made through that worker. SC will request authorizations related to their intervention (using T1017) and any authorizations in relation to ABA. It is the expectation that SC to attend Child Family Team meetings at a minimum monthly, provide monthly monitoring of ABA intervention, and complete periodic reviews specific to ABA quarterly via a chart note.

MSHN Form Requirements

Updates to any and all of the areas listed below should be completed in the IPOS (if applicable) with the MSHN Autism Benefit ABA Authorization Form filled out by the SC and should be submitted to the Administrative Coordinator each time.

- Initial Start of ABA services for the treatment episode
- Annual IPOS completed
- Change In hours for
    - Direct ABA (individual, group or 2:1 staffing)
    - Supervision
    - Family Guidance (individual and group)
    - Request for FBA
- Change in assigned Behavior Consultant and/or their credentials.
- Change in ABA Provider
- Change in Insurance (whether commercial insurance or Medicaid or both)

Telepractice:

If providers are requesting the use of Telepractice, the SC should notify the Autism Program Supervisor prior to approve the request. The SC is to complete an addendum clearly indicating the following:

a. Codes, along with "GT" modifier (change authorizations to include). If authorizations end sooner than the requested time frame of the Telepractice, the portal upload document is to reflect the end date of the authorization and a new portal upload document will be needed. This needs to be included in upload to MSHN.
b. Family consent, must be family driven, not provider driven
c. Goals/objectives for Telepractice related to Family Guidance and/or Observation and Direction of Applied Behavior Analysis
d. Identifying what it is being used for
e. Scope to include "Telepractice"

Pertinent documents relevant to this procedure include:

Autism Program Re-Evaluation Feedback Form
Quarterly Periodic Review
Quarterly Monitoring Checklists
Pre-plan and Individual Plan of Service (IPOS) Documentation Expectations

These documents can be obtained either through the Autism Program Supervisor or Autism Program Administrative Coordinator.

<table>
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<tr><td>Subject: Autism Eligibility Determination and Re-Evaluation</td><td>Chapter: 09.06.10 – Autism Program</td><td>Subject No: 09.06.10.08</td></tr>
<tr><td colspan="3">Autism Program</td></tr>
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Authored By:
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Purpose:
The purpose of this procedure is to establish a formal process that all network providers are to follow for establishing initial eligibility for consumers to be in the program as well as ongoing re-evaluation as directed by Michigan Department of Health and Human Services (MDHHS).

Application:
This procedure applies to all internal and network provider staff conducting eligibility determinations and re-evaluations. In addition, Centralized Access and Intake and internal/external service providers may use this as a guide when referring for an Eligibility Determination.

Policy:
None

Standards:
None

Definitions:
None

References:

A. 02.03.21, SCCMHA Policy and Procedure Manual, Autism Spectrum Disorder (ASD) Program MDHHS Bulletin (MSA 15-59)
B. Mid-State Health Network (MSHN) Policy, Autism Benefit Re-Evaluation Eligibility
C. MSHN Policy, Autism Benefit Compliance Monitoring Procedure
D. Medicaid Autism Spectrum Disorder Screening, Evaluation and Treatment Recommendation Best Practice Guidelines

Exhibits:
None

Procedure:
Credential Verification
It is the procedure of Saginaw County Community Mental Health Authority (SCCMHA) that all providers administering Eligibility Determinations and Re-Evaluations attend in-person training on the Autism Diagnostic Observation Schedule-2 (ADOS-2), including the Toddler Module. In addition, individuals must meet the following criteria to perform evaluations:

Evaluations are performed by a qualified licensed practitioner (QLP) working within their scope of practice and who is qualified and experienced in diagnosing Autism Spectrum Disorder (ASD). A qualified licensed practitioner includes: a physician with a specialty in psychiatry or neurology; a physician with a sub-specialty in pediatrics or other appropriate specialty with training, experience or expertise in ASD and/or ASD and/or behavior health; a physician assistant with training, experience, or expertise in ASD and/or behavioral health; or a clinical social worker, working within their scope of practice, and is qualified and experienced in diagnosing ASD and has a clinical MSW, not a macro MSW.

Prior to performing services for SCCMHA, the following will be sent to SCCMHA's Auditing Supervisor for credential verification:

- Training certificates from ADOS-2 (including Toddler Module)
- Copy of license with expiration date
- Proof of training, experience, or expertise in ASD and/or behavioral health (provide an Employer letter, education/transcript, job description, resume', CV, or other documentation)

In addition, network providers are to provide their own ADOS-2 kits and protocol booklets as well as ADI-R protocol booklets, should they choose to use that tool. The booklets are to be maintained by the provider until the consumer is 6 years past the age of majority and last date of service plus 10 years. They are to be provided to SCCMHA upon request.

Eligibility Determinations

- A comprehensive diagnostic evaluation, using the ADOS-2 and developmental symptom history, shall be administered to all children and adults who meet medical necessity criteria to complete.
- Assessors are to record the date and time spent face-to-face with the consumer and family. It is anticipated that ADOS administrations will typically take 1 hour and developmental symptom history administration will take approximately 2 hours, making the total time of the evaluation 3 hours. If there is a variance in that, the Assessor is to document why. Per the Medicaid ASD Best Practice Guidelines, "Evaluators should be spending at an absolute minimum two hours, but more routinely up to six hours of direct face-to-face time with the family and child being assessed." Following direct time, evaluators need several hours for scoring, record review, data interpretation, and report writing. This indirect time is essential for diagnostic accuracy and making the evaluation helpful to the family. Documentation of indirect dates and times should also be recorded.
- Symptoms are to be rated using the Developmental Disabilities-Children's Global Assessment Scale (DD-CGAS).
- Assessors may refer to other providers or request authorization themselves to complete a psychological evaluation, which includes other tools to determine a diagnosis and medical necessity service recommendations. Other tools may include: cognitive/developmental tests such as the Mullen Scales of Early Learning, Wechsler Preschool and Primary Scale of Intelligence-IV (WPPSI-IV), Wechsler Intelligence Scale for Children-IV (WISC-IV), Wechsler Intelligence Scale for Children-V (WISC-V), or Differential Ability Scales-II (DAS-II); adaptive behavior tests such as the Vineland Adaptive Behavior Scale-II (VABS-II), Adaptive Behavior Assessment System-III (BHTS-III), or Diagnostic Adaptive Behavior Scale (DABS) and/or; symptom monitoring such as the Social Responsiveness Scale-II (SRS-II) or Aberrant Behavior Checklist.
- Documentation of the eligibility determination is to occur using the Autism Program Eligibility Determination and is to be written in a language easily understood by caregivers.
- The Eligibility Determination is to be a comprehensive evaluation including differential diagnosing and treatment recommendations. Treatment recommendations need to include recommendations whether the child is found eligible for Behavioral Health Treatment (BHT) or not. Please refer to "Ancillary Services Available to SCCMHA Consumers" for additional information. If recommending BHT, please include the intensity for which services should be completed. *Note: Applied Behavior Analysis (ABA) and BHT are to be used interchangeably, however, for the purposes of consistency with MDHHS verbiage, BHT will be in place of ABA throughout this document.
- Assessors are to complete a progress note indicating whether the Eligibility Determination occurred and if not, why not.
- Assessors are to contact caregivers upon completion of documentation to explain results (feedback session) and it is to be documented that contact was made. A face-to-face visit is to be offered within 30 days of date of last face-to-face contact and documented.

- Upon completion, the diagnosis in SENTRI-II must be changed to reflect current diagnosis (whether it was "ruled-out" or confirmed/ "Active").
- It is required that prior to submitting Eligibility Determinations to SCCMHA, they be reviewed for grammatical and spelling errors as this often delays the consumer getting into services. If corrections are requested by Autism Program Supervisor, timely response to these corrections is imperative as this may delay service entry for individuals.
- Assessors are to include additional recommendations for treatment service array. Refer to "Ancillary Services Available to SCCMHA Consumers" for more information.

Medical necessity for BHT services is determined by the Assessor. The child must demonstrate substantial functional impairment in social communication, patterns of behavior, and social interaction as evidenced by meeting criterion A and B listed below:

A. The child currently demonstrates substantial functional impairment in social communication and social interaction across multiple contexts, and is manifested by all of the following:

1. Deficits in social-emotional reciprocity ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation, to reduced sharing of interests, emotions, or affect, to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction ranging, for example, from poorly integrated verbal and nonverbal communication to abnormalities in eye contact and body language or deficits in understanding and use of gestures, to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships ranging, for example, from difficulties adjusting behavior to suit various social contexts, to difficulties in sharing imaginative play or in making friends, to absence of interest in peers.

B. The child currently demonstrates substantial restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least two of the following:

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g. simple motor stereotypes, lining up toys or flipping objects, echolalia, and/or idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, and/or need to take the same route or eat the same food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g. strong attachment to or preoccupation with unusual objects, and/or excessively circumscribed or perseverative interest).

4. Hypo- or hyper-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures).

In addition, the following requirements for determining eligibility for BHT services for a child with a confirmed diagnosis of ASD must be met. Please refer to the "ABA Referral Considerations" document when assessing whether a child could benefit from BHT:

1. Child is under 21 years of age.
2. Child received a diagnosis of ASD from a qualified licensed practitioner utilizing valid evaluation tools.
3. Child is medically able to benefit from BHT treatment.
4. Treatment outcomes are expected to result in a generalization of adaptive behaviors across different settings to maintain the BHT interventions and that they can be demonstrated beyond the treatment sessions. Measurable variables may include increased social-communication, increased interactive play/age appropriate leisure skills, increased reciprocal communication, etc.
5. Coordination with the school and/or early intervention program is critical. Collaboration between school and community providers is needed to coordinate treatment and to prevent duplication of services. This collaboration may take the form of phone calls, written communication logs, participation in team meetings (i.e. Individual Education Plan/Individual Family Service Plan (IEP/IFSP), Individual Plan of Service (IPOS), etc.)
6. Services are able to be provided in the child's home (if deemed appropriate) and community, including centers and clinics.
7. Symptoms are present in the early developmental period (symptoms may not fully manifest until social demands exceed limited capacities, or may be masked by learned strategies later in life).
8. Symptoms cause ***clinically significant impairment*** in social, occupational, and/or other important areas of current functioning that are fundamental to maintain health, social inclusion, and increased independence.
9. A qualified licensed practitioner recommends BHT services and the services are medically necessary for the child.
10. Services must be based on the individual child and the parent's/guardian's needs and must consider the child's age, school attendance requirement, and other daily activities as documented in the Individual Plan of Service (IPOS).

Re-Evaluation

- Re-evaluations are to be conducted by qualified licensed practitioners as outlined above.
- Caregivers will be provided the Autism Program Re-Evaluation Informational Sheet.
- Qualified Licensed Practitioners shall address the ongoing eligibility of the autism benefit participants and are updated at least every three (3) years or sooner as medically necessary.
- Re-evaluations consist of utilizing the ADOS-2 and symptoms are rated using the DD-CGAS.

- Anticipated length of the re-assessments is 2 hours face-to-face. If there is a variance in that, the Assessor is to include why in the report.
- It is a requirement that the practitioner conduct a brief interview with the parent/guardian to determine symptomatology that isn't discovered during administration of the ADOS-2. The Assessor may use additional tools, such as questions from a developmental symptom history, to gain information about other symptoms the child is experiencing. Additional tools listed above under Eligibility Determinations may be used if the clinician feels it is necessary to determine ongoing medical necessity and recommend services.
- When a referral is made to an Assessor for a Re-Evaluation by the Autism Program Administrative Coordinator, it is to include the Autism Program Re-Evaluation Feedback Form. It is expected Assessors are to use this document in their review of consumers' continued eligibility.
- Assessors are to include additional recommendations for treatment service array, in particular if the individual is found no longer eligible for the benefit.
- If the child is no longer found eligible for BHT services during the yearly re-evaluation, caregiver will be sent an appeal notice.
    - If a caregiver requests a second re-evaluation, this will be scheduled within 30 days of the request. Should the caregiver/child fail to show for this appointment, the results of the initial re-evaluation will stand and no additional appointment times will be offered. The caregiver waives their right to a second re-evaluation in the future.

Documentation of the Re-Evaluation is to occur in the SENTRI-II electronic medical record under Therapist Assessment and is to include the following:

1. The purpose of the re-evaluation
2. Date and time of face to face contact, including the length of time it took
3. Date and time of indirect time spent calculating scores and writing reports
4. A description of the ADOS-2 and what module used (do not include a score)
5. What occurred during the ADOS activities
6. A description of the DD-CGAS
7. DD-CGAS score along with how that score was determined
8. Information collected from interview with parent/guardian
9. Whether the child continues to meet medical necessity criteria for BHT services and if so, that he/she will be evaluated again in one year
- Must include treatment recommendations. Treatment recommendations need to include recommendations whether the child is found eligible for BHT or not. Please refer to "Ancillary Services Available to SCCMHA Consumers" for additional information. If recommending BHT, please include the intensity for which services should be completed.
10. That caregiver was contacted and informed of the results. A face-to-face visit is to be offered within 30 days of last face to face contact and documented.

Medical necessity for BHT services is determined by the Assessor. The child must demonstrate substantial functional impairment in social communication, patterns of behavior, and social interaction as evidenced by meeting criterion A and B listed below:

A. The child currently demonstrates substantial functional impairment in social communication and social interaction across multiple contexts, and is manifested by all of the following:

1. Deficits in social-emotional reciprocity ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation, to reduced sharing of interests, emotions, or affect, to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction ranging, for example, from poorly integrated verbal and nonverbal communication, to abnormalities in eye contact and body language or deficits in understanding and use of gestures, to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships ranging, for example, from difficulties adjusting behavior to suit various social contexts, to difficulties in sharing imaginative play or in making friends, to absence of interest in peers.

B. The child currently demonstrates substantial restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least two of the following:

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g. simple motor stereotypes, lining up toys or flipping objects, echolalia, and/or idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, and/or need to take the same route or eat the same food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g. strong attachment to or preoccupation with unusual objects, and/or excessively circumscribed or perseverative interest).
4. Hypo- or hyper-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures).

Other Considerations

- Assessors are to determine whether the individual can benefit from BHT understanding that even if a child has a diagnosis of ASD, BHT may not be appropriate. Assessors are to do thorough review of deficits and needs and recommend alternative less intensive services when appropriate. Assessors may refer to the document "Ancillary Services Available to SCCMHA Consumers" for alternative treatment options.

- Differential and co-morbid diagnoses are to be explored and documented.
- Assessors are to complete the Mid-State Health Network (MHSN) Autism Benefit Evaluation Form upon completion of Eligibility Determinations and Re-Evaluations, with the appropriate box checked respectively. The Autism Administrative Coordinator is to e-mail encrypted MSHN form to MSHN Autism Waiver Coordinator. *All documentation to be completed within 5 business days and forwarded to Autism Program Administrative Coordinator per SCCMHA policy.*
- Autism Program Administrative Coordinator to enter the re-evaluation information into the Waiver Support Application (WSA) for approval by the MSHN Autism Waiver Coordinator.
- If Assessors offer time slots and are unable to no longer accommodate that, he/she is to reschedule the consumer directly (within 5 business days of the initial appointment) and notify the Autism Program Administrative Coordinator of date/time of re-scheduled appointment.
- Assessors are to follow the guidelines set forth by the Medicaid Autism Spectrum Disorder Screening, Evaluation and Treatment Recommendation Best Practice Guidelines manual at all times

Pertinent documents relevant to this procedure include:

Autism Program Re-Evaluation Feedback Form
Autism Program Eligibility Determination
Autism Program Re-Evaluation Informational She
Referral Packets
Referral Flow Chart
Rescheduling of Appointments Info-graph
What is ABA?
Ancillary Services Available to SCCMHA Consumers

These documents can be obtained either through the Autism Program Supervisor or Autism Program Administrative Coordinator.

Autism Program Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Autism Program Orientation Meeting	**Chapter**: 09.06.10 – Autism Program	**Subject No:** 09.06.10.09
Autism Program		
Effective Date: 6/29/18	**Date of Review/Revision**: 3/27/19, 2/26/20, 5/3/21, 3/3/22, 3/6/23, 4/1/24 **Supersedes**:	**Approved By**: Kristie Wolbert, Executive Director of Clinical Services **Authored By**: Director of Children's Services **Reviewed By**: Autism Program Support Coordinators, Amanda Elliott

Purpose:
The purpose of this procedure is to outline what is reviewed with caregivers upon entry to the Autism Program during the Orientation Meeting. It is SCCMHA's intention to educate parents about Applied Behavior Analysis (ABA) using educational materials, cancellation protocol, in-home ABA intervention, and transportation.

Application:
This applies to the Autism Program Supervisor and assigns Supports Coordinator.

Policy:
None

Standards:
Each new consumer who enters the Autism Program must attend an Orientation Meeting with the Autism Program Supervisor or designee and assigned Supports Coordinator if available. Exceptions to this may include siblings of current consumers who are being served in the Autism Program or consumers who have previously been served through the program. Caregivers are also provided a copy of their child's Autism Program Eligibility Determination and asked if they have questions or concerns. Further, individuals are informed that their child will need to come for re-evaluation once per year to determine if he/she continues to meet medical necessity criteria for ABA, otherwise, the benefit is available to them until their child turns 21 years of age. Documentation of the Orientation Meeting is done by the assigned Supports Coordinator or designee indicating the above was reviewed with the caregiver.

Team Orientation Checklist

The use of SCCMHA's Team Orientation Checklist is to be used and caregivers are to sign off on the checklist. Caregivers are to be informed that staff are mandated reporters. In addition, discussion of as needed transportation to intervention to occur.

Cancellation Protocol

This document is reviewed with caregivers to outline the importance of engaging and committing to ABA. If caregivers choose not to pursue ABA within 90 days, disenrollment from the benefit will occur. If a provider dismisses a child due to attendance issues, a meeting with the Autism Program Supervisor and assigned Supports Coordinator BEFORE the child is referred to another provider will occur. The purpose of this is preventing re-occurrence of attendance issues. This document is a fluid document and may be used with families already engaged in services, not merely during the Orientation Meeting.

Autism Program Re-Evaluation Informational Sheet

This outlines Michigan Department of Community Health's requirement for annual re-evaluations to determine medical necessity for continued treatment.

In-Home ABA

It is preferable that ABA services be provided in a facility in an effort to assure quality outcomes, however, in-home services can be made available upon caregiver request if the home environment is found to be suitable as defined as a "designated, sanitary room in a quiet environment with no distractions." Caregivers are asked to consider what is listed within the document when deciding whether in-home ABA is an option for them. This document is a fluid document and may be used with families already engaged in services, not merely during the Orientation Meeting.

School and ABA

Informs parents regarding the inability to provide ABA during the school day and other processes regarding school and ABA.

Rights and Responsibilities

Discusses caregivers/consumers rights being served through Saginaw County Community Mental Health Authority. Further discusses care-givers responsibility in receiving services.

Pertinent documents relevant to this procedure include:
Team Orientation Checklist (Modified for Autism Program)
Welcome to Saginaw County Community Mental Health Authority Autism Program
Autism Program Mission/Vision Statement
Applied Behavior Analysis
Individual Plan of Service
Saginaw County Community Mental Health Applied Behavior Analysis Cancellation Protocol
In-Home Applied Behavior Analysis

Autism Services Brochure
Parent Resource Guide Brochure
Autism Spectrum Disorder Fact Sheet
ABA Terms Parents Should Know
A Parent's Guide to Evidence Based Practice and Autism (book-cover sheet only-to be provided on loan to families per request)
Autism Program Re-Evaluation Informational Sheet
SCCMHA Autism Program Participants Rights
School and Applied Behavior Analysis

These can be obtained either through the Autism Program Supervisor or Autism Program Administrative Coordinator.

Definitions:
None

References:

A. 09.06.00.12, SCCMHA Clinical Team Orientation Policy
B. 09.06.10.08, Autism Program Eligibility Determination and Re-Evaluation Eligibility
C. 02.03.21, Autism Spectrum Disorder (ASD) Program
D. Mid-State Health Network (MSHN) Policy, Autism Benefit Re-Evaluation Eligibility
E. MSHN Policy, Autism Spectrum Disorder Benefit

Exhibits:
None

Procedure:
None

<table>
<tr><td colspan="3">Autism Program Procedure Manual
Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: Referrals for Autism Spectrum Disorder Eligibility Determination Evaluations for Applied Behavior Analysis (ABA)</td><td>Chapter: 09.06.10 – Autism Program</td><td>Subject No: 09.06.10.10</td></tr>
<tr><td colspan="3">Autism Program</td></tr>
<tr><td rowspan="2">Effective Date:
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3/6/23, 4/1/24</td><td rowspan="3">Approved By:
Kristie Wolbert, Executive Director of Clinical Services

Authored By:
Director of Children’s Services

Reviewed By:
Allison Kalmes-Hadd, Amanda Elliott</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
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Purpose:
The purpose of this procedure is to clarify the course of action that must occur when consumers present with a request to receive an Autism Evaluation (Eligibility Determination) for autism spectrum disorder with the intent of seeking the treatment of Applied Behavior Analysis (ABA) and therefore becoming an active participant in the Autism Program.

Application:
This procedure applies to children and adults up to the age of 21 seeking an evaluation to determine the need for Applied Behavior Analysis from Saginaw County Community Mental Health Authority (SCCMHA).

Policy:
It is the policy of SCCMHA that consumers/parents/caregivers who present with concerns regarding possible symptoms of Autism are initially screened and assessed using best practice guidelines, as well as assessed for other potential developmental delays and behavioral issues that may be impacting their level of functioning. Therefore, it is the policy of SCCMHA that referrals specific to Autism and Applied Behavior Analysis (ABA) treatment are initiated by the consumer’s primary care physician, and upon receipt include medical necessity to support the request for further evaluation. Specifically, per the

Michigan Medicaid Provider Manual the primary care physician is required to complete the following:

(1) a full medical and physical examination *before* the child is referred to the local PIHP (Pre-Paid Inpatient Health Plan) to assist with ruling out other medical or behavioral conditions other than Autism Spectrum Disorder and include those conditions that may have behavioral implications and/or may co-occur with Autism Spectrum Disorder.

(2) It is also requested that upon referral the primary care provider complete an Autism Spectrum Disorder screen (i.e., Social Communication Questionnaire [SCQ] or Modified-Checklist for Autism in Toddlers [M-CHAT]) to provide support for the request for further evaluation by the SCCMHA.

***SCQ** scores 15 and above suggest the individual is likely to be on the autism spectrum and a more extensive evaluation should be carry out.*

***M-CHAT** scores 3-7 demonstrate Medium-Risk for ASD, and a Follow-Up Interview should be performed. If a child's total score is 8-20 points, they are at High-Risk for ASD and a Follow-Up Interview can be performed to gain clarity on at-risk responses and refer the child for a diagnostic evaluation and early intervention services. A total score of 0-2 means the child passed the screener and surveillance should continue at all subsequent health supervision visits.*

If the primary care physician submits an incomplete referral (missing either of the two above items) SCCMHA Intake Specialist will contact the primary care physician directly and inform them of the above-mentioned requirements that are needed to move forward with a full ASD evaluation for applied behavior analysis. This request should also be explained to the consumer/parent/caregiver to assist with the process. Additionally, the Intake Specialist should seek to clarify with primary care physician and consumers/parents/caregivers the importance of ruling out other medical or behavioral conditions other than ASD as well as identifying conditions that may have behavioral implications and/or may co-occur with ASD. Ultimately, SCCMHA seeks to effectively communicate and assist families and primary care physicians in understanding the importance of completing all the necessary steps of assessing a consumer for autism spectrum disorder, since not doing so could result in improper treatment planning, time lost for the consumer, and poor use of Medicaid funds. Additionally, it should be explained to the consumer/parents/caregivers the intent of autism evaluations is to determine if Applied Behavior Analysis is the best treatment for the presenting symptoms. Whereas if they are seeking only to rule in or rule out a diagnosis of autism spectrum disorder without the intention of engaging in Applied Behavior Analysis treatment then other diagnostic referrals can and should be coordinated with the consumer/parents/caregivers through SCCMHA.

Consumers who are transfers from other CMH's or previous ABA receiving consumers presenting to SCCMHA Central Access and Intake (CAI) should be reviewed for eligibility for the Autism Benefit by CAI obtaining records from other CMH's such as a consumers last Autism Eligibility Determination and last ABA assessment/treatment plan. No additional referral from the Primary Care Physician is needed for consumers who have completed an Autism Eligibility Determination with another CMH.

Consumers with private insurance need to verify with their insurance carrier the details and the extent of their autism benefit as insurance plans and benefit packages are different for each. Additionally, consumers who have BCBS as their primary insurance are required to be evaluated for autism by an Approved Center for Excellence and therefore need to be directed to the appropriate service provider. For these consumers autism evaluations completed elsewhere are not accepted unless prior approval has been granted by BCBS. Approval documentation must be obtained, reviewed, and scanned into the record, and an OTM is scheduled with the consumer prior to scheduling an autism eligibility determination through SCCMHA. If these consumers are eligible for other services outside of the autism benefit those services should be coordinated as appropriate and assigned to the corresponding treatment team. If the consumer is found eligible for Applied Behavior Analysis later though SCCMHA, then the treatment team and case holder would be transitioned to the Autism Program upon the receipt of the positive Autism Eligibility Determination.

For consumers who have a private insurance as primary and Medicaid as secondary SCCMHA will follow the Medicaid provider guidelines regarding coinsurance/deductible and/or copayments section 3.3.

Standards:
None

Definitions:

ASD- Autism Spectrum Disorder- ASD is a range of developmental conditions that can make social interaction and communication challenging. Spectrum means signs and symptoms can vary from one child to another and range from mild to severe. ASD includes autism disorder, Asperger syndrome, and pervasive developmental disorder, not otherwise specified. These terms are sometimes used interchangeably with ASD. he main signs and symptoms are social interaction problems and repeated behaviors. These prevent your child from functioning easily in social settings, such as school. Signs and symptoms are usually noticed during the early developmental period, often by 3 years. Your child may not reach expected milestones. He or she may reach milestones but then lose skills that were gained. ASD sometimes becomes noticeable later, when children need to interact with others at school.

ABA- Applied Behavior Analysis- also known as ABA – is the most evidence-based treatment for individuals with ASD (Cohen, Amerine-Dickens & Smith, 2006; Sallows & Graupner, 2005; Warren et al., 2011). ABA is a therapeutic approach based on principles of learning and behavior that involves identifying connections between an individual's behavior and antecedents and consequences of that behavior. This approach heavily utilizes positive reinforcement, which is the provision of something valued by an individual (a reward) immediately after the individual engages in a desired behavior. Behaviors that are consistently reinforced subsequently occur more often. Complex skills can be broken down into small steps and taught in a hierarchical fashion or gradually shaped by reinforcing successive approximations of the final behavioral goal. When treating problematic behavior, ABA focuses on understanding the function of the problem behavior when developing effective interventions. Although many of these principles of learning can be applied successfully outside of the context of ABA, this therapeutic approach must be practiced by professionals (in collaboration with family members) with appropriate clinical training.

MSHN- Mid-State Health Network- The Pre-Paid Inpatient Health Plan for Saginaw County Community Mental Health that receives Medicaid funding from the state and distributes to those within the MSHN network of Community Mental Health Providers based on services performed by each Community Mental Health Provider.

ADOS-Autism Diagnostic Observation Schedule - The ADOS-2 is a required component of the ASD evaluation and should be utilized and scored whenever the individual falls within the scope of the standardization sample (notable exceptions are discussed in the differential and special populations sections of this guideline). While highly useful data, the ADOS-2 is intended to be only one component of the comprehensive ASD evaluation and should never be used in isolation, but rather utilized as part of an integrated assessment with multiple domains and sources (ADOS-2 manual; Lord et al., 2012). The ADOS-2 should be used as it was standardized in a clinic-based setting and not at the family's home; while home-based observations can be a useful component of ASD evaluation in some cases, the clinical tools should be administered in a clinic-based setting

SCQ- Social Communication Questionnaire - brief instrument helps evaluate communication skills and social functioning in children who may have autism or autism spectrum disorders. Completed by a parent/adult or other primary caregiver in less than 10 minutes, the SCQ is a cost-effective way to determine whether an individual should be referred for a complete diagnostic evaluation. The questionnaire can be used to evaluate anyone over age 4.0, as long as his or her mental age exceeds 2.0 years. It is available in two forms—*Lifetime* and *Current*—each composed of just 40 yes-or-no questions. Both forms can be given directly to the parent, who can answer the questions without supervision.

M-CHAT- Modified Checklist for Autism in Toddlers The ***M-CHAT*** is a two-stage screening tool. It is designed to be completed by parents of children 16-30 months old. The initial screening consists of 23 yes/no questions about the child's usual behavior. Children who fail 3 or more items total or 2 or more critical items (particularly if these scores remain

elevated after the ***M-CHAT*** Follow-up Interview) should be referred for diagnostic evaluation by a specialist trained to evaluate ASD in very young children.

References:

A. Michigan Medicaid Provider Manual, MedicaidProviderManual.pdf (state.mi.us) Coordination of Benefits, Section 3.3
B. BCBS Center of Excellence Finding approved autism evaluation centers and licensed behavior analysts: Blue Cross and BCN (bcbsm.com)
C. SCCMHA Departmental Procedure 09.02.02.01 Coordination of Benefits (COB)
D. SCCMHA Departmental Procedure 09.02.04.03 Medicaid Deductible
E. SCCMHA Departmental Procedure 09.02.03.05 Insurance Verification
F. MSHN Policy, Autism Spectrum Disorder Benefit
G. 09.06.00.12, SCCMHA Clinical Team Orientation Policy
H. 09.06.10.02, Autism Program Entry to Services Program Policy
I. 09.06.10.08, Autism Program Eligibility Determination and Re-Evaluation Eligibility
J. 02.03.21, Autism Spectrum Disorder (ASD) Program

Exhibits:

None

Procedure:

Following is a detailed procedure for Referrals for Autism Eligibility Determination from Centralized Access and Intake.

ACTION	RESPONSIBILITY
• Autism referral received by Central Access and Intake (CAI)	Central Access and Intake Dept.
○ CAI verifies the referral is complete and correct: ✓ Sent by PCP and includes- ✓ full medical and physical examination documentation. ✓ A completed Autism Screener that indicates the concerns that initiated the referral. **If a referral is received and the included documentation does not give reason for further evaluation the referral should be reviewed by CAI*	CAI Specialist /CAI Supervisor

Supervisor for guidance on next steps due to the inconsistencies identified. Immediate follow up with the referring PCP is recommended to obtain the correct information.	
• Referral paperwork has been obtained and findings are reviewed with the parent/caregiver.	CAI Specialist
• Verification of Insurance coverage and details of benefits are reviewed as well as the Ability to Pay.	CAI Specialist
• Initial Intake Assessment is completed, seeking to gather all pertinent information that would assist with appropriate preliminary diagnosis and treatment planning.	CAI Specialist
• Determine if the consumer would benefit from other behavioral health services as indicated by the initial intake assessment and presenting concerns.	CAI Specialist
• Parent/caregiver is provided detailed information on what the intent of an Autism Eligibility Determination entails. This step is important as parents need to be able to make an informed decision regarding the evaluation process and potential treatment recommendations that will follow. <u>Autism Eligibility Determination entails:</u> • Determination of Autism Spectrum Disorder Diagnosis • Severity of symptoms • Determine if ABA Tx is recommended	CAI Specialist
• Parents are informed that if their child is found not eligible for the Autism benefit, other recommendations will be provided based on the evaluation results.	CAI Specialist

• If parent/guardian wishes to proceed in an eligibility determination CAI Intake Specialist will email Care Management requesting approval to proceed with scheduling an Autism Eligibility Determination, as well as to request other needed behavioral health services identified.
  • It is recommended that consumers who would benefit from other behavioral health services (in addition to an autism eligibility determination) begin these services prior to their autism ED.
  • If the consumer is found eligible for Autism ABA treatment, service coordination with existing providers will be done with the least amount to disruption as possible.
	Care Management Specialist/ CAI Specialist

• Care Management will review the request for further evaluation and verify appropriate documentation and medical necessity are accounted for.	Care Management Specialist
• Care Management will verify insurance coverage and benefit details to ensure that all information has been collected and authorization for services can be provided.	Care Management Specialist
• Once verified, Care Management will communicate approval through email to CAI to move forward with scheduling an Eligibility Determination (ASD Evaluation) • If appropriate documentation and medical necessity are not verifiable Care Management will communicate the concern with CAI to seek a timely resolution.	Care Management/ Specialist CAI Specialist
• Following approval from Care Management to proceed with Autism Evaluation, CAI staff will schedule an Orientation Meeting (OTM) with the primary treatment team identified. using Sentri Calendar system and then contact the caregiver to inform of orientation meeting date, time, and location.	CAI Specialist

• Email indicating the OTM date, time and location/method of OTM (phone, DOXY, face to face) is then sent to:
  • Care Management
  • CAI Administrative Coordinator
  • Autism Administrative Coordinator and
  • Autism Program Supervisor
 	
See 09.06.10.02 Autism Program Entry to Services Program Policy for additional guidance.
	CAI Specialist

<table>
<tr><td colspan="3">Salter Place Housing Resource Center Procedure Manual
Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject:
Referral/Application, Screening and Eligibility Determination</td><td>Chapter: 09.06.12 - Housing Resource Center</td><td>Subject No: 09.06.12.09</td></tr>
<tr><td colspan="3">Housing Support Services of SCCMHA</td></tr>
<tr><td rowspan="2">Effective Date:
3/20/2009</td><td>Date of Review/Revision:
7/12/10, 6/28/18, 7/29/19, 4/27/20, 3/18/21, 3/6/23, 3/19/24</td><td rowspan="2">Approved By:
Kristie Wolbert, Executive Director of Clinical Services

Authored By:
Director of Services for Persons with Mental Illness

Reviewed By:
Debbie Jones-Burt, Director of Services of Persons with Mental Illness</td></tr>
<tr><td>Supersedes:</td></tr>
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Purpose:
The purpose of this policy is to describe the process by which consumers of SCCMHA are referred to the Housing Resource Center for housing services and how eligibility is determined for acceptance on one of the housing assistance grants administered by SCCMHA.

Application:

	This procedure applies to Programs, Grants or Benefits Checked
X	HUD Tenant Based Permanent Supportive Housing (CoC Program)
X	SCCMHA Housing Resource Center
X	SCCMHA Housing Assistance Program
X	SCCMHA Provider Manual

Policy:
It is the policy of SCCMHA that consumers of mental health services may be referred to the Housing Resource Center for housing services by the SCCMHA network. Referrals for

participation in rental assistance grants or any other type of funding activity is to be submitted on a Housing Referral Form. Referrals for other types of assistance and information (Apartment searches, subsidized housing complexes, landlord information, community resources, etc.) can be made directly by contacting the HRC staff for the required assistance. Intakes are scheduled for referred applicants when their names rise to the top of the priority list (see "Priority List" policy 09.08.02.04). Intakes are performed to determine eligibility for placement on one of the grants.

Standards:

1. Intakes will be scheduled within ten business days of names rising to the top of the priority list.

2. The participant and Case Manager will return all necessary documents and information within fourteen days of the intake.

3. Consumers enrolled in SCCMHA rental assistance grant will meet the HUD definition of Homelessness prior to enrollment. (Exhibit from McKinney-Vento).

4. Consumers enrolled in SCCMHA rental assistance grants will meet the definition of disability for the specific grant in which they are enrolled at the time of enrollment.

5. Consumers enrolled in SCCMHA rental assistance grant will meet the income-limit requirements at time of enrollment.

Definitions:

- Homeless: (See: References)
- Chronically Homeless: (See: References)
- Disability: (See: References)
- *Housing Assistance* means: any of the various services provided out of the SCCMHA Salter Place Housing Resource Center (HRC).
- *Applicant* means: an individual referred for housing assistance to the HRC but not yet approved for assistance.
- *Participant* means: an individual who has been referred and approved for services by the HRC.

References:

- SCCMHA Housing Policy 09.08.02.01; "Eligibility Criteria".
- 24 CFR Section 582.5 Definitions

Exhibits:

Exhibit A - Housing Referral Form
Exhibit B - Intake Packet
  - SCCMHA Housing Assessment
  - Full Application for Admission to Shelter Plus Care program.

- Homeless Declaration
- Verification of Disability
- Income and Asset release of information
- Applicant-Tenant Authorization
- HMIS Release
- Declaration of Citizenship
- Household Documents Checklist
- SSA Income Verification
- DHS Income Verification
- Case Manager Agreement

Exhibit C - Enrollment Packet
- Participant Agreement
- Participation Termination Agreement

Procedure:

Assistance and Information: Requests for assistance and information, from SCCMHA and provider network staff, are made directly to HRC via electronic mail or inter-office correspondence.

Grant Referrals/Funded Services: Referrals for funded services made to the Housing Resource Center are to be received in hardcopy form from SCCMHA staff and provider network staff. This "Housing Assistance Referral Form" is available electronically on agency network or sent by HRC staff either electronically or in hardcopy to provider network staff who do not have access to SCCMHA internal computer network. The referral form is completed by the referring staff person and returned to the Housing Resource Center staff. Upon receipt of the referral form, the referral is logged electronically into the HRC referral log in chronological order. Once the referral is logged it stays in the 'queue' and moves up the list as names above it are removed, either because of ineligibility or acceptance into a rental assistance program. *(see, "Priority Lists" policy 09.08.02.04)*

Screening/Intake: Once a consumer name rises to the top of the priority list, the referring staff (service Provider) and the client are contacted, and an intake meeting is scheduled. It is during the course of the intake that the information necessary to make an eligibility determination is gathered. An Intake packet is prepared.

During the intake meeting the applicant completes the following forms:
- SCCMHA Housing Assessment
- Full Application for Admission to the Shelter Plus Care program
- Homelessness Declaration
- Declaration of Citizenship
- Applicant/Tenant Authorization and Certification
- Income and Asset release of information
- HMIS release of information

Also, during the intake, the following documents are obtained:

- Picture identification
- Birth Certificate
- Social Security card
- Pay check stubs (if employed)
- Bank account information

During the intake meeting the Case Manager is provided with and required to return the following forms:

- Homelessness Declaration
- Verification of Disability

The Case Manager is also required to sign to Homelessness Declaration on behalf of the client. If the applicant is staying at a homeless shelter the Case Manager is required to acquire shelter verification in the form of a letter from the shelter indicating the applicant is a resident.

After collecting the proper releases of information during the intake, the HRC staff verify the following third-party information:

- Income/Resources (SSI, DHS, unemployment, etc.)
- Assets (bank accounts, trusts, etc.)
- Food stamps

If there are additional adults in the household (over 18), they must provide:

- Marriage License or verification of long-term relationship
- Signature on Full Application
- Releases of information
- Verification of income
- Picture ID
- Birth Certificate
- Social Security card
- School verification (if a child under age 24)

If there are children in the household (under 18), they must provide:

- Birth Certificate
- Social Security card

Eligibility Determination: Third-party verifications are conducted after the intake is completed. After any third-party verifications are received (if necessary) the intake file is reviewed against eligibility requirements for the specific grant opening. (See: SCCMHA Housing Policy 09.08.02.01; "Eligibility Criteria"). Eligibility determinations are based on the following common criteria:

- Signed verifications of homelessness.
    - For persons living on the streets: signed statement from outreach worker, other organization, or participant attesting to applicant's homeless status.

- For persons living in emergency shelters: signed statement from shelter provider attesting the applicant is residing there.
- For persons exiting transitional housing: signed statement from transitional housing provider attesting that applicant is residing there and was homeless upon entry.
- For persons leaving an institution following short-term stay (30 days or less): signed statement from institution verifying residence of less than 30 days and attesting that applicant was homeless at time of entry.
- For chronically homeless persons: one of the above documents to verify current status and duration of homelessness, plus, if applicable, a signed statement from the applicant attesting to past homeless episodes.

- Verification of Disability Form signed by a qualified health care professional trained to make such a determination. Case managers are not qualified to sign the verification unless they are a qualified health care professional.

- Verification of income eligibility. Applicant's annual income as documented by government assistance program printouts and/or pay stubs must not exceed 50% of AMI.

- Signed Case Manager/Therapist Agreement between SCCMHA and eligible service provider

Based on the review of the application packet, the HRC Coordinator will make one of the following determinations:

1. File is complete and applicant is eligible. The HRC Coordinator will calculate the tenant rent portion (see Section 13) and schedule an application meeting (see below).

2. File is incomplete. If eligibility cannot be determined, the HRC Coordinator will notify the applicant and case manager that additional information is needed. If the requested information is not supplied within 30 days, the applicant will be determined to be ineligible.

3. Applicant is ineligible. The application will be denied and the reasons given in writing to the applicant and case manager. The applicant may appeal the denial of eligibility by following the process described in "SCCMHA Housing Appeals/Grievance Procedure 0.08.05.02".

If the consumer is determined to be ineligible for the grant that has an opening available, but is eligible for a different grant, the consumer remains in the queue until an opening occurs for the grant they are eligible for. At that point eligibility is re-determined. If a consumer is found to be ineligible for any of the currently supported grants, their name is removed from the queue and they are sent a rejection letter explaining why they are ineligible.

Enrollment/Orientation Meeting: If the referred consumer is determined to be eligible, then a briefing meeting is scheduled where the program expectations are explained and a Enrollment paperwork is completed by the consumer. At this point, the consumer is considered to be enrolled into the grant and the process of finding a suitable apartment is begun.

At the Orientation Meeting the HRC Coordinator will:

- Review the program requirements and obligations with the participant.
- Explain what the participant's portion of the rent will be and how it was calculated.
- Explain the process for securing a housing unit.
- Review and have the participant sign:
    - Participation Agreement
    - Participant Termination Agreement
    - Release of Information (HMIS)

ACTION	RESPONSIBILITY
Referral for assistance sent to the Housing Resource Center.	SCCMHA and Network provider staff
Request for assistance.	HRC staff contacted directly by SCCMHA and Network provider staff
Referrals screened for initial eligibility during client intake.	HRC staff
Client placed on Priority list	HRC Staff
Intake Scheduled/performed	HRC Staff
Documentation provided	Applicant/Case Manager
Verifications provided	Case Manager/Therapist/Service Provider
3rd party verifications	HRC Staff
Eligibility for funded program determined.	HRC Supervisor
Briefing meeting scheduled/held	HRC Staff

Exhibit A

Saginaw County Community Mental Health Authority
Housing Assistance Referral Form

Referral Date: _____

A. Demographic Information

Case #: _____ Name: _____ Phone: _____
Where is client currently staying? _____ Subsidized? Yes No

Does anyone live with client? Yes No - If yes, please identify:_____

Is the client a veteran? Yes No Does Client have Guardian ? _____ Payee?_____
Does client require physical accommodations? Yes No

Has the client ever been in jail? Yes No Prison? Yes No
Is client now on parole/probation? Yes No Are any charges pending? Yes No
Type of offense:_____

Does client have unpaid balances on utilities? Yes No How much?_____
Does client have previous landlord judgments or court-ordered evictions? Yes No

B. Eligibility Criteria

1. Homeless or At Risk: (If not in a shelter or place not meant for habitation, what is the of imminent risk for homelessness): _____
How long has client been homeless? _____ How many times has client been homeless? ____

Shelter/Homeless verification included with referral? Yes No

Disability verification included with referral? Yes No

2. Mental health and substance abuse treatment:

a) Mental Health
Diagnosis:_____
Currently receiving services? Yes No - If "Yes", for how long? _____

b) Substance Abuse
Does this client have a current or past history of substance abuse? Yes No
Alcohol _____ Marijuana _____ Prescription Drugs _____ Other Street Drugs?____

3. Income:

Client Income Per Month:_____Source(s) of Client Income:_____
_____
Other Family Income Per Month: $_____ Source(s) of Household Income:_____
_____
Food Stamps: Yes No - Amount: $_____ Medicaid: Yes No Medicare: Yes No

C. Services Requested (circle): **Rental Assistance** **Deposit** **Utilities** **Other**

Reason for referral: _____

_____

_____

I verify that this client is receiving case management services and I am recommending that the above listed services be provided.

Case Manager: _____ **Phone**_____

_____

Please follow up after you send the referral – otherwise it is presumed the problem has been resolved!

Revised 1/2016 (RA)

Exhibit B

Housing Support Services of SCCMHA

S.C.C.M.H.A. Housing Assessment

1. Please check all of the housing services are you seeking help with?

☐ Paying for Housing? ☐ Finding Housing? ☐ Furniture/furnishings?
☐ Utility Assistance? ☐ Repairs/Maintenance? ☐ Moving?
☐ Other_____ .

2. About You

Name:_____ **Sex: ☐Male ☐ Female**

Marital Status: ☐ Married ☐ Single ☐ Living together ☐ Divorced ☐ Separated

D.O.B._____ **Age:**_____ **SSN#** _____-_____-_____

3. Current Address

_____ **Apt. #** _____

_____
City, State, Zip

Home Phone ( ) _____Cell or Alternate Phone ( ) _____

Date you moved into current address _____ (mm/dd/yy)

County _____ City _____ TWP _____

Are you a U.S. Citizen? ☐ Y ☐ N

Please provide information for all <u>family members</u> living with you:

Name	D.O.B.	Age	Gender	SSN#	Relationship to you	U.S. Citizen

Are you or anyone that lives with you pregnant? ☐ Y ☐ N
If yes, please give their name and Baby due date:

Name of Pregnant Person	Baby Due Date

Emergency/Next of Kin Information:

Name _____ Relationship _____ Contact #( ) _____

4. Are you disabled? ☐ **Y** ☐ **N**

Do YOU have a developmental disability? ☐ Yes ☐ No

Do you have a child under the age of 18? ☐ Yes ☐ No

Do you, as a person with a disability, require SPECIFIC accommodation(s) to fully use our programs and services? ☐ Y ☐ N

List specific accommodation(s) required: _____

Is your disability: (if any)

☐ **Physical** ☐ **Mental Health** ☐ **Can you climb stairs?**
☐ **Sensory** ☐ **Substance Abuse (past HX)** ☐ **Learning Difficulty**
☐ **Other _____**

Do you receive disability income? ☐ Yes ☐ No
☐ **SSD?** ☐ **SSI?** ☐ **VA Benefits?**

Are you a VETERAN? ☐ Y ☐ N

Do you currently receive V.A. services? ☐ Y ☐ N

Would you like information on where to receive V.A. services? ☐ Yes ☐ No

Why or Why Not?

_____
_____
_____

5. Details about where you live

Please tell us about where you are living now.

☐ **Apartment**	☐ **House**	☐ **Emergency Shelter**
☐ **SIP Home**	☐ **Subsidized Housing**	☐ **Hospital/Institution**
☐ **AFC Home**	☐ **No home**	☐ **Hotel/Motel**
☐ **With Friends**	☐ **With family**	☐ **On the street/dumpster**
☐ **Under bridge**	☐ **Abandoned house/building**	☐ **Prison/jail**

Have you been placed in a temporary accommodation by another agency? ☐ **Y** ☐ **N**
If so, which agency placed you?

_____

What floor do you live on? (ground, first, second, etc.) _____

What is your zip code? _____

Tell us about your previous housing

Have you been on a rental subsidy program before? ☐ **Y** ☐ **N**
Are you CURRENTLY on a rental subsidy? ☐ **Y** ☐ **N**

If you are currently renting, is your rent paid to date? ☐ **Y** ☐ **N**
Have you been evicted or asked to leave your current residence? ☐ Y ☐ **N**
If so, when do you have to leave? _____

6. Please tell us of any other problems or needs (serious disrepair, rent arrears) where you live now.

_____
_____

7. List housing preferences (House/Apartment/Duplex, etc.):

_____
_____
_____

Address/Move History (for the last three years)

Street	**City/State**	**Move-in/Move-out date**	**Why did you leave?**
1.			

2. _____
3. _____
4._____
5._____

Can you please explain the events that lead to your current housing status_____
_____
_____
_____

8. Employment and Income

Are you, or anyone in your household employed? ☐ Y ☐ N
If yes, who? What is the gross monthly income?

Name	Hourly Rate	Hours per week	Gross Income	Pay Period (weekly, bi-weekly, monthly

Please list ALL other sources of income and gross amounts.

Source of Income	Monthly GROSS amount

☐ Do you have a payee? ☐ Yes ☐ No Name_____ Phone _____

☐ Do you receive Food Stamps? ☐ Yes ☐ No

If yes, Name of DHS Case Worker _____

☐ Do you have Medical Insurance? ☐ Yes ☐ No

If yes, please complete the following:

Name of Insurer (insurance) _____

Name of Insured Person _____

Insurance Premium amount _____per_____

9. Do you have any past credit or legal history that might prevent you from obtaining housing? ☐ Y ☐ N

Please Explain:

_____
_____
_____
_____

Corrections Related Status:

☐ **Probation from Jail**
☐ **Paroled from Prison**
☐ **Court Supervision**
☐ **Awaiting Trial**
☐ **Awaiting Sentencing**
☐ **Not problems with the law**

Education Summary

Highest Level of Education Attained:

☐ **College Degree**
☐ **Graduate Degree**
☐ **Less than High School**
☐ **Some College**
☐ **Some High School**
☐ **Some Technical School**
☐ **Technical School Certification**
☐ **No Schooling Completed**
☐ **Nursery school to fourth grade**
☐ **5th grade or 6th grade**
☐ **7th grade or 8th grade**
☐ **9th grade**
☐ **10th grade**
☐ **11th grade**
☐ **12th grade**
☐ **High School Diploma**
☐ **GED**
☐ **Post Secondary School**

Primary Race: (required)

☐ **American Indian or Alaskan Native**
☐ **Native Hawaiian or other Pacific Islander**
☐ **Asian**
☐ **Black or African American (HUD)**
☐ **White (HUD)**
☐ **Other**
☐ **Other Multi-racial**

Secondary Race:

☐ **American Indian or Alaskan Native**
☐ **Native Hawaiian or other Pacific Islander**
☐ **Asian**
☐ **Black or African American (HUD)**
☐ **White (HUD)**
☐ **Other**
☐ **Other Multi-racial**

Ethnicity (required): ☐ Hispanic/Latino ☐ Other (Non-Hispanic/Latino)

For Office Use Only

Date Received:_____ Staff Initials_____

Bedroom Size : EFF____ 1 Bdrm ____ 2Bdrm _____ 3 Bdrm ____ 4Bdrm ____

Housing Choice Voucher? Y or N

Total Household Income $.....

Housing Support Services of SCCMHA

HOMELESS DECLARATION

This declaration certifies you meet one or more of the following criteria.

Please check all of the following that apply to you.

☐ I am living in places not meant for human habitation, such as cars, parks, sidewalks, and/or abandoned building (including fleeing domestic violence)

☐ I am living in an emergency shelter

☐ I am living in transitional housing for homeless persons but I originally came from the streets or an emergency shelter.

☐ I am in one of the three categories listed above but most recently spent less than 30 days in jail or an institution

One of the above must be checked to be eligible for Shelter Plus Care or Permanent Housing for people with disabilities

☐ I am being discharged within a week from an institution where I have spent more than 30 days.

☐ I am being evicted within seven (7) days and have no resources to secure housing (third party documentation must be attached)

☐ I have been homeless at least four times in the past three years and am currently homeless

☐ I have been continuously homeless for a year or more

☐ Third party documentation of the above is attached

A person who is living in substandard housing is not considered homeless. However, a person living in housing that has been officially condemned as unfit for human habitation is considered homeless (see box 1 above)

A person who is living in doubled-up housing is not considered homeless.

_____ _____

CLIENT SIGNATURE *Date*

_____ _____

CLIENT SIGNATURE *Date*

_____ _____

SERVICE PROVIDER SIGNATURE *Date*

Housing Support Services of SCCMHA

Income, Asset and Eligible Expense Information for Income Providers

Release of Information

In signing this consent form, you are authorizing SCCMHA, its agents, employees, affiliates to request income, asset and eligible expense information from all income providers (i.e. Social Security Administration, Department of Human Services, employers, etc.) listed on your Income Checklist and any other related application forms. This information is needed for purposes of determining eligibility for this rental assistance program. Private owners may not request information authorized by this form.

Failure to sign the consent form many result in denial of assistance or termination of benefits.

CONSENT

I/We hereby allow SCCMHA, and its affiliates to request and obtain income and asset information from all providers (i.e. Social Security Administration, The Michigan Department of Human Services, etc.) listed on my/our Income Checklist and any other related application forms.

I agree that the copies of this authorization may be used for the above stated purposes.

Applicant Signature	*Date*
Co-Applicant Signature	*Date*
Other Adult Household Member	*Date*
Other Adult Household Member	*Date*

Housing Support Services of SCCMHA

APPLICANT/TENANT AUTHORIZATION AND CERTIFICATION
Shelter Plus Care

Saginaw County Community Mental Health Authority

The undersigned certifies that the information given to SCCMHA for Shelter Plus Care on household members, income, net family assets, allowances, and deductions are accurate.

I certify that only the people listed on my Lease and Occupancy Agreement will occupy the unit.

I understand that I must report all income and family size changes immediately to SCCMHA.

The undersigned authorizes SCCMHA to contact any agencies, offices, groups, organizations, or employers to obtain information that is pertinent to eligibility, level of benefits, or continued participation in Shelter Plus Care - HUD-funded Housing Programs. This authorization, and the information obtained with it, may be used to administer and enforce program rules and policies. This information is needed for purposes of determining eligibility for this rental assistance program. Private owners may not request information authorized by this form.

Failure to sign the consent form many result in denial of assistance or termination of benefits.

I understand that false statements or information are:

✓ grounds for termination of housing assistance.

I agree that photocopies of this authorization may be used for the purposes stated above.

_____

Applicant Signature *Date*

_____

Co-Applicant Signature *Date*

_____

Other Adult Household Member *Date*

SCCMHA Housing Services

HMIS AUTHORIZATION FOR

RELEASE OF CLIENT INFORMATION

I, _____, hereby authorize THE SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY**, its Director, and/or its professional staff, to release information about my case to the computerized ClientTrack system (an Internet based client and information system) used by participating agencies in the Saginaw County Consortium of Homeless Assistance Providers (SC-CHAP). I understand that only demographic information, including household/family data and income information will be shared with no personal identifying information released.**

1. **Only demographic information will be disclosed to and among authorized agencies that are formal participants of the ClientTrack network in SC-CHAP. A list of participating agencies is available upon request.**

2. **This information will be used to provide aggregate numbers for mandatory state reports and to provide statistics for future grant proposals.**

Expiration of Consent: **This consent to release information will remain active while I am receiving services from SC-CHAP participating agencies or if I request services in the future. Further, this consent is subject to revocation at any time upon my written request. I understand that all information gathered regarding me is personal and private, and I understand I am not required to authorize the release of the information. I may withdraw this consent at any time by giving written notice to this Agency; however, any action already taken in reliance on my consent may not be revoked.**

_____ Grant:_____

Print or Type Name

_____ _____

Client Signature Date Signed

_____ _____

Staff Signature Date Signed

This Client Information release authorization form is intended to protect an individual's right to privacy of information

SCCMHA - Revised 3/01/09

Housing Support Services of SCCMHA

DECLARATION OF CITIZENSHIP STATUS (SECTION 214)

NOTICE TO APPLICANTS AND TENANTS:
In order to be eligible to receive the housing assistance you seek, you, as an applicant or current recipient of housing assistance, must be lawfully within the U.S. Please read the Declaration statements carefully, check that which applies to you, and sign and return the document to the Housing Authority Office. Please feel free to consult with an immigration lawyer or other immigration expert of your choosing.

I, _____, certify, under penalty of perjury 1/, that, to the best of my knowledge, I am lawfully within the United States because (please check the appropriate box):

( ) I am a citizen by birth, a naturalized citizen or a national of the United States; or

( ) I have eligible immigration status and I am 62 years of age or older. Attach evidence of proof of age 2/; or

( ) I have eligible immigration status as checked below (see reverse side of this form for explanations). Attach INS document(s) evidencing eligible immigration status and a signed verification consent form.

( ) Immigrant status under §101(a)(15) or 101(a)(20) of the Immigration and Nationality Act (INA) 3/; or

( ) Permanent residence under §249 of INA 4/; or

( ) Refugee, asylum, or conditional entry status under §§207, 208, or 203 of the INA 5/; or

( ) Parole status under §§212(d)(5) of the INA 6/; or

( ) Threat to life or freedom under §243(h) of the INA 7/; or

( ) Amnesty under §245 of the INA 8/.

_____ _____
(Signature of Family Member) (Date)

( ) Check box if signature is of adult residing in the unit who is responsible for child named on statement above.

FOR HA ONLY: INS/SAVE Primary Verification #: _____Date: _____

1) **Warning:** 18 U.S.C. 1001 provides, among other things, that whoever knowingly and willfully makes or uses a document or writing containing any false, fictitious, or fraudulent statement or entry, in any matter within the jurisdiction of any department or agency of the United States, shall be fined not more than $10,000, imprisoned for not more than five years, or both.

The following footnotes pertain to noncitizens who declare eligible immigration status in one of the following categories:

2) **Eligible immigration status and 62 years of age or older.** For noncitizens who are 62 years of age or older or who will be 62 years of age or older and receiving assistance under a Section 214 covered program on June 19, 1995. If you are eligible and elect to select this category, you must include a document providing evidence of proof of age. No further documentation of eligible immigration status is required.

3) **Immigrant status under §§101(a)(15) or 101(a)(a)(20) of INA.** A noncitizen lawfully admitted for permanent residence, as defined by §101(a)(20) of the Immigration and Nationality Act (INA), as an immigrant, as defined by §101(a)(15) of the INA (8 U.S.C. 1101(a)(20) and 1101(a)(15), respectively [*immigrant status*]. This category includes a noncitizen admitted under §§210 or 210A of the INA (8 U.S.C. 1160 or 1161), [*special agricultural worker status*], who has been granted lawful temporary resident status.

4) **Permanent residence under §249 of INA.** A noncitizen who entered the U.S. before January 1, 1972, or such later date as enacted by law, and has continuously maintained residence in the U.S. since then, and who is not ineligible for citizenship, but who is deemed to be lawfully admitted for permanent residence as a result of an exercise of discretion by the Attorney General under §249 of the INA (8 U.S.C. 1259) [*amnesty granted under INA 249*].

5) **Refugee, asylum, or conditional entry status under §§207, 208 or 203 of INA.** A noncitizen who is lawfully present in the U.S. pursuant to an admission under §207 of the INA (8 U.S.C. 1157) [*refugee status*]; pursuant to the granting of asylum (which has not been terminated) under §208 of the INA (8 U.S.C. 1158 [*asylum status*]; or as a result of being granted conditional entry under §203(a)(7) of the INA (U.S.C. 1153 (a)(7)) before April 1, 1980, because of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity [*conditional entry status*].

6) **Parole status under §212(d)(5) of INA.** A noncitizen who is lawfully present in the U.S. as a result of an exercise of discretion by the Attorney General for emergent reasons or reasons deemed strictly in the public interest under §212(d)(5) of the INA (8 U.S.C. 1182(d)(5)[*parole status*].

7) **Threat to life or freedom under §243(h) of INA.** A noncitizen who is lawfully present in the U.S. as a result of the Attorney General's withholding deportation under §243(h) of the INA (8 U.S.C. 1253(h) [*threat to life or freedom*].

8) **Amnesty under §245A of INA.** A noncitizen lawfully admitted for temporary or permanent residence under §245A of the INA (8 U.S.C. 1255a)[*amnesty granted under INA 245A*].

Instructions to Housing Authority: Following verification of status claimed by persons declaring eligible immigration status (other than for noncitizens age 62 or older and receiving assistance on June 19, 1995), HA must enter INS/SAVE Verification Number and date that it was obtained. A HA signature is not required.

Instructions to Family Member For Completing Form: On opposite page, print or type first name, middle initial(s), and last name. Place an "X" or "√" in the appropriate boxes. Sign and date at bottom of page. Place an "X" or "√" in the box below the signature if the signature is by the adult residing in the unit who is responsible for Child.

Housing Support Services of SCCMHA

Tenant Name: _____

Household Document Checklist

Birth Certificates

☐ Head of household ☐ _____ ☐ _____ ☐ _____

Notes: _____

Social Security Cards

☐ Head of household ☐ _____ ☐ _____ ☐ _____

Medicaid/Medicare Cards

☐ Head of household ☐ _____ ☐ _____ ☐ _____

Picture ID's

☐ Head of household ☐ Other adult _____

Declaration of Citizenship

☐ Head of household ☐ _____ ☐ _____ ☐ _____

Marriage Certificates

☐ Head of household

Guardianship-Power of Attorney

☐ Head of household ☐ _____ ☐ _____ ☐ _____

☐ **Live-in Aide Certificates/Verifications**

The Saginaw County Community Mental Health Authority

500 Hancock, Saginaw, MI 48602

Shelter Plus Care Program
Case Manager/Therapist Agreement

RE client: _____

I am referring this consumer for enrollment or continued participation in the Housing Assistance Program which is a program of the Housing Resource Center at the Saginaw County Community Mental Health Authority (SCCMHA). If this consumer is accepted into the program or participates for another year I understand that I will have some ongoing responsibilities including the following:

a) I will be responsible to see that the consumer continues to receive appropriate mental health services including substance abuse treatment if dually diagnosed;

b) I will be responsible to inform the Shelter Plus Care coordinator if the consumer discontinues services or does not keep appointments;

c) I will be responsible to inform the Shelter Plus Care coordinator if I become aware that the consumer has moved from the apartment that is being subsidized;

d) I will be responsible to inform the Shelter Plus Care coordinator if I become aware of any housing related problems that the consumer is facing such as a shut-off notice, non-payment of rent, Eviction Notice, arrest and incarceration, etc.;

e) I will be responsible to inform the Shelter Plus Care coordinator of special services that the consumer needs and/or receives including Crisis Intervention, hospitalization, job training, etc.

f) I will be responsible to inform the Shelter Plus Care coordinator before closing the case if this consumer is non-compliant with treatment or passes away.

g) In the event that I am no longer responsible for this consumer (resignation, reassignment, etc.) I will be responsible to see that my replacement and/or supervisor is aware that that this consumer is in the Shelter Plus Care Program and aware of the special responsibilities for the therapist or case manager who will subsequently be working with this consumer.

Case manager/therapist	Date
S+C Coordinator	Date

Updated March, 2010- S+C Grants – General - Agreement

Exhibit C

Saginaw County Community Mental Health Authority

Supportive Housing Grant Participant Agreement

By my signature below, I am asking to participate in or continue to participate in the SCCMHA Permanent Supportive Housing Program. I also agree to the following:

I agree to pay my share of the rent (30% of my income) as determined by the SCCMHA, I will notify the program staff if I am more than 2 weeks behind with my rent.

If my income significantly changes (by more than $40 a month), I will notify the program staff within 10 days of the change.

If I receive a shut-off notice either for my utilities or water, I will notify the program staff to the shut-off date.

If I receive a Seven Day Notice, a Notice to Quit or an Eviction Notice, I will notify the program staff within 5 days of receiving the notice.

I will notify the program staff if I want to move out of my current apartment.

I will not let others move into my apartment without first getting permission from the landlord and program staff.

I will notify the program staff if I am arrested, incarcerated or hospitalized.

I will not give the keys to anyone or allow others to stay in my apartment except as provided for in the lease.

I understand that my failure to comply with these regulations may result in my termination from the Permanent Supportive Housing (PSH) program. I also understand that giving false information to the Permanent Supportive Housing program staff will result in my termination from the Permanent Supportive Housing program.

Print or Type Client Name

Client Signature **Date Signed**

Staff Signature **Date Signed**

Saginaw County Community Mental Health Authority
Permanent Supportive Housing

Participant Termination Agreement

As a participant of the Salter Place HRC - Permanent Supportive Housing program, I understand that I may be terminated from the program for the following reasons:

1. Voluntarily request to be removed from the program.
2. Moves without prior consent from the Coordinator or moves outside of Saginaw County.
3. Violation of the Landlord/Tenant Agreement or eviction by the landlord. Eviction from your apartment serves as possible termination from the program.
4. Becomes approved for another HUD housing program.
5. Incarcerated or in SUD treatment for more than 90 days.
6. Hospitalized for either medical or psychiatric reasons more than 90 consecutive days.
7. Lack of cooperation with Shelter Plus Care personnel.

Due process notification will be utilized in all cases where participants are threatened with termination. If a program participant meets any of the above criteria for program termination, appropriate written notification will be served to notify the participant of their pending program termination.

You may appeal the decision of termination in writing by submitting your request along with any documentation to support your appeal within 30-days of your termination notice. Your appeal will be considered by an Appeals Officer at SCCMHA and a decision will be rendered within 30-days after receipt of your letter request. The appeal board's decision will be final. If you are terminated from the program, you are not prohibited from resuming assistance at a later date. This means that you can re-apply to the program and your case will be reviewed.

Acknowledgements:

_____ _____
Shelter Plus Care Participant *Date*

_____ _____
Program Staff *Date*

Salter Place Housing Resource Center Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Housing Assessment and Plan	**Chapter**: 09.06.12 - Housing Resource Center	**Subject No:** 09.06.12.11
Housing Support Services of SCCMHA		
Effective Date: 3/20/2009	**Date of Review/Revision**: 7/12/10, 6//28/18, 7/29/19, 4/27/20, 3/18/21, 3/8/23, 3/19/24	**Approved By**: Kristie Wolbert, Executive Director of Clinical Services
	Supersedes:	**Authored By:** Director of Services for Persons with Mental Illness **Reviewed By**: Debbie Jones-Burt, Director of Services for Persons with Mental Illness

Purpose:
To provide guidance to Case Managers on their role in assisting consumers develop a housing goals in the Person-Centered Planning process and to ensure the participants are successful in maintaining their housing with adequate support services.

Application:

	This procedure applies to Programs, Grants or Benefits Checked
	HUD Tenant Based Permanent Supportive Housing (CoC Program)
X	SCCMHA Housing Resource Center
	SCCMHA Medicaid Housing Assistance Program
X	SCCMHA Provider Network

Policy:
Case Managers shall assist consumers who wish to participate in the Permanent Supportive Housing (CoC Program) who receive Housing Assistance to develop goals related to obtaining, maintaining, or improving their housing and housing stability.

Standards:
Authorization for housing subsidies for participants in Shelter Plus Care and consumers receiving Housing Assistance require both an assessment of need and a plan for support services.

Definitions:
None

References:
1. SCCMHA 02.03.03 Person Centered Planning
2. HUD Title 24, Chapter V, Section 582.300(b & c) Ongoing Assessment, Adequate Support Services
3. HUD Monitoring Manual, Chapter 12 Shelter Plus Care, Exhibit 4(3)

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
1. All Shelter Plus Care participants shall receive a comprehensive assessment at intake and annually thereafter with ongoing monitoring of their need for support services needed to maintain their participation in the housing program.	1. Case Managers
2. Consumers' needs related to housing might include treatment services as well as skill training and community living supports. The Case Manager shall help the consumer identify tasks related to maintaining their housing which can be addressed by themselves, by natural supports and those which require SCCMHA authorized supports.	2. Case Managers
3. The Housing Plan included in the IPOS shall include the needs identified in the assessment.	3. Case managers and participant/consumers.
4. The assessment and plan shall be entered in the SCCMHA Sentri electronic medical record and reviewed by the Housing Resource Center Supervisor prior to requesting authorization for housing assistance (T2038) or application for other Housing Services.	4. Case manager, HRC Supervisor

Salter Place Housing Resource Center Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Housing Search and Placement for TRA Programs	**Chapter**: 09.06.12 - Housing Resource Center	**Subject No:** 09.06.12.13
Housing Support Services of SCCMHA		
Effective Date: 3/20/2009	**Date of Review/Revision**: 7/12/10, 6/27/16, 6/28/18, 7/29/19, 4/27/20, 3/18/21, 3/8/23, 3/19/24 **Supersedes**:	**Approved By**: Kristie Wolbert, Executive Director of Clinical Services **Authored By:** Director of Services for Persons with Mental Illness **Reviewed By**: Debbie Jones-Burt, Director of Services of Persons with Mental Illness

Purpose:
To describe how rental assistance participants identify and select housing units for occupancy and the time frames available for doing so.

Application:
This policy applies to each of the SCCMHA housing grants administered out of the Housing Resource Center.

	This procedure applies to Programs, Grants or Benefits Checked
X	HUD Tenant Based Shelter Plus Care
X	SCCMHA Housing Resource Center
X	SCCMHA Housing Assistance Program
X	SCCMHA Provider Network

Policy:
Upon acceptance for housing assistance, SCCMHA Housing Resource center will assist participants in identifying and selecting rental units using a variety of resources. The type

of unit available to the participant will be determined by the rental assistance grant they are participating in.

Standards:
The type of housing available for selection by the applicant/participant will be determined during the intake/eligibility process. That determination will include the following factors:

- Eligibility – what types/sizes of units the participant qualifies for. (see: "Occupancy Standards" policy 09.08.03.01)
- Availability – what the market has available and what units are available for occupancy.

Definitions:
Tenant-based rental assistance (TRA). Tenant-based rental assistance provides grants for rental assistance which permit participants to choose housing of an appropriate size in which to reside. Participants retain the rental assistance if they move.

References:
24 CFR 582.100 Program Component Descriptions

http://www.michiganhousinglocator.com
http://www.zillow.com
http://www.apartments.com
http://www.rentlinx.com

Exhibits:
Exhibit A - Request For Tenancy (RFT-HUD)

Procedure:
SCCMHA Housing Services will perform the following activities when participants are ready to conduct a housing search:

TRA Programs:

A. Housing Enrollment

SCCMHA will enroll each participating household and enrollment is valid for 60 days from the date of enrollment. Participants must locate a suitable unit within the 60-day term of the enrollment. If an applicant does not locate a unit within the 60-day term, the applicant may request an extension. Extension requests will be considered by the HRC Coordinator on a case-by-case basis.

B. Housing Search Process

Participants may search for a unit anywhere Saginaw County. All applicants receive instructions on searching available housing in Saginaw County during the briefing meeting. These instructions include primarily usage of apartment rental websites and a Landlord List provided by the HRC. It is a responsibility of the Service Provider Agency to assist

the participant in locating housing. If an applicant is having difficulty finding a housing unit, the S+C Specialists are available to assess their housing search strategy and make any suggestions or help with locating available units.

Landlords are legally obligated to screen Permanent Supportive Housing (CoC Program) applicants in the same way as non-Permanent Supportive Housing (CoC Program) applicants.

C. Request for Tenancy/Lease Approval

Once an applicant locates a suitable unit, he or she will work with the landlord to complete the Request for Tenancy/Lease Approval (RFT). The RFT must be turned in to the HRC Program staff before the applicant's Voucher expires.

An HRC Staff will review the RFT for completeness and accuracy. If the form is not complete, the HRC Staff person will contact the applicant and/or the case manager to obtain the needed information.

ACTION	RESPONSIBILITY
Housing search instructions provided-TRA	HRC Staff
Housing Search conducted-TRA	Participant Case Manager/Service Provider
Request for Tenancy/Lease Approval completed and returned to HRC Coordinator. -TRA	Participant Landlord
Housing options offered to participant-SRO	HRC Coordinator
Housing selection made SRO	Participant

Exhibit A

Housing Support Services of SCCMHA

REQUEST FOR TENANCY

Owner/Management Agent Name:		
Mailing Address (Number & Street):		
City:	State:	Zip Code:
Home Phone: ( )	Work Phone: ( )	

Applicant Name:		
Current Address (Number & Street):		
City:	State:	Zip Code:
Home Phone: ( )	Work Phone: ( )	

INSTRUCTIONS:

This form should be completed by the Applicant and the Owner to request the Program Administrator's approval of the unit for which the Applicant has elected to receive rental assistance.

LANDLORD/OWNER: Fill out this form completely and return it to: HRC -2723 State St. Saginaw MI 48602 Fax # 989-790-2370

IMPORTANT: DO NOT SIGN A LEASE UNTIL THE PROGRAM ADMINISTRATOR HAS INSPECTED AND APPROVED THE UNIT.

TYPE OF HOUSING:

___ Apt. 2-4 units ___Apt. 5+ units ___Manufacured Home ___Single Family ___Duplex/Townhouse ___Other

UTILITIES-CHECK THE ITEMS THAT APPLY AND WHO PAYS FOR THEM:

	PAID BY								
UTILITIES	Owner	Tenant	Natural Gas	Electric	Fuel Oil	Propane	Wood	Coal	Solar/Other
Heating									
Cooking									
Water Htg.									
Electricity									
Air Cond.									
Water/Well									
Swr/Septic									
Trash Coll.									

APPLIANCES	PROVIDED BY	
Refrigerator		
Range/Stove		

UNIT INFORMATION

Address of Unit:

Number of Bedrooms in Unit	Approx. yr. built:	Approx. Sq. Footage:

Most Recent Monthly Rent:	Proposed Monthly Rent:	Security Deposit Amount:
$	$	$

THE REASON FOR ANY DIFFERENCE BETWEEN THE MOST RECENT MONTHLY RENT AND THE PROPOSED MONTHLY RENT IS:

IS THIS A SUBSIDIZED UNIT OR COMPLEX? ___NO ___YES-IF YES, ENTER COMPLEX NAME _____

BASIC RENT $_____ MARKET RENT $_____ TYPE OF SUBSIDY _____

IS THIS A **HOME** RENTAL **REHAB** UNIT? ___NO ___YES

INCOME AND HOUSING INFORMATION: Request for Tenancy

Salter Place Housing Resource Center Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Medicaid Housing Assistance Benefit	**Chapter**: 09.06.12 - Housing Resource Center	**Subject No:** 09.06.12.18
Housing Support Services of SCCMHA		
Effective Date: 3/20/2009	**Date of Review/Revision**: 7/12/10, 6/28/18, 7/30/19, 4/27/20, 3/18/21, 3/29/23, 3/19/24	**Approved By**: Kristie Wolbert, Executive Director of Clinical Services
	Supersedes:	**Authored By:** Director of Services for Persons with Mental Illness **Reviewed By**: Debbie Jones-Burt Director of Services for Persons with Mental Illness

Purpose:
To ensure that the Medicaid B3 benefit of Housing Assistance is provided in a service delivery context that leverages consumer supports for successful independent living.

Application:

	This procedure applies to Programs, Grants or Benefits Checked
X	HUD Tenant Based Permanent Supportive Housing (CoC Program)
X	SCCMHA Housing Resource Center
X	SCCMHA Medicaid Housing Assistance Program
X	SCCMHA Provider Network

Policy:
SCCMHA shall authorize "Housing Assistance" in accordance with the Medicaid Provider Manual and shall incorporate this benefit with a comprehensive program of housing subsidy and support services including Peer Supports and Community Living Support Services.

Standards:
None

Definitions:
None

References:
Medicaid Provider Manual, Mental Health and Substance Abuse Services, most recent publication April 1, 2020.

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
1. SCCMHA shall authorize the Medicaid B3 Housing Assistance benefit (T2038) for consumers who are seeking to obtain or maintain independent living. The authorization will require an assessment of the consumers skills needed for independent living, of resources available for sustaining independent living if initiated with Medicaid funds, and of ongoing supports required for successful tenure in chosen housing.	1. Care Management, Case Managers
2. The Medicaid Housing Assistance benefit is defined as short term and SCCMHA further describes this as a period not to exceed four months. During this time a consumer must be able to obtain ongoing housing subsidy if needed to remain in independent housing. This benefit cannot be used to cover the cost of room and board. A transition housing plan must be in place at the time of authorization describing how the rent or other form of payment for housing will be accomplished by the consumer. This might include a Section 8 application or referral via the SCCHAP Coordinated Entry process, however, a realistic estimate of attainment of this will be required.	2. Case Managers; HRC staff

3. When authorization for Housing Assistance is requested to prevent homelessness due to imminent eviction, loss of utilities or similar crisis likely to result in displacement from housing, the Case Manager should include in the assessment an analysis of the consumer's unmet needs related to the crisis. For example, if the consumer spent this month's rent on something other than rent which precipitated the crisis, then the Case Manager should examine if the consumer needs help with budgeting and address this in an amendment to the PCP.	3. Case Manager
4. Housing Assistance may be authorized to assist with damage deposits, back utilities, new utilities, acquisition of basic furniture, or other reasonable expense as long as the consumer is the named owner of the housing either on the title of the property or as tenant on the lease. Housing assistance will not be authorized to children and cannot be used to cover the cost of rent (room and board.)	4. Care Management
5. Purchases made with the Housing Assistance benefit will be directly to a vendor who has been identified on the purchase order which is processed through the SCCMHA Finance Department. Checks to the vendor will be given to the Case Manager who will assist the consumer with acquisition, or they will be mailed to the provider.	5. Finance Department, Case Manager

Salter Place Housing Resource Center Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Support Services	**Chapter**: 09.06.12 - Housing Resource Center	**Subject No:** 09.06.12.21
Housing Support Services of SCCMHA		
Effective Date: 3/20/2009	**Date of Review/Revision**: 7/12/10, 6/28/18, 7/29/19, 4/27/20, 4/23/21, 3/30/23, 3/20/24 **Supersedes**:	**Approved By**: Kristie Wolbert, Executive Director of Clinical Services **Authored By:** Director of Services for Persons with Mental Illness **Reviewed By**: Debbie Jones-Burt

Purpose:
To ensure that all housing services are provided in conjunction with the necessary and appropriate support services to ensure that participants are successful in remaining housed.

Application:

	This procedure applies to Programs, Grants or Benefits Checked
X	HUD Tenant Based Permanent Supportive Housing (CoC Program)
	SCCMHA Housing Resource Center
	SCCMHA Medicaid Housing Assistance Program
X	SCCMHA Provider Network

Policy:
SCCMHA will assess the needs of every participant for services which they might benefit from in order to remain in housing. This service array includes both services provided by or purchased by SCCMHA as well as services from other human service agencies in the community. SCCMHA will actively participate in the Interagency Service Team of the Continuum of Care to ensure that we collaborate with other agencies in providing a comprehensive array of services to meet participants' needs.

Standards:
1. All participants will be assessed for needed support services and these shall be planned for and provided through the Person-Centered Planning process and documented in the Sentri electronic medical record.

Definitions:
None

References:
1. HUD Title 24, Chapter V, Section 582.300 (c) Shelter Plus Care, General Operations, Adequate Support Services
2. SCCMHA 02.03.03 Person Centered Planning

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
1. Every participant will be assessed initially and annually for needed support services.	1. Case Managers
2. Support services will be provided either through the SCCMHA provider network or by other community agencies as appropriate including: the Department of Human Services for food stamps and health insurances such as Medicaid or ABW, legal services through Legal Services of Eastern Michigan, Health Care provided by great Lakes Bay Health System, our county Federally Qualified Health Provider, Green House neighborhood resource center, Partnership Center, Guardianship Services, Community Action Committee, Michigan Cooperative Extension, United Way of Saginaw County and others. A list of the SCCMHA provider network agencies and their types of Services will be made available to consumers.	2. SCCMHA Provider Network HRC Supervisor & SC-CHAP Interagency Services Team
3. Support services used by the consumers will be documented either by consumer report or by documentation from the SCCMHA encounter data. Participants will be requested to report the services used through other agencies.	3. Participants

Salter Place Housing Resource Center Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Case Manager Agreement	**Chapter**: 09.06.12 - Housing Resource Center	**Subject No:** 09.06.12.22
Housing Support Services of SCCMHA		
Effective Date: 3/20/2009	**Date of Review/Revision**: 7/12/10, 6/28/18, 7/29/19, 4/27/20, 4/23/21, 3/30/23, 3/20/24 **Supersedes**:	**Approved By**: Kristie Wolbert, Executive Director of Clinical Services **Authored By:** Director of Services for Persons with Mental Illness **Reviewed By**: Debbie Jones-Burt

Purpose:
So that clients referred to the Housing Resource Center for Housing Assistance receive appropriate services that will ensure a successful housing experience. To enlist the Case Manager or Therapist as an active participant in the housing services received by the client so that the client can maintain their household; and when eligibility is not met, to aid the client in transition from housing assistance to suitable alternatives. To ensure relevant information is disseminated in a timely manner.

Application:

	This procedure applies to Programs, Grants or Benefits Checked
X	HUD Tenant Based Permanent Supportive Housing (CoC Program)
	SCCMHA Housing Resource Center
X	SCCMHA Housing Assistance Program
X	SCCMHA Provider Network

Policy:
When a housing referral is made and a client intake is performed, the referring professional agrees that: they will continue to provide services and support while the client is participating; they have a clear understanding of the responsibilities and expectations of the program; they will notify the Housing Resource Center staff when

they obtain information that is relevant to their client's participation on one of the housing assistance grants administered by SCCMHA.

Standards:
This policy pertains to all professionals in the SCCMHA provider network referring clients for Housing Assistance. The *Case Manager Agreement* will be signed by the Service Provider upon initial intake of their client to the housing program and annually during the recertification process.

Definitions:
Housing Assistance: for the purposes of this policy, Housing Assistance means any of the services offered by SCCMHA out of the Housing Resource Center. These grants include rental assistance and utility assistance where appropriate.
Program: means one of the grants (housing assistance program) administered by the Housing Resource Center.
Case Manager/Therapist: for the purpose of this policy, it is meant to be the referring service provider, whether they are a Case Manager, Therapist, Nurse, Psychologist or psychiatrist.

References:
None

Exhibits:
Exhibit A - Case Manager/Therapist Agreement

Procedure:
During the initial referral, the client is not yet accepted for Housing Assistance. The Case Manager/Therapist Agreement is signed and becomes effective at the client intake when the eligibility information is obtained. The Case Manager/Therapist Agreement is reviewed by the referring professional and the HRC staff. The referring professional signs the agreement indicating understanding and acceptance. The HRC staff place the agreement in the clients housing file. This agreement is signed at initial intake and annually at recertification.

ACTION	RESPONSIBILITY
Agreement is presented and explained to the Case Manager/Therapist.	Housing Resource Center Staff.
Agreement is signed.	Case Manager/Therapist or referring professional. Housing Resource Center Staff.
Agreement is collected and placed in client's file.	Housing Resource Center Staff.

Exhibit A

The Saginaw County Community Mental Health Authority

500 Hancock, Saginaw, MI 48602

Case Manager/Therapist Housing Agreement

RE:_____

I am referring this consumer for enrollment or continued participation in the Housing Assistance Program which is a program of the Housing Resource Center at the Saginaw County Community Mental Health Authority (SCCMHA). If this consumer is accepted into the program or participates for another year, I understand that I will have some ongoing responsibilities including the following:

a) I will be responsible to see that the consumer continues to be offered appropriate mental health services including substance abuse treatment if dually diagnosed.

b) I will be responsible to inform the HRC Coordinator if the consumer discontinues services or does not keep appointments.

c) I will be responsible to inform the HRC Coordinator if I become aware that the consumer has moved from the apartment that is being subsidized.

d) I will be responsible to inform the HRC Coordinator if I become aware of any housing related problems that the consumer is facing such as a shut-off notice, non-payment of rent, Eviction Notice, arrest and incarceration, etc.

e) I will be responsible to inform the HRC Coordinator of special services that the consumer needs and/or receives including Crisis Intervention, hospitalization, job training, etc.

f) I will be responsible to inform the HRC Coordinator before closing the case if this consumer is non-compliant with treatment or passes away.

g) In the event that I am no longer responsible for this consumer (resignation, reassignment, etc.) I will be responsible to see that my replacement and/or supervisor is aware that that this consumer is in the PSH Program and aware of the special responsibilities for the therapist or case manager who will subsequently be working with this consumer.

_____ _____

Case Manager/Therapist ***Date***

_____ _____

Housing Resource Center Staff ***Date***

Updated July, 2019 (RA)

Salter Place Housing Resource Center Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Annual Recertification	**Chapter**: 09.06.12 - Housing Resource Center	**Subject No:** 09.06.12.23
Housing Support Services of SCCMHA		
Effective Date: 3/20/2009	**Date of Review/Revision**: 7/12/10, 6/27/16, 6/28/18, 7/30/19, 4/27/20, 4/23/21, 3/30/23, 3/20/24 **Supersedes**:	**Approved By**: Kristie Wolbert, Executive Director of Clinical Services **Authored By:** Director of Services for Persons with Mental Illness **Reviewed By**: Debbie Jones-Burt

Purpose:
To describe the annual recertification process to determine continued eligibility and participants rent portion.

Application:
Annual recertification applies to all participants receiving rental assistance under any of the SCCMHA Housing Services supported grants.

	This procedure applies to Programs, Grants or Benefits Checked
X	HUD Tenant Based Permanent Supportive Housing (CoC Program)
X	SCCMHA Housing Resource Center
	SCCMHA Medicaid Housing Assistance Program
X	SCCMHA Provider Network

Policy:
On an annual basis, SCCMHA Housing Services will reexamine a participant's income, family composition and disability information to ensure that the participant remains eligible for rental assistance. Information will be gathered from the participant, the Case Manager and Third parties.

Leases that coincide with the anniversary date will be reviewed and Housing Quality Inspections will be performed. Housing Quality Standards will be conducted in

accordance with SCCMHA policy 09.08.03.03 “Housing Unit Inspection and Housing Quality”. Lease Reviews and Rent Calculations will be conducted in accordance with SCCMHA policy 09.08.03.06 “Rental Agreements”. Rent reasonableness will be conducted in accordance with SCCMHA policy 09.08.03.05 “Rent Reasonableness”.

If a family fails to comply with re-examination requirements, they may be terminated from the program for lack of cooperation. Annual appointments will be scheduled for eleven months to give the client opportunity to reschedule twice if necessary.

Standards:
Annual recertification is to be completed by a participants’ anniversary date. Interim recertification may be performed in order to adjust date with other scheduling processes. The recertification process will start thirty (30) days in advance of a participant’s anniversary date so that the required verifications and information can be obtained in a timely manner.

Definitions:
Anniversary date means the date the client was initially placed in housing.

References:
24 CFR Section 582.310 Resident Rent
SCCMHA Housing Service Policy 09.08.03.04 “Housing Unit Inspection & Housing Quality”
SCCMHA Housing Service Policy 09.08.03.05 “Rent Reasonableness”
SCCMHA Housing Service Policy 09.08.03.06 “Rental Agreements”
SCCMHA Housing Service Policy 09.08.05.01 “Termination of Assistance”

Exhibits:
Exhibit A - Household Documents Checklist
Exhibit B - Housing Assessment
Exhibit C - Income and Asset Release of Information
Exhibit D - Participant Agreement Form
Exhibit E - Case Manager Agreement
Exhibit F - Verification of Disability
Exhibit G - Applicant Tenant Authorization

Procedure:
Participant: Thirty days prior to the anniversary date the HRC Staff will send the participant a notice requiring recertification along with a scheduled appointment time to meet with the staff and complete paperwork. The notification will include instructions to the participant about which types of household documents should be brought in to assist in the process. During the recertification meeting the HRC Staff will collect from the participant:

- Current income information for all household members
- Completed Annual Assessment including Household Composition Table

- Completed Applicant/Tenant Program Agreement, signed by all adults 18 and older
- Releases of information
- Verifications for any deductions claimed: medical, childcare, or student

Other documentation that needs to be provided by the participant that is not provided at the recertification meeting will be indicated on the "Household Documents Checklist". A copy of this will be provided to the participant and they will have two weeks to return the items and information indicated on the list.

If for health reasons (hospitalization, public health emergency such as the COVID-19 pandemic) the client is unable to attend the recertification appointment in-person a recertification packet will be mailed to the participant to be completed and returned to the SCCMHA HRC by the re-certification deadline determined by HRC staff.

Case Manager: The Case Manager will be sent the following documents to be completed and returned to the HRC staff:

- Case Manager/Service Provider Agreement
- Verification of Disability signed by a medical doctor

If the participant fails to show up for their scheduled appointment another will be scheduled as soon as possible. If the participant fails to show up for the second scheduled appointment a final reschedule will be sent explaining failure to attend will result in termination of rental assistance.

Exceptions:

- If tenant/participant is incarcerated, hospitalized, or incapacitated, all efforts will be made to acquire recertification documents and signatures prior to the annual certification date. If the tenant will need housing assistance upon release from institution and there is a known or planned discharge date in place the tenant will not be terminated if said discharge date is within 60 days of annual recertification date.

After the recertification meeting with the participant, HRC Staff will send out income verification requests to third party sources. Chief among these are:

- Social Security Administration (SSI, SSD, SS)
- Department of Human Services (Food stamps, TANF, etc.
- Banks (checking accounts, saving accounts, assets)
- Insurance companies
- Etc.

Once all recertification information is collected, the participant will be notified of any rent portion adjustments. If a participant is found to be ineligible during the recertification process because of income or disability, that person will be notified in

writing and the termination process will commence (See policy: 09.08.05.01 "Termination of Housing Assistance")

ACTION	RESPONSIBILITY
Notice sent of reexamination appointment to participant	HRC Staff
Case Manager Agreement and Disability Verification sent to Service Provider	HRC Staff
Household documents verifying family composition and provided to HRC Staff	Participant
Case Manager Agreement and Disability Verification returned to HRC Staff	Case Manager/Service Provider
Third Party verification conducted in the form of letters, faxes, etc.	HRC Staff

Exhibit A

Housing Support Services of SCCMHA

Tenant Name: _____

Household Document Checklist

Birth Certificates

☐ Head of household ☐ _____ ☐ _____ ☐ _____

Notes: _____

Social Security Cards

☐ Head of household ☐ _____ ☐ _____ ☐ _____

Medicaid/Medicare Cards

☐ Head of household ☐ _____ ☐ _____ ☐ _____

Picture ID's

☐ Head of household ☐ Other adult _____

Declaration of Citizenship

☐ Head of household ☐ _____ ☐ _____ ☐ _____

Marriage Certificates

☐ Head of household

Guardianship-Power of Attorney

☐ Head of household ☐ _____ ☐ _____ ☐ _____

☐ **Live-in Aide Certificates/Verifications**

Exhibit B

Housing Support Services of SCCMHA

S.C.C.M.H.A. Housing Assessment

Name:_____ **Date:**_____

Current Address:_____

Phone Number:_____

☐ Authorizations/Consent to Release Information required every year—These forms must be signed by every member of the household who is 18 years of age or older who will reside in the assisted unit.

Need, if we don't already have:

☐ Picture IDs- copies of Picture IDs for all adult household members [all those 18years old or older]

☐ Birth Certificates- copies of proof of birth for all household members [birth certificate or cradle roll]

☐ Social Security Number- copies of social security cards for all household members.

Please provide information for yourself and **all family members living with you**:

Full Name	DOB	Age	Sex	SSN#	Relationship to you	Ethnicity Code*		Hispanic (Y/N)
	- -			- -	SELF			

***Ethnicity Codes (enter one or more):**
1 – White 2 - Black/African American 3 – American Indian or Native Alaskan 4 – Asian
5 – Native Hawaiian/Other Pacific Islander

Marital Status: ☐ Married ☐ Single ☐ Living together ☐ Divorced ☐ Separated	
Are you a U.S Citizen?	☐ Yes ☐No
Is anyone in your household NOT a U.S. citizen? If yes, who? _____	☐ Yes ☐No
Are you or anyone in your household a VETERAN?	☐ Yes ☐No
Do you or anyone in your household currently receive V.A. services?	☐ Yes ☐No
If you or someone in your household is a veteran, would you like information on where to receive V.A. services?	☐ Yes ☐No
Are you or anyone that lives with you pregnant? If yes, please give their name and Baby due date: Name:_____ Due Date: _____	☐ Yes ☐No

Please list names, addresses, and phone numbers of two relatives or friends who generally know how to contact you:

Name	Relationship to you	Address	Phone

Other Service Provider Information: List Case Managers, DHS Workers, other community supports (job coach, transportation, etc.)

Name	Relationship to you	Agency	Phone

Do you require SPECIFIC accommodation(s) to fully use our programs and services? ☐ Y ☐ N

List specific accommodation(s) required: _____

_____

Is your disability: (check all that apply to you)

☐ Physical	☐ Mental Health	☐ Problems with stairs
☐ Sensory	☐ Substance Abuse (past HX)	☐ Learning Difficulty
☐ Other _____		

Corrections Related Status:

☐ Probation from Jail	☐ Awaiting Trial
☐ Paroled from Prison	☐ Awaiting Sentencing
☐ Court Supervision	☐ No problems with the law

Do you have any past credit or legal history that might prevent housing you? ☐ Y ☐ N

Please Explain:

_____

_____

_____

Do you owe money for Utility Bills? ☐ Y ☐ N, If yes, how much?_____

Do you owe money for Water Bills? ☐ Y ☐ N, If yes, how much?_____

Have you or anyone in your household ever been arrested for illegal use of a controlled substance or activities related to an abuse of alcohol? ☐ Yes ☐ No

If yes, When? Date(s):_____

Education Summary

Highest Level of Education Attained:

☐ Bachelors Degree	☐ Technical School Certification	☐ 10th grade
☐ Graduate Degree	☐ No Schooling Completed	☐ 11th grade
☐ Associates Degree	☐ Nursery school to fourth grade	☐ 12th grade
☐ Some College	☐ 5th grade or 6th grade	☐ High School Diploma
☐ Some High School	☐ 7th grade or 8th grade	☐ GED
☐ Some Technical School	☐ 9th grade	☐ Post Secondary School

Have you been placed in a temporary accommodation by another agency? If so, which agency placed you? _____	☐ Yes ☐ No
Have you been on a rental subsidy program before?	☐ Yes ☐ No
Are you CURRENTLY on a rental subsidy?	☐ Yes ☐ No
If you are currently renting, is your rent paid to date?	☐ Yes ☐ No
Have you been evicted or asked to leave your current residence? If yes, when did you, or will you, have to leave? _____	☐ Yes ☐ No
Have you ever been evicted from Public Housing, Indian Housing, a Section 23 or Section 8 program? If yes, When? _____Reason: _____ Name of Housing Authority or owner: _____	☐ Yes ☐ No

Address/Move History (for the last three years)

Street /Apt	City/State/Zip	Dates There/ Length of stay	Reason for Leaving

Previous landlord (if applicable):

Name:_____ Phone:_____
Address: _____

Details about where you currently live

Please check all that apply to you

☐ Apartment	☐ House	☐ Emergency Shelter
☐ SIP Home	☐ Subsidized Housing	☐ Hospital/Institution
☐ AFC Home	☐ No home	☐ Hotel/Motel
☐ With Friends	☐ With family	☐ On the street/dumpster
☐ Under bridge	☐ Abandoned house/building	☐ Prison/jail

Current landlord (if applicable):

Name: _____ Phone:_____
Address: _____

Please tell us of any other problems or needs (serious disrepair, rent arrears) where you live now:

_____
_____
_____
_____

List housing preferences such as type of housing, area, amenities, etc.

1._____ 4._____
2._____ 5._____
3. _____ 6._____

What is the cause of your homelessness?

_____
_____
_____
_____
_____

What would you like to accomplish through the Shelter Plus Care Program?

Employment and Income

Do you, or anyone in your household work full-time, part-time, or seasonally?? ☐ Y ☐ N
If no, skip to next question.

Name	Name and Address of employer	Hourly Rate	Hours/ week	Monthly Income	Paid how often?

Please attach a months worth of recent ORIGINAL pay stubs for each job.

Housing Support Services of SCCMHA

Does any member of your household:

Earn income from self employment? If yes, please provide proof of income.	☐ Yes ☐ No
Work part time, full time or seasonally? (If no, skip to question #)	☐ Yes ☐ No
Expect a leave of absence from work due to lay-off, medical, maternity, or military leave?	☐ Yes ☐ No
Work for someone who pays them cash?	☐ Yes ☐ No
Receive tips? If yes, who? _____ How much per week? $_____ Source:_____	☐ Yes ☐ No
Expect to work for any period during the next year?	☐ Yes ☐ No
Receive payment from pension or retirement funds? If yes, who? _____ Monthly amount:_____ Source:_____	☐ Yes ☐ No
Receive unemployment benefits? If yes, who? _____ Monthly amount:_____ Date benefits began:_____ Date benefits will end:_____ Source:_____	☐ Yes ☐No
Receives workman's compensation, disability or death benefits other than Social Security? If yes, who?_____ Monthly amount:_____ Source: _____	☐ Yes ☐No

*** Please provide most recent check stubs or award letters! ***

All other sources of income such as DHS, SSI, SSDI, State Disability

Name of person receiving income/benefit source	Source of Income or benefits	Monthly GROSS amount

If you do receive any of these sources of income or benefits, please provide proof for each dated within the past 60 days.

A member of the household receives adoption assistance payments. If yes, provide proof and monthly amount: _____	☐ Yes ☐No
A member of the household receives child support and/or alimony. If yes, attach the original payment disbursements printout for the past 6 months.	☐ Yes ☐No
Is child support paid directly to DHS? Friend of the Court Name: _____ Contact Person: _____ Address: _____ Phone: _(___)____-_____ City, State, Zip: _____ Fax #:_____	☐ Yes ☐No
A member of the household owns real estate, mobile home or land contracts.	☐ Yes ☐No
A member of the household receives income from rental of real estate or personal property. If yes, provide monthly amount: _____	☐ Yes ☐No
A member of the household receives income from Indian Trust Land.	☐ Yes ☐No
A member of the household has personal property held for investment purposes. (jewelry, coin or stamp collections, etc.)	☐ Yes ☐No

A member of the household has a life insurance policy with a cash surrender value. If yes, list source and balance (do not include burial policies): _____	☐ Yes ☐No
An adult member of the household is a student. If yes, attach the original most recent check stub and/or award letter. Name: _____ School: _____ Address:_____ Phone: _____	☐ Yes ☐No
A member of the household has assets such as savings, checking, stocks, bonds, IRA's etc. If yes, list account and current balance:	☐ Yes ☐No

Name	Account Type	Bank/ Institution	Address, city, zip	Phone	Balance
1.					$
2.					$
3.					$

If yes, attach original statements. For checking accounts send most recent original bank statement.	
A member of the household has sold, given away, or otherwise transferred ownership of assets within the last two (2) years, valued over $1,000 (do not include personal vehicle). If yes, explain:	☐ Yes ☐No

A member of the household has income earned or unearned not previously listed. If yes, list monthly amount:	☐ Yes ☐No

Household Member	Source	Address, city, state, zip of source	Phone	Amount
1.				
2.				
3.				

A member of the household who is elderly (age 62 or older) or disabled pays medical insurance premiums, other than Medicare. If yes, complete.				☐ Yes ☐ No
Household Member	Insurance Company	Address, city, state, zip of source	Phone	Amount
1.				$
2.				$
If yes, attach original premium statement(s) showing amount and frequency of payment.				

A member of the household who is elderly (age 62 or older) or disabled pays for medical expenses or services, or handicap equipment that are not reimbursed by insurance or DHS/other Agency. (List separately each pharmacy, licensed health care, and chore care provider who you pay directly to meet your medical/health/disability needs. Estimate monthly amount) If yes, list monthly amount not paid by DHS				☐ Yes ☐No
Household Member	Provider	Address, city, state, zip of source	Phone	Amount
1.				$
2.				$
3.				$
4.				$
5.				$
6.				$
If yes, attach the original listing of annual expenses or statement from the provider.				

Yes ☐ No ☐ I pay childcare or handicap care expenses for a member of the household in order to be gainfully employed or to further my education. Note: Expense is not deduction if provider is a member of the household. If yes, list monthly amount:				
Household Member	Provider	Address, city, state, zip of source	Phone	Amount
1.				
2.				
If yes, attach the original most recent (4) receipts for the care provider payments.				

Yes ☐	No ☐	If a member in the family is disabled, under the age of 62, and does not receive SSI, list the licensed health care provider who will verify the disability:			
Household Member		Care Provider	Address, city, state, zip	Phone	Fax
1.					
2.					
If yes, attach the original most recent (4) receipts for the care provider payments.					

Yes ☐	No ☐	I have a member of the household(s) age 5 or under who has an identified Environmental Intervention Blood Lead Level (EIBLL)
List their names: _____ If yes, attach documentation indicating EIBLL.		

Use this space to provide any additional general information or to complete questions above. To complete questions indicate the Question number and the information that was requested.	
Question #	

☐ Do you have a payee? ☐ Yes ☐ No Name_____ Phone _____

Are you receiving cash assistance from DHS? ☐ Yes ☐ No
*If "No" Did you recently lose your cash assistance? ☐ Yes ☐ No

If yes, Name of DHS Case Worker _____

Do you have Medical Insurance? ☐ Yes ☐ No

If yes, please complete the following:

Name of Insurer (insurance) _____

Name of Insured Person/s _____

Do you have an insurance premium? ☐ Yes ☐ No

If yes, Insurance Premium amount _____per_____

Certification:

I certify that only the people listed on page one of this form, will occupy the unit. I hereby attest that I have reviewed this entire form and that all of my family information, income, assets and expenses have been accurately reported. I understand that providing false information will result in denial or termination of benefits. I understand that I must report any increase of income in writing 14 calendar days of the increase.

_____ _____
Signature of the Head of Household Date

_____
Print Name:

NOTE TO APPLICANTS: If you believe you have been discriminated against, you may call the Fair Housing and Equal Opportunity National Toll-free Hot Line at (800) 424-8590.
*Add state law, if applicable.

For Office Use Only
☐ New Admission ☐ Annual Re-examination

Date Received:_____ Staff Initials_____

Bedroom Size : EFF____ 1Bdrm ____ 2Bdrm _____ 3Bdrm ____ 4Bdrm ____

Total Household Income $.....

Exhibit C

Housing Support Services of SCCMHA

Income, Asset and Eligible Expense Information for Income Providers
Release of Information

In signing this consent form, you are authorizing SCCMHA, its agents, employees, affiliates to request income, asset and eligible expense information from all income providers (i.e. Social Security Administration, Department of Human Services, employers, etc.) listed on your Income Checklist and any other related application forms. This information is needed for purposes of determining eligibility for this rental assistance program. Private owners may not request information authorized by this form.

Failure to sign the consent form many result in denial of assistance or termination of benefits.

CONSENT

I/We hereby allow SCCMHA, and its affiliates to request and obtain income and asset information from all providers (i.e., Social Security Administration, The Michigan Department of Human Services, etc.) listed on my/our Income Checklist and any other related application forms.

I agree that the copies of this authorization may be used for the above stated purposes.

Applicant Signature	*Date*
Co-Applicant Signature	*Date*
Other Adult Household Member	*Date*
Other Adult Household Member	*Date*

Exhibit D

Housing Support Services of SCCMHA

Saginaw County Community Mental Health Authority

S+C Participant Agreement

By my signature below, I am asking to participate in or continue to participate in the SCCMHA Shelter Plus Care Program. I also agree to the following:

I will receive mental health services and/or substance abuse services and comply with my treatment plan.

I agree to pay my share of the rent (30% of my income) as determined by the SCCMHA, I will notify the program staff if I am more than 2 weeks behind with my rent.

If my income significantly changes (by more than $40 a month), I will notify the program staff within 10 days of the change.

If I receive a shut-off notice either for my utilities or water, I will notify the program staff to the shut-off date.

If I receive a Seven Day Notice, a Notice to Quit or an Eviction Notice, I will notify the program staff within 5 days of receiving the notice.

I will notify the program staff if I move out of my current apartment.

I will notify the program staff if I am arrested, incarcerated or hospitalized.

I will not give the keys to anyone or allow others to stay in my apartment except as provided for in the lease.

I understand that my failure to comply with these regulations will result in my termination from the **Shelter Plus Care Program** I also understand that giving false information to the Shelter Plus Care program staff will result in my termination from the Shelter Plus Care program.

_____ Grant:_____
Print or Type Client Name

_____ _____
Client Signature Date Signed

_____ _____
Staff Signature Date Signed

The Saginaw County Community Mental Health Authority

Exhibit E

500 Hancock, Saginaw, MI 48602

Shelter Plus Care Program
Case Manager/Therapist Agreement

RE client: _____

I am referring this consumer for enrollment or continued participation in the Housing Assistance Program which is a program of the Housing Resource Center at the Saginaw County Community Mental Health Authority (SCCMHA). If this consumer is accepted into the program or participates for another year, I understand that I will have some ongoing responsibilities including the following:

a) I will be responsible to see that the consumer continues to receive appropriate mental health services including substance abuse treatment if dually diagnosed.

b) I will be responsible to inform the Shelter Plus Care coordinator if the consumer discontinues services or does not keep appointments.

c) I will be responsible to inform the Shelter Plus Care coordinator if I become aware that the consumer has moved from the apartment that is being subsidized.

d) I will be responsible to inform the Shelter Plus Care coordinator if I become aware of any housing related problems that the consumer is facing such as a shut-off notice, non-payment of rent, Eviction Notice, arrest and incarceration, etc.;

e) I will be responsible to inform the Shelter Plus Care coordinator of special services that the consumer needs and/or receives including Crisis Intervention, hospitalization, job training, etc.

f) I will be responsible to inform the Shelter Plus Care coordinator before closing the case if this consumer is non-compliant with treatment or passes away.

g) In the event that I am no longer responsible for this consumer (resignation, reassignment, etc.) I will be responsible to see that my replacement and/or supervisor is aware that that this consumer is in the Shelter Plus Care Program and aware of the special responsibilities for the therapist or case manager who will subsequently be working with this consumer.

_____	_____
Case manager/therapist	Date
_____	_____
S+C Coordinator	Date

Exhibit F

Housing Support Services of SCCMHA

Saginaw County Community Mental Health Authority
Housing Services
VERIFICATION OF DISABILITY AND/OR SPECIAL MEDICAL NEEDS

Licensed Health Care Provider:

Section A – TENANT INFORMATION

PLEASE COMPLETE SECTION A ONLY AND RETURN TO ADDRESS LISTED ON THE BOTTOM OF PAGE 2.
***Your Program Administrator** will forward to your Licensed Health Care Provider.*

Head of Household Name	County	Telephone Number
Client/Patient Name	Social Security Number	Voucher Number

You are authorized to release information concerning my disability and/or special medical needs to the SCCMHA Salter Place housing Resource Center and the Michigan State Housing Development Authority.

SEE ATTACHED AUTHORIZATION FORM

Client/Patient Signature _____ Date _____

STOP HERE *Please complete Section A & C and return to address on back.*

Client/Patient Name	Head of Household Name	Voucher Number

Section B – VERIFICATION OF DISABILITY (To be completed by Licensed Health Care Provider)

Per authorization in Section A, please provide the information requested so we can quickly determine the client/patient's disability status.

Federal law gives special consideration to a person or family of a person who is disabled in order to be eligible to receive federally-aided housing. To qualify for such special consideration, at least one of the heads of the household must:

a) **be unable to engage in any substantial gainful activity** by reason of any medically determined physical or mental impairment which can be expected to last for a continuous period of **not less than 12 months**; or

b) in the case of an individual who is 55 years of age and is blind, be unable by reason of blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time; or

c) be a disabled person which is defined as a person having a physical or mental impairment which:

1) is expected to be of a continuous and indefinite duration, and

2) substantially impedes the ability to live independently, and

3) is of such a nature that such ability could be improved by more suitable housing conditions; or

d) be developmentally disabled which means a severe, chronic disability of a person which:

1) is attributable to a mental or physical impairment or combination of mental and physical impairments; and

2) is manifested before the person is twenty-two; and

3) is likely to continue indefinitely; and

4) results in substantial functional limitation in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self- direction, capacity for independent living, and economic self-sufficiency, and reflects the person's need for a combination and sequence of special inter-disciplinary, or generic care, treatment, or other services which are life-long or of extended duration and are individually planned and coordinated.

In my opinion, _____
Client/Patient Name

☐ is ☐ is not disabled as defined above for a continuous period of not less than 12 months. An explanation of the disability is:

_____

_____

☐ This client/patient is disabled as defined above **permanently**.

As a duly licensed Health Care Provider, I certify the information given is correct.

_____ Type or Print Name | _____ Title | ( ) _____ Telephone Number

_____ Street Address | _____ City | _____ State | _____ ZIP Code

_____ Signature | _____ Date Signed

Please return the completed form to:

Rollin Archangeli, Housing Resource Center Supervisor
SCCMHA
500 Hancock St.
Saginaw, MI 48602

Exhibit G

Housing Support Services of SCCMHA

APPLICANT/TENANT AUTHORIZATION AND CERTIFICATION
Shelter Plus Care

Saginaw County Community Mental Health Authority

The undersigned certifies that the information given to SCCMHA for Shelter Plus Care on household members, income, net family assets, allowances, and deductions are accurate.

I certify that only the people listed on my Lease and Occupancy Agreement will occupy the unit.

I understand that I must report all income and family size changes immediately to SCCMHA.

The undersigned authorizes SCCMHA to contact any agencies, offices, groups, organizations, or employers to obtain information that is pertinent to eligibility, level of benefits, or continued participation in Shelter Plus Care - HUD-funded Housing Programs. This authorization, and the information obtained with it, may be used to administer, and enforce program rules and policies. This information is needed for purposes of determining eligibility for this rental assistance program. Private owners may not request information authorized by this form.

Failure to sign the consent form many result in denial of assistance or termination of benefits.

I understand that false statements or information are:

✓ grounds for termination of housing assistance.

I agree that photocopies of this authorization may be used for the purposes stated above.

_____

Applicant Signature *Date*

_____

Co-Applicant Signature *Date*

_____

Other Adult Household Member *Date*

Salter Place Housing Resource Center Procedure Manual Saginaw County Community Mental Health Authority		
Subject: Housing Appeals and Grievance	**Chapter**: 09.06.12 - Housing Resource Center	**Subject No:** 09.06.12.28
Housing Support Services of SCCMHA		
Effective Date: 3/20/2009	**Date of Review/Revision**: 7/12/10, 4/29/20, 4/23/21, 3/30/23, 3/21/24	**Approved By**: Kristie Wolbert, Executive Director of Clinical Services
	Supersedes:	**Authored By:** Director of Services for Persons with Mental Illness **Reviewed By**: Debbie Jones-Burt

Purpose:
To ensure that SCCMHA housing program participants in Shelter Plus Care are provided with federally required due process.

Application:

	This procedure applies to Programs, Grants or Benefits Checked
X	HUD Tenant Based Permanent Supportive Housing (CoC Program)
	PATH Homeless Outreach
X	SCCMHA Housing Resource Center
X	SCCMHA Medicaid Housing Assistance Program
X	SCCMHA Provider Network

Policy:
SCCMHA will provide due process to Shelter Plus Care and other participants in housing subsidy grants administered through the SCCMHA, through the SCCMHA Local Appeal Process. This Local Appeal process is administered through the SCCMHA Customer Service Department.

Standards:
Participants in housing services from the Salter Place Housing Resource Center of SCCMHA that are either terminated, or experience a reduction in services, have the right

to appeal the decision by the Housing Resource Center Supervisor and staff with an independent third party. That party is the Customer Service and Recipient Rights office of SCCMHA.

Definitions:
Adverse Action: any action taken by SCCMHA to terminate, reduce or change services which have been authorized. This would include rent calculations, choice of location of housing, decisions to stop leases due to failure to meet Housing Quality Standards, etc.

References:
1. SCCMHA Policy 02.01.11.02 Local Appeal
2. SCCMHA Housing Policy 09.08.05.01 "Termination of Housing Assistance"
2. HUD Title 24, Chapter V, Section 582.320, Termination of assistance to participants.

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
1. Notice of access to the SCCMHA Local Appeal Process will be: ▪ posted in the Housing Resource Center, ▪ provided to all consumers at intake and at annual recertification and ▪ included in any written communication to the consumer regarding any adverse action.	1. Housing Resource Center Supervisor
2. The Supervisor of Customer Service will review any Consumer/Participant grievance or appeal with the Housing Resource Center Supervisor at the first step.	2. Supervisor of Customer Service & Recipient Rights
3. The Housing Resource Center Supervisor will provide for review a summary of the action supported and any evidence that supports the decision to the Supervisor of Customer Service and Recipient Rights.	3. Housing Resource Center Supervisor

Tab 5

Regulatory Management/ HIPAA Compliance

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: SCCMHA Network HIPAA Compliance</td><td>Chapter: 05 - Organizational Management</td><td>Subject No: 05.07.02</td></tr>
<tr><td rowspan="2">Effective Date:
June 1, 2005</td><td>Date of Review/Revision:
8/2/05, 6/23/09, 6/7/12, 6/3/14, 5/6/16, 6/13/17, 7/5/18, 7/1/20, 8/1/21, 8/26/22, 6/26/23, 9/9/24</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer

Authored By:
Jennifer Keilitz, Director of Network Services, Public Policy & Continuing Ed

Additional Reviewers:
Holli McGeshick, Quality and Medical Records Supervisor

Kentera Patterson, Officer of Recipient Rights and Compliance</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
To ensure that all service staff and network providers understand and adhere to the full scope of the Health Insurance Portability and Accountability Act (HIPAA) regulations, including security, transaction, and privacy requirements.

To provide a general broad HIPAA policy that will direct varied network providers in the compliance with HIPAA requirements.

Policy:
SCCMHA staff, service programs and network providers will abide by current HIPAA requirements to protect the privacy and security of the health information of persons who are service recipients of SCCMHA. SCCMHA is a "Covered Entity" as defined by HIPAA and HIPAA compliance is an employment and contractual obligation for all the members of the SCCMHA workforce.

Application:
The HIPAA Security Rule, and this policy, applies to SCCMHA, its business associates, and any subcontractor that is required to access or use PHI to complete its contracted duties. Business Associates and subcontractors may elect to adopt and comply with the relevant SCCMHA Policy or develop their own policy and procedure which complies with the applicable section of the HIPAA Security Rule.

Standards:
A. SCCMHA will make routine HIPAA training available. All staff and providers must complete training in both HIPAA privacy and security as required from SCCMHA to comply.
B. SCCMHA has two HIPAA required officers appointed by the CEO who are responsible to oversee HIPAA compliance: a SCCMHA HIPAA Security Officer and a SCCMHA HIPAA Privacy Officer. SCCMHA HIPAA officers are available for staff or provider consultation on HIPAA related matters.
C. Business Associates and Contractual providers who are a 'covered entity' according to HIPAA regulations, as is SCCMHA, are expected to identify their Privacy Officer to SCCMHA; all other service contractors are asked to identify a 'privacy liaison' to SCCMHA.
D. SCCMHA will include all relevant HIPAA policies in the SCCMHA Network Services Provider Manual.
E. Business Associates and Contractual providers who are covered entities are expected to have appropriate and required HIPAA policies and procedures that are available for SCCMHA review by audit and compliance individuals.
F. Providers who conduct or purchase electronic billing must abide by HIPAA transaction requirements.
G. Providers who are not covered entities are expected to be familiar with and adhere to SCCMHA HIPAA policies as applicable to their service provision.
H. Providers will direct HIPAA compliance related questions to SCCMHA whenever indicated or appropriate.
I. Providers must make every reasonable effort to protect the privacy and security of protected information of consumers as defined and required in HIPAA regulations.
J. Providers are expected to promptly report HIPAA violations to SCCMHA regarding SCCMHA recipients of services and assist with any remedy.
K. Providers may be sanctioned by SCCMHA for non-compliance on HIPAA related requirements.
L. Primary providers and record holders must abide by SCCMHA policies (or their own comparable policies that meet HIPAA requirements) in the notice, use and disclosure of all protected health information.
M. SCCMHA will offer HIPAA-related guidance for network providers.

Definitions:
See SCCMHA Policy 08.05.00.01 – Compliance Definitions policy for the following terms.
- PHI – Personal Health Information

References:
All SCCMHA HIPAA related Policies and Procedures
SCCMHA Regulatory Management Policy
SCCMHA Competency Requirements for the SCCMHA Network, Policy 05.06.03

Exhibits
Exhibit A - Email & PHI Compliance Tips

Procedure:
None

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Email & Protected Health Information (PHI) Compliance Tips

1. Never use the name of a person served in external emails; this includes sending any attachments which contain the name of a person served or other PHI.
2. External emails include any emails outside SCCMHA outlook system, including contract providers, who certainly may have legitimate need for receipt of consumer PHI information from SCCMHA staff.
3. For all persons served related communication with contracted providers, the preferred method is the Sentri messaging system if possible. If you need guidance on how to use this system inside the SCCMHA electronic health record, please check with your supervisor or SCCMHA.
4. Other options for external persons served related communications are encrypted emails (see your Information Technology department for assistance), fax, regular mail, hand delivery or voicemails, any of these options are acceptable in the protection of PHI.
5. External PHI email cautions also apply to primary care, any other service delivery, or support coordination of the person being served; a release signed by the persons served to share information with that party does not negate the restrictions about PHI and external emails.
6. **If sending internal emails within SCCMHA, or your contracted organization, it is expected you use somewhere in the subject header the following content: PHI Content Caution. This will alert others not to forward the email externally and to exercise caution with the email.**
7. While you may technically include the name of a person served or other necessary PHI relative to the intended purpose of the communication in internal emails inside SCCMHA, please do so with caution and as always against "need to know" practice standards. Use only the PHI needed for communication purposes. When feasible, use Sentri case numbers rather than the name or initials to identify the individual.
8. PHI regulatory compliance violations by individuals are subject to rights and compliance hotline reports and may result in employee discipline and/or provider sanctions.
9. Be cautious about emails you might receive from others which contain the name of a persons served, sometimes the name is embedded in the content of the email chain; if you receive an internal email containing a name of a person served anywhere in the content or attachments, and you forward the email externally for some reason, you have violated the PHI protection requirements.

Email & Protected Health Information (PHI) Compliance Tips

10. Remember, PHI is any information that could be used to identify a specific person, including but not limited to: demographic and individually identifiable health information, such as name, address, zip code, admission or discharge dates, social security number, email address, unique webpage, phone/fax number(s), date of birth, beneficiary health or record numbers, photographs, finger/voice prints, vehicle serial or license plate numbers, any personal account or license numbers, or any other descriptors that might promote identification of a specific person. Use of multiple identifiers increases the risk of PHI breach.

11. Emails are not part of the records of persons served and do not replace correct documentation in the record about persons served plans and progress; summary information at times may need to be taken from email content to place in the record, however, do be thoughtful what needs to be included from email in the record, and this should be done by the author, not others.

12. If you receive, read, or become aware of inappropriate or questionable email use of PHI by anyone in the SCCMHA system, or if you have any questions about the protection of PHI, please promptly contact the SCCMHA Officer of Recipient Rights and Compliance or Chief Quality and Compliance Officer with this information so that it may be addressed.

13. All e-mail messages sent or received that concern the diagnosis or treatment of a patient are considered part of that client's PHI and are to be treated with the same degree of confidentiality as other parts of the medical record through the secure Sentri II system.

14. All information about consumer treatment, payment for services or service delivery MUST be sent through the secure Sentri II system or by encrypting the email within Microsoft Outlook. Note: the preferred method of sending PHI is to use the messaging module within the Sentri II system. Do not put any PHI in the subject line of an email. The email should contain the least amount of PHI as possible.

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Information Technology Definitions</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.06.00.01</td></tr>
<tr><td>Effective Date:
7/5/23</td><td>Date of Review/Revision:
9/9/24
Supersedes:</td><td rowspan="2">Approved By:
Sandra M. Lindsey, CEO

Responsible Director:
AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer

Authored By:
Christina Saunders

Reviewed By:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
The purpose of this policy is to establish standard definitions for all Information Technology and Information Security policies and procedures.

Policy:
All terms identified in this policy shall be referenced when they are used in any SCCMHA policies and procedures.

Application:
This policy applies to all staff, contractors, and business associates of SCCMHA.

Standards:
These definitions will be updated annually to reflect any additions or modifications that are needed.

- **User Access or Authentication:** the ability to log into and use SCCMHA's information systems for clinical or administrative purposes by providing 2 points of authentication (2-Factor Authentication).
- **Ambient temperature** the temperature of the air within a room, for purposes of this policy, this refers to server rooms, communication rooms, storage rooms, offices, and any other location which IT equipment is stored...
- **Anti-virus software** the software that detects or prevents malicious software from entering a network or workstation.

- **Application Programming Interface (API)** a program that allows a developers to access certain data securely within other applications.
- **Authorized staff / personnel / users** Refers to a group of individuals, including staff, students, contractors**,** business associates and volunteers, engaged in the provision of SCCMHA (Saginaw County Community Mental Health Authority) services or business functions.
- **Authentication** When an information system using various strategies to ensure that the person or entity is the one claimed to be.
- **Backup** creating a retrievable, exact copy of data.
- **Breach is** a violation of the HIPAA Privacy or Security or other .
- **Break the Glass** is a type of record access which is accessible by any user which requires them to document an explanation of why they need access to that record. and the user's actions when accessing these records are logged, tracked, and possibly monitored as needed.
- **Business Intelligence (BI)** is a technology driven process for analyzing data and delivering actionable information that helps executives, managers and workers make informed business decisions.
- **Computer Resource** Any computer hardware, software, purchased computer service, and/or computer support services.
- **Confidential or Private Information** information that, if disclosed, could violate the privacy of individuals, or cause significant damage to the agency. Examples of confidential information are medical records, personnel records, operating plans, strategic plans, etc.
- **Confidentiality** when data or information is not to be made available or disclosed to unauthorized persons or processes.
- **Confidential medical information** individually identifiable health information in any form (paper or electronic) aka e-PHI (electronic patient health information).
- **Contingency Plan or Operations** procedures that allow facility access in support of restoration of lost data under the disaster recovery plan and emergency mode operations in the event of an emergency.
- **Data Integrity (DI)** the overall accuracy, completeness, and consistency of data.
- **Disaster** means an event that causes harm or damage to SCCMHA information systems. Disasters include earthquakes, fires, extended power outages, equipment failures, or a significant computer virus outbreak.
- **C drive** the fixed, internal hard drive inside workstation PCs.
- **G drive** the network drive on which SCCMHA employees save business documents and data which apply to agency wide operations or department specific operations.
- **H drives** the network drive on which SCCMHA employees save their personal work files and data.
- **DRP (**Disaster Recovery Plan) a policy or procedure designed to assist an organization in executing recovery processes in response to a disaster to protect business IT infrastructure and promote expedited recovery.

- **Electronic storage media** includes memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, digital memory card, or USB Drives.
- **Transmission media** used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, Virtual Private Networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including paper, facsimile, and voice, via telephone, are not considered transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.
- **Electronic protected health information (EPHI)** means individually identifiable electronic patient health information that is transmitted or maintained by electronic media.
- **Emergency** A situation where normal daily functioning has been interrupted to the point where the staff person can no longer function without having Information Systems render an immediate service to remedy the situation.
- **Encryption** means the conversion of data into scrambled or unreadable code which is only readable with a key known by the user.
- **External Service** An external IT service provided by an external vendor or provider.
- **Facility Security Plan** policies and procedures to safeguard the facility and the equipment from unauthorized physical access, tampering, and theft.
- **Generic or group identifier** a user ID that is shared by more than one user and does not uniquely identify an individual.
- **Hardware** refers to the tools, machinery, and other durable equipment such as the computer's tangible components or delivery system that store and run the written instructions provided by the software.
- **HIPAA Privacy Rule** is the rule that requires appropriate safeguards to protect the privacy of protected health information and sets limits and conditions on the uses and disclosures that may be made of such information without an individual's authorization.
- **HIPAA Security Rule** establishes national standards to protect individuals' electronic personal health information that is created, received, used, and maintained by a covered entity.
- **Information Access Management** a framework to identify, track, control and manage authorized or specified users' access to a system.
- **Information Custodian** the staff designated by the owner to the responsible for maintaining safeguards established by the owner.
- **Information Owner** the staff responsible for creating the information.
- **Information system (IS)** means an interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people.

- **Information Technology (IT)** equipment used for storing, retrieving, and sending data.
- I.S. Service: The scope of I.S. service includes, but is not necessarily limited to, Sentri II system work, PC workstation hardware issues, hardware set up, phone issues or set up, all questions or development work involving any SCCMHA license-owned software, network analysis and troubleshooting, proprietary databases, proprietary systems, operating systems, etc.
- **IT Equipment** this refers to old, retired pieces of computer hardware and software, printers, mice, keyboards, cables, monitors, or other PC peripherals
- **Internal Use** information that is intended for use by all employees when conducting agency business. Examples of internal use information are operational business reports, agency phone book, agency policies, standards and procedures, internal agency announcements, etc.
- **Internet Key Exchange (IKE)** a standard protocol used to set up a secure and authenticated communication channel between two parties via a virtual private network (VPN).
- **Internet Protocol Security (IPsec)** is a robust VPN standard that covers authentication and encryption of data traffic over the internet.
- **Internet Service Provider (ISP)** a company that provides subscribers with access to the internet.
- **Intranet** SCCMHA's internal website.
- **IS/IT Administrator** Staff and/or Department identified as the entity responsible for staff and equipment related to IS/IT Systems.
- **Local Area Network (LAN)** a computer network that links devices within a building or group of adjacent buildings.
- **Management of Information Systems (MIS)** people, technology, organizations, and the relationships among them.
- **Multi-Factor Authentication (MFA)** multiple methods of authentication to ensure the person logging into the system is the intended user.
- **Network user** Any SCCMHA staff member that has a network account and uses a PC to connect to the network.
- **Peripherals** IT equipment that plugs into via cord, Wi-Fi, or Bluetooth such as cameras, microphones, speakers, keyboards, and mice.
- **Physically Secure Area** an area where unauthorized persons do not have access to IT equipment. These areas must always be locked when the staff member is not present, even if only for a few minutes.
- **Privacy** ensuring the authorized control and access of electronic health information.
- **Privacy Officer** A person identified by the organization to administer Privacy Regulations. Typically, at SCCMHA the Compliance Officer is the Privacy Officer, SCCMHA also requires all provider contract agencies to have a designated Privacy Officer.
- **Proprietary Information** information that belongs to SCCMHA.
- **Protected Health Information (PHI)** individually identifiable patient health information in any form (paper or electronic) that has been maintained or

transmitted by a covered entity- that includes but is not limited to, AIDS/HIV information, mental health and developmental disabilities information, alcohol and drug abuse information, and other sexually transmitted disease information.

- **Point-to-Point Tunneling Protocol (PPTP)** a networking technology that supports multi-protocol virtual private networks (VPN), enabling remote users to access corporate networks securely across the Microsoft Windows operating systems and other point-to-point protocol (PPP)- enables systems to dial into a local internet service provider to connect securely to their corporate network through the internet.
- **Public Information is** information that has been made available for public distribution through authorized company channels. Examples of public information are the agency annual report, public service bulletins, newsletters, marketing brochures, advertisements, etc.
- **Purchased Computer Service** An external computer service. Such as, an Internet account, provided by an external vendor.
- **Restoration** means the retrieval of files previously backed up and returning them to the condition they were at the time of backup.
- **Risk** means the likelihood of a given threat exercising a particular vulnerability and resulting impact of that event.
- **Role-based access control** is a means of restricting access to data or objects based on a user's role and the mapping of that user's role to a system-defined role.
- **Server files** All computer files that reside on the SCCMHA servers.
- **Secure Folder** A storage area where only the user or a select few are approved for access to a non-public folder the requesting individual must obtain permission from the "owner" of the folder and that employee's Director.
- **Security incident** means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
- **Security Measures** means security policies, procedures, standards, and controls.
- **Security Officer** a person identified by the organization to administer the HIPAA/HITECH Security Regulations. Typically, at SCCMHA the Security Officer is the Chief Information Officer.
- **Sentri** is the software system used to capture medical records, billing for fee or service reimbursement information. Also known as EHR- Electronic Health Record or EMR – Electronic Medical Record.
- **Share drive** A designated public or private drive set up as a work area for the Agency staff on the server.
- **Software Information systems**. **Examples include but are not limited to** software products that control Desktop computers, central processing computers, network servers, modems, scanners, printers, computer mice, computer cards, and any computer peripheral that is connected to any of the hardware. Exclusions to the definition of software are Fax machines, copiers, any computer-related supplies (I.E., wrist supports, glare screens, power plugs), and the phone system (if the phone system & the administrative computer system are not linked).
- TDX Portal: Saginaw County Community Mental Health Authority Team Dynamix Portal

- **The State Medicaid Health Information Technology Plan (SMHP)** provides the foundation for Medicaid health system transformation and administration that enables care coordination among clinicians.
- **Technical Evaluation** means an evaluation of the technical components of the computer network and related devices.
- **Two-Factor Authentication (MFA)** is a second method of authentication to ensure the person logging into the system is the intended user.
- **User** a person granted access to systems. OR employees authorized by the owner to access information and use the safeguards established by the owner.
- **User ID** an identifier chosen for the user to represent themselves when logging into the electronic health records or other network system. The User ID should never be changed, it is permanently associated that user.
- **Virtual Private Network (VPN)** a method of tunneling securely through the internet to a network, whereby a personal PC becomes an extension of that private business's network allowing a user to access data files remotely.
- **Vulnerability** means a flaw or weakness in system security procedures, design, implementation, or internal controls that can be exploited and result in misuse or abuse of data.
- **Workstation** An electronic computing device, for example, a laptop or desktop computer, tablet or any other device that performs similar functions, and electronic media stored in its immediate environment.
- **Workforce member** employees, volunteers, and other persons whose conduct, in the performance of work for SCCMHA, is under the direct control of SCCMHA, whether or not they are paid by SCCMHA. This includes full and part time employees, affiliates, associates, students, volunteers, contractors, and staff from third party entities who provide services to SCCMHA.

References:
None.

Exhibits:
None.

Procedure:
None

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: HIPAA Security: Security Sanctions	**Chapter**: 08 - Management of Information	**Subject No**: 08.06.04
Effective Date: April 20, 2005	**Date of Review/Revision**: 9/13/22, 11/14/18, 9/8/04, 8/4/23, 9/9/24	**Approved By**: Sandra M. Lindsey, CEO
	Supersedes:	
SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		**Responsible Director:** Amy Lou Douglas, Chief Information Officer | Chief Quality and Compliance Officer **Authored By**: Amy Lou Douglas, Chief Information Officer | Chief Quality and Compliance Officer **Additional Reviewers**: Brett Lyon, Senior Applications, Information Security & BI Administrator Chad Brown, Senior Data Warehouse and Applications Administrator Ben Pelkki, Senior Database & Microsoft 365 Administrator David Wolfcale, Systems, Information Security & Microsoft 365 Administrator Matthew Devos, Senior Network Administrator, Fred Stahl, Director of Human Resources Kentera Patterson, Officer of Recipient Rights and Compliance

Purpose:
To outline the procedures and criteria to *"Apply appropriate sanctions against workforce members who fail to comply with the security policies and procedures of the covered entity."* 45 CFR 164.308(a)(1)(ii)(C) This policy ensures adherence to Health Insurance Portability and Accountability Act (HIPAA) and other relevant regulations by enforcing sanctions for violations to maintain the confidentiality, integrity, and availability of SCCMHA information systems.

Policy:
SCCMHA is committed to enforcing appropriate sanctions against workforce members who fail to comply with security policies and procedures. Sanctions are designed to be fair and proportionate to the severity of the violation and to ensure compliance with all applicable laws and regulations Under HIPAA, penalties for misuse or misappropriation of health information can include both civil and criminal penalties. Civil penalties range from $100 for each violation to a maximum of $25,000 per year for the same violations. Criminal penalties vary from $50,000 and/or 1 year imprisonment to $250,000 and/or 10 years imprisonment (42USC §1320d).

Application:
This policy applies to all workforce members of Saginaw County Community Mental Health Authority (SCCMHA) including employees, contractors, subcontractors, network providers, and other agents with access to SCCMHA information systems.

Standards:
1. Compliance Requirements:
    - Obligation: All SCCMHA workforce members must comply with all applicable SCCMHA security policies and procedures. Compliance is necessary to ensure the confidentiality, integrity, and availability of information systems.
    - Education: SCCMHA will provide training and resources to ensure that all members are aware of and understand the policies and procedures related to information security.
2. Application of Sanctions:
    - Sanction Levels: Sanctions will vary based on factors such as the severity and intent of the violation, whether it was a one-time incident or part of a pattern of improper behavior, and the impact on SCCMHA's operation and data security.
    - Types of Sanctions: Potential sanctions include, but are not limited to, verbal or written warnings, mandatory retraining, suspension, demotion, or discharge. The decision of appropriate sanctions will be made in accordance with SCCMHA's disciplinary processes.
3. Investigation and Documentation:
    - Incident Reporting: All security violations must be reported to the designated security officer or compliance department immediately upon discovery.

- Investigation Process: An investigation will be conducted to determine the facts surrounding the violation, including interviews with involved parties and review of relevant documentation.
- Documentation: All investigations, findings, and sanctions imposed will be documented thoroughly and maintained in accordance with SCCMHA record keeping policies.

4. Legal & Regulatory Notifications:
    - Severe Violations: Employees, agents, and other contractors should be aware that violations of a severe nature may result in notification to law enforcement officials as well as regulatory, accreditation, and/or licensure organizations.
    - Compliance: SCCMHA will cooperate with investigations conducted by these bodies and provide necessary documentation and information.
5. Protection for Whistleblowers & Legal Rights:
    - Whistleblower Protections: The policy and procedures contained herein do not apply specifically when members of SCCMHA's workforce exercise their right to file a complaint with HHS, testify, assist, or participate in an investigation, compliance review, proceeding, or hearing under Part C of Title XI; or
    - Opposition to Unlawful Acts: Employees who oppose any act made unlawfully by the HIPAA Security Rule; provided the individual or person has a good faith belief that the act opposed is unlawful, and the manner of the opposition is reasonable and does not involve a disclosure of protected health information in violation of the HIPAA Security Rule.
    - Disclosure by Whistleblower: disclose protected health information as a whistleblower and the disclosure is in a health oversight agency; public health authority; or an attorney retained by the individual for purposes of determining the individual's legal option with regard to the whistleblower activity; or
    - Victim Disclosure: an employee who is a victim of a crime and discloses protected health information to a law enforcement official, provided that the protected health information is about a suspected perpetrator of the criminal act and is limited to the information listed in the SCCMHA policy related to Disclosing Protected Health Information for Law Enforcement Release.

Definitions:
None

References:
- HIPAA Security Rule, 45 CFR 164.308(a)(1)(ii)(C)
- SCCMHA Employee Handbook
- Policy 05.07.01 – Regulatory Management Policy
- SCCMHA Policy Number 801 – Information Technology

Exhibits
None

Procedure:

ACTION	RESPONSIBILITY
1. Sanctions for failure to comply with policies or procedures or with the requirements of HIPAA regulations will be made by the management of SCCMHA.	SCCMHA Management Team
2. All sanctioning of employees, agents and contractors will be documented and retained for a period of at least 6 years from the date of its creation or the date when it was last in effect, whichever is later.	Officer of Recipient Rights and Compliance. HIPAA Privacy Officer. Director of Human Resources

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: HIPAA Security - Security Management Process	**Chapter**: 08 – Management of Information	**Subject No**: 08.06.08.01
Effective Date: October 01, 2020	**Date of Review/Revision**: 9/13/22, 8/4/23, 9/9/24 **Supersedes**: 08.06.02	**Approved By**: Sandra M. Lindsey, CEO **Responsible Director:** AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer **Authored By**: AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer **Additional Reviewers**: Brett Lyon, Senior Applications, Information Security & BI Administrator Chad Brown, Senior Data Warehouse and Applications Administrator Ben Pelkki, Senior Database & Microsoft 365 Administrator Matthew Devos, Senior Network Administrator David Wolfcale, Systems, Information Security & Microsoft 365 Administrator Fred Stahl, Director of Human Resources Matthew Briggs, Chief of Network Business Operations Chad Revell, Inventory Management and Mobile Device Specialist

Purpose:
To ensure compliance with the HIPAA (Health Insurance Portability and Accountability) Security Rule, §164.308(a)(1) – Security Management Process, by establishing a framework for identifying, assessing, and managing risks to the confidentiality, integrity, and availability of Electronic Protected Health Information (ePHI) at SCCMHA.

Policy:
SCCMHA will develop, implement, and maintain policies and procedures to prevent, detect, contain, and correct security violations related to the EPHI. This includes conducting regular risk assessments, implementing appropriate security measures, and enforcing compliance with HIPAA requirements.

Application:
This policy applies to SCCMHA, its business associates, and subcontractors who require access to or use of EPHI to fulfill their contractual obligations. Business associates and subcontractors may choose to adopt SCCMHA's policies or develop their own, provided they comply with the applicable sections of the HIPAA Security Rule.

Violations of this policy may result in disciplinary action up to and including termination of employment or contract. Compliance with this policy is mandatory for all relevant parties, and SCCMHA will ensure adherence through regular reviews, monitoring, and enforcement measures.

Standards:
Policies and procedures to prevent, detect, contain, and correct security violations related to the EPHI of SCCMHA consumers will be implemented.

A. Risk Identification and Assessment:
- Risk Identification: SCCMHA must regularly identify, define, and prioritize risks to the confidentiality, integrity, and availability of its information systems containing EPHI. Security Risk Assessment (SRA): An accurate and thorough SRA (Security Risk Assessment) of the potential risks and vulnerabilities. This assessment will include:
    i. Inventory and Assessment: All information systems that house EPHI are to be identified and periodically inventoried, including all hardware and software that are used to collect, store, process, or transfer EPHI.
- The SRA Components:
    i. The SRA & Process- Evaluation of the overall SRA process.
    ii. Security Policies – Review of existing security policies.
    iii. Security & Workforce – Assessment of workforce training and compliance.
    iv. Security & Data - Evaluation of data protection measures.
    v. Security & the Practice – Review of security practices and procedures.
    vi. Security & Business Associates – Assessment of security measures related to business associates
    vii. Contingency Planning – Evaluation of contingency plans and disaster recovery measures.
- Risk Analysis Methodology: The method of risk analysis SCCMHA chooses must be based on the following steps:

i. Inventory. SCCMHA must conduct a regular inventory of its information systems containing EPHI and the security measures protecting those systems.
ii. Threat identification. SCCMHA must identify all potential threats to its information systems containing EPHI. Such threats may be natural, human, or environmental.
iii. Vulnerability identification. SCCMHA must identify all vulnerabilities on its information systems containing EPHI. This should be done by regularly reviewing vulnerability sources and performing security assessments.
iv. Security control analysis. SCCMHA must analyze the security measures implemented or will be implemented to protect its information systems containing EPHI; this includes both preventive and detective controls.
v. Risk likelihood determination. SCCMHA must assign ratings to specific risks that indicate the probability that a vulnerability will be exploited by a particular threat. Three factors should be considered: 1) threat motivation and capability, 2) type of vulnerability, and 3) existence and effectiveness of current security controls
vi. Impact analysis. SCCMHA must determine the impact to confidentiality, integrity or availability that would result if a threat were to successfully exploit a vulnerability on a SCCMHA information system containing EPHI.
vii. Risk Determination. SCCMHA must use the information obtained in the above six steps to identify the level of risk to specific information systems containing EPHI. For each vulnerability and associated threat, SCCMHA must make a risk determination based on:
    1. The likelihood a certain threat will attempt to exploit a specific vulnerability.
    2. The level of impact should the threat successfully exploit the vulnerability.
    3. The adequacy of planned or existing security controls.

viii. Documentation: The results of each of the above steps must be formally documented and securely maintained. The above steps do not prescribe any method, but the method selected for the Risk Analysis should address all the concerns

B. Security Measures:
- Implementation: SCCMHA will implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level to comply with §164.306(a) of the HIPAA Security Rule will be implemented. Specifically, SCCMHA must:

    1. Confidentiality, Integrity & Availability: Ensure the confidentiality, integrity, and availability of all EPHI that SCCMHA creates, receives, maintains, or transmits,

2. Threat & Hazard Protection: Protect against any reasonably anticipated threat or hazard to the security or integrity of such information,

3. Unauthorized Use or Disclosure: Protect against any reasonably anticipated use or disclosure of such information that are not permitted or required under the HIPAA Security Rule, and

4. Workforce Compliance: Ensure compliance with the HIPAA Security Rule by its workforce.

C. Workforce Training & Compliance:
   - Training: SCCMHA workforce members are expected to comply with all applicable policies and procedures related to the HIPAA Security Rule. Training will be issued prior to being issued a user ID and access to ePHI, annual refresher training is required.
   - Sanctions: SCCMHA will apply appropriate sanctions against members of its workforce who fail to comply with SCCMHA policies and procedures, including disciplinary action up to and including discharge in compliance with the SCCMHA Employee Handbook. Members of the SCCMHA workforce should be aware that severe violations may result in notification to law enforcement officials and regulatory, accreditation, and/or licensure organizations.

D. Monitoring & Review:
   - Activity Review: regularly review records of information system activity, such as audit logs, access reports, and security incident tracking reports will be implemented.
   - Incident management: Procedures will be established for reporting, investigating and documenting security incidents. The Security Incident Log will be maintained and reviewed by the SCCMHA Compliance and Policy Team.

E. Business Associate and Subcontractor Compliance:
   - Contractual Requirements: Business Associates and subcontractors must adhere to SCCMHA's policies or develop their own, compliant with the HIPAA Security Rule. SCCMHA will review and ensure compliance with these requirements.

Definitions:
See SCCMHA Policy 08.06.00.01, which contains a full list of relevant words and terms used in this section's Policies.

References:
- The HIPAA Security Rule §164.308(a)(1)
- The HIPAA Security Rule §164.306(a)
- SCCMHA Policy Number 201 – Standards of Conduct

- SCCMHA Policy Number 205 – Corrective Action
- SCCMHA Policy Number 801 – Information Technology
- NIST SP 800-30

Procedure:

ACTION	RESPONSIBILITY
Identify Relevant Information Systems	
1. Identify all information systems that house EPHI, including hardware and software used to collect, store, process, or transmit EPHI.	1. HIPAA Security Officer Senior Database & Microsoft 365 Administrator IT/IS Team
2. Analyze business functions and verify ownership and control of information system elements, as necessary.	2. HIPAA Security Officer Senior Database & Microsoft 365 Administrator IT/IS Team
Conduct Risk Assessment	
3. An accurate and thorough SRA of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of EPHI held by SCCMHA and its Business Associates will be conducted periodically and as needed.	3. HIPAA Security Officer Senior Database & Microsoft 365 Administrator IT/IS Team
Implement a Risk Management Program	
4. Security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level (See Section 164.306(a) of the HIPAA Security Rule) will be implemented, inclusive of SCCMHA's Business Associates and Contract Providers.	4. HIPAA Security Officer Senior Database & Microsoft 365 Administrator IT/IS Team Director of Human Resources
Develop and Implement a Sanction Policy	

5. Appropriate sanctions against workforce members who fail to comply with the security policies and procedures will be applied.	5. HIPAA Security Officer Senior Database & Microsoft 365 Administrator IT/IS Team
Develop and Deploy the Information System Activity Review Process	
6. Implement procedures to regularly review records of information system activity, such as audit logs, access reports, and security incident tracking reports.	6. HIPAA Security Officer Senior Database & Microsoft 365 Administrator IT/IS Team

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<tr><td>Subject: HIPAA Security: Assigned Security Responsibility</td><td>Chapter: 08 – Management of Information</td><td>Subject No:
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AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer & HIPAA Security Officer

Authored By:
AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer & HIPAA Security Officer

Additional Reviewers:
None</td></tr>
</table>

Purpose:
To ensure compliance with the HIPAA Security Rule, §164.308(a)(2) – Assigned Security Responsibility, by defining the roles and responsibilities of individuals responsible for developing, implementing, and maintaining security policies and procedures at SCCMHA.

Policy:
SCCMHA will appoint a designated HIPAA Security Officer responsible for development, implementation, and enforcement of security policies and procedures required by the HIPAA Security Rule for SCCMHA. This individual will serve as the point contact for all HIPAA Security-related matters.

Application:
The HIPAA Security Rule and this Policy applies to SCCMHA, its business associates, and any subcontractor required to access or use PHI to complete its contracted duties. Business Associates and subcontractors may elect to adopt and comply with the relevant SCCMHA Policy or develop their own Policy and Procedure which complies with the applicable section of the HIPAA Security Rule.

Violations of this policy will result in appropriate disciplinary action up to and including termination of employment or contract. Non-compliance with HIPAA Security Rule requirements may also result in legal and regulatory consequences**.**

Standards:

A. Appointment and Responsibilities of the HIPAA Security Officer

- Designation**:** SCCMHA will appoint a HIPAA Security Officer who will be responsible for all aspects of HIPAA Security Rule compliance.
- Responsibilities: The identified SCCMHA HIPAA Security Officer will have responsibility for:
    1. Oversight & Development: The oversight, development, and communication of security policies and procedures.
    2. Communication: Ensure effective communication of security policies and procedures to all relevant staff and stakeholders.
    3. Risk Assessment: Conducting the risk assessment required under the HIPAA Security Rule §164.308(a)(1)(i).
    4. Security Evaluations: Reviewing the results of periodic security evaluations and continuous monitoring required under §164.308(a)(1)(ii)(D) and communicating those results to the SCCMHA Compliance and Policy Team.
    5. Addressing Security Concerns: Ensuring that security concerns have been appropriately addressed. Implementing corrective action and follow up to verify that issues have been resolved.
    6. Documentation: Maintain comprehensive records of all security activities, including risk assessments, security evaluations, incident reports, and corrective actions taken.

B. Implementation and Monitoring:

- Policy Development: The HIPAA Security Officer will develop policies and procedures that meet the requirements of the HIPAA Security Rule, including those for:
    - Access Control: Policies for granting, modifying, and terminating access to PHI.
    - Data Protection: Procedures for safeguarding PHI against unauthorized access, use, and disclosure.
    - Incident Response: Protocols for responding to and managing security incidents and breaches.
- Training and Awareness: Programs for training staff on security policies and procedures and raising awareness about security risks. Monitoring & Enforcement: The HIPAA Security Officer will:
    - Continuously Monitor: Oversee continuous monitoring of security controls and systems to ensure ongoing compliance.
    - Periodic Reviews: Conduct periodic reviews and updates of security policies and procedures to address new threats, vulnerabilities, and changes in regulations.

- Incident Management: Manage and coordinate responses to security incidents, including conducting investigations, documenting findings, and implementing corrective actions.

C. Reporting and Accountability:

- Reporting: the HIPAA Security Officer will report directly to the Chief Compliance Officer and SCCMHA Compliance and Policy Team to provide regular updates on the status of security policies, risk assessments, and security evaluations.
- Accountability: The HIPAA Security Officer is accountable for ensuring that all security measures are effectively implemented and adhered to. This includes holding relevant staff accountable for compliance with security policies and procedures.

D. Compliance and Training:

- Compliance: Ensure that SCCMHA's security policies and procedures comply with the HIPAA Security Rule and other applicable regulations.
- Training: Oversee the development and delivery of training programs to educate staff on security policies, procedures, and their roles in maintaining compliance.

E. Business Associate and Subcontractor Oversight

- Monitoring: Monitor and ensure that business associates and subcontractors adhere to the security policies and procedures, either through direct oversight or through contractual requirements. Information regarding BAAs can be found in Policy 08.06.08.09: BAAs and other Arrangements.
- Contractual Compliance**:** Ensure that business associate agreements and subcontractor contracts include provisions for compliance with HIPAA Security Rule requirements.

Definitions:

See I.T./I.S. Policy 08.06.00.01, which contains a full list of relevant words and terms used in this section's Policies.

References:

- The HIPAA Security Rule §164.308(a)(2)
- SCCMHA Job Description – Chief Information Officer | Chief Quality and Compliance Officer

Procedure:

ACTION	RESPONSIBILITY
1. Identify the security official responsible for developing and implementing the policies and procedures required by the HIPAA Security Rule.	1. Chief Information Officer | Chief Quality and Compliance Officer

2. Document this assignment to one individual's responsibilities in a job description.	2. Chief Information Officer | Chief Quality and Compliance Officer

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<tr><td>Subject: HIPAA Security: Workforce Security</td><td>Chapter: 08 – Management of Information</td><td>Subject No:
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Melissa Gutzwiller - Environmental Services, Customer Service, Security</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
To assure compliance with the HIPAA Security Rule, §164.308(a)(3) – Workforce Security by establishing and maintaining policies and procedures that regulate workforce access to Electronic Protected Health Information (ePHI) and prevent unauthorized access.

Policy:

SCCMHA will implement comprehensive policies and procedures to ensure that all members of its workforce have appropriate access to electronic protected health information, as provided under the HIPAA Privacy Rule, and to prevent those workforce members who do not have appropriate access under the HIPAA Privacy Rule from obtaining access to electronic protected health information.

Application:
The HIPAA Security Rule, and this Policy, applies to SCCMHA, its business associates, and any subcontractor that is required to access or use PHI to complete its contracted duties. Business Associates and subcontractors may elect to adopt and comply with the relevant SCCMHA Policy or develop their own Policy and Procedure which complies with the applicable section of the HIPAA Security Rule.

Compliance with this policy is mandatory. Violations of the policy will result in disciplinary action, up to and including termination of employment or contract. Non-compliance may also lead to legal and regulatory consequences.

Standards:
Authorization and Supervision: Procedures will be developed and implemented for the authorization and/or supervision of workforce members who work with EPHI or in locations where it might be accessed with be implemented.

A. Access Authorization:
    - Access Request: All requests for access to EPHI must be documented and submitted through a formal process, including justification for access based on job role and responsibilities.
    - Role-Based Access: Access to EPHI will be granted based on the principle of least privilege, meaning access will be limited to the minimum necessary for the performance of job duties.
    - Authorization Review**:** Access requests will be reviewed and approved by designated managers or supervisors in coordination with the Security Officer. Access will only be granted after approval is obtained.

B. Supervision:
    - Monitoring Access: Workforce members who have access to EPHI will be subject to regular monitoring to ensure that access is appropriate and that no unauthorized activities occur.
    - Training: All workforce members with access to EPHI will receive training on data protection policies, security protocols, and their responsibilities under the HIPAA Privacy and Security Rules.

Access Appropriateness: Procedures will be developed and implemented to determine that the access of a workforce member to EPHI is appropriate.

A. Periodic Review:
    - Access Reviews: Access to EPHI will be reviewed periodically, at least annually, to ensure that it remains appropriate. This review will include verifying that current access aligns with the individual's job role and responsibilities.

- Adjustments**:** Any changes in job roles, responsibilities, or employment status that affect access to EPHI will trigger a review of access privileges. Adjustments will be made as necessary to ensure compliance with the principle of least privilege.

B. Access Justification:
   - Documentation: Each workforce member's access to EPHI will be documented, including the rationale for access and the specific EPHI accessed. Documentation will be maintained and available for audit purposes.
   - Authorization Record: The Security Officer will maintain a record of all access authorizations, including approvals, modifications, and terminations.

Termination of Access: Procedures for terminating access to EPHI when the employment of, or other arrangement with, a workforce member ends.

A. Access Termination Procedures:
   - Exit Process: When a workforce member's employment or other arrangement ends, their access to EPHI will be promptly terminated. This includes deactivating user accounts, retrieving access credentials, and revoking physical access to areas where EPHI is stored or processed.
   - Notification**:** The Security Officer and IT department will be notified immediately of any termination or changes in employment status to initiate the access termination process.

B. Access Revocation:
   - Revocation Process: Procedures for revoking access will be in place to ensure that access rights are promptly adjusted or removed in response to role changes or termination. Access will be terminated within 24 hours of notification of the change.
   - Audit and Verification: After access termination, the IT department will conduct an audit to verify that all access rights have been removed and that no unauthorized access has occurred.

Enforcement and Compliance:

A. Compliance Monitoring:
   - Regular Audits: SCCMHA will conduct regular audits to ensure compliance with access control procedures and identify any potential gaps or issues in access management.
   - Compliance Reports: Regular reports will be generated and reviewed by the SCCMHA Compliance and Policy Team to monitor compliance with access control policies and procedures.

B. Sanctions:
   - Disciplinary Actions: Workforce members who fail to comply with access control policies and procedures will be subject to disciplinary actions as outlined in the SCCMHA Employee Handbook. This may include corrective actions, retraining, or termination of employment.

- Incident Reporting**:** Any suspected or actual unauthorized access to EPHI will be reported to the Security Officer and investigated. Appropriate actions will be taken to address and rectify the situation.

Documentation and Record Keeping:

A. Policy Documentation:
   - Policy Access: All policies and procedures related to workforce security will be documented and made accessible to relevant staff.
   - Record Maintenance**:** Documentation of access authorizations, changes, terminations, and periodic reviews will be maintained securely and retained for a minimum of six years or as required by applicable regulations.

Definitions:
See IT/IS Policy **08.06.00.01** which contains a comprehensive list of relevant words and terms used within the Policies of this section.

References:
- The HIPAA Security Rule §164.308(a)(3)
- The HIPAA Privacy Rule - 45 CFR Part 160 and Part 164, Subparts A and E
- SCCMHA Policy 08.04.02 - Electronic Health Record Identity and Access Management

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Procedures for Authorization and/or Supervision	
1. Procedures will be developed and implemented for the authorization and/or supervision of workforce members who work with EPHI or in locations where it might be accessed.	Environmental Services, Customer Service, Security, HIPAA Security Officer, Senior Systems & Desktop Support Administrator, Senior Applications, Information Security & BI Administrator, Senior Database & Microsoft 365 Administrator
Establish Clear Job descriptions and Responsibilities	
2. Define roles and responsibilities for all job functions	Human Resources Director

3. Assign appropriate levels of security oversight, training, and access	IT Department Staff
4. Identify in writing who has the business need, and who has been granted permission, to view, alter, retrieve, and store EPHI, and at what times, under what circumstances, and for what purposes.	Human Resources Director
Establish Criteria and Procedures for Hiring and the Assignment of Tasks	
5. Ensure that members of the workforce have the necessary knowledge, skills, and abilities to fulfill roles, and that these requirements are included as part of the hiring process.	Human Resources Director
Establish a Workforce Clearance Procedure	
6. Implement procedures to determine that the access of a workforce member to EPHI is appropriate.	IT Department Staff HIPAA Security Officer, Senior Applications, Information Security & BI Administrator, Senior Database & Microsoft 365 Administrator
7. Implement a procedure for obtaining clearance from appropriate offices or individuals where access is provided or terminated.	Human Resources Director
Establish Termination Procedures	
8. Implement procedures for terminating access to EPHI when the employment of a workforce	Human Resources Director

members ends or as required by determinations made as specified in the Policy.	
9. Develop a standard set of procedures that should be followed to recover access to control devices, (identification [ID] badges, keys, access cards, etc.) when employment ends.	HIPAA Security Officer, Senior Applications, Information Security & BI Administrator, Senior Database & Microsoft 365 Administrator
10. Deactivate computer access accounts (e.g., disable user IDs and passwords).	Senior Systems & Desktop Support Administrator, Senior Applications, Information Security & BI Administrator, Senior Database & Microsoft 365 Administrator IT Department Staff

<table>
<tr><td colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: HIPAA Security: Information Access Management & Access Control</td><td>Chapter: 08 – Management of Information</td><td>Subject No:
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Sandra M. Lindsey, CEO</td></tr>
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<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td><td>Responsible Director:
AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer

Authored By:
AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer, Security Officer

Reviewers:
Brett Lyon, Senior Applications, Information Security & BI Administrator
Chad Brown, Senior Data Warehouse and Applications Administrator
Ben Pelkki, Senior Database & Microsoft 365 Administrator
David Wolfcale, Systems, Information Security & Microsoft 365 Administrator
Matthew Devos, Senior Network Administrator</td></tr>
</table>

Purpose:
To ensure compliance with the HIPAA Security Rule, §164.308(a)(4) – Information Access Management and to safeguard electronic protected health information (ePHI) against unauthorized access.

Policy:
SCCMHA is committed to implementing and maintaining robust policies and procedures for authorizing access to EPHI. These measures will align with the applicable requirements of the HIPAA Privacy Rule Subpart E (Privacy of Individually Identifiable Information) of CFR §164.

Application:
The HIPAA Security Rule and this Policy applies to SCCMHA, its business associates, and any subcontractor required to access or use PHI to complete its contracted duties. Business Associates and subcontractors may elect to adopt and comply with the relevant SCCMHA Policy or develop their own Policy and Procedure which complies with the applicable section of the HIPAA Security Rule.

Standards:

A. Access Authorization:
    - SCCMHA will establish and enforce policies and procedures for granting, managing, and terminating access to EPHI. This includes controlling access to workstations, transactions, programs, processes, or other mechanisms used to handle PHI.
    - Access will be granted based on the principles of least privilege, ensuring that individuals have the minimum necessary access required to perform their job functions.

B. Access Control Procedures:
    - Role-Based Access Control (RBAC): Access to EPHI will be assigned based on job roles and responsibilities. Each role will have predefined access levels that reflect the need to know and perform job functions.
    - Authentication Mechanisms: Access to systems containing EPHI will require strong authentication mechanisms, such as passwords and multi-factor authentication (MFA).
    - Access Reviews: SCCMHA will conduct regular reviews and audits of user access rights to ensure that access is appropriate and reflects current job functions. Any unnecessary or outdated access rights will be promptly adjusted or revoked.
    - Access Modifications: Procedures for modifying access rights will be documented and enforced to ensure that changes in job roles, responsibilities, or employment status are reflected in access privileges in a timely manner.

C. Security measures:
    - Physical Security: Access to physical workstations and systems where EPHI is stored or processed will be secured against unauthorized access through measures such as locked facilities, secure rooms, and controlled access points.
    - Technical Safeguards: Systems handling EPHI will have technical safeguards in place, including encryption, firewalls, and intrusion

detection systems, to protect against unauthorized access and cyber threats.

- Training and Awareness: All employees, business associates, and subcontractors will receive training on access management policies, the importance of safeguarding EPHI, and the procedures for reporting security incidents or breaches.

Definitions:
See I.T./I.S. Policy 08.06.00.01, which contains a full list of relevant words and terms used in this section's Policies.

References:

- The HIPAA Security Rule §164.308(a)(4)
- HIPAA Privacy Rule Subpart E
- CFR §§164

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Implement Policies and Procedures for Authorizing Access	
1. Policies and Procedures for granting and restricting access to EPHI, for example, through access to a workstation, transaction, program, process, or other mechanism, will be implemented.	HIPAA Security Officer and Chief Information Officer & Chief Quality and Compliance Officer Senior Applications, Information Security & BI Administrator
2. Access control methods will be evaluated and applied (e.g., identity based, role-based, or other reasonable and appropriate means of access.)	HIPAA Security Officer and Chief Information Officer & Chief Quality and Compliance Officer, Senior Applications, Information Security & BI Administrator
3. Determine when and if direct access to EPHI is appropriate for individuals external to SCCMHA (e.g., Business Associates, Contract Providers, or person served seeking access to their own EPHI).	HIPAA Security Officer and Chief Information Officer & Chief Quality and Compliance Officer Senior Applications, Information Security & BI Administrator

Implement Policies and Procedures for Access Establishment and Modification	
4. Develop and implement procedures that, based upon SCCMHA's access authorization policies, establish, document, review and modify a user's right of access to a workstation, transaction, program, or process.	HIPAA Security Officer and Chief Information Officer & Chief Quality and Compliance Officer Senior Applications, Information Security & BI Administrator
5. Formal authorization from the proper authority will be provided to an individual before that individual to granted access to EPHI.	HIPAA Security Officer and Chief Information Officer & Chief Quality and Compliance Officer Senior Applications, Information Security & BI Administrator
Evaluate Existing Security Measures Related to Access Controls	
6. The security features of access controls will be evaluated to determine if they are aligned with other existing management, operational, and technical controls, such as policy standards and personnel procedures, maintenance and review of audit trails, identification and authentication of users, and physical access controls.	HIPAA Security Officer and Chief Information Officer & Chief Quality and Compliance Officer Senior Applications, Information Security & BI Administrator

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Security: Security Awareness and Training</td><td>Chapter: 08 – Management of Information</td><td>Subject No:
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<tr><td rowspan="2">Effective Date:
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Sandra M. Lindsey, CEO

Responsible Director:
AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer

Authored By:
AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer, Security Officer

Additional Reviewers:
Alecia Schabel, Continuing Education Supervisor
Kentera Patterson, Officer of Recipient Rights and Compliance & Privacy Officer
Matthew Devos, Senior Network Administrator,
David Wolfcale, Systems Information Security & Microsoft 365 Administrator
Chad Revell, Inventory Management and Mobile Device Specialist</td></tr>
<tr><td>Supersedes:
08.01.04
08.06.14
08.01.03</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
To ensure compliance with the HIPAA Security Rule, §164.308(a)(5) – Security Awareness Training, and to enhance the protection of electronic protected health information (ePHI) through comprehensive security awareness and training programs.

Policy:
SCCMHA is committed to implementing and maintaining a robust security awareness and training program for all members of its workforce, including management, to ensure effective safeguarding of PHI and to adhere to the HIPAA Security Rule requirements.

Application:
The HIPAA Security Rule, and this Policy, applies to SCCMHA, its business associates, and any subcontractor that is required to access or use PHI to complete its contracted duties. Business Associates and subcontractors may elect to adopt and comply with the relevant SCCMHA Policy or develop their own Policies and Procedures which comply with the applicable section of the HIPAA Security Rule.

Standards:

A. Security Awareness Training:
    - Mandatory Training: All staff, including management, must complete Security Awareness Training upon hire and participate in ongoing training sessions.

B. Periodic Security Updates:
    - Regular Updates: SCCMHA will provide updates on emerging security threats, new policies, and changes in regulatory requirements.
    - Communication of Updates: Updates will be communicated through various channels – including emails, Microsoft Teams channels, and internal broadcasts.

C. Malicious Software Protections:
    - Detection and Reporting: Training programs will include procedures for identifying, preventing, and reporting malicious software (malware), such as viruses, worms, and ransomware.
    - Preventative Measures: Workforce members will be trained in safe computer practices, including avoiding suspicious links, attachments, and downloads.

D. Monitoring and Reporting Log-In Attempts:
    - Log-In Monitoring: Training programs will include procedures for monitoring and reporting unauthorized or suspicious log-in attempts and access activities.

E. Password Management:
    - Creation and Maintenance: program will cover best practices for creating strong passwords, changing passwords regularly, and safeguarding passwords.

F. Evaluation, Improvement, and Documentation:
    - Continuous Improvement: The effectiveness of the security awareness training program will be evaluated regularly through assessments, feedback surveys, and testing. SCCMHA will use evaluation results to update and improve the training program as needed.

- Training Records: Documentation of training completion, including dates, participants, and topics covered, will be maintained.

Definitions:
See I.T./I.S. Policy **08.06.00.01** which contains a comprehensive list of relevant words and terms used within the Policies of this section.

References:
- The HIPAA Security Rule §164.308(a)(5)

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Conduct a Training Needs Assessment	
1. Determine SCCMHA's training needs, related to HIPAA Security and EPHI.	HIPAA Security Officer, Chief Information Officer & Chief Quality and Compliance Officer, IT Department, Continuing Education Supervisor
Develop and Approve a Training Strategy and a Plan	
2. Assess the specific HIPAA policies that require security awareness and training in the security awareness and training program	HIPAA Security Officer, Chief Information Officer & Chief Quality and Compliance Officer, IT Department, Continuing Education Supervisor
3. Outline the security awareness and training program; the scope of the security awareness and training program; the goals and various target audiences of the security awareness and training program; the learning objectives, the deployment methods, evaluation, and measurement techniques and the frequency of the training.	HIPAA Security Officer, Chief Information Officer & Chief Quality and Compliance Officer, IT Department, Continuing Education Supervisor

Protection from Malicious Software; Log-in Monitoring; and password Management	
4. As reasonable and appropriate, train members of the workforce regarding procedures for: • Guarding against, detecting, and reporting malicious software • Monitoring log-in attempts and reporting discrepancies; • Creating, changing, and safeguarding passwords	HIPAA Security Officer, Chief Information Officer & Chief Quality and Compliance Officer, IT Department, Continuing Education Supervisor
5. Incorporate information concerning workforce members' roles and responsibilities in implementing the HIPAA Security Rule standards into training and awareness efforts.	HIPAA Security Officer, Chief Information Officer & Chief Quality and Compliance Officer, IT Department, Continuing Education Supervisor
Develop Appropriate Awareness and Training Content, materials, and methods	
6. Select topics that may need to be included in the training materials	HIPAA Security Officer, Chief Information Officer & Chief Quality and Compliance Officer, IT Department, Continuing Education Supervisor
7. Incorporate new information from email advisories, online IT security daily news Web sites, and periodicals, as is reasonable and appropriate.	HIPAA Security Officer, Chief Information Officer & Chief Quality and Compliance Officer, IT Department, Continuing Education Supervisor
Training Implementation	
8. Schedule and conduct training outlined in the strategy and plan.	HIPAA Security Officer, Chief Information Officer & Chief Quality and Compliance Officer, IT Department, Continuing Education Supervisor

9. Implement reasonable techniques to disseminate the security messages to the organization, including newsletters, screensavers, email messages, teleconferencing sessions, staff meetings, and computer-based training.	HIPAA Security Officer, Chief Information Officer & Chief Quality and Compliance Officer, IT Department, Continuing Education Supervisor
Implement Security reminders	
10. Implement periodic security-reminder updates.	HIPAA Security Officer, Chief Information Officer & Chief Quality and Compliance Officer, IT Department, Continuing Education Supervisor
11. Provide periodic security updates to staff, business associates and contract providers.	HIPAA Security Officer, Chief Information Officer & Chief Quality and Compliance Officer, IT Department, Continuing Education Supervisor

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: HIPAA Security: Security Incident Procedures	**Chapter**: 08 – Management of Information	**Subject No**: 08.06.08.06
Effective Date: October 01, 2020	**Date of Review/Revision**: 9/13/22, 8/4/23, 9/9/24	**Approved By**: Sandra M. Lindsey, CEO
	Supersedes:	
SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		**Responsible Director:** AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer **Authored By**: AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer, Security Officer **Additional Reviewers**: Compliance & Policy Team, Matthew Briggs – Chief of Network Business Operations, Ben Pelkki – Senior Database & Microsoft 365 Administrator David Wolfcale, Systems, Information Security & Microsoft 365 Administrator

Purpose:
To ensure compliance with the HIPAA Security Rule, §164.308(a)(6) – Security Incident Procedures by establishing procedures for identifying, responding to, and documenting security incidents involving Protected Health Information (PHI).

Policy:
SCCMHA will implement and maintain comprehensive policies and procedures to effectively address and manage security incidents, ensuring that appropriate actions are taken to mitigate harm and comply with HIPAA requirements.

Application:
The HIPAA Security Rule and this Policy applies to SCCMHA, its business associates, and any subcontractor required to access or use PHI to complete its contracted duties. Business Associates and subcontractors may elect to adopt and comply with the relevant SCCMHA Policy or develop their own Policy and Procedure which complies with the applicable section of the HIPAA Security Rule.

Standards:
A. Incident Identification and Reporting:
- Detection Mechanism: SCCMHA will employ monitoring tools and techniques to identify potential security incidents, including unauthorized access, data breaches, and system malfunctions.
- Reporting Protocols: staff must promptly report any suspected or known security incidents to the designated HIPAA Security Officer.

B. Incident Response and Management:
- Immediate Response: Upon identification of a security incident, SCCMHA will initiate an immediate response to contain and mitigate the incident, including isolating affected systems and preventing further unauthorized access.
- Assessment and Analysis: The Security Officer or designated response team will assess the scope and impact of the incident, determining the extent of damage and potential exposure of PHI.
- Containment and Eradication: Steps will be taken to contain the incident, eradicate the root cause, and restore normal operations while ensuring that no further harm is caused to the system or data.

C. Mitigation of Harm:
- Impact Reduction: SCCMHA will implement measures to reduce the harmful effects of security incidents, such as notifying affected individuals, providing support, and offering credit monitoring services if necessary.
- Communication: The organization will communicate relevant information about the incident to affected parties, regulatory bodies, and other stakeholders as required by HIPAA and other applicable regulations.

D. Documentation and Reporting:
- Incident Documentation: Detailed records of each security incident, including the nature of the incident, response actions taken, and outcomes, will be maintained.
- Outcome Analysis: Documentation will include an analysis of the incident's impact, lessons learned, and recommendations for improving security measures and incident response procedures.
- Compliance Reporting: SCCMHA will comply with HIPAA's reporting requirements by notifying the Department of Health and Human Services (HHS) and other regulatory agencies as required and providing breach notifications to affected individuals.

E. Review, Improvement & Training:

- Incident Review: Each incident will be reviewed to assess the effectiveness of the response and identify any areas for improvement in policies, procedures, or training.
- Policy Updates: Based on incident reviews and evolving security threats, SCCMHA will update security incident procedures and related policies as necessary to enhance response capabilities and safeguard PHI.
- Training: Regular training updates will be provided to ensure that all relevant parties are aware of current procedures and best practices for incident management.

Definitions:
See I.T./I.S. Policy 08.06.00.01, which contains a full list of relevant words and terms used in this section's Policies.

References:
- The HIPAA Security Rule §164.308(a)(6)

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Determine Goals of Incident Response Determine how SCCMHA will respond to a security incident and establish a reporting mechanism and a process to coordinate responses to the security incident.	HIPAA Security Officer Senior Database & Microsoft 365 Administrator
Provide direct technical assistance, advise vendors to address product-related problems, and provide liaisons to legal and criminal investigative groups as needed.	HIPAA Security Officer, Chief Information Officer & Chief Quality and Compliance Officer, Chief of Network Business Operations, Senior Database & Microsoft 365 Administrator
Develop and Deploy an Incident Response Team or Other Reasonable and Appropriate Response Mechanism.	
Identify appropriate individuals to be a part of a formal incident response team.	HIPAA Security Officer, Chief Information Officer & Chief Quality

	and Compliance Officer, Senior Database & Microsoft 365 Administrator
Develop and Implement Procedures to Respond to and Report Security Incidents.	
Identify and respond to suspected or known security incidents; mitigate, to the extent practicable, harmful effects of security incidents known to SCCMHA; and document security incidents and their outcomes.	HIPAA Security Officer, Chief Information Officer & Chief Quality and Compliance Officer, Senior Database & Microsoft 365 Administrator
Document incident response procedures that can provide a single point of reference to guide the day-to-day operations of the incident response team.	HIPAA Security Officer, Chief Information Officer & Chief Quality and Compliance Officer, Senior Database & Microsoft 365 Administrator
Review incident response procedures with staff with roles and responsibilities related to incident response, solicit suggestions for improvements, and make changes to reflect input if reasonable and appropriate.	HIPAA Security Officer, Chief Information Officer & Chief Quality and Compliance Officer, Senior Database & Microsoft 365 Administrator
Incorporate Post-incident Analysis into Updates and Revisions.	
Measure effectiveness and update security incident response procedures to reflect lessons learned and identify actions to take that will improve security controls after a security incident.	HIPAA Security Officer, Chief Information Officer & Chief Quality and Compliance Officer, Senior Database & Microsoft 365 Administrator

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Security: Contingency Plan</td><td>Chapter: 08 – Management of Information</td><td>Subject No:
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<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td><td>Responsible Director:
AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer

Authored By:
AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer, Security Officer

Additional Reviewers:
Matthew Devos - Senior Network & Information Security Administrator,
Benjamin Pelkki, Senior Database & Microsoft 365 Administrator
David Wolfcale, Systems, Information Security & Microsoft 365 Administrator
Brett Lyon, Senior Applications, Information Security & BI Administrator</td></tr>
</table>

Purpose:
To ensure compliance with the HIPAA Security Rule, §164.308(a)(7) – Contingency Plan by establishing and implementing policies and procedures for responding to emergencies and other occurrences that could damage systems containing Electronic Protected Health Information (ePHI), ensuring the continuity and security of operations.

Policy:
SCCMHA will develop and maintain a comprehensive contingency plan to address emergencies and incidents such as fire, vandalism, system failures, and natural disasters that could impact systems containing ePHI. This plan is designed to safeguard ePHI, maintain business operations, and facilitate recovery.

Application:
The HIPAA Security Rule and this Policy applies to SCCMHA, its business associates, and any subcontractor required to access or use PHI to complete its contracted duties. Business Associates and subcontractors may elect to adopt and comply with the relevant SCCMHA Policy or develop their own Policy and Procedure which complies with the applicable section of the HIPAA Security Rule.

Standards:
A. Data Backup & Retrieval:
- Backup Procedures: SCCMHA will establish and implement procedures to create and maintain retrievable exact copies of EPHI. Regular backups will be performed and securely stored to ensure data integrity and availability as stated in SCCMHA Policy 08.06.40: Data Backup & Storage.
- Backup Storage: Backup copies will be stored in a secure location, separate from the primary data source, to protect against data loss due to physical damage or theft.

B. Data Restoration:
- Restoration Procedures: SCCMHA will establish procedures for restoring ePHI following any data loss incident. These procedures will ensure that data can be quickly and accurately restored from backups to minimize downtime and disruption.
- Restoration Testing: Regular tests will be conducted to verify the effectiveness of data restoration procedures and to ensure that backup copies are complete and functional.

C. Emergency Mode Operations:
- Critical Business Processes: SCCMHA will establish procedures to enable continuation of critical business processes during emergencies or system failures. This includes implementing temporary measures to protect the security of ePHI and maintain essential operations.

D. Testing & Revision:
- Contingency Plan Testing: SCCMHA will implement procedures for periodic testing of the contingency plan to ensure effectiveness and readiness. Testing will include simulations of various emergency scenarios and evaluation of response capabilities.
- Plan Revisions: The contingency plan will be reviewed and revised as needed based on test results, changes in business operations, technological advancements, and lessons learned from actual incidents.

E. Assessment of Criticality:
- Application and Data Assessment: SCCMHA will assess the criticality of specific applications and data to prioritize recovery efforts and resource

allocation during an emergency. This assessment will guide the development and implementation of contingency plan components.

- Impact Analysis: An analysis of the potential impact of data loss or system failure on critical business functions will be conducted to inform contingency planning and risk management strategies.

F. Communication and Training:

- Communication Plan: A communication plan will be established to ensure that all relevant parties, including employees, business associates, and subcontractors, are informed of contingency procedures and their roles during an emergency.
- Training: Regular training sessions will be conducted to familiarize staff with the contingency plan and their responsibilities in executing it. This training will include response procedures, data protection measures, and emergency contact information.

Definitions:
See I.T./I.S. Policy 08.06.00.01, which contains a full list of relevant words and terms used in this section's Policies.

References:

- The HIPAA Security Rule §164.308(a)(7)

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Develop Contingency Planning Policy	
1. Define SCCMHA's overall contingency objectives.	1. Information Security Team
2. Establish SCCMHA's framework, roles, and responsibilities for this area.	2. Information Security Team
3. Address scope, resource requirements, training, testing plan maintenance, and backup requirements	3. Senior Network & Information Security Administrator Information Security Team Chief Information Officer & Chief Quality and Compliance Officer
Conduct an Applications and Data Criticality Analysis	

4. Assess the relative criticality of specific applications and data in support of other Contingency Plan components.	4. Information Security Team Chief Information Officer & Chief Quality and Compliance Officer Team
5. Identify the activities and material involving EPHI that are critical to business operations.	5. Information Security Team Chief Information Officer & Chief Quality and Compliance Officer
6. Identify the critical services or operations, and the manual and automated processes that support them, involving EPHI.	6. Information Security Team Chief Information Officer & Chief Quality and Compliance Officer
7. Determine the amount of time that SCCMHA can tolerate disruption to these operations, material, or services (e.g., due to power outages).	7. Information Security Team Chief Information Officer & Chief Quality and Compliance Officer
8. Establish cost-effective strategies for recovering these critical services or processes.	8. Information Security Team Chief Information Officer & Chief Quality and Compliance Officer
Identify Preventive Measures	
9. Identify preventive measures for each defined scenario that could result in loss of a critical service operation involving the use of EPHI.	9. Senior Network & Information Security Administrator Information Security Team Chief Information Officer & Chief Quality and Compliance Officer
10. Ensure that preventive measures are practical and feasible in terms of their applicability in a given environment.	10. Senior Network & Information Security Administrator Information Security Team Chief Information Officer & Chief Quality and Compliance Officer Chief of Network Business Operations
Develop Recovery Strategy	
11. Finalize the set of contingency procedures that should be involved for all identified impacts, including emergency mode operations. The strategy must be adaptable to the existing operating	11. Senior Network & Information Security Administrator Information Security Team Chief Information Officer & Chief Quality and Compliance Officer Compliance & Policy Team

environment and address allowable outage times and associated priorities identified above.	Chief of Network Business Operations
12. Ensure, if part of the strategy depends on external organizations for support, that formal agreements are in place with specific requirements stated.	12. Chief of Network Business Operations
Data Backup Plan and Disaster Recovery Plan	
13. Establish and implement procedures to create and maintain retrievable exact copies of EPHI.	13. Senior Network & Information Security Administrator Information Security Team Chief Information Officer & Chief Quality and Compliance Officer
14. Establish (and implement as needed) procedures to restore any loss of data.	14. Senior Network & Information Security Administrator Information Security Team Chief Information Officer & Chief Quality and Compliance Officer
Develop and Implement an Emergency Mode Operation Plan	
15. Establish (and implement as needed) procedures to enable continuation of critical business processes for protection of the security of EPHI while operating in emergency mode.	15. Senior Network & Information Security Administrator Information Security Team Chief Information Officer & Chief Quality and Compliance Officer
Testing and revision Procedure	
16. Implement procedures for periodic testing and revision of contingency plans.	16. Senior Network & Information Security Administrator Information Security Team Chief Information Officer & Chief Quality and Compliance Officer
17. Test the contingency plan on a predefined cycle.	17. Senior Network & Information Security Administrator Information Security Team Chief Information Officer & Chief Quality and Compliance Officer
18. Train those with a defined plan of responsibilities in their roles.	18. Senior Network & Information Security Administrator Information Security Team

	Chief Information Officer & Chief Quality and Compliance Officer

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: HIPAA Security: Evaluation – Security Risk Assessment	**Chapter**: 08 – Management of Information	**Subject No**: 08.06.08.08
Effective Date: October 01, 2020	**Date of Review/Revision**: 9/14/22, 8/4/23, 9/9/24 **Supersedes**: 08.06.27	**Approved By**: Sandra M. Lindsey, CEO
		Responsible Director: AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer **Authored By**: AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer, Security Officer **Additional Reviewers**: Ben Pelkki – Senior Database & Microsoft 365 Administrator Matthew Devos, Senior Network Administrator David Wolfcale- Systems, Information Security & Microsoft 365 Administrator

Purpose:
To ensure compliance with the HIPAA Security Rule, §164.308(a)(8) – Security Incident Procedures by establishing and implementing procedures for periodic technical and non-technical evaluations of security risks. This policy aims to assess the effectiveness of SCCMHA's security measures and policies in protecting Electronic Protected Health Information (ePHI) and to adapt to changes in the environment or operation that may impact security.

Policy:
SCCMHA will conduct regular and comprehensive security risk assessments, encompassing both technical and nontechnical aspects, to evaluate the effectiveness of security policies and procedures in protecting ePHI. These assessments will be performed

based initially upon the standards set forth by the HIPAA Security Rule and subsequently in response to environmental or operational changes affecting the security of EPHI.

Application:
The HIPAA Security Rule, and this Policy, applies to SCCMHA, its business associates, and any subcontractor that is required to access or use PHI to complete its contracted duties. Business Associates and subcontractors may elect to adopt and comply with the relevant SCCMHA Policy or develop their own Policy and Procedure which complies with the applicable section of the HIPAA Security Rule.

Standards:
A. Risk Assessment Schedule:
- Initial Assessment: SCCMHA will perform an initial risk assessment to evaluate the current security posture against the standards of the HIPAA Security Rule.
- Periodic Reviews: Risk assessments will be conducted at least annually or more frequently if significant changes occur in the environment, operations, or security landscape.

B. Scope of Assessment:
- Technical Evaluation: This includes assessing the effectiveness of technical safeguards such as access controls, encryption, and system security configurations.
- Non-Technical Evaluation: This involves reviewing administrative and physical safeguards, such as policies, procedures, staff training, and facility security.

C. Assessment Methodology:
- Risk Identification: The assessment will identify potential security threats and vulnerabilities that could impact the confidentiality, integrity, or availability of EPHI.
- Risk Analysis: The likelihood and potential impact of identified risks will be analyzed to determine the level of risk and prioritize mitigation efforts.
- Control Evaluation: The effectiveness of existing security controls and measures will be evaluated to ensure they are adequate in addressing identified risks.

D. Response to Findings:
- Mitigation Strategies: Based on the assessment findings, SCCMHA will develop and implement strategies to mitigate identified risks and address any weaknesses in security controls.
- Policy and Procedure Updates: Security policies and procedures will be updated as necessary to reflect changes in risk levels, operational practices, and regulatory requirements.

E. Documentation and Reporting:
- Assessment Documentation: Detailed records of each risk assessment, including methodologies, findings, and actions taken, will be maintained.

- Reporting: Summary reports of risk assessments and remediation efforts will be provided to senior management and other relevant stakeholders as appropriate.

F. Continuous Improvement:
   - Feedback Mechanism: Feedback from risk assessments and security incidents will be used to improve security measures and assessment processes.
   - Review and Update: The risk assessment policy and procedures will be reviewed and updated regularly to ensure they remain effective and aligned with current security best practices and regulatory requirements.

Definitions:
See I.T./I.S. Policy **08.06.00.01** which contains a comprehensive list of relevant words and terms used within the Policies of this section.

References:
- The HIPAA Security Rule §164.308(a)(8)

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Determine Whether Internal or External Evaluation – Security Risk Assessment is Most Appropriate	
1. Decide whether the Evaluation – Security Risk Assessment will be conducted with internal staff resources or external consultants.	1. Chief Information Officer | Chief Quality and Compliance Officer
2. Engage external expertise to assist the internal Evaluation – Security Risk Assessment team where additional expertise to assist the internal Evaluation – Security Risk Assessment team where additional skills and expertise is determined to be reasonable and appropriate.	2. Chief Information Officer | Chief Quality and Compliance Officer
Develop Standards and Measurements for Reviewing All Standards and Implementation Specifications of the Security Rule	

3. Use an Evaluation – Security Risk Assessment strategy and tool that considers all elements of the HIPAA Security Rule and can be tracked, such as a questionnaire or checklist.	3. Chief Information Officer | Chief Quality and Compliance Officer Systems, Information Security & Microsoft 365 Administrator Senior Network Administrator Systems
4. Implement tools that can provide reports on the level of compliance, integration, or maturity of a particular security safeguard deployed to protect EPHI.	4. Chief Information Officer | Chief Quality and Compliance Officer Systems, Information Security & Microsoft 365 Administrator Senior Network Administrator Systems
5. Leverage any existing reports or documentation that may already be prepared by SCCMHA that may already be prepared by SCCMHA addressing compliance, integration, or maturity of a particular security safeguard deployed to protect EPHI.	5. Chief Information Officer | Chief Quality and Compliance Officer Systems, Information Security & Microsoft 365 Administrator Senior Network Administrator
Conduct Evaluation – Security Risk Assessment	
6. Determine, in advance, what departments and/or staff will participate in the Evaluation – Security Risk Assessment.	6. Chief Information Officer | Chief Quality and Compliance Officer Systems, Information Security & Microsoft 365 Administrator Senior Network Administrator
7. Collect and document all needed information. Collection methods may include the use of interviews, surveys, and outputs of automated tools, such as access control auditing tools, system logs, and results of penetration testing.	7. Chief Information Officer | Chief Quality and Compliance Officer Systems, Information Security & Microsoft 365 Administrator Senior Network Administrator
Documentation Results	
8. Document each Evaluation – Security Risk Assessment finding, remediation options and	8. Chief Information Officer | Chief Quality and Compliance Officer Systems, Information Security & Microsoft 365 Administrator

recommendations and remediation decisions.	Senior Network Administrator
9. Document known gaps between identified risks and mitigating security controls, and any acceptance of risk, including justification.	9. Chief Information Officer | Chief Quality and Compliance Officer Systems, Information Security & Microsoft 365 Administrator Senior Network Administrator Systems
10. Develop security program priorities and establish targets for continuous improvement.	10. Chief Information Officer | Chief Quality and Compliance Officer
Repeat Evaluation – Security Risk Assessments Periodically	
11. Establish the frequency of Evaluation – Security Risk Assessments, considering the sensitivity of the EPHI controlled by SCCMHA.	11. Chief Information Officer | Chief Quality and Compliance Officer
12. In addition to periodic Evaluation – Security Risk Assessments, consider repeating Evaluation – Security Risk Assessments when environmental and operational changes are made	12. Chief Information Officer | Chief Quality and Compliance Officer

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Security: Business Associate Agreements (BAAs) and Other Arrangements</td><td>Chapter: 08 – Management of Information</td><td>Subject No:
08.06.08.09</td></tr>
<tr><td rowspan="2">Effective Date:
10/1/20</td><td>Date of Review/Revision:
10/1/20, 7/3/23, 9/9/24</td><td rowspan="3">Approved By:
Sandra M. Lindsey, CEO

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Authored By:
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<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
To ensure compliance with the HIPAA Security Rule, §164.308(b) and §164.314(a)(1) – by establishing procedures for Business Associate Agreements (BAAs) and other Arrangements. This policy ensures that SCCMHA and its business associates adequately safeguard Electronic Protected Health Information (ePHI) and meet HIPAA requirements.

Policy:
SCCMHA will enter into Business Associate Agreements with any business associate before permitting them to create, receive, maintain, or transmit electronic protected health information on SCCMHA's behalf. SCCMHA must receive satisfactory assurances

(documented through a written agreement or other arrangement referred to as a Business Associate Agreement) that the business associate will appropriately safeguard the information as required by §164.314. If SCCMHA subcontractors use vendors that require access to PHI or ePHI, they too need to enter into business associate agreements with their subcontractors. In accordance with HIPAA (45 CFR 164.502(e)(1)) a business associate agreement is not required and does not apply to disclosures by a covered entity (e.g., SCCMHA) to a health care provider for treatment purposes.

Application:
The HIPAA Security Rule, and this Policy, applies to SCCMHA, its business associates, and any subcontractor that is required to access or use PHI to complete its contracted duties. Business Associates and subcontractors may elect to adopt and comply with the relevant SCCMHA Policy or develop their own Policies and Procedures which comply with the applicable section of the HIPAA Security Rule.

Standards:

1. Requirement for Business Associate Agreements:
    - Satisfactory Assurances: SCCMHA will only permit a Business Associate to handle ePHI if satisfactory assurances are obtained through a written Business Associate Agreement (BAA) that the business associate will appropriately safeguard the information in accordance with the HIPAA Security RuleExceptions: SCCMHA is not required to obtain such satisfactory assurances from a business associate that is a mental health service subcontractor.
2. Subcontractor Agreements:
    - Assurances for Subcontractors: A business associate may only allow a subcontractor to handle EPHI on its behalf only if the business associate obtains satisfactory assurances through a BAA with a subcontractor, in accordance with the HIPAA Security Rule §164.314(a).
3. Documenting Assurances:
    - Written Agreements: The satisfactory assurances required must be documented through a written agreement or other arrangement with the business associate that meets the applicable requirements of the HIPAA Security Rule §164.314(a).

        i. Incident Reporting: The BAA must include provisions requiring the business associate to report any security incident to SCCMHA, including breached of unsecured protected health information as required by §164.410
        ii. Subcontractor Requirements: The requirements of this policy also apply to the agreement or other arrangement between a business associate and a subcontractor consistent with HIPAA Security Rule § 164.308(b)(4).
4. Indemnification and Governing Law:
    - Indemnification: SCCMHA requires that Business Associate Agreements (BAAs) include indemnification provisions to protect SCCMHA from any

losses or damages resulting from the business associate's breach of agreement.
    - Governing Law: SCCMHA requests that Business Associate Agreements which involve SCCMHA specify that the State of Michigan is the governing law in the agreement, ensuring clarity on jurisdictional matters.
5. Review & Monitoring:
    - Regular Reviews: SCCMHA will periodically review BAAs to ensure compliance with HIPAA regulations and to address any necessary updates due to changes in regulation or operations.
    - Compliance Monitoring: SCCMHA will monitor business associates and subcontractors to ensure they adhere to the terms of the BAAs and effectively safeguard ePHI.

Definitions:
None

References:
- The HIPAA Security Rule §164.308(a)(8)(b)
- The HIPAA Security Rule §164.314

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Identify Entities that Are Business Associates under the HIPAA Security Rule	
1. Identify the individual or department who will be responsible for coordinating the execution of business associate agreements or other arrangements.	Chief Information Officer | Chief Quality and Compliance Officer , Contracts Manager, Director of Network Services, Public Policy & Continuing Ed
2. Periodically, and as necessary, reevaluate the list of business associates to determine who has access to EPHI in order to assess whether the list is complete and current.	Contracts Manager
Written Contract or Other Arrangements	

3. Document the satisfactory assurances required by this Policy through a written agreement or other arrangement with the business associate that meets the applicable requirements of section 164.314(a).	Contracts Manager
4. Execute new or update existing agreements or arrangements as appropriate.	Contracts Manager
5. Include security requirements in business associate agreements to address confidentiality, integrity, and availability of EPHI.	Contracts Manager
6. Specify any training requirements associated with the agreement or other arrangement, if reasonable and appropriate.	Contracts Manager
Establish Process for Measuring Agreement Performance and Terminating the Agreement if Security Requirements are Not Being Met	
7. Maintain clear lines of communication with business associates.	Contracts Manager, Continuing Education Supervisor
8. Conduct periodic security reviews of business associates.	Contracts Manager
9. Establish criteria for measuring agreement performance of business associates.	Security Officer, Contracts Manager, Director of Network Services, Public Policy & Continuing Ed
10. Agreements must provide that Business Associates adequately protect EPHI.	Security Officer, Contracts Manager, Director of Network Services, Public Policy & Continuing Ed

11. Agreements must provide that Business Associate's Agents adequately protect EPHI.	Security Officer, Contracts Manager, Contracts Manager
12. Agreements must provide that Business Associates will report security incidents.	Security Officer, Contracts Manager, Director of Network Services, Public Policy & Continuing Ed Security Officer, Contracts Manager
13. Agreements must provide that Business Associates will authorize termination of the Agreement if it has been materially breached.	Security Officer, Contracts Manager, Director of Network Services, Public Policy & Continuing Ed Security Officer, Contracts Manager

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Security: Facility Access Controls</td><td>Chapter: 08 – Management of Information</td><td>Subject No: 08.06.10.01</td></tr>
<tr><td rowspan="2">Effective Date: October 01, 2020</td><td>Date of Review/Revision: 9/15/22, 8/4/23, 9/9/24</td><td rowspan="3">Approved By: Sandra M. Lindsey, CEO</td></tr>
<tr><td>Supersedes:</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
<tr><td colspan="2"></td><td>Responsible Director: AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer

Authored By: AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer, Security Officer

Additional Reviewers: Fred Stahl – Director of Human Resources / Transportation / Facilities, Melissa Gutzwiller, Director of Environmental Services, Customer Service and Security</td></tr>
</table>

Purpose:
To ensure compliance with the HIPAA Security Rule, §164.310(a) – Facility Access Controls, and to protect the integrity and confidentiality of electronic information systems and facilities housing such systems.

Policy:
SCCMHA will implement comprehensive policies and procedures to limit physical access to its electronic information systems and facilities, while ensuring that authorized access is granted according to established criteria. These procedures will protect against unauthorized access, tampering and theft.

Application:
The HIPAA Security Rule and this Policy applies to SCCMHA, its business associates, and any subcontractor required to access or use PHI to complete its contracted duties. Business Associates and subcontractors may elect to adopt and comply with the relevant

SCCMHA Policy or develop their own Policies and Procedures which comply with the applicable section of the HIPAA Security Rule.

Standards:

A. Contingency Operations:
   - Disaster Recovery Access: Establishment and implementation of procedures that allow facility access to restore lost data under the disaster recovery plan and emergency mode operations.
   - Emergency Contacts: A list of authorized personnel who can access the facility during emergencies will be maintained, and SCCMHA will ensure the authorized personnel are trained in the emergency access procedures.

B. Facility Security Plan:
   - Physical Security Measures: Implementation and maintenance of security measures to safeguard the facility, including physical barriers (i.e. walls, doors, locks), surveillance systems (i.e. cameras), and alarm systems.
   - All individuals must use their assigned access badge to enter secured areas within SCCMHA. Tailgating (where an unauthorized person follows an authorized person into a secure area) is prohibited and will be monitored to ensure compliance.
   - Access Controls: Procedures will be developed and implemented for granting, modifying, and revoking physical access to the facility. Ensure access is restricted to authorized personnel based on their roles and responsibilities.
      i. Areas that require special access controls:
         1. Server Rooms
         2. IT Offices & Areas
         3. Data Centers
   - Security Audits: Regular security audits to identify vulnerabilities and ensure that physical security measures are effective.

C. Badge Use & Requirements:
   - All individuals must present their access badge at the door reader to gain entry.
   - Badges must be worn visibly at all times while on SCCMHA premises.

D. Access Control and Validation Procedures:
   - Access Authorization: Defined and implemented procedures for authorizing access to facilities based on role, function, and necessity. This includes a formal process for requesting and approving access.
   - Doors equipped with access control systems must be opened using the individual's access badge. The system will log each access attempt, including date, time, and badge ID.
   - Visitor Management**:** Implement visitor control procedures, including registration, identification, and escorting policies. Ensure visitors are only allowed access to areas necessary for their visit.
   - Testing and Revision Access: Control access to areas and systems used for testing and revisions. Ensure that such access is strictly managed and monitored.

E. Maintenance Records:
    - Documentation: Comprehensive policies and procedures to document repairs and modifications to the physical components of a facility which are related to security, including changes to physical components (for example, hardware, walls, doors, and locks) will be implemented.

F. Access Control Monitoring:
    - Access Logs: Implement and maintain logs for all facility access, including entry and exit times, personnel involved, and reasons for access. Regularly review these logs to detect and respond to unauthorized access.
    - Surveillance: Use surveillance systems to monitor activity within and around the facility. Ensure that surveillance footage is stored securely and is accessible for review as needed by authorized personnel.

G. Training and Awareness:
    - Employee Training: Provide regular training to employees on facility access procedures, security measures, and emergency protocols. Ensure that staff understand their roles and responsibilities in maintaining facility security.
    - Security Awareness: Promote awareness of facility security policies and procedures among all personnel, emphasizing the importance of protecting EPHI and maintaining physical security.

H. Reporting & Incident Response:
    - Incident Management**:** Develop and implement procedures for responding to security incidents related to facility access. This includes investigating, documenting, and addressing incidents of unauthorized access or tampering.
    - Special Access Areas: To ensure the integrity and security of our facilities, it is crucial that access is strictly controlled and monitored. If an area that requires special access controls (i.e. Server Rooms, Data Centers, and IT areas) are found unattended or lacking an authorized individual, it constitutes a serious security violation. Such situations could potentially expose our sensitive systems and data to unauthorized access or tampering.
    - Reporting Security Violations:
        i. If you observe any of the following scenarios, please report them to the CIO office immediately.
            - Unattended Server Room: The server room is found open or left unattended without an authorized IT staff member present.
            - Unauthorized Access: Individuals who are not authorized IT personnel are present in the server room without proper supervision or clearance.
            - Security Protocols Breach: Any breach in established security protocols regarding server room access and monitoring.
            - Tailgating: Staff should report any observed instances of tailgating to the HIPAA Security Officer.
    - Timely reporting of such violations is critical in maintaining the security of our network and protecting our organizational assets.

Responsibilities

- Security Personnel: Monitor access control systems, investigate incidents of tailgating, and enforce policy compliance.
- Employees and Contractors: Adhere to badge usage requirements, report security incidents, and ensure compliance with access control procedures.
- Management: Support the implementation and enforcement of this policy and ensure all personnel receive proper training.

Definitions:
See I.T./I.S. Policy 08.06.00.01, which contains a full list of relevant words and terms used in this section's Policies.

References:

- The HIPAA Security Rule §164.310(a)

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Conduct an Analysis of Existing Physical Security Vulnerabilities	
1. Inventory facilities and identify shortfalls and/or vulnerabilities in current physical security capabilities.	Director or Environmental Services, Customer Service and Security
2. Assign degrees of significance to each vulnerability identified and ensure that proper access is allowed.	Director or Environmental Services, Customer Service and Security Chief Information Officer & Chief Quality and Compliance Officer
3. Determine which types of facilities require access controls to safeguard EPHI, such as: • Data Centers • Peripheral equipment locations • IT staff offices • Workstation locations	Director of Environmental Services, Customer Service and Security
Identify Corrective Measures	

4. Identify and assign responsibilities for the measures and activities necessary to correct deficiencies and ensure that proper access is allowed.	Director of Environmental Services, Customer Service and Security
5. Develop and deploy policies and procedures to ensure that repairs, upgrades, and/or modifications are made to the appropriate physical areas of the facility while ensuring that proper access is allowed.	Director of Environmental Services, Customer Service and Security
Develop a Facility Security Plan	
6. Implement policies and procedures to safeguard the facility and the equipment therein from unauthorized physical access, tampering, and theft.	Director of Environmental Services, Customer Service and Security
7. Implement appropriate measures to provide physical security protection for EPHI in SCCMHA's possession.	Director of Environmental Services, Customer Service and Security
8. Include documentation of the SCCMHA inventory, information about the physical maintenance records and the history of changes, upgrades, and other modifications.	Director of Environmental Services, Customer Service and Security
9. Identify points of access to the facility and existing security controls.	Director of Environmental Services, Customer Service and Security
Develop Access Control and Validation Procedures	
10. Implement procedures to control and validate a person's access to facilities based on their role or location, including visitor control, and control of access to software programs for testing and revision.	Director of Environmental Services, Customer Service and Security

11. Implement procedures to provide facility access to authorized personnel and visitors and exclude unauthorized persons.	Director of Environmental Services, Customer Service and Security
Establish Contingency Operations Procedures	
12. Establish (and implement as needed) procedures that allow facility access in support of restoration of lost data under the Disaster Recovery Plan and Emergency Mode Operations Plan in the event of an emergency.	Director of Environmental Services, Customer Service and Security
Maintain Maintenance Records	
13. Implement policies and procedures to document repairs and modifications to a facility's physical components related to security (for example, hardware, walls, doors, and locks).	Director of Environmental Services, Customer Service and Security

<table>
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Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: HIPAA Security: Device and Media Transport & Disposal</td><td>Chapter: 08 – Management of Information</td><td>Subject No:
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08.06.39</td><td rowspan="2">Approved By:
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Authored By:
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<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
</table>

Purpose:
To ensure compliance with the HIPAA Security Rule, §164.310(d) – Workstation Use, and to protect electronic protected health information (EPHI), this policy governs the receipt, removal, and movement of hardware and electronic media containing EPHI within and outside SCCMHA facilities.

Policy:
SCCMHA will implement comprehensive policies and procedures that govern the movement, receipt, storage, and removal of hardware and electronic media that contain electronic protected health information (ePHI) All activities involving these items will be tracked, logged, and managed to ensure the protection and security of ePHI.

Application:

The HIPAA Security Rule and this Policy applies to SCCMHA, its business associates, and any subcontractor required to access or use PHI to complete its contracted duties. Business Associates and subcontractors may elect to adopt and comply with the relevant SCCMHA Policy or develop their own Policies and Procedures which comply with the applicable section of the HIPAA Security Rule.

Standards:

1. Tracking & Logging:
    - Movement Tracking: All movement of SCCMHA information systems and electronic media containing EPHI into and out of its facilities must be tracked and logged. Those responsible for such movement must take all appropriate and reasonable actions to protect EPHI. This includes both EPHI received by SCCMHA and created within SCCMHA.

2. Authorization and Documentation:
    - Authorization Requirement: all uses or movement of information system or electronic media containing EPHI outside SCCMHA's premises must be authorized by appropriate SCCMHA management. Such authorization must be tracked and logged.
    - Documentation Details: At a minimum, such tracking and logging must provide the following information:
        - Date and time of movement of system or media
        - Brief description of person using or sending EPHI on system or media
        - Brief description of where EPHI is to be sent or how used
        - Name of person authorizing such transaction

3. Protection and Responsibility:
    - Employee Responsibility: employees and associates must ensure that electronic media or information systems containing EPHI are protected against damage, theft, and unauthorized access during movement. This includes securing the items physically and logically.

4. Data Backup and Storage:
    - Pre-Movement Backup: Before moving equipment containing PHI, ensure that a retrievable, exact copy of electronic protected health information will be created and stored securely.
    - Backup Security: backups must be encrypted and stored in a secure location that meets SCCMHA's security requirements.

5. Disposal Procedures:
    - Final Disposition: Implementation of procedures for the secure disposal of ePHI and any hardware or electronic media that stored ePHI. This includes data wiping, physical destruction, or other secure methods of disposal.

- Documentation: Document the disposal process, including details of the destruction and individual responsible for overseeing it.

6. Media Reuse:
    - Data Removal: Before electronic media is made available for reuse, ensure that EPHI is completely removed using approved methods such as data wiping or physical destruction.
    - Verification: Verify that no recoverable EPHI remains on the media before it is repurposed.
7. Encryption and Security Measures:
    - Encryption Standards: Implement encryption for EPHI stored on electronic media, both in transit and at rest, to protect against unauthorized access.
    - Security Protocols: Follow industry best practices for securing electronic media during transport and while stored.
8. Accountability and Record Keeping:
    - Movement Records: A record will be maintained of the movements of hardware and electronic media and the identity of responsible individuals.
    - Access to Records: Ensure that records are accessible to authorized personnel for review and auditing purposes.
9. Training & Awareness:
    - Employee Training: Provide regular training to SCCMHA workforce members on the procedures for handling, moving, and disposing of EPHI-containing hardware and electronic media.
    - Awareness Programs: Implement awareness programs to reinforce the importance of data protection and adherence to policies.
10. Compliance Monitoring:
    - Audits: Conduct periodic audits to ensure compliance with this policy and identify any areas for improvement.
    - Reporting: Establish a reporting mechanism for any incidents or deviations from policy and address them promptly.

Responsibilities:

- **IT Department:** Oversees the implementation of encryption, backup procedures, and secure storage. Manages tracking, logging, and authorization processes.
- **HIPAA Privacy and HIPAA Security Officers:** Ensures adherence to HIPAA regulations and SCCMHA's policies. Reviews and audits compliance.
- **All Employees:** Follow procedures for handling, moving, and disposing of hardware and electronic media containing EPHI. Participate in training and adhere to security measures.

Definitions:
See I.T./I.S. Policy 08.06.00.01, which contains a full list of relevant words and terms used in this section's Policies.

References:

- The HIPAA Security Rule §164.310(d)

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Implement Methods for Final Disposal of EPHI	
1. Implement policies and procedures to address the final disposition of EPHI and/or the hardware or electronic media on which it is stored.	• Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist
2. Determine and document the appropriate methods to dispose of hardware, software, and the data itself.	• Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist
3. Assure the EPHI is properly destroyed and cannot be recreated.	• Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist Help Desk, Network, Information and Desktop Support.
Develop and Implement Procedures for Reuse of Electronic Media	
4. Implement procedures for removal of EPHI from electronic media before the media are made available for reuse.	• Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist.
5. Ensure that EPHI previously stored on electronic media cannot be accessed and reused.	• Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist Help Desk, Network, Information and Desktop Support.
6. Identify removable media and their use.	• Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist Help Desk, Network, Information and Desktop Support.

7. Ensure that EPHI is removed from reusable media before they are used to record new information.	Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist Help Desk, Network, Information and Desktop Support.
Maintain Accountability for Hardware and Electronic Media	
8. Maintain an inventory and record of the movements of hardware and electronic media and any person responsible for such movement.	• Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist Help Desk, Network, Information and Desktop Support.
9. Ensure that EPHI is not inadvertently released or shared with any unauthorized party.	• Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist Help Desk, Network, Information and Desktop Support.
10. Ensure that an individual is responsible for, and records the receipt and removal of, hardware and software which contains EPHI.	• Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist Help Desk, Network, Information and Desktop Support.
Develop Data Backup and Storage Procedures	
11. Ensure that a retrievable exact copy of EPHI is created when needed before movement of equipment.	• Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist Help Desk, Network, Information and Desktop Support.
12. Ensure that an exact retrievable copy of the data is retained and protected to protect the integrity of EPHI during equipment relocation.	• Senior Systems and Applications Administrator & Inventory Management and Mobile Device Specialist Help Desk, Network, Information and Desktop Support.

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: HIPAA Security: Audit Controls	**Chapter**: 08 – Management of Information	**Subject No**: 08.06.12.02
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SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		**Responsible Director:** AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer **Authored By**: AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer; Security Officer **Additional Reviewers**: Brett Lyon, Senior Applications, Information Security & BI Administrator Ben Pelkki, Senior Database & Microsoft 365 Administrator Compliance & Policy Team David Wolfcale, Systems, Information Security & Microsoft 365 Administrator Matthew Devos, Senior Network & Information Security Administrator

Purpose:
To ensure compliance with the HIPAA Security Rule, §164.312(b) – by establishing and implementing Audit Controls that record and examine activities within information systems containing or using Electronic Protected Health Information (ePHI). This policy

aims to protect ePHI by providing mechanisms to monitor, detect, and respond to security incidents and ensure proper handling of sensitive information.

Policy:
SCCMHA will implement and maintain hardware, software, and/or procedural mechanisms to record, monitor, and examine activity within information systems that contain or use electronic protected health information (ePHI). These audit controls will be designed to support the integrity, confidentiality, and availability of ePHI by providing detailed tracking and analysis capabilities.

Application:
The HIPAA Security Rule and this Policy applies to SCCMHA, its business associates, and any subcontractor required to access or use PHI to complete its contracted duties. Business Associates and subcontractors may elect to adopt and comply with the relevant SCCMHA Policy or develop their own Policies and Procedures which comply with the applicable section of the HIPAA Security Rule.

Standards:

1. Scope of Audit Controls:
    - Risk Assessment: SCCMHA will determine the scope of audit controls required based on a comprehensive risk assessment. This assessment will consider the sensitivity of ePHI, potential threats, vulnerabilities, and an overall impact on information security.
    - Organizational Factors: The scope will also account for organizational factors, including system architecture, data flow, and compliance requirements.
2. Audit Mechanisms:
    - Hardware & Software: SCCMHA will deploy appropriate hardware and software solutions to facilitate the recording and examination of activities related to ePHI. This includes implementing audit trails, logging mechanisms, and monitoring tools.
    - Procedural Control: In addition to technical measures, procedural controls will be established to ensure that audit data is reviewed regularly, anomalies are investigated, and appropriate responses are taken.
3. Responsibility and Management:
    - Information Systems (IS) Department: The SCCMHA Information Systems (I.S.) department is responsible for the installation, configuration, and maintenance of audit control mechanisms. This includes ensuring that hardware, software, and related services are properly implemented and functioning as intended.
    - Regular Updates: The I.S. department will ensure that audit controls are regularly updated to address evolving threats and changes in the information system environment.

4. Monitoring and Reporting:
    - Activity Monitoring: SCCMHA will continuously monitor activities within information systems to detect and respond to potential security incidents. This includes reviewing logs and audit trails for suspicious or unauthorized actions.
    - Incident Reporting: Any discrepancies, anomalies, or potential security incidents identified through audit controls will be reported to the appropriate personnel for investigation and remediation.
5. Review and Compliance:
    - Periodic Review: Audit control mechanisms and their effectiveness will be reviewed periodically to ensure they remain effective and aligned with HIPAA requirements. This includes assessing the adequacy of logging, monitoring, and reporting practices.
    - Compliance Checks: SCCMHA will conduct regular compliance checks to verify that audit controls meet the standards set by the HIPAA Security Rule and other applicable regulations.
6. Training and Awareness:
    - Staff Training: All relevant staff will receive training on the importance of audit controls, how to interpret audit logs, and their role in maintaining the security of EPHI.
    - Ongoing Education: Continuous education and updates will be provided to keep staff informed about new audit control technologies and practices.

Definitions:
See I.T./I.S. Policy 08.06.00.01, which contains a full list of relevant words and terms used in this section's Policies.

References:
- The HIPAA Security Rule §164.312(b)

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Determine the Activities that Will Be Tracked or Audited	
1. Determine the appropriate scope of audit controls that will be necessary	Chief Information Officer, Compliance & Policy Team

in information systems that contain or use EPHI based on SCCMHA's risk assessment and other organizational factors.	
2. Determine what data needs to be captured.	Chief Information Officer, Compliance & Policy Team
Select the Tools that Will Be Deployed for Auditing and System Activity Reviews	
3. Evaluate existing system capabilities and determine if any changes or upgrades are necessary.	Senior Applications, Information Security & BI Administrator Senior Database & Microsoft 365 Administrator
Develop and Deploy the Information System Activity Review/Audit Policy	
4. Document and communicate to the workforce the facts about the organization's decisions on audits and reviews.	Compliance & Policy Team Systems, Information Security & Microsoft 365 Administrator Chief Information Officer, Compliance & Policy Team
Implement the Audit/System Activity Review Process	
5. Activate the necessary audit system.	Senior Applications, Information Security & BI Administrator Senior Database & Microsoft 365 Administrator Compliance & Policy Team Systems, Information Security & Microsoft 365 Administrator
6. Perform logging and auditing procedures.	Senior Applications, Information Security & BI Administrator Senior Database & Microsoft 365 Administrator Compliance & Policy Team Systems, Information Security & Microsoft 365 Administrator

<table>
<tr><td colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: HIPAA Security: Integrity</td><td>Chapter: 08 – Management of Information</td><td>Subject No:
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<tr><td rowspan="2">Effective Date:
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Sandra M. Lindsey, CEO</td></tr>
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<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td><td>Responsible Director:
AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer

Authored By:
AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer, Security Officer

Additional Reviewers:
Brett Lyon, Senior Applications, Information Security & BI Administrator
Matthew Devos, Senior Network & Information Security Administrator
David Wolfcale, Systems Information Security & Microsoft 365 Administrator</td></tr>
</table>

Purpose:
To assure compliance with the HIPAA Security Rule, §164.312(c) – workstation use by establishing procedures to protect Electronic Protected Health Information (EPHI) from unauthorized alteration or destruction. This policy aims to maintain the integrity and confidentiality of EPHI in workstation environments.

Policy:
SCCMHA will implement comprehensive procedures and technical controls to ensure protection of EPHI from unauthorized alteration or destruction at workstations. These measures will include electronic mechanisms and physical safeguards to maintain the integrity and security of ePHI.

Application:
The HIPAA Security Rule and this Policy applies to SCCMHA, its business associates, and any subcontractor required to access or use PHI to complete its contracted duties. Business Associates and subcontractors may elect to adopt and comply with the relevant SCCMHA Policy or develop their own Policies and Procedures which comply with the applicable section of the HIPAA Security Rule.

Standards:

A. Electronic Mechanisms:
    - Access Controls: Implement and maintain electronic access controls to restrict access to workstations where ePHI is created, received, maintained, or transmitted. Access to these workstations will be limited to authorized personnel only.
    - Audit Trails: Utilize audit trails and logging mechanisms to monitor and record activities related to EPHI. These logs will be regularly reviewed to detect any unauthorized access or alterations.
    - Data Integrity Checks: Implement electronic mechanisms to verify the integrity of EPHI. This includes using hash functions or checksums to detect any unauthorized changes or corruption of data.

B. Physical Safeguards:
    - Workstation Security: Ensure that physical workstations are secured to prevent unauthorized access. This includes locking devices when not in use and using secure locations for storing devices containing EPHI.
    - Environmental Controls: Protect workstations from environmental hazards that could impact EPHI, such as fire, water damage, or physical tampering. Use physical barriers and environmental controls to mitigate these risks.

C. Procedural Controls:
    - User Training: Provide training to all staff on the proper use of workstations and the importance of protecting EPHI. This includes instructions on how to handle and safeguard EPHI, as well as recognizing and reporting potential security incidents.
    - Incident Response: Establish procedures for responding to and investigating incidents of suspected unauthorized alteration or destruction of EPHI. This includes identifying the cause, mitigating any damage, and implementing corrective actions.

D. Monitoring and Compliance:
    - Regular Audits: Conduct regular audits of workstation use and security measures to ensure compliance with this policy and HIPAA requirements. Audit findings will be used to enhance and improve security practices.
    - Compliance Checks: Regularly verify that electronic and physical controls are functioning correctly and that procedures are being followed. Address any issues or deficiencies identified during these checks.

Definitions:

See I.T./I.S. Policy 08.06.00.01, which contains a full list of relevant words and terms used in this section's Policies.

References:

- The HIPAA Security Rule §164.312(c)

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Identify All Users Who Have Been Authorized to Access EPHI	
1. Identify all approved users with the ability to alter or destroy data, if reasonable and appropriate.	Senior Applications, Information Security & BI Administrator Senior Network & Information Security Administrator HIPAA Security Officer
2. Address this identification in conjunction with the identification of unauthorized sources (see below) that may be able to intercept the information and modify it.	Senior Applications, Information Security & BI Administrator Senior Network & Information Security Administrator
Identify Any Possible Unauthorized Sources that May Be Able to Intercept the Information and Modify It	
3. Identify scenarios that may result in modification to the EPHI by unauthorized sources (e.g., hackers, disgruntled employees, business competitors).	Senior Applications, Information Security & BI Administrator Senior Network & Information Security Administrator
4. Conduct this activity as part of the risk analysis.	Senior Applications, Information Security & BI Administrator Senior Network & Information Security Administrator HIPAA Security Officer
Develop the Integrity Policy and Requirements	

5. Establish a formal (written) set of integrity requirements based on the results of the analysis completed in the previous steps.	Senior Applications, Information Security & BI Administrator Senior Network & Information Security Administrator HIPAA Security Officer
Implement Procedures to Address These Requirements	
6. Identify and implement methods that will be used to protect the information from modification.	Senior Applications, Information Security & BI Administrator Senior Network & Information Security Administrator HIPAA Security Officer
7. Identify and implement tools and techniques to be developed or procured that support the assurance of integrity.	Senior Applications, Information Security & BI Administrator Senior Network & Information Security Administrator HIPAA Security Officer
Implement a Mechanism to Authenticate EPHI	
8. Implement electronic mechanisms to verify that EPHI has not been altered or destroyed unauthorizedly.	Senior Applications, Information Security & BI Administrator Senior Network & Information Security Administrator HIPAA Security Officer
9. Consider possible electronic mechanisms for authentication such as: • Error-correcting memory • Magnetic disk storage • Digital signatures • Check some technology.	Senior Applications, Information Security & BI Administrator Senior Network & Information Security Administrator HIPAA Security Officer
Establish a Monitoring Process to Assess How the Implemented Process Is Working	
10. Review existing processes to determine if objectives are being addressed.	Senior Applications, Information Security & BI Administrator Senior Network & Information Security Administrator

	HIPAA Security Officer
11. Reassess integrity processes continually as technology and operational environments change to determine if they need to be revised.	Senior Applications, Information Security & BI Administrator Senior Network & Information Security Administrator HIPAA Security Officer

<table>
<tr><td colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</td></tr>
<tr><td>Subject: HIPAA Security: Person or Entity Authentication</td><td>Chapter: 08 – Management of Information</td><td>Subject No:
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<tr><td>Effective Date:
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Sandra M. Lindsey, CEO</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td><td>Responsible Director:
AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer

Authored By:
AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer, Security Officer

Additional Reviewers:
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Chad Revell, Inventory Management and Mobile Device Specialist
Ben Pelkki, Senior Database & Microsoft 365 Administrator
Brett Lyon, Senior Applications, Information Security & BI Administrator
David Wolfcale, Systems, Information Security & Microsoft 365 Administrator</td></tr>
</table>

Purpose:
To ensure compliance with the HIPAA Security Rule, §164.312(d) – Person or Entity Authentication by establishing procedures to verify the identity of individuals and entities

seeking access to Electronic Protected Health Information (ePHI) and to safeguard against unauthorized access.

Policy:
SCCMHA will implement and maintain procedures to authenticate the identity of person or entities seeking access to EPHI. This includes using secure authentication mechanisms to ensure that access is granted only to authorized individuals and entities.

Application:
The HIPAA Security Rule and this Policy applies to SCCMHA, its business associates, and any subcontractor required to access or use PHI to complete its contracted duties. Business Associates and subcontractors may elect to adopt and comply with the relevant SCCMHA policy or develop their own policies and procedures which comply with the applicable section of the HIPAA Security Rule.

Standards:
A. Authentication Mechanisms:
    - Username & Passwords: To log into any Information Systems that are managed and administered by SCCMHA's Information Technology Department, the following is required:
        - Unique username: Each user must be assigned a unique username to track and manage their access.
        - Password Complexity: Passwords must meet complex requirements, including a minimum length, the inclusion of uppercase and lowercase letters, numbers, and special characters. Passwords must be changed regularly.
        - Multifactor Authentication (MFA): MFA must be integrated into the login process for accessing EPHI and other sensitive systems.
B. Credential Management:
    - Prohibition of Sharing: Users will NEVER use another person's logon credentials. Each individual is responsible for their own credentials and must ensure they are not disclosed or used by unauthorized persons.
    - Account Compromise: If a user's credentials are suspected to be compromised, the user's account will be disabled immediately, and the user's password will be reset. The IT department will investigate the compromise, and the user's account will only be re-enabled once the issue is resolved, and the user's identity is confirmed.
C. Provisioning and Deactivation:
    - Access Provisioning: User's will be provisioned, and system access credentials will be provided by a member of the IT department when:
        - Human Resources notifies the IT department.
        - A Helpdesk ticket is created requesting activation.
        - Approval has been granted by the authorized MT member or Department Director
        - All required information has been submitted to establish and validate user access, including role and access level.

- Account Deactivation: Access rights will be promptly revoked for users who leave the organization or no longer require access. The IT department will manage deactivation in accordance with HR policies and procedures regarding termination or change of employment status.

D. Authentication Policy Enforcement:
   - Policy Adherence: Users must acknowledge and comply with authentication policies during onboarding and periodic security training. Non-compliance with authentication requirements may result in disciplinary action.
   - Auditing and Monitoring: Authentication logs will be maintained and reviewed regularly to detect any unauthorized access attempts or anomalies.

E. Incident Management:
   - Incident Reporting: Users must report any suspected or actual breaches of their authentication credentials immediately to the IT Department.
   - Incident Investigation: The IT Department will investigate incidents of credential compromise, including determining the impact and taking appropriate corrective actions to prevent recurrence.

Responsibilities:
- IT Department: Responsible for implementing and managing authentication mechanisms, provisioning and deactivating credentials, monitoring authentication logs, and investigating incidents.
- Human Resources: Responsible for notifying IT of new hires, terminations, and changes in employment status affecting access.

Definitions:
See I.T./I.S. Policy 08.06.00.01, which contains a full list of relevant words and terms used in this section's Policies.

References:
- The HIPAA Security Rule §164.312(d)

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Determine Authentication Applicability to Current Systems/Applications	
1. Identify methods available for authentication. Under the HIPAA Security Rule, authentication is the corroboration that a person is the one claimed. (45 CFR § 164.304).	1. IT Department's Information Security Team Chief Information Officer & Chief Quality and Compliance Officer

Authentication requires establishing the validity of a transmission source and/or verifying an individual's claim that he or she has been authorized for specific access privileges to information and information systems.	
Evaluate Authentication Options Available	
2. Weigh the relative advantages and disadvantages of commonly used authentication approaches. There are four commonly used authentication approaches available: • Something a person knows, such as a password, • Something a person has or is in possession of, such as a token (smart card, ATM card, etc.), • Some type of biometric identification a person provides, such as a fingerprint, or • A combination of two or more of the above approaches.	2. IT Department's Information Security Team Chief Information Officer & Chief Quality and Compliance Officer
Select and Implement Authentication Option	
3. Consider the results of the analysis conducted regarding the authentication options, select appropriate authentication methods, and implement the methods selected into SCCMHA's operations and activities.	3. IT Department's Information Security Team Chief Information Officer & Chief Quality and Compliance Officer
Network Access	
4. System Access will be granted upon proper approval process and the submission of a Helpdesk	4. IT Department's Network & Helpdesk Teams

ticket. User credentials will be provided to that user and no others.	
5. Passwords will be reset upon notice to the IT Helpdesk.	5. IT Department's Clinical Applications & Helpdesk Teams
Sentri EHR (Electronic Health Record)	
6. System Access will be granted upon proper approval process and the submission of a Helpdesk ticket. User credentials will be provided to that user and no others.	6. IT Department's Network & Helpdesk Teams
7. When Access has been granted, the IS staff will send an email to the staff with a cc: to the responsible HIPPA privacy officer, the user's supervisor, SCCMHA's training department, SCCMHA's auditing department and the staff that is requesting access.	7. IT Department's Network & Helpdesk Teams
8. The first logon will require the staff to change their password, no exception.	8. IT Department's Network & Helpdesk Teams
9. System Access will be granted upon proper approval process and the submission of a Helpdesk ticket. User credentials will be provided to that user and no others.	9. IT Department's Network & Helpdesk Teams

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Security: Transmission Security</td><td>Chapter: 08 – Management of Information</td><td>Subject No:
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Sandra M. Lindsey, CEO</td></tr>
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<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td><td>Responsible Director:
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Additional Reviewers:
Matt Devos, Network & Information Systems Administrator
Brett Lyon, Senior Applications, Information Security & BI Administrator
Ben Pelkki, Senior Database & Microsoft 365 Administrator
David Wolfcale, Systems, Information Security & Microsoft 365 Administrator</td></tr>
</table>

Purpose:
To ensure compliance with the HIPAA Security Rule, §164.312(e) – Transmission Security, by implementing measures to protect electronic protected health information (ePHI) during electronic transmission and safeguard against unauthorized access and modification.

Policy:
SCCMHA will implement and maintain technical security measures to protect ePHI during electronic transmission over networks to prevent unauthorized access and ensure data integrity.

Application:
The HIPAA Security Rule and this policy applies to SCCMHA, its business associates, and any subcontractor required to access or use PHI to complete its contracted duties. Business Associates and subcontractors may choose to adopt and comply with the relevant SCCMHA policy or develop their own policies and procedures which comply with the applicable section of the HIPAA Security Rule.

Standards:

A. **Integrity Controls**: Security measures to ensure that electronically transmitted electronic protected health information is not improperly modified without detection until disposed of will be implemented.
    - **Data Integrity:** Implement mechanisms to ensure the integrity of ePHI transmitted electronically. This includes using digital signatures to verify that the data has not been altered or corrupted during transmission.
    - **Validation and Verification**: Procedures must be in place to validate the authenticity of data received and confirm that it has not been improperly modified or tampered with during transmission.

B. **Encryption:** A mechanism to encrypt EPHI whenever deemed appropriate will be implemented.
    - **Encryption Mechanisms:** Use encryption to protect EPHI during transmission over public and private networks. This includes the use of secure protocols (e.g., TLS/SSL for web traffic, S/MIME for email, and VPNs for remote access).
    - **Key Management:** Implement procedures for managing encryption keys, including key generation, distribution, storage, and retirement. Ensure that keys are kept secure and are accessible only to authorized personnel.

C. Access Controls:
    - **Authentication:** Ensure that systems and applications involved in transmitting EPHI use strong authentication mechanisms to verify the identity of users and systems.
    - **Authorization:** Implementation of access controls to restrict transmission of EPHI to authorized individuals and entities only. This includes role-based access controls and least privilege principles.

D. Transmission Security Measures:
    - **Secure Channels:** Ensure that EPHI is transmitted over secure channels, such as SENTRI messaging, encrypted emails, or secure file transfer protocols (e.g., SFTP). Avoid using unencrypted or insecure methods for transmitting EPHI.

- **Network Security:** Protect the network infrastructure used for transmitting EPHI by implementing firewalls, intrusion detection/prevention systems, and network segmentation.

E. Incident Management:
   - **Incident Reporting:** Establish procedures for reporting and responding to incidents involving unauthorized access or modifications to EPHI during transmission. Users must report any suspicious activity or breaches immediately.
   - **Incident Investigation:** The IT Department will investigate incidents involving the transmission of EPHI, determine the impact, and implement corrective actions to prevent recurrence.

F. Monitoring and Auditing:
   - **Activity Logging:** Implementation of logging and monitoring mechanisms to track the transmission of EPHI and detect any anomalies or unauthorized access attempts. Logs should be reviewed regularly to identify potential security issues.
   - **Regular Audits:** Conduct periodic audits of transmission security controls to ensure they are effective and up to date with current security standards and compliance requirements.

G. Training & Awareness:
   - **Security Training:** Provide ongoing training for all workforce members on secure transmission practices, including the use of encryption, secure channels, and recognizing phishing or other attacks targeting transmission of EPHI.

Responsibilities:

- **IT Department:** Responsible for implementing and managing encryption technologies, access controls, network security, and incident response related to transmission security.
- **Compliance Officer:** Responsible for overseeing the policy's implementation, conducting audits, and ensuring compliance with HIPAA regulations.
- **Management:** Responsible for ensuring staff awareness and adherence to transmission security policies.
- **Users:** Responsible for following procedures for securely transmitting EPHI and reporting any security incidents promptly.

Definitions:
See I.T./I.S. Policy 08.06.00.01, which contains a full list of relevant words and terms used in this section's Policies.

References:

- The HIPAA Security Rule §164.312(e)

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Identify Any Possible Unauthorized Sources that May Be Able to Intercept and/or Modify the Information	
1. Identify scenarios that may result in modification of the EPHI by unauthorized sources during transmission (e.g., hackers, disgruntled employees, business competitors).	1. Information Security Team & HIPAA Security Officer
Develop and Implement Transmission Security Policy and Procedures	
2. Establish a formal (written) set of requirements for transmitting EPHI.	2. Information Security Team & HIPAA Security Officer
3. Identify methods of transmission that will be used to safeguard EPHI.	3. Information Security Team & HIPAA Security Officer
4. Identify tools and techniques that will be used to support the transmission security policy.	4. Information Security Team & HIPAA Security Officer
5. Implement procedures for transmitting EPHI using hardware and/or software, if needed.	5. Information Security Team & HIPAA Security Officer
Implement Integrity Controls	
6. Implement security measures to ensure that electronically transmitted EPHI is not improperly modified without detection until disposed of.	6. Information Security Team & HIPAA Security Officer
Implement Encryption	
7. Implement a mechanism to encrypt EPHI whenever deemed appropriate.	7. Information Security Team & HIPAA Security Officer

Policy and Procedure Manual Saginaw County Community Mental Health Authority		
Subject: HIPAA Security: Policies, Procedures, and Documentation	**Chapter**: 08 – Management of Information	**Subject No**: 08.06.16.01
Effective Date: October 01, 2020	**Date of Review/Revision**: 9/20/22, 6/28/23, 9/9/24 **Supersedes**:	**Approved By**: Sandra M. Lindsey, CEO
SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY		**Responsible Director:** AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer & HIPAA Security Officer **Authored By**: AmyLou Douglas, Chief Information Officer | Chief Quality and Compliance Officer & HIPAA Security Officer **Additional Reviewers**: Jennifer Keilitz, Director of Network Services, Public Policy, and Continuing Ed and Kentera Patterson, Officer of Recipient Rights and Compliance & Privacy Officer

Purpose:
To ensure compliance with the HIPAA Security Rule, §164.316 – Policies and Procedures and Documentation Requirements, by establishing comprehensive policies and procedures for maintaining, reviewing, and managing documentation related to electronic protected health information (ePHI) and security practices.

Policy:
SCCMHA will implement and maintain policies and procedures to comply with the HIPAA Security Rule. All actions, activities, and assessments required by the HIPAA

Security Rule will be documented in written form (which may be electronic), and these records will be maintained according to the established standards.

Application:
The HIPAA Security Rule, and this Policy, applies to SCCMHA, its business associates, and any subcontractor that are required to access or use PHI to complete its contracted duties. Business Associates and subcontractors may elect to adopt and comply with the relevant SCCMHA Policy or develop their own Policies and Procedures which comply with the applicable section of the HIPAA Security Rule.
Designated individuals or teams responsible for managing documentation, conducting reviews, and implementing updates to ensure accountability and adherence to this policy.

Standards:

1. Documentation and Assurance for Business Associates:
    - Business Associate Agreements: Before permitting a Business Associate to create, receive, maintain, or transmit EPHI on behalf of SCCMHA, satisfactory assurances must be obtained, that the business associate will appropriately safeguard the information. This assurance is formalized through Business Associate Agreements (BAAs) that specify security and privacy obligations, in accordance with the HIPAA Security Rule and according to Policy 08.06.08.09: HIPAA Security – BAAs and Other Arrangements.
    - Document Retention: Any documentation related to BAAs and assurances must be retained for 6 years from the date of creation or from the date when the document was last was in effect, whichever is later.
2. Availability of Documentation:
    - Accessibility: documentation will be made readily available to personnel responsible for implementing and enforcing the applicable policy or procedures. This includes making sure that all relevant staff have access to the documents necessary for their roles.
3. Periodic Review & Updates:
    - Regular Reviews: The documentation will be reviewed periodically, and updated as needed, to ensure its continued effectiveness and relevance. This includes assessing the adequacy of documentation in light of environmental or operational changes that may impact the security of electronic protected health information.
    - Updates & Revisions: Documentation will be updated as needed to reflect changes in regulations, organizational practices, and results of security assessments. Changes will be documented, and previous versions will be archived according to retention policies.
4. Documentation of Actions & Assessments:
    - Record Maintenance: Maintain comprehensive records of all actions, activities, and assessments related to the implementation and enforcement of security policies. This includes risk assessments, security evaluations, training records, and incident response activities.

- Audit Trail: Ensure that an audit trail is maintained for all significant actions, changes, and updates to policies and procedures. This includes documenting who made changes, the nature of the changes, and the rationale for such changes.
- Compliance Monitoring: Regular audits will be conducted to ensure compliance with the policies and procedures. Non-compliance will be addressed through corrective actions and disciplinary measures as appropriate.

5. Documentation Storage and Security:
    - Secure Storage: All documentation, including electronic records, will be stored securely to protect against unauthorized access, alteration, or destruction. Access to documentation will be conducted based on roles and responsibilities.

Responsibilities:

- **HIPAA Privacy & HIPAA Security Officers:** Oversees the implementation and enforcement of this policy, including ensuring that documentation is maintained and reviewed in accordance with HIPAA requirements.
- **IT Department:** Responsible for secure storage and management of electronic documentation and for implementing technical controls to protect electronic records.
- **Management:** Ensures that all staff are aware of and comply with the documentation requirements and participates in periodic reviews and updates.
- **All Employees:** Responsible for adhering to the policies and procedures outlined, participating in training, and reporting any issues related to documentation or policy compliance.

Definitions:
See I.T./I.S. Policy **08.06.00.01** which contains a comprehensive list of relevant words and terms used within the Policies of this section.

References:

- The HIPAA Security Rule §164.316

Exhibits:
None

Procedure:

ACTION	RESPONSIBILITY
Create and Deploy Policies and Procedures	
1. Implement reasonable and appropriate procedures to comply with the HIPAA Security Rule.	HIPAA Security Officer & HIPAA Privacy Officer

2. Periodically evaluate written policies and procedures to verify that: a) Policies and procedures are sufficient to address the standards, implementation specifications, and other requirements of the HIPAA Security Rule. b) Policies and procedures accurately reflect the actual activities and practices exhibited by SCCMHA, its workforce, its systems, and its business associates.	HIPAA Security Officer& HIPAA Privacy Officer
Update Documentation of Policy and Procedures	
3. Change policies and procedures as is reasonable and appropriate, at any time, provided that the changes are documented and implemented in accordance with the requirements of the HIPAA Security Rule.	HIPAA Security Officer & HIPAA Privacy Officer
Draft, maintain and Update Required Documentation	
4. Written documentation may be incorporated into existing manuals, policies, and other documents, or may be created specifically for the purpose of demonstrating compliance with the HIPAA Security Rule.	HIPAA Security Officer & HIPAA Privacy Officer
Retain Documentation for at Least Six Years	
5. Retain required documentation of policies, procedures, actions, activities, or assessments required by the HIPAA Security Rule for	HIPAA Security Officer & HIPAA Privacy Officer Director of Network Services, Public Policy

six years from the date of its creation or the date when it last was in effect, whichever is later.	
Assure that Documentation is Available to those Responsible for Implementation	
6. Make documentation available to those persons for implementing the procedures to which the documentation pertains.	HIPAA Security Officer & HIPAA Privacy Officer Director of Network Services, Public Policy
Update Documentation as Required	
7. Review documentation periodically, and update as needed, in response to environmental or operational changes affecting the security of the EPHI.	HIPAA Security Officer & HIPAA Privacy Officer

<table>
<tr><th colspan="3">Policy and Procedure Manual
Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: HIPAA Security - Data Backup and Storage</td><td>Chapter: 08 - Management of Information</td><td>Subject No: 08.06.40</td></tr>
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Brett Lyon – Senior Applications, Information Security & BI Administrator</td></tr>
<tr><td>Supersedes:</td></tr>
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</table>

Purpose:
To ensure that SCCMHA's data on its information systems and electronic media is backed up regularly, securely stored, and recoverable, thereby supporting data integrity and availability in alignment with industry standards and compliance requirement.

Policy:
All data on SCCMHA's information systems and electronic media must be regularly backed up, securely stored, and tested for restoration. This policy ensures data protection

against loss, damage, and unauthorized access through comprehensive backup and recovery procedures.

Application:
This policy applies to all data residing on SCCMHA-owned components of the Management Information System, including data stored on servers, workstations, and other electronic media. It excludes SCCMHA data located offsite which has been entrusted to a third party via a contractual agreement but includes oversight and coordination with such third parties where applicable.

Standards:
1. Backup Frequency & Scope:

    - Daily Backup: Backup copies of all data on SCCMHA electronic media and information systems must be made each business day. This includes both data received by SCCMHA and created within SCCMHA.

    - Comprehensive Coverage: Backups must cover all data across SCCMHA's servers, workstations, and other relevant information systems, ensuring no critical data is excluded.

2. Backup Systems & Testing:

    - Adequate Backup Systems: SCCMHA must have adequate backup systems that ensure that all data can be recovered following a disaster or media failure. These systems must be evaluated and regularly tested to ensure their effectiveness.

    - Testing Schedule: Backup and restoration procedures must be tested at least semi-annually. Tests should simulate actual disaster scenarios and recovery processes to validate system reliability and performance.

3. Storage and Security of Backup Data:

    - Secure Remote Storage: Backup of data on SCCMHA information systems and electronic media, together with accurate and complete records of the backup copies and documented restoration procedures, must be stored in a secure remote location, at a sufficient distance from SCCMHA facilities to escape damage from a disaster at SCCMHA. (*See SCCMHA I.S. Departmental procedures 09.07.01.05 – Backup procedure, 09.07.01.10 – Restore Procedure and SCCMHA's DRP plan for full server restore procedure*).

    - Physical & Environmental Protections: The backup media containing SCCMHA's data at the remote backup storage site must be given an appropriate level of physical and environmental protection consistent with the standards applied to data physically at SCCMHA.

4. Access & Retrieval: Backup copies of data stored at secure remote locations must be accessible to authorized SCCMHA employees or delegated contractors for timely retrieval of the information.

5. Data Encryption Standards: Backup data must be encrypted both in transit and at rest to protect against unauthorized access and data breaches. Encryption keys must be managed securely and separately from the encrypted data.

6. Retention and Archival:
    - Retention Period: The retention period for backup of Electronic Protected Health Information (EPHI) on SCCMHA information systems and electronic media and any requirements for archive copies to be permanently retained must be defined and documented.
    - Archival Requirements: Specify any requirements for archive copies that need to be permanently retained. Documentation of archival procedures should detail the process for managing long-term data storage.

7. Cloud-Based Backups:
    - Integrations: In addition to all on-prem backups, the servers must also be backed up to a cloud-based service. Ensure that the cloud backup solution meets SCCMHA's security and compliance standards.
    - Management: Regularly review and update cloud backup configurations and contracts to ensure they align with SCCMHA's backup policies and security requirements.
8. Accountability and Documentation:
    - Documentation and Reporting**:** Maintain accurate records of backup activities, including schedules, test results, and recovery operations. Regularly review and report on backup status and incidents to ensure ongoing compliance and improvement.

Responsibilities:

- **IT Department:** Responsible for implementing and configuring automatic locking mechanisms, conducting compliance checks, and managing exception requests.
- **Chief Information Officer (CIO):** Reviews and approves any exceptions to the standard inactivity timeout, ensuring that risk assessments are completed.
- **All Employees:** Must adhere to session management procedures, including logging off or locking workstations as required.

Definitions:

See I.T./I.S. Policy **08.06.00.01** which contains a comprehensive list of relevant words and terms used within the Policies of this section.

References:

Information Systems Policies and Procedures manual, Version 4: modified 12/15/01.
Jonathon Tomas's "The Compliance Guide to HIPAA & the HHS Regulations."

Phoenix Health Systems

Exhibits:
None

Procedure:
None

Tab 8

Network Services

Quality Systems Procedure or Plan Manual Saginaw County Community Mental Health Authority		
Subject: Agency Naming Convention Standardization	**Chapter**: 09 - Department Procedures	**Subject No**: 09.08.01.03
Quality Assurance		
Effective Date: April 20, 2023	**Date of Review/Revision**: 7/30/2024 **Supersedes**: 09.03.05.03	**Approved By**: AmyLou Douglas, Chief Information Officer, Chief Quality and Compliance Officer **Authored By**: Holli McGeshick **Additional Reviewers**: LaDonna Presley & Business Intelligence Data Integrity Workgroup

Purpose:
To ensure that all Saginaw County Community Mental Health Authority (SCCMHA) Sentri 2 Users are using standard naming conventions for data entry within the Sentri 2 Electronic Health Record (EHR) and Consumer Demographics.

Policy:
This policy serves as the SCCMHA standard for consistent naming convention guidelines for all Sentri 2 users keeping information within Sentri 2 organized and easy to process while assisting in analyzing large volumes of data for reporting purposes, correction of errors and applying Data Integrity principles as defined by the Business Intelligence Data Integrity Workgroup.

Data Integrity principles are designed to support and maintain data that is:

- Accurate
- Complete
- Secure
- Consistent
- Timely

Application:
All Sentri 2 users must be familiar with the policy and demonstrate competence in the requirements of the policy.

Standards:
All Sentri 2 users will learn the proper naming conventions and consistently apply these standards.

USPS Postal Addressing Standards are to be used for all addresses.

Consumer Demographic Data:

A. Data entry for the following fields should be consistent for every entry.
   a. First Name
      i. Title case
      ii. If two first names, use title case with one space between.
      iii. Use an apostrophe when applicable (A'niilah).
      iv. If using a hyphenated first name, separate using "-" without spaces in between (Carter-James).
      v. Capitalize appropriately for letters after the initial capital letter (MacKenzie, McKinley, NajUwa, etc.).
      vi. Do not enter nickname with first name; use "Aliases" field .
   b. Middle Name
      i. Title case
      ii. If there are two middle names, use title case with one space between.
      iii. Use an apostrophe when applicable (A'niilah).
      iv. If using a hyphenated middle name, separate using "-" without spaces in between (Carter-James).
      v. Capitalize appropriately for letters after the initial capital letter (MacKenzie, McKinley, NajUwa, etc.).
      vi. Do not enter nickname with first name; use "Aliases" field.
   c. Last Name
      i. Title case
      ii. Capitalize appropriately for letters after the initial capital letter (MacDonald, DeWitt, etc.).
      iii. Use an apostrophe when applicable (O'Donnell).
      iv. If using a hyphenated last name, separate using "-" without spaces in between (Smith-Jones).
   d. Suffix
      i. Jr, Sr, I, II, III, IV (no periods)
   e. Maiden Name
      i. See A.c.
   f. Aliases
      i. Enter an additional name that the consumer uses.
   g. Other Identifying Information
      i. Enter any additional information if needed. This is a free text box.
   h. SSN

i. Include dashes: 999-99-9999

i. Address
   i. No punctuation (commas, periods, number sign, or other non-alphanumeric characters.
   ii. No identifiers other than address or "homeless", do not enter "n/a", "none", apartment number, complex name, AFC home name, notes, or an alias.
   iii. Follow abbreviations for standard usage: ***See Exhibit A***
j. Address 2 (second line in address)
   i. See A.f.i. & A.f.iii.
   ii. Enter "Apartment ", "Suite ", or "Building" followed by the number or name (if applicable).
   iii. Enter "PO Box" (no periods) followed by the box number (if applicable).
k. City
   i. Title Case
   ii. No periods (i.e., St Louis)
   iii. Use hyphens when it is part of the city name
l. State
   i. Two-character standard abbreviation, capitalized
m. Zip
   i. 5-digit Zip Code followed by the 4-digit extension, separated by a "-" with no spaces: 99999-9999.
   ii. Zip Code lookup website: https://tools.usps.com/go/ZipLookupAction!input.action
   iii. If no 4-digit extension populates on the Zip Code lookup website, change the house number by a few digits in the lookup to see if that generates the +4. Remember if changing, odd number must remain odd number and even number must remain an even number.
   iv. In the event that the 4-digit extension cannot be found, use 0000. This is to be used sparingly.
n. Phone
   i. (999) 123-4567 Encapsulate the area code with parenthesis followed by a space between the area code and the exchange code.
   ii. (999) 123-4567 999 For numbers with an extension, add the extension at the end, prefaced by a space.
o. Alternate Phone
   i. See A.m.
p. Email
   i. someone@host.com
q. Date of Birth
   i. 01/01/2001 Sentri requires this format
r. Consumer Mailing Address (if different from Home Address)
   i. See A.f. - A.j., and Exhibit A
s. Consumer Contacts
   i. See A.a. - A.d.
   ii. If First Name and Middle Name are used, put both in First Name field with one space between.

iii. If suffix applies, put last name, followed by the suffix in the Last Name field with one space between.

t. School: Name/Address
   i. Name: follow official name of school as listed; use Title Case
   ii. Address: See A.h. - A.l., and Exhibit A

Staff Demographics:

B. Data entry for the following fields should be consistent for every entry.
   a. First Name
      i. Title case
      ii. If two first names, use title case with one space between.
      iii. Use an apostrophe when applicable (A'niilah).
      iv. If using a hyphenated first name, separate using "-" without spaces in between (Carter-James).
      v. Capitalize appropriately for letters after the initial capital letter (MacKenzie, McKinley, NajUwa, etc.).
      vi. Do not enter nickname with first name; use "Aliases" field.
   b. Middle Name
      i. Title case
      ii. If there are two middle names, use title case with one space between.
      iii. Use an apostrophe when applicable (A'niilah).
      iv. If using a hyphenated middle name, separate using "-" without spaces in between (Carter-James).
      v. Capitalize appropriately for letters after the initial capital letter (MacKenzie, McKinley, NajUwa, etc.).
      vi. Do not enter nickname with first name; use "Aliases" field.
   c. Last Name
      i. Title case
      ii. Capitalize appropriately for letters after the initial capital letter (MacDonald, DeWitt, etc.).
      iii. Use an apostrophe when applicable (O'Donnell).
      iv. If using a hyphenated last name, separate using "-" without spaces in between (Smith-Jones).
   d. Suffix
      i. Jr, Sr, I, II, III, IV (no periods)
   e. SSN
      i. Include dashes: 999-99-9999
   f. Address
      i. No punctuation (commas, periods, number sign, or other non-alphanumeric characters.
      ii. No identifiers other than address or "homeless", do not enter "n/a", "none", apartment number, complex name, notes, or an alias.
      iii. Follow abbreviations for standard usage: ***See Exhibit A***
   g. Address 2 (second line in address)
      i. See A.f.i. & A.f.iii.

ii. Enter “Apartment “, “Suite “, or “Building” followed by the number or name (if applicable).
iii. Enter “PO Box” (no periods) followed by the box number (if applicable).

h. City
   i. Title Case
   ii. No periods (i.e., St Louis)
   iii. Use hyphens when it is part of the city name

i. State
   i. Two-character standard abbreviation, capitalized

j. Zip
   i. 5-digit Zip Code followed by the 4-digit extension, separated by a “-” with no spaces: 99999-9999.
   ii. Zip Code lookup website: https://tools.usps.com/go/ZipLookupAction!input.action
   iii. If no 4-digit extension populates on the Zip Code lookup website, change the house number by a few digits in the lookup to see if that generates the +4. Remember if changing, odd number must remain odd number and even number must remain an even number.
   iv. In the event that the 4-digit extension cannot be found, use 0000. This is to be used sparingly.

k. Phone
   i. (999) 123-4567 Encapsulate the area code with parenthesis followed by a space between the area code and the exchange code.
   ii. (999) 123-4567 999 For numbers with an extension, add the extension at the end, prefaced by a space.

l. Alternate Phone
   i. See A.m.

m. Email
   i. someone@host.com

n. Date of Birth
   i. 01/01/2001 Sentri requires this format

Provider Address Demographics:

a. Provider: Name/Address
   ii. Name: follow official name of school as listed; use Title Case
   iii. Address: See A.h. - A.l., and Exhibit A

Provider Contracts Demographics:

C. Data entry for the following fields should be consistent for every entry.

a. First Name
   i. Title case
   ii. If two first names, use title case with one space between.
   iii. Use an apostrophe when applicable (A'niilah).
   iv. If using a hyphenated first name, separate using “-” without spaces in between (Carter-James).

v. Capitalize appropriately for letters after the initial capital letter (MacKenzie, McKinley, NajUwa, etc.).
vi. Do not enter nickname with first name; use "Aliases" field.

b. Last Name
   i. Title case
   ii. Capitalize appropriately for letters after the initial capital letter (MacDonald, DeWitt, etc.).
   iii. Use an apostrophe when applicable (O'Donnell).
   iv. If using a hyphenated last name, separate using "-" without spaces in between (Smith-Jones).

c. Suffix
   i. Jr, Sr, I, II, III, IV (no periods)

d. SSN
   i. Include dashes: 999-99-9999

e. Address
   i. No punctuation (commas, periods, number sign, or other non-alphanumeric characters.
   ii. No identifiers other than address or "homeless", do not enter "n/a", "none", apartment number, complex name, notes, or an alias.
   iii. Follow abbreviations for standard usage: ***See Exhibit A***

f. Address 2 (second line in address)
   i. See A.f.i. & A.f.iii.
   ii. Enter "Apartment ", "Suite ", or "Building" followed by the number or name (if applicable).
   iii. Enter "PO Box" (no periods) followed by the box number (if applicable).

g. City
   i. Title Case
   ii. No periods (i.e., St Louis)
   iii. Use hyphens when it is part of the city name

h. State
   i. Two-character standard abbreviation, capitalized

i. Zip
   i. 5-digit Zip Code followed by the 4-digit extension, separated by a "-" with no spaces: 99999-9999.
   ii. Zip Code lookup website: https://tools.usps.com/go/ZipLookupAction!input.action
   iii. If no 4-digit extension populates on the Zip Code lookup website, change the house number by a few digits in the lookup to see if that generates the +4. Remember if changing, odd number must remain odd number and even number must remain an even number.
   iv. In the event that the 4-digit extension cannot be found, use 0000. This is to be used sparingly.

j. Phone
   i. (999) 123-4567 Encapsulate the area code with parenthesis followed by a space between the area code and the exchange code.

ii. (999) 123-4567 999 For numbers with an extension, add the extension at the end, prefaced by a space.

k. Alternate Phone
    i. See A.m.
l. Email
    i. someone@host.com

Definitions:

A. **Data Integrity:** the overall accuracy, completeness, and consistency of data maintained by processes, rules, and standards developed by the SCCMHA Business Intelligence Data Integrity Workgroup.
B. **Sentri 2 EHR**: The Electronic Health Record system used by SCCMHA and their contracted provider network.
C. **Sentri 2 Users**: Users who access the Sentri EHR through a login and password
D. **Naming Convention**: a convention for filling in fields to ensure consistency throughout the system to assist with keeping information organized and searchable in the Sentri 2 EHR.
E. **Title Case:** Major words are capitalized, and most minor words are lowercase. For names, the first letter of each name is capitalized, with special exceptions given to names that contain more than one capital letter, such as McDonald, DeSoto, MacIntosh, O'Brien, etc. For these situations, follow the direction given by the responsible party.
F. **USPS:** United States Postal Service

References:

https://apastyle.apa.org/style-grammar-guidelines/capitalization/title-case

Sentri -Help / Resources: Address Entry Instructions and Guideline

https://pe.usps.com/text/pub28/28apc_002.htm

https://pe.usps.com/text/pub28/28apc_003.htm

https://pe.usps.com/text/pub28/28apf.htm

Exhibits:

Exhibit A – Address Standardization Guide
Exhibit B – Secondary Unit Designators

Procedure:
None

Exhibit A –

Address Standardization (No Commas, No Periods)	
Possible Variation	*Standard Usage*
Street	St
Road	Rd
Avenue	Ave
Drive	Dr
Boulevard	Blvd
Court	Ct
P.O. Box	PO Box
Parkway	Pkwy
Suite	Ste
Place	Pl
Highway	Hwy
North	N
South	S
East	E
West	W
Center	Ctr

Exhibit B –

Secondary Unit Designators	
Possible Variation	*Standard Usage*
Apartment	Apt
Building	Bldg
Department	Dept
Floor	Fl
Lot	Lot
Penthouse	Ph
Room	Rm
Space	Spc
Stop	Stop
Suite	Ste
Trailer	Trlr
Unit	Unit