



DBHDD

# Request for Specialized Treatment Funding

## **Types of special needs bridge funding (BF)**

Request for Special Needs Bridge Funding (BF)

Request for Specialized Treatment Funding

Specialized Treatment Funding is utilized to assist individuals currently:

1. Admitted to a state hospital, presenting with unique needs that are preventing them from discharge to a community setting; **OR**
2. In the community setting, but are experiencing significant functional impairments that place them at risk for re-hospitalization. Individuals meeting this criteria typically are high utilizers of inpatient settings.

Specialized Treatment Funding is time limited (maximum of 90 days) and not otherwise covered through Special Needs Bridge Funding or the Georgia Housing Voucher Program. To be eligible for Specialized Treatment Funding, all other resources and treatment alternatives must have been attempted prior to application.

**Purpose of request form:** To collect detailed and comprehensive information needed to determine eligibility of Specialized Treatment Funding. Information needed includes:

1. History of hospitalizations, including diagnoses given and discharge plans attempted.
2. Current presenting concerns, medications, and barriers to discharge.
3. Previous attempts to reintegrate and sustain individual in community setting.
4. A detailed Recovery Plan addressing what is needed to sustain the individual in community setting, especially once funds have been exhausted.
5. An itemized description of funds needed minus current financial resources.
6. A strengths, needs, and preference assessment.
7. Current Individual Recovery Plan (IRP).
8. Crisis/Safety Plan

## **Process for submission:**

1. The Hospital Social Worker (SSP) or Community Service Provider will collaborate with the Regional Transitional Specialist (TS) or Regional Field Office (RFO) respectively, to ensure that all resources have been explored and exhausted, to include natural and formal supports.
2. The RFO TS will complete the Request for Specialized Treatment Funding in collaboration with the SSP or Community Service Provider, submitting all necessary documentation to support the request.
3. The RFO TS will review the request with the Regional Services Administrator (RSA) for submission to the Office of Adult Mental Health.
4. The RSA will sign off on the completed form and submit to the State Office, Residential Services Coordinator (RSC) via email at [Community.Residential@dbhdd.ga.gov](mailto:Community.Residential@dbhdd.ga.gov).
5. The RSC will review submission and request any additional documentation and/or meetings needed prior to discussing application with the Director of Adult Mental Health for final determination.



D-B-H-D-D

## Request for Specialized Treatment Funding

Staff Completing Request	
Current Hospital of Admission (if applicable)	
Hospital Staff Contact Information	
Current Community Service Provider (if applicable)	
Community Service Provider Contact Information	
Assigned Regional Field Office	
Regional Field Office Contact Information	

Personal Information		
Individuals Name:	Date of Birth:	CID#:

Detailed list of psychiatric inpatient admissions (State or Private Hospitals, BHCC or CSU) beginning with the current admission (if additional space is needed, please include a separate Word document):

Psychiatric Inpatient Admissions History				
Hospital	Admission Date	Discharge Date	Diagnosis	Discharge Plan

Number of hospitalizations in the past year:

Number of hospitalizations in a lifetime:



D-B-H-D-D

## Request for Specialized Treatment Funding

Detailed description of factors, stressors, or recurrent themes which lead to the current situation. Be sure to include the individuals age, gender, and SPMI diagnosis.

Presenting Concerns

Current Medications	
Psychotropic	Medical

Detailed list of previous medications tried and reasons why they were discontinued (i.e. non-compliance, allergies, not effective, etc.)

Medication History	
Medication Name	Reason for Discontinuation



Request for Specialized Treatment Funding

Detailed description of current barriers to transition from inpatient setting or current factors affecting community stabilization and what has been tried to remove barrier/factor. This can include lack of family/natural supports, income, insurance, etc.

Current Barriers to Transition or Factors Affecting Community Stabilization	
Barriers/Factors	What has been tried to remove barrier/factor

Describe all previous attempts to transition from inpatient setting and/or attempts at maintaining community integration, to include any specialized treatment and the outcome of each attempt. Please be very detailed in the reasons for past disruptions focusing on recurrent themes and/or possible triggers.

Transition and Treatment Plans Previously Attempted



D·B·H·D·D

## Request for Specialized Treatment Funding

Describe the longest amount of time this individual has remained stable in the community and what made it successful? Any recurrent themes related to maintaining stability and recovery?

### Success Stories

Detailed description of current needs that will enable community stability and recovery. This includes a community transition plan if discharging from a state hospital and cost analysis. Please add an additional Word document if additional space is needed.

### Recovery Plan



D-B-H-D-D

## Request for Specialized Treatment Funding

What financial resources does the individual current have and can contribute to treatment? If none, what date was an application for entitlements submitted and what is the status of application?

Personal Resource					
Resource	Amount	Denied	Received	Waiting List	Pending
Hospital Trust Account					
SSI					
SSDI					
Medicaid					
Medicaid Waiver					
Medicare					
Private Insurance					
Personal Bank Accounts					
Natural Supports					
Food Stamps					
VA Assistance/Pension					
Railroad Pension					
Homeless Assistance Program					
Religious Groups					
Civic Organization					
Other (Specify)					
Total Financial Resources					

Detailed description of how the individual's stability and community integration will be supported once funding is exhausted.

### Strengths, Needs, and Preferences

Identify individuals stated strengths, likes and dislikes, which contribute to maintaining their recovery in the community.



D-B-H-D-D

## Request for Specialized Treatment Funding

Identify individuals stated needs which have and will continue to contribute to maintaining their recovery in the community.

Identify individuals stated preferences as it relates to their ideal living situation, especially if requesting 1:1 staffing supports.

Is the individual in agreement with current recommendation for Specialized Treatment? Why or why not?

Has a Needs for Supported Housing (NSH) application been completed? If not, why? If completed, what is the status of application?



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## Request for Specialized Treatment Funding

### Attachments

If requesting 1:1 Residential Supports:

1. Staffing Pattern per shift with Cost Analysis.
2. Interventions provided and for how long each day.
3. Step-down/transition plan for reduction of 1:1 staff.

If requesting funding for a specialized treatment modality (i.e. DBT, CBT, EMDR, etc.) or treatment facility:

1. Letter of Acceptance to services.
2. Detailed description of services to be provided and for how long.
3. W-9 (Note: Funding will only be approved through a DBHDD funded provider. Providers will need to make payments to outside contractors upon receipt of invoice and will be reimbursed by DBHDD.)
4. PCH or CLA License as applicable.
5. Plan to review progress with RFO.
6. Procedures to decrease disruption of plan.

For individuals with or without income:

1. Benefits award letter or verification of submission of benefits application.

### Signature of Acknowledgment

By signing this form, you are verifying the request for funding to support the transition of the above-named individual is needed and that **due diligence has been met**.

RFO Regional Support Administrator Signature

Print Name

Date

### For Office Use Only

Date Received:

Received by:

Date Forwarded:

Status of Request:

Date of Status:

Explanation:

Total Approved:

Invoice Received:

Date Invoice Received:

AMH Director Signature

Print Name

Date