

County: _____

Date: _____

- May 1st Submission (September 1st through February 28th Reporting Period)
- October 1st Submission (March 1st through August 31st Reporting Period)

Name and Contact Information County Child Welfare Department Repres					
Name:					
Title:					
Agency Name:					
Address:					
City:		State:		Zip Code:	
Phone:		E-mail:			

Name and Contact Information County Mental Health Department Representative					
Name:					
Title:					
Agency Name:					
Address:					
City:		State:		Zip Code:	
Phone:		E-mail:			

County: _____

Date: _____

If your answer below is blank or zero, please provide an explanation.

PART A: Potential Subclass Members Identified During the Reporting Period			
Item #	Information Requested	Column 1 Beneficiary Count	Column 2 Next Steps/Timelines
1	Potential Subclass Members		
2	Potential Subclass Members who received a mental health assessment and do not meet medical necessity criteria for SMHS.		
3	Potential Subclass Members who have been referred to MHP for a full mental health assessment to determine medical necessity criteria for SMHS, and have not yet been assessed.		
4	Potential subclass members who were unknown to the MHP during the reporting period.		

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If your answer below is blank or zero, please provide an explanation.

PART B: Services Provided to Identified Subclass Members at Any Time During the Reporting Period

Item #	Information Requested	Column 1 Beneficiary Count	Column 2 Timelines
1	Subclass Members		
2	Receiving Intensive Care Coordination (ICC).		
3	Receiving Intensive Home Based Services (IHBS).		
4	Receiving intensive Specialty Mental Health Services (SMHS) through a Wraparound Program or Full Service Partnership Program consistent with the Core Practice Model (CPM), but not claimed as ICC and IHBS. <i>Do not include youth already counted in 2 or 3 above.</i>		
5	Receiving other intensive SMHS, but not receiving ICC or IHBS. Examples of intensive SMHS may include: Therapeutic Behavioral Services (TBS), Intensive Treatment Foster Care (ITFC), or Multidimensional Treatment Foster Care (MTFC). <i>Do not include youth already counted in 2, 3, or 4</i>		
6	Receiving mental health services not reported in 2, 3, 4, & 5 above (include children who are receiving mental health services outside of the Medi-Cal mental health system, i.e. services paid for by private insurance or other sources).		
7	Not receiving mental health services (neither through Medi-Cal nor through any other program or funding source).		
8	Declined to receive ICC or IHBS.		

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If your answer below is blank or zero, please provide an explanation.

PART C: Projected Services			
Item #	Service	Projected number of subclass members to be receiving services by August 31 st	Strategy/Timeline Description Provide County action steps and timelines to be used to provide (and claim for) ICC and IHBS to subclass members.
1 (a)	ICC		
1 (b)	IHBS		

Is your county experiencing the following implementation barriers?

Hiring	Yes	No
Training	Yes	No
Service Availability	Yes	No
County Contracting Process	Yes	No

Please provide an explanation for any Yes responses above. Are there other barriers not listed above? Explain and add pages, as needed.

County: _____

Reporting Period: _____

Date Completed: _____

Please provide an update to the Readiness Assessment Tool counties completed in May 2013. Describe activities related to each section during the reporting period, including actual or anticipated results. Include activities that support family-centered principals, and promote implementation of the ICC and IHBS using Core Practice Model. Identify activities that occur jointly and those that occur separately by child welfare and mental health agencies. Include information about barriers, as appropriate, and strategies to address them.

For each section, please indicate if training or technical assistance from the state is needed. When indicated, CDSS and DHCS will contact the county child welfare and mental health departments for further information. Please note that training and technical assistance needs will be addressed in a coordinated manner through each county’s child welfare and mental health contacts.

Use additional pages, if necessary.

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
<p>Agency Leadership <i>Leadership’s experience implementing family-centered services in a collaborative setting.</i></p>		
<p>Systems and Interagency Collaboration <i>How collaborative approaches are used when serving children and families.</i></p>		
<p>Systems Capacity <i>The collective strength of administrative structures, workforce capacity, staff skills & abilities, and operating resources.</i></p>		
<p>Service Array <i>Available services are culturally responsive and include trauma informed care, evidence based practices, promising practices, innovative practices, and culturally specific healing practices and traditions.</i></p>		

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
<p>Involvement of Children, Youth & Family <i>How Core Practice Model family-centered principles are reflected in current systems.</i></p>		
<p>Cultural Responsiveness <i>Agency ability to work effectively in cross-cultural settings.</i></p>		
<p>Outcomes and Evaluation <i>The strength of current data collection practices, and how outcomes data is used to inform programs and practice.</i></p>		
<p>Fiscal Resources <i>How fiscal policies, practices, and expertise support family-centered services.</i></p>		