F. Accessing Services

Consistent with the Health and Human Services Agency's "No Wrong Door" policy (BHIN 22-011), members may access services through organizational providers and County-operated facilities in the following ways:

- Calling the organizational provider or County-operated program directly
- Walking into an organizational provider or County-operated program directly
- Calling the Access and Crisis Line at 1-888-724-7240

MCPs are required to provide or arrange for the provision of the following non-specialty mental health services (NSMHS):

- Mental health evaluation and treatment, including individual, group and family psychotherapy.
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
- Outpatient services for purposes of monitoring drug therapy.
- Psychiatric consultation.
- Outpatient laboratory, drugs, supplies, and supplements.

The County BHP shall provide or arrange for clinically appropriate covered SMHS to include prevention, screening, assessment, treatment services. These services are covered and reimbursable even when:

- Services were provided prior to determining a diagnosis, during the assessment, or prior to determining whether SMHS access criteria are met.
- The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.
- The member has a co-occurring mental health condition and substance use disorder; or
- NSMHS and SMHS services are provided concurrently if those services are coordinated and not duplicated.

For more information about all the subsections below, please visit the following DHCS FAQ page: CalAIM Behavioral Health Initiative FAQS

Screening for Access to Specialty Mental Health Services

All referrals shall be screened by a clinician for access criteria for specialty mental health services and appropriate level of care. Screening will facilitate timely and appropriate services which are family centered and support maximizing capacity at the Organizational Provider level. Depending on screening information obtained and the level of care to which the member is referred, additional screening may be required by the receiving program prior to offering the member an appointment.

Timely Access Data Standards (TADT)

In accordance with BHIN 24-020, Behavioral Health Plans (BHPs) are required to have a system in place for tracking and measuring timeliness of care. To align with the Department of Health Care Services (DHCS) documentation requirements recorded inquiries should be documented within three (3) business days of the request for services in the electronic health record, with the exception of emergent or urgent type which shall be completed within one (1) calendar day. To see a step by step guide for documenting timely access to services refer to the CalMHSA website.

BHPs must use the TADT to report on new members who request a non-psychiatry SMHS, and any new or established member requests for psychiatric services. BHPs are required to submit timely access data for the following:

- An urgent or non-urgent appointment with a non-physician mental health provider of an outpatient SMHS;
- An urgent or non-urgent appointment with a provider of psychiatry;
- Non-urgent follow-up appointments with a non-physician mental health provider;
- Appointments with OON providers in cases where appointments with network providers are not available within timely access standards.

DHCS calculates compliance using the Date of First Contact to Request Services and the number of business days between that date and the date of the first **available** appointment that qualifies as a billable service. For a BHP to be in compliance with the timely access standards, eighty percent (80%) of members must have been **offered** an available appointment within the applicable time frame. Programs shall issue a Notice of Adverse Benefit Determination (NOABD) when the access standard in the table below

is not met. The access times listed below apply for all members (Adults and Children/Youth) accessing care under the BHP:

Urgent Condition: The County further refers to an "Urgent" as a condition for which treatment should not wait for a normally scheduled appointment, as it would place the health or safety of the individual or another individual in serious jeopardy in the absence of an intervention.

Urgent Psychiatric Condition: Title 9 defines an "Urgent Psychiatric Condition" as a condition, which without timely intervention, is certain to result in an immediate emergency psychiatric condition. The County further refers to Urgent as a condition for which treatment should not wait for a normally scheduled appointment, as it would place the health or safety of the individual or another individual in serious jeopardy in the absence of an intervention.

Non-Urgent (Routine) Condition: A "Non-Urgent (Routine) Condition" is defined as a relatively stable condition and there is a need for an initial assessment for Specialty Mental Health Services (SMHS).

Service Type	Standard
Outpatient non-urgent with nonphysician (routine) – Adults and Children/ Youth	Offered an appointment within ten (10) business days from request for services
Psychiatric Services - Adults and Children/ Youth	Offered an appointment within fifteen (15) business days of request for services.
SMHS Urgent Appointments- Adults and Children/ Youth	Forty-eight (48) hours from request for services
Children and adolescents requiring emergency services	Seen within one (1) hour of contact with program- They may be seen at the program or referred to the Children and Youth Crisis Stabilization Unit (CYCSU).
Children and adolescents being discharged from acute psychiatric hospital care	Assessed by program within seventy-two (72) hours

Urgent Walk-In Clinical Standards for Programs Serving Adult/Older Adults

Individuals who walk in and who are not currently receiving services will be triaged/screened. If they are not deemed in need of urgent services, they may be referred to a primary care provider with known capacity, outpatient mental health provider, or a fee for service provider, via the Access and Crisis Line. The member's choice prevails as per DHCS regulations. Members who are already receiving mental health services and walk in to request medication will be triaged/screened. If they are not deemed in need of urgent services, they may be referred back to their own provider/ prescribing physician.

Members with urgent mental health needs and/or urgent medication needs shall be triaged/screened and offered appropriate services, regardless if the member may be already receiving services.

New members assessed as needing urgent services that are referred from a Hospital or Jane Westin Center must be prioritized for admission at an outpatient clinic within forty-eight (48) hours. All referrals received that indicate urgency or high risk and that do not show up to the walk-in clinic will prompt a response from the walk-in clinic to the referring party for follow up. If the referring party is a Hospital or Crisis Residential program, the walk-in clinic will follow up with the member directly.

Outpatient Clinics with Walk-In Urgent Components

All outpatient clinics in all shall accommodate their opened members for urgent services to prevent them from needing access to walk in services. All members who are triaged/screened and are deemed appropriate for routine admission must be admitted in accordance with acceptable access times already established for routine services, or according to the seventy-two (72) hour policy for members leaving twenty-four (24) hour settings or known case management members. Institutions and Case Managers can call a clinic to arrange for a triage day during walk-in times, within seventy-two (72) hours, and individuals will be given the highest priority to be triaged/screened that day.

New members assessed as needing urgent services that are referred from Hospitals or Jane Westin Center must be prioritized for admission at an outpatient clinic within forty-eight (48) hours. Programs must have processes in place to follow up with members who come in for walk-in services, are triaged/screened and not deemed urgent, but need specialty mental health services at the clinic and are asked to return the following day but who do not show up.

Members receiving urgent or at-risk referrals are responsible for ensuring members are screened within designated timelines and shall be responsible for contacting the member for follow up if they do not show up during walk in times.

All Programs:

- The initial site providing service shall ensure that members do not have to go to multiple facilities for an evaluation.
- MD's/Nurse Practitioners (NP's) must be prepared to provide care to a member who is in urgent need of medications even though the member may be open at another clinic.
- MD's/NP's should be prepared to provide outpatient detox medications to COD members entering County-contracted detox programs, if in the MD's/NP's opinion it is deemed safe. This will be evaluated on a case-by-case basis.
- All programs shall post signage to inform members what to do after hours. i.e. "In case of an emergency after business hours please go to the nearest emergency room, call the Access and Crisis Line at-1-888-724-7240, or call 911."
- *HIPAA Privacy Rule* (Sec. 164.506) states that a covered entity may use or disclose protected health information for treatment. This would apply in the case of a clinical referral source (another clinic, case management, hospital, IMD, etc.) inquiring whether a referred member appeared for their intake process.

Priority List: Prioritization is always based on clinical judgment regarding highest acuity and risk; however the following will generally be highest priority: A member appearing agitated in the waiting room, any member referred/discharging from a Psychiatric hospital/crisis residential, a member brought in by Police/PERT, jail, a member referred from an IMD Client/Out of County locked facility, a member with a case manager, a member referred/discharged from an acute facility (i.e. CSU) acute, any member that is homeless or at risk of homelessness with SMI or co-occuring disorder or a member whose mental status jeopardizes SUD residential placement.

SMHS Provided During the Assessment Period

Clinically appropriate SMHS are covered and reimbursable during the assessment process prior to determination of a diagnosis or a determination that the member meets access criteria for SMHS. Services rendered during the assessment period remain reimbursable even if the assessment ultimately indicates the member does not meet criteria for access to SMHS. BHPs must not deny or disallow reimbursement for SMHS provided during the assessment process described above if the assessment determines that the member does **not** meet criteria for access to SMHS or meets the criteria for NSMHS.

BHPs, DMC and DMC-ODS programs and providers may use the following options during the assessment phase of a member's treatment when a diagnosis has yet to be established:

- ICD-10 codes Z55-Z65: "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP).

- ICD-10 code Z03.89: "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA or LMHP during the assessment phase of a member's treatment when a diagnosis has yet to be established.

Per CalAIM, a mental health disorder diagnosis is not required to receive medically necessary SMHS. However, ICD diagnostic codes are required on claims in order for DHCS to receive federal financial participation. Z codes meet the federal requirement for claims and do not indicate a diagnosis of a mental health disorder or a substance use disorder (BHIN 22-013). LPHA and LMHP may use any clinically appropriate ICD-10 code. Programs should maintain history of their intakes/documentation even if they do not end up fully enrolling with the program.

Medi-Cal Transformation Initiative for Co-Occurring Treatment Disorders

Members with co-occurring mental health and substance use issues are common in the public mental health system and present complex needs. The presence of substance use should be explored with all members and caretakers as part of routine screening at the point of initial evaluation, as well as during the course of ongoing treatment. For all members who do not meet the criteria for access to Specialty Mental Health services, but do have an identified substance use issue, the provider will make appropriate services referrals and document actions taken.

The Medi-Cal Transformation initiative seeks to reduce or eliminate barriers to treatment for members with co-occurring disorders. Therefore, services provided in the presence of co-occurring disorders will be reimbursable when a medically necessary service is documented. BHPs must not deny or disallow reimbursement for SMHS provided to a member who meets SMHS criteria based on the member having a co-occurring SUD, when all other Medi-Cal and service requirements are met.

Please note, Department of Health Care Services is not allowing specialty mental health providers to automatically bill DMC services- specialty mental health program

providers must still deliver covered specialty mental health services at sites that have specialty mental health certifications.

When serving adults, children, adolescents, or their families that meet the criteria for co-occurring disorders these guidelines are to be implemented:

- Documentation on the Admission Checklist that the member and/or family was given a copy of your program's *Welcoming Statement* outlining the programs capacity to address co-occurring needs as well as physical health needs, including tobacco use.

- Include substance use and abuse issues in your initial screening, assessment and assessment updates. In addition, use any screening tools that may be adopted or required. For members under the age of twenty- one (21), the Child and Adolescent Needs and Strengths (CANS) Assessment tool may be utilized to help inform the assessment domain requirements.

- If both types of disorders are indicated for the member at diagnostic levels, list the mental health diagnosis or Z03.89 Deferred Diagnosis as the primary disorder and the substance use diagnosis as the secondary disorder. This indicates that the mental health diagnosis will be the primary focus of treatment, not necessarily that the mental health disorder is the more important disorder or the cause of the substance use.

Treatment services and documentation shall focus on the primary mental health diagnosis and the identified functional impairment(s). Treatment planning should deal with the substance use issue, either by referral or direct treatment. The co-occurring substance use issue may be integrated into the member's problem list and service may be provided in relation to how it impacts the functional impairment related to the mental health diagnosis.

Documentation of treatment services and interventions must meet the federal and W&I Code 14184.402 requirements if mental health services are to be claimed to Medi-Cal. Progress notes should be carefully stated to remain within Medi-Cal guidelines. If the substance use concerns a collateral person, the progress note must focus on the impact of the substance use on the identified member. In most instances, it is preferable to approach the substance use in the context of the mental health disorder and create an integrated note and treatment regime.

It is not appropriate to exclude a member from services solely because of the presence of a substance use disorder or a current state of intoxication. This decision should be made based on the member's accessibility for treatment, as well as member and provider safety concerns.

Concurrent NSMHS and SMHS

Members may concurrently receive NSMHS via FFS or MCP provider and SMHS via a BHP provider when the services are clinically appropriate, coordinated and not duplicative. When a member meets criteria for access to both NSMHS and SMHS, the member should receive services based on individual clinical need and established therapeutic relationships. BHPs must not deny or disallow reimbursement for SMHS provided to a member based on the member also meeting NSMHS criteria and/or also receiving NSMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative.

Likewise, MCPs must not deny or disallow reimbursement for NSMHS provided to a member based on the member also meeting SMHS criteria and/or receiving SMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative. Any concurrent NSMHS and SMHS for adults, as well as children under twenty- one (21) years of age, must be coordinated between MCPs and BHPs to ensure member choice. BHPs must coordinate with MCPs to facilitate care transitions and guide referrals for members receiving SMHS to transition to a NSMHS provider and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the member. Such decisions should be made via a patient-centered shared decision-making process.

Members with established therapeutic relationships with a FFS or MCP provider may continue receiving NSMHS from the FFS or MCP provider (billed to FFS or the MCP), even if they simultaneously receive SMHS from an BHP provider (billed to the BHP), as long as the services are coordinated between these delivery systems and are non-duplicative (i.e. a member may only receive psychiatry/ therapy services in one network, not both networks).

Members with established therapeutic relationships with a BHP provider may continue receiving SMHS from the BHP provider (billed to the BHP), even if they simultaneously receive NSMHS from an FFS provider or MCP provider (billed to FFS or the MCP), as long as the services are coordinated between these delivery systems and are non-duplicative.

Network Adequacy

The State requires County Behavioral Health Plans to comply with BHIN 26-023 to ensure covered services are available, accessible, and in accordance with timely access requirements as well as time or distance standards per the Medicaid Managed Care Final Rule (Mega Regs). Behavioral Health Plans are required, per BHIN 22-032, to report data on its network providers using the “274” standard which is an Electronic Data Interchange selected by DHCS to ensure provider network data submitted to DHCS is consistent, uniform, and aligns with national standards. This information is

used by DHCS to monitor whether the BHP's provider network is adequate to support the estimated need and demand for behavioral health services. For these purposes, required provider information, inclusive of identifying information, is sent to DHCS on a monthly basis

Out of Network (OON) Access

The State Department of Health Services (DHCS) requires that Behavioral Health Plans (BHPs) ensure that Members receive medically necessary services within applicable time, distance, and timely access standards. If the BHP's provider network is unable to meet those standards, the BHP shall allow Members to access out-of-network services and ensure they are adequately and timely covered. Accordingly, when required access standards cannot be met through in-network providers, the BHP must arrange and authorize services through an Out-of-Network (OON) provider at no greater cost to the Member.

San Diego BHP contracts with Optum as its Administrative Services Organization (ASO) to administer and execute Out-of-Network (OON) authorizations through Accommodation Agreements. MHP and DMC-ODS providers shall refer Members to in-network providers when arranging services related to the Member's care. If medically necessary services are not available within required time, distance, or timely access standards, Members may access services from an OON provider through the process described below.

Procedure for Out-of-Network Service Access

1. **Criteria for Executing an Accommodation Agreement:** Accommodation Agreements with OON providers are carried out when one or more of the following criteria are met:

    a. There are no San Diego County network providers within a reasonable geographic range who meet the cultural, ethnic, and/or clinical needs of the member

    b. Treatment by an OON provider is in the best clinical interest of the member as determined by County of San Diego Behavioral Health Services (BHS)

    c. Special requests made by designated County BHS staff, which may include reimbursement of providers with non-Medi-Cal funds

2. **Referring Provider Responsibilities:** When a provider determines that medically necessary SMHS or SUD services cannot be delivered within required time, distance, or timely access standards:

a. The provider shall provide case management services.

b. The provider shall assist the Member in contacting the ASO's Access and Crisis Line at 888-724-7240 (TTY 711) for referral to an appropriate provider.

c. The provider shall facilitate a warm handoff to ensure continuity of care.

d. Providers shall initiate and support the established OON process when required access standards cannot be met.

3. **ASO (Optum) Responsibilities:** Upon receipt of an OON service request:

   a. ASO Review and Processing

      i. Send written acknowledgment to the Member within three (3) working days.

      ii. Determine whether network adequacy or timely access standards cannot be met.

      iii. Complete review and authorization within thirty (30) calendar days of receipt of required documentation.

      iv. If standards cannot be met:
         1. Identify an appropriate OON provider; or
         2. Offer telehealth when clinically appropriate.

      v. If telehealth is declined and no in-network provider can meet standards, coordinate transportation for an in-person visit.

      vi. Notify the Member in writing within seven (7) calendar days of approval.

   b. Execution of Accommodation Agreement. If OON criteria are met, the ASO shall:

      i. Contact the identified OON provider.

      ii. Execute an Accommodation Agreement requiring the OON provider to:
         1. Follow County standard care procedures;
         2. Accept standard Medi-Cal rates unless otherwise negotiated;
         3. Submit required documentation (license, liability insurance, DEA if applicable).

4. Verify licensure (Primary Source Verification through the Credentialing Committee does not occur).
5. Establish the provider in the Designated Database (DDS) to enable authorization and payment.

Accommodation Agreements are time-limited and apply only to authorized service dates.

4. Member Protections

a. The Member may access the OON provider for as long as medically necessary, unless the OON provider agrees to provide services for a shorter timeframe.

b. If the BHP does not have an in-network provider able to meet applicable access standards, OON authorization shall be maintained as necessary to ensure uninterrupted access to medically necessary services.

c. The BHP shall ensure that the cost to the Member for authorized OON services is no greater than it would be if services were provided in-network.

Non- Behavioral Health Plan Services: Screening, Referral and Coordination

All providers shall give appropriate referrals and/or coordination for treatment of services provided outside of the Behavioral Health Plan's (BHP's) jurisdiction. When an individual contacts a provider and requests referral and coordination of services that are outside of the BHP's jurisdiction, (education, health, Regional Center, housing, transportation, vocational, etc.), the provider will make or coordinate such referrals based on the individual's residence and specific need.

Appropriate referrals will include providing necessary information such as phone numbers, addresses, etc. If the provider lacks the necessary information, they will offer the individual two options:

1. Give the individual the number to Optum's Access and Crisis line # at 1-888-724-7240 **or**

2. Get the individual's phone number and call them back with requested information. Requests for assistance shall be entered in the Access to Services Journal in the EHR.

Access Criteria

Criteria for Members Twenty- One (21) Years of Age or Older

As specified in Welfare and Institutions Code section 14184.402, the revised definitions and criteria below are effective January 1, 2022. AB 133 gives DHCS authority to implement the criteria for access to SMHS and medical necessity through BHIN 20-073 and supersedes California Code of Regulations (CCR), title 9, sections 1830.205 and 1830.210 and other guidance published prior to January 1, 2022 regarding access criteria for BHP reimbursement of SMHS (other than psychiatric inpatient hospital and psychiatric health facility services) until DHCS implements new regulations.

For more information, please reference DHCS Behavioral Health Information Notice BH IN 25-020 which provides guidance on screening and Transition of Care tools; BHIN 26-002 which addresses criteria for member access to SMHS, medical necessity and other coverage requirements and BHIN 22-011 '*No Wrong Door for Mental Health* 'Policy.

When the provider conducts an assessment of a member who has called or walked into the program, providers will follow the "*SmartCare Walk-in Workflow*" located at the Optum Website> *SmartCare* tab. If the Access and Crisis Line refers a member to an organizational provider or to a County-operated facility, the ACL completes an inquiry for each member. The provider's program staff is then responsible for recording all ongoing activity for that member into the EHR.

For members twenty-one (21) years of age or older, a county behavioral health plan shall provide covered specialty mental health services for members who meet **both of the following criteria**, (1) and (2) below:

The member has **one or both** of the following:

1. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.

2. A reasonable probability of significant deterioration in an important area of life functioning.

AND

The member's condition as described in paragraph (1) is due to either of the following:

1. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.

2. A suspected mental disorder that has not yet been diagnosed.

Criteria for Members Under Twenty- One (21) Years of Age

For members under age 21, a service is medically necessary if it meets criteria of Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services necessary to correct and ameliorate mental illness or condition discovered by a screening service, despite if such services are covered under the State Plan. Mental health services need not be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition and are covered as EPSDT.

Covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria below. Please note: If a member under age 21 meets the criteria as described in (1) above, the member meets criteria to access SMHS; it is not necessary to establish that the member also meets the criteria in (2) above.

1. The members have a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness

    a. (Note: Children/Youth meeting medical necessity due to significant trauma shall be based on the assessment of a licensed mental health professional.).

OR

The member meets **both of the following** requirements in a) and b) below:

a. The member has at least one of the following:

    1. Significant impairment

    2. A reasonable probability of significant deterioration in an important area of life functioning

    3. A reasonable probability of not progressing developmentally as appropriate.

4. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

AND

b. The member's condition as described in subparagraph (2) above is due to one of the following:

1. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.

2. A suspected mental health disorder that has not yet been diagnosed.

3. Significant trauma* placing the member at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

    a. *If it has been determined that a youth trauma screening tool is necessary to identify whether a member under 21 years old meets access criteria to the SMHS delivery system, as of April 1, 2026, only the DHCS-approved tools listed in Enclosure 1 may be used. DHCS Approved Youth Trauma Screening Tools. Please note that the County already requires the CA IP-CANS as an integrated part of the intake workflow.

This criterion shall not be construed to exclude coverage for, or reimbursement of, a clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service under any of the following circumstances:

a. Services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process.

b. The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.

c. The member has a co-occurring substance use disorder.

Adult and Youth Screening Tools for Medi-Cal Behavioral Health Services

The Adult and Youth Screening Tools are designed to capture information necessary for identification of initial indicators of a member's mental health needs for the purpose of determining whether the BHP must refer the member to their MCP or to an BHP provider (county-operated or contracted) to receive an assessment. DHCS is requiring MCPs and BHPs to use the Screening and Transition of Care Tools – for all members age twenty- one (21) and under (children/youth) and ages twenty- one (21) and over (adults). (BHIN 22-065) The Adult and Youth Screening Tools include both screening questions and an associated scoring methodology.

The Adult and Youth Screening Tools determine the appropriate delivery system referral for members who are not currently receiving behavioral health services when they contact the MCP or BHP. The Screening Tools are not required or intended for use with members who are currently receiving behavioral health services. The Screening Tools are also not required for use with members who contact behavioral health providers directly to obtain services.

Behavioral health providers who are contacted directly by members seeking mental health services are able to begin the assessment process and provide services during the assessment period without using the Screening Tools, via the *No Wrong Door for Mental Health Services Policy* (BHIN 22-011) or subsequent updates.

The Screening Tool will be completed by either the MCP or Optum ACL and if deemed appropriate, a referral will be made to the appropriate individual FFS or organizational provider. Upon receiving the referral, the provider/program will ensure that Timeliness Standard requirements are followed.

The Adult and Youth Screening Tools do **not** replace:

- BHPs' protocols for emergencies or urgent and emergent crisis referrals and/or P&Ps. For instance, if a member is in crisis or experiencing a psychiatric emergency, the BHP's emergency and crisis protocols shall be followed.
- BHP protocols that address clinically appropriate, timely, and equitable access to care.
- BHP clinical assessments, level of care determinations, and service recommendations.
- BHP requirements to provide EPSDT services.

Completion of the Adult or Youth Screening Tool is not considered an assessment. Once a member is referred to the MCP or BHP, they shall receive an assessment from a provider in that system to determine medically necessary mental health services.

Adult Screening Tool

The Adult Screening Tool includes screening questions that are intended to elicit information about the following:

- Safety: whether the member needs immediate attention and the reason(s) a member is seeking services.
- Clinical Experiences: whether the member is currently receiving treatment, if they have sought treatment in the past, and their current or past use of prescription mental health medications.
- Life Circumstances: challenges the member may be experiencing related to school, work, relationships, housing, or other circumstances.
- Risk: suicidality, self-harm, emergency treatment, and hospitalizations. Please note that If the member responds affirmatively to the question related to suicidality, the BHP must immediately coordinate referral to an BHP provider (County-operated or contracted) for further clinical evaluation of suicidality after the screening is complete.
- Substance Use: The Adult Screening Tool also includes questions related to substance use disorder (SUD). If a member responds affirmatively to these SUD questions, they shall be offered a referral to the county behavioral health plan for SUD assessment. The member may decline this referral without impact to their mental health delivery system referral.

Youth Screening Tool

The Youth Screening Tool includes screening questions designed to address a broad range of indicators for members under the age of twenty-one (21). A distinct set of questions are provided for when a member under the age of twenty-one (21) is contacting the BHP on their own. A second set of questions with slightly modified language is provided for use when a person is contacting the BHP on behalf of a member under the age of twenty-one (21).

The Youth Screening Tool screening questions are intended to elicit information about the following:

- Safety: whether the member needs immediate attention and the reason(s) a member is seeking services.

- System Involvement: whether the member is currently receiving treatment and if they have been involved in foster care, child welfare services, or the juvenile justice system.

- Life Circumstances: challenges the member may be experiencing related to family support, school, work, relationships, housing, or other life circumstances.

- Risk: suicidality, self-harm, harm to others, and hospitalizations. Please note-If the member responds affirmatively to the question related to suicidality, the BHP must immediately coordinate referral to an BHP provider (county-operated or contracted) for further clinical evaluation of suicidality after the screening is complete.

- SMHS Access Criteria- including those related to involvement in foster care or child welfare services, involvement in the juvenile justice system, and experience with homelessness. If a member under the age of twenty-one (21), or the person on their behalf, responds affirmatively to the questions related to SMHS access criteria, they shall be referred to the BHP for an assessment and medically necessary services. Please reference BHIN 23-041 for additional detail on SMHS criteria and definitions of key terminology.

- Substance Use: If a member under the age of twenty-one (21), or the person on their behalf, responds affirmatively to the question related to substance use, they shall be offered a referral to the county behavioral health plan for SUD assessment. The member may decline this referral without impact to their mental health delivery system referral.

Administering the Adult and Youth Screening Tools

The Adult and Youth Screening Tools can be administered by clinicians or non-clinicians in alignment with BHP protocols and in a variety of ways, including in person orby telephone/video conference. Adult and Youth Screening Tool questions shall be asked in full using the specific wording provided in and in the specific order they appear in the tools. Additional questions shall not be added to the tools. The scoring methodologies within the Adult and Youth Screening Tools shall be used to determine an overall score for each screened member. The score determines whether a member is referred to their MCP or the BHP for assessment and medically necessary services.

The Adult and Youth Screening Tools are available on the Optum Website > *UCRM* tab. For instructions on how to complete the Adult and Youth Screening Tools, please refer to the *Explanation Sheets* and other resources that can be found on the Optum Website > *UCRM* and *SmartCare* tabs.

BHPs are not required to use the PDF format and instead may build the Adult and Youth Screening Tools into existing software systems, such as electronic health records (EHRs). Contents of the Adult and Youth Screening Tools, including the specific wording, the order of questions, and the scoring methodology shall remain intact.

Following Administration of the Adult and Youth Screening Tools

After administration of the Adult or Youth Screening Tool, a score is generated. Based on their screening score, the member shall be referred to the appropriate Medi-Cal behavioral health delivery system (i.e., either the MCP or the BHP) for a clinical assessment. If a member is referred to the BHP by the MCP, based on the score generated by the Screening Tool, the BHP must offer and provide a timely clinical assessment to the member without requiring an additional screening and in alignment with existing standards and medically necessary mental health services.

If a member is referred to the MCP by the BHP based on the score generated by the Screening Tool, BHPs shall coordinate member referrals with MCPs or directly to MCP providers delivering NSMHS. Referral coordination should include sharing the completed Adult or Youth Screening Tool with the receiving program(s) and following up to ensure a timely clinical assessment has been made available to the member. Members shall be engaged in the process and provide appropriate consents in accordance with accepted standards of clinical practice.

Access and Crisis Line: 1-888-724-7240

Optum, the Administrative Services Organization (ASO) for the BHP, operates the statewide San Diego County Access and Crisis Line (ACL) which provides telephone crisis intervention, suicide prevention services, behavioral health information and referral twenty- four (24) hours a day, seven (7) days a week. The ACL may be the initial access point into the BHP for routine, urgent or emergency situations.

All ACL staff evaluates the degree of immediate danger and determines the most appropriate intervention. In an emergency, ACL staff makes direct contact with an appropriate emergency services provider to request immediate evaluation and/or admission for the member at risk. The ACL staff makes a follow-up call to that provider to ensure that the member was evaluated and that appropriate crisis services were provided. The ACL also provides access to interpreter services through the Language Line, which provides telephonic interpreter services for approximately one hundred and forty (140) languages at the point of an initial ACL screening. Members who have hearing impairment may contact the ACL via the TTY line at 711.

Provider Interface with the ACL

Providers may utilize the ACL as an adjunct to services in emergencies and after hours. To provide the most effective emergency response and back-up to their services, office voice mail should state: "*If this is a mental health emergency or crisis, please contact the Access and Crisis Line at 1-888-724-7240."* If a member is high risk and may be calling the ACL for additional support, the member's therapist or care coordinator may call (with member's approval) the ACL in advance on behalf of the member.

Referrals to the ACL

Providers shall inform members about the option of directly using the Access and Crisis Line by calling 1-888-724-7240. It is appropriate to refer individuals to the ACL for:

- Access to publicly funded Specialty Mental Health Services
- Crisis intervention for urgent situations
- Suicide Prevention
- Referrals for routine behavioral health services
- Information about mental health and mental illness
- Referrals to community resources for vocational, financial, medical, and other concerns.

Mobile Crisis Services

Mobile crisis services provide rapid response, individual assessment and community-based stabilization to members experiencing a behavioral health crisis. Goals include providing services through de-escalation and stabilization techniques; reducing immediate risk of danger and subsequent harm; and avoiding unnecessary emergency department care and psychiatric inpatient hospitalizations.

Psychiatric Emergency Response Team (PERT)

PERT has been designed to improve collaboration between the behavioral health and law enforcement systems with the goal of a more humane and effective handling of incidents involving law enforcement officers and members with mental illness, developmental disabilities and/or substance use disorders.

- The PERT team shall provide direct member interventions in conjunction with law enforcement officers to individuals experiencing a mental health crisis.

- The PERT team works to reduce inappropriate hospitalization and/or incarceration and refer members to the most appropriate, least restrictive mental health program.

- Contractor shall refer to and link members to the services needed and provides follow-up services as appropriate.

Mobile Crisis Response Teams (MCRT)

The County of San Diego has contracted with current system of care providers to provide these services and align with the requirements outlined in BHIN 23-025. Mobile crisis services are provided by a multidisciplinary mobile crisis team at the location where the member is experiencing the behavioral health crisis. Mobile crisis services shall be available to members experiencing behavioral health crises twenty- four (24) hours a day, seven (7) days a week, and three hundred and sixty-five (365) days a year. Mobile crisis response teams shall arrive at the community-based location where a crisis occurs in a timely manner within sixty (60) minutes of the member being determined to require mobile crisis services in urban and within one hundred and twenty (120) minutes in rural areas. Follow-ups to the member shall occur within seventy-two (72) hours of the initial crisis response. (2 42 U.S.C. § 1396w–6(b)(2)(C); CMS, SHO #21-008, (Dec. 28, 2021) p. 7),

Mobile crisis services include warm handoffs to appropriate settings and providers when the member requires additional stabilization and/or treatment services; coordination with and referrals to appropriate health, social and other services and supports, as needed; and short-term follow-up support to help ensure the crisis is resolved and the member is connected to ongoing care. Mobile crisis services are directed toward the member in crisis but may include contact with a family member(s) or other significant support person(s) if the purpose of the support person's participation is to assist the member in addressing their behavioral health crisis and restoring the member to the highest possible functional level.

For children and youth, in particular, mobile crisis teams shall work extensively with parents, caretakers and guardians, as appropriate and in a manner that is consistent with all federal and state laws related to minor consent, privacy and confidentiality.

Assisted Outpatient Treatment- Laura's Law

Laura's Law/Assisted Outpatient Treatment authorizes court-ordered outpatient treatment pursuant to Welfare and Institutions Code (WIC) Sections 5345-5349.5 for

individuals who have a history of untreated mental illness and meet all seven of the following criteria stipulated in the Code:

1. The person is at least eighteen (18) years of age.

2. The person is mentally ill as defined in WIC 5600.3

3. There has been a clinical determination based on the person's treatment history and current behavior that at least one of the following is true:

    a. The person is clinically determined to be unlikely to survive safely in the community without supervision.

    b. The person needs assisted outpatient treatment in order to prevent relapse or deterioration that would result in grave disability or serious harm to the person or others.

4. The person has a history of treatment non-compliance as evidenced by one of the following:

    a. Two occurrences of hospitalizations, or mental health treatment in prison or jail within the last thirty- six (36) months

    OR

    b. One occurrence of serious and violent behavior (including threats) within the last forty-eight (48) months.

5. The person has been offered treatment (including services described in WIC Section 5348) and continues to fail to engage in treatment.

6. Assisted Outpatient Treatment must be the least restrictive placement to ensure the person's recovery and stability.

7. The person is expected to benefit from AOT.

A request for an assisted outpatient treatment examination is made through one of the two In Home Outreach Team (IHOT) programs: Telecare or Mental Health Systems, Inc. The IHOT program is an outreach and engagement program for individuals who are resistant to treatment.

In the event that the referred individual is not engaged in IHOT services, a clinical determination will be made to refer the individual for an assisted outpatient examination. Following the assisted outpatient examination, the individual will be provided with the opportunity to voluntarily enter the assisted outpatient treatment program.

If the individual refuses to enter the assisted outpatient treatment program voluntarily, and the individual continues to meet all nine (9) criteria as stated in Laura's Law, a request for an assisted outpatient treatment examination is made through the BHS Director or his designee. Upon receiving the request, the BHS Director or his designee must conduct an investigation into the appropriateness of the filing of the petition.

1. The petition with an affidavit from the designated IHOT licensed mental health clinician (LMHC) shall state that s/he has personally evaluated the person within ten (10) days prior to the submission of the petition; the person meets all nine (9) criteria; the LMHC recommends AOT and is willing and able to testify at the hearing on the petition,

   OR

   The licensed mental health clinician has made within ten (10) days of filing the petition appropriate attempts to elicit the cooperation of the person but has not been successful in persuading the person to submit for the AOT examination and is willing and able to testify at the hearing on the petition.

2. If the individual refuses to be examined by a licensed mental health clinician from IHOT, the court may request the individual's consent to the examination by a licensed MH treatment clinician appointed by the court. In the County of San Diego, the Public Conservator's Office is the designated program to conduct the AOT court order examination for individuals who refused the initial examination by IHOT.

3. If the individual does not consent and the court finds reasonable cause, the court may conduct the hearing in the person's absence OR order an individual to be transported to San Diego County Psychiatric Hospital for examination by a licensed mental health professional under WIC 5150. The hold may not exceed seventy-two (72) hours.

4. In the event that the AOT examination is upheld, the County's designee, San Diego County Counsel, will file the petition with the AOT Judge and upon receipt of the petition, the court must schedule a hearing within five (5) business days. Individuals will be personally served with the petition and notice of hearing date.

5. If after hearing all evidence the court finds the individual does not meet criteria for AOT, the court may dismiss the petition.

6. If the court finds that all nine (9) criteria are met, the court may order the person to AOT for an initial period not to exceed six (6) months. The individual may voluntarily enter into a settlement agreement for services after a petition for an order of AOT is filed, but before the conclusion of the hearing. Settlement

agreements may not exceed one hundred and eighty (180) days and has the same force as an order for AOT.

7. If the person is court ordered for AOT services and is not participating in the AOT program, and if unsuccessful attempts are made to engage the person in AOT, the person may be transported to San Diego Psychiatric Hospital for up to seventy-two (72) hours to be examined to determine if the person is in need of treatment pursuant to Section 5150.

Accessing Services for Specific Populations

Community Assistance Recovery and Empowerment (CARE) Act

The Community Assistance, Recovery and Empowerment (CARE) Act program was implemented on October 1, 2023. In collaboration with County and community partners, the CARE Act program creates a new pathway to deliver mental health and substance use services to individuals who are diagnosed with schizophrenia or other psychotic disorders and are not engaged in treatment. Families, clinicians, first responders, and others may begin the process by filing a petition with the civil court to connect adult members to court-ordered, voluntary treatment if they meet criteria and may benefit from the program.

CARE Eligibility Criteria:

An individual shall qualify for the CARE process only if **ALL** of the following are true:

1. The person is eighteen (18) years of age or older.

2. The person is currently experiencing a severe mental illness, as defined in paragraph (2) of subdivision (b) of Section 5600.3 and has a diagnosis identified in the disorder class: schizophrenia spectrum and other psychotic disorders, as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders.

    a. This section does not establish respondent eligibility based upon a psychotic disorder that is due to a medical condition or is not primarily psychiatric in nature, including, but not limited to, physical health conditions such as traumatic brain injury, autism, dementia, or neurologic conditions.

    b. A person who has a current diagnosis of substance use disorder as defined in paragraph (2) of subdivision (a) of Section 1374.72 of the Health and Safety Code, but who does not meet the required criteria in this section shall not qualify for CARE process.

c. A person with a diagnosis identified in the class of mood disorders, including mood disorders with psychotic features, does not meet the required eligibility criteria for CARE process.

3. The person is not clinically stabilized in on-going voluntary treatment.

4. Participation in a CARE plan or CARE agreement would be the least restrictive alternative necessary to ensure the person's recovery and stability.

5. It is likely that the person will benefit from participation in a CARE plan or CARE agreement.

6. At least one of the following is true:

   a. The person's condition is substantially deteriorating.

   b. The person is in need of services and supports in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or others, as defined in Section 5150.

CARE Process

1. Referral**:** A referral can be initiated by family members, behavioral health providers, first responders, or other approved petitioners, by filing a petition with the Superior Court. Petitions must include required State documentation to establish clinical history. Detailed instructions on filing a CARE petition and forms can be found here: CARE Act | Superior Court of California - County of San Diego

2. Initial Determination: The Superior Court makes an initial determination as to whether the petition appears to meet criteria for the CARE Act program. If the petition appears to meet initial criteria, the Superior Court will order County Behavioral Health Services (BHS) to conduct an investigation.

3. Investigation and Engagement: County BHS will investigate and report back to the Superior Court within 14 days with a recommendation regarding the establishment of a CARE Act case. During the investigative process, BHS will conduct outreach and attempt to engage petitioned individuals with treatment and may avoid the need for a CARE Act case.

4. Establishing a CARE Agreement/ Plan: If the Superior Court determines that a case should be established, a CARE Agreement/Plan will be developed with County BHS, in partnership with the petitioned individual and their counsel. The CARE Agreement/Plan will be submitted to the Superior Court for review.

5. Connection to Services: Once a CARE Agreement/Plan is accepted by the Superior Court, BHS and its network of community-based providers such as the Telecare CARE ACT team, will actively engage the individual for whom a CARE Agreement/Plan has been established to connect to services, including behavioral health treatment, stabilization medication, a housing plan, and other supports as needed.

Program participation is twelve (12) months but may be extended for an additional twelve (12) months depending upon individual circumstances.

Secure Facility/ Long-Term Care (SF/LTC) – Adult Mental Health Services

Locked/secure facilities service those residents of San Diego County who experience serious psychiatric disabilities and require a secure, safe, and structured environment; these residents are not entitled to services through other systems, either public or private. SF/LTC Facilities funded by the County of San Diego include Institution for Mental Disease Mental Health Rehabilitation Centers (MHRC), Skilled Nursing Facilities/Special Treatment Program (SNF-STP), additional funds for a County SNF Patch, and State Hospitals.

Target Population: The persons served should have the potential to benefit functionally from psychiatric rehabilitation services and have the capacity to progress to a less restrictive level of care. The member must have a Title 9, ICD 10 psychiatric diagnosis (as the primary diagnosis) and meet the Medi-Cal criteria for psychiatric inpatient services at the time of application. The person will have been certified as gravely disabled, despite active acute care interventions and will have a temporary or permanent Lanterman-Petris-Short (LPS) Conservator. For an MHRC and SNF/STP, the age range is eighteen to sixty-four years old (18-64).

Admission: Optum provides Utilization Management for County-funded locked/secure facilities. Referring agencies shall submit an information packet to the Optum Long-Term Care (LTC) Coordinator. Please refer to the **resources** below for further details on eligibility criteria, referral process, and forms.

Placement: Individuals who meet SF/LTC Admission Criteria are placed in SF/LTC facilities that are contracted with the County of San Diego. Placement decisions are made by County Contracted SF/LTC facilities and Optum. At times, placement in a County-funded, out-of-County located program may be appropriate.

Resources:

- For additional information, processes and forms, please utilize the Long-Term Care page on the Optum Website > *Long Term Care*.

- Please also reference the Long Term Care Handbook.

BHP and MCP Responsibility to Provide Services for Eating Disorders

BHIN 22-009 states that the BHPs and MCPs share a joint responsibility to provide medically necessary services to Medi-Cal members with eating disorders. Some treatments for eating disorders (both inpatient and outpatient SMHS) are covered by BHPs. Some treatment for eating disorders is also covered by MCPs. Since eating disorders are complex conditions involving both physical and psychological symptoms and complications, the treatment typically involves blended physical health and mental health interventions, which MCPs and BHPs are jointly responsible for providing.

1. MCPs are responsible for the physical health components of eating disorder treatment and NSMHS, and BHPs are responsible for the SMHS components of eating disorder treatment.

2. BHPs must provide or arrange and pay for medically necessary psychiatric inpatient hospitalization and outpatient SMHS.

3. MCPs must provide inpatient hospitalization for members with physical health conditions, including those who require hospitalization due to physical complications of an eating disorder and who do not meet criteria for psychiatric hospitalization.

4. MCPs must cover and pay for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations.

5. For partial hospitalization and residential eating disorder programs, BHPs are responsible for the medically necessary SMHS components, and MCPs are responsible for the medically necessary physical health components.

6. DHCS does not require a specific funding split for BHPs and MCPs to share the cost of services provided in partial hospitalization and residential eating disorder programs. DHCS recommends that both parties mutually agree upon an arrangement to cover the cost of these medically necessary services.

Mental Health Services for American Indian (AI)/Native American (NA) Enrollees

The contract between the State DHCS and the BHP, to the extent that the BHP has a provider network, which enroll AI/NA must:

- Require the BHP to demonstrate that there is sufficient Indian Health Care Providers (IHCP) participating in the provider network of the BHP to ensure timely access to services available under the contract from such providers for AI/NA enrollees who are eligible to receive services.

- Require that IHCPs, whether participating or not, be paid for covered services provided to AI/NA enrollees who are eligible to receive services from such providers.

- Permit AI/NA enrollees to obtain services covered under the contract from out-of-network IHCPs from whom the enrollee is otherwise eligible to receive such services.

The BHP shall provide behavioral health care services to AI/NA enrollees who choose to have their services delivered by an Indian Health Care Provider. Programs shall contact Optum to arrange for services and payment for members referred to Indian Health Care Providers.

Mental Health Services for Parolees

On a regular basis, individuals are discharged on parole from California State penal institutions; the list of institutions can be located on the Optum Website. In many instances, these persons are in need of mental health services. State law requires the California Department of Corrections to establish and maintain outpatient clinics that are designed to provide a broad range of mental health services for parolees. Sometimes, parolees are not aware of the availability of these services and present themselves to the County of San Diego Mental Health Services (MHS) outpatient clinics for their mental health needs. It shall be the responsibility of staff to ensure that all parolees from California State penal institutions who present for mental health services at a San Diego County program are appropriately served, or referred for service, in accordance with federal, State and County regulations as set out in the following guidelines:

- Parolees who fall under the Forensic Conditional Release Program (CONREP) will be provided services in accordance with the current contract between the California Department of Health Care Services and the County of San Diego.

- Parolees who present for emergency mental health services shall be provided appropriate emergency assessment and crisis stabilization services, including processing for inpatient admission, if necessary.

- Parolees with Medi-Cal coverage can receive inpatient services at any County contracted acute care hospital. Indigent parolees can receive inpatient services at the San Diego Psychiatric Hospital.

- Parolees who are Medi-Cal members and who meet specialty mental health access criteria, as specified in Welfare and Institutions Code section 14184.402 and BHIN 20-073 will be provided medically necessary Medi-Cal covered mental health services.

- Parolees, whether or not they are Medi-Cal members, who do not meet specialty mental health access criteria will be referred for services at the local Department of Corrections-established outpatient mental health clinic, which is designed to meet the unique treatment needs of parolees, or to another health care provider.

- Parolees who are not Medi-Cal members and who do meet specialty mental health access criteria will be informed of the availability of services at the local Department of Corrections-established outpatient mental health clinic and may choose to receive services from either County Mental Health or from the local Department of Corrections outpatient mental health clinic.

Mental Health Services for Veterans

Federal law has established the Department of Veterans Affairs (USDVA) to provide benefits to veterans of armed services. In 1996, the U.S. Congress passed the Veterans' Health Care Eligibility Reform Act, which created the Medical Benefits Package, a standardized, enhanced health benefits plan (including mental health services) available to all enrolled veterans. A prior military service record, however, does not automatically render a person eligible for these benefits. Only veterans who have established eligibility through the USDVA and have enrolled may receive them. In recognition of the fact that there are veterans in need of mental health services who are not eligible for care by the USDVA or other federal health care providers, the legislature of the State of California in September 2005 passed AB599, which amended section 5600.3 of the California Welfare and Institutions Code (WIC).

Specifically, veterans who are ineligible for federal services are now specifically listed as part of the target population to receive services under the mental health account of the local mental health trust fund ("realignment"). California veterans in need of mental health services who are <u>not</u> eligible for care by the USDVA or other federal health care provider and who meet the existing eligibility requirements of section 5600.3 of the WIC shall be provided services to the extent resources are available. It shall be the responsibility of staff to ensure that all veterans who present for mental health services at a San Diego County program are appropriately assessed and assisted with accessing their eligible benefits provided through the USDVA or other federal health care program or are referred and provided services through a San Diego County program.

<u>Referral Process for Providing Mental Health Services to Veterans</u>

1. **Adult/Older Adult Mental Health Services: Staff** will ask the member if he or she is receiving veterans' services benefits. If the member states he or she is

receiving benefits or claims to have served in the military, the staff will be responsible for completing the following procedure:

a. The staff will complete "*Request for Verification of Veterans Eligibility for Counseling and Guidance Services Fax Form*" that will contain all appropriate demographic information and required member signature.

b. The form shall be faxed to the Veterans Service Office for verification at (858) 505-6961, or other current fax number.

c. If an urgent response is required, the mental health provider shall note on the Request Form in the Comment Section and contact the office by telephone after faxing the Request Form. All individuals who present for emergency mental health services shall be provided appropriate emergency assessment and crisis stabilization services, including processing for inpatient admission, if necessary.

d. If the member meets the eligibility criteria for seriously mentally ill persons and is receiving veteran benefits but needs mental health services not offered by the USDVA, the member can be offered mental health services.

e. If the member meets the eligibility criteria for seriously mentally ill persons and eligibility for veterans' services is pending, the member can be offered mental health services until the veterans' services benefit determination is completed.

2. **Veterans Service Office:** The Veterans Service Office will receive the "Request for Verification Eligibility to Counseling and Guidance Services Fax Form" confirming member's eligibility or ineligibility for veterans' services and mail or fax findings to the County mental health program or contracted program.

   a. The Veterans Service Office will respond to the Request for Verification of Veterans Eligibility for Counseling and Guidance Services Fax Form within two (2) to three (3) business days upon receipt of the Fax Request.

   b. The Veterans Service Office will make referrals for benefit determination for an individual upon verification of eligibility status for veterans' services. The Veterans Service Office will also assist individuals in getting an appointment set up for evaluation of services if needed.