587 TRANSITION TO ADULTHOOD

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REFERENCES: A.R.S. § 36-551; A.R.S. § 36-550; A.R.S. § 36-501; A.A.C. R4-6-212; IDEA Part B, Section 1415 (m); Section 504 of the Rehabilitation Act of 1973; AMPM 587; AMPM 520; AMPM 320-P

PURPOSE

This policy establishes the Division of Developmental Disabilities' (Division's) requirements for providing behavioral health services and supports to Members who are transitioning to adulthood by strengthening practice in the Integrated System of Care and promoting continuity of care through collaborative planning. This policy is an optional resource for the Tribal Health Program and is not a requirement for the Tribal Health Program.

DEFINITIONS

1. "Adult Recovery Team" or "ART" is a group of individuals that, following the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, work in collaboration and are actively involved in a Member's assessment, service planning, and service delivery. At a minimum, the team consists of the Member, Member's Health Care Decision Maker if

applicable, advocates if assigned, and a qualified behavioral health representative. The team may also include the Member's family, physical health, behavioral health or social service Providers, other agencies serving the Member, professionals representing various areas of expertise related to the Member's needs, or other individuals identified by the Member.

2. "Adult System of Care" or "ASOC" means a spectrum of effective community-based services and supports for adult Members and their families who live with, or who are at risk for, physical or behavioral health challenges. The ASOC is organized into a coordinated network, builds meaningful partnerships with families and Members, and addresses their cultural and linguistic needs in order to help them to function better at home, in school, work, in the community, and throughout life.
3. "Assessment" means the ongoing collection and analysis of an individual's medical, psychological, psychiatric, and social conditions in order to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the individual's service plan is

designed to meet the individual's and family's current needs and long-term goals.

4. "Child and Family Team" or "CFT" is a group of individuals that includes, at a minimum, the child and their family, or Health Care Decision Maker. A behavioral health representative, and any individuals important in the child's life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare Providers, coaches, and community resource Providers, representatives from churches, temples, synagogues, mosques, or other places of worship/faith, agents from other service systems like the Arizona Department of Child Safety (DCS) or the Division. The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore, expand and contract as necessary to be successful on behalf of the child.

5. "Children's System of Care" or "CSOC" means a spectrum of effective community-based services and supports for children and their families who live with, or who are at risk for, physical or behavioral health challenges. The CSOC is organized into a coordinated network, builds meaningful partnerships with families and Members, and addresses their cultural and linguistic needs in order to help them to function better at home, in school, in the community, and throughout life.

6. "Health Care Decision Maker" or "HCDM" means an individual who is authorized to make health care treatment decisions for a Member. As applicable to the situation, this may include a parent of an unemancipated minor or an individual lawfully authorized to make health care treatment decisions as specified in A.R.S. §§ Title 14, Chapter 5, Article 2 or 3; or A.R.S. §§ 8514.05, 36-3221, 36-3231 or 36-3281.

7. "Integrated Systems of Care" or "ISOC" means the coordination of physical and behavioral health care within the AHCCCS health care delivery system to ensure appropriate, adequate, and

timely services for all Members.

8. "Member" means the same as "Client", a person receiving developmental disabilities services from the Division, as specified in A.R.S. § 36-551.

9. "Mental Disorder" means, as specified in A.R.S. § 36-501, a substantial disorder of the person's emotional processes, thought, cognition, or memory. Mental Disorder is distinguished from:

    a. Conditions that are primarily those of drug abuse, alcoholism, or intellectual disability, unless, in addition to one or more of these conditions, the person has a Mental Disorder.
    b. The declining mental abilities that directly accompany impending death.
    c. Character and personality disorders characterized by lifelong deeply ingrained antisocial behavior patterns, including sexual behaviors that are abnormal and prohibited by statute unless the behavior results from a

Mental Disorder.

10. "Provider" means, for purposes of this policy, an agency or individual operating under a contract or service agreement to engage in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State.

11. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability, or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

12. "Seriously Mentally Ill" or "SMI" means, as specified in A.R.S. § 36-550, persons who as a result of a Mental Disorder exhibit emotional or behavioral functioning that is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. In these persons mental disability is severe and persistent, resulting in a long-term limitation of their functional capacities for primary activities of

daily living such as interpersonal relationships, homemaking, self-care, employment, and recreation.

13. "Serious Mental Illness Evaluation" means the process of analyzing current and past treatment information including assessment, treatment, other medical records, and documentation for purposes of making a determination as to an individual's Serious Mental Illness eligibility.
14. "Service Plan" means a complete written description of all covered health services and other informal supports which includes individualized goals, family support services, peer-and-recovery support, care coordination activities and strategies to assist the Member in achieving an improved quality of life.
15. Transition Planning means an individualized, collaborative process that helps Members acquire skills to prepare for adulthood by:
    a. Providing services and supports that reinforce the Member's health and wellness.

b. Ensuring a seamless transition from the Children's System of Care to the Adult System of Care.

c. Fostering an understanding that becoming a stable and productive adult is a process that occurs over time and can extend beyond the age of eighteen.

POLICY

A. REQUIREMENTS FOR MEMBERS TRANSITIONING TO ADULTHOOD

1. The Division shall require Providers to utilize the best practices outlined in this policy for assisting Members in transitioning to adulthood.
2. The Division shall require clinical practice and behavioral health Providers to deliver services that are:
   a. Individualized;
   b. Strengths-based; and
   c. Culturally sensitive.
3. The Division shall require Providers to begin Transition Planning when the Member reaches the age of 16.

4. The Division shall require Providers to begin Transition Planning prior the Member's 16th birthday if:
    a. The Child and Family Team (CFT) determines that planning should begin in advance to identify needed supports; and
    b. To allow more time for the Member to acquire the necessary life skills.
5. The Division shall require Providers to begin Transition Planning immediately for Members who are age 16 and older at the time they enter the Children's System of Care.

B. TRANSITION TO ADULT BEHAVIORAL HEALTH SERVICES

1. The Division shall require Providers to complete an evaluation and referral for a Serious Mental Illness (SMI) eligibility determination for Members, at the age of 17.5 if:
    a. It is determined that the Member has a qualifying SMI diagnosis; or
    b. If an evaluation is requested by any member of the CFT, unless declined by the Responsible Person.

2. The Division shall require children's behavioral health Providers to contact and invite the adult behavioral health Provider to upcoming planning meetings if:
    a. The Member is determined eligible for services as a person with a SMI; and
    b. The Responsible Person consents.
3. The Division shall require the adult behavioral health services case manager to join the CFT and participate in the Transition Planning process.
4. The Division shall require the Provider who is directly responsible for behavioral health service planning and delivery to ensure collaboration occurs when more than one behavioral health Provider is involved in the Member's care.
5. The Division shall require the AdSS to have a process for ensuring collaboration and coordination of care between the CFT and the SMI Provider.
6. The Division shall allow Members not eligible for an SMI designation to retain their current CFT team members and

Providers until the Member turns 21, when requested by the Responsible Person.

7. The Division shall require the children's behavioral health Provider to coordinate Transition Planning with the adult general mental health Provider four months prior to the transition to adult services when the young adult Member is not eligible for services as a person with a SMI.
8. The Division shall require the child and adult behavioral health Providers, when Transition Planning, to:
    a. Coordinate service delivery;
    b. Identify services that will be needed; and
    c. Identify the methods for ensuring payment for those services to meet the individualized needs of the Member.

C. REQUIREMENTS FOR INFORMATION SHARING PRACTICES, AND ELIGIBLE SERVICE FUNDING

1. The Division shall require the CFT and adult behavioral health Providers to review and follow health record disclosure requirements specified in Division Medical Policy 940 prior to releasing treatment information.

2. The Division shall require Providers to assist the Member with seeking services that may be available under non-Medicaid funding if the Member is not Medicaid eligible as an adult, as specified in AMPM Policy 320-T1.

D. TRANSITION PLANNING REQUIREMENTS

1. The Division shall require Providers to obtain updated treatment documents that require signature when the Member turns 18 with:
   a. The Member's signature; or
   b. The Responsible Person's signature, if the Responsible Person is someone other than the Member and changed upon the Member turning 18.
2. The Division shall not require Providers to conduct a full Assessment at the time of transition from child to adult behavioral health services unless:
   a. An annual update is due; or
   b. There have been significant changes to the Member's status that clinically indicates the need to update the Assessment.

3. The Division shall require behavioral health Providers to orient the Member and their family to potential changes they may experience as part of the transition to the Adult System of Care to:
    a. Minimize any barriers that may hinder seamless service delivery; and
    b. Support the Member's and family's understanding of their changing roles and responsibilities.
4. The Division shall require the AdSS to ensure that its subcontracted network of Providers:
    a. Evaluate the need for a referral to a family support partner or peer mentor to assist the Member and family with transition to the Adult System of Care;
    b. Complete crisis and safety planning prior to the Member's transition to the Adult System of Care as specified in 320-O; and
    c. Notify the Member of the type of crisis services that will be available through the Adult System of Care and how to access crisis services when needed.

E. PERSONAL CHOICE

The Division shall require the AdSS to ensure their subcontracted network of Providers support Members with:

a. Making informed decisions about their treatment, unless there is a Responsible Person other than Member;

b. Developing goals and identifying methods, services, and supports necessary to meet the needs of transitioning to adulthood;

c. Including supportive team members, their parents, and any other identified natural supports;

d. Acquiring self-advocacy skills to assist them in learning how to speak and advocate on their own behalf as outlined in Division Medical Policy 584;

e. Providing information about how the behavioral health service delivery systems operate in accordance with the Arizona Vision and 12 Principles for Children's Service Delivery and nine guiding principles for recovery-oriented adult behavioral health services and systems, as specified in AMPM 100;

f. Utilizing best practices to build community supports and pro-social activities for Members who have disclosed to the behavioral health service Provider their self-identity as gay, lesbian, bisexual, or transgender;

g. Maintaining or building a support structure as the Member transitions to adulthood; and

h. Aligning services with the family and Member's cultural beliefs while transitioning to adulthood.

F. COLLABORATION WITH SYSTEM PARTNERS

1. The Division shall require the AdSS to ensure their subcontracted network of Providers coordinate with the following system partners to promote collaborative planning and seamless transitions to the Adult System of Care:

   a. Schools

      i. Prepare Members and their parents in developing an understanding of what happens as Members transition from secondary education to adult life;

ii. Collaborate with school staff to receive individualized plans and gather information to assist the behavioral health Provider with Transition Planning;

iii. Collaborate with school staff to determine if the Member is eligible for a transition plan through the Individualized Education Plan (IEP); and

iv. Collaborate with the school to determine if the Member is eligible to participate in school-based work activities.

b. Department of Child Safety (DCS)

Work with the DCS Specialist to determine if Members in foster care may be eligible for services through the Young Adult Program (YAP) and Transitional Independent Living Program (TILP).

c. Department of Economic Security/Rehabilitation Services Administration (DES/RSA)

Discuss the appropriateness of a referral to DES/RSA under a Vocational Rehabilitation program with the CFT as early as age 14 or any time thereafter when the Member is ready to work.

2. The Division shall require behavioral health Providers to assist Members and their families or caregivers in accessing or preparing necessary documentation, including:

   a. Birth certificates;

   b. Social security cards and social security disability benefit applications;

   c. Driver's license or State identification cards;

   d. Medical records including any eligibility determinations and evaluations;

   e. IEP Plans;

   f. Certificates of achievement, diplomas, General Education Development transcripts, and application forms for college;

g. Case plans for Members continuing in the foster care system;

h. Treatment plans;

i. Selective Service registration;

j. Documentation of completion of probation or parole conditions.;

k. Guardianship applications.;

l. Advance directives;

m. Redeterminations of Division eligibility; and

n. Voter registration.

G. TRANSITION PLANNING ACTIVITIES

1. The Division shall require the AdSS to ensure their network of behavioral health Providers perform the following Transition Planning activities:

a. Assess self-care and independent living skills needs of each

Member;

b. Provide Members services and supports that meet their self-care and independent living skills needs;

c. Collaborate with other system partners to plan and prepare the Member for employment or other vocational opportunities, through the following activities:

i. Utilizing career interest inventories or engaging in vocational assessment activities to identify potential career preferences, volunteer opportunities, or other meaningful activities;

ii. Identifying skill deficits and effective strategies to address these deficits;

iii. Determining training needs and providing opportunities for learning through practice in real world settings;

iv. Learning about school-to-work programs that may be available in the community and eligibility

requirements;

v. Developing vocational skills such as building a resume, filling out job applications, interviewing preparation, use of online job sites, etc.;

vi. Learning federal and state requirements for filing annual income tax returns; and

vii. Offering opportunities for work experience in the community, whether it is through employment, volunteering, or internship experience when the Member reaches the age of 14.

d. When postsecondary education is the goal for the Member, assist the Member with the following:

i. Matching the Member's interests with the right school;

ii. Connecting the Member to the preferred schools, and assisting with applications for scholarships or other financial aid; and

iii. Connecting the Member with the Disability Resource Centers from their preferred postsecondary institutions if accommodations are needed.

e. Plan for medical and physical healthcare by assisting the Member with the following:

i. Transferring healthcare services from a pediatrician to an adult health care Provider, if pertinent;

ii. Applying for medical and behavioral health care coverage, including how to select a health plan and a physician;

iii. Preparing an application for submission at age 18 to AHCCCS for ongoing Medicaid services;

iv. Obtaining personal and family medical history (e.g., copies of immunization records, major illnesses, surgical procedures);

v. Providing information to the Member on advance

directives as indicated in the Division Medical Policy 640;

vi. Identifying methods and supports needed for managing healthcare appointments, keeping medical records, following treatment recommendations, and taking medication;

vii. Assessing the supports or training needed to identify healthcare concerns, address questions during appointments, and consult with doctors regarding diagnosis, treatment, and prognosis; and

viii. Assessing the supports or training needed for the Member to understand and manage the symptoms of their mental illness and obtaining knowledge of the benefits, risks, and side effects of their medication.

f. Evaluate and plan for the Member's living arrangements to include:

i. Assessing the ability to live independently;

ii. Identifying the level of community supports needed;

iii. Identifying the least restrictive living arrangement options to meet the Member's assessed needs and personal preferences;

iv. If needed, assisting the Member with completing and filing applications for public housing or other subsidized housing programs;

v. Allowing Members to continue to receive treatment at a BHIF at the time they turn 18 if they continue to require treatment and give their consent; and

vi. Allowing licensed residential agencies to continue providing behavioral health services to individuals aged 18 or older if the following conditions are met as specified in A.A.C. R9-10-318 (B):

1) Person was admitted before their 18th birthday and is completing high school or a high school equivalency diploma, or is participating in a job

training program, is not 21 years of age or older; or

2) Through the last day of the month of the person's 18th birthday.

g. Complete financial planning to include:

i. Reviewing and updating any federal and state financial forms to reflect the Members's change in status to avoid disruptions in healthcare or financial assistance services, including applying for food stamps, housing, or other emergency assistance;

ii. Assisting Members who are eligible for Social Security Income (SSI) benefits as a child with obtaining disability redetermination during the month preceding the month of their 18th birthday;

iii. Assisting the Member and their family or caregiver with identifying any changes related to Social Security benefits, including opportunities for Social

Security Work Incentives;

iv. Setting up a simple checking and/or savings account to learn how it can be used to pay bills, save money, and keep track of transactions, if needed;

v. Identifying weekly/monthly expenses that occur such as food, clothes, school supplies, and leisure activities and determining the monetary amount for each area if needed;

vi. Learning how to monitor spending and budget financial resources if needed;

vii. Providing education on how credit cards work and differ from debit cards, including an understanding of finance charges and minimum monthly payments if needed; and

viii. Understanding the short and long-term consequences of poor financial planning (e.g., overdrawn account [NonSufficient Funds fee],

personal credit rating, eligibility for home and/or car loans, potential job loss) if applicable.

h. Address legal considerations when the Member is 17.5 years of age to ensure the Member has the necessary legal protections upon reaching the age of majority, including:

i. Guardianship;

ii. Conservator;

iii. Special needs trust; and

iv. Advance directives (e.g., living will, powers of attorney).

i. Educate the family and Member on the transportation options available through the adult service delivery system to support the Member's continued attendance at behavioral health treatment appointments; and

j. Identify and plan for other transportation needs that are not necessarily associated with accessing medical or

behavioral health services.

H. TRAINING AND SUPERVISION RECOMMENDATIONS

1. The Division shall require the AdSS to ensure:

   a. Providers are trained and understand how to implement the practice elements outlined in this policy;

   b. The AdSS' network and Provider agencies are notified of changes in policy and additional training is available if required; and

   c. The AdSS provides documentation demonstrating that all required network and Provider staff have been trained on this policy upon request from AHCCCS or the Division.

2. The Division shall monitor the AdSS for incorporation of this policy into other supervision processes the AdSS and their network and Provider agencies have in place for direct care clinical staff, in alignment with A.A.C. R4-6-212, Clinical Supervision Requirements.

I. DIVISION OVERSIGHT AND MONITORING OF AdSS

The Division shall provide oversight and monitoring of compliance by Administrative Services Subcontractors serving Members enrolled in a DDD subcontracted health plan with respect to any contractual delegation of duties specific to this policy and as specified in AdSS Medical Policy 587 using one or more of the following methods:

a. Completing annual operational reviews of compliance;

b. Reviewing applicable policies and procedures;

c. Review of deliverable reports or other data as applicable;

d. Conducting oversight meetings with each AdSS for the purpose of reviewing compliance and addressing any systemic access to care concerns or other quality of care concerns; and

e. Reviewing data submitted by the AdSS demonstrating ongoing compliance monitoring of their network and Provider agencies through Behavioral Health Clinical Chart

Reviews.

SUPPLEMENTAL INFORMATION

A. Transition to adulthood is a process that occurs over many years and varies depending on the individual. Involving families in the Transition Planning process and collaborating with the Member to identify the individual needs acknowledges the diversity that is needed when accessing services and supports.

B. Often, Members who successfully transition to adulthood are those that acquire a set of skills and the maturational level to use these skills effectively. Transition Planning can emphasize interpersonal skill training through a cognitive-behavioral approach to help youth develop positive social patterns, assume personal responsibility, learn problem-solving techniques, set goals, and acquire skills across various life domains.

C. Planning for a Member's transition to adulthood involves a working partnership among team members in the Children's System of Care and the Adult System of Care.

D. Whenever possible, it is recommended that the young adult and their family be given the choice of whether to stay with the children's

Provider or transition to the adult behavioral health service Provider. The importance of securing representation from the adult service Provider in this process cannot be overstated, regardless of the person's identified behavioral health category assignment (SMI, General Mental Health, Substance Use). The children's behavioral health Provider should be persistent in its efforts to make this occur.

E. Members, upon turning age 18, will be required to sign documents that update their responsibilities with relation related to their behavioral health treatment as an adult. Some examples include a new consent to treatment and authorizations for sharing protected health information to ensure that the team members can continue as active participants in service planning.

F. Members who learn about financial matters prior to age 18 have a better opportunity to acquire the skills necessary for money management.

G. Some families/caregivers may decide to seek legal advice from an attorney who specializes in mental health, special needs and/or disability law in planning for when their child turns 18 if they believe legal protections are necessary. Parents, caregivers, or guardians may

choose to draw up a will or update an existing one to ensure that adequate provisions have been outlined for supporting their child's continuing healthcare and financial stability.

H. Persons with developmental disabilities, their families and caregivers may benefit from information about different options that are available when an adult with a disability needs the assistance of another person in a legally recognized fashion to help manage facets of their life. Refer to the Disability Rights Arizona's Legal Options Manual for access to information and forms. This publication also addresses tribal jurisdiction in relation to the guardianship process for individuals who live on a reservation. While this resource is focused on planning for individuals with disabilities, teams can utilize this information to gain a basic understanding of the legal rights of individuals as they approach the age of majority.

I. OTHER LEGAL CONSIDERATIONS

1. Transfer of Rights' Requirement for Public Education Agencies.

   Under Arizona State law, a child reaches the age of majority at 18. The right to make informed educational decisions transfers

to the young adult at that time.

a. According to IDEA, "beginning not later than one year before the child reaches the age of majority under State law, a statement that the child has been informed of the child's rights under this title, if any, that will transfer to the child on reaching the age of majority under section 1415(m)" must be included in the student's IEP. This means that schools must inform all youth with disabilities on or before their 17th birthday that certain rights will automatically transfer to them upon turning age 18; and

b. In order to prepare Members with disabilities for their transfer of rights, it is necessary for parents/caregivers to involve their child in educational decision-making processes early. The CFT or ART, in conjunction with the adult behavioral health Provider, should assist the Member/parent/caregiver with this process.

2. A student with a disability between the age of 18 and 22, who has not been declared legally incompetent, and has the ability to

give informed consent, may execute a Delegation of Right to Make Educational Decisions. The Delegation of Right allows the student to appoint their parent or agent to make educational decisions on their behalf. The student has the right to terminate the agreement at any time and assume their right to make decisions.

J. For Housing options, refer to Arizona 2-1-1 for state and federally funded programs, and other areas for consideration when addressing housing needs.

Signature of Chief Medical Officer: Anthony Dekker (Feb 11, 2025 08:44 MST)