104 CMR 29.00: APPLICATION FOR DMH SERVICES, REFERRAL, SERVICE PLANNING AND APPEALS

Section

29.01: Scope and Purpose

(1) Scope. 104 CMR 29.00 applies to the application for and the provision of DMH services in community programs and services that are contracted for, or operated by the Department.

(2) Purpose. 104 CMR 29.00 is issued to provide a framework by which DMH services are provided in the community to adults with serious and long term mental illness and children and youth with serious emotional disturbance.

29.02: Definitions

Adult. For purposes of 104 CMR 29.00, an individual who is 22 years of age or older.

Area Director. The individual responsible for the administration and operation of Department activities in the DMH Area where the individual or, in the case of a minor, where his or her legally authorized representative resides.

Area Medical Director. The senior psychiatrist with clinical oversight of Department activities in the DMH Area where the individual or, in the case of a minor, where the minor's legally authorized representative resides; the role of Area Medical Director may be delegated to a child psychiatrist with clinical oversight of services provided to youth in the Area.

Case Management, Including Critical Need Case Management and Transition Case Management. A service operated by the Department, which is performed in accordance with the provisions of 104 CMR 29.00. The scope of Case Management is set forth at 104 CMR 29.05.

Client. An individual for whom DMH services have been authorized and who is enrolled in a DMH service.

DMH. Department of Mental Health.

DMH Community Services. Community based services contracted for or operated by the Department, but which do not include: Case Management, or short term services provided pursuant to 104 CMR 29.04(1)(h), outpatient clinic services, forensic or court ordered evaluations, or acute mental health services, such as crisis intervention or emergency screening. DMH Community Services do not include services provided in facilities licensed pursuant to 104 CMR 27.00: *Licensing and Operational Standards for Mental Health Facilities*.

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DMH Services. DMH Community Services and/or Case Management.

Preadmission Screening and Resident Review (PASRR). For purposes of 104 CMR 29.00, an assessment required by federal regulations, 42 CFR 483.100 *et seq*., which is performed prior to admission to a nursing facility and periodically during the time one has already been admitted to a nursing facility, to identify in accordance with applicable federal law whether an individual has a serious mental illness for the purposes of PASRR specialized services or other services to address the individual's needs related to their serious mental illness. The initial identification function is termed a Level I Screen. A Level II is the evaluation conducted for purposes of confirming the identification of a serious mental illness and evaluating and determining whether nursing facility services and specialized services are needed or whether the individual is better served in the community.

Short Term Admission. For purposes of 104 CMR 29.00 a short-term admission applies to:

(a) an individual who is admitted to a nursing facility under a time limited PASRR categorical determination as specified in the Massachusetts Medicaid State Plan for individuals with certain diagnoses, levels of severity of illness, or need for a particular service; or

(b) an individual admitted to a nursing facility for up to 30 days for treatment of a medical condition under a PASRR exempted hospital discharge as provided in 43 CFR 483.106(2)(b).

Specialized Services. For purposes of 104 CMR 29.00, Specialized Services, as provided in the Massachusetts Medicaid State Plan, are services which exceed the services ordinarily provided by nursing facilities and which address specific service needs related to a person's serious mental illness in accordance with 42 CFR 483.120(a)(1).

Youth. An individual younger than 22 years old.

29.03: General Provisions

(1) The Department is responsible for providing or arranging for DMH services to adults with serious and long term mental illness, and children and youth with serious emotional disturbance, who are determined to meet clinical criteria and to need DMH services. DMH services are provided along a continuum of intensity, and are authorized in accordance with individuals' needs, as determined pursuant to 104 CMR 29.00. DMH service planning activities include provisions for transitions between levels of intensity as individuals' needs may change. An individual will only be authorized to receive a DMH community service if the Department has the available capacity and resources to provide the DMH community service.

(2) To be authorized to receive a DMH service, an individual must:

(a) be domiciled within Massachusetts;

(b) meet the clinical criteria set forth in 104 CMR 29.04(3); and

(c) be determined to need a DMH service in accordance with 104 CMR 29.04(4).

(3) An individual requesting DMH services, or a legally authorized representative requesting services on behalf of an individual, from the Department shall be informed that provision of DMH services is contingent upon the availability of services and funding, and the:

(a) need to apply and be approved for DMH services;

(b) obligation to provide, or to assist the Department in obtaining, necessary and relevant information about the individual's needs and resources, including access to entitlements, insurance and other services, as determined by the Department;

(c) individual's right to participate in DMH services planning activities as set forth in 104 CMR 29.06;

(d) process of service planning in determining individual needs at time of service authorization and as individual needs change during the course of service delivery;

(e) authority of the Department or its providers to charge for and, if applicable, adjust charges for services pursuant to 104 CMR 30.04: *Charges for Services* and for services and support to 104 CMR 30.06: *Charges for Residential Services and Supports in the Community*;

(f) right to appeal:

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1. a denial of an application for DMH services based on clinical criteria or a determination regarding an individual's need for DMH services in accordance with 104 CMR 29.16; and

2. a DMH services planning activity or implementation decision, as included in an individual service plan or community service plan, in accordance with 104 CMR 29.16(4); and

(g) the authority of the Department to maintain the individual's personal health information, and to manage its confidentiality in accordance with state and federal law.

(4) All information given to individuals pertaining to the application and DMH services planning activities pursuant to 104 CMR 29.00, including notifications, comprehensive assessment of needs, clinical and other assessments, individual service plans and community service plans shall be conveyed or written in language that is easy to understand, and to the extent practicable, in the individual's preferred language.

(5) DMH services are designed to be flexible in accordance with an individual's needs, to promote access to treatment and resiliency, be culturally competent, facilitate recovery, and support individuals to live, attend school, work and participate in their communities.

(6) To the maximum extent feasible, individuals authorized to receive DMH services will receive services that are age and developmentally appropriate and culturally competent.

(7) Unless otherwise specified, computation of time for any action required to be taken under 104 CMR 29.00 shall be in accordance with 104 CMR 25.04: *Computation of Time*.

29.04: Application for DMH Services; Domicile, Clinical Criteria and Determination of Need; Services Provided Pursuant to a PASRR Evaluation and Determination

Except as provided in 104 CMR 29.04(6) for individuals determined to have a serious mental illness as a result of a PASRR Level II evaluation, 104 CMR 29.04 shall apply to all individuals for whom an application for DMH services is submitted.

(1) Application for DMH Services.

(a) An application for DMH services for an individual shall be submitted to the DMH Area Office where the individual or, in the case of a minor, where the minor's legally authorized representative, resides.

(b) An application may be submitted by:

1. An individual or the individual's legally authorized representative. An individual may be assisted by another person in completing the application.

2. A facility or program on behalf of an individual:

a. if the facility or program submitting the application has obtained authorization from the individual or the individual's legally authorized representative to do so; or

b. if the facility or program believes an individual lacks the capacity to apply for services, and has filed a petition with the Probate and Family Court for guardianship for the individual.

(c) An application shall include the following:

1. a completed application form;

2. supporting documentation of psychiatric evaluations and clinical records, and place of domicile that are available to the individual. The individual or the individual's legally authorized representative may be asked to authorize the Department to obtain additional information which it deems necessary to support the application.

(d) The Department may, in its discretion, require a personal interview and/or a clinical evaluation of the individual to gather additional information to support the application.

(e) An application shall be considered complete when the Department has received the completed application form and such additional information which it deems necessary to support the application.

(f) Time frame for actions to be taken on an application:

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1. Within five business days of receipt of an application form, the Area Director or designee shall review the application to determine whether additional information is required, and shall notify the applicant that the application has been received and request any additional information identified. If it appears that the applicant is not domiciled within Massachusetts, as provided in 104 CMR 29.04(2), the Area Director or designee shall deny the application and shall so notify the applicant pursuant to 104 CMR 29.04(2)(c).

2. Within 20 business days of receipt of an application form, the Area Director or designee shall determine whether the application is complete, and if any additional information requested has not been received, and shall so notify the applicant or take other appropriate steps to obtain such information.

3. Within 20 business days of receipt of the completed application, including any additional information requested by the Department, the Area Director or designee shall determine whether the individual meets clinical criteria set forth in 104 CMR 29.04(3).

4. During the pendency of an application, the Area Director or designee shall actively engage the applicant in completing the application process, including provision of any additional information. Such engagement may include provision of critical need case management pursuant to 104 CMR 29.05(3) or other short term services that do not require full service authorization pursuant to 104 CMR 29.04(1)(i)

a. If within 90 days of receipt of the application, any additional information, personal interviews and/or clinical evaluations have not been received or completed, the Area Director or designee may make a determination on the application based upon such information as is then available.

b. If at the end of such 90-day period the Area Director or designee determines that there is insufficient information upon which to make a determination, but the applicant and/or the applicant's family is engaged in the application process, the Area Director or designee shall extend the 90-day period for a reasonable length of time in order to complete the process.

c. If at the end of such 90-day period, or extension thereof, the Area Director or designee determines that there is insufficient information upon which to make a determination and the applicant and/or the applicant's family is not engaged in the application process, and if despite active attempts to engage the applicant, the applicant refuses to provide such additional information or to participate in a personal interview and/or clinical evaluation, the application may be deemed withdrawn.

5. Within 20 business days of an individual being determined to meet clinical criteria for DMH services as set forth in 104 CMR 29.04(3), the Area Director or designee shall determine whether the individual needs DMH services as set forth in 104 CMR 29.04(4).

6. The Area Director or designee may extend the time periods within 104 CMR 29.04(1)(f) for good cause.

(g) The Department may redetermine whether a client continues to meet the criteria for DMH Services pursuant to 104 CMR 29.04(3) and (4) annually; when a client's circumstances have changed; or when information becomes available that may affect the Department's decision regarding service authorization.

(h) If during the application process the Area Director or designee determines that the individual is in need of short term services, in addition to active engagement as provided in 104 CMR 29.04(1)(f)4, including critical need case management, the Area Director or designee may authorize such services. During this period, the individual's application shall be considered "pending". Provision of such services does not indicate whether an application will be approved, and shall not be subject to appeal pursuant to 104 CMR 29.16.

(i) The Department may develop services that, in the Department's sole discretion, may be authorized without requiring an applicant to submit a full application or to meet the clinical and service need requirements as provided in 104 CMR 29.04.

1. Requests for and approval of such services shall be based on criteria determined by the Department to be applicable to such services.

2. An individual who receives such services shall not be considered a DMH client for purposes of 104 CMR 29.00; provided however, a provider of such services may be required by contract to comply with service planning provisions of 104 CMR 29.00.

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3. An individual receiving services pursuant to 104 CMR 29.04(1)(i) may, in addition, apply for and be authorized for services pursuant to 104 CMR 29.03.

4. Denial of a request for services pursuant to 104 CMR 29.04(1)(i) shall not be subject to appeal pursuant to 104 CMR 29.16.

(2) Domicile. The following factors shall be used in determining whether an individual is domiciled within Massachusetts:

(a) An individual will be determined to be domiciled within Massachusetts if the individual:

1. lives within Massachusetts with the intention to remain a resident of Massachusetts permanently or for an indefinite period; or

2. is a minor whose parent(s) or legal guardian lives within Massachusetts with the intention to remain a resident of Massachusetts permanently or for an indefinite period.

(b) There shall be a presumption that the following individuals are not domiciled in Massachusetts:

1. Individuals who reside in a home, group living environment, residential school, or other setting subject to licensure or regulation by Massachusetts, which residence was arranged or is being funded by another State, including any agency or political subdivision thereof and any entity under contract with the other State for such purposes;

2. Persons who reside in a home, group living environment, residential school, or other setting subject to licensure or regulation by Massachusetts, which residence were arranged by a parent, guardian, or family member who is not domiciled in Massachusetts, and was not so domiciled at the time of the person's placement.

(c) An individual whose application for services is denied based on a determination that the individual is not domiciled within Massachusetts shall be so notified and shall be informed that such determination may be appealed in accordance with 104 CMR 29.16.

(3) Clinical Criteria for DMH Services.

(a) Adult Services. To meet the clinical criteria to receive DMH services, individuals 22 years of age or older, must have a serious, and persistent mental illness that, except as provided in 104 CMR 29.04(3)(c), meets the criteria for the following qualifying diagnostic categories specified within the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*:

1. Schizophrenia Spectrum and other Psychotic Disorders;
2. Bipolar and Depressive Disorders;
3. Anxiety Disorders;
4. Dissociative Disorders;
5. Feeding and Eating Disorders;
6. Borderline Personality Disorder;
7. Obsessive-compulsive and Related Disorders;
8. Trauma and Stressor Related Disorders; and

which mental illness is the primary cause of functional impairment that substantially interferes with or limits the individual's performance of one or more major life activities, and is expected to do so in the succeeding year.

(b) Child and Youth Services. To meet the clinical criteria to receive DMH services, individuals younger than 22 years old at the time of application, must have a serious emotional disturbance that, except as provided in 104 CMR 29.04(3)(c)(2), meets diagnostic criteria for a diagnosis specified within the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, which is the primary cause of functional impairment that substantially interferes with or limits the individual's performance of one or more major life activities, and is expected to do so in the succeeding year.

(c) Non-qualifying Disorders.

1. The following diagnoses do not qualify as the primary cause of functional impairment for the purpose of adult service authorization:

a. Under Bipolar and Depressive Disorders: Persistent Depressive Disorder (Dysthymia), Disruptive Mood Dysregulation Disorder and Premenstrual Dysphoric Disorder;

b. Under Anxiety Disorders: Separation Anxiety Disorder and Selective Mutism;

c. Under Feeding and Eating Disorders: Binge Eating DO;

d. Under Obsessive Compulsive and Related Disorders: Hoarding DO;

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e. Under Trauma and Stressor Related Disorders: Adjustment Disorders;

f. Other diagnoses identified in interpretive guidelines that may be issued by the Department.

2. The following diagnoses do not qualify as the primary cause of functional impairment for the purpose of service authorization for any individual of any age:

a. Neurodevelopmental Disorders;

b. Neurocognitive Disorders;

c. Mental Disorders Due to a Another Medical Condition (*e.g.*, traumatic brain injury);

d. Substance-related/Induced and Addictive Disorders;

e. Disruptive, Impulse Control and Conduct Disorders; or

f. Other diagnoses identified in interpretive guidelines that may be issued by the Department.

(d) Individuals 18 through 21 Years of Age at the Time of Application: For transition planning purposes, the determination of whether an individual who is 18 through 21 years of age at the time of application meets clinical criteria for youth pursuant to 104 CMR 29.04(3)(b) shall include a consideration of whether the individual is likely to meet the clinical criteria for adults pursuant to 104 CMR 29.04(3)(a).

1. If it appears that the individual is likely to meet clinical criteria for adults pursuant to 104 CMR 29.04(3)(a), then the determination of need conducted pursuant to 104 CMR 29.04(4) shall include consideration of services the individual may need after the individual's 22nd birthday.

2. If it appears that the individual meets clinical criteria for youth pursuant to 104 CMR 29.04(3)(b), but is not likely to meet clinical criteria for adults pursuant to 104 CMR 29.04(3)(a), then the determination of need conducted pursuant to 104 CMR 29.04(4) shall include planning for, and consideration of, transitional services and support that may be offered to assist the individual in the individual's transition out of DMH services.

(e) No later than 12 months before the individual's 22nd birthday, a youth who was determined to meet clinical criteria pursuant to 104 CMR 29.04(3)(b), and is enrolled in a DMH service shall be referred for determination of whether the youth meets clinical criteria under 104 CMR 29.04(3)(a).

1. If the youth is determined to meet clinical criteria under 104 CMR 29.04(3)(a), the individual shall continue to receive the DMH service previously authorized until such time as the individual's service needs are reviewed in accordance with 104 CMR 29.04(4) and it is determined that the individual's service needs have changed.

2. If the youth is determined not to meet clinical criteria under 104 CMR 29.04(3)(a), then the youth will be engaged in planning and will be offered transitional services and support to assist in the individual's transition out of DMH services.

(f) Result of Determination Relative to Clinical Criteria.

1. If an individual is found to meet the clinical criteria for DMH services as set forth in 104 CMR 29.04(3), then the Area Director or designee shall determine whether the individual needs DMH services as provided in 104 CMR 29.04(4).

2. If an individual does not meet the clinical criteria set forth in 104 CMR 29.04(3), a notice denying the application for DMH services will be sent to the individual and the individual's legally authorized representative and, if appropriate, to the facility or program that submitted the application in accordance with 104 CMR 29.04(1)(b)2. The notice shall:

a. set forth the reasons for the denial;

b. inform the individual and the individual's legally authorized representative of the right to appeal the denial of the application for DMH services based on clinical criteria pursuant to 104 CMR 29.16(3); and

c. inform the individual and the individual's legally authorized representative of other community services that may be available to meet the individual's needs.

If after reasonable efforts, neither the individual nor the individual's legally authorized representative can be located, the denial shall be noted in the individual's application file and no further action will be required.

(4) Determination of Need for DMH Services. The determination of whether an individual who has been found to meet the clinical criteria for DMH services as set forth in 104 CMR 29.04(3), needs DMH services, will be based on the following:

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(a) contact with the applicant and the applicant's legally authorized representative to review the individual's request for services and the individual's current status;
(b) determination of whether the individual's service needs, personal goals, and service preferences can be met by a DMH service;
(c) assessment of the individual's current resources, entitlements, and insurance that allow for provision of appropriate services in the community; and
(d) assessment of the availability of appropriate services from other public or private entities.

(5) Result of Determination of Need for DMH Services.
(a) If it is determined that the individual needs DMH Services, and that there is existing capacity in an appropriate service, the services will be authorized. The Area Director or designee will notify the individual and the individual's legally authorized representative and, if appropriate, the facility or program which submitted the application on the individual's behalf pursuant to 104 CMR 29.04(1)(b)2. The notice shall:
1. state that services have been authorized;
2. state the DMH services identified as needed; and
3. identify the service provider who will be contacting the individual to engage in service planning and delivery.
(b) If it is determined that an individual needs DMH services, but there is no capacity in such service(s), the Area Director or designee will so notify the individual and the individual's legally authorized representative and, if appropriate, the facility or program which submitted the application on the individual's behalf pursuant to 104 CMR 29.04(1)(b)2.
1. The Area Director or designee will thereafter periodically contact the individual or the individual's legally authorized representative regarding the individual's status and continued need for DMH service(s).
2. At such time when the DMH service(s) becomes available, the individual will be offered a referral to such service(s); provided however, that:
a. the Department may request updated information to determine whether the individual still needs the particular DMH service being offered;
b. if it has been more than 12 months since the individual was determined to meet criteria for DMH services pursuant to 104 CMR 29.04(3) and (4), the Area Director or designee may refer to the individual for redetermination of whether the individual continues to meet such criteria.
(c) If the individual or the individual's legally authorized representative indicates that the individual no longer needs or wants DMH services, a notice will be sent to the individual and the individual's legally authorized representative that the application is considered withdrawn.
(d) If after reasonable efforts, neither the individual nor the individual's legally authorized representative can be located, the application will be deemed withdrawn; provided however, if the applicant reapplies for services within 12 months of the applicant's application being deemed withdrawn, the applicant shall be presumed to continue to meet the clinical criteria for DMH services; and provided further, the Department may require updated information to conduct service planning.
(e) If it is determined that the individual does not need DMH services, the application will be denied and the Area Director or designee will so notify the individual and the individual's legally authorized representative and, if appropriate, the facility or program which submitted the application on the individual's behalf pursuant to 104 CMR 29.04(1)(b)2. The notice shall:
1. set forth the reasons for the denial;
2. inform the individual and the individual's legally authorized representative of the right to appeal the denial of the application for DMH services based on need pursuant to 104 CMR 29.16(4); and
3. inform the individual and the individual's legally authorized representative of other community services that may be available to meet the individual's service needs.

If after reasonable efforts, neither the individual nor the individual's legally authorized representative can be located, the denial shall be noted in the individual's application file and no further action will be required.

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(f) If an individual whose application was denied because of a determination that the individual did not need DMH services reapplies due to a change in circumstances within 12 months of such denial, the individual shall be presumed to continue to meet the clinical criteria for DMH services; provided however, the Department may require updated information to complete a determination of need pursuant to 104 CMR 29.04(4).

(6) Services Provided Pursuant to a PASRR Evaluation and Determination. The provisions of 104 CMR 29.04(6) shall apply to individuals who are subject to a PASSR evaluation as a result of a referral for or admission to a nursing facility.

(a) Level II Evaluation and Determination. An individual who is determined by the Department to have a serious mental illness as the result of a PASRR Level II evaluation shall:

1. be deemed to meet the domicile requirements of 104 CMR 29.04(2).
2. be deemed to meet the clinical criteria for DMH services as set forth in 104 CMR 29.04(3).
3. be determined to need any Specialized Services identified in the applicable PASRR Level II evaluation, and if such service is a DMH service, shall be authorized to receive such service.
4. Additional Services: When the applicable PASRR Level II evaluation recommends additional services that may facilitate a diversion or discharge from a nursing facility, DMH shall:
   a. authorize transition case management services.
   b. determine whether such recommended services are DMH services;
   c. determine the individual's need for such services in accordance with 104 CMR 29.04(4);
   d. authorize such services in accordance with 104 CMR 29.04(5); provided, however, that if DMH does not have the capacity to provide the needed service, transition case management shall remain engaged with the individual to assist in identifying other services that may be appropriate or until the needed service is available; and
   e. support the individual in obtaining recommended services that are needed and which DMH does not provide.

(b) Determinations regarding provision of services made pursuant to 104 CMR 29.04(6)(a)4 shall be subject to appeal in accordance with 104 CMR 29.16.

(c) No application for DMH services shall be required for the provision of services pursuant to 104 CMR 29.04(6); provided, however, that DMH shall provide the individual with required information and notices, as provided in 104 CMR 29.03(3), and may require additional information from the individual and authorization for the communication of personal health information between previous health care providers and providers of such services.

(d) Upon diversion or discharge from a nursing facility of an individual with serious mental illness, determinations regarding clinical criteria, need for services and service authorizations made in accordance with 104 CMR 29.04(6) shall remain in effect, subject to the provisions of 104 CMR 29.00; provided, however, that except as provided in 104 CMR 29.15, no such individual shall be discharged from DMH services without the approval of the applicable Area Director and Area Medical Director.

29.05: Case Management

(1) Individuals who are determined to need Case Management shall be referred to the appropriate case management office.

(2) Case Management. Case Management shall include:

(a) arranging for and completing comprehensive assessments of service needs;
(b) convening service planning meetings;
(c) developing and reviewing individual service plans;
(d) reviewing community service plans, when applicable, to ensure compatibility with clients' individual service plans;

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(e) assisting clients in obtaining other available services from public or private entities as are identified in clients' individual service plans, including behavioral health and medical benefits available through commercial and publicly funded health plans and programs;
(f) coordinating services for clients, and/or monitoring the coordination of DMH and non DMH services;
(g) providing outreach, as needed;
(h) providing intensive support and advocacy, as needed;
(i) reviewing private and public health plan entitlements and options to assist the client in selecting third party benefits that best match service needs and maintain continuity of care;
(j) other services within the scope of the Medicaid service known as targeted case management.

(3) Critical Need Case Management; Transition Case Management.
(a) The Area Director or designee may authorize critical need case management for an individual during the pendency of a service authorization application, as provided in 104 CMR 29.04(1)(g), or after an individual has been authorized for DMH services, if a specific critical need is identified within the scope of Case Management Services.
(b) Critical need case management shall include active short term engagement to complete an assessment of service needs and service planning activities required for Case Management pursuant to 104 CMR 29.06 and 104 CMR 29.07 and may include other activities as provided in 104 CMR 29.05(2); provided however, the assessment of service needs, specific activities and time frames for such activities may be modified in the sole discretion of the Area Director or designee as necessary to meet the identified critical need.
(c) Transition case management shall be authorized for an individual as provided in 104 CMR 29.04(6).
(d) Transition case management shall include active engagement, assessment of service needs and service planning activities to facilitate the diversion or discharge of individuals from nursing facilities.

29.06: General Provisions for All DMH Services Planning Activities

(1) Planning activities incorporate strengths, preferences, service needs and goals of clients, and where appropriate, of their families and include assessments, the development and review of individual service plans and community service plans. Clients who receive Case Management will have individual service plans developed in accordance 104 CMR 29.06 and 104 CMR 29.07. Clients who receive DMH community services will have community service plans developed in accordance with 104 CMR 29.06 and 104 CMR 29.11.

(2) DMH Services planning activities are:
(a) trauma informed, person centered, and strength based; and when the client is a youth, are also youth guided and family driven;
(b) sensitive and responsive to a client's cultural, ethnic, linguistic background, sexual orientation, gender identity, parental status, and other individual family needs, where appropriate;
(c) based on the results of assessments which are reviewed and modified as the client's service needs, preferences or circumstances change;
(d) informed by information obtained through interactions with the client, when appropriate the client's family, other natural supports, and the client's service providers with the appropriate authorizations, as well as previous records as available;
(e) conducted in the client's preferred language by staff fluent in the language or through competent interpreters; and
(f) coordinated with the client, the client's legally authorized representative, current and potential service providers, other Department staff, and any other person, including family members, whose participation is requested or consented to by the client or the client's legally authorized representative.

(3) The goals of DMH Services planning activities are to:
(a) promote client recovery and resiliency;
(b) identify the services, treatment and other community supports a client needs that are culturally competent and age and developmental-stage appropriate;

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(c) facilitate or provide access to those services, treatment, and supports, including strategies to ensure client engagement in such services; and

(d) ensure that the provision of services is consistent with the client's strengths, preferences, service needs, and goals, is provided in the least restrictive setting possible, and promotes community participation and independence to the fullest extent possible.

(e) identify goals demonstrating successful completion of service and plans for transition.

(4) All planning activities will be conducted in partnership with clients, client's families as authorized, and client's legally authorized representatives. Clients will be:

(a) engaged and supported to participate actively in the planning processes to the maximum extent possible;

(b) present at all applicable planning and review meetings, unless client is unwilling or unable to attend;

(c) encouraged and assisted to engage family members or other persons of the client's choice to participate; and

(d) encouraged to identify and discuss their goals, preferred services and programs during planning meetings and shall otherwise be supported to participate in a meaningful way in the discussions and decision making process.

(5) When clients are unable or choose not to take part in a meaningful way in planning activities, steps shall be taken to minimize obstacles to such participation. Such steps may include, but are not be limited to:

(a) developing plans for increasing the ability of clients to participate;

(b) modifying the schedule or structure of the meetings or making other accommodations designed to increase client participation;

(c) educating clients to facilitate and increase their participation; and

(d) continuing to actively engage clients in ways that assist them to make choices regarding their services to the maximum extent possible.

29.07: Individual Service Plans

(1) Each client who receives Case Management shall have a written individual service plan based on a comprehensive assessment of service needs conducted in accordance with 104 CMR 29.07(2) and developed in accordance with 104 CMR 29.07; provided however, for individuals who receive critical need case management or transition case management, the content and time frame for conducting the assessment of service needs and development of an individual service plan may be modified consistent with the reasons for which critical need case management or transition case management was approved pursuant to 104 CMR 29.05(3).

(2) Comprehensive Assessment of Service Needs. The individual service plan shall be based on a comprehensive assessment of the client's strengths, preferences, service needs and goals.

(a) The case manager shall arrange for and complete a comprehensive assessment of the client's service needs within 20 business days of assignment, unless an extension is granted by the Area Director or designee.

(b) The comprehensive assessment of service needs shall include review of the documents submitted with the client's application and other records, as needed; a personal interview with the client that will include, but not be limited to, identification of the client's service preferences and recovery goals; an interview with the client's legally authorized representative; and interviews with other persons as agreed upon by the case manager and the client or the client's legally authorized representative, and shall be documented using a Department approved report form.

(c) The comprehensive assessment of service needs shall be updated at least once each year before the completion of the annual individual service plan review provided in 104 CMR 29.09.

(3) Development of Individual Service Plans.

(a) General Provisions.

29.07: continued

1. The individual service plan shall identify the strengths, preferences, service needs and goals of the client and family, as appropriate; and the treatment, services and programs which address the identified strengths, service needs and goals, including DMH services and those available from other public and private entities. The plan shall be developed together with the client, and such others, including family members as authorized by the client or legally authorized representative, and in collaboration with other services providers as applicable.

2. Services included on an individual service plan shall be, to the maximum extent possible, consistent with the client's strengths, preferences, service needs and goals, and shall be provided in the least restrictive setting.

3. The individual service plan shall be developed with the fullest possible coordination with the client's other services and treatment, including educational services and special education services, where applicable.

4. The individual service plan shall include specified treatment, services, programs, service providers and goals. If specified services are not available, the individual service plan shall detail other available services which are, to the maximum extent possible, consistent with the client's identified strengths, preferences, service needs and goals, and provided in the least restrictive setting.

5. In developing the individual service plan, the case manager shall try to informally resolve any differences that may occur between service providers. If the case manager is unable to informally resolve any such differences, within five business days after identification of the dispute, the Area Director or designee shall be notified of the need for intervention.

(b) Preparation of the Individual Service Plan.

1. Within ten business days of the completion of the comprehensive assessment of service needs, the case manager, together with the client, shall convene a meeting to prepare the individual service plan. In addition to the case manager and the client, persons invited to attend the meeting shall include the client's legally authorized representative, and may include:

a. current and potential service providers;

b. other Department staff;

c. any other person, including family members, whose participation is requested or consented to by the client or the client's legally authorized representative.

2. Preparation of the individual service plan shall include a discussion of the following:

a. the client's goals;

b. the preferences of the client and the client's legally authorized representative regarding services;

c. the client's service needs in the context of the client’s assessed strengths;

d. recommended services for the client;

e. currently available treatment and services, including those provided through commercial and publicly funded health plans and programs or available from other agencies or entities, and including, where appropriate, services available to support the client's family in assisting the client to meet the client’s goals;

f. potential and present service providers;

g. dates, actual or anticipated, for commencement of each service;

h. the steps necessary to complete and implement the individual service plan, and to achieve the client's goals;

i. criteria for completion of services and plan for transition;

j. a description of the financial assistance and services from federal, state and local agencies available to the client, including any benefits to which the client may be entitled but is not currently receiving;

k. the client's need for a guardian or a financial fiduciary.

(c) A request for authorization for DMH services recommended in the individual service plan that have not been previously authorized shall be made to, and acted upon, by the Area Director or designee within five business days of the individual service plan meeting, after which time the individual service plan will be finalized and given to the client and the client’s legally authorized representative for acceptance or rejection, in accordance with 104 CMR 29.08.

29.08: Acceptance or Rejection of the Individual Service Plan

(1) Once the written individual service plan is complete, it shall be given to the client and, if applicable, the client's legally authorized representative for acceptance or rejection.

(a) Upon acceptance by the client or the client's legally authorized representative, the individual service plan shall be implemented.

(b) If the client or the client's legally authorized representative does not reject the individual service plan within 20 days of receipt, the plan shall be deemed to be accepted.

(c) If the client, or the client's legally authorized representative rejects some or all of the services identified in the individual service plan, the case manager shall record this rejection in the client's record and shall inform the client's of the right to meet with the case manager within five business days of the rejection to discuss the individual service plan and possible modifications. If agreement regarding any such modifications is not reached and the client or the client's legally authorized representative continues to reject the proposed plan, the client, or the client's legally authorized representative may appeal the individual service plan pursuant to 104 CMR 29.16.

(2) The parts of the individual service plan that are accepted by the client or the client's legally authorized representative may be implemented immediately, if appropriate.

29.09: Annual Review of the Individual Service Plan

(1) No later than one year from the date of the last completed or substantially modified individual service plan, the case manager, the client, and the client's legally authorized representative shall complete a review of the client's individual service plan. The purpose of this review is to:

(a) ensure that treatment and services continue to be consistent with the client's strengths, preferences, service needs and goals as identified in the comprehensive assessment of needs, as it may have been revised;

(b) determine whether there has been progress toward attainment of goals and objectives stated in the client's individual service plan;

(c) ensure services continue to be, to the maximum extent possible, consistent with the client's strengths, preferences, service needs, and goals; and where appropriate, the strengths, preferences, service needs, and goals of the client's family, and with the goals of the individual service plan and are provided in the least restrictive setting;

(d) to reassess, if appropriate, the client's need for a guardian, or other fiduciary; and

(e) ensure the client's community service plans, if any, continue to be compatible with the individual service plan and to determine if service goals have been met.

(2) Within ten business days of the completion of the annual review, the case manager, together with the client, shall convene a meeting to prepare an updated individual service plan. In addition to the case manager and the client, persons invited to attend the meeting shall include:

(a) the client's legally authorized representative;

(b) current and potential service providers;

(c) other Department staff;

(d) any other person, including family members, whose participation is requested or consented to by the client or the client's legally authorized representative.

Preparation of the updated individual service plan shall include discussion of the factors outlined in 104 CMR 29.07(3)(b)2.

(3) A request for authorization for DMH services recommended in the individual service plan that have not been previously authorized shall be made to, and acted upon by, the Area Director or designee within five business days of the individual service plan meeting.

(4) The written individual service plan shall be given to the client, or the client's legally authorized representative, for acceptance or rejection as provided in 104 CMR 29.08.

(5) If at the time of the annual review it appears that the client may no longer meet the criteria for DMH services, the client will be referred for redetermination in accordance with the provisions of 104 CMR 29.04. Action on any such redetermination shall be subject to 104 CMR 29.04 and 104 CMR 29.13 or 29.14, as applicable, and shall be subject to appeal pursuant to 104 CMR 29.16.

29.10: Modification of the Individual Service Plan

(1) Requests for modification of an individual service plan may be initiated by the client, the client's legally authorized representative, the client's DMH community service provider(s), or the client's case manager.

(2) Modifications shall be made in an individual service plan whenever it is determined at an annual review or at any other time, in accordance with the service planning procedures required by 104 CMR 29.00, that such a change will permit the client to receive more appropriate or less restrictive services consistent with the client's strengths, preferences, service needs and goals, or that the client no longer needs a service or services.

(3) No modification of an individual service plan shall be made without the acceptance of the client or the client's legally authorized representative unless it is determined that the modification is required:

(a) to comply with state contracting requirements (*e.g.*, that compliance with state purchase of service regulations or other applicable contracting requirements requires a change in a service provider); or

(b) to avoid a serious or immediate threat to the health, mental health or safety of the client or other persons.

(4) The client or the client's legally authorized representative may reject and appeal a proposed or denied modification pursuant to 104 CMR 29.16. No modification under appeal may be implemented before the appeal is decided without the consent of the client, or the client's legally authorized representative, unless it is determined that the modification is required for the reasons stated in 104 CMR 29.10(3)(a) or (b).

(5) Clients may have additional remedies, including the protections enumerated under the Community Residence Tenancy Law, M.G.L. c. 186, § 17A.

(6) If the modification involves a substantial change in assessment of the client's service needs, as determined by the case manager and the client or the client's legally authorized representative, the modification may follow the procedures outlined in 104 CMR 29.09, and serve as the client's annual review. In such case, the date of the next annual review shall be calculated from the date of acceptance of the modified plan. If the modification is minor, as determined by the case manager and the client or the client's legally authorized representative, the individual service plan will be reviewed no later than 12 months from the last time the individual service plan was completed or reviewed.

29.11: Community Service Plans

(1) Each client who receives a DMH community service shall have a community service plan that is consistent with applicable service standards. The plan shall be developed by the program that provides the service, together with the client, and the client's legally authorized representative and family members, if appropriate, and in collaboration with other service providers, if applicable.

(2) General Provisions.

(a) In accordance with applicable service standards:

1. Community service plans are based on assessments, including clinical assessments, conducted or arranged for by the program that provides the community service, as appropriate.

2. To the maximum extent possible, community service plans should reflect the strengths, preferences, service needs and goals of the client and family, as appropriate.

3. Community service plans contain measurable criteria for the completion of the service and anticipated transition plan.

(b) Upon acceptance, community service plans and reviews are signed by the client or legally authorized representative.

(c) Copies of the community service plans and reviews are given to the client or legally authorized representative, and to the client's other service providers as authorized by the client, or legally authorized representative.

29.11: continued

(d) If a client receives Case Management, the case manager is included in the planning activities, and a copy of the client's community service plan and modifications thereto are submitted to the case manager. The community service plan shall be compatible with the client's individual service plan.

(e) If a client is not receiving Case Management, the client's community service plan and modifications thereto are provided to the Department upon request.

29.12: Acceptance or Rejection of the Community Service Plan

(1) Once the written community service plan is complete, it shall be given to the client or the client's legally authorized representative for acceptance or rejection.

(a) Upon acceptance by the client or the client's legally authorized representative, the community service plan shall be implemented.

(b) If the client, or the client's legally authorized representative, does not object to the community service plan within 20 days of receipt, the plan shall be deemed to be accepted.

(c) If the client, or the client's legally authorized representative, rejects some or all of the community service plan, the program shall inform the client's of the right to meet to discuss the community service plan and to discuss possible modifications.

(d) If agreement regarding any such modifications is not reached and the client or the client's legally authorized representative continues to reject the proposed plan, the client or the client's legally authorized representative may appeal the plan pursuant to 104 CMR 29.16.

(2) The parts of the community service plan that are accepted by the client or the client's legally authorized representative may be implemented immediately, if appropriate.

29.13: Review of the Community Service Plan

(1) All community service plans are reviewed by the provider together with the client and the client's legally authorized representative at least annually, or at intervals determined by the applicable service standards, as needs change, or upon the request of the client, or the client's legally authorized representative. The purpose of this review is to:

(a) evaluate the client's progress and current status in meeting the goals set forth in the community service plan; and

(b) evaluate whether the services, goals, objectives, and interventions continue to be consistent with the client's strengths, preferences, service needs, goals and individual service plan, if any, and to modify the community service plan as appropriate, and to determine if service goals have been met.

(2) If a community service plan is modified as a result of a review conducted pursuant to 104 CMR 29.13, the modified community service plan will be given to the client and the client's legally authorized representative for acceptance or rejection as provided in 104 CMR 29.12.

(3) If after reviewing the community service plan, the DMH community service provider recommends the client no longer receive a DMH community service, including attainment of the goals of the service as reflected in the community service plan, the service provider will notify the Area Director or designee for appropriate action, which may include a redetermination of whether the client continues to meet the clinical criteria for DMH services in accordance with 104 CMR 29.04. Action on any such redetermination shall be subject to 104 CMR 29.04 and 104 CMR 29.13 or 104 CMR 29.14, as applicable, and shall be subject to appeal pursuant to 104 CMR 29.16.

(4) The Department may conduct utilization review activities to determine whether the client's community service plan is meeting the service needs and addressing the goals of the client.

(5) If the DMH community service provider determines the client has not met the client's responsibility, to the extent of the client's ability, to respect the rights of other clients and staff in the program or residential site of the program, or to conform to reasonable operational rules of the program or residential site of the program, there shall be a review of the client's community service plan. The program director, or designee, shall document the situation, including any known precipitating factors and efforts at resolution; and in conjunction with the client and the client's legally authorized representative, shall develop a plan to address the situation;

29.13: continued

(a) If the plan does not resolve the situation, the client may be asked to leave the program or residential site of the program; provided however, that any modification of an community service plan necessitated by such request shall be governed by the provisions of 104 CMR 29.13;
(b) No client shall be discriminated against or asked to leave a program due to the exercise of any right set forth in 104 CMR 28.00: *Licensing and Operational Standards for Community Services*;
(c) The program director shall notify the Department before a client is asked to leave a program or residential site of a program;
(d) A client who is asked to leave a program or residential site of a program may request a review of that decision by the Human Rights Committee or by the Area Director or designee;
(e) Clients may have additional remedies, including the protections enumerated under the Community Residence Tenancy Law, M.G.L. c. 186, § 17A.

29.14: Transition from DMH Services to Other Levels of Service

(1) If upon redetermination in accordance with 104 CMR 29.04, the Area Director or designee determines that the client no longer meets the clinical criteria for DMH services or no longer needs such services, a date will be set for transition planning to other levels of service, as appropriate. The Area Director or designee shall:
(a) notify the client and the client's legally authorized representative of the basis for the determination and, the date that transition planning will begin;
(b) notify the client and the client's legally authorized representative of the right to appeal the determination based on clinical criteria pursuant to 104 CMR 29.16(3) or based on need for DMH services pursuant to 104 CMR 29.16(4);
(c) note the determination in the applicable community record;
(d) engage the client in transition planning to the fullest extent possible and state on the individual plan, if applicable, a transition plan with appropriate follow-up services, the name and contact information of the agency or person, if any, responsible for the provision of future services to the individual, or state that no further services are currently needed.

(2) If an appeal is filed pursuant to 104 CMR 29.16, transition shall be deferred until the appeal is completed.

(3) With the consent of the individual or the individual's legally authorized representative, the Department will, for 30 days after the date of transition, support the individual to engage in appropriate services, and provide assistance in securing such services, as necessary. Such 30-day period may be extended by the Area Director or designee.

(4) If a client who has transitioned from DMH services, pursuant to 104 CMR 29.14 or 104 CMR 29.15, reapplies due to a change in circumstances, the client shall be presumed to meet clinical criteria pursuant to 104 CMR 29.04; provided however, the Department may require updated information to confirm that the client continues to meet clinical criteria or to conduct a determination of need pursuant to 104 CMR 29.04. Resumption of services shall be contingent upon a determination the client needs DMH services, and the availability of such services, as provided in 104 CMR 29.04(4).

29.15: Requests for Discharge from Services; Disengagement from Services

(1) If a client or the client's legally authorized representative requests discharge from DMH services, the request will be referred to the Area Director or designee for review.
(a) If the Area Director or designee concurs with the request, the client shall be discharged.
(b) If such request is against the advice of the Area Director or designee, the Department shall direct efforts, for a reasonable period of time, to encourage the client or the client's legally authorized representative to continue such services. If, notwithstanding such efforts, the client or the client's legally authorized representative still requests discharge, the client shall be discharged. Efforts to encourage continued participation and discharge from services shall be documented in the client's record.

29.15: continued

(2) If a client disengages from DMH services without formal request or notification, the Department shall direct efforts to reengage the client. The mechanisms and time frame for such reengagement efforts shall be determined by the Area Director or designee.

(a) When a clinical decision is made that reengagement efforts have failed and are unlikely to succeed in the foreseeable future, the Area Director or designee shall be notified.

(b) If the Area Director or designee concurs, the client shall be discharged and shall no longer be a client. Efforts to reengage the client and discharge from services shall be documented in the client's record.

29.16: Appeals of Denials of DMH Services and Services Planning

(1) General Provisions.

(a) 104 CMR 29.16(3) contains the standards and procedures for appeals of determinations relative to clinical criteria pursuant to 104 CMR 29.04(3).

(b) 104 CMR 29.16(4) contains the standards and procedures for appeals of a determination that an individual is not domiciled within Massachusetts pursuant to 104 CMR 29.04(2), a determination of need pursuant to 104 CMR 29.04(4), of major individual and community service planning and implementation decisions, and of discharges from DMH services pursuant 104 CMR 29.14.

(c) To the maximum extent possible, disagreements should be informally resolved prior to utilizing this appeal mechanism.

(d) An appeal may be initiated by any of the following individuals:

1. an individual whose application for DMH services has been denied, or the individual’slegally authorized representative;
2. a client or the client’s legally authorized representative;
3. a person designated by the individual or client to act as the individual’s or client’s representative if there is no legally authorized representative.

(2) Subject Matter of an Appeal.

(a) The following issues may be appealed pursuant to 104 CMR 29.16:

1. whether denial of an application for DMH services, based on domicile pursuant to 104 CMR 29.03, clinical criteria pursuant to 104 CMR 29.04(3), or the determination that an individual no longer meets clinical criteria pursuant to 104 CMR 29.04(4), has a reasonable basis;
2. whether the result of a determination of need pursuant to 104 CMR 29.04(4) has a reasonable basis;
3. whether the comprehensive assessment of service needs and the individual service plan, or any modifications thereof, have a reasonable basis and were developed and reviewed and implemented in accordance with the requirements of 104 CMR 29.06 through 104 CMR 29.10;
4. whether assessments and the community service plan, or any modifications thereof, have a reasonable basis and were developed, reviewed and implemented in accordance with the requirements of 104 CMR 29.06 and 104 CMR 29.11 through 104 CMR 29.13;
5. whether discharge from DMH services pursuant to 104 CMR 29.14 has a reasonable basis;
6. whether the determination regarding provision of services made pursuant to 104 CMR 29.04(6)(a)4. has a reasonable basis.

(b) The following issues are not subject to appeal pursuant to 104 CMR 29.16:

1. Decisions regarding the available capacity of DMH services;
2. Decisions regarding provision of services pursuant to 104 CMR 29.04(1)(h) and (i);
3. Decisions regarding whether DMH will offer a service outside of its customary operated or contracted service system (*e.g.*, specialized residential services);
4. Decisions based on whether DMH has available resources to pay for or provide a particular service; and
5. Decisions regarding the provider available to provide a particular service.

(3) Appeal of Denial of an Application for DMH Services Based on Clinical Criteria. Denial of an individual's application, or a redetermination, for DMH services based on clinical criteria may be appealed as follows:

29.16: continued

(a) Request for Resolution Conference. Within ten days of receipt of the notice of the denial of application based on clinical criteria, the individual or the individual's legally authorized representative may request a resolution conference with the Area Director or designee.

1. The Area Director may accept a request for a resolution conference received after ten days for good cause shown.

2. The resolution conference may be waived by agreement between the individual or the individual's legally authorized representative and the Area Director or designee, in which case the individual or the individual's legally authorized representative may submit a request for reconsideration pursuant to 104 CMR 29.16(3)(c).

(b) Within ten business days of receipt of the request for a resolution conference, or at such later date as the individual or the client's legally authorized representative and the Area Director may agree, the Area Director or designee shall hold a resolution conference with the individual and the individual's legally authorized representative.

1. The individual or the individual's legally authorized representative may include other persons to this conference, if the individual wishes.

2. After such meeting, if the issues are not resolved, the individual or the individual's legally authorized representative shall be notified that a written notice of appeal may be submitted to the Area Medical Director.

(c) Area Clinical Appeal. The individual or the individual's legally authorized representative may submit a written notice of appeal to the Area Medical Director within ten days after conclusion of the informal conference or the agreement to waive such conference. The Area Medical Director may accept a notice of appeal received after ten days for good cause shown.

1. The notice of appeal must state the basis of the request for appeal of the denial of the application, and shall include any additional information which might support a reversal of the denial of the application.

2. The Area Medical Director may request a face-to-face assessment and/or such additional assessments or information as may be necessary to supplement the service authorization file.

3. The Area Medical Director shall render a written decision within 20 business days of receipt of the notice of appeal, face-to-face assessment, or receipt of such additional assessment or information as Area Medical Director may have requested, unless the time is extended by mutual consent of the Area Medical Director and the person filing the notice of appeal. If the individual declines to participate in a requested face-to-face assessment, or to provide such additional information or assessment within a reasonable period of time, then the appeal shall be considered withdrawn.

4. If the denial of the application is sustained by the Area Medical Director, a written decision letter shall be sent to the individual and the individual's legally authorized representative. The decision letter shall include notice of the right to request a fair hearing pursuant to 104 CMR 29.16(5).

5. If the denial of the application is reversed by the Area Medical Director, a written decision letter shall be sent to the individual and the individual's legally authorized representative, and the Area Director or designee shall proceed with a determination of need for DMH services pursuant to 104 CMR 29.04. A decision by the Area Medical Director to reverse the denial of an application is not subject to appeal.

6. In appropriate cases, the Area Medical Director may designate another psychiatrist, including the Area Child, Youth and Family Division Psychiatrist to act as Area Medical Director pursuant to 104 CMR 29.16.

(4) Appeal on All Other Appealable Matters.

(a) An appeal on matters listed in 104 CMR 29.16(2)(a) is initiated by submitting a written statement to the Area Director, indicating what is being appealed and the basis for the appeal.

(b) An appeal must be initiated within ten days after the occurrence of the action or inaction which forms the basis for the appeal. The Area Director may, however, accept an appeal after ten days for good cause.

(c) Resolution Conference.

1. The Area Director or designee shall hold a resolution conference with the client and the client's legally authorized representative within ten business days of notification of the appeal for the purpose of resolving the matter being appealed.

29.16: continued

2. Participants in the resolution conference may also include, as applicable and appropriate, the client's case manager, the program director, and other invited persons.
3. The individual or the individual's legally authorized representative may include other persons to this conference, if the individual wishes.
4. If resolution of the appeal is not achieved, the Area Director or designee shall clarify issues for appeal and shall determine the agreement, if any, of the parties as to the material facts of the case.
5. Except to the extent that statements of the parties are reduced to an agreed statement of facts, all statements of the parties made during the resolution conference shall be considered as offers in compromise, and shall be inadmissible in any subsequent hearing or court proceedings pursuant to the provisions of 104 CMR 29.16.
6. The Area Director and the appealing party may agree to waive the resolution conference; in which case, the appeal shall be forwarded to the Commissioner as a petition for a fair hearing pursuant to 104 CMR 29.16(5).
7. The results of any resolution conference in which the Area Director does not personally participate shall be subject to the Area Director's review and approval.

(5) Fair Hearing.

(a) An appealing party may petition the Commissioner for a fair hearing regarding any appealable issue not resolved pursuant to 104 CMR 29.16(3) or 104 CMR 29.16(4).

(b) A petition for fair hearing must be submitted to the Commissioner within 20 days after receipt of the Area Medical Director's decision with regard to clinical criteria pursuant to 104 CMR 29.16(3), or the completion or the waiver of the resolution conference pursuant to 104 CMR 29.16(4).

1. Within ten business days of such petition, the Commissioner or designee shall appoint a hearing officer, who shall schedule a hearing date which is agreeable to both parties. Said fair hearing shall be conducted in a manner consistent with M.G.L. c. 30A and 104 CMR 29.16(5) and shall be governed by the informal fair hearing rules of the standard adjudicatory rules of practice and procedure at 801 CMR 1.02: *Informal/Fair Hearing Rules*.
2. While the appeal is pending, the parties may agree to implement any part of the individual service plan or community service plan, or other matter under appeal without prejudice.
3. The fair hearing shall be conducted by an impartial hearing officer designated by the Commissioner or designee. The hearing officer may be an employee of the Department; provided however, that no person shall be designated as a hearing officer in a particular appeal who is subject to the supervision of any facility or office within the service area in which the individual applying for services is currently served or is proposed to be served.
4. The appealing party shall have the right to be represented by an individual designated by the individual, at the individual's own expense.
5. The appealing party and the Department shall have the right to present any evidence relevant to the issues under appeal, and shall have the right to call and examine witnesses.
6. The appealing party shall have the right to examine all records held by the Department pertaining to the individual or client and all records that form the basis of an individual service plan or community service plan that is under appeal.
7. The fair hearing shall not be open to the public. The appealing party may invite persons of the party's choosing to attend. Invited persons may attend the hearing, as long as they do not disturb the hearing.
8. Within 20 days of the close of the hearing, the hearing officer shall prepare and submit to the Commissioner a recommended decision which shall include a summary of the evidence presented, findings of fact, proposed conclusions of law, the recommended decision and the reasons for the decision.
9. The findings of fact in the recommended decision shall be binding on the Commissioner. The Commissioner may modify the conclusions of law and recommended decision where the conclusions or decision are: in excess of the agency's statutory authority or jurisdiction; based on an error of law; arbitrary, capricious, an abuse of discretion; or otherwise not in accordance with law.

29.16: continued

10. Within 15 business days after receipt of the hearing officer's recommended decision, the Commissioner shall issue a decision.

a. The Commissioner's decision shall include a summary of the evidence presented, findings of fact, a decision on each of the issues appealed, the reasons for such decision, and a notice of the individual's right to appeal the decision to the Superior Court pursuant to M.G.L. c. 30A.

b. The Commissioner's decision shall be mailed to the appealing party and the appealing party's legally authorized representative.

c. Unless the Commissioner or designee orders a rehearing pursuant to 104 CMR 29.16(6), the decision of the Commissioner is the final decision of the Department on all issues.

(6) Rehearing.

(a) Within ten days of receipt of the decision of the Commissioner by the client or the client's legally authorized representative, a party aggrieved by the decision may petition the Commissioner to order a rehearing on one or more of the following grounds:

1. that new evidence was discovered by the appealing party subsequent to the hearing; and that the new evidence is such that it would be likely to materially affect the issues being appealed;

2. that the hearing was conducted in a manner which was inconsistent with 104 CMR 29.16(5) or was prejudicially unfair to the client or other appealing party;

3. that the decision is based on inappropriate standards or contains other errors of law; and

4. that the decision is unsupported by any substantial evidence.

(b) The failure of the Commissioner to grant or deny a petition for rehearing within ten business days of the submission of the petition shall be considered a denial of the petition.

(c) Upon order for a rehearing by the Commissioner, a hearing shall be conducted and a decision rendered anew, pursuant to 104 CMR 29.16(5).

(7) Standard and Burden of Proof.

(a) The standard of proof on all issues shall be a preponderance of the evidence.

(b) Burden of Proof.

1. The burden of proof on the issue of denial of an application for DMH services shall be on the individual whose application has been denied.

2. The burden of proof on the issues of whether the provisions of 104 CMR 29.06 through 104 CMR 29.11 have been complied with, and whether the comprehensive assessment of service needs, individual service plan, and community service plans are reasonable and consistent with the service needs of the client, shall be on the Department or on the DMH community service provider responsible for developing the community service plan.

3. The burden of proof on issues relating to a discharge from DMH Services, pursuant to 104 CMR 29.14, shall be on the Department.

4. The burden of proof may be met only by evidence known to the Department at the time the Department's decision was made. Evidence, whether verbal or written, not known to the Department at the time the Department's decision was made, may be admitted only upon leave of the Hearing Officer and must be provided to the other party no later than five business days prior to the date of hearing.

(8) Judicial Review. A client or the client's legally authorized representative aggrieved by a final decision of the Department pursuant to 104 CMR 29.16 may, within 30 days of receipt of the decision or a decision after a rehearing, seek judicial review of the decision, in accordance with the standards and procedures contained in M.G.L. c. 30A, § 14.

REGULATORY AUTHORITY

104 CMR 29.00: M.G.L. c. 19, §§ 1 and 16; M.G.L. c. 123, § 2.