



MERIDIAN
HEALTHCARE

MERIDIAN PROGRAM REFERENCE AND INTERNAL REFERRAL GUIDE

THIS IS A CATALOG OF THE VARIOUS PROGRAMS AND KEY ADMINISTRATIVE DEPARTMENTS MERIDIAN HAS TO OFFER AND IS DESIGNED AS A REFERENCE POINT FOR STAFF. A BASIC OUTLINE OF EACH PROGRAM/DEPARTMENT IS PROVIDED ALONG WITH DETAILS FOR CONTACTING AND REFERRING INDIVIDUALS TO THE PROGRAM.

**STEP-BY-STEP INSTRUCTIONS FOR INITIATING, RECEIVING, AND COMPLETING
INTERNAL REFERRALS ARE INCLUDED IN APPENDIX A (PAGE [23](#))**

-- PLEASE BE SURE TO NOTIFY CLIENTS WHEN YOU ARE MAKING A REFERRAL ON THEIR BEHALF --

BELOW IS THE BASIC TEMPLATE USED FOR EACH PROGRAM *

PROGRAM NAME		Program Manager(s) / Director(s)
Population(s) Served: e.g., Adult MH, Adult SA, Adult Co-occurring, Child MH, Child SA, Child Co-occurring, or any Specialized Population		
Brief overview of program operations, functions, services provided, etc.		
Minimum Eligibility Criteria: - Minimum criteria for program participation		
Exclusionary Criteria: - Any factors that may prevent participation		
Point(s) of Contact: Name / Title [Specific individual(s) within the department where staff should initially direct all program-related inquiries]	POC Contact Info – Extension and/or MBH Cell [Email will not be listed unless it differs from name(s) listed as POC]	
Internal Referrals / Requests: - Specific instructions related to internal referrals or requests and/or to whom they should be directed		
External Referrals / Requests: - Specific instructions related to referrals or requests initiated from external sources and/or to whom they should be directed		
Important Notes: - Any additional notes about the program or other important program-related info to convey [This may include things like answers to FAQs, common issues/discrepancies, or other relevant program info]		

*** To add new programs or make changes to programs listed, please fill in all of the program information using the grid above or update the existing program grid and email to: QI_Department@mbhci.org.**

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ACCESS CENTER

Program Vice President – Tina Harkness

Program Manager – Cathy Winfrey

Population(s) Served: All

A centralized triage, information, and referral system designed to allow clients ease of access to the most clinically appropriate and cost-effective treatment services available.

Access Center processes referrals from various sources, such as doctors' offices, Department of Juvenile Justice, County Health Departments, Schools, etc and can schedule both in person and telehealth intake Biopsychosocial Evaluations for all 13 Meridian Clinic and telehealth. Access Center also schedules the Post-Inpatient Therapy appointments as follow-up for clients who have been discharged from inpatient Acute Care facilities and Correctional facilities. In addition to scheduling, Access Center begins processes program-specific Internal Referrals for the following: Buprenorphine Clinic; Vivitrol Clinic, Bridge House Residential, MIST Residential, and Recovery Center.

When external referrals come into the Access Center, they are processed in the following manner: two separate calls are made to the number(s) on file, then, if no contact is made, a letter is sent informing the individual advising them that they have been referred for services and requesting they call in to schedule an appointment. All individuals should be encouraged to contact the Access Center to follow up on their referral. Please note, individuals may self-refer to Meridian at any time to schedule an appointment; a referral is not required prior to engaging in services.

Minimum Eligibility Criteria:

- Ages 3+

Exclusionary Criteria:

- Follow-up (e.g., Individual Therapy) or Med Services psychiatric appointments are handled by the Scheduling Line and should be referred to
- Baker Act and Marchman Act requests, questions and/or concerns should be forwarded to the Emergency Screening programs located in the Gainesville and Lake City Acute Care - Crisis Stabilization Units; Emergency Screening can be reached at 352-647-0420.

Point of Contact: Cathy Winfrey

Office:

Internal Referrals:

-
- Email: accesscenter@mbhci.org

External / New Patient Referrals:

- Send to Fax: 352.244.0308
- Complete online: <https://www.mbhci.org/getting-started/referrals/>

Important Notes:

- Access Center serves as Meridian's official Crisis Line during normal business hours; after hours, the Crisis Line rolls to the Emergency Screening program
- Clinical evaluations to determine if individuals meet criteria for different programs are NOT conducted by Access Center; the specific criteria for each program is determined and assessed by their clinical staff/management
- Access Center uses ONLY Ext. 5096, though extensions 5155 and 2001 were formerly used – Please DO NOT use or give out any old extensions

ACUTE CARE – CRISIS STABLIZATION UNIT (CSU)**Medical Director – Mathew Nguyen****Administrator/Director of Operations - Deborah Most****Nurse Manager (Lake City) – Shalonda Ford and Dominic Beasley****Nurse Manager (Gainesville) – Shawntavious Murphy and Kneisha Means****Clinical Director of Inpatient Services (GNV & LC) – Dawn Pasciuto**

Population(s) Served: Adult MH & Child MH

Meridian's CSUs provide short-term stabilization for individuals in crisis situations and acute mental health needs for adults and children. Each unit serves as a Baker Act Receiving Facility and accepts any patient meeting Baker Act criteria. Individuals may also be admitted to the CSUs voluntarily if less restrictive treatment is not assessed to be more appropriate at the time. CSUs provide physical and psychiatric evaluations, medication, counseling, therapeutic activities, and discharge planning. CSUs may also petition the court for longer-term treatment as needed. Follow-up psychiatric and clinical services may be provided in the office of the client's county of residence, either at Meridian or a provider of the patient's choice.

Minimum Eligibility Criteria:

- Severe symptoms related to MH diagnosis(es)
- Imminent danger to self/others or at risk of danger/decompensation without intervention

Exclusionary Criteria:

- Inpatient level of care not appropriate

Points of Contact:

Deborah Most
Rontica Samuel (Unit Supervisor & Interim Contact) – Gainesville

Cell: 352.647.2773 Office: 352.450.8142
Cell: 352.810.0965 Office: 352.450.8261

Internal Referrals:

- Any clinician within Meridian who is initiating an involuntary examination must complete the BA3052 within the EMR
- Clients on the Gainesville or Lake City campuses should be walked directly to the CSU for screening and admission
- For clients in the community or outlying clinics, staff should contact local law enforcement to assist with transport

External Referrals:

- Fax to: 352.244.0295

Important Notes:

- If an individual's primary issue/concern is needing medications refilled, please refer to the Medical Service Psychiatry program (Page [13](#))

ACUTE CARE – DETOX – ADDICTIONS RECEIVING FACILITY (ARF)**Medical Director – David Kirby****Administrator/Director of Operations - Deborah Most****Nurse Manager – Shawntavious Murphy AND Kneisha Means****Clinical Director of Inpatient Services (GNV & LC) – Dawn Pasciuto**

Population(s) Served: Adult SA, Adult Co-occurring

Detox is an ASAM Level 3.7-D program located on the Gainesville campus. The program provides medical and non-medical (non-narcotics) detoxification services under the supervision of a physician and nursing staff primarily for alcohol, benzodiazepines, and opiates. Admissions are screened for tuberculosis

**ACUTE CARE – DETOX –
ADDICTIONS RECEIVING FACILITY (ARF)**

**Medical Director – David Kirby
Administrator/Director of Operations - Deborah Most
Nurse Manager – Shawntavious Murphy AND Kneisha Means
Clinical Director of Inpatient Services (GNV & LC) – Dawn
Pasciuto**

and risk factors associated with HIV and provided with assessments and HIV education and treatment. The admissions process includes medical and psychological assessment, consent to treatment or Marchman Act, nursing assessment, vital signs, inventory of personal effects and program introduction and orientation. Vital signs are checked per physician order. Laboratory tests, medications and referral for further medical evaluation may be initiated upon order from physician. Alco-sensor checks are done regularly on clients with alcohol intoxication until they have a .00 reading. Clients are reevaluated by a licensed nurse at least once each shift to determine the appropriateness of participation in unit activities.

In order to remain in the program after acute intoxication or withdrawal passes, the client must have an established history of dependence, want to pursue treatment, or be court ordered to do so, and have a history of at least 3 severe use complications, which include 2 of the following: blackouts, continued signs or symptoms of withdrawal, health problems related to substance abuse, neglect of self-care, overdoses, suicidality or suicide attempt.

Medical and supportive counseling provide additional assistance to clients in active withdrawal from the physiological effects of mood-altering substances. Clients also meet with the Discharge Planner and are referred to other programs and services, as appropriate.

Minimum Eligibility Criteria:
- Meet ASAM 3.7-D criteria

Point of Contact: Deborah Most

Cell: 352.647.2773 Office: 352.450.8142

Internal Referrals:
- For additional information or bed availability inquiry, please call the emergency screeners

External Referrals:
- Clients being referred can arrive to the unit 24/7 on a walk-in basis for screening and admission, as appropriate

Important Notes:
- There is no inpatient or medical detoxification from marijuana or cocaine; individuals using primarily/exclusively these substances do not meet criteria for inpatient detoxification admission

ACUTE CARE – Central Receiving Services

**Administrator/Director – Jennifer Barber, LMHC
Manager (Gainesville) – Kori Hanks
Manager (Lake City) – Stephanie Sheppard**

Population(s) Served: Adult MH, Adult Substance Use Disorders, Adult Co-occurring, Child MH, Child Substance Use Disorders, Child Co-occurring

MH Screening, Assessment, Substance Use Screening, Referral / Linking to Outside Services- Gainesville and Lake City

Minimum Eligibility Criteria:
- None

Minimum criteria for program participation:
- None

Exclusionary Criteria:
Please see CRS FACT sheet.

Points of Contact:
Lake City and Gainesville – Jennifer Barber, Administrator-Program Director

Cell: 352.647.1892 Office: 352.450.8205

Internal & External Referrals:
- Specific instructions related to internal referrals or requests and/or to whom they should be directed: Central Receiving Services - 352-374-5600 opt 1

Important Notes:
- Central Receiving Services (CRS) operates as a coordinated system designed to provide timely evaluation and stabilization for individuals in crisis. At the core of CRS is the Central Receiving Facility (CRF), which serves as the primary point of entry into the mental health and substance use treatment network. The CRF ensures that adults and children experiencing a behavioral health crisis receive immediate, streamlined access to appropriate care and support.

ACUTE CARE – SHORT TERM RESIDENTIAL PROGRAM

**Deborah Most - Administrator/Director of Operations
Mathew Nguyen - Medical Director
Matt Butler - Clinical Director of Inpatient Services
Shawntavious Murphy and Kneisha Means - Nurse Manager**

Population Served: Child MH

The Children and Adolescent Short-term Residential Treatment (C/A-SRT) Program is an 8-bed acute care residential alternative service. The purpose of the C/A-SRT is to provide intensive short-term treatment (typical lengths of stay of 90 days or less) to children and adolescents who need a 24-hour per day therapeutic setting. The C/A-SRT's individualized, stabilizing services meet the needs of children and adolescents who are experiencing an acute or immediately sub-acute crisis and who, in the absence of a suitable alternative, would require hospitalization.

Minimum Eligibility Criteria:
- Between the ages of 5 and 17
- Temporarily in need of a 24-hour-a day structured therapeutic setting in a less restrictive, but longer-stay alternative to hospitalization

Exclusionary Criteria:
- Inpatient Level of Care not appropriate

Point(s) of Contact:
- Deborah Most
- Matthew Butler

POC Contact Info –
Cell: 352.647.2773 Office: 352.450.8142
Cell: 352.681.9784 Office: 352.450.8239

Internal Referrals / Requests:
- Internal referrals will be sent through our inpatient providers who work with the Children CSUs.

ADVANCEMENT: MARKETING, EXTERNAL COMMUNICATIONS, PHILANTHROPY **Vice President – Kandra Albury**

Population(s) Served: All Meridian Employees and External Stakeholders

Meridian’s Advancement department is responsible for planning, organizing and directing all phases of comprehensive marketing, communications, media relations, and philanthropy plans. Internally we stock, manage, and distribute promotional items, brochures, and collateral pieces. Externally we create and manage messages about Meridian and increase support through public relations and philanthropic support. All calls for sponsorships, contributions, advertising, media contact, and community development activities should be routed to the Advancement department.

Points of Contact: Kandra Albury – VP of Marketing & Advancement Joni Perkins – Manager of Philanthropy & Engagement Jeremy Lee – Marketing Coordinator Sheila Singleton – Administrative Assistant	Office: 352.450.8556 Office: 352.450.8553 Office: 352.450.8549 Office: 352.450.8587
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Internal Requests:
- Brochures, flyers, and promo items should be requested in advance via the employee intranet under “Marketing” in the “Quick Links” menu on the right

External Requests/Contacts:
- All external media requests and contacts should be forwarded to Lauren Cohn.
- Please forward anyone who wishes to help/support Meridian to Kandra Albury.

AFTERCARE **Vice President South- Terri Faul**
Vice President North- Lizette Lopez

Population(s) Served: Adult SA, Adult Co-occurring

Aftercare is an ASAM Level 1 program that operates as a step-down for individuals with substance use disorders recently and successfully discharged from a higher level of care. Treatment in Aftercare takes place in a group setting with a focus on maintaining and building upon positive gains in treatment thus far. All groups include a discussion of relapse prevention techniques and related concerns, including recognition of triggers and warning signs of regression. Aftercare services support a healthy living environment and provide a forum for individuals to continue their education and development of new positive social skills/habits and coping strategies. With the highest occurrence of relapse being immediately following treatment, Aftercare engagement greatly increases the likelihood of continuing sobriety by offering continued growth in a safe environment while living in the community setting.

Minimum Eligibility Criteria:
- Meet ASAM Level 1 criteria
- Recent discharge from residential treatment

Exclusionary Criteria:
- No SA diagnosis

Point of Contact: Terri Faul	Office: 352.450.8779
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Internal Referrals:
- Alan Paulin

External Referrals:
- Not eligible currently.

Important Notes:
- At present, Aftercare only accepts clients stepping down from Bridge House Residential Treatment program; please contact Program Director for more info.

BILLING & COLLECTIONS **Program Director – Cherise Elmore**

Population(s) Served: All

Responsible for program set-up and maintenance of allowable services in SmartCare, timely billing of services, and Accounts Receivable management. Staff conduct daily reviews of services that have errors or require authorization and correct before event processing. Weekly claims submissions are completed to all insurances and monthly invoicing is done to fee-for-service contracts and self-pay accounts. Daily posting of all fee-for-service payments made in SmartCare and self-pay deposit reconciliation for all locations. Billing Clerks work errors received on insurance remittance, advise payments, and work all services that have not been paid. Staff work to support our patients with issues or questions regarding balances that are made via phone, internet, or website.

Points of Contact: Ronnie Williams – Billing Manager Cherise Elmore – Director of Billing	Office: 352.450.8581 Office: 352.450.8528
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Internal & External Referrals/Requests:
- 352.450.8581/352.450.8528 or Email billingandumrteam@mbhci.org

BRIDGE HOUSE – RESIDENTIAL TREATMENT **Program Director – VACANT**

Population(s) Served: Adult SA, Adult Co-occurring

Bridge House is a 36-bed coed residential substance abuse treatment program located in Gainesville. Our philosophy is based on the 12 Step Model of Recovery and provides a 28-day to 90-day treatment program depending on diagnoses, severity of symptoms and aftercare planning. Meals are provided and clients are required to attend 12-step meetings and work with a sponsor while in residence. During their stay, clients will participate in daily groups, weekly individual therapy sessions, discharge planning, and daily activities, in addition to the 12-step meetings. Clients are eligible for weekly visitation after the first 7 days of admission, and employment after 28 days as approved by the Treatment Team. Bridge House is a tobacco-free environment.

Minimum Eligibility Criteria:
- SA Diagnosis Primary
- Must meet ASAM Level 3.5 criteria for admission
- Must be free from intoxication or withdrawal symptoms that require 24-hour care, observation, or monitoring
- 30-days’ worth of any prescribed medications

Exclusionary Criteria:
- Cannot accommodate registered sex offenders due to proximity to MIST Unit
- Family members, significant others, paramours, etc. are not permitted to be on the unit at the same time; they will remain on the waitlist until eligible for admission

Point of Contact: Elizabeth Madison	Cell: 352.672.0947 Office: 352.450.8849
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BRIDGE HOUSE – RESIDENTIAL TREATMENT**Program Director – VACANT****Internal & External Referrals:**

- Contact assigned Access Center staff to obtain required info and place client on waitlist, or reach out to Admissions Coordinator Marcus Watson 352.450.8822

Important Notes:

- If an individual has been actively using opiates, alcohol, or benzodiazepines, they must be cleared by Acute Care - Detox Unit/ARF prior to admission
- Bridge House waitlist considers priority populations as required/defined in Chapter 394, Florida Statute (please reach out to Access Center and/or Admissions Coordinator for more info on priority populations)
- Clients being referred from other Meridian programs need to have an internal referral form completed in addition to completing the Bridge House admission packet, in addition to submitting a Negative TB test, Documentation of income, and Physical completed within 30 days of admission.
- Clients from the community should contact the Access Center to begin the admission process in addition to completing the Bridge House Admission Packet.

CASE MANAGEMENT (Program **Inactive) – CARE COORDINATION****Vacant
Program VP – Christy McBee**

Population(s) Served: Adult MH, Adult Co-occurring, Child MH, Child Co-occurring

Meridian offers targeted case management services to eligible clients, which includes assessment, planning, linkage, advocacy, service coordination and monitoring to assist beneficiaries in gaining increased independence through access to needed health and dental services, financial assistance, housing, employment, education, social services, as well as any other services and natural supports identified for development through the person-centered planning process. Targeted case management is provided in a responsive, coordinated, person-centered and effective and efficient manner focusing on processes and outcomes.

Minimum Eligibility Criteria - Adults:

- Chronic MH diagnosis(es); and at least ONE of the following:
 - » 2+ admissions to crisis stabilization unit within the past 12 months
 - » 3+ inpatient admissions (crisis stabilization unit and/or addictions receiving facility/detox) within the past 6 months
 - » 16+ days spent inpatient within the past 6 months
 - » Placed in an Assisted Living Facility
 - » Recently discharged from State Hospital

Minimum Eligibility Criteria - Children:

- Mental disability (emotional disturbance) which requires advocacy for and coordination of services to maintain/improve level of functioning.
- Must lack a natural support system with the ability to access needed medical, social, and other services.

Exclusionary Criteria:

- Private insurance
- Receiving duplicate case management services (e.g., Homeless Recovery, Forensic Intervention, CAT program, FACT Teams, Agency for Persons with Disabilities, etc.)
- Co-occurring with MH diagnosis(es) not primary

Points of Contact:

Christy McBee

Cell: 352.647.6308 Office: 386.357.0204

Internal & External Referrals:

- Megan Rhoades – Alachua, Dixie, Gilchrist, Levy
- Rana Tallador – Baker, Bradford, Columbia, Hamilton, Lafayette, Suwannee, Union

Important Notes:

- Case Managers do NOT assist with obtaining or changing social security benefits payees
- For information on the SOAR disability application/appeals process, see SOAR program (Page [20](#))

CENTRALIZED INTAKE TEAM (CIT)**Program Vice President – Tina Harkness
Program Manager – Cathy **W**infrey**

Population(s) Served: All

The Centralized Intake Team (CIT) provides same-day, walk-in, and telehealth evaluations from 8am – 5pm, with the last intake at 4pm, for individuals who wish to begin services with Meridian. The CIT completes the biopsychosocial evaluation, which is the first step to access Meridian services. Based on the intake evaluation, the CIT completes appropriate referrals and/or schedules clients for follow-up services.

Minimum Eligibility Criteria:

- Must live in the state of Florida.
- Must have a working camera on their computer/laptop/tablet/smart phone if utilizing telehealth services.

Exclusionary Criteria:

- Out-of-state residents.

Points of Contact:Centralized Intake Coordinator
Cathy WinfreyOffice:
Cell: Office:**Internal & External Referrals/Requests:**

- For in person biopsychosocial evaluations, client may come to any Meridian office during the hours that the office is open.
- For telehealth, client can access services at <https://www.mbhci.org/telehealth/>.

Important Notes:

- There are some exceptions made to schedule an appointment for a Biopsychosocial, please reach out to the Program Manager or Access Center for further details.
- The last intake will be at 4pm.
- Clients may experience wait times, and they are encouraged to come into the office as soon as possible when services are needed.
- Clients that come into a MBH office after 5:00pm will be encouraged to reach out via MEND/Telehealth or return to the office the following business day.
- CIT services may be utilized for DCF, Court, and Probation mandated Mental Health and Substance Use Evaluations.

**CERTIFIED COMMUNITY BEHAVIORAL HEALTH
CENTER (CCBHC) IMPROVEMENT & ADVANCEMENT GRANT****Program Vice President – Tina Harkness
Program Director – Thea Baglino**

Population(s) Served: Adult MH, Adult SA, Adult Co-occurring, Child MH, Child SA, Child Co-occurring

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTER (CCBHC) IMPROVEMENT & ADVANCEMENT GRANT**Program Vice President – Tina Harkness
Program Director – Thea Baglino**

The CCBHC-IAP-Grant program provides monitoring and connections with wrap-around treatment and services for children and adults with mental health diagnosis and/or co-occurring substance use diagnoses. It involves more intensive services than traditional outpatient and is designed for individuals who need multiple services. Clients engaged with the CCBHC program work with care coordinators and peer specialists to address their ongoing needs, facilitate referrals to needed treatment, services, and community resources, and to provide ongoing monitoring assessments consistent with the grant requirements. Some examples of the resource's individuals may be connected with via the CCHBC staff are: primary/medical care, social supports, financial assistance, and housing support. Connecting individuals with these important resources will assist them in having their basic needs managed and will allow them to focus on other areas, such as their mental health, leading to greater progress.

Minimum Eligibility Criteria:

- Ages 5+
- Must have a MH and/or SA diagnosis
- Has identified needs in more than one area
- Must be opened to a new episode of care

Exclusionary Criteria:

- Under age 5 (see notes)
- Limited treatment/services needs
- Unwilling/unable to engage in routine monitoring
- Engaged in MBH services for more than 30 days (unless recent circumstances alter level/intensity of care needs)

Points of Contact:

Thea Baglino – Program Director
Tina Harness – VP Admissions/Access

Cell: 352.810.6566 Office: 352.450.8780
Cell: 352.647.1229 Office: 352.450.8784

Internal & External Referrals:

- Send to Rhonda Lynch

Important Notes:

- Clients must be willing to participate in routine assessments required for compliance with the federal grant requirements

CLIENT RELATIONS**Program Manager North – Kennidra Rossin
Program Manager South – Sheremah DeJesus
Director of Medical Services Operations – Alexis Day**

Population(s) Served: All

The Client Relations department serves as the initial point of contact and front-line support for all clients coming into one of Meridian's outpatient clinics and for many individuals reaching out to Meridian by phone. The Customer Service Specialists and Operators provide a variety of intake, billing/fee collection, follow-up assistance, client support/direction, staff support, and client concern reporting. Depending on the size, location and services offered at a particular clinic, Client Relations staff may provide specialized assistance.

Points of Contact:

Sheremah DeJesus – Alachua, Dixie, Gilchrist, Levy, Marion
Kennidra Rossin – Baker, Bradford, Columbia, Hamilton, Suwannee, Union, Putnam

Office: 352.450.8773
Office: 386.357.0439

Internal & External Referrals/Requests:

- Sheremah DeJesus or Kennidra Rossin based on service area/location

Important Notes:

- Client Relations staff are NOT clinically trained to handle clients exhibiting extreme behaviors and may reach out to clinical management or other clinical staff on-site for assistance in situations requiring de-escalation or other clinical interventions; clinical management/staff should make every effort to respond as quickly as possible in these situations

COMMUNITY ACTION TEAMS (CAT)**Program Manager – Christina Colquitt (Tri-County)
Program Manager - Emily Masten (Macclenny)
Program Manager – VACANT (Lake City)**

Population(s) Served: Adult MH, Adult Co-occurring, Child MH, Child Co-occurring

Our CAT programs are intensive and short-term, with treatment and services typically lasting 3 to 9 months. The program structure is designed specifically for young people with a mental health diagnosis or co-occurring substance use diagnosis who are at risk for out-of-home placement and for whom less intensive levels of treatment have been ineffective or inappropriate. Clients engaged with CAT programs receive a full range of wrap-around services including case management, counseling, medication management, and mentoring.

Minimum Eligibility Criteria:

- Ages 11 to 21 with at least one of following:
 - » Repeated failures at less intensive levels of care
 - » Involvement with law enforcement, Dept. of Juvenile Justice, Partnership for Strong Families or Dept. of Children & Families
 - » 2 or more hospitalizations or repeated failures
 - » Poor academic performance and/or suspensions/expulsions
 - » Currently in Statewide Inpatient Psychiatric Program (SIPP) or residential treatment
- Children under 11 may be eligible for services if they meet 2 or more of the criteria above

Exclusionary Criteria:

- Ages 22+
- Out of Home Placements (not including foster care)

Points of Contact:

Emily Masten – North Team Lead (Baker, Bradford, Nassau, Union)
Christina Colquitt – Tri-County Team Lead (Dixie, Gilchrist, Levy)

Cell: 352.316.4301
Cell: 352.538.6791

Internal Referrals:

- Emily Masten
- Christina Colquitt

External Referrals:

- Send to: catreferral@mbhci.org

Important Notes:

- NE CAT program provides treatment and services in Nassau County, which is outside Meridian's normal service area; Nassau contains several northeast cities, including Fernandina Beach, Yulee, and parts of Jacksonville

FACT Lite (LATTERS)**Program Manager – Vickie Tuell
VP Wraparound North Director – Christy McBee**

Population(s) Served: e.g., Adult MH, Adult Co-occurring

LATTERS is a clinical case management model with medical services, wellness management, and recovery support for individuals struggling to remain stable after multiple crisis episodes. Our goal is to promote independent functioning, improve community involvement by assisting individuals in developing a community support system, and improve their overall quality of life by using a wraparound approach to recovery. We have Counseling, Care Coordination, Nursing, Peer services, AND provide medication management appointments in the community, which eliminates the barriers of needing transportation to all appointments other than primary care. We can provide medication drop off daily for clients that struggle with medication maintenance and can complete their injections of MH medications in the community to promote recovery longevity.

Minimum Eligibility Criteria:

- Age 18 or older
- Reside within Baker, Bradford, Union, Columbia, Suwannee, Lafayette, or Hamilton Counties
- Be a high utilizer defined by one of the following:
 - Three or more inpatient/residential stays within 1 calendar year
- OR
- One inpatient/residential stay lasting 16 days or longer
- OR
- Multiple, recent hospital/inpatient/residential admissions of 50 – 90 days within the last calendar year or 150 days within the last 3 years
- Have a Severe Mental Illness as primary diagnosis; Schizophrenia, Schizoaffective Disorder, Bipolar, Anxiety, Depression, etc. (or co-occurring)
- Symptoms interfere with maintaining employment and sage living situation
- Disruption in social relationships and ability to function in the community
- Disturbance in daily living skills
- Destructive, harmful, or neglectful behavior or choices related to self or others
- Not benefited from traditional services
- Meet the following criteria:
 - These individuals need:
 - ongoing, community based psychiatric outreach and supports to ensure stability and avoid significant negative consequences such as death, victimization, hospitalization, homelessness, or violence that will compromise recovery, or
 - a strategic, titrated transition to minimize the risk of relapse and/or psychiatric decompensation. (coming from NEFSH, out of CSU)

Exclusionary Criteria:

- Primary identified focus of treatment non-compliance
- Primary diagnosis of Borderline Personality Disorder, Dementia, Intellectual and Developmental Disability
- Traditional treatment methods have not been fully utilized

Point(s) of Contact:

Christy McBee
 Jessica Jones
 Robert Miller
 Beth Raga
 Tynavia Woodard
 Johanna Stith
 Tommy Houk
 Stephane Ilunga

C: (352) 647-6308 O: 386.357.0204**Internal Referrals / Requests:**

- Please send internal referrals via SmartCare to Christy McBee and select MH Adult LATTERS with any pertinent information needed to make a determination.

Important Notes:

We do not have SOAR coordination currently for social security, so we do not offer that service yet. We do not have an Employment Specialist currently but hope to have this open in the future.

FAMILY SERVICES – FAMILY TREATMENT COORDINATION (FTC)**Program Manager North and South – Rana Tallador
Vice President – Christy McBee**

Population(s) Served: SA Adult

The Family Treatment Coordination program is for parents whose substance use impairs their parenting ability or judgement to safely care for their children. Priority is given to families in which a newborn has tested positive for drugs or there are substance abuse concerns in a home with children ages 0 to 3. Services include substance abuse and mental health assessments, linkages to local services/treatment options, monitoring of drug use and advocacy for the client in order to reduce barriers to engaging in treatment. Referrals for this program must come directly from DCF/PSF. Other referrals can be made internally from Meridian for clients who are Lutheran Services consumers only, who have a substance use diagnosis and need linkages to local services/treatment options and monitoring of their cases linkages to local services/treatment options.

Minimum Eligibility Criteria:

- Current child welfare involvement due to parental substance abuse negatively impacting ability to adequately parent

Exclusionary Criteria:

- Not actively involved with child welfare

Points of Contact:

Rana Tallador – Program Manager North and South

Cell: 386.209.0195 Office: 386.357.0502

Internal Referrals:

- Internal referrals at Meridian are accepted. See above.

External Referrals:

- Referrals submitted to FTC workers by Child Protective Investigator or Family Care Counselor

Important Notes:

- FTC works with clients through Partnership for Strong Families and Department of Children and Families

FINANCIAL COUNSELORS**Program Manager – Carolann Cutright**

Population(s) Served: All

FINANCIAL COUNSELORS**Program Manager – Carolann Cutright**

The Financial Counselors are responsible for completing crucial tasks with clients to ensure reimbursement for services are accurate and provided. The Financial Counselors work to ensure each, and every client has valid up-to-date Consent to Treat documentation on file. Financial Counselors work with Access Center to determine insurance by checking eligibility, co-pay, and deductible and attempt to qualify uninsured for Lutheran Services at initial contact and check daily schedules for patients that need review. Financial Counselors also completed checks Medicaid eligibility on all active clients at the beginning of each month. If staff need support related to these topics, or notice a missing or incorrect payor source, and/or if the client has questions on copay/benefits, they can be referred to the Financial Counselors for assistance.

Minimum Eligibility Criteria:

- Must be a resident of Florida to be eligible for sliding scale

Exclusionary Criteria:

- Sliding scale not available for anyone with active insurance benefits.

Point of Contact:

AzzuDee Johnson - Lead Financial Counselor
Carolann Cutright - Program Manager

Office: 352.450.8673

Office: 352.450.8525

Internal & External Referrals:

- 352.450.8525 or Email: financial_counselors@mbhcci.org

Important Notes:

- Family size and income are used to determine where individuals fall on the sliding scale
- Income guidelines are set by the state
- Financial Counselors may not be posted in all outlying clinics; staff in these areas can reach out to Financial Counselors if there are any questions about client responsibility, Consent to Treat documentation, or eligibility/benefits
- For questions related to insurance authorizations or authorization requests, please refer to Utilization Management program (Page [22](#))

FLORIDA ASSERTIVE COMMUNITY TREATMENT (FACT)**Program Manager: VACANT
Vice President – Tara Morton**

Population(s) Served: Adult MH, Adult SA, Adult Co-occurring – Significant Impairment

The Florida Assertive Community Treatment (FACT) teams are a service delivery model for providing comprehensive community-based treatment to persons with serious mental illness. FACT is a self-contained mental health program made up of a multidisciplinary mental health staff who function as part of a team. This team provides the majority of an individual's treatment that is needed to achieve identified goals. The multidisciplinary team ensures integrated and ongoing intensive treatment that is individualized and includes assessment, rehabilitation, and community support services.

Minimum Eligibility Criteria -

- Age 18 or older
 - » Reside within Baker, Bradford, Union, Columbia, Suwannee, Lafayette, or Hamilton Counties
 - » Be a high utilizer defined by one of the following:
 - » Three or more inpatient/residential stays within 1 calendar year OR One inpatient/residential stay lasting 16 days or longer OR
 - » Multiple, recent hospital/inpatient/residential admissions of 50 – 90 days within the last calendar year or 150 days within the last 3 years
 - » Have a Severe Mental Illness as primary diagnosis; Schizophrenia, Schizoaffective Disorder, Bipolar, Anxiety, Depression, etc. (or co-occurring)
 - » Symptoms interfere with maintaining employment and sage living situation.
 - » Disruption in social relationships and ability to function in the community.
 - » Disturbance in daily living skills
 - » Destructive, harmful, or neglectful behavior or choices related to self or others.
 - » Not benefited from traditional services

Exclusionary Criteria:

- Primary identified focus of treatment non-compliance
- Primary diagnosis of Borderline Personality Disorder, Dementia, Intellectual and Developmental Disability, TBI
- Traditional treatment methods have not been fully utilized

Points of Contact:

Jacqueline Quarles
Tara Morton

Cell: 352.647.1225

Cell: 352.647.1908

Internal Referrals:

- **Send to Jacqueline Quarles**

External Referrals:**FORENSICS MULTIDICIPLINARY TEAM (MDT)****Program Director(S) / DIRECTOR(S)****Letisha Francis – North****Fabian Robels Fontan – Alachua Co.****Daniel Lieberman – Marion County****Vice President Wraparound Service North – Christy McBee****Vice President Wraparound Services South – Tara Morton**

Population(s) Served: Forensic Court-involved Adult MH, Adult SA, Adult Co-occurring

Forensics programs are involved in the specialty mental health courts – Felony Forensics and Misdemeanor Mental Health Courts. The team assists the courts and attorneys with criminal proceedings, release plans, and provides competency restoration training in the jail and community. The Forensics Team is responsible for monitoring and providing treatment for participants who have been deemed Incompetent to Proceed (ITP) or Not Guilty by Reason of Insanity (NGI), diverting them from forensic state hospitals, and monitoring participants in Forensic State Hospitals. They also provide jail- and community-based competency restoration services for clients with pending charges and provide case management services to clients involved in the criminal justice system.

The team addresses specialty needs applying the Sequential Intercept Model (SIM), utilizing outreach, intervention, and treatment services. The team also provides outreach, training, and collaboration with key stakeholders, including Law Enforcement agencies, Department of Corrections, Probation and Parole, the Courts, attorneys, and county governments.

Minimum Eligibility Criteria:

- Determined by a court to be incompetent to proceed (ITP) or Not Guilty by reason of Insanity (NGI) on felony offense or serious and persistent mental illness and charged with a felony offense prior to adjunction.

Exclusionary Criteria:

- Individual with only misdemeanor charges

FORENSICS MULTIDICLINARY TEAM (MDT)

Program Director(S) / DIRECTOR(S)
Letisha Francis – North
Fabian Robels Fontan – Alachua Co.
Daniel Lieberman – Marion County
Vice President Wraparound Service North – Christy McBee
Vice President Wraparound Services South – Tara Morton

Points of Contact:

Letisha Francis
 Fabian Robles Fontan
 Daniel Lieberman

Cell: 352-647-1915 Office: 386.357.0468
 Cell: 352-810-6233 Office: 352.450.8706
 Cell: 352-647-2769 Office: 352.352.4706

Internal and External Referrals:

- Will need to be sent to the appropriate MDT manager depending on the county. Letisha Fransis for Columbia Co. & surrounding Counties, Fabian Robels Fontan for Alachua Co. Or Daniel Lieberman for Marion Co.

Important Notes:

- For all outlying counties, except Levy, only felony NGI and ITP cases can be accepted.
 - Cases in Levy County may be eligible for their Mental Health Court Program; these cases must be referred through Levy County Public Defender's Office.

HOUSING – JOYCE HOUSE**Program Manager - Carey Schacht**

Population(s) Served: Adult MH, Adult Co-occurring

Joyce House is an AHCA-licensed Level 4 Residential Treatment Facility located in Gainesville. It serves as a long-term housing option for individuals within the severe and persistent mental illness (SPMI) client population who benefit from living in the residential housing environment, but who do not require 24/7 monitoring or care. Joyce House provides semi-structured opportunities for participation in psychoeducational groups, including life skills, social skills, and rehabilitation services groups. Independence is encouraged for Joyce House residents, and they are frequently engaged in other Meridian programs/services to address their ongoing needs. Staff provide routine engagement, consistent with this less restrictive level of care, and assist residents in their continued development of independent living skills. The ultimate goal of the staff is to enable individuals to achieve their maximum level of independence, thus enabling them to be able to transition to a less restrictive living environment.

Minimum Eligibility Criteria:

- MH diagnosis(es) consistent with SPMI population

Exclusionary Criteria:

- Unable to complete Activities of Daily Living independently

Point of Contact: Kandis Patrick (Director & Interim Contact)

Cell: 352.316.5263

Internal & External Referrals:

- Kandis Patrick

Important Notes:

- Joyce House is a voluntary program; individuals must be able to understand and adhere to program guidelines

HOUSING – LODGE AT MERIDIAN**Program Manager – Kandis Patrick**

Population(s) Served: Adult MH, Adult SA, Adult Co-occurring

The Lodge at Meridian offers short-term transitional housing for individuals with mental health and/or substance abuse concerns and who are either homeless or in danger of homelessness and are at risk for decompensation or relapse if homeless and in the community environment. All individuals housed at the Lodge must be actively engaged and receiving treatment and/or services through one of Meridian's outpatient programs. The Lodge also provides a step-down option for individuals who are being discharged from the State Hospital and require more routine Case Management or Care Coordination involvement.

Minimum Eligibility Criteria:

- Serious MH and/or SA concerns
 - Actively receiving services from an outpatient program

Exclusionary Criteria:

- Unable to complete activities of daily living independently

Point of Contact: Kandis Patrick (Director & Interim Contact)

Cell: 352.316.5263

Internal & External Referrals:

- Kandis Patrick

Important Notes:

- Housing staff are not able or qualified to provide any monitoring or assistive services to individuals in the Lodge; primary MBH program is responsible

HOUSING – NEW HORIZONS PROPERTIES**Program Manager – Mellissa Ellis**

Population(s) Served: Adult MH, Adult Co-occurring

New Horizons Properties (NHP) partners with Meridian to offer housing for individuals with chronic and persistent mental health concerns. Individuals live in apartment-style settings and are responsible for independently maintaining their residence. Tenant screening and selection procedures are based upon the NHP Tenant Selection Plan, which is reviewed and updated annually by the NHP Board of Directors in accordance with HUD regulations and monitoring. Considerations when screening for final eligibility and placement include the following: disability status (corroborated and documented by a physician), income level, rental history, criminal background check, sex offender conviction/registration and credit checks.

Minimum Eligibility Criteria:

- Physician-documented history of severe and persistent MH concerns
 - Meets minimum and maximum income threshold requirements

Exclusionary Criteria:

- Unable to complete activities of daily living
 - Co-occurring; MH not primary

Point of Contact: Kandis Patrick (Director & Interim Contact)

Cell: 352.316.5263

Internal & External Referrals:

- Kandis Patrick

HOUSING – NEW HORIZONS PROPERTIES**Program Manager – Mellissa Ellis****Important Notes:**

- Individuals completing housing application must provide copies of the following: birth certificate and social security card for all individuals, identification card and proof of income/government benefits (or self-certification of no income) for all adults in the household

HOUSING – TRANSITIONS**Program Manager – Carey Schacht**

Population(s) Served: Adult MH, Adult Co-occurring

Transitions is an AHCA-licensed Level 2 Residential Treatment Facility located in Gainesville. It serves as a long-term housing option for individuals with severe and persistent mental illness (SPMI) who benefit from living in a residential housing environment. Individuals in Transitions require a higher level of care, including 24/7 monitoring and outside assistance and/or prompting to address their activities of daily living. Transitions staff utilize best practice techniques to emphasize recovery-based living in every aspect of daily life for all residents, with a focus on staff training in the seven competencies for effective psychiatric rehabilitation. Transitions provides a structured group recovery setting that offers monitoring of medication self-administration, assistance and education on monitoring of medical/psychiatric conditions, opportunities to participate in psychoeducational groups on life skills, social skills, and rehabilitation services, utilization of community resources and activities. The goal of the staff is to enable individuals to achieve their maximum level of independence, thus enabling them to be able to transition to a less restrictive living environment.

Minimum Eligibility Criteria:

- MH diagnosis(es) consistent with SPMI population

Exclusionary Criteria:

- Unable to complete Activities of Daily Living with prompting
- Serious/complex medical condition(s)

Point of Contact: Kandis Patrick (Director & Interim Contact)

Cell: 352.316.5263

Internal & External Referrals:

- Kandis Patrick

Important Notes:

- Transitions is voluntary program; individuals must be able to understand and adhere to program guidelines

HOUSING – WILLIAMS MANOR**Program Manager - Mike Hosey**

Population(s) Served: Adult MH, Adult SA, Adult Co-occurring

Residential community housing program geared toward enhancing, improving, or teaching independent living skills and moving residents toward more independent housing options when that is possible.

Minimum Eligibility Criteria:

- Residents must have a qualifying mental illness diagnosis.
- Residents must be at least 18 years of age, and no more than 70 years of age.
- Residents must be ambulatory and capable of independent self-transfer.

Exclusionary Criteria:

- Ongoing violent, threatening, or disruptive behaviors.
- Active psychosis.
- Dementia diagnosis or Severe Developmental Disability diagnoses.
- Incapable of self-preservation or prompt evacuation.
- Medical conditions that require ongoing nursing services.

Point of Contact: Mike Hosey

Cell: 352.647.1004

Internal Referrals / Requests:

- Send to Mike Hosey

External Referrals / Requests:

- Send to Access Center

Important Notes:

- Physical exams within 30 days of admission are required.

INFORMATION SERVICES (IS)

Program Vice President: Melisa Urrutia
Program Director Jeffreys Howland
IT Coordinator - Vacant

The Information Services (IS) department serves as the technological backbone of our organization, encompassing three vital teams: Information Technology (IT), Business Information (BI), and Electronic Health Record (EHR).

The IT team is the cornerstone, responsible for maintaining and optimizing our entire technological infrastructure. From network administration to hardware maintenance, OS management to cybersecurity, IT ensures that our systems run smoothly and securely. Their expertise spans across a variety of domains, including cloud computing, equipment management, and user support.

Working in tandem with IT, the Business Information (BI) team focuses on leveraging data to drive strategic decisions and enhance operational efficiency. They develop and maintain databases, analytics tools, and reporting systems to extract valuable insights from our wealth of information. By transforming raw data into actionable intelligence, BI empowers stakeholders at all levels to make informed choices and adapt to evolving market dynamics.

The Electronic Health Record (EHR) team specializes in the management and optimization of our healthcare information systems. With a deep understanding of regulatory requirements and industry standards, they ensure the seamless integration of electronic health records across our healthcare ecosystem. From patient information to clinical workflows, EHR plays a pivotal role in enhancing patient care, streamlining administrative processes, and facilitating interoperability between healthcare providers.

Together, these teams form the backbone of our Information Services department, driving innovation, efficiency, and excellence across our organization.

Point of Contact: IT Helpdesk

352.450.8600

Important Notes:

- Links to the Helpdesk, IT Self-Help – Aids and Guides, and Meridian Training Videos are located on everyone's desktop, for reference.

INTENSIVE OUTPATIENT (IOP)**Program Directors/Managers:****Vacant** (Lake City)**Nathalie Hervy** (Tri-County)**Vacant** (Gainesville)

Population(s) Served: Adult SA, Adult Co-occurring

Intensive Outpatient Program (IOP) services are offered in Lake City, Gainesville, and Tri-County. IOP is an intensive substance abuse group program which is more restrictive than regular outpatient, but not as restrictive as residential treatment. Clients are expected to participate in a minimum of 9 hours of treatment per week and IOP groups are generally conducted 3 to 4 days per week for 3 hours at a time.

Minimum Eligibility Criteria:

- Age 18+
- Moderate to severe substance use manageable at an outpatient level

Exclusionary Criteria:

- MH diagnosis(es) only
- Neighbors, relatives, spouses, and/or significant others cannot be in the same group (except for Family Therapy)

Points of Contact:

Megan Flanagan – Outpatient Clinician

Office: 352.740.2843

Internal Referrals:

- Vacant – Columbia
- Megan Flanagan – Gilchrist, Levy
- Vacant – Alachua

External Referrals:

- Access Center

Important Notes:

- IOP groups are not conducted in all locations; clients wishing to participate would need to travel to one of the available locations for groups
- Program rules are more intensive than traditional outpatient and include, but are not limited to, the following:
 - » Two absences are allowed; three may result in discharge and/or referral to higher level of care
 - » If more than 15 minutes late or leave more than 15 minutes early, client will not receive credit for group and will require makeup
 - » Abstinence-based; positive screens will result in added support and intensified treatment, including possible recommendations to higher level of care
- In cases where clients are referred to higher level of care, they may return to IOP upon successful completion

MEDICAL SERVICES – PSYCHIATRY**Program Manager – Tia Jones**

Population(s) Served: Adult MH & Child MH

The Medical Services Psychiatry department consists of staff Psychiatrists, Advanced Practice Registered Nurses, and Certified Medical Assistants who provide triage and intake nursing, initial psychiatric evaluation, ongoing psychiatric medication management and monitoring, and prescription medication assistance to individuals seeking medication treatment and services for mental health. Medical Services Psychiatry department is not an intake program, so individuals must first minimally be seen for an initial screening by an Outpatient provider. Providers may also refer clients in their program if they are determined in need of psychiatric evaluation and/or medication-based interventions.

Minimum Eligibility Criteria:

- Ages 5+; Under age 5 requires prior approval by emailing Alexis Day & Tia Jones
- Biopsychosocial Evaluation must be completed by MBH staff prior to scheduling a Psychiatric Evaluation and recommending psychiatric services

Exclusionary Criteria:

- Seeking SA services only
- We are a Control-Free Program; any patients over 18 seeking stimulants or controls will be informed and alternative medication options will be initiated.

Point of Contact: Medical Services Support Email

Department Extension: 4000

Department Fax Number: 352-565-1044

medservsupport@mbhci.org

Internal Referrals:

- Send to Tia Jones or Jasmine Sapp

External Referrals:

- Contact Access Center

Important Notes:

- Disability, Fitness for Duty, and any other clearance evaluations or paperwork will NOT be completed and should not be scheduled with psychiatric providers

MEDICATION ASSISTED TREATMENT (MAT) – BUPRENORPHINE CLINIC**Medical Director – David Kirby****Director – Gade Duerksen****Nurse Manager – Vacant****Clinical Manger (Palatka) – Dale Eichenberg****Clinical Manger (Chiefland, Live Oak & Lake City) – Michelle NesSmith****Clinical Manager (Gainesville & Ocala) – Jeremiah Mikell**

Population(s) Served: Adult SA

Medicated Assisted Treatment (MAT) provides evidence-based practice that combines pharmacological interventions (medication) with substance use disorder counseling for those struggling with addiction to opiates, alcohol, or both. Buprenorphine is a mixed opioid receptor agonist-antagonist and has been shown to reduce withdrawal symptoms and block the effects of subsequently administered opioids; this allows individuals the opportunity to establish a more stabilized lifestyle. Individuals receiving medications from the Buprenorphine Clinic will also receive individual and group outpatient therapy. All services are provided to adults and their families/significant others by a treatment team of qualified individuals. The goal of therapy is to help the person served cope with individual problems that caused him/her to initially abuse drugs, and to affect a lifestyle change, both emotionally and physically.

Pregnant females, regardless of age, who have a documented addiction to opioid drugs in the past and who may be in jeopardy of abruptly stopping the use of opioids or returning to opioid drug use during pregnancy may be admitted to MAT programs. The MAT clinics will adhere to accepted medical standards of care regarding pregnancy, adequate dosing, and education regarding withdrawal, and appropriate treatment services will be initiated on a priority basis.

MEDICATION ASSISTED TREATMENT (MAT) – BUPRENORPHINE CLINIC

Medical Director – David Kirby
Director – Gade Duerksen
Nurse Manager – Vacant
Clinical Manger (Palatka) – Dale Eichenberg
Clinical Manger (Chiefland, Live Oak & Lake City) – Michelle NesSmith
Clinical Manager (Gainesville & Ocala) – Jeremiah Mikell

Minimum Eligibility Criteria:

- Addiction to opioids

Exclusionary Criteria:

- Patients under the age of 18 (except pregnant females)

Point of Contact:

- Dale Eichenberg
- Michelle NesSmith
- Jeremiah Mikell

Cell: 352.647.0009 Office: 386.600.4707
Cell: 352.316.4301 Office: 386.357.0488
Cell: 352.647.2838 Office: 352.450.8171

Internal & External Referrals:

- Send to

Important Notes:

- All MAT clinics accept Medicaid and have self-pay options; some of the clinics may have a limited amount of grant funding available.

MEDICATION ASSISTED TREATMENT (MAT) – OPIATE TREATMENT PROGRAM (OTP) – METHADONE CLINIC

Medical Director – David Kirby
Director – Gade Duerksen
Nurse Manager – Vacant
Clinical Manger (Palatka) – Dale Eichenberg
Clinical Manger (Chiefland, Live Oak & Lake City) – Michelle NesSmith
Clinical Manager (Gainesville & Ocala) – Jeremiah Mikell

Population(s) Served: Adult SA, Adult Co-occurring

The OTP program is a SAMHSA-certified clinic providing evidence-based practice treatment combining pharmacological interventions (methadone) with counseling in individual & group sessions for those struggling with addiction to opiates, including heroin. Methadone is taken orally and a dose usually lasts 24-30 hours. In proper dosages, there is no narcotic high, which allows individuals the opportunity to establish a more stabilized lifestyle. Once stabilized, the person served is required to adhere to a strict program of rehabilitative therapy, which includes attendance for medication administration, individual and group counseling based on program phase, monitored/observed drug screens at least monthly depending on program phase, and pregnancy status. There is an emphasis on positive social engagement. These services are provided to adults and their families/significant others by a treatment team of qualified individuals.

Methadone is dispensed to individuals daily for in the beginning phase of this treatment program, and individuals must come to the clinic to receive their dose. A person served can move through a phase system that allows take-home medication once the required phase is reached and upon approval of the physician. An individual who is admitted or placed into the methadone detoxification program is not allowed medication take-homes unless approval is obtained from the state and federal authorities. Pregnant females, regardless of age, who have a documented addiction to opioid drugs in the past and who may be in jeopardy of abruptly stopping the use of opioids or returning to opioid drug use during pregnancy may be admitted to the OTP on a priority basis. The OTP adheres to accepted medical standards of care regarding pregnancy, adequate dosing, and education regarding withdrawal from methadone once started, and appropriate treatment services.

Minimum Eligibility Criteria:

- Must have at least 1 year of addiction to opioids; special conditions apply to pregnant women and those who were in a penal institution prior to intake appt.

Exclusionary Criteria:

- Under the age of 18

Points of Contact:

- Dale Eichenberg
- Michelle NesSmith
- Jeremiah Mikell

Cell: 352.647.0009 Office: 386.600.4707
Cell: 352.316.4301 Office: 386.357.0488
Cell: 352.647.2838 Office: 352.450.8171

Internal & External Referrals:

- Send to

Important Notes:

- All MAT clinics accept Medicaid and have self-pay options; some of the clinics may have a limited amount of grant funding available.

MEDICATION ASSISTED TREATMENT (MAT) – VIVITROL CLINIC

Medical Director – David Kirby
Director – Gade Duerksen
Nurse Manager – Vacant
Clinical Manger (Palatka) – Dale Eichenberg
Clinical Manger (Chiefland, Live Oak & Lake City) – Michelle NesSmith
Clinical Manager (Gainesville & Ocala) – Jeremiah Mikell

Population(s) Served: Adult SA, Adult Co-occurring

Medicated Assisted Treatment (MAT) provides evidence-based practice that combines pharmacological interventions (medication) with substance use disorder counseling in individual and group sessions for those struggling with addiction to opiates, alcohol, or both. Vivitrol is a non-addictive, non-narcotic, once-monthly injection used to treat opioid and alcohol addiction. Vivitrol facilitates relapse prevention and has been identified to reduce opiate and alcohol cravings in a majority of patients. It is an opioid antagonist, or blocking medication, that attaches itself to opioid receptors (without dopamine activation) preventing opioids from attaching and activating excessive dopamine release. Individuals seeking admission to the Vivitrol clinic must be free of using any opioids and/or alcohol for at least 7 to 14 days.

Vivitrol is generally considered not safe to take during pregnancy. Individuals who are pregnant and seeking MAT services for addiction may be eligible for admission to the Vivitrol clinic. The MAT physician in conjunction with the individual's obstetrician can evaluate the risks of using Vivitrol versus the continued use of substances on the developing fetus and/or discuss alternative options for treatment.

MEDICATION ASSISTED TREATMENT (MAT) – VIVITROL CLINIC

Medical Director – David Kirby
Director – Gade Duerksen
Nurse Manager – Vacant
Clinical Manger (Palatka) – Dale Eichenberg
Clinical Manger (Chiefland, Live Oak & Lake City) – Michelle NesSmith
Clinical Manager (Gainesville & Ocala) – Jeremiah Mikell

Minimum Eligibility Criteria:

- Must be opioid-free for at least 7 to 14 days and preferably alcohol-free for at least 7-14 days before starting

Exclusionary Criteria:

- Pregnant women (unless approved by the physician)
 - Liver Disease determined from blood work (unless approved by the physician)
 - Currently using alcohol or opioids

Point of Contact:

- Dale Eichenberg	Cell: 352.647.0009 Office: 386.600.4707
- Michelle NesSmith	Cell: 352.316.4301 Office: 386.357.0488
- Jeremiah Mikell	Cell: 352.647.2838 Office: 352.450.8171

Internal & External Referrals:

- Send to

Important Notes:

- All MAT clinics accept Medicaid and have self-pay options; some of the clinics may have a limited amount of grant funding available.

MENTAL HEALTH FIRST AID (MHFA)

Prevention Director – Madeline Adkins

Population(s) Served: Meridian Staff & External Agencies

Mental Health First Aid program staff provide mental health first aid training under the Mental Health Awareness Grant. The instructors provide training for Adult, Youth and Spanish speaking community members. Staff coordinate all MHFA classes offered under the grant, provide community outreach to promote MHFA, and coordinate classes that are not covered under the grant.

The target populations for MHFA provision are veterans and families, parents of high-risk youth, college-age students, faith-based groups, aging elders' groups, NAMI and peer groups, school-based personnel, forensic and criminal justice, child welfare, and Spanish-speaking.

Point of Contact: Madeline Adkins

maddie_adkins@mbhci.org; Office: 352.450.8566

Internal & External Referrals:

- Anyone interested in scheduling a Mental Health First Aid class can reach out to Madeline Adkins

Important Notes:

- We offer Mental Health Training Sessions for adults. Topics include: Noticing Signs and Symptoms, Suicide Prevention, Support After Trauma, Self-Care, Administering Narcan, Burnout Prevention, Occupational Health, and more as requested.

MOBILE RESPONSE TEAM (MRT)

Program Vice President: Tina Harkness
Program Managers:
MRT North (Columbia, Hamilton, Lafayette, Suwannee) – Delora Rollins
MRT South (Tri-County) – Rhonda Lynch
MRT East (Baker, Bradford, Union) – Pretina Hutchinson

Population(s) Served: People experiencing mental health or substance use crisis (does not have to be current Meridian client)

Mobile Response Teams (MRT) provides 24/7 mobile crisis services to people in the community experiencing a mental health or substance use crisis. MRT is offered in all counties except Alachua. They respond to crisis in the community within 60 minutes for crisis de-escalation for the purpose of preventing a Baker Act whenever it is safe to do so. Following the crisis, the MRT team provides care coordination and follow up services to assist the client with access to mental health care for 72 hours.

Minimum Eligibility Criteria:

- Actively experiencing a critical mental health and/or substance abuse crisis

Exclusionary Criteria:

- Crisis in Alachua County (if person in Alachua County is in crisis, please contact the Alachua Crisis Center at 352-264-6789). If crisis is in MBH housing in Alachua County, we can respond.

Points of Contact:

MRT Line, for immediate crises	800.330.1615 – Select Option 1, then Option 2
Pretina Hutchinson (East)	Cell: 352.681.8204
Delora Rollins (North)	Cell: 352-339-0063
Rhonda Lynch (South)	Cell: 352-672-1868

Internal Referrals: & External Referrals:

- MRT can be reached at 1.800.330.1615, Option 1, then Option 2

Important Notes:

- There is no charge for MRT services.
 - MRT is operated under a five-year grant-funded program by LSF and aims to reduce Baker Acts, hospitalizations, and incarcerations.
 - Callers do not have to be a current Meridian client.
 - Can provide face-to-face telehealth services.

MOTHERS INTENSIVE SUPPORTIVE TREATMENT (MIST) – RESIDENTIAL

Program Director – Arthronia Hosley

Population(s) Served: Adult SA, Adult Co-occurring

MOTHERS INTENSIVE SUPPORTIVE TREATMENT (MIST) – RESIDENTIAL**Program Director – Arthronia Hosley**

MIST is a 22-bed, multi-faceted treatment program for pregnant and parenting women who struggle with addiction. The program is housed within the Sid Martin Bridge House in Gainesville. In the MIST program, infants stay with the mother, allowing for crucial bonding that takes place in the early months of development while allowing the mothers to receive treatment and remain drug-free during nursing. The program strives to empower women to become self-sufficient, responsible mothers who are capable of creating a bright future for themselves and their children. Women admitted into the program will remain in the residential component of the program of 6-12 months and then are referred to a less intensive level of care. Treatment is individualized to the needs of the client and their family.

Clients must meet ASAM criteria and provide a physical and proof of shot records for the baby upon admission to the program. Children must be less than 12 months old and only one child is allowed in the program with the mother; visitation with multiple children is allowed.

Minimum Eligibility Criteria:

- Pregnant or within 12 months postpartum
- SA diagnosis primary
- Meets ASAM Level 3.5
- Interventions at less intensive levels of care have failed; and/or,
- History of repeated incarcerations with pattern of relapse
- Living/social environment poses high risk of neglect or abuse
- Medical conditions (including MH) are stable and/or currently being treated

Exclusionary Criteria:

- Males
- Acute intoxication or withdrawal

Point of Contact: Arthronia Hosley

Cell: 352.647.6404 Office: 352.450.8846

Internal & External Referrals:

- Contact Access Center – Email: accesscenter@mbhci.org

Important Notes:

- For postpartum mothers: The dependent child (under 12 months) is not required to be in the client’s care/custody at the time of admission to MIST; however, if the child is not in their custody, reunification does need to be the goal

OUTPATIENT – ADULT**Program Directors:**

- Director - Nathalie Hervy** (Tri-County)
- Vice President - Terri Faul** (Gainesville, Palatka, Ocala)
- Vice President - Lizette Lopez** (Lake City)
- Director - Dr. Ivey Mitchell** (Macclenny)
- Director - Valeria Gorden** (Starke & Lake Butler)
- Manager – Jeremy Demos** (Marion)
- Manager – Cynthia Aleman** (Hamilton, Lafayette & Suwannee)

Population(s) Served: Adult MH, Adult SA, Adult Co-occurring

The Adult Outpatient Program provides services to individuals experiencing serious behavioral/emotional disturbances and/or substance use disorders to address related functional impairments where there is an indicated need for therapeutic intervention. Outpatient providers utilize evidence-based practices to target the alleviation of adverse symptoms and restoration or development of age-appropriate behaviors, interpersonal skills, coping strategies, etc. that are necessary to achieve and maintain healthy emotional and behavioral functioning.

Outpatient services may be provided on an individual basis or in a group setting; telehealth services are also available. Services are provided by qualified professionals who foster a therapeutic environment that facilitates the development of recovery-oriented goals and objectives to work towards the reduction of symptoms and increased functional engagement and satisfaction. Telehealth and therapy-assisted online counseling options are offered.

Minimum Eligibility Criteria:

- Age 18 and over

Exclusionary Criteria:

- Autism Spectrum as primary diagnosis

Points of Contact:

- Vacant – Executive Program Assistant
- Cynthia Aleman (Hamilton, Lafayette & Suwannee)
- Cyd Marie Medina (Columbia)
- Nathalie Hervy (Tri-County)
- Dr. Ivey Mitchell (Baker)
- Vacant (Alachua & Putnam)
- Valeria Gorden (Bradford & Union)
- Jeremy Demos (Marion)

Cell: 352.647.1227 Office: 386.339.4726
 Cell: 352.672.3851 Office: 386.357.0344
 Cell: 352.672.3851 Office: 352.715.2839
 Cell: 352.514.4028 Office: 904.227.7409

Cell: 352.359.8586 Office: 904.833.4034
 Cell: 352.214.9210 Office: 352.352.4711

Internal Referrals:

- Vacant – Hamilton, Lafayette, Suwannee
- Cyd Marie Medina – Columbia
- Nathalie Hervy – Dixie, Gilchrist, Levy
- Dr. Ivey Mitchell – Baker
- Vacant – Alachua, Putnam
- Valeria Gorden – Bradford, Union

External Referrals:

- Contact Access Center

Important Notes:

- Outpatient programs do not offer Sexual Offender or Batterers Intervention therapy programs
- Groups are available for topics related to substance use, depression, anxiety, stress, anger, and well-being

OUTPATIENT – CHILD

Program Directors:
Vacant (Gainesville)
Vacant (Jasper, Mayo & Live Oak)
Nathalie Hervy (Tri-County)
Cyd Marie Medina (Lake City/Columbia)
Dr. Ivey Mitchell (Macclenny)
Valeria Gorden (Lake Butler & Starke)
Jeremy Demos (Ocala)
Manager – Cynthia Aleman (Hamilton, Lafayette & Suwannee)

Population(s) Served: Child MH, Child SA, Child Co-occurring

The Children’s Outpatient Program encompasses therapeutic treatment in the clinic, school, and community-based settings utilizing both individual and group therapy modalities and focusing on children and adolescents with serious behavioral or emotional disturbances and related functional impairments that require intervention. All clients receive a comprehensive biopsychosocial assessment that guides treatment and establishes expected outcomes. Through the use of evidence-based practices, therapeutic services target the alleviation of symptoms and the restoration or development of age-appropriate behavioral, interpersonal, or other skills needed for effective functioning in home, social and school environments. Treatment interventions may include services to help caregivers and/or families build emotional stability and parenting competence, establish appropriate boundaries and roles, facilitate healthy communication patterns, prevent disruptions in living or placement situations within natural families, and/or strengthen the parent-child bond.

Services are provided in the setting and at the level of intensity most appropriate for the child. Thus, some children are seen in their family home and/or school environment, and some are seen in the clinic. Services such as intervention programs, psychiatric consultation and community resources are sought as needed to facilitate recovery. Clinic, school-based, and in-home counseling options are available, as are telehealth and therapy-assisted online counseling. Clinicians are also able to work with children who are involved with Partnership for Strong Families (PSF) and Department of Children and Families (DCF).

Minimum Eligibility Criteria:

- Under age 18

Exclusionary Criteria:

- Autism Spectrum as primary diagnosis

Points of Contact

Vacant (North) – Executive Program Assistant (Alachua & Putnam)
 Cynthia Aleman (Hamilton, Lafayette & Suwannee)
 Cyd Marie Medina (Lake City/Columbia)
 Nathalie Hervy (Tri-County)
 Dr. Ivey Mitchell (Baker)
 Valeria Gorden (Bradford & Union)
 Jeremy Demos (Ocala)

Ext.
 Cell: 352.647.1227 Office: 386.339.4726
 Cell: 386.361.0197 Office: 386.357.0344
 Cell: 352.672.3851 Office: 352.715.2839
 Cell: 352.756.3459 Office: 904.227.7409
 Cell: 352.359.8586 Office: 904.833.4034
 Cell: 352.214.9210 Office: 352.352.4711

Internal Referrals:

- Vacant – Alachua, Putnam
- Vacant– Hamilton, Lafayette and Suwannee
- Cyd Marie Medina – Lake City/Columbia
- Nathalie Hervy – Dixie, Gilchrist, Levy
- Dr. Ivey Mitchell – Baker
- Valeria Gorden – Bradford, Union

External Referrals:

- Contact Access Center

Important Notes:

- In Tri-County, SA treatment is only offered via individual therapy.
- In Ocala, currently only accepting MM and Lutheran clients.
- Groups are currently available for topics related to depression, anxiety, stress, anger, and well-being
- For clients involved with PSF and DCF, their case worker MUST attend the initial session to sign consent; placement letter must also be provided at the initial visit for clinician to provide services with foster parent involvement.

OUTREACH AND REFERRAL – PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH)

Program Vice President – Vacant

Population(s) Served: Adult MH, Adult Co-occurring

Projects for Assistance in Transition from Homelessness (PATH) is a grant-funded program to facilitate engagement in mental health services and service provision for individuals with serious mental illness experiencing homelessness. The PATH program provides the following services: community outreach, brief assessment/referral, service connection and engagement in services.

PATH programs must be capable of linking PATH-enrolled individuals with needed services. PATH programs must place emphasis on street outreach and case management activities to engage individuals who are or are at risk of homelessness and are not already connected with mainstream services (e.g., substance abuse, mental health, housing, employment, etc.). Programs are encouraged to prioritize individuals that meet PATH eligibility who are Veterans and/or are part of the annual Disparity Impact Statement target population.

Minimum Eligibility Criteria:

- Ages 18+
- Serious mental illness (may have co-occurring SA)
- Homeless or at imminent risk of homelessness

Exclusionary Criteria:

- SA disorder without co-occurring MH diagnosis(es) primary
- Behavior/symptoms that present danger to self or others
- Medical conditions requiring skilled nursing care

Points of Contact:

Demetra Dasher – Outreach Specialist
 Sylvia Anderson – Outreach Case Manager

Cell: 352.317.5149 Office: 352.450.8695
 Cell: 352.538.7439 Office: 352.450.8777

Internal Referrals:

- Send to Demetra Dasher

External Referrals:

- Fax referral form to 352.224.2744

**OUTREACH AND REFERRAL –
PROJECTS FOR ASSISTANCE IN TRANSITION FROM
HOMELESSNESS (PATH)**

Program Vice President – Vacant

Important Notes:

- PATH is operated under a grant, which encompasses the following counties: Alachua, Baker, Bradford, Gilchrist, Levy, and Union

PREVENTION SERVICES

Program Director – Madeline Adkins

Population(s) Served: School-aged Youth

Evidence-Based Prevention Programs (i.e., All Stars, Life Skills, Girls Circle, RadKIDS, Elephant in the Room, etc.) intended to reduce the risk of developing behavioral health problems (e.g., underage alcohol consumption or the abuse of drugs, legal or illegal, suicide ideology/behavior) and increase coping and resilience strategies. These programs are taught in schools or other community-based youth serving organizations and youth must sign up through an organization that is offering them. Additionally, Meridian offers services to school districts to help meet state Department of Education mandates requiring instruction for youth on Mental Health, Human Trafficking, and Substance Use Education. Lastly, Mental Health First Aid certification course trains participants to identify and respond to potential mental illness or substance use disorders until appropriate professional help can arrive. Meridian offers community classes plus business, organization, and school trainings.

Minimum Eligibility Criteria:

- Open to school-aged youth through schools and organizations contracting with Meridian to provide these programs to their populations

Exclusionary Criteria:

- Adult populations (see important notes)

Point of Contact: Madeline Adkins

Office: 352.450.8566

Internal & External Referrals:

- Contact Madeline Adkins

Important Notes:

- Prevention programs are not to be used for intervention, as prevention funding is prohibited from being used this way
 - Grant funding is available to provide programs at no cost to the organization in some cases; prevention staff can help determine if funding exists for a particular request or if minimal charges will apply
 - See Mental Health First Aid program (Page [15](#)) for additional information

PRIMARY CARE CLINIC

**Program Manager – Donna Rowland
Director of Medical Services – Alexis Day**

Population(s) Served: Clients 12 and up that meet the following criteria

Primary Care clinic offers primary care services in the Gainesville and Lake City locations. Primary Care offers disease management, specialty referrals, and general medical care. We do not offer childhood vaccinations or gynecological exams.

Minimum Eligibility Criteria:

- Age 12+
- United Healthcare
- Sunshine
- Straight Medicare
- Uninsured or LSF who meet the following criteria:
 - High need/high utilizer (3 or more acute care admissions in the past 180 days or an admission for more than 16 days)
 - Grandfathered in being seen prior to 2019 without more than a 6-month break.

Referred from:

- FACT Team
- LATTERS
- Any of Meridian's residential programs. Local insured clients should be seen by their Primary Care Provider.
 - Self-Pay
 - MAT, Med Services, etc. Providers should be referring to Primary Care when there are medical concerns.

Exclusionary Criteria:

- Must be engaged in other Meridian services or if new, they need to schedule a Bio.

Point of Contact: Primary Care Reception

386.357.0555

Internal Referrals:

- Contact Primary Care Reception Desk

External Referrals:

- We only except external clients that have UHC Medicaid or Sunshine Medicaid.

PSYCHOSOCIAL REHABILITATION

**Program Manager– Brian Wilson (Alachua)
Program Manager – Natasha Davies (Columbia)**

Population(s) Served: Adult MH, Adult Co-occurring

Our Psychosocial Rehabilitation program serves people with certain psychiatric diagnoses who wish to understand more about mental health, and who wish to improve their coping methods, social dexterity, communication, and independent living skills. We work on topics like budgeting, conflict management, emotional management, peer negotiation, and many other areas that are necessary to help a person improve their social competence and independence. The program encourages every member/client to actively contribute to the planning and treatment process as part of an interactive team with their counselors and mental health providers. We strive to work together with other providers, along with family and community support.

Minimum Eligibility Criteria:

- 18 years of age or older
- Have an approved DSM-V psychiatric diagnosis
- Must have approved Medicaid Insurance
- Must be able to independently follow the schedule of classes

Exclusionary Criteria:

- Under 18 years of age

Point of Contact:

Brian Wilson – Gainesville
Natasha Davies – Lake City

Office: 352.450.8676
Office: 386.357.0492

PSYCHOSOCIAL REHABILITATION	Program Manager– Brian Wilson (Alachua) Program Manager – Natasha Davies (Columbia)
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Internal & External Referrals:
 - Brian Wilson – Alachua
 - Natasha Davies – Columbia

Important Notes:
 - Program consists of daily classes starting at 7:00 a.m. and running through 12:00 p.m.
 - Clients are responsible for transportation to and from classes
 - Develops treatment plan with assigned 1:1 PSR counselor

QUALITY IMPROVEMENT / RISK MANAGEMENT	Program Vice President – Michelle Lisk
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The Quality Improvement / Risk Management (QI) department manages a variety of activities, including, but not limited to: regulatory compliance, incident reporting, ADA accommodations, deaf and hard of hearing conformance, concern escalations, legal matters (e.g., subpoenas, law suits, etc.), consumer satisfaction, fire and emergency drills, Center-wide procedures, licensure/permits/accreditation, internal and external audits and corrective action plans, internal surveys, internal and external performance measures and standards (e.g., peer review audits, Medicaid audits, contract deliverables, etc.), and insurance facility credentialing. The QI department also oversees Meridian’s Emergency Response Team and Quality Improvement Committees: Care Coordination, Health & Safety, Pharmacy, Risk Management, Recovery Oriented Systems of Care Transformation, Seclusion & Restraint Oversight, Stakeholder Relations, and Standards of Care.

Points of Contact: Tayler Courtney – QI Specialist Sammi Schiappucci – QI Analyst & Deaf and Hard of Hearing SPOC David Johnson – Program Evaluator Michelle Lisk – Sr. Vice President	Office: 352.450.8591 Office: 352.450.8583 Office: 352.450.8532 Cell: 352.363.7381 Office: 352.450.8572
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Important Notes:
 - Critical Incidents require verbal reporting to QI and an online incident report; please refer to Chapter 4 procedures in PolicyTech for specifics/details
 - Please do not send complaint calls to QI – Client Concerns can be received/entered by any staff using the incident reporting system; an effort to resolve the issue should also be made by receiving staff/appropriate mgmt. so resolution is not further delayed
 - When auditors/external agencies come onsite to preform inspections, please notify a member of QI at the time of inspection.

RECOVERY CENTER – RESIDENTIAL	Program Manager – Shelley Stroud
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Population(s) Served: Child SA, Child Co-occurring

Located in Lake City, the Recovery Center is an 18-bed substance abuse residential treatment program for adolescents ages 13 to 17. The program is six months in duration, and admission is based on ASAM Residential Level 3.5 criteria.

The program offers a variety of activities and services, including counseling, medical (medications), supportive interventions, therapeutic individual and group activities, and facilitation of educational requirements and goals. All activities and services are provided in a structured environment that stresses the development of healthy coping and problem-solving skills to enable adolescents to better deal with family, personal, and social problems, and they are designed to increase post-discharge resiliency.

School attendance is mandatory and is conducted through the Columbia County School System. There are options for GED, with parental approval, and credit recovery assistance for those who have fallen severely behind.

Minimum Eligibility Criteria:
 - Ages 12 to 17
 - Substance Use Diagnosis(es); must be primary
 - ASAM Level 3.5 Criteria
 - Must have physical within the last 30 days.
 - Must have immunization records.
 - Must have a TB test completed within the past 30 days.

Exclusionary Criteria:
 - Legal involvement with no substance use.
 - History of serious violence and/or sexual offenses.

Point of Contact: Shelley Stroud	Cell: 352.647.1911 Office: 386.357.0518
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Internal Referrals:
 - Send to Shelley Stroud, MS

External Referrals:
 - Contact Access Center

Important Notes
 - Individuals involved in the legal system may still be eligible for admission, especially those with charges related to substances.

RECOVERY CENTER – RESPITE	Program Manager – Shelley Stroud
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Population(s) Served: Child MH, Child Co-occurring

MBH Respite is a room and board program with supervision for children. The main function of the program is to provide children experiencing behavioral and/or social obstacles an opportunity to disengage from their home environment and provide a healthy, safe, nurturing atmosphere which will allow children to reflect on their actions, identify stressors that have led to negative outcomes and work to develop the skills necessary to make positive decisions in the future.

Residents participate in various structured activities including, but not limited to, the following: parental involvement in assessment and development of treatment goals, therapeutic and group activities to facilitate positive communication and working relationships between parent(s) and children, continued attendance at home schools to prevent interruption in academic and social routine when possible, participation in on-site school when necessary, daily psycho-educational and life skills workshops, daily “study hall” to promote academic achievement and school engagement, and weekly youth support groups to allow residents to share and help one another.

RECOVERY CENTER – RESPITE		Program Manager – Shelley Stroud
Minimum Eligibility Criteria: - Age 17 and under. - Mental Health diagnosis(es); must be primary. - Must have physical within the last 30 days. - Must have immunization records.		
Exclusionary Criteria: - Age 18+ - Youth who are actively psychotic, homicidal, or suicidal.		
Point of Contact: Shelley Stroud	Cell: 352.647.1911 Office: 386.357.0518	
Internal Referrals: - Send to Shelley Stroud		
External Referrals: - Contact Access Center		
Important Notes - Meridian provides Respite Care under contracts with LSF and Partnership for Strong Families - Current Physical and Immunization records are required.		

RECRUITING		Program Director – Yemaele (Mya) Porter
Meridian’s Recruiting department is responsible for planning, organizing and directing all phases of a comprehensive and diversified recruiting program. We partner with managers to develop staffing strategies, implement cost effective recruitment plans, provide consultation throughout the selection process to maximize fit and retention and work with employees to determine potential internal growth opportunities within the organization.		
Points of Contact: Mya Porter Teresa Edwards Chelsea Hadley	Office: 352.450.8594 Office: 352.450.8592 Office: 352.450.8527	
External Referrals: - Employee Referral Bonuses Available – See HR Zone on Intranet for details.		
Important Notes: - Internal Applications may be downloaded via the Employee Intranet or you can reach out to the recruiting team to get a copy sent via Adobe. - All Internal Applications must be vetted by Recruiting prior to conducting any interviews.		

SSI/SSDI OUTREACH, ACCESS, AND RECOVERY (SOAR)		Program Director – Thea Baglino Vice President – Tina Harkness
Population(s) Served: Adult MH, Adult Co-occurring		
The SSI/SSDI Outreach, Access, and Recovery (SOAR) program is designed to utilize a more direct process to assist individuals with applications and appeals for disability benefits. The program was designed for eligible individuals who are experiencing or at risk of homelessness and have a mental illness, medical impairment, and/or a co-occurring substance use disorder.		
The SOAR Specialist operates as the point of contact and facilitates collection of all documentation and information needed from the Social Security Administration (SSA) and Disability Determination Services (DDS). This documentation minimally includes all relevant medical records and generates a Medical Summary Report (MSR) for submission. The MSR provides an overview of the individual and is the critical component of the SOAR process as it is a comprehensive, concise summary of the individual’s medical history and gives a description of functional impairments preventing the individual from being able to work. The goal of SOAR services is to increase direct communication and collaboration with SSA and DDS, thus providing an expedited application, appeal, and determination process overall.		
Minimum Eligibility Criteria: - Serious mental or physical illness that affect ability to work - Illness(es)/condition(s) have lasted or are expected to last at least 12 months or result in death - Currently exhibiting symptoms of mental illness or has periods of worsening symptoms preventing sustainable employment - Marked restrictions in at least TWO of these functional areas: » Understanding, remembering, or applying information » Interacting with others » Concentrating, persisting, or maintaining pace on activities/tasks » Adapting or managing themselves - Eligible for CCBHC care coordination		
Exclusionary Criteria: - Under 18 years of age - Submitted an application for SSI/SSDI and awaiting decision - Working with a disability attorney or other representative on SSI/SSDI case - Active employment		
Point of Contact: Tyler Zimmermann – SOAR Specialist Valarie Duhart-Holly – SOAR Specialist		
Internal Referrals: - Send to Rhonda Lynch		
Important Notes: - For information on targeted case management services, please refer to Case Management program (Page 7) - For information on CCBHC care coordination, please refer to CCBHC Grant program (Page 7)		

STAFFING		Program Administrator – Danielle Dixon
Staff Served: Nurses, Mental Health Techs, Emergency Screening Coordinators, & Recovery Specialists working in 24/7 programs		
Meridian’s Staffing department oversees all staffing administration and schedule management for 200+ employees, ensuring we are in line with center-wide strategic initiatives, federal staffing regulations and budget. The Staffing department provides On-Call coverage 24/7 for staffing emergencies and callouts in the following programs: Bridge House, SAPP, MIST, Transitions, Lodge, Recovery Center, Williams Manor, CSU’s and Addiction Receiving.		
Point of Contact: Danielle Dixon – Staffing Administrator	352.275.4780	

SUBSTANCE ABUSE PICC PROGRAM (SAPP)	Addictions Medical Director – David Kirby Program Director – VACANT
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Population(s) Served: Adult SA

Meridian’s Substance Abuse PICC Program (SAPP) is a diversion program that allows for patients in hospitals who have a history of IV drug use which prevents them from returning home with a PICC line for their antibiotics and have current severe infection that requires antibiotics through a PICC line to come to this specialized unit for services. Instead of the patient staying in the hospital for 6-8 weeks or longer, if needed, they can receive 24/7, monitored treatment in the SAPP clinic, as well as other services relating to their condition for a fraction of the cost. All referrals for this program should go to the Medical Director for approval and then will be seen bedside at the hospital for an assessment of appropriateness for the SAPP Unit. This is a Residential Unit so clients must be independent in all activities of daily living and able to self-administer medications following instruction from hospital and home health aide. Most of these clients are receiving narcotics for pain so they must be weaned every 8 hours for pain management as there is not a nurse on the unit from 11pm – 7am to give a controlled substance. There is a nurse in the SAPP program Monday through Friday from 8am-5pm and nursing coverage from Bridge House nurse from until 11pm during the week and on weekends.

Minimum Eligibility Criteria:

- Taking controlled substances at a frequency of every 8 hours or less
- Independent in performing all activities of daily living
- Must have signed consent from client

Exclusionary Criteria:

- Cannot be taking any Benzos, unless prior approval obtained from the Medical Director

Point of Contact: Sabrina Brown	Cell: 352.672.0695
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Internal & External Referrals:

- Send all to Sabrina Brown, Program Manager Elizabeth Madison, Admission Coordinator Marcus Watson
- Shands HomeCare Specialist 352.265.0111 x50476; Cell: 407.421.9901

Important Notes:

- SAPP is a locked unit; clients are to only leave the unit in the company of the nurse, clinician or recovery specialist
- Clients are transported to and from any medical appointments by approved center drivers in MBH vehicles and monitored during this time to prevent inappropriate use of the PICC line
- Clients are encouraged to attend at minimum 2 groups per day

SUPPORTED EMPLOYMENT	Program Manager – Brian Wilson
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Population(s) Served: Adult MH & SA

The Supported Employment program is offered to clients of Meridian who already receive services at the agency through other primary programs, such as: Adult Outpatient, Rehabilitative Services, and Psychiatric Services. The Job Coach assists clients in finding and maintaining employment in the surrounding community. The Job Coach provides support in resume development, job searching, completing applications, interviewing techniques, coping with job/workplace stressors and learning about resources in the community.

Minimum Eligibility Criteria:

- Must be 18 or older
- Active in primary treatment program
- Live in Gainesville

Exclusionary Criteria:

- Under 18 years of age
- Not actively engaged in treatment with another program at Meridian
- Live outside of Gainesville

Point of Contact: Brian Wilson	Office: 352.450.8676
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Internal Referrals:

- Send to Brian Wilson

External Referrals:

- Referrals are not accepted from external sources

Important Notes:

- Please discuss the requirements of program with the client (ensuring they meet them) before submitting internal referral
- Client’s primary program will maintain responsibility for completing treatment plan updates

SUPPORTIVE SERVICES FOR VETERAN FAMILIES (SSVF)	Program Manager – Tanaka Gates
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Population(s) Served: Veterans & Families

Supportive Services for Veteran Families (SSVF) is a federally funded program through the Department of Veterans Affairs (VA) that was established to help Veteran families who are homeless or at risk of homelessness quickly regain or maintain stability in permanent housing. Meridian was granted awarded funding to provide supportive services to eligible individuals. The SSVF program is in Gainesville in separate offices off-site of the main Gainesville Campus. Although the offices are in Alachua County, the SSVF program offers an array of outreach and engagement serves to individuals throughout the following 11 counties: Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, and Union. The annual program goal is to serve 250 Veteran households per grant year and services are free of charge providing eligibility requirements are met.

SSVF purpose and focus is centered on the Housing First Model in which housing stability is the primary intervention in working with people experiencing homelessness. Housing First moves the individual or household immediately from the streets or shelters into their own permanent housing. The Housing First approach is based on the concept that a homeless individual or household’s first and primary need is to obtain stable housing and other issues that may affect the household can and should be addressed once housing is obtained. Housing is not contingent on compliance with support services, but participants must comply with a standard lease agreement and are provided with services and support that are necessary to help them do so successfully. Meridian SSVF utilizes the Housing First model to ensure we make available all the supports our Veterans need while transitioning into housing, and that we place particular emphasis on those that assist them in meeting their responsibilities as tenants and in complying with a standard lease agreement.

Staff work with Veterans to complete a screening packet and can assist with any emergency referrals that may be determined to be needed during the intake process. Part of the screening process ensures Veterans meet the eligibility criteria and are appropriate for services. Staff then work with individuals and community partners to obtain and maintain housing. Supportive services specialists meet with participants and conduct home visits to adequately assess issues that could jeopardize continued tenancy, review for any additional services needed, and to assist in preserving landlord-tenant-grantee relationships

SUPPORTIVE SERVICES FOR VETERAN FAMILIES (SSVF)**Program Manager – Tanaka Gates**

so participating landlords will be willing to house other Veteran households. Under Housing First, home visits by SSVF supportive services specialists increase the likelihood of preserving both the Veteran’s housing and the grantee’s relationship with the landlord.

Minimum Eligibility Criteria:

- Eligible Veteran
- Homeless or at risk of homelessness
- Meets HUD income guidelines for their area
- Meets “But for Rule,” and must have NO other:
 - » Subsequent housing options
 - » Financial resources to obtain or remain in immediate housing
 - » Support network or resources needed to obtain or remain in immediate housing

Exclusionary Criteria:

- Currently in stable/permanent housing

Point of Contact: Tanaka Gates

Office: 352.244.9827

Internal & External Referrals:

- Send to: SSVF@MBHCI.org
- Contact Tanaka Gates

Important Notes:

- SSVF offices are located at 1405 NW 13th Street, Suite B; Gainesville 32601

TREATMENT FOR INDIVIDUALS EXPERIENCING HOMELESSNESS (TIEH)**Program Manager – Lindsay Smith**

Population(s) Served: Adult MH, Adult SA, Adult Co-occurring. Individuals who are currently homeless or at risk of becoming homeless.

TIEH is a five-year SAMHSA funded program that provides comprehensive, coordinated and evidenced-based services for individuals with a serious mental illness, serious emotional disturbance or co-occurring disorder who are also experiencing homelessness or at imminent risk of homelessness. Recipients of this grant will be expected to 1) engage and connect the population of focus to behavioral health treatment, case management, and recovery support services, 2) assist with identifying sustainable permanent housing by collaborating with homeless services organizations and housing providers, including public housing agencies, and 3) provide case management that includes care coordination/service delivery planning and other strategies that support stability across services and housing transitions. With this program, the aim is to further expand opportunities to improve access to and delivery of coordinated, comprehensive services mental health services and improve housing stability.

Minimum Eligibility Criteria:

- Be actively homeless or at risk of becoming homeless.
- Have a current mental health and/or substance use disorder.
- Willing to participate in all aspects of the program—counseling, care coordination, and peer support services.

Exclusionary Criteria:

- The grant serves individuals who are located in Alachua and Putnam counties.

Points of Contact:

Point(s) of Contact: Lindsay Smith, MSW
 Treatment for Individuals Experiencing Homelessness (TIEH) Program
 Manager

lindsay_smith@mbhci.org or 352.810.0366

Internal Referrals / Requests:

Internal referrals can be sent via SmartCare, or an email can be sent to Lindsay Smith at lindsay_smith@mbchi.org

External Referrals / Requests:

External referrals can be emailed to Lindsay Smith at lindsay_smith@mbhi.org

Important Notes:

- TIEH is not a housing program, it is a treatment program. TIEH falls under Homeless Recovery Services and is a part of Outpatient. While connecting the client with housing is one of the objectives of TIEH, the main objective of the program is treatment.

UTILIZATION MANAGEMENT**Program Manager – Carolann Cutright**

Population(s) Served: All

The Utilization Clerks and Utilization Review Counselors operate together in conjunction with the Financial Counselors (see Important Notes section for more info) to ensure maximum reimbursement is obtained for the treatment and services we provide. The Utilization Clerks and Utilization Review Counselors work mainly with MBH providers and insurances to determine what documentation is required and provide adequate justification of medical necessity in order to ensure continued payment for treatment and services provided.

Utilization Clerks work on outpatient services along with providers to manage those accounts that have services requiring ongoing authorization. They work closely with clinical staff to complete the authorization request forms and to gather as much clinical information as possible to support the individual’s continued need for treatment and services. Utilization Review Counselors manage inpatient bed days and work closely with the physicians, nursing, and counseling staff to gather sufficient clinical documentation to support the medical necessity of the admission and request for continued stay. They manage a “dashboard” that gives the inpatient Billing Clerks essential information about what was allowed and covered by insurance and provides secondary assurance that all the information has been entered correctly in SmartCare.

Points of Contact:

AzzuDee Johnson – Lead Financial Counselor
 Carolann Cutright – Utilization Manager

Office: 352.450.8673
 Office: 352.450.8525

Internal & External Referrals/Requests:

- AzzuDee Johnson

Important Notes:

- For questions related to client responsibility, Consent to Treat documentation, or eligibility/benefits, please refer to Financial Counselors program (Page [9](#))

APPENDIX A – HOW TO COMPLETE & REVIEW INTERNAL REFERRALS IN SMARTCARE

STEPS WHEN SENDING A REFERRAL

- Have an Active Client in SmartCare, and use the Search Magnifying Glass to type Internal Referral Document:



- Should your client not ever have had an Internal Referral be put in before this screen may be blank, in this case you will click on the “New” button which is the blank sheet of paper in the upper right corner.

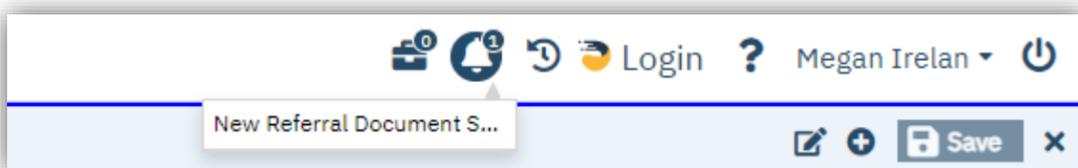


- If your client has had Internal Referrals before you will see them on the screen.

- You will begin by adding the Request Date, what Program the client is being referred from, the staff referring (if not you), and Reason/Need for Assessment or Referral.
- Receiving Staff and Referred to Program will need to be filled in as well, as this is how the Document travels. The original author signs the document.

RECEIVING AN INTERNAL REFERRAL

- A Notification will appear, and when you click it will indicate there is a new Internal Referral that has been sent to you.



- You can use the notification to take you to the alert, please *Be Mindful that you may need to adjust the Filters/Dates*

- Click on the Title of the Reference Document, and you will be at the Internal Referral Document screen.
- The Receiving Staff will then complete the process by completing the workflow set by their program or department regarding new potential clients sent by internal referrals and completing the internal referral form by filling out the bottom of the form.