# 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 24)**

***-- 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:**<br>- Minimum criteria for program participation<br><br>**Exclusionary Criteria:**<br>- Any factors that may prevent participation | |
| **Point(s) of Contact:** Name / Title<br>*[Specific individual(s) within the department where staff should initially direct all program-related inquiries]* | **POC Contact Info** – Extension and/or MBH Cell<br>*[Email will not be listed unless it differs from name(s) listed as POC]* |
| **Internal Referrals / Requests:**<br>- Specific instructions related to internal referrals or requests and/or to whom they should be directed<br><br>**External Referrals / Requests:**<br>- Specific instructions related to referrals or requests initiated from external sources and/or to whom they should be directed | |
| **Important Notes:**<br>- Any additional notes about the program or other important program-related info to convey<br>*[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**<br>**Program Manager – Jessica Pitts** |
|---|---|
| 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.<br><br>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.<br><br>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:**<br>- Ages 3+<br><br>**Exclusionary Criteria:**<br>- Follow-up (e.g., Individual Therapy) or Med Services psychiatric appointments are handled by the Scheduling Line and should be referred to Ext. 5097<br>- 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 Ext. 5095 | |
| **Point of Contact:** Jessica Pitts | Ext. 8285 |
| **Internal Referrals:**<br>- Ext. 5096<br>- Email: accesscenter@mbhci.org<br><br>**External / New Patient Referrals:**<br>- Complete online: https://www.mbhci.org/getting-started/referrals/ | |
| **Important Notes:**<br>- Access Center serves as Meridian's official Crisis Line during normal business hours; after hours, the Crisis Line rolls to the Emergency Screening program<br>- 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<br>- 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**<br>**Director of Acute Care – Deborah Most**<br>**Nurse Manager** (Lake City) **– Shalonda Ford**<br>**Nurse Manager** (Gainesville) **– Shawntavious Murphy, Calaysia Jones, and Kneisha Means**<br>**Inpatient Counseling Manager (GNV & LC) – Lizette Lopez**<br>**Manager Emergency Screening (GNV) – Mary Wright** |
|---|---|
| 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:**<br>- Severe symptoms related to MH diagnosis(es)<br>- Imminent danger to self/others or at risk of danger/decompensation without intervention<br><br>**Exclusionary Criteria:**<br>- Inpatient level of care not appropriate | |
| **Points of Contact:**<br>Deborah Most<br>Rontica Samuels (Unit Supervisor & Interim Contact) – Gainesville | <br>Ext. 8216; Cell: 352.647.2773<br>Ext. 6372; Cell: 352.810.0965 |
| **Internal Referrals:**<br>- Any clinician within Meridian who is initiating an involuntary examination must complete the BA3052 within the EMR<br>- Clients on the Gainesville or Lake City campuses should be walked directly to the CSU for screening and admission<br>- For clients in the community or outlying clinics, staff should contact local law enforcement to assist with transport<br><br>**External Referrals:**<br>- Fax to: 352.244.0295 | |
| **Important Notes:**<br>- If an individual's primary issue/concern is needing medications refilled, please refer to the Medical Service Psychiatry program (Page 14) | |

| **ACUTE CARE – DETOX –<br>ADDICTIONS RECEIVING FACILITY (ARF)** | **Medical Director – John Abernathy**<br>**Vice President – Deborah Most**<br>**Nurse Manager – Shawntavious Murphy, Calaysia Jones, AND Kneisha Means**<br>**Director Inpatient Counseling – Lizette Lopez**<br>**Manager of Emergency Screening – Mary Wright** |
|---|---|
| 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 – John Abernathy**<br>**Vice President – Deborah Most**<br>**Nurse Manager – Shawntavious Murphy, Calaysia Jones, AND Kneisha Means**<br>**Director Inpatient Counseling – Lizette Lopez**<br>**Manager of Emergency Screening – Mary Wright** |
|---|---|

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

**Exclusionary Criteria:**
- Negative drug screen (excludes alcohol)

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|---|---|
| **Point of Contact:** Deborah Most | Ext. 8216; Cell: 352.647.2773 |

**Internal Referrals:**
- For additional information or bed availability inquiry, please call the emergency screeners at ext. 5095

**External Referrals:**
- Clients being referred for detox 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 – EMERGENCY SCREENING | **Program Vice President – Deborah Most**<br>**Manager (**Gainesville) **– Mary Wright**<br>Manager (Lake City) **– Vacant** |
|---|---|

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

Emergency Screening is a 24/7 program that offers screening, assessment and referral for individuals in crisis and in need of services. Individuals may utilize services on a voluntary or involuntary basis, as appropriate/eligible. The Screening departments are housed on the Lake City and Gainesville campuses and serve as the point of reception for all Acute Care programs. As such, Emergency Screeners evaluate individuals for admission to the Acute Care programs, i.e., Adult Addictions Receiving Facility/Inpatient Detoxification, and the Adult and Child Crisis Stabilization Units.

In cases where individuals are determined inappropriate or ineligible for admission to inpatient Acute Care services, discharge planning services are provided prior to release to connect them to Outpatient or other community-based programs and services.

Emergency Screening also operates as the afterhours Crisis Line between the hours of 5:30 p.m. and 7:30 a.m., when Access Center is closed.

**Minimum Eligibility Criteria:**
- Ages 18+: In Acute MH or SA Crisis
- Under age 18: In Acute MH Crisis

**Exclusionary Criteria:**
- Minors are not eligible for SA Acute Care services

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|---|---|
| **Points of Contact:**<br>Lake City and Gainesville – Deborah Most | <br>Ext. 8216; Cell: 352.647.2773 |

**Internal & External Referrals:**
- Ext. 5095

**Important Notes:**
- Staff referring clients for Emergency Screening, under a Baker Act or voluntarily, should:
  - » Provide report on behavior/symptoms and reason for referral to Emergency Screening staff or Program Director; and,
  - » Complete/sign all related clinical documentation as soon as possible, to ensure it is available for Screening staff to reference when completing intake evaluation and determining eligibility and/or appropriateness for admission to Acute Care.

| ADVANCEMENT: MARKETING, EXTERNAL COMMUNICATIONS, PHILANTHROPY | **Program Senior Vice President – *Vacant*** |
|---|---|

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.

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| **Points of Contact:** | |
| Kandra Albury – VP of Marketing & Advancement | Ext. 8630 |
| PENDING/OPEN – Manager of Partnerships & Engagement | Pending |
| Eliza Philbin – Marketing Coordinator | Ext. 8991 |
| Sheila Singleton – Administrative Assistant | Ext. 8210 |

| ADVANCEMENT: MARKETING, EXTERNAL COMMUNICATIONS, PHILANTHROPY | Program Senior Vice President – *Vacant* |
|---|---|
| **Internal Requests:**<br>- Brochures, flyers, and promo items should be requested in advance via the employee intranet under “Marketing” in the “Quick Links” menu on the right<br><br>**External Requests/Contacts:**<br>- All external media requests and contacts should be forwarded to Lauren Cohn.<br>- Please forward anyone who wishes to help/support Meridian to Sara Desmartin. | |

| AFTERCARE | Vice President South- Terri Crawford<br>Vice President North- Latifa Ranganadan |
|---|---|
| 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:**<br>- Meet ASAM Level 1 criteria<br>- Recent discharge from residential treatment<br><br>**Exclusionary Criteria:**<br>- No SA diagnosis | |
| **Point of Contact:** Terri Crawford | Ext. |
| **Internal Referrals:**<br>- Alan Paulin<br><br>**External Referrals:**<br>- Not eligible currently. | |
| **Important Notes:**<br>- At present, Aftercare only accepts clients stepping down from Bridge House Residential Treatment program; please contact Program Director for more info. | |

| ASSERTIVE COMMUNITY TREATMENT (ACT) TEAM | Program Director – Rhonda Lynch |
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| Population(s) Served: Adult MH, Adult Co-occurring | |
| The ACT model utilizes a multi-disciplinary team designed to provide comprehensive wrap-around treatment and services to individuals with severe and persistent mental illness who have not been successful maintaining stability in less intensive programs. To be eligible for the program, individuals must be defined as high utilizer by meeting one of the following criteria: three or more inpatient/residential admissions within one calendar year, one inpatient/residential admission 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 three years. At present, the ACT Team only serves individuals who reside within the Gainesville city limits.<br><br>The ACT Team includes members from psychiatry, nursing, outpatient, care coordination, and peer support who work collaboratively to provide integrated services. With the acuity of the individuals participating in ACT program, services are most often provided in the living environment with the goal of assertive engagement in treatment. ACT Team members conduct a weekly staffing for each client to closely monitor their status and enhance or adjust services to meet the individual’s ongoing needs. As services are highly tailored, there is a low staff-to-client ratio in the program and a limited caseload overall. | |
| **Minimum Eligibility Criteria:**<br>- Ages 18 and older<br>- Gainesville resident<br>- Severe, chronic MH diagnosis is primary<br>- Meet high-utilizer criteria<br><br>**Exclusionary Criteria:**<br>- Under the age of 18<br>- Lives outside of service area<br>- Not willing/able to engage in intensive services<br>- Traditional treatment methods have not been fully utilized | |
| **Point of Contact:** Rhonda Lynch | Ext. 8972; Cell: 352.672.1868 |
| **Internal Referrals / Requests:**<br>- Send to Rhonda Lynch | |
| **Important Notes:**<br>- Clients are required to meet at least weekly with ACT Team<br>- ACT Team is part of the CCBHC Grant program (see Page **8** for more about CCBHC Grant) | |

| 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 to our patients with issues or questions regarding balances that are made via phone, internet, or website. | |
| **Points of Contact:**<br>Amanda Cox-Miller – Billing Manager<br>Cherise Elmore – Director of Billing | <br>Ext. 8236<br>Ext. 8075 |
| **Internal & External Referrals/Requests:**<br>- Ext. 8323; 8075 or Email billing@mbhci.org | |

| BRIDGE HOUSE – RESIDENTIAL TREATMENT | Program Director – Elizabeth Madison Ext. 8259 |
|---|---|
| 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:**<br>- SA Diagnosis Primary<br>- Must meet ASAM Level 3.5 criteria for admission<br>- Must be free from intoxication or withdrawal symptoms that require 24-hour care, observation, or monitoring<br>- 30-days' worth of any prescribed medications<br><br>**Exclusionary Criteria:**<br>- Cannot accommodate registered sex offenders due to proximity to MIST Unit<br>- 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:** Sabrina Brown | Ext. 8869; Cell: 352.672.0695 |
| **Internal & External Referrals:**<br>- Contact assigned Access Center staff to obtain required info and place client on waitlist, or reach out to Admissions Coordinator Marcus Watson x 8308 | |
| **Important Notes:**<br>- If an individual has been actively using opiates, alcohol, or benzodiazepines, they must be cleared by Acute Care - Detox Unit/ARF prior to admission<br>- 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)<br>- 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.<br>-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) | Vacant<br>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:**<br>- Chronic MH diagnosis(es); and at least ONE of the following:<br>» 2+ admissions to crisis stabilization unit within the past 12 months<br>» 3+ inpatient admissions (crisis stabilization unit and/or addictions receiving facility/detox) within the past 6 months<br>» 16+ days spent inpatient within the past 6 months<br>» Placed in an Assisted Living Facility<br>» Recently discharged from State Hospital<br><br>**Minimum Eligibility Criteria - Children:**<br>- Mental disability (emotional disturbance) which requires advocacy for and coordination of services to maintain/improve level of functioning.<br>- Must lack a natural support system with the ability to access needed medical, social, and other services.<br><br>**Exclusionary Criteria:**<br>- Private insurance<br>- Receiving duplicate case management services (e.g., Homeless Recovery, Forensic Intervention, CAT program, FACT Teams, Agency for Persons with Disabilities, etc.)<br>- Co-occurring with MH diagnosis(es) not primary | |
| **Points of Contact:**<br>Rana Tallador – North<br>Jennifer LaCasse- South | <br>Ext. 8074; Cell: 386.209.0195<br>Ext. 8781; Cell: 352.339.0567 |
| **Internal & External Referrals:**<br>- Megan Rhoades – Alachua, Dixie, Gilchrist, Levy<br>- Rana Tallador – Baker, Bradford, Columbia, Hamilton, Lafayette, Suwannee, Union | |
| **Important Notes:**<br>- Case Managers do NOT assist with obtaining or changing social security benefits payees<br>- For information on the SOAR disability application/appeals process, see SOAR program (Page 21) | |

| CENTRALIZED INTAKE TEAM (CIT) | Program Vice President – Tina Harkness<br>Program Manager – Jessica Pitts |
|---|---|
| Population(s) Served: All | |
| The Centralized Intake Team (CIT) provides same-day, walk-in, and telehealth evaluations from 8am – 3pm 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:**<br>- Must live in the state of Florida.<br>- Must have a working camera on their computer/laptop/tablet/smart phone if utilizing telehealth services.<br><br>**Exclusionary Criteria:**<br>- Out-of-state residents. | |
| **Points of Contact:**<br>Centralized Intake Coordinator<br>Jessica Pitts | <br>Ext. 8243<br>Ext. 8285; Cell: 352.538.3577 |

| CENTRALIZED INTAKE TEAM (CIT) | Program Vice President – Tina Harkness<br>Program Manager – Jessica Pitts |
|---|---|

**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:**
- Depending on their insurance, clients may have to schedule their biopsychosocial evaluation for a later date.
- 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 an MBH office after 3:00 pm 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<br>Program Director – Thea Baglino |
|---|---|

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

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 | Ext. 8972; Cell: 352.810.6566 |
| Tina Harness – VP Admissions/Access | Ext. 6144; Cell: 352.647.1229 |

**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
- Children in Alachua & Columbia Counties are served by the CMHC Grant program (Page 9)

| CLIENT RELATIONS | Program Manager North – Kennidra Rossin<br>Program Manager South – Sheremah DeJesus<br>VP of Business Relations – Shantel Dix |
|---|---|

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 to 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, Putnam | Ext. 8266 |
| Kennidra Rossin – Baker, Bradford, Columbia, Hamilton, Suwannee, Union | Ext. 8079 |

**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 Director – Terran Dillhyon |
|---|---|

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)

| COMMUNITY ACTION TEAMS (CAT) | Program Director – Terran Dillhyon |
|---|---|
| **Points of Contact:**<br>Vacant – Lake City Team Lead (Columbia, Hamilton, Lafayette, Suwannee)<br>Emily Masten – North Team Lead (Baker, Bradford, Nassau, Union)<br>Christina Gerhard – Tri-County Team Lead (Dixie, Gilchrist, Levy) | <br><br>Cell: 352.316.4301<br>Cell: 352.538.6791 |
| **Internal Referrals:**<br>- Transfer to Terran Dillhyon<br><br>**External Referrals:**<br>- Send to: catreferral@mbhci.org | |
| **Important Notes:**<br>- 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 | |

| COMMUNITY MENTAL HEALTH CENTER (CMHC) GRANT | Program Manager North – Vacant<br>Program Manager South – Jeremiah Mikell (Vacant on 06/12/2024)<br>VP Wraparound North Director – Christy McBee |
|---|---|
| Population(s) Served: Adult MH, Adult SA, Adult Co-occurring, Child MH, Child SA, Child Co-occurring | |
| Our CMHC program provides wrap-around treatment and services designed specifically for children, adolescents, and young adults with a mental health diagnosis and/or co-occurring substance use diagnosis. It is an intensive, short-term program, with services typically lasting around six months. Clients engaged with the CMHC program receive a full range of treatment and services including care coordination, counseling, medication management, and peer specialist involvement. | |
| **Minimum Eligibility Criteria:**<br>- Between ages 5 to 25<br>- Must have a MH and/or SA diagnosis<br>- Must live within our service areas<br><br>**Exclusionary Criteria:**<br>- Over the age of 25<br>- Not willing to engage in intensive services | |
| **Points of Contact:**<br>Morgan Gish – Alachua & Tri-County (Dixie, Gilchrist, Levy)<br>Rana Tallador – Columbia, Hamilton, Lafayette, Suwannee<br>Christy McBee – Columbia, Hamilton, Lafayette, Suwannee | <br>352.810.0383<br>386.209.0195<br>Ext. 8019; 352.647.6308 |
| **Internal & External Referrals:**<br>- Email or send to Rana Tallador North or Jeremiah Mikell South | |
| **Important Notes:**<br>- No financial qualifiers needed; Accept both Medicaid and private insurance | |

| FAMILY SERVICES – FAMILY INTENSIVE TREATMENT TEAM (FITT) | Program Manager North - Vacant<br>Vice President Wraparound Service North – Christy McBee |
|---|---|
| Population(s) Served: SA Adult | |
| The Family Intensive Treatment Team (FITT) provides wrap-around clinical services for families involved with the child welfare system/Dept. of Children and Families (DCF) with the goal of reducing child welfare recidivism. Eligible families are those that reside in Alachua or Levy County, have a substance use disorder that impairs the parenting, judgement, or ability to safely care for the child in the family, and a child in the family has been determined to be "unsafe." Families are not eligible for FITT if there is no goal of reunification or are no safety concerns in the home. For admission to the program, referrals must come directly from DCF/Partnership for Strong Families (PSF). | |
| **Minimum Eligibility Criteria:**<br>- Parent with an identified substance abuse problem that is negatively attributing to their ability to parent<br>- Must have in-home or judicial involvement with PSF<br>- Parents must have at least one child between the ages of 0 and 10<br>- Residents of Alachua & Levy Counties<br><br>**Exclusionary Criteria:**<br>- No current involvement with PSF | |
| **Point of Contact:**<br>Rana Tallador – Program Manager North<br>Christy McBee | <br>Ext. 8074 Cell: 386.209.0195<br>Ext. 8019.Cell:352.647.6308 |
| **Internal Referrals:**<br>- Send directly to Megan Rhoades<br>- Must indicate confirmation on referral of current involvement with PSF and a child between the ages of 0 and 10.<br><br>**External Referrals:**<br>- Referrals from PSF are sent directly to Program Manager | |
| **Important Notes:**<br>- FITT works with clients with involvement in the Child Welfare system<br>- Internal referrals are evaluated for appropriateness but cannot be accepted until an official referral is received from PSF | |

| FAMILY SERVICES – FAMILY TREATMENT COORDINATION (FTC) | Program Manager North – Rana Tallador<br>Vice President Wraparound Service North – Christy McBee |
|---|---|
| Population(s) Served: SA Adult and SA Child | |
| 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. | |
| **Minimum Eligibility Criteria:**<br>- Current child welfare involvement due to parental substance abuse negatively impacting ability to adequately parent | |

| FAMILY SERVICES – FAMILY TREATMENT COORDINATION (FTC) | Program Manager North – Rana Tallador<br>Vice President Wraparound Service North – Christy McBee |
|---|---|
| **Exclusionary Criteria:**<br>- Not actively involved with child welfare | |
| **Points of Contact:**<br>Rana Tallador – Program Manager North<br>Jennifer LaCasse | <br>Ext. 8074; Cell: 386.209.0195<br>Ext. 8781; Cell: 352.339.0567 |
| **Internal Referrals:**<br>- Internal referrals not accepted<br><br>**External Referrals:**<br>- Referrals submitted to FIS workers by Child Protective Investigator or Family Care Counselor | |
| **Important Notes:**<br>- FIS works with clients through Partnership for Strong Families and Department of Children and Families | |

| FINANCIAL COUNSELORS | Program Manager – Carolann Cutright |
|---|---|
| Population(s) Served: All | |
| 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:**<br>- Must be a resident of Florida to be eligible for sliding scale<br><br>**Exclusionary Criteria:**<br>- Sliding scale not available for anyone with active insurance benefits. | |
| **Point of Contact:**<br>AzzuDee Johnson - Lead Financial Counselor<br>Carolann Cutright - Program Manager | <br>Ext. 8955<br>Ext. 8034 |
| **Internal & External Referrals:**<br>- Ext. 5099 or Email: financial_counselors@mbhci.org | |
| **Important Notes:**<br>- Family size and income are used to determine where individuals fall on the sliding scale<br>- Income guidelines are set by the state<br>- 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<br>- For questions related to insurance authorizations or authorization requests, please refer to Utilization Management program (Page **23**) | |

| FLORIDA ASSERTIVE COMMUNITY TREATMENT (FACT) LITE | Program Manager: Julian Pearson<br>Vice President Wraparound North – Christy McBee |
|---|---|
| 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 -**<br>- Age 18 or older<br>» Reside within Baker, Bradford, Union, Columbia, Suwannee, Lafayette, or Hamilton Counties<br>» Be a high utilizer defined by one of the following:<br>» Three or more inpatient/residential stays within 1 calendar year OR One inpatient/residential stay lasting 16 days or longer OR<br>» Multiple, recent hospital/inpatient/residential admissions of 50 – 90 days within the last calendar year or 150 days within the last 3 years<br>» Have a Severe Mental Illness as primary diagnosis; Schizophrenia, Schizoaffective Disorder, Bipolar, Anxiety, Depression, etc. (or co-occurring)<br>» Symptoms interfere with maintaining employment and sage living situation.<br>» Disruption in social relationships and ability to function in the community.<br>» Disturbance in daily living skills<br>» Destructive, harmful, or neglectful behavior or choices related to self or others.<br>» Not benefited from traditional services<br>**Exclusionary Criteria:**<br>• Primary identified focus of treatment non-compliance<br>• Primary diagnosis of Borderline Personality Disorder, Dementia, Intellectual and Developmental Disability, TBI<br>• Traditional treatment methods have not been fully utilized | |
| **Points of Contact:**<br>Julian Pearson<br>Christy McBee (Alternate) | <br>Cell: 352.810.1048<br>Cell: 352.647.6308 |
| **Internal Referrals:**<br>- **Send to Julian Pearson or Johanna Stith**<br>**External Referrals:**<br>- FACT_Columbia@mbhci.org | |

| FORENSICS MULTIDICIPLINARY TEAM (MDT) | Program Director(S) / DIRECTOR(S)<br>Letisha Francis – North<br>Fabian Robels Fontan – Alachua Co.<br>Daniel Lieberman – Marion County<br>Vice President Wraparound Service North – Christy McBee<br>Vice President Wraparound Services South – Morgan Gist |
|---|---|
| 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.<br><br>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:**<br>- 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.<br>**Exclusionary Criteria:**<br>- Individual with only misdemeanor charges | |
| **Points of Contact:**<br>Letisha Francis<br>Fabian Robles Fontan<br>Daniel Lieberman | <br>Ext. 6332 cell - 352-647-1915<br>Ext. 8224 cell - 352-810-6233<br>Ext. 6485 cell - 352-647-2769 |
| **Internal and External Referrals:**<br>- 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 Courtney Collins for Marion Co. | |
| **Important Notes:**<br>- For all outlying counties, except Levy, only felony NGI and ITP cases can be accepted.<br>- 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. | |

| GRANTS FOR THE BENEFIT OF HOMLESS INDIVIDUALS (GBHI) (Ending June 30, 2024) | Vice President Outpatient Services South – Terri Crawford |
|---|---|
| Population(s) Served: Adult SA, Adult Co-occurring | |
| GBHI provides wrap around treatment and services for people who have experienced chronic homelessness and a mental health and/or substance abuse issue. Clients who would like to engage in treatment toward recovery from homelessness will work with a community-based team made up of clinicians, care coordinators, peer specialists and a nurse. Mental health, substance abuse, income stability, housing resources, community connectedness, and overall well-being will be the focus of treatment while working with GBHI. | |
| **Minimum Eligibility Criteria:**<br>- Currently homeless or at risk of homelessness<br>- Substance use disorder(s) or co-occurring MH and SUD<br>- Must have a VI-SPDAT assessment completed by Meridian GHBI staff<br>- Individual must be located in Alachua County<br><br>**Exclusionary Criteria:**<br>- Has stable housing<br>- Client who does not meet minimum scoring on VI-SPDAT | |
| **Point of Contact:**<br>Homeless Recovery Services Program Line<br>Shawnta Walker – GBHI Program Manager | <br>Ext. 8948<br>Cell: 352.647.1779 |
| **Internal Referrals:**<br>- Send to Shawnta Walker<br><br>**External Referrals:**<br>- Route to Ext. 8948 | |
| **Important Notes:**<br>- Currently able to work with individuals at varying stages of homelessness; Program ending in 2024 | |

| HOUSING – JOYCE HOUSE | Director of Housing Services – Kandis Patrick |
|---|---|
| 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:**<br>- MH diagnosis(es) consistent with SPMI population<br><br>**Exclusionary Criteria:**<br>- Unable to complete Activities of Daily Living independently | |
| **Point of Contact:** Dane Bernard | Main Line: 352.374.5600<br>Daytime Phone: 352.565.1822<br>Cell Phone: 352.810.1074 (Call or text 8a-5p) |

| HOUSING – JOYCE HOUSE | Director of Housing Services – Kandis Patrick |
|---|---|
| **Internal & External Referrals:**<br>- Dane Bernard | |
| **Important Notes:**<br>- 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:**<br>- Serious MH and/or SA concerns<br>- Actively receiving services from an outpatient program<br><br>**Exclusionary Criteria:**<br>- Unable to complete activities of daily living independently | |
| **Point of Contact:** Reda Buchanan | Ext. 8651<br>Cell: 352.275.7168 |
| **Internal & External Referrals:**<br>- Kandis Patrick | |
| **Important Notes:**<br>- 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 – Kandis Patrick |
|---|---|
| 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 setting 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:**<br>- Physician-documented history of severe and persistent MH concerns<br>- Meets minimum and maximum income threshold requirements<br><br>**Exclusionary Criteria:**<br>- Unable to complete activities of daily living<br>- Co-occurring; MH not primary | |
| **Point of Contact:** Reda Buchanan | Ext. 8651<br>Cell: 352.275.7168 |
| **Internal & External Referrals:**<br>- Kandis Patrick | |
| **Important Notes:**<br>- Individuals completing housing application must provide copies of the following: birth certificate and social security card for all individuals, and identification card and proof of income/government benefits (or self-certification of no income) for all adults in the household | |

| HOUSING – TRANSITIONS | Program Manager – Kandis Patrick |
|---|---|
| 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:**<br>- MH diagnosis(es) consistent with SPMI population<br><br>**Exclusionary Criteria:**<br>- Unable to complete Activities of Daily Living with prompting<br>- Serious/complex medical condition(s) | |
| **Point of Contact:** Dane Bernard | Main Line: 352.374.5600<br>Daytime Phone: 352.565.1822<br>Cell Phone: 352.810.1074 (Call or text 8a-5p) |
| **Internal & External Referrals:**<br>- Dane Bernard | |
| **Important Notes:**<br>- Transitions is voluntary program; individuals must be able to understand and adhere to program guidelines | |

| Housing - Williams Manor RTF | Program Manager - Mike Hosey |
|---|---|
| Population(s) Served: Adult MH, Adult SA, Adult Co-occurring, Child MH, Child SA, Child Co-occurring, or any Specialized Population | |
| 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. | |

| Housing - Williams Manor RTF | Program Manager - Mike Hosey |
|---|---|
| **Minimum Eligibility Criteria:**<br>- Residents must have a qualifying mental illness diagnosis.<br>- Residents must be at least 18 years of age, and no more than 70 years of age.<br>- Residents must be ambulatory and capable of independent self-transfer.<br><br>**Exclusionary Criteria:**<br>- Ongoing violent, threatening, or disruptive behaviors.<br>- Active psychosis.<br>- Dementia diagnosis or Severe Developmental Disability diagnoses.<br>- Incapable of self-preservation or prompt evacuation.<br>- Medical conditions that require ongoing nursing services. | |
| **Point of Contact:** Mike Hosey, Program Manager | Extension: 8030<br>Cell: 352.647.1004 |
| **Internal Referrals / Requests:**<br>- Send to Mike Hosey<br><br>**External Referrals / Requests:**<br>- Send to Access Center | |
| **Important Notes:**<br>- Physical exams within 30 days of admission are required. | |

| Idalia FEMA Grant | Program Manager: Deanna Sheppard<br>Team Leader: Monica Williams |
|---|---|
| Population(s) Served: Residents of Levy/Gilchrist/Dixie County who are recovering from effects of Hurricane Idalia | |
| The FEMA Team provides emotional support and links to various resources available to Hurricane Idalia survivors in the Tri-County (Levy, Gilchrist, Dixie) area through continuous outreach in all three counties. There are four Crisis Counselors, a Child Specialist, and a Community Liaison who serve this area. Outreach is done through community events, food banks, health departments, local businesses, local government education, etc.<br><br>Crisis Counselors work closely with those referred (by others or self) to assess needs, provide emotional support for a brief time, and provide information for resources to the survivors. Survivors needing in-depth case management are referred to the Disaster Case Management Agency and those in need of mental health or substance abuse treatment are referred internally to the appropriate program.<br><br>The survivors who receive temporary crisis counseling through this program are entered into SmartCare as Meridian clients only as long as referrals for services and/or emotional support are needed. All encounters are tracked separately through the Crisis Counseling Provider program for FEMA. Outreach contacts, public education, and brief encounters are counted only for FEMA. Once all support available through the Crisis Counselors is delivered (usually 4-5 encounters) the survivor is closed to Meridian if there are no other programs with whom the survivor is enrolled. | |
| **Minimum Eligibility Criteria:**<br>**- a resident of Levy/Gilchrist/Dixie County when Hurricane Idalia made landfall (August 2023)**<br>**- need of emotional support or links to resources for funding to provide relief (financial, emotional, mental health, housing, food, utilities)**<br><br>**Exclusionary Criteria:**<br>**- did not live in the Tri-County Area at the time of impact** | |
| **Point(s) of Contact:**<br>**Deanna Sheppard, Project Manager**<br>**Monica Williams, Team Leader** | <br>Deanna Sheppard 352-647-0485<br>Monica Williams 352-647-4011 |
| **Internal Referrals / Requests:**<br>**- Contact Deanna Sheppard or Monica Williams**<br><br>**External Referrals / Requests:**<br>**Referrals can be provided for others or for self to any of the FEMA Team. The information needed is at least the name and phone number of the survivor in need of assistance.** | |
| **Important Notes:**<br>This program is funded by a time limited grant with September 29, 2024, as the anticipated expiration date. | |

| INFORMATION SERVICES (IS) | Program Vice President: Melisa Urrutia<br>Program Director *Jeffreys Howland*<br>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).<br><br>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.<br><br>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.<br><br>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.<br><br>Together, these teams form the backbone of our Information Services department, driving innovation, efficiency, and excellence across our organization. | |
| **Point of Contact:** IT Helpdesk | Ext. 8346 |
| **Important Notes:**<br>- 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:**<br>***Vacant*** (Lake City)<br>**Nathalie Hervy** (Tri-County)<br>**Stefanie Jasper** (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 are 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:**<br>- Age 18+<br>- Moderate to severe substance use manageable at an outpatient level<br><br>**Exclusionary Criteria:**<br>- MH diagnosis(es) only<br>- Neighbors, relatives, spouses, and/or significant others cannot be in the same group (except for Family Therapy) | |
| **Points of Contact:**<br>Secily Johnson – Executive Program Assistant<br>Megan Flanagan – Outpatient Clinician<br>Regina Romblad – Outpatient Clinician | <br>Ext. 8409<br>Ext. 6297<br>Ext. 8136 |
| **Internal Referrals:**<br>- Latifa Ranganadan – Columbia<br>- Megan Flanagan – Gilchrist, Levy<br>- Regina Romblad – Alachua<br><br>**External Referrals:**<br>- Access Center | |
| **Important Notes:**<br>- IOP groups are not conducted in all locations; clients wishing to participate would need to travel to one of the available locations for groups<br>- Program rules are more intensive than traditional outpatient and include, but are not limited to, the following:<br>» Two absences are allowed; three may result in discharge and/or referral to higher level of care<br>» If more than 15 minutes late or leave more than 15 minutes early, client will not receive credit for group and will require makeup<br>» Abstinence-based; positive screens will result in added support and intensified treatment, including possible recommendations to higher level of care<br>- In cases where clients are referred to higher level of care, they may return to IOP upon successful completion | |

| **MEDICAL SERVICES – PSYCHIATRY** | **Program Director – Alexis Day** |
|---|---|
| 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:**<br>- Ages 5+; Under age 5 requires prior approval by emailing Alexis Day & Tia Jones<br>- Biopsychosocial Evaluation must be completed by MBH staff prior to scheduling a Psychiatric Evaluation and recommending psychiatric services<br><br>**Exclusionary Criteria:**<br>- Seeking SA services only<br>- 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<br>Department Extension: 4000<br>Department Fax Number: 352-565-1044 | medservsupport@mbhci.org |
| **Internal Referrals:**<br>- Send to Tia Jones or Jasmine Sapp<br><br>**External Referrals:**<br>- Contact Access Center | |
| **Important Notes:**<br>- 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**<br>**Nurse Manager – Dedrie Godbolt**<br>**Clinical Manger (Palatka) – Christine Livingston**<br>**Clinical Manger** (Chiefland, Live Oak & Lake City) **– Michelle NesSmith**<br>**Clinical Manager** (Gainesville & Ocala) **– Patricia Jeter** |
|---|---|
| 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. The frequency and requirements for attendance will vary based on whether the individual is engaged in MAT services through the Outpatient or Outpatient Detox level of care. 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.<br><br>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**<br>**Nurse Manager – Dedrie Godbolt**<br>**Clinical Manger (Palatka) – Christine Livingston**<br>**Clinical Manger** (Chiefland, Live Oak & Lake City) **– Michelle NesSmith**<br>**Clinical Manager** (Gainesville & Ocala) **– Patricia Jeter** |
|---|---|
| **Minimum Eligibility Criteria:**<br>- Addiction to opioids<br><br>**Exclusionary Criteria:**<br>- Patients under the age of 18 (except pregnant females) | |
| **Point of Contact:** Grace Okine | Ext. 8262 |
| **Internal & External Referrals:**<br>- Send to Dedrie Godbolt | |
| **Important Notes:**<br>- 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**<br>**Nurse Manager – Dedrie Godbolt**<br>**Clinical Manger (Palatka) – Christine Livingston**<br>**Clinical Manger (Chiefland, Live Oak & Lake City) – Michelle NesSmith**<br>**Clinical Manager (Gainesville & Ocala) – Patricia Jeter** |
|---|---|
| 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.<br><br>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:**<br>- 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.<br><br>**Exclusionary Criteria:**<br>- Under the age of 18 | |
| **Points of Contact:**<br>Dedrie Godbolt | Ext. 8976 |
| **Internal & External Referrals:**<br>- Send to Dedrie Godbolt | |
| **Important Notes:**<br>- 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**<br>**Nurse Manager – Dedrie Godbolt**<br>**Clinical Manger (Palatka) – Christine Livingston**<br>**Clinical Manger (Chiefland, Live Oak & Lake City) – Michelle NesSmith**<br>**Clinical Manager (Gainesville & Ocala) – Patricia Jeter** |
|---|---|
| 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.<br><br>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. | |
| **Minimum Eligibility Criteria:**<br>- Must be opioid-free for at least 7 to 14 days and preferably alcohol-free for at least 7-14 days before starting<br><br>**Exclusionary Criteria:**<br>- Pregnant women (unless approved by the physician)<br>- Liver Disease determined from blood work (unless approved by the physician)<br>- Currently using alcohol or opioids | |
| **Point of Contact:** Dedrie Godbolt | Ext. 8976 |
| **Internal & External Referrals:**<br>- Send to Dedrie Godbolt | |

| MEDICATION ASSISTED TREATMENT (MAT) – VIVITROL CLINIC | **Medical Director – David Kirby**<br>**Nurse Manager – Dedrie Godbolt**<br>**Clinical Manger (Palatka) – Christine Livingston**<br>**Clinical Manger (Chiefland, Live Oak & Lake City) – Michelle NesSmith**<br>**Clinical Manager (Gainesville & Ocala) – Patricia Jeter** |
|---|---|
| **Important Notes:**<br>- 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.<br><br>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 | Ext. 8652 |
| **Internal & External Referrals:**<br>- Anyone interested in scheduling a Mental Health First Aid class can reach out to Madeline Adkins | |
| **Important Notes:**<br>- For school-aged children, please see Prevention program (Page 18) for additional information | |

| MOBILE RESPONSE TEAM (MRT) | **Program Vice President:** Tina Harkness<br>**Program Managers:**<br>**MRT North** (Columbia, Hamilton, Lafayette, Suwannee) **– Delora Rollins**<br>**MRT South** (Tri-County) **–** Rhonda Lynch<br>**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:**<br>- Actively experiencing a critical mental health and/or substance abuse crisis<br><br>**Exclusionary Criteria:**<br>- 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:**<br>MRT Line, for immediate crises<br>Pretina Hutchinson (East)<br>Delora Rollins (North)<br>Rhonda Lynch (South) | <br>800.330.1615 – Select Option 1, then Option 2<br>Cell: 352.681.8204<br>Cell: 352-339-0063<br>Cell: 352-672-1868 |
| **Internal Referrals: & External Referrals:**<br>- MRT can be reached at 1.800.330.1615, Option 1, then Option 2 | |
| **Important Notes:**<br>- There is no charge for MRT services.<br>- MRT is operated under a five-year grant-funded program by LSF and aims to reduce Baker Acts, hospitalizations, and incarcerations.<br>- Callers do not have to be a current Meridian client.<br>- 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 | |
| MIST is a 22-bed, multi-faceted treatment program for pregnant and parenting women wo 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.<br><br>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. | |

| MOTHERS INTENSIVE SUPPORTIVE TREATMENT (MIST) – RESIDENTIAL | Program Director – Arthronia Hosley |
|---|---|
| **Minimum Eligibility Criteria:**<br>- Pregnant or within 12 months postpartum<br>- SA diagnosis primary<br>- Meets ASAM Level 3.5<br>- Interventions at less intensive levels of care have failed; and/or,<br>- History of repeated incarcerations with pattern of relapse<br>- Living/social environment poses high risk of neglect or abuse<br>- Medical conditions (including MH) are stable and/or currently being treated<br><br>**Exclusionary Criteria:**<br>- Males<br>- Acute intoxication or withdrawal | |
| **Point of Contact:** Arthronia Hosley | Ext. 8257; Cell: 352.647.6404 |
| **Internal & External Referrals:**<br>- Contact Access Center – Ext. 5096 or Email: accesscenter@mbhci.org | |
| **Important Notes:**<br>- 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:**<br>**Vice President Latifa Ranganadan** (Jasper & Live Oak)<br>**Nathalie Hervy** (Tri-County)<br>**Vacant** (Gainesville & Palatka)<br>**Vice President Latifa Ranganadan** (Lake City)<br>**Dr. Ivey Mitchell (Macclenny)**<br>**Valeria Gorden** (Starke & Lake Butler) |
|---|---|
| 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.<br><br>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:**<br>- Age 18 and over<br><br>**Exclusionary Criteria:**<br>- Autism Spectrum as primary diagnosis | |
| **Points of Contact:**<br>Vacant – Executive Program Assistant<br>Vice President Latifa Ranganadan (Hamilton, Lafayette & Suwannee)<br>Cyd Marie Medina (Columbia)<br>Nathalie Hervy (Tri-County)<br>Dr. Ivey Mitchell (Baker)<br>Vacant (Alachua & Putnam)<br>Valeria Gorden (Bradford & Union) | Ext.<br>Ext. 8967, 8420; Cell: 386.361.0197<br>Ext. 8784; Cell: 352.672.3851<br>Ext. 6370; Cell: 352.756.3459<br>Ext. 8116; Cell: 352.514.4028<br>Ext.<br>Ext. 8805; Cell: 352.359.8586 |
| **Internal Referrals:**<br>- Latifa Ranganadan – Hamilton, Lafayette, Suwannee<br>- Cyd Marie Medina – Columbia<br>- Nathalie Hervy – Dixie, Gilchrist, Levy<br>- Dr. Ivey Mitchell – Baker<br>- Stefanie Jasper – Alachua, Putnam<br>- Valeria Gorden – Bradford, Union<br><br>**External Referrals:**<br>- Contact Access Center | |
| **Important Notes:**<br>- Outpatient programs do not offer Sexual Offender or Batterers Intervention therapy programs<br>- Groups are available for topics related to substance use, depression, anxiety, stress, anger, and well-being | |

| OUTPATIENT – CHILD | **Program Directors:**<br>**Vacant** (Gainesville)<br>**Latifa Ranganadan** (Jasper, Mayo & Live Oak)<br>**Nathalie Hervy** (Tri-County)<br>**Cyd Marie Medina** (Lake City/Columbia)<br>**Dr. Ivey Mitchell (**Macclenny)<br>**Valeria Gorden** (Lake Butler & Starke) |
|---|---|
| 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. | |

| **OUTPATIENT – CHILD** | **Program Directors:**<br>**Vacant** (Gainesville)<br>**Latifa Ranganadan** (Jasper, Mayo & Live Oak)<br>**Nathalie Hervy** (Tri-County)<br>**Cyd Marie Medina** (Lake City/Columbia)<br>**Dr. Ivey Mitchell (**Macclenny)<br>**Valeria Gorden** (Lake Butler & Starke) |
|---|---|

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) | Ext. |
| Latifa Ranganadan (Hamilton, Lafayette & Suwannee) | Ext. 8271; Cell: 352.275.6896 |
| Cyd Marie Medina (Lake City/Columbia) | Ext. 8967, 8420; Cell: 386.361.0197 |
| Nathalie Hervy (Tri-County) | Ext. 8784; Cell: 352.672.3851 |
| Dr. Ivey Mitchell (Baker) | Ext. 6370; Cell: 352.756.3459 |
| Valeria Gorden (Bradford & Union) | Ext. 8805; Cell: 352.359.8586 |

**Internal Referrals:**
- Vacant – Alachua, Putnam
- Latifa Ranganadan – 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.
- 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 –<br>PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH)** | **Program Vice President – Christine Block** |
|---|---|

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 | Ext. 8921; Cell: 352.317.5149 |
| Sylvia Anderson – Outreach Case Manager | Ext. 8280; Cell: 352.538.7439 |
| Ashley Means – Administrative Assistant | Ext. 8627; Cell: 352.213.1329 |

**Internal Referrals:**
- Send to Demetra Dasher

**External Referrals:**
- Fax referral form to 352.224.2744

**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

| PREVENTION SERVICES | Program Director – Madeline Adkins |
|---|---|
| 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:**<br>- Open to school-aged youth through schools and organizations contracting with Meridian to provide these programs to their populations<br><br>**Exclusionary Criteria:**<br>- Adult populations (see important notes) | |
| **Point of Contact:** Madeline Adkins | Ext. 8652 |
| **Internal & External Referrals:**<br>- Contact Madeline Adkins | |
| **Important Notes:**<br>- Prevention programs are not to be used for intervention, as prevention funding is prohibited from being used this way<br>- 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<br>- See Mental Health First Aid program (Page **16**) for additional information | |

| PRIMARY CARE CLINIC | Program Manager – Donna Rowland<br>Program Sr. Vice President – Ashley Tozier |
|---|---|
| Population(s) Served: Meridian Clients | |
| 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 for clients who are receiving services at Meridian. | |
| **Minimum Eligibility Criteria:**<br>- Age 12+<br>- United Healthcare<br>- Sunshine<br>- Uninsured or LSF who meet the following criteria:<br>  o High need/high utilizer<br>  o Grandfathered in prior to 2019<br>  o Referred from:<br>  ▪ FACT Team<br>  ▪ Bridge House<br>  ▪ Williams Manor<br>  ▪ Recovery Center<br>  ▪ MIST<br>- Self-Pay<br>- MAT, Med Services, etc. Providers should be referring to Primary Care when there are medical concerns.<br>**Exclusionary Criteria:**<br>- Must be engaged in other Meridian services. Not all LSF clients are eligible currently. | |
| **Point of Contact:** Primary Care Reception | Ext. 8990 |
| **Internal Referrals:**<br>- Contact Primary Care Reception Desk<br><br>**External Referrals:**<br>- NA - Must be open to other program/services with MBH | |

| PSYCHOSOCIAL REHABILITATION | Program Manager– Brian Wilson (Alachua)<br>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 supports. | |
| **Minimum Eligibility Criteria:**<br>- 18 years of age or older<br>- Have an approved DSM-V psychiatric diagnosis<br>- Must have approved Medicaid Insurance<br>- Must be able to independently follow the schedule of classes<br><br>**Exclusionary Criteria:**<br>- Under 18 years of age | |
| **Point of Contact:**<br>Brian Wilson – Gainesville<br>Natasha Davies – Lake City | <br>Ext. 8311<br>Ext. 8481 |
| **Internal & External Referrals:**<br>- Brian Wilson – Alachua<br>- Natasha Davies – Columbia | |
| **Important Notes:**<br>- Program consists of daily classes starting at 7:00 a.m. and running through 12:00 p.m.<br>- Clients are responsible for transportation to and from classes<br>- Develops treatment plan with assigned 1:1 PSR counselor | |

| QUALITY IMPROVEMENT / RISK MANAGEMENT | Program Vice President – Michelle Lisk |
|---|---|
| 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, Seclusion & Restraint Oversight, Stakeholder Relations, and Standards of Care. | |
| **Points of Contact:**<br>Michelle Lisk – Director<br>Sammi Schiappucci – QI Analyst & Deaf and Hard of Hearing SPOC<br>Damion Joyer – Internal Auditor | <br>Ext. 8219; Cell: 352.363.7381<br>Ext. 8317<br>Ext. 8347 |
| **Important Notes:**<br>- Critical Incidents require verbal reporting to QI and an online incident report; please refer to Chapter 4 procedures in PolicyTech for specifics/details<br>- 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 | |

| RECOVERY CENTER – RESIDENTIAL | Program Manager – Shelley Stroud |
|---|---|
| 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.<br><br>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.<br><br>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:**<br>- Ages 12 to 17<br>- Substance Use Diagnosis(es); must be primary<br>- ASAM Level 3.5 Criteria<br>- Must have physical within the last 30 days.<br>- Must have immunization records.<br>- Must have a TB test completed within the past 30 days.<br><br>**Exclusionary Criteria:**<br>- Legal involvement with no substance use.<br>- History of serious violence and/or sexual offenses. | |
| **Point of Contact:** Shelley Stroud | Ext. 8021; Cell: 352.647.1911 |
| **Internal Referrals:**<br>- Send to Shelley Stroud, MS<br><br>**External Referrals:**<br>- Contact Access Center | |
| **Important Notes**<br>- 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 |
|---|---|
| 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.<br><br>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. | |
| **Minimum Eligibility Criteria:**<br>- Age 17 and under.<br>- Mental Health diagnosis(es); must be primary.<br>- Must have physical within the last 30 days.<br>- Must have immunization records.<br><br>**Exclusionary Criteria:**<br>- Age 18+<br>- Youth who are actively psychotic, homicidal, or suicidal. | |
| **Point of Contact:** Shelley Stroud | Ext. 8021; Cell: 352.647.1911 |
| **Internal Referrals:**<br>- Send to Shelley Stroud<br><br>**External Referrals:**<br>- Contact Access Center | |
| **Important Notes**<br>- Meridian provides Respite Care under contracts with LSF and Partnership for Strong Families<br>- Current Physical and Immunization records are required. | |

| RECRUITING | Program Director – Yemaelle (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:**<br>Mya Porter<br>Frank White<br>Teresa Edwards<br>Michael Wlodarczyk | <br>Ext. 8294<br>Ext. 6101<br>Ext. 8334<br>Ext. 8998 |
| **External Referrals:**<br>- Employee Referral Bonuses Available – See HR Zone on Intranet for details. | |
| **Important Notes**:<br>- Internal Applications may be downloaded via the Employee Intranet or you can reach out to Michael Wlodarczyk to get a copy sent via Adobe.<br>- All Internal Applications must be vetted by Recruiting prior to conducting any interviews. | |

| SSI/SSDI OUTREACH, ACCESS, AND RECOVERY (SOAR) | Program Director – Thea Baglino<br>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.<br><br>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 generating 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:**<br>- Serious mental or physical illness that affect ability to work<br>- Illness(es)/condition(s) have lasted or are expected to last at least 12 months or result in death<br>- Currently exhibiting symptoms of mental illness or has periods of worsening symptoms preventing sustainable employment<br>- Marked restrictions in at least TWO of these functional areas:<br>» Understanding, remembering, or applying information<br>» Interacting with others<br>» Concentrating, persisting, or maintaining pace on activities/tasks<br>» Adapting or managing themselves<br>- Eligible for CCBHC care coordination<br><br>**Exclusionary Criteria:**<br>- Under 18 years of age<br>- Submitted an application for SSI/SSDI and awaiting decision<br>- Working with a disability attorney or other representative on SSI/SSDI case<br>- Active employment | |
| **Point of Contact:**<br>Tyler Zimmermann – SOAR Specialist<br>Valarie Duhart-Holly – SOAR Specialist | |
| **Internal Referrals:**<br>- Send to Rhonda Lynch | |
| **Important Notes:**<br>- For information on targeted case management services, please refer to Case Management program (Page 7)<br>- For information on CCBHC care coordination, please refer to CCBHC Grant program (Page 8) | |

| 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 | Ext. 8880; 352.275.4780 |

| SUBSTANCE ABUSE PICC PROGRAM (SAPP) | Addictions Medical Director – David Kirby<br>Program Director – *Elizabeth Madison Ext. 8259* |
|---|---|
| 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. | |

| SUBSTANCE ABUSE PICC PROGRAM (SAPP) | Addictions Medical Director – David Kirby<br>Program Director – *Elizabeth Madison Ext. 8259* |
|---|---|
| **Minimum Eligibility Criteria:**<br>- Taking controlled substances at a frequency of every 8 hours or less<br>- Independent in performing all activities of daily living<br>- Must have signed consent from client<br><br>**Exclusionary Criteria:**<br>- Cannot be taking any Benzos, unless prior approval obtained from the Medical Director | |
| **Point of Contact:** Sabrina Brown | Ext. 8869; Cell: 352.672.0695 |
| **Internal & External Referrals:**<br>- Send all to Sabrina Brown, Program Manager Elizabeth Madison, Admission Coordinator Marcus Watson<br>- Shands HomeCare Specialist 352.265.0111 x50476; Cell: 407.421.9901 | |
| **Important Notes:**<br>- SAPP is a locked unit; clients are to only leave the unit in the company of the nurse, clinician or recovery specialist<br>- 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<br>- Clients are encouraged to attend at minimum 2 groups per day | |

| SUPPORTED EMPLOYMENT | Program Manager – Brian Wilson |
|---|---|
| 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:**<br>- Must be 18 or older<br>- Active in primary treatment program<br>- Live in Gainesville<br><br>**Exclusionary Criteria:**<br>- Under 18 years of age<br>- Not actively engaged in treatment with another program at Meridian<br>- Live outside of Gainesville | |
| **Point of Contact:** Brian Wilson | Ext. 8311 |
| **Internal Referrals:**<br>- Send to Brian Wilson<br><br>**External Referrals:**<br>- Referrals are not accepted from external sources | |
| **Important Notes:**<br>- Please discuss the requirements of program with the client (ensuring they meet them) before submitting internal referral<br>- Client's primary program will maintain responsibility for completing treatment plan updates | |

| SUPPORTIVE SERVICES FOR VETERAN FAMILIES (SSVF) | Program Manager – Tanaka Gates |
|---|---|
| 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.<br><br>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.<br><br>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 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:**<br>- Eligible Veteran<br>- Homeless or at risk of homelessness<br>- Meets HUD income guidelines for their area<br>- Meets "But for Rule," and must have NO other:<br>» Subsequent housing options<br>» Financial resources to obtain or remain in immediate housing<br>» Support network or resources needed to obtain or remain in immediate housing<br><br>**Exclusionary Criteria:** | |

| SUPPORTIVE SERVICES FOR VETERAN FAMILIES (SSVF) | Program Manager – Tanaka Gates |
|---|---|
| - Currently in stable/permanent housing | |
| **Point of Contact:** Tanaka Gates | Office: 352.244.9827 |
| **Internal & External Referrals:**<br>Send to: SSVF@MBHCI.org<br>- Contact Tanaka Gates | |
| **Important Notes:**<br>- SSVF offices are located at 1405 NW 13th Street, Suite B; Gainesville 32601 | |

| TREATMENT FOR INDIVIDUALS EXPERIENCING HOMELESSNESS (TIEH) | Program Director – Terri Crawford, VP Outpatient Services South |
|---|---|
| Population(s) Served: Individuals with Serious Mental Illness, Serious Emotional Disturbance, or Co-Occurring Disorders experiencing homelessness | |
| This program supports the implementation of a mobile unit to provide outreach, screening, assessment, and treatment services on-site in target neighborhoods where encampment sites are located. Outreach and engagement services occur through the collaboration of Meridian, Grace Marketplace, Gainesville Opportunity Center, and other community partners. This collaborative service system operates as a strategic co-responder team to identify and actively engage individuals experiencing homelessness and assist them with accessing services. Services offered include mental health, substance use, and co-occurring disorder screening, assessment, and treatment; healthcare; recovery services, including recovery housing; permanent housing assistance; mainstream benefits; employment assistance; case management/care coordination; and other related services. The program also focuses on strengthening social and family support systems, poverty and socioeconomic needs, and community connectedness. Peer-related support and services are an integral part of the project. Telehealth/telemedicine services will be available to promote accessibility and reduce stigma. | |
| **Points of Contact:**<br>Terri Crawford, VP of Outpatient Services South | Ext. 8159 |
| **Internal & External Referrals/Requests:**<br>Terri Crawford @ ext. 8159 | |
| **Important Notes:**<br>- Goal is to serve 250 clients annually, 1,250 over the five-year project period 09.30.2023 – 09.29.2028, the focus is on areas in African American neighborhoods where many encampment sites are located and disparities are evident | |

| 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.<br><br>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:**<br>AzzuDee Johnson – Lead Financial Counselor<br>Carolann Cutright – Utilization Manager | <br>Ext. 8955<br>Ext. 8034 |
| **Internal & External Referrals/Requests:**<br>- AzzuDee Johnson | |
| **Important Notes:**<br>- For questions related to client responsibility, Consent to Treat documentation, or eligibility/benefits, please refer to Financial Counselors program (Page 10) | |

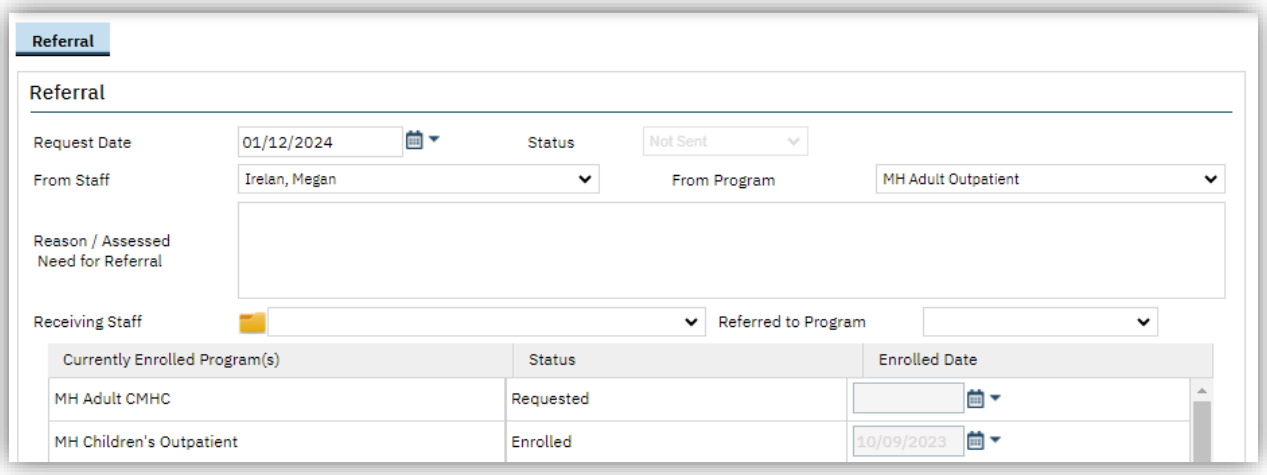
# APPENDIX A – HOW TO COMPLETE & REVIEW INTERNAL REFERRALS IN SMARTCARE

## STEPS WHEN SENDING A REFERRAL

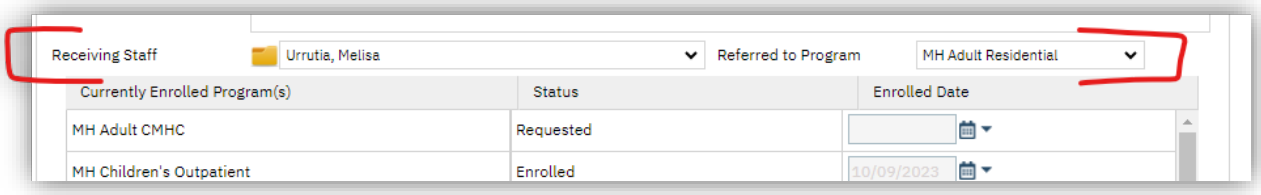
- Have an Active Client in SmartCare, and use the Search Magnifying Glass to type Internal Referral Document:


- 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.

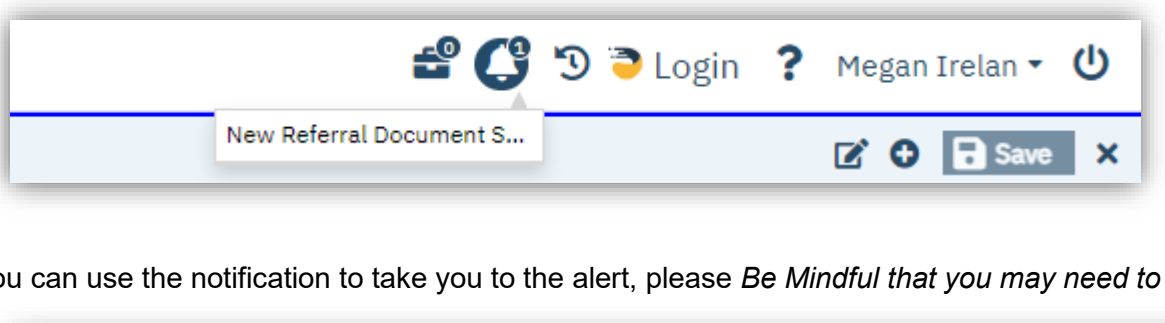



- You will begin by adding the Request Date, what Program the client is being referred from, the staff referring (if not you), and Reason/Need for Assessment or Referral.
- Receiving Staff and Referred to Program will need to be filled in as well, as this is how the Document travels. The original author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

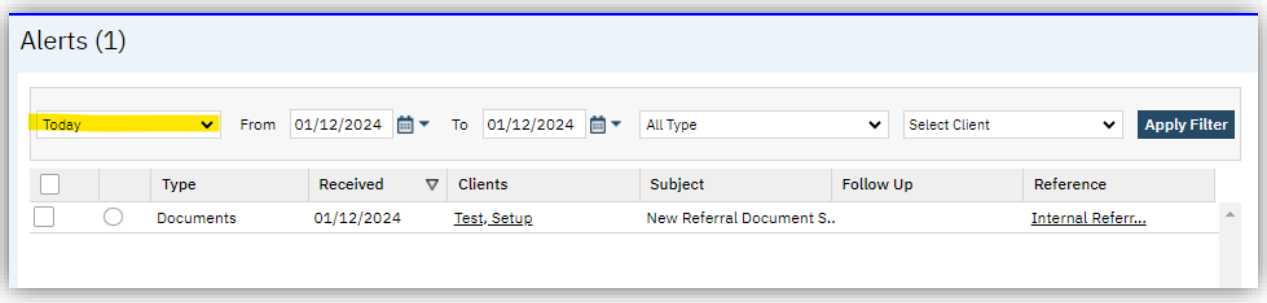



## RECEIVING AN INTERNAL REFERRAL

- 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.