Chapter 503

Licensed Behavioral Health Center (LBHC) Services

Appendix 503H

Community-Based Mobile Crisis Intervention Services

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BACKGROUND

Community-Based Mobile Crisis Intervention Services are designed to address the acute needs of Medicaid members experiencing a suspected mental health and/or substance use disorder (SUD) - related crisis. Community-based mobile crisis services can be accessed using the 1-844-435-7498 (HELP4WV) referral line or the toll-free crisis hotline (988). The toll-free crisis hotline connects members to mobile crisis response teams that are available throughout the state and staffed 24 hours per day, seven days a week. The mobile crisis response team provides timely intensive support, stabilization of the crisis event, and time-limited rehabilitation intervention services intended to achieve crisis symptom reduction. In addition, the team will help restore members to their baseline function and maintain them in their homes when possible. Community-Based Mobile Crisis Intervention Services will be:

- Provided at the member's home, work, school, and/or other natural setting.
- Tailored to meet the member's individualized needs and family/caregiver needs.
- Trauma-informed and culturally and linguistically responsive.

Community-Based Mobile Crisis Intervention Services cannot be delivered to a member admitted to an inpatient facility.

Appendix 503H complies with terms and conditions found in *Chapter 503, Licensed Behavioral Health Centers,* and all other general chapters of the West Virginia Medicaid Manual.

503H.1 MEDICAL NECESSITY CRITERIA

A West Virginia Medicaid member who is experiencing a suspected mental health and/or SUD-related crisis is eligible for Community-Based Mobile Crisis Intervention Services reimbursed by Medicaid. Community-Based Mobile Crisis Intervention Services cannot be delivered to a member who is currently admitted to an inpatient facility.

503H.2 ADMISSION CRITERIA

The following criteria must be met:

- The member is experiencing an acute psychological change marked by an increase in distress in which the distress exceeds the abilities and resources of those involved, including, but not limited to, the member in distress, their family or caregivers, or other community members.
- The member is demonstrating at least one of the following signs of distress:
    - Suicidal, assaultive, destructive ideas, self-harm, threats, plans, or actions that represent a risk to self or others.
    - Impairment in mood/thought/behavior disruptive to home, school, or the community.
    - Behavior escalating to the extent that a higher intensity of services will likely be required.
    - The community-based mobile response is necessary to further evaluate, resolve, and/or stabilize the member's condition.

503H.3 DISCHARGE CRITERIA

One of the following criteria must be met:

1. The member demonstrates a reduction of distress that no longer meets the admission criteria (returns to pre-crisis state or baseline functioning).
2. The member has been admitted to an inpatient facility, hospital, or emergency room for treatment.
3. The member, if able to consent for services and decides to no longer receive the service; or if the member is unable to consent and their parent, caregiver, or legal representative withdraws consent to receive the service.

503H.4 COMMUNITY-BASED MOBILE CRISIS INTERVENTION SERVICES

Community-Based Mobile Crisis Intervention Services may include one or more of the following service components:

- Screening and Assessment
- Crisis Planning and Brief Counseling
- Crisis Resolution and Debriefing
- Crisis Coordination

503H.5 SCREENING AND ASSESSMENT

Providers shall conduct initial and ongoing screening and assessments to determine the need for further evaluation and to make treatment recommendations and/or referrals to other health and/or behavioral health services as clinically indicated. Mobile crisis teams will determine what type of screening and assessments would be clinically indicated for each member, such as mental health status and nationally recognized evidenced-based screening and assessments.

Assessments include, but may not be limited to:

- Risk of harm to self
- Risk of harm to others
- Current and recent history of mental status and substance use
- Intoxication and potential for serious withdrawal
- History of psychiatric and medical treatment
- History of psychiatric and medical stability
- Prescribed medications
- Medication-assisted treatments for substance use
- Presenting problem(s)
- Review of immediate needs
- Identification of support(s)

503H.6 CRISIS PLANNING AND BRIEF COUNSELING

Crisis planning assists the member and their family or other natural support when the assistance directly benefits the member in one of the following areas:

- Effectively identifying a potential psychiatric or personal crisis
- Identifying potential triggers
- Developing a crisis management, safety plan, or wellness plan to assist members to help prevent relapse
- Identify early warning signs of decompensation, and cope or seek support to restore stability and functioning

Crisis planning includes developing a crisis safety plan to address future distress by identifying triggers, natural supports, coping strategies, contact information and emergency contacts.

Short-term interventions include:

- Counseling/conversing during the initial contact when the mobile crisis response team arrives,
- De-escalating activities to help reduce the impact of the immediate stressor(s),
- Addressing immediate safety/risk concerns,
- Obtaining consents to treat, and
- Obtaining consents to communicate with other providers for referrals and member history according to state and federal guidelines.

An appropriate release of information form that meets all Health Insurance Portability and Accountability Act (HIPAA) and 42 Code of Federal Regulations (CFR) Part C of the federal code requirements must be obtained and approved prior to sharing information in any situation other than those described here. Access to medical records is limited to the member, the parent or legal guardian (when the member is a minor), authorized facility personnel, and others outside the facility whose request for information access is permitted by law and is covered by assurances of confidentiality and whose access is necessary for administration of the facility and/or services and reimbursement.

A member may review their medical record in the presence of professional personnel of the facility and on the facility premises. Such a review is carried out in a manner that protects the confidentiality of other family members and other individuals whose contacts may be contained in the record. Access to medical records is limited and should be available on a medical need-to-know basis and as permitted under federal and state law and any relevant court rulings.

503H.7 CRISIS RESOLUTION AND DEBRIEFING

Brief counseling can be delivered to the member to alleviate:

- Psychiatric or substance use,
- Maintain stabilization following a crisis episode, and
- Help prevent symptom escalation.

Brief counseling may include but is not limited to supportive counseling services to promote application and generalization of age-appropriate skills. Age-appropriate skills may include problem solving, interpersonal relationships, anger management, relaxation, and emotional control. When considering the use of brief counseling the impacts of the member's behavioral health condition must be considered as they relate to the member's daily functioning and how it will promote continued progress toward the member's identified goals and the impact on the member's day-to-day behavioral and emotional functioning, remediates psychiatric or substance use symptoms, and deescalates crises. Brief counseling may also provide conflict resolution, monitoring of high-risk behaviors, clinical consultation, and consultation with psychiatric prescribers. All counseling must be provided according to the member's needs and the counselor's expertise in accordance with the scope of service certification or licensure.

Peer support includes crisis resolution, person-centered goal planning, modeling effective coping skills, crisis support, facilitating community connections and engagement, and parental and community living skills development. Peer support may be provided by direct care staff who have the direct benefit of the member being served and may include one or more of the following, a peer parent support mentor, a youth peer mentor or an Adult Peer Mentor who has shared experiences as the member, family/caregiver, or both, and provide knowledge about community services, programs, and strategies they have used, offer self-advocacy skills and emotional support from their lived experience. Peer support staff assist members in overcoming barriers, helping them bridge gaps between members' needs and available community resources to sustain their recovery process. A PRSS is a self-identified individual who is successful in the recovery process and has lived experience with SUD or co-occurring mental health and SUD.

Peer parent support services are designed to offer support to the parent/legal representative who has a child with a Serious Emotional Disorder (SED). The services are geared toward promoting parent/legal representative empowerment, enhancing community living skills, and developing natural supports. This service connects the parent/legal representative with parent(s) who are raising or have raised a child with SED and are personally familiar with the associated challenges. Peer parent support providers are mentors who have shared experiences as a member, family, or both member and family; they also provide support and guidance to the member and their family. Peer parent support providers explain community services, programs, and strategies they have used to achieve the waiver member's goals.

503H.8 CRISIS COORDINATION

Crisis coordination includes follow-up and documentation of follow-up with the member and/or family, referrals for necessary services, facilitation of engagement in outpatient services, confirmation, and coordination and consultation with qualified service providers to help ensure the member receives or is scheduled to receive necessary services.

The following activities are recognized within the crisis care coordination component:

Needs Assessment and Reassessment

The needs assessment and reassessment include reviewing the member's current and potential strengths, resources, deficits, and need for medical, social, educational, and other services. Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary) will help develop a complete assessment and inform the eligible member, their parent(s) and/or guardian(s), and the case manager to determine whether services are needed and, if so, to develop a person-centered service plan.

Coordinating Revisions of the Member's Service Plan or Plan of Care

If the mobile response team has identified through the crisis event and follow up the need to update the safety plans, or a need to refer to additional community services and supports, then those updates need to be made by the individual monitoring the member's service plan or plan of care.

Referral and Related Activities

Referral and related activities include facilitating the member's access to the care, services, and resources through linkage, such as coordination, referral, consultation, and monitoring. This is accomplished through in-person and telephone contacts with the member, family/caregiver or legal guardian, case manager, and providers. Referral and facilitation may include physical accessibility to services such as arranging transportation to medical, social, educational, and other services; facilitating communication between the member, family/caregivers, case manager, and providers; or arranging for translation or another mode of communication. It also includes advocating for the member in matters regarding access, appropriateness, and proper utilization of services; and evaluating, coordinating, and arranging immediate services or treatment needed in situations that appear to be emergent in nature or require immediate attention or resolution to avoid, eliminate, or reduce a crisis for a specific member. This may also include acquainting the member or family/caregiver or legal guardian with resources in the community and providing information for obtaining services through community programs. When reporting abuse and neglect, a member of the mobile crisis provider team should complete the Centralized Intake for Abuse and Neglect Form.

Follow-Up Activities

The crisis response team shall conduct follow-up activities with the member, the member's family/caregiver, or legal guardian, or with other related service providers. If the member cannot be stabilized by the responding mobile crisis team in the community, services may also include facilitation of a safe transition to a higher level of care. The transition may include warm handoffs and coordinating transportation only if situations warrant transition to other locations and/or higher levels of care.

503H.9 PROVIDER QUALIFICATIONS

Organizational provider types eligible to provide Mobile Crisis Intervention Services include:

- Licensed Behavioral Health Centers
- Comprehensive Mental Health Centers
- Federally Qualified Health Centers

To participate in the West Virginia Medicaid Program and receive reimbursement from the Bureau for Medical Services (BMS), providers must meet all enrollment criteria as described in *Chapter 300, Provider Participation Requirements*.

Providers should review the West Virginia BMS Policy Manual.

All provider organizations must be licensed and/or certified, as required by BMS and the Office of Health Facility Licensure and Certification (OHFLAC).

503H.10 STAFF QUALIFICATIONS

Community-Based Mobile Crisis Intervention Services are provided by multidisciplinary Mobile Crisis Response Teams. These teams comprise at least two individuals: At a minimum, one Clinical staff with experience in crisis response and one direct care staff. For safety, a minimum of two staff must be present for the face-to-face intervention. Clinical care staff must be fully engaged in the intervention by meeting face-to-face with the member or via telehealth as appropriate. For the safety of the mobile response team, teams must consist of a minimum of two individuals for face-to-face responses. While two staff are required to respond, one staff can respond on an emergency basis only.

Community-Based Mobile Crisis Intervention Services shall be delivered directly by, or under the supervision of a clinical supervisor who must be licensed under at least one of the following licensure categories:

Clinical Supervisory Staff:

- Physician; OR
- Non-physician practitioner (NPP) e.g., Registered Nurse (RN), Advance Practice Registered Nurse (APRN), Physician Assistant (PA) or equivalent; OR
- A Licensed Psychologist (LP) or Supervised Psychologist (SP); OR
- A Licensed Graduate Social Worker (LGSW) or Licensed Certified Social Worker (LCSW) or Licensed Independent Clinical Social Worker (LICSW), or Licensed Professional Counselor (LPC) or Advanced Alcohol Drug Counselor (AADC) who has the authority to provide, or supervise the provision of, these services.

Any Community-Based Mobile Crisis Intervention Service described herein may be provided to a member by any qualified provider type described below, subject to any limitations on scope of practice and requirements for access to supervisory clinicians.

All Community-Based Mobile Crisis staff must complete a criminal background check and child abuse registry. Please see *Chapter 700, West Virginia Clearance for Access: Registry & Employment Screening (WV CARES)* for fingerprint-based background check requirements.

503H.11 SUPERVISORY STAFF

Community-Based Mobile Crisis Intervention Services shall be delivered directly by, or under the supervision of, a clinical supervisor who must be licensed under at least one of the following licensure categories:

- Physician
- APRN
- PA
- RN
- LP or SP; or LPC or LICSW
- An LGSW, LCSW, or AADC who has the authority to provide, or supervise the provision of, these services.

503H.12 CLINICAL STAFF (MASTER'S-LEVEL CLINICAL RESOURCE)

Mobile Crisis Response Teams shall, as needed, have access to a master's-level or higher-level staff with a master's degree in counseling, social work, or psychology and two years of experience in behavioral health services. Clinical staff including clinical supervisors may provide assessment(s) within their authorized scope of practice under state law and training to help determine the needs of the individual. The clinical supervisor may serve as the clinical staff component of the Mobile Crisis Response Team. Community-Based Mobile Crisis Intervention Services shall be delivered directly by, or under the supervision of a clinical supervisor.

503H.13 DIRECT-CARE STAFF

Direct-care staff include crisis specialists and peer mentors. These providers are direct care staff members of the mobile crisis response team who provide direct crisis response services. Crisis specialists must hold, at minimum, a bachelor's degree in human services (i.e., social work, psychology, sociology, or other approved human services field) with one year of documented experience working with individuals with mental health and/or substance use disorders. A clinical supervisor and/or a master's-level clinical resource also may directly provide Community-Based Mobile Crisis Intervention Services.

Crisis Specialist

Crisis specialists are members of the mobile crisis response team who provide direct crisis response services. Crisis specialists must hold, at minimum, a bachelor's degree in a human services area (social work, psychology, sociology, or other human services field) with one year of documented experience working with this population. A clinical supervisor and/or a master's-level clinical resource may directly provide Community-Based Mobile Crisis Intervention Services. Crisis specialists may provide Community-Based Mobile Crisis Intervention Services under the supervision of a clinical supervisor.

Peer Parent Support

A peer parent support staff must have lived experience as an individual or family member of a child with a SED or lived experience parenting children or youths with social, emotional, behavioral, or substance use challenges and must possess a high school diploma or passed a general education development test (GED). The individual will complete specialized training to support parents and caregivers from the provider agency. All peer parent support staff must be able to provide attestations to support their credentialing. The peer parent support staff shall not perform services outside of the boundaries and scope of their expertise, shall be aware of the limits of their training and capabilities, and shall collaborate with other professionals and recovery support specialists to best meet the needs of the member served. Peer parent support mentors may provide Community-Based Mobile Crisis Intervention Services under the supervision of a clinical supervisor.

Additional information may be found in *Chapter 502, Children with Serious Emotional Disorders Section 502.25.3.*

Adult Peer Mentor

An adult peer mentor is an individual who shares the direct experience of addiction and recovery and is certified as a Peer Recovery Support Specialist (PRSS). Recovery support services are nonclinical services that assist individuals to recover from alcohol or drug issues. Adult Peer Mentors use their own lived experience of recovery from addiction, in addition to skills learned in formal training, to deliver services in SUD settings to promote mind-body recovery and resiliency. All adult peer mentors must be able to provide attestations to support their credentialing. Adult peer mentors may provide Community-Based Mobile Crisis Intervention Services under the supervision of a clinical supervisor. Adult peer mentors who hold a PRSS certification must have a National Provider Identifier (NPI), a valid and active West Virginia Certification Board for Addiction and Prevention Professionals (WVCBAPP) Peer Recovery Certification and must maintain all requirements for continuation of that certification. Additional information and the application for the peer recovery certification can be found on the WVCBAPP website.

Additional information may be found in *Chapter 504 Substance Use Disorder Services, Section 504.15.1*.

Youth Peer Mentor

The youth peer mentor must have either lived experience of recovery from mental health disorders or an associate degree in a behavioral health or related human services field. They will complete formal training or education in peer recovery support. The youth peer mentor must be 18 years of age or older. Youth peer mentors may provide Community-Based Mobile Crisis Intervention Services under the supervision of a clinical supervisor.

503H.14 DOCUMENTATION

All Community-Based Mobile Crisis Intervention providers must have internal written policies and procedures for each crisis service they provide, including, but not limited to:

- Criteria for face-to-face response and follow-up services
- Assessment criteria and clinical intervention
- Coordination of services with existing providers and identified supports
- Coordination with law enforcement, Child Protective Services, Adult Protective Services, local schools, etc.
- Provision of services to members who are non-English speaking, deaf, or hard of hearing
- Member's rights
- Coordination of referrals to other service providers (e.g., care coordinator, other treatment providers and/or programs for mental health, substance use, and/or medical needs, etc.)
- Staff conduct and safety measures
- Documentation of crisis services
- Documentation of payor sources

Mobile crisis response services must be documented in the member's chart within 24 hours of the completion of the response to the crisis to identify discrete billable crisis response services related to a qualifying event. Documentation for mobile crisis response services should include a summary of the crisis response, as follows, and as information is made available to the provider during the encounter:

- Rationale for mobile crisis response
- Source of referral and cause for concern
- Engagement of the family/caregiver, including consent to treat and consent to communicate with other providers on the behalf of members unable to consent for themselves
- Presenting problem and/or precipitating factors
- Alert history and psychosocial history, if available
- Collaterals on-scene participating in the crisis resolution
- Mental status examination of the member
- History of psychiatric and/or substance use treatment
- History of medical, emotional, and/or social needs
- Review of prescribed medications and compliance
- Identification of current treatment providers with contact information
- Identification of supports/resources, member and family strengths, and coping skills
- Suicide and safety assessment and safety planning
- Consents to release information
- Date and duration of service
- Copy of safety plan
- Documentation on SUD event with use of naloxone

Mobile Crisis providers will also be responsible for helping to ensure clinically appropriate follow-up occurs, including follow-up with the member and/or family/caregiver/guardian up to four weeks post-contact/response. Follow-up contact between the Mobile Crisis staff and the member, service providers, and identified supports will be initiated within 24 hours of the initial crisis or by the next business day. Providers must document their attempts to contact, including date, time, who they attempted to contact or contacted, and how they made contact (e.g., telephone, face-to-face, direct mail, email). If three attempts to contact the member are made and are unsuccessful by either face-to-face or telephone contact, the

provider must send, via direct mail, an attempt to contact the member prior to discontinuing their efforts for follow-up. Direct contact with providers, in addition to email, voicemail, or fax, helps ensure receipt of information and must be done in accordance with privacy and confidentiality rules. Documentation of follow-up services should include:

- Content of follow-up between the Mobile Crisis staff and existing and/or anticipated service providers and identified supports; this information should be documented within 24 hours of the initial behavioral health crisis or by the next business day in a progress note and signed by assigned staff.
- Progress notes related to the service summary for every member and collateral contact (signed by the staff member who provided the service)
- Documentation of (re)linkage to identified services or supports.
- Identification of barriers to linkage, if applicable
- Additional information necessary to complete and/or update the case record and/or service summary; this information may be obtained from program staff, the referral source, and/or outside medical and psychiatric staff, including the member's most recent mental health and/or substance use service provider, upon consent.

A member's case record is confidential, and access to it is dictated by regulatory requirements.

Confidentiality

An appropriate release of information form must be obtained and approved prior to sharing information in any situation other than those described here. Access to medical records is limited to the member, parent/legal representative, authorized facility personnel, and others outside the facility whose request for information access is permitted by law and covered by assurances of confidentiality and whose access is necessary for administration of the facility and/or services and reimbursement.

A member may review their medical record with professional personnel of the facility and on the facility premises. Such a review is carried out in a manner that protects the confidentiality of other family members and other individuals whose contacts may be contained in the record. Access to medical records is limited and should be available on a medical need-to-know basis and as permitted under federal and state law and any relevant court rulings. Pictures of Medicaid members may be used for identification purposes only (contained in the member medical record and medication administration record). Usage for any other purposes, including public displays, social media posts, or for promotional materials, are prohibited. All Medicaid member information must be locked in a secure place.

HIPAA Regulations

Providers must comply with all requirements of HIPAA and all corresponding federal regulations and rules. The enrolled provider will provide, upon the request of BMS, timely evidence and documentation that they are in compliance with HIPAA. The form of the evidence and documentation to be produced is at the sole discretion of BMS. Additional information on HIPAA may be found in *Chapter 300, Provider Participation Requirements*.

503H.15 BILLING PROCEDURES

Community-Based Mobile Crisis Intervention Services begin with the initial call and initiation of a mobile crisis response team. The initial three hours of the response must be within the same calendar day using Procedure Code S9485 with documented medical necessity criteria. Additional time spent beyond the initial three hours per diem may be reimbursed in one-hour increments within the same calendar day with documented medical necessity.

If a member meets the discharge criteria within the same calendar day, then meets the admission criteria later in the same calendar day, the mobile response team can submit for reimbursement of one per-diem payment during the same calendar day. Furthermore, any additional hours in that same period can be reimbursed using Procedure Code S9484, with documented medical necessity. The per-diem procedure code can only be reimbursed one unit per calendar day Mobile Crisis follow-up may be reimbursed up to four weeks after the initial Mobile Crisis per diem with documented medical necessity.

Procedure Code	Description	Service Unit	Service Limits	Prior Authorization
S9485	Mobile Crisis Per Diem (Up to three hours for initial crisis intervention)	**Per diem**	**One per calendar day**	**No**
S9484	Mobile Crisis Add-On (Every hour beyond the first three hours of intervention)	**One hour**	**Up to 21 hours per calendar day**	**No**
T1016	Mobile Crisis Follow-Up (Follow-up services provided by mobile crisis teams should not continue beyond four weeks post contact/ response; by this time, teams should have provided links and warm handoffs to further care and services, as necessary)	**15 minutes**	**Up to eight units per day**	**No**

REFERENCES

West Virginia State Plan references reimbursement for Community-Based Mobile Crisis Intervention Services in West Virginia Chapter 503H; additional information on accessing crisis services can be found on the HELP4WV website.

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms*, apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

Adult Peer Mentor: Members of the mobile crisis response team who provide direct crisis response services. An adult peer mentor is an individual who shares the direct experience of addiction and recovery and is certified as a peer recovery support specialist (PRSS). Adult peer mentors use their own lived experience of recovery from addiction, in addition to skills learned in formal training, to deliver services in SUD settings to promote mind-body recovery and resiliency. All adult peer mentors must be able to provide attestations to support their credentialing.

Clinical Staff (specific to Community-based Mobile Intervention): Members of the mobile response team that serve as the clinical supervisor and/or clinical staff. Clinical staff hold a master's degree in counseling, Social Work, or Psychology and who shall have two years of experience in behavioral health services.

Community-Based Mobile Crisis Intervention Services: Community-Based Mobile Crisis Intervention Services will assist with the specific crisis and provide referrals to and/or linkages with other mental health and/or substance use services or organizations. The provider organization providing services will be responsible for helping to ensure clinically appropriate follow-up occurs including documentation of follow-up with the member and/or family/caregiver/guardian within 24 hours of initial contact/response and up to four weeks post-contact/response.

Crisis Specialists: Members of the mobile crisis response team who provide direct crisis response services. Crisis specialists must hold, at minimum, a bachelor's degree in a human services area (social work, psychology, sociology, or other human services field) with one year of documented experience working with this population. A clinical supervisor and/or a master's-level clinical resource may directly provide direct crisis response services.

Direct Care Staff (specific to Community-based Mobile Intervention): Members of the Mobile Crisis Response Team who provide direct-crisis response services. Direct-care staff may include crisis specialists, parent peer support mentors, youth peer mentors and adult peer mentors.

Mobile Crisis Response Team: A group of trained staff comprised of at least three individuals including, at a minimum, one supervisory staff with experience in crisis response, and two direct care staff. mobile crisis response teams shall have access to at least one clinical staff resource.

Peer Parent Support Mentor: Members of the mobile crisis response team who provide direct-crisis response services. A peer parent support mentor must have lived experience as an individual or family member of a child with serious emotional disturbance (SED) or lived experience parenting children or youths with social, emotional, behavioral, or substance use challenges, and must possess a high school

diploma or general education development test (GED). The individual will complete specialized training to support parents and caregivers.

Supervisory Staff: Member of the Mobile Crisis Response Team that are clinical supervisors who must be licensed under at least one of the following licensure categories:

- Physician;
- Non-physician practitioner (NPP) e.g., Registered Nurse (RN),
- Advance Practice Registered Nurse (APRN),
- Physician Assistant (PA) or equivalent;
- A Licensed Psychologist or Supervised Psychologist;
- A Licensed Graduate Social Worker (LGSW) or Licensed Certified Social Worker (LCSW)
- Licensed Independent Clinical Social Worker (LICSW),
- Licensed Professional Counselor (LPC)
- Advanced Alcohol Drug Counselor (AADC) who has the authority to provide, or supervise the provision of, these services.

Youth Peer Mentor: Members of the mobile crisis response team who provide direct crisis response services. The youth peer mentor must have either lived experience of recovery from mental health disorders or an associate degree in a behavioral health or related human services field. They will complete formal training or education in peer recovery support and must be 18 years of age or older.

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
New Chapter	Chapter 503 Licensed Behavioral Health Centers Appendix H Community-Based Mobile Crisis Intervention Services	February 1, 2024