CommunityConnect

My Recovery. My Story.

PROGRAM GUIDANCE

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NORTH Dakota Be Legendary. | Behavioral Health HEALTH & HUMAN SERVICES

North Dakota Department of Health and Human Services
Behavioral Health Division

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Purpose of This Program Guidance

This document serves as both a process guide and a training manual for Community Connect providers, including Care Coordinators and Peer Support Specialists. It is intended to reinforce best practices and provide a consistent reference for effective program delivery.

Program Background/Highlights

In 2017, the Department of Health and Human Services and the Department of Corrections and Rehabilitation collaborated to establish a community-based behavioral health program, Free Through Recovery. The program was designed to increase access to recovery support services for individuals engaged with the criminal justice system and who have behavioral health concerns. Stakeholders in the North Dakota Behavioral Health System Study 2018 reported that North Dakota's current behavioral health system is "primarily crisis oriented and pays inadequate attention to rehabilitative and community-based services." The study identified a recommendation to ensure access to needed recovery support services, including providing funds to support the implementation of a Free Through Recovery - like program separate from the criminal justice system. During the 2019 North Dakota legislative session, Senate Bill 2012 passed which created a new section in ND Century Code (50-06-41.2) and provided funding to implement such a program (see ND Century Code excerpt below).

Systems assisting individuals are often disjointed, there are no clear steps or responsibility, the individual's current services do not meet their needs, and there is a separation in services for individuals. Without supportive community-based services, this disjointed environment can lead to criminal justice involvement, utilization of emergency services, foster placements, unemployment, and homelessness.

Community Connect was developed to connect and assist individuals in navigating appropriate services to address their needs and goals, preventing individuals from becoming further involved in other systems such as child welfare and criminal justice systems. Providing cross sector partnership across government agencies and community-based providers to assist with responding more proactively to meet the needs of individuals in communities before they reach a higher level of risk or need.

Community Connect launched on February 1, 2021. The program provides community-based behavioral health services designed to assist participants with meeting their needs and goals through the provision of care coordination, recovery services and peer support services. Services are delivered statewide through a diverse network of providers, including traditional, culturally specific, faith-based, and specialized organizations.

The Department of Health and Human Services' Behavioral Health Division (BHD) enters into agreements with community providers who deliver comprehensive care coordination and peer support.

According to state law, Community Connect operates under a pay-for-performance model, with payment determined by participant progress in four outcome areas: housing, recovery, employment, and law enforcement contact. Outcomes are reported each period by the provider, and the BHD reconciles these reports, verifies service delivery, and issues payments accordingly.

North Dakota Century Code 50-06-41.2. Community behavioral health program.

1. The Department of Human Services shall establish and implement a community behavioral health program to provide comprehensive community-based services for individuals who have serious behavioral health conditions.
2. In developing the program, the department shall:
    a. Establish a referral and evaluation process for access to the program.
    b. Establish eligibility criteria that includes consideration of behavioral health condition severity.
    c. Establish discharge criteria and processes.
    d. Develop program oversight and evaluation processes that include outcome and provider reporting metrics.
    e. Establish a system through which the department:
        i. Contracts with and pays behavioral health service providers.
        ii. Supervises, supports, and monitors referral caseloads and the provision of services by contract behavioral health service providers.
        iii. Requires contract behavioral health service providers to accept eligible referrals and to provide individualized care delivered through integrated multidisciplinary care teams.
        iv. Provides payments to contract behavioral health service providers on a per-month per-referral basis based on a pay-for-performance model that includes consideration of identified outcomes and the level of services required.

Administrative Roles in Community Connect

The Department of Health and Human Services' Behavioral Health Division (BHD) is responsible for:

- Onboarding approved provider agencies
- Ensuring adherence to behavioral health best practices
- Issuing provider payments and monitoring contract compliance
- Reviewing service delivery and participant outcomes
- Providing training, technical assistance, and fidelity monitoring
- Managing participant admissions, discharges, and transfers
- Monitoring provider service delivery

Administrative roles in Community Connect are carried out by the BHD Lead Administrator and BHD Administrators.

The BHD Lead Administrator responsibilities include, but is not limited to, overseeing applications and eligibility determination, statewide program operations, ensuring adherence to behavioral health best practices, and monitoring provider performance. BHD Administrators responsibilities include, but is not limited to, managing provider oversight, addressing contract and service concerns, reviewing all documentation, and providing training and technical assistance when needed.

All administrative roles work in coordination to ensure program quality, effective service delivery, and successful participant outcomes.

Program Mission and Principles

Mission

The mission of Community Connect is to provide quality, community-based behavioral health services that promote collaboration and partnership to meet the individual needs of every individual served.

Goals

The goals of Community Connect are to connect and assist individuals in navigating appropriate services to address their needs and goals and provide cross sector partnership to assist with responding more proactively to meet the needs of individuals in communities to prevent further system involvement by:

1. Improving engagement in quality services:
    a) Participants engage with a Care Coordinator who identifies their needs and helps the participant find creative, effective, and pro-social ways to meet them.
    b) Participants engage with a Peer Support Specialist with lived experience with a serious behavioral health condition

2. Providing access to individualized services that are responsive to each person's specific needs.
    a) Care Coordinators establish relationships with behavioral healthcare providers, government agencies, housing resources and recovery support services.
    b) Care Coordinators and Peer Supports help with access to recovery services which include access to nourishment assistance programs, supportive housing, educational opportunities, meaningful employment, leisure activities and wellness, family and community social supports, parenting education, spiritual engagement, and any other individualized resources the person needs to help them lead a healthy and fulfilling life.
    c) Communities identify and report service gaps or barriers to meeting the needs of Community Connect participants that are specific to their location.

Principles

ND Department of Health and Human Services' Behavioral Health Division Principles

The North Dakota Department of Health and Human Services (HHS) is a state government agency with the mission to foster positive, comprehensive outcomes by promoting economic, behavioral, and physical health, ensuring a holistic approach to individual and community well-being.

The North Dakota HHS Behavioral Health Division (BHD) is committed to the principles outlined below. These principles are not all-inclusive-other values and best practices may also guide the continued development and implementation of this program.

Person-Centered

Person-centered care focuses on developing and implementing individualized plans based on each participant's preferences, strengths, and choices. A meaningful life is realized when family, friends, providers, and community members actively listen and honor what matters most to the individual. Participants should have control over their services—including amount, duration, scope, and provider—and be supported in defining their own happiness and desired life.

- **Emphasize Person First with Customized Supports:** The person, not their diagnosis or system involvement, directs the planning process. Their voice, values, and relationships should guide and shape all services received.
- **Focus on Strengths:** Identify and build upon each person's talents, skills, and sources of pride. Engage those who know them well to help realize their goals and lifelong growth.
- **Balance Choice and Risk:** Respect individual autonomy by recognizing what is important *to* and *for* the person. Dignity, self-esteem, and growth often come through taking informed risks.
- **Meet the Person Where They Are:** Understand and respect the person's culture, values, and lived experiences, including past trauma. Approach with humility, recognizing that health, well-being, and community are interconnected. Avoid imposing personal beliefs or values.
- **Regularly Review Goals:** Acknowledge that needs and goals change over time. Services and supports must be flexible and updated promptly to remain aligned with the person's evolving vision.
- **Build Equity of Voice:** Empower participants to engage in decision-making. Create inclusive opportunities for underrepresented individuals to be heard and actively involved in their care and advocacy.
- **Equip for Informed Decision-Making:** Clearly explain available options and ensure the person understands potential benefits and consequences. Provide the information needed to make informed, confident choices.
- **Be Kind:** Lead with genuine compassion and care. Kindness builds trust and supports the delivery of high-quality, person-centered services aligned with the individual's needs and aspirations.

These guiding principles serve to **empower individuals**, **honor their voice and dignity**, and ensure care is truly centered around their unique life and goals

Recovery-Oriented

A recovery-oriented approach prioritizes access to a comprehensive continuum of behavioral health care, going beyond traditional clinical treatment. It integrates recovery-based supports such as peer support, recovery coaching, physical healthcare, housing, and employment assistance, recognizing that recovery is multi-dimensional and unique to each individual.

This approach is grounded in hope, empowerment, and personal choice, offering services that affirm the belief that recovery is possible for everyone. Recovery-oriented systems are strengths-based, engaging individuals with mental health and substance use conditions in care that promotes resilience, connection, and long-term recovery.

> *"Systems of health and human services that affirm hope for recovery, exemplify a strengths-based orientation, and offer a wide spectrum of services and supports aimed at engaging people with mental health and substance use conditions into care and promoting their resilience and long-term recovery—from which they and their families may choose."*
> *— SAMHSA*

- **Multiple Pathways:** There is no single path to recovery; individuals find healing in diverse ways.
- **Self-Directed & Empowering:** Recovery is led by the individual and driven by their choices.
- **Personal Transformation:** It begins with recognizing the need for change and the desire for growth.
- **Holistic:** Recovery addresses the whole person—mind, body, spirit, and life circumstances.
- **Culturally Responsive:** It honors cultural background, identity, and values.
- **Health & Wellness Continuum:** Recovery progresses over time and looks different for each person.
- **Hope & Gratitude:** These are essential foundations for resilience and healing.
- **Healing & Self-Redefinition:** Recovery involves redefining oneself beyond the diagnosis or past experiences.
- **Overcoming Stigma:** Recovery includes confronting discrimination and rising above shame and stigma.
- **Peer & Community Support:** Encouragement from peers and allies is essential.
- **Reintegration:** Recovery is about (re)joining and (re)building a meaningful life in the community.
- **Recovery is Real:** Recovery is not only possible, it happens every day.

Source: *Glossary of Recovery Terms*, SAMHSA. Retrieved May 18, 2015, from Guiding Principles and Elements of Recovery-Oriented Systems of Care

Trauma-Informed Care

A trauma-informed approach is grounded in an understanding of the widespread impact of trauma and the need to create safe, supportive environments for both participants and providers. It is a strengths-based framework that prioritizes physical, psychological, and emotional safety, with the goal of fostering trust, empowerment, and healing.

This approach recognizes that trauma is common, affecting not only program participants but also the workforce. By integrating this awareness into all aspects of service delivery, trauma-informed care aims to avoid re-traumatization and support recovery.

Core Elements of a Trauma-Informed Approach

1. **Realize** the widespread impact of trauma.
2. **Recognize** how trauma affects all individuals within the program, including staff.
3. **Respond** by integrating trauma knowledge into policies, procedures, and practices.
4. **Resist re-traumatization** by creating safe, predictable, and respectful environments.

Guiding Principles of Trauma-Informed Care

- **Safety:** Everyone—participants and staff—should feel physically and emotionally safe throughout all levels of the organization.
- **Trustworthiness & Transparency:** Organizational practices and decisions are made openly, fostering trust among staff, participants, and their families.
- **Peer Support & Mutual Self-Help:** Peer relationships are essential for building trust, promoting recovery, and fostering empowerment for participants and staff alike.
- **Collaboration & Mutuality:** Healing occurs in relationships where power is shared. Everyone in the organization, from direct care staff to leadership, plays a role in creating a trauma-informed culture. *One does not have to be a therapist to be therapeutic.*
- **Empowerment, Voice, & Choice:** A trauma-informed approach honors individuals' strengths, builds on their skills, and supports informed choices. Services are tailored to meet unique needs, recognizing the resilience of individuals, families, and communities.
- **Cultural, Historical, & Gender Responsiveness:** The approach actively addresses cultural stereotypes, acknowledges historical trauma, and provides culturally and gender-responsive services. It incorporates traditional healing practices and respects diverse identities and experiences.

Note: Individuals' experiences with trauma are unique, and trauma-informed care must be flexible and responsive to these differences.

Source: SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

Data Driven

Program data will be regularly shared with stakeholders to support their engagement and alignment with program goals. This includes providing timely and relevant feedback to inform decision-making, service delivery and continuous quality improvement.

Transparency in sharing data ensures that all partners are informed and able to adjust practices to better meet participant needs and enhance program outcomes.

How to Access Services & Individual Eligibility

Accessing Community Connect Services

The participant application for Community Connect is web-based and accessible to any person.

- www.hhs.nd.gov/behavioral-health/community-connect

An individual who is interested in receiving the services provided by Community Connect can complete the application for eligibility independently or with the help of a friend, family, or other service provider. When a person applies for the Community Connect program, they are given the option to select a provider. Upon submission, the BHD reviews the eligibility application and notifies the applicant of the outcome via their preferred communication method. If the application is not approved, the applicant will receive notice along with information on alternative community-based resources.

The BHD is responsible for the administration of Community Connect and may make changes to the application, process and prioritization of referrals.

Eligibility

To be eligible for participation in Community Connect, an individual must meet **all** the following criteria:

- **Age**:
  - 18 years of age or older

- **Residency**:
  - Reside in North Dakota

- **Behavioral Health Need:**
  - Mental health or substance use disorder diagnosis impacting functionality in multiple domains including:
    - Housing
    - Employment
    - Parenting
    - Physical health
    - Community connections

Applications for eligibility will be prioritized based on the severity of impact from the identified behavioral health conditions, with additional priority given to:

1. Parents and caregivers
2. Parents and caregivers with child protection services involvement
3. Pregnant women
4. Individuals who utilize emergency and detox centers
5. Recent intravenous drug usage
6. Individuals who are experiencing homelessness

Providing Agencies

North Dakota's behavioral health system is strengthened by a diverse network of providers who honor participant choice and support multiple pathways to recovery. Agencies may serve as program providers by entering into a formal agreement with the North Dakota Department of Health and Human Services, Behavioral Health Division (BHD). This agreement authorizes agencies to deliver care coordination, peer support, and access to recovery support services as part of the program.

Provider Expectations & Requirements

To maintain the integrity and effectiveness of the Community Connect program all providers must meet the following expectations.

- Adhere to all terms outlined in the Provider Agreement.
- Notify BHD administrator within one business day when a Care Coordinator or Peer Support Specialist is no longer working in the program. Include the departure date, reason, and transition plan for impacted participants.
- Report any potential conflicts of interest immediately to BHD.
- Assign Care Coordinators within one business day of receiving an approved referral. Assignments must align with the participant's region.
- Match participants with Care Coordinators and Peer Support Specialists based on needs, demographics, personality, and lived experience.
- Ensure timely, accurate documentation of all services by Care Coordinators and Peer Support Specialists in accordance with program standards.
- Provide back-up Care Coordination and Peer Support coverage during any staff absence.
- Serve individuals with complex needs, including those with mental illness, substance use disorders, brain injuries, and criminal justice involvement.
- Present Care Coordination and Peer Support as equally essential. All participants must be offered Peer Support and may opt out; if they do, the reason must be documented in detail and services should be re-offered as needs evolve.
- Ensure separate individuals provide Care Coordination and Peer Support to the same participant.
- Uphold clear role distinctions between Care Coordinators and Peer Support Specialists, ensuring all staff are trained accordingly.
- Acknowledge that referrals may be paused by BHD or the provider at any time.
- Understand the BHD reserves the right to refuse to allow an individual to serve in the role of Care Coordinator or Peer Support for participants.
- Have the capacity for timely, accurate needs assessments
- Build empathetic, respectful relationships with participants
- Identify and develop creative resolution of gaps in community-based supports

Becoming a Provider Agency

Organizations interested in becoming a Community Connect provider agency may complete the Community Connect Program Provider Application sfn00986.pdf and submit all required documents, in their entirety, in one of the three ways:

1. Email: comconnect@nd.gov
2. Mail: 600 E. Boulevard Ave. – Dept. 325
   Bismarck, ND 58505-0250
3. Fax: 701-328-8979

Reporting Provider Concerns

To report concerns regarding a Community Connect provider's service delivery, email comconnect@nd.gov and include Attn: Community Connect Lead Administrator in the subject line.

Care Coordination

Care coordination ensures that participants receive comprehensive, coordinated services tailored to their needs. Care Coordinators connect individuals to resources, unify care teams, and reduce service gaps, improving continuity, follow-up, and outcomes. Every participant in the program must be matched with a Care Coordinator. The primary function of care coordination is to connect and organize services across systems—ensuring participants receive the right care, at the right time, from the right provider, the "glue" that binds together multiple service systems (clinical, housing, justice, employment, and recovery supports).

Qualifications

- **Background Check**: Must be completed through the Community Connect agency before care coordination training, provider portal access, or service delivery.
- **Education/Experience**: Degree in a related field **or** at least 1 year of human services experience.

How to become a Care Coordinator in Community Connect

1. Be hired by an approved Community Connect provider.
2. Must complete a background check through the Community Connect agency before provider portal access or service delivery begins.
3. Complete Behavioral Health Division approved onboarding.
4. Complete Behavioral Health Division in-person Care Coordinator Training.

Service Expectations

- **Assess:** Assess the participant's strengths, preferences and needs, addressing social determinants of health and monthly outcome areas.
- **Person-Centered Care**: Develop and update collaborative care plans within ten (10) business days of referral; review monthly, or as needed.
- **Collaborative Staffing**: Regularly coordinate with care team members/agencies and peer support specialists; document all staffing.
- **Referrals & Follow-Up**: Initiate connections to community services early, follow up to ensure effectiveness, and avoid dependency on staff as the sole support.
- **Crisis & Safety Planning**: Provide 24-hour crisis resources and individualized safety plans.
- **Ethics & Boundaries**: Follow the Care Coordinator Code of Ethics; maintain professional boundaries and scope of expertise.
- **Training & Technical Assistance:** Participate in required meetings, training, and technical assistance.

Documentation Standards

- Enter all contact, attempted contact, staffing, and updates in the provider portal within five (5) business days.
- Monitor and update care plans monthly, or more often, as needed.
- Submit outcomes by the 5th of each month.
- All documentation must be submitted by the 5th of each month.

Coordination with Peer Support

- The same individual may not serve as both the Care Coordinator and Peer Support Specialist for

a participant.
- If a participant declines peer support, the Care Coordinator must fulfill all engagement requirements and document why the participant declined peer support services in detail.

Service Delivery Requirements

- Care Coordinator should reside in the same North Dakota region as the participant unless otherwise approved by BHD Administrator.

NEW! Code of Ethics for Care Coordinators

All Care Coordinators must read, acknowledge, and adhere to the Care Coordinator Code of Ethics. A signed acknowledgment form must be retained in the Care Coordinator's personnel file by the provider agency.

Care Coordinators are expected to uphold ethical standards in all professional and potential personal interactions with participants. Lack of awareness or misunderstanding of the Code does not excuse misconduct.

Care Coordinators must:

- Practice within the scope of their expertise and training,
- Recognize the limits of their capabilities,
- Collaborate with other professionals to best serve participants,
- Maintain objective, ethical relationships at all times.

Violations may result in disqualification from providing care coordination services within the program.

Peer Support Specialists

A Peer Support Specialist is an individual with lived experience of recovery from a mental health condition, substance use disorder, brain injury, or a combination thereof. Using both personal experience and formal training, they provide behavioral health services and support to individuals facing similar challenges. Peer support offers a level of acceptance, understanding, and validation not always found in other professional relationships.

Qualifications

To become a **Certified Peer Support Specialist** in North Dakota, individuals must:

- Have at least one year of healthy living and/or recovery, and
- Reside or work in North Dakota, and
- Identify as being in recovery from a mental health disorder, brain injury, substance use disorder, or combination thereof, and
- Possess a high school diploma, GED, or equivalent literacy skills, and
- Successfully complete an approved Peer Support Training Program.

For information on how to become a North Dakota Certified Peer Support Specialist visit, www.hhs.nd.gov/behavioral-health/peer-support/certification.

How to become a Peer Support Specialist in Community Connect

1. Be hired by a Community Connect provider.
2. Must complete a background check through the Community Connect agency **before** provider portal access or service delivery begins.
2. Meet the state certification requirements, and become certified within ninety (90) days of becoming a service provider
3. Complete onboarding requirements.

Service Expectations

- **Engagement:** Meet with the participant as described in level guidance.
- **Advocate:** Advocate and promote self-advocacy.
- **Person-Centered Care:** Understand a participant's goals on their care plans and help support the participants in reaching their goals.
- **Navigation and Connection:** Assist with navigation and connection to services and resources, avoid dependency on staff as the sole support.
- **Communicate:** Collaborate and communicate with the participant's care team.
- **Documentation:** Document meetings, service provided, and work done with or on behalf of the individual through case notes.
- **Ethics & Boundaries**: Follow the Peer Support Code of Ethics; maintain professional boundaries and scope of expertise.
- **Training & Technical Assistance:** Participate in required meetings, training, and technical assistance.

NEW! Documentation Standards

- Enter all contact, attempted contact, staffing, and updates in the provider portal within five (5) business days.
- Monitor and update care plans monthly, or more often, as needed.
- All documentation must be submitted by the 5th of each month.

Coordination with Care Coordinator

- The same individual may not serve as both the Care Coordinator and Peer Support Specialist for a participant.
- If a participant declines peer support, Care Coordinator must fulfill all engagement requirements and document the refusal in detail

Service Delivery Requirements

- Peer Support Specialist should reside in the same North Dakota region as the participant unless otherwise approved by BHD Administrator.

NEW! Code of Ethics for Peer Support Specialists

All Peer Support Specialists must read, acknowledge, and adhere to the Peer Support Code of Ethics. A signed acknowledgement form must be retained in the Peer Support's personnel file by the provider agency.

Peer Supports are expected to uphold ethical standards in all professional and potential personal interactions with participants. Lack of awareness or misunderstanding of the Code does not excuse misconduct.

Peer Support Specialists must:

- Practice within the scope of their expertise and training,
- Recognize the limits of their capabilities,
- Collaborate with other professionals to best serve participants, and
- Maintain objective, ethical relationships at all times.

Violations may result in disqualification from providing peer support services within the program.

Recovery Support Services

Recovery is a personal, non-linear process that may include clinical treatment, medication, faith-based approaches, peer and family support, self-care, and other strategies. It involves ongoing growth and improvement in health, well-being, and quality of life.

Four Dimensions of Recovery

1. **Health:** Managing symptoms and making informed choices that support physical and emotional well-being.
2. **Home:** Maintaining a safe, stable place to live.
3. **Purpose:** Engaging in meaningful activities (work, school, volunteering, caregiving, creative pursuits) and having the resources to participate in society.
4. **Community:** Building supportive relationships and networks that provide hope and connection.

Recovery Support Services

These services help individuals and families:

- Access and navigate care systems.
- Remove barriers to engagement.
- Stay connected to recovery resources.
- Lead fulfilling lives in their chosen communities.

Examples of recovery support services include *food assistance, supportive housing, education, employment, leisure and wellness activities, parenting support, spiritual engagement, and other individualized needs.*

Considerations

- Recognize recovery looks different for each person.
- Involve supportive family and friends when possible.
- Facilitate participant choice and problem-solve provider concerns.
- Encourage community connection through support groups, volunteer opportunities, and healthy activities.
- Identify and reinforce strengths regularly.
- Build rapport by listening actively, meeting in safe and comfortable locations, and showing genuine interest in the person beyond their diagnosis.
- Use appropriate self-disclosure to foster trust.
- Explore goals beyond treatment (educational, recreational, relational, spiritual, financial).

North Dakota Resources

FirstLink
24/7 support, referrals, and crisis intervention. Call 211 or 988.
myfirstlink.org

GamblerND
Resources, treatment and recovery support for problem gambling.
www.gamblernd.com

ND Brain Injury Network
Support for individuals and families affected by brain injury.
www.ndbin.org

ND Mental Health Program Directory
Statewide mental health service locator.
www.hhs.nd.gov/behavioral-health/directory

ND Medicaid 1915i Services
Home and community-based behavioral health supports.
www.hhs.nd.gov/1915i

Recovery Housing Assistance Program (RHAP)
Up to 12 weeks of living expenses for eligible individuals in recovery housing.
www.hhs.nd.gov/behavioral-health/recovery-housing/providers

State-Operated Behavioral Health Clinics
Regional services for counseling, treatment, and other supports.
www.hhs.nd.gov/HSC

SUD Voucher Program
Increases access to substance use disorder treatment.
www.hhs.nd.gov/behavioral-health/sudvoucher

Community Connect Care Team

The Care Team includes the participant, Care Coordinator, Peer Support Specialist, family or loved ones, and other professionals such as counselors, social workers, housing coordinators, probation officers, or healthcare providers.

Care Team Collaboration

- Clearly define each member's role and responsibilities.
- Meet regularly to review goals, track progress, address barriers, share resources, and coordinate efforts.
- Best practice: Hold structured monthly staffings to avoid duplication and ensure appropriate care, with urgent meetings convened as needed based on participant needs.

Documentation

The Care Coordinator and/or Peer Support Specialist documents care team activities in the participant's care plan and Provider Portal Case Notes.

The responsibilities of a **Care Coordinator** and **Peer Support Specialist** are different, but the roles complement each other and are equally valuable in the delivery of person-centered recovery support.

Care Coordinator	Peer Support Specialist
Perform initial and ongoing assessments	Meet with the individual regularly
Identify the individual's inter-disciplinary team	Advocate and promote self-advocacy
Develop and maintain Plan of Care	Implement Care Plan • *The Peer Support Specialist is **accountable** for the implementation of the Plan of Care*
Provide referrals and facilitate connections	Assist with navigation to services and resources
Monitor service delivery and progress toward desired outcomes • *Care Coordinator is **responsible** for the implementation of the Plan of Care*	Document and share the individual's progress
Care Coordinator & Peer Support Specialist	
Communicate and collaborate with the individual's interdisciplinary care team	
Document meetings, service provided, and work done with and on behalf of the individual through case notes	

Community Connect Provider Portal

The Community Connect Provider Portal is a web-based system that offers access for providers to complete all required program documentation. All Community Connect providers are required to use the Provider Portal for the purposes of documentation.

All Community Connect Provider Portal training documents, videos and forms can be found online at www.hhs.nd.gov/behavioral-health/community-connect/training-resources.

Important Compliance Information

Provider portal access may be revoked for a portal user for any of the following reasons, but not limited to:

- A portal user shares their password or gives access to their portal account to another person; this includes other portal users within the same provider.
- There is unauthorized use of the portal or information found within the portal. This may also result in termination of the Provider Agreement.
- A portal user submits false documentation to receive payment for services. This may also be grounds for termination of a Provider Agreement.

NEW! Confidentiality

Confidentiality is the foundation of ethical behavioral health practice. All providers, including Care Coordinators and Peer Support Specialists, must protect participant information and ensure compliance with federal and state confidentiality laws.

1. **Respect for Privacy**
   - Information shared by participants is private and must not be disclosed unless required or permitted by law.
   - Confidentiality applies to verbal conversations, written notes, electronic records, and all other formats.
2. **Legal and Ethical Compliance**
   - Providers must:
     - Comply with all state and federal laws and regulations pertaining to use, disclosure, maintenance, retention, and safeguarding of confidential information regarding participants, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at 45 CFR Part 160 and Part 164.
     - Comply with Federal privacy law for Substance Use Disorder patient records, 42 USC § 290dd-2, and its implementing regulations, 42 CFR Part 2, and other confidentiality laws and regulations that may apply.
     - Assume responsibility for obtaining any Authorization to Disclose Information forms that may be necessary to meet coordination requirements and data reporting per this Agreement.
3. **Minimum Necessary Standard**
   - Only the minimum amount of participant information necessary to accomplish the intended purpose may be shared.

Provider Responsibilities

- **Confidentiality Agreements**: All staff must sign and comply with agency confidentiality policies and applicable codes of ethics.
- **Documentation Practices**:
  - Use secure systems (e.g., Community Connect Provider Portal) for records.
  - Avoid unnecessary details that could disclose sensitive information to unauthorized readers.
- **Secure Communication**:
  - Do not use personal email, text messaging, or social media to share participant information.
  - Follow agency-approved methods for electronic communication.
- **Environmental Awareness**:
  - Conduct discussions in private spaces.
  - Avoid talking about participants in public settings or with individuals not involved in their care.

Breach of Confidentiality

- A breach occurs when participant information is shared inappropriately or without authorization.
- All breaches must be reported immediately according to agency policy and state/federal requirements.
- Corrective action, retraining, or disciplinary measures may result from breaches.

Key Takeaways for Providers

- **Confidentiality is ongoing,** it does not end when a participant leaves the program.
- **When in doubt, don't disclose,** always consult agency policy or a supervisor before releasing information.
- **Trust is central,** protecting confidentiality builds participant trust and supports recovery.

NEW! Dual Relationships and Conflict of Interest

To ensure professional boundaries, protect the integrity of services, and safeguard the well-being of participants, all behavioral health providers must be alert to and avoid dual relationships and conflicts of interest in the provision of care.

Definitions

- **Dual Relationship**: A situation where a provider has more than one type of relationship with a participant (e.g., personal, financial, social, or business in addition to the professional relationship).
- **Conflict of Interest**: A situation where a provider's personal, financial, or professional interests may interfere with their ability to act in the best interest of a participant.

Core Principles

1. **Professional Boundaries**
   - Providers must always maintain clear and professional relationships with participants.
   - Boundaries are essential to ensure that services remain focused on the participant's recovery and wellness.
2. **Avoiding Exploitation**
   - Providers must not use their professional position to gain personal, financial, or other benefits from participants.
3. **Transparency**
   - Any potential dual relationship or conflict of interest must be disclosed immediately to a supervisor.
   - Decisions should always be guided by the best interest of the participant.

Examples of Dual Relationships (Not Allowed)

- Entering into personal friendships or romantic relationships with current participants.
- Providing behavioral health services to close friends, family members, or individuals with whom the provider has/had a significant personal relationship.
- Engaging in business, financial, or service exchanges with participants inside or outside of the treatment relationship (e.g., lending/borrowing money, buying/selling goods or services).

Conflict of Interest Situations

- Favoritism or bias in service delivery due to personal connections.
- Accepting gifts, favors, or services from participants that could influence professional judgment.
- Referring participants to services or vendors from which the provider benefits financially.
- While not always inherently unethical, dual relationships require careful consideration to avoid conflicts of interest and to protect prior participants from harm and/or exploitation.

> *Example: While hiring a past participant may be appropriate, depending on the circumstances, it would be unethical to terminate services in order to hire an individual.*

Provider Responsibilities

- **Maintain Boundaries**: Ensure relationships remain professional and recovery focused.
- **Consult and Report**: If a situation arises that could be perceived as a dual relationship or conflict of interest, seek immediate guidance from a supervisor or agency administrator.
- **Decline Gifts or Favors**: Providers should politely decline offers of gifts, money, or services from participants.
- **Avoid Over-Familiarity**: Keep communications and interactions professional and focused on the participant's goals and service plan.

Agency Expectations

- **Training:** Provide regular training and supervision on boundaries, dual relationships, and conflicts of interest.
- **Policies:** Follow agency's internal policies and procedures for dual relationships and conflicts of interest.
- **Supervision:** Support staff in identifying, preventing, and managing potential conflicts.

Key Takeaways

- **Keep relationships professional.** Personal, social, or financial entanglements with participants are not appropriate.
- **Protect trust and recovery.** Boundaries ensure participants feel safe and respected.
- **Disclose and consult.** When in doubt, report potential conflicts to a supervisor.

NEW! Crisis Intervention

Behavioral health providers play a critical role in recognizing, responding to, and supporting individuals experiencing a behavioral health crisis. This guidance outlines expectations and best practices to ensure a safe, person-centered, and effective crisis response.

Definition of Crisis

A crisis is any situation in which an individual perceives an event or experience as intolerable, overwhelming, or threatening, and their usual coping skills are not effective.

- Suicidal thoughts or behaviors
- Self-harm or risk of harm to others
- Severe emotional distress (e.g., panic, trauma response)
- Acute symptoms of a mental illness or substance use disorder
    - Symptoms may include but are not limited to isolating, physical change in appearance, neglecting self-care, dilated or constricted pupils, confusing thoughts or verbalizations, extreme mood changes, irritability, lethargy, impaired judgment or decision making.
- Situations of abuse, neglect, or unsafe living conditions

Other examples of a crisis could include feeling overwhelmed with applying for jobs, cravings to use, CPS involvement, law enforcement involvement, receiving an eviction notice, not having enough food, etc.

Provider Responsibilities in a Crisis

Step 1: Immediate Assessment

- Evaluate the participant's safety and risk level.
- Use agency-approved screening tools when available.

Step 2: Response Actions

- If the participant is at imminent risk of harm, call 911 or appropriate emergency responders.
- If not imminent but urgent, connect the participant with local crisis response resources through the 988 call line.
- Utilize de-escalation techniques to help the participant regain a sense of control.
- Utilize a formal safety plan to assist the participant in utilizing resources and coping skills.

Step 3: Communication

- Notify supervisors or agency leadership of crisis events per agency protocol.
- Document the incident factually and promptly in the participant record, noting actions taken and resources involved.

Step 4: Follow-Up

- Ensure continuity of care after a crisis.
- Revisit the participant's care plan to add or strengthen crisis prevention strategies.
- Offer debriefing and emotional support to participants and staff impacted by the crisis.

Core Principles of Crisis Intervention

1. **Safety First**
    - Prioritize the immediate physical and emotional safety of the participant, provider, and others.
    - Assess risk of harm to self or others promptly.

2. **Calm and Supportive Presence**
    - Approach the participant with empathy, patience, and respect.
    - Use a calm tone and non-threatening body language.

3. **Least Restrictive Approach**
    - Intervene in the least restrictive manner possible while maintaining safety.
    - Support participant autonomy and choice whenever feasible.

4. **Collaboration and Connection**
    - Partner with the participant to identify immediate needs and potential coping strategies.
    - Engage natural supports, when appropriate, with participant consent.

Crisis Prevention and Planning

Work with participants proactively to develop individualized Crisis Prevention and Safety Plans, which may include:

- Identifying early warning signs of crisis.
- Outlining coping strategies and grounding techniques.
- Listing supportive contacts (family, friends, sponsors, peers).
- Providing crisis hotline numbers (e.g., 988 Suicide & Crisis Lifeline).
- Naming preferred hospitals or providers if emergency care is needed.

A **Crisis Safety Plan template** can be found here: predprod-behavioralhealth.x-shops.com/988/crisis-life-plan

Agency Expectations

- **Policies**: Follow your agency's policies and procedures for crisis intervention, suicide prevention, and de-escalation techniques.
- **Resources**: Providers must be familiar with local and state crisis response systems and how to access them.
- **Collaboration**: Providers are expected to coordinate with law enforcement, emergency medical services, mobile crisis teams, and community partners when appropriate.

NEW! Suicide Prevention and Intervention

Suicide is a critical public health issue that impacts individuals, families, and communities. Providers play a vital role in recognizing risk, offering support, and connecting individuals to lifesaving resources.

Understanding Suicide Risk

- **Complex Causes:** Suicide is rarely caused by a single event. Risk arises from multiple factors at the individual, relationship, community, and societal levels.
- **Warning Signs:** Changes in mood, withdrawal, hopelessness, or direct statements about wanting to die should always be taken seriously.
- **Risk and Protective Factors:** Prevention efforts should focus on reducing risks (such as access to lethal means, untreated mental illness, or isolation) while increasing protective factors (such as connection, coping skills, and access to care).

Provider Responsibilities

Care Coordinators and Peer Support Specialists may be the first point of contact when a participant is struggling. Your role includes:

- Recognizing warning signs and risk factors.
- Asking directly about suicide when concerns are present.
- Establishing immediate safety and connecting individuals to resources.
- Supporting participants with compassion while maintaining self-care and professional boundaries.
- Following your agency's internal policies and procedures for suicide prevention and crisis intervention.

Five Key Steps for Suicide Prevention

1. **Ask Directly:** "Are you thinking about suicide?"
    - Using clear, direct language shows care and reduces stigma. Asking does **not** increase risk.
    - **Ask: Are you thinking about suicide?**

2. **Keep Them Safe:** Determine if the participant has access to lethal means and address safety.
    - For more information, visit: Lethal Means Safety in North Dakota | Health and Human Services North Dakota. **Keep Them Safe: Establish immediate safety.**

3. **Be There:** Stay with the person in crisis or remain connected by phone until other supports are in place. **Be There: Be there or speak with them on the phone.**

4. **Help Them Connect:** Link participants to crisis services, supports, and ongoing care. **Help Them Connect: Connect them with resources.**
    - www.hhs.nd.gov/behavioral-health/directory

5. **Follow Up:** Check in after the initial crisis to show continued support and encourage engagement in services. **Follow Up: Follow up to see how they're doing.**

Training and Tools

- **Columbia-Suicide Severity Rating Scale (C-SSRS):** Care Coordinators and Peer Support Specialists are encouraged to attend training on use of the C-SSRS suicide screening tool, provided by FirstLink.
    - Example Demonstrations:

        Low Risk: *FirstLink C-SSRS Demonstration*

        Moderate Risk: *FirstLink C-SSRS Demonstration*

        High Risk: *FirstLink C-SSRS Demonstration*

- **988 Suicide & Crisis Lifeline:** Promote awareness of the 988 Lifeline, which provides free, confidential support 24/7 through call, text, or chat. Lifeline also connects individuals to local resources. 988lifeline.org

Provider Self-Care

Supporting individuals experiencing suicidal thoughts can bring up strong emotions. Providers are encouraged to:

- Practice self-care strategies regularly.
- Seek supervision or peer consultation when needed.
- Utilize your agency's support systems and employee resources.
- If needed, call 988 for support.

By recognizing warning signs, addressing risk factors, using direct and compassionate communication, and promoting resources like 988, Care Coordinators and Peer Support Specialists play a vital role in suicide prevention.

NEW! Assertive Engagement and Active Efforts

Assertive Engagement

Assertive engagement is a purposeful and proactive approach to connecting people with services.

- Meeting locations should be chosen by the participant, whether at home, work, or another community setting, to ensure comfort and accessibility.
- Interactions are person-centered and tailored to the unique needs, circumstances, and preferences of each individual.

Key Principles of Assertive Engagement

- Prioritize meeting participants in their chosen environment.
- Build rapport and trust before introducing motivational approaches.
- Address immediate, tangible needs (e.g., food, ID, medical care) to establish credibility and encourage continued engagement.
- Provide direct assistance in accessing resources. not just referrals. Examples include:
    - Accompanying the participant to sign up for a class.
    - Helping complete a job application.
    - Joining a meeting with family to plan support.
    - Taking the participant to view available housing.

Assertive Engagement is *Not*

- Offering generic resources without tailoring them to the participant's situation.
- Telling participants what to do without providing adequate, hands-on support.
- Sending only text "check-ins" such as "Hi! Do you need anything this week?" without other forms of engagement.
- Waiting for the participant to initiate contact.
- Relying solely on verbal updates and documenting them as service delivery.

Active Efforts

Active efforts are continuous, intentional actions to assess needs, identify goals, track progress, and connect participants with supports that help them succeed. They apply across all levels of care and require ongoing follow-through.

Core Actions in Active Efforts

- **Diligent outreach:** Make persistent/diligent attempts to locate and engage with participants, including community visits when contact is difficult.
- **Prompt follow-up:** Address missed appointments immediately with a renewed engagement plan.
- **Service delivery at the point of contact:** Provide meaningful assistance during meetings, ensuring there is a reason for participants to stay engaged.
- **Participant-first approach:** Place their needs, priorities, and preferences at the center of decision-making.
- **Hands-on navigation:** Help them overcome barriers by directly facilitating access to services and natural supports.

Minimal Efforts (Not Acceptable)

Minimal efforts involve doing only the bare minimum to fulfill program requirements without advancing meaningful progress for the participant.

Indicators of Minimal Effort

- Simply filling out required forms without addressing barriers.
- Being reactive rather than proactive.
- Relying on quick “check-ins” or participant-reported updates with no follow-up action.
- Failing to pursue engagement when a participant is out of contact.

Minimal efforts fail to meet the expectations of behavioral health support services and are not acceptable.

It is the responsibility of the Care Coordinator and Peer Support Specialist to:

- Take the lead in initiating engagement.
- Develop creative, effective strategies for connection.

Active Efforts	Minimal Efforts
Assisting the participant in contacting the service provider to get connected, with regular follow-up.	Providing a phone number or providing a generic list without tailoring to participant need, no follow-up.
Calling participant to introduce program and role.	Initial contact is text message with no previous attempts at calling.
Using various types of outreach methods.	Sending text messages only.
Collaborating with other care team members, including other community providers.	Not connecting with or collaborating with other care team members or community providers.
Proactively scheduling the next meeting to meet the needs of participant.	Not scheduling the next meeting at the end of their current meeting.
Scheduling meetings based on participant's needs.	Scheduling meetings based on payment rate.
Actively working to engage participant and work on goals and action steps during each meeting to work towards program completion.	Completing "check ins"
Anticipate challenges and implement prevention and early intervention strategies.	Only respond when a crisis occurs.
Relationship-centered approach that promotes recovery, self-determination, and trust.	Transactional interactions focused on tasks.

NEW! Referral and Intake Guidelines

Upon program approval, a referral is sent to the applicant's chosen provider via the provider portal. The intake is the starting point for building rapport, identifying needs, and planning for both service delivery and eventual program completion. Assessment begins here and continues throughout the participant's time in Community Connect.

Timelines & Preparation

- The Care Coordinator must offer and schedule an intake meeting with each participant within three (3) business days of receiving the referral. The face-to-face intake meeting must be conducted within five (5) business days of receiving the referral.
- Before the meeting, the Care Coordinator should review the participant's Community Connect application.
- If a face-to-face intake meeting has not occurred by the end of the month in which the referral was received, the provider may submit a discharge request by the last calendar day of that month.
- Providers may continue outreach efforts beyond the initial month; however, if a face-to-face intake meeting has not occurred within sixty (60) days from the referral date, the participant must be discharged.

The intake meeting should:

1. **Clarify Roles**
    a. Explain the roles of the Care Coordinator and Peer Support Specialist (in plain language).
    b. Provide Peer Support contact info if not present; best practice is to have them attend.
2. **Identify Needs & Barriers**
    a. Explore Social Determinants of Health (SDOH):
        i. Food insecurity
        ii. Housing instability
        iii. Financial strain
        iv. Transportation needs
        v. Exposure to violence
        vi. Socio-demographic factors (e.g., language, education, immigration status)
    b. Assess behavioral health needs and natural support networks.
3. **Explore Strengths & Goals**
    a. Discuss what is important to the participant, existing strengths, and skills that can support goal achievement.
    b. Identify key people to include in the care team; obtain necessary Authorization to Disclose Information forms.
4. **Address Health Coverage**
    a. Confirm insurance status and coverage details.

Begin Discharge Planning at Intake

- Participant may explain what successful completion of program would look like for them.
- Begin planning with the end goal in mind.

Intake Documentation Requirements (Provider Portal)

Record as a face-to-face case note including:

- Meeting location, length, and date.
- Role clarification and Peer Support discussion.
- Intake paperwork and Authorization to Disclose Information forms completed.
- Strengths and needs identified (including SDOH).
- Care Plan discussion and agreed next steps.
- Follow-up expectations for both coordinator and participant.
- Date and time of next meeting.

Documentation Guidance

This section outlines expectations, timelines, and types of documentation for Community Connect in the Community Connect Provider Portal. Documentation is essential for communication within the care team, ensuring service quality, and determining provider payment.

Purpose of Case Notes

Case Notes are the designated place in the Provider Portal to document:

- Contact
- Attempted contact
- Work completed on behalf of a participant
- Care team staffings

Why Case Notes Matter:

- Communicate participant progress, frequency of contact, barriers, and goals with the care team.
- Allow the BHD Administrator to verify services and determine payment.
- Serve as official record.

Documentation Expectations

- **Timeliness:** Document any contact, attempted contact, or participant-related work. Complete documentation within five (5) business days. All documentation must be submitted by the 5th of each month.
  Examples: care team staffings, scheduling appointments, coordinating services, researching resources.
- **Accuracy:** Documentation must reflect actual events.
- **Language:** Use person-first, objective, clear, descriptive, relevant, and concise language. Avoid opinions, slang, and assumptions.
  Example: "The participant presented today with slurred speech and droopy eyelids."
- **Meetings or outreach:** Notes must demonstrate that meetings occurred or attempts to meet, fulfilling level requirements, or payment may be denied. *(See Levels Guidance for details.)*
- **It is the responsibility of the individual portal user to confirm that their documentation is saved each time it is completed**.

Case Note Standards

Case notes must be:

- **Objective** – Factual, unbiased.
- **Accurate** – Truthful and precise.
- **Clear** – Avoid jargon, acronyms, or ambiguous terms.
- **Descriptive** – Provide enough detail to understand what occurred.
- **Relevant** – Relate directly to outcomes, Care Plan goals, and barriers.
- **Concise** – Summarize without writing a full transcript.

Case Notes Should Include:

Information supporting the **four outcome areas**:

- Housing; Employment/Finance; Recovery; Criminal Justice Involvement

Other possible topics: Care Plan updates, level changes, discharge planning, transfers, gap funding, parenting, barriers, successes, referrals, and upcoming appointments. Details such as:

- Length and location of meeting
- New risks, challenges, or barriers and plans to address them
- Supports provided, referrals made, resources connected
- Collaboration with other providers or agencies
- Updates to Care Plan
- Plan for next meeting (best practice: schedule before ending the meeting)
- What the participant will work on before the next meeting

Types of Contact

Attempted Contact	• Tried to contact the participant but received no response. • Weekly active engagement attempts may use varied methods (phone, text, email, letter, outreach).
Face-to-Face	• Planned in-person meeting covering Care Plan areas and/or active service efforts.
No Show	• Participant did not attend a scheduled meeting without prior notice.
Phone call	• A phone conversation occurs with the program participant.
Text Message	• A text message conversation occurs with the program participant.
Web-based video	• A web-based/ phone or video call occurs with the program participant.
Incidental Contact	• Contact occurs with the participant that was not planned.
Email	• There is correspondence with the program participant through email.
Mail	• There is correspondence with the program participant through mail.
Care Staff or Care Team	• Contact with any member of the care team to discuss participant's program participation. • Can also be used when Care Coordinator or Peer Support Specialist contacts an organization/agency, etc. on behalf of the participant.
Other	• Care Coordinator and/or Peer Support Specialist documents pertinent program information that does not fit another category.

Additional Documentation Considerations

- Editing Case Notes:
    - Can be edited within 24 hours of submission via the "Edit" button.
    - After 24 hours, contact the BHD Administrator for corrections.

- All portal users are required to confirm their documentation saved in the provider portal.

Care Plan

A Care Plan is a person-centered roadmap that outlines strengths, needs, and goals. It supports participants in identifying and working toward their personal objectives while enabling the Care Coordinator, Peer Support Specialist, and other team members to monitor progress and address changing needs.

The Care Plan is a living document, reviewed at least monthly, and serves as a critical tool for guiding participants toward program completion and building long-term connections to community and natural supports.

Keys to Successful Care Planning

- Approach all interactions without judgment.
- Communicate expectations clearly.
- Identify motivators important to the participant.
- Review and update monthly to remain relevant.

Common mistakes to avoid:

- Attempting to motivate through fear or unrealistic threats.
- Using false accountability or consequences.
- Relying on motivators that are not meaningful to the participant.

Motivational Interviewing is recommended for uncovering personal reasons for change. Additional resources are available at motivationalinterviewing.org.

Components of the Community Connect Care Plan

1. **Reason for Community Connect Program Participation (Reason for referral)-** What is the participant hoping to accomplish by participating in the program?
2. **Strengths/Needs**- Summarize strengths and needs identified during intake; update as circumstances change.
3. **Goal Descriptions (Long-Term Goals)**- Written in the participant's own words, connecting identified needs to what matters most to them.
    a. **Goal Outcome Domain**- Identify the most relevant outcome domain from the five available: Housing, Employment/Financial, Recovery/Social Supports, Criminal Justice Involvement, Other
    b. **Goal Status Options**- In Progress, Complete, Discontinued
        i. In Progress- participant is currently working towards successfully completing this goal
        ii. Complete- participant has completed this goal
        iii. Discontinued- participant declines to continue working towards this goal
4. **Action Steps (Short-Term Goals)-** Specific, measurable, and time-limited steps toward each objective. Track the start date and update status upon completion or change.
    a. Start Dates: Date the participant agrees to start working on the action step
    b. Completion Dates: Date the participant completes the action step identified

Care Plan Expectations and Timelines

- **Initiation** – Care Coordinator will develop the plan within ten (10) days of receiving the referral
- **Collaboration** – Care Coordinator will work with the participant, Peer Support Specialist, and any other individuals the participant chooses to involve.
- **Approach** – Care Coordinator and Peer Support Specialist will use person-centered practices and **motivational interviewing** to create both short- and long-term goals.
- **Goal Structure**:
    - **Long-Term Goals (Goal Descriptions)** – Foster hope, empower the participant, and remain focused on recovery.
    - **Short-Term Goals (Action Steps)** – Address immediate priorities, serve as stepping-stones, and focus on what is important *to* and *for* the participant.
- **Participant Voice** – Goals should reflect the participant's perspective, with direct quotes included when appropriate.

Ongoing Review and Updates

The Care Plan, including all objectives and action steps, should be reviewed by the Care Coordinator at least monthly, or as needed.

- Add new objectives and steps as needed.
- Update completed goals.
- Discontinue objectives no longer relevant to the participant's progress.

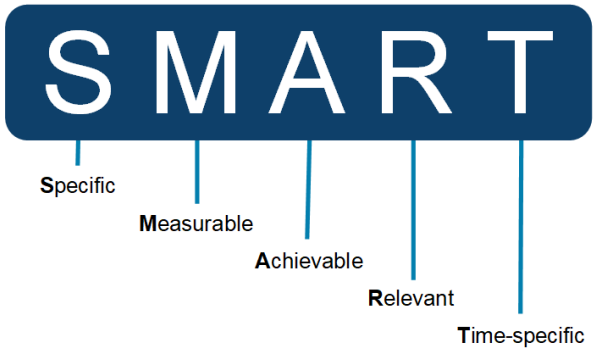
When an objective is achieved, the Care Coordinator is responsible for guiding the participant in either updating the goal or developing a new one, ensuring the plan remains relevant, motivating, and aligned with the participant's recovery journey.

NEW! SMART GOALS

In Community Connect, goals and related action steps should follow the SMART framework to ensure they are meaningful, achievable, and measurable.

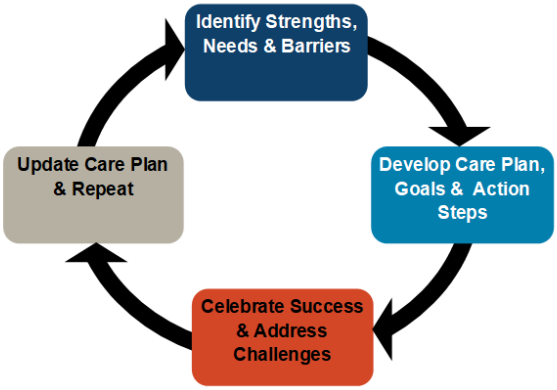
SMART Framework

- **Specific** – Clearly defined
- **Measurable** – Include objective measures of success; define the evidence that will show progress
- **Attainable** – Realistic and achievable with the resources available, while still being challenging
- **Relevant** – Aligned with the participant's short- and long-term goals and important to them personally
- **Time-Specific** – Include a realistic and ambitious end date with progress milestones



Evaluating progress on goals and action steps is essential to determine whether goals need to be adjusted, added, or removed. Reviews should also highlight participant successes and reinforce motivation.

Goals must be reviewed at least monthly with the participant to ensure they remain relevant, achievable, and aligned with their recovery journey.



Example: Bob's Goals and Action Steps

For Bob's first goal, he wants to address his lack of stable employment. This would directly correlate to the outcome area of Employment/Financial. We know from identifying his strengths, that he enjoys cooking and spending time with his dog, he is caring and wants stability in his life. He has a desire to feel accomplished.

Goal #1: *"I want to find stable employment that I enjoy."* - In Progress

Action Steps:

1. Complete Indeed job search for work involving cooking or with animals by 1/10/2026- Complete, 1/6/2026
2. Develop a list of potential jobs based on job search by 1/25/2026- In Progress, 1/15/2026
3. Apply to top 5 jobs by 2/10/2026- In Progress, 2/5/2026

Considerations:

Bob enjoys cooking, spending time with his dog, and wants stability in life. He struggles with motivation due to mental health challenges and uses alcohol to cope. Addressing these barriers will support his employment success.

For his second goal, Bob wants to address his mental health needs. This would directly correlate to the outcome area of Recovery/Social Supports.

Goal #2: *"I want to feel motivated to work on my depression without drinking*." -In Progress

Action Steps:

1. I will identify a therapist and schedule an intake appointment by 1/15/2026 – Complete, 1/1/2026
2. I will attend all individual therapy appointments as scheduled, through March 2026. - In Progress, 01/12/2026
3. I will complete an annual physical exam by 2/28/2026 to include discussion of medications for depression - In Progress, 01/12/2026

For his third goal, Bob wants to address his lack of positive support. This would be directly correlated to the outcome area of Recovery/Social Supports. We know from identifying his strengths that he wants to have social relationships, and he has a history of spending time with people who use substances which is a large factor in his substance use.

Goal #3: *"I really want to hang out with people that will not tempt me to use so I can stay out of jail."* – In Progress

Action Steps:

1. I will identify and join a local support group I am interested in by 2/28/2026 - In Progress, 2/1/2026
2. I will take my dog to the dog park two times a week through 2/28/2026. - In Progress, 2/1/2026
3. I will explore social activities in the community – InProgress 2/22/2026

Outcomes

Outcomes measure and evaluate participant progress toward, or maintenance in, four core areas: **Housing, Employment/Finances, Recovery, and Criminal Justice Involvement**. Outcomes determine payment.

Outcomes are person-centered, considering each participant's choices, circumstances, and characteristics. What is progress for one participant may not be for another.

Example:

- If a participant moves from an unstable, unsafe living situation into supportive shelter housing, the Housing outcome for that period would likely be "Yes."
- If a participant moves from stable supportive housing into a shelter due to eviction, the Housing outcome for that period would likely be "No."

Program Outcome Categories

Housing	Employment/ Finances	Recovery	Criminal Justice Involvement
Is the participant living in a safe and recovery-supportive residence?	Is the participant making progress toward or maintaining employment and/or financial stability?	Is the participant demonstrating efforts to reduce harmful substance use or improve mental health functioning?	Is the participant avoiding law enforcement contact that results in arrest, criminal charges, or probation/parole revocation?
○ Includes independent housing, living with family/friends, halfway houses, or other safe housing arrangements. ○ Progress or maintenance varies by individual needs.	○ May include job seeking, current employment, meeting basic needs through income, or participating in work alternatives such as school, training, or internships.	○ May include abstinence from non-prescribed substances, harm reduction strategies, participation in treatment or therapy, and connection to prosocial, supportive relationships.	○ Includes no serious law enforcement interactions or new arrests ○ May include compliance with supervision requirements if under state or federal probation

Outcomes Submission Requirements

- **Reporting Period:** A calendar month.
  Example: October reporting covers 10/1/25-10/31/25; The deadline for submitting documentation is November 5th.
- **Due Date:** Outcomes for each participant must be submitted between the **1st and 5th** of each month, regardless of weekends or holidays.
- **Responsible Parties:** Care Coordinators are responsible for entering participant Outcomes at the end of each reporting period.
- **Non-Compliance:** Failure to submit by the 5th of each month results in ineligibility for payment.
- **Monthly Notifications:** Providers receive an automated email on the 1st of each month listing all expected Outcomes for the previous calendar month. A second email is sent on the 5th, highlighting any outstanding Outcomes.
    - **Editing Window:** Providers can edit and correct submitted Outcomes between the 1st and 5th of each month. This window allows agencies to review submissions for accuracy before BHD review.

Example of Internal Agency Workflow: Agencies may set their own internal deadlines, for example, requiring all Outcomes to be submitted by the 3rd, followed by supervisor review and corrections between the 3rd and 5th, using the list received on the 5th.

Documentation Standards

- Outcomes must be objective, fact-based, and free from opinions, bias, assumptions, or slang.
- Comments are required for each outcome and must explain the evidence supporting a "Yes" or "No" determination.
  Example: Housing – "Has own apartment that is safe and supportive."
- Review any comments or feedback from BHD Administrators.

Participant Updates

Participant Updates are formal program change requests submitted through the provider portal to reflect a participant's current engagement and needs. Once submitted, each request will be reviewed by a BHD Administrator within five (5) business days. The BHD Administrator may contact the care team for additional information or clarification.

There are **four types** of Participant Update requests:

1. **Level of Care**: The care team, in collaboration with the participant, determines whether a change to a lower or higher level of care is appropriate based on current needs and progress.
    - Before submitting this request, refer to the section titled "Level Changes" to determine the most appropriate level of service for the participant.
2. **Program Discharge**: The care team may determine that it is appropriate for a participant to be discharged from the program. The participant should be involved in this discussion, especially in cases where the discharge type involves voluntary and/or successful completion.
    - Refer to the "Discharge Guidance" section to assess whether a program discharge is appropriate and review Types of Discharge.
3. **Provider Transfer**: A Provider Transfer request should be submitted when:
    - The participant requests to work with a different provider. In this case, the current provider must submit the request within the provider portal and follow the transfer guidance. Provider may also help participant choose a new provider and document that in the request; thus making the request process much easier and quicker.
        ** Unless otherwise approved by a BHD Administrator, the current provider must continue to provide services to participant until the transfer has been completed to avoid a gap in services.*
    - The participant relocates within the state and current provider doesn't provide services in the participant's new region.
4. **Gap Funding Exception Request**: This request is used when:
    - A participant has a financial need that cannot be met through their own resources or other community supports, and
    - The item or service needed:
        - Is not included on the Categories List, or
        - Costs more than $100, or
        - Would exceed the participant's remaining balance in that funding category.

Care teams should ensure all standard options have been explored before submitting an exception request.

Levels and Payment Guidance

Service levels are designed to deliver **person-centered care** by adjusting the frequency of services to align with each participant's goals and needs. Level movement supports participant progress, strengthens community connections, and promotes successful program completion.

All participants enter the program in level 3.

Level 3

The Care Coordinator and Peer Support Specialist should focus on building rapport, developing and implementing a care plan, assessing needs and progress, making referrals to community-based services and resources, navigating services and supports and providing cross-sector partnership and collaboration with care team members.

Meeting Standards

At **Level 3**, the participant must be **given the opportunity** to meet face-to-face with their Care Coordinator and/or Peer Support Specialist at least weekly (calendar week) **and** meet face to face with their Care Coordinator at least one time per month to:

- Work on identified care plan goals
- Build and maintain rapport
- Assess outcome areas
- Make referrals and assist with navigating community resources
- Collaborate with other providers involved in the participant's care (care team)

Level 3	During reporting period:
Performance Pay	There is case note documentation indicating the participant was **given the opportunity** to meet face-to-face with their Care Coordinator and/or Peer Support Specialist at least weekly (calendar week) **and** meet face to face with their Care Coordinator at least one time per month **Participant has 3 or more positive outcomes.**
Base Pay	There is case note documentation indicating the participant was **given the opportunity** to meet face-to-face with their Care Coordinator and/or Peer Support Specialist at least weekly (calendar week) **and** meet face to face with their Care Coordinator at least one time per month **Participant has 2 or less positive outcomes.**
Diligence	There is case note documentation indicating the participant was **given the opportunity** to meet face-to-face with their Care Coordinator and/or Peer Support Specialist at least weekly (calendar week); however, Care Coordinator did not meet face to face with the participant at least one time per month. **Outcomes were unable to be assessed by the Care Coordinator.**
Ineligible	**Provider did not fulfill meeting standards**, there is no case note documentation indicating that the participant was **given the opportunity** to meet face-to-face with their Care Coordinator and/or Peer Support Specialist at least weekly (calendar week), or the Provider did not submit outcomes.

Level 2

The Care Coordinator and Peer Support Specialist should continue working to connect the participant to long-term community-based services.

Meeting Standards

At **Level 2,** the participant must meet face-to-face with their Care Coordinator at least one time per month to:

- Work on identified care plan goals
- Build and maintain rapport
- Assess outcome areas
- Make referrals and assist with navigating community resources
- Collaborate with other providers involved in the participant's care (care team)
- The Peer Support Specialist may continue to meet and engage with the participant throughout the reporting period, however the in person, face-to-face meeting must include the Care Coordinator.

Level 2	During reporting period:
Performance Pay	There is case note documentation indicating that the Care Coordinator met face-to-face with the participant at least once during the reporting period. **Participant has 3 or more positive outcomes.**
Base Pay	There is case note documentation indicating that the Care Coordinator met face-to-face with the participant at least once during the reporting period. **Participant has 2 or less positive outcomes.** *If outcomes indicate that a higher level may be beneficial, a higher level of care should be discussed with the participant and staffed with the care team.*
Diligence	There is case note documentation indicating the Care Coordinator did not meet face-to-face with the participant at least one time per month. Documentation must indicate a minimum of two attempts to meet diligence criteria. **Outcomes were unable to be assessed by the Care Coordinator.**
Ineligible	**Provider did not fulfill meeting standards.** Documentation indicates one or less attempts were made to contact the participant, and the Care Coordinator did not meet with the participant face to face during the month. Or the Provider did not submit outcomes.

Level 1

The Care Coordinator and/or Peer Support Specialist must be accessible to the participant in order to quickly respond to changes in the participant's needs and care plan. The participant is independently maintaining services and supports.

Meeting Standards

At **Level 1,** the participant must meet with their Care Coordinator at least one time per month. This meeting is not required to be face to face and can be we-based video or phone call. Text messaging, emailing or any form of direct messaging does not meet this requirement.

During the monthly meeting the Care Coordinator should:

- Monitor continued progress or completion of identified care plan goals
- Build and maintain rapport
- Assess outcome areas, if outcomes indicate that a higher level may be beneficial, a higher level of care should be discussed with the participant and staffed with the care team.
- Assist with information on referrals to community resources, as needed
- Collaborate with other providers involved in the participant's care (care team)

Level 1	During reporting period:
Performance Pay	There is case note documentation indicating that the Care Coordinator met with the participant at least once during the reporting period. **Participant has 3 or more positive outcomes.**
Base Pay	There is case note documentation indicating that the Care Coordinator met with the participant at least once during the reporting period. **Participant has 2 or less positive outcomes.**
Diligence	Not Applicable. There is no diligence pay for level 1
Ineligible	**Provider did not fulfill meeting standards.** Documentation indicates the Care Coordinator did not meet with the participant during the month. Or the Provider did not submit outcomes.

Levels FAQ:

Web-Based or Phone Services (Level 2 and 3 only)

- All web based or phone meetings intended to replace the face-to-face meeting requirement for payment must be pre-approved by a BHD Administrator.
- BHD Administrators retain discretion to approve or disapprove web-based or phone services in place of face-to-face meetings that were not pre-approved due to unusual circumstances.

Missed Meetings

- If a scheduled meeting is missed, due to a participant's circumstances, the reason must be documented in the case note. If a participant misses a meeting or declines to meet, this must be documented in case notes.
- After sixty (60) days without documentation supporting a reason for continuing services the provider may be ineligible for payment.

Coverage Responsibilities:

- If a Care Coordinator or Peer Support Specialist has a planned/unplanned absence, the provider must have a coverage plan to meet the face-to-face meeting requirement.

Incidental Contact with Program Participant

- Incidental contact does not meet the face-to-face meeting requirement. Incidental contact is defined as contact with the participant that was not intended for a care coordination or peer support meeting in Community Connect, such as running into the participant grocery shopping.

Level Changes

- A provider may request to increase or decrease a participant’s level throughout the reporting period to align with the participant’s goals. The provider will be reimbursed at the highest level that the participant was in anytime during the reporting period, as long as documentation supports the level of care.

Level Changes

Adjusting a participant's service level ensures they receive person-centered support that matches their progress, needs, and circumstances. Level changes may be **increases** or **decreases** depending on participant outcomes, care plan goals, and barriers.

Decreasing Levels

A decrease in level should be considered when:

- The participant has demonstrated several months of positive outcomes.
- There has been progress on care plan goals.
- The participant's needs have naturally declined.

When decreasing a level:

1. **Discuss with the participant** – The conversation should be natural, positive, and focus on their progress and success.
2. **Consult with the participant's care team-** Document the discussion in the case notes.
3. **Submit the request** – Submit a Participant Update- Level Change in the provider portal.

Example conversation (Level 3 to Level 2):

"I've noticed you've continued to make progress on all your goals and have been doing really well for the past several months. I'm really impressed with the progress you have made. I'd like to begin meeting with you once a month rather than weekly. What do you think?"

Increasing Levels

An increase in level should be considered when:

- The participant's needs have increased while on Level 1 or Level 2.
- Barriers to stability have emerged (e.g., loss of housing, difficulty managing medications).

When increasing a level:

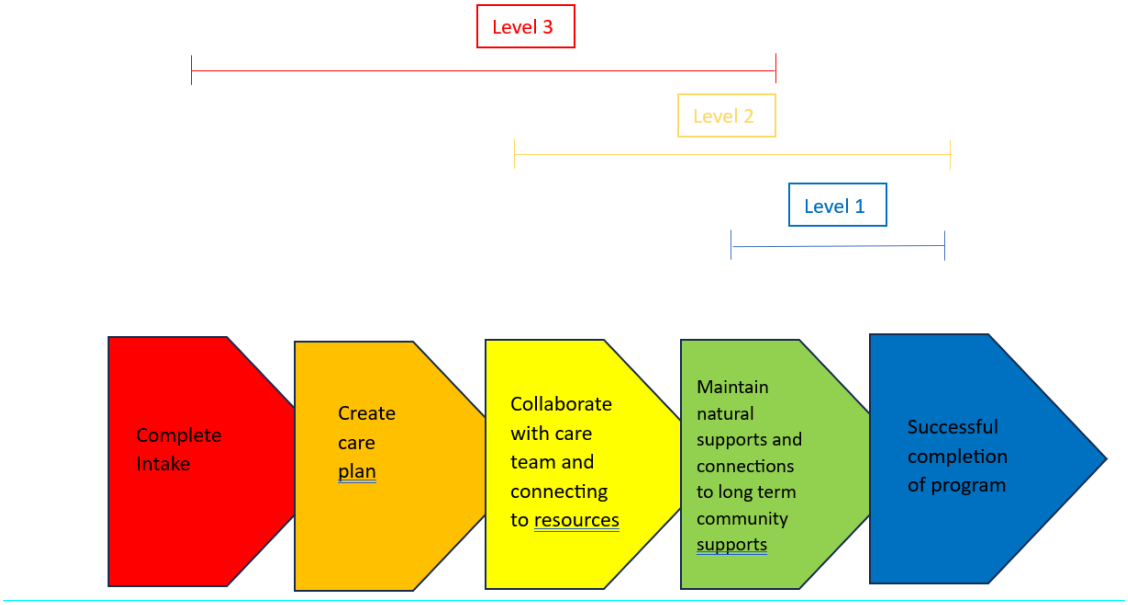
1. **Discuss with the participant** – The conversation should be supportive, strengths-based, and focused on working together to address barriers.
2. **Update the care plan** – Ensure it reflects new goals and barriers.
3. **Submit the request** – Submit a Participant Update-Level Change in the provider portal.

Example conversation:

"You have been working so hard these past couple of months and recently hit some bumps in the road. You recently lost your housing, and it has been challenging for you to take medications consistently. It's normal to experience setbacks during recovery, and I'm confident we can work together to get things back on track. I'd like to begin meeting with you again on a weekly basis."

Procedural Notes for All Level Changes

- **Care Plan Review-** Before requesting any level change, review the care plan with the participant to ensure it reflects the change in level of care and includes any new goals or barriers.
- **Special Circumstances** -If a participant is unable to meet in person according to their current level (e.g., incarceration, hospitalization, treatment), consider decreasing their level of care.



Payment

The Community Connect reporting period is a calendar month. Care Coordinators must submit outcomes for each participant by no later than the 5th of each month.

Starting on the first business day following the 5th of the month, the BHD Administrator will:

- Review case notes to confirm meeting standards were fulfilled, based on their assigned level.
- Review outcomes submitted by the provider, including any comments.
- Determine payment, justifications for payment decisions are added as comments.

Payments are made using a **pay-for-performance model**, with each Level assigned a specific payment tier. Below is the payment structure and explanation.

Provider Reimbursement Rates Per Level

Level of Service	Level 3	Level 2	Level 1
Ineligible	$0	$0	$0
Diligence	$214	$161	NA
Base Pay	$428	$214	$107
Performance Pay	$514	$300	$193

Provider Transfer

A transfer occurs when:

- A participant requests to move to another provider.
- A participant relocates within the state and needs a new provider.

Transfer Process

1. Current provider assists the participant in choosing a new provider.
2. Provider submits a Participant Update-Transfer Request in the provider portal.
3. BHD Administrator reviews the Transfer Request and completes the transfer.
4. Current Care Coordinator continues providing services until the transfer is complete.
5. Provider cannot discharge or transfer a participant so they can be hired by the provider.

Provider Responsibilities Before Transfer

- Update all case notes before the transfer is finalized.
- Submit outcomes for last month of service.

New Provider Responsibilities After Transfer

- The new provider will outreach the participant within three (3) business days
- The new provider will create a new Care Plan within ten (10) days.
- The new provider will obtain the necessary Authorization to Disclose Information forms to ensure continuity of care.

Gap Funding

- The 12-month gap funding period is based on the participant's original program start date (does not reset upon transfer).

Discharge Guidance

When to Talk About Discharge

- Discharge planning starts at intake.
- Participants should know what successful completion looks like for them.
- Discuss discharge during Care Plan creation and monthly goal reviews.

    Example question to ask early: "What does success look like for you, and how will we know when you're ready to complete the program?"

Loss of Engagement

When a participant stops meeting with the Care Coordinator and/or Peer Support Specialist despite repeated contact attempts, the provider must staff with agency supervisor and/or care team to develop engagement strategies.

- **After 30 days of no contact**: Care Coordinator must staff with supervisor and/or care team to discuss engagement strategies.
- **After 60 days of no contact**: Care Coordinator must submit a Participant Update-Discharge request in the Provider Portal.

Program Length

- No set time limit, length depends on each participant's needs.
- Providers must assess monthly whether the program is still appropriate for the participant.

When to Discharge Successfully

Consider discharge if:

- The participant has had several months of positive outcomes.
- All Care Plan goals are met or supports are in place to continue progress.
- Needs have naturally declined through level decrease.
- The participant has built recovery supports and natural/community connections.
- The participant has other services and supports in place to continue progress and meet their needs**.**

Always consider participant choice when considering discharge.

Example conversation: "You've made great progress on your goals for several months. Let's talk about completing the program and what that timeline looks like."

Provider Responsibilities in Discharge

- Document discharge planning discussions in case notes.
- Help connect participants to community resources and supports before discharge.
- Make sure participants know about additional resources and services in the community, if they may need them in the future.
- All participants are engaged in this program voluntarily; therefore, a participant may choose to opt out of services at any time.
- Provider cannot discharge or transfer a participant so they can be hired by the provider.

Requesting a Discharge

- Once discharge is agreed upon, the Care Coordinator submits a Participant Update- Discharge request via the provider portal.
- Enter Discharge Reason
- Enter Participant Last Day of Care (including staffings, collateral contacts, etc.).
    - A BHD Administrator will review and either approve, deny, or request more information. The submitter will be notified of the decision.
- Care Coordinator submits outcomes for final reporting period.

Types of Discharge

1. **Individual stopped participating/no contact**- Participant has stopped communicating with provider. If after 60 days the participant still has not re-engaged, despite attempts made by the Care Coordinator or Peer Support Specialist, this category type may be used.
2. **Participant no longer wants services**- Participant has indicated that they no longer desire services.
3. **Participant completed program**- Participant is no longer in need of services and has long-term services established in the community. (*See 'When to Discharge Successfully' under Discharge Guidance.)*
4. **Participant moved out of ND**- Participant has moved out of the state of North Dakota.
5. **Participant has been or will be incarcerated for over 60 days**- Participant will be or has been incarcerated for over 60 days. Contact BHD Administrator for further information if unsure.
6. **Adverse program termination**- Participant is discharged for reasons such as death, inappropriate or dangerous behavior towards provider, etc. Contact BHD Administrator for further information if unsure.
7. **Unable to initiate participant engagement**- Care Coordinator and/or Peer Support were unable to complete a face-to-face meeting within the first month following referral acceptance.
8. **Duplication of Services (participant is also in Free Through Recovery program)**- Participant is also in the Free Through Recovery program and will remain in that program.

Gap Funding Guidance

What is Gap Funding

Gap funding is designed to help participants overcome financial barriers that prevent them from meeting their outcomes and goals, after all other resources and funding options have been exhausted in the community.

What is the purpose of gap funding?

- To fill a “gap” when all community resources/funding have been exhausted.
- Community Connect is **not** a monthly or ongoing financial assistance program.

Provider Expectations

- Each provider must follow their own internal process that aligns with this guidance.
- Internal processes may include steps specific to the agency. Consult your provider’s administration for details.

Gap Funding Categories

The Gap Funding Categories List is a list of approved categories and items that a participant may utilize gap funding for without pre-approval.

Purchases requiring prior approval that are made before approval will be denied for reimbursement.

Housing (Requests are limited to $100 per 12-month period)	**ELIGIBLE**: • Rental application fees • Security deposit • Emergency overnight sheltering • Rent assistance • Required Documentation: • Copy of application, lease, or itemized bill/proof of cost including the participant's name. • Itemized receipts for hotel stays showing all charges. **NOTES**: • Housing-related background checks must be submitted to the Gap Funding Committee for review.
Transportation (Requests are limited to $100 per 12-month period)	**ELIGIBLE**: • Gas *(receipt from pump purchase required — no gas card reimbursement)* • Bike and bike lock • Bus fare/replacement bus pass • Uber, Lyft, or taxi (excluding tips or donations) • Driver's license, state or tribal ID fees **NOTES**: • Transportation expenses for Care Coordinators or Peer Support Specialists are not included. • Uber Eats gift cards will not be approved. • Registration and reinstatement fees are not included; submit to the Gap Committee for review.
Employment (Requests are limited to $100 per 12-month period)	**ELIGIBLE**: • Work-related attire (boots, shoes, uniforms, black pants, or clothing required by employer) • Tools or supplies necessary to gain or sustain employment **NOTES**: • Employment-related background checks must be submitted to the Gap Committee for review.
Education (Requests are limited to $100 per 12-month period)	**ELIGIBLE**: • Application fees

Basic Needs (Requests are limited to $100 per 12-month period)	**ELIGIBLE**: • Toilet paper • Toothpaste, toothbrush • Shampoo, conditioner, soap • Deodorant • Feminine hygiene products • Razor, shaving cream • Band-aids/first aid supplies • Socks, underwear • Laundry supplies: detergent • Bedding: sheets, pillow, blanket, mattress, air mattress, cot • Bath towels: body towels, hand towels • Cleaning supplies: cloth rag, sponge, disinfectant, broom/dustpan • Winter/cold weather clothing: jacket, hat, mittens/gloves, boots • Over-the-counter pain relievers: Tylenol, Advil, Ibuprofen, etc. • Prenatal vitamins • Fees for ordering a birth certificate
Communication (Requests are limited to $100 per 12-month period)	**ELIGIBLE**: • Cell phone *(participant use only)* • Cell phone minutes/cards *(including while participant is incarcerated to contact CC or PSS)*
Clinical Services (Requests are limited to $100 per 12-month period)	**ELIGIBLE**: • One clinical assessment per year when other funding opportunities are exhausted • May not be used to fulfill criminal sanctions/court orders **NOTES**: • Does not include medical exams/visits, eye exams, or dental exams.
Family (Requests are limited to $100 per 12-month period)	**ELIGIBLE**: • Car seat • Diapers • Wet wipes • Bottles • Crib/child's bed • Child's clothes and/or shoes • Child's birth certificate or social security card • Bus fare for minor child

**A participant's 12-month period starts when they are referred to the program, this resets after 12 months and a new 12-month period starts. It is the responsibility of the provider to track and verify that the request falls within the number of requests allowed yearly.

Gap Funding Process

Step 1: Determine the Need

1. Identify if a financial obstacle is preventing the participant from reaching their goals.
2. The Care Coordinator/Peer Support Specialist must:
    a. Explore all other funding options and community resources.
    b. Assist the participant in accessing community referrals.
    c. Determine if the participant can cover part of the cost.
    d. Use gap funding only after all other options are exhausted.
3. If the expense is recurring, work with the participant to create a future payment plan.

Step 2: Determine the Type

1. Requests Not Requiring Prior Approval
    - Expense is on the Gap Funding Category list and
    - Total cost is less than $100 and
    - Participant has remaining funds in the category.
      (Limit: $100 per category per participant per 12-month period.)

2. Requests Requiring Prior Approval
    - Not on the Gap Funding Category list, or
    - On the list but cost exceeds $100, or
    - Participant has no remaining funds in that category.

3. Process for requesting Prior Approval:
    - Submit a Participant Update- Gap Funding Exception request in the Provider Portal to include:
        - Updated participant budget including all income, expenses and total remaining balance
        - Denial letters from community resources
        - Proof of cost of the item
        - Copy of lease if request is rent-related
        - Future payment plan (if recurring)
    - If all the information listed above is not submitted in its entirety, the request will be denied. Provider may re-submit when all documentation is obtained.
    - Allow at least one week for a decision or request for more information.
    - If approved, make the purchase according to the provider's policies.
        - Itemized receipt should include only gap funding items.

Step 3: Reimbursement

1. Submit the Gap Funding Invoice in the Provider Portal by the 15th of each month. Gap Funding Invoice must include the following attachments:
    - Valid receipt for service which includes:
        - Vendor name
        - Date of purchase
        - Itemization
        - Participant name or CC number (may be handwritten when appropriate)
        - Total amount

    Itemized receipt should include only gap funding items.

2. Requests will be denied or adjusted if:
    - Items are not on the Gap Funding Category list.
    - Purchase exceeded available participant funds.
    - Gap Funding Exception Request was denied, or purchase was made before the request was submitted to the committee for review.
    - Incomplete requests submitted (e.g. missing receipts or missing other required information)
    - Late reimbursement submissions or resubmissions

3. **Deadlines:** All reimbursements must be submitted by the 15th of month following the purchase. *Example: Purchases made in July must be submitted by August 15th, purchases made in August must be submitted by September 15th and so on.*
    - If required information isn't provided in the initial submission (e.g., non-itemized hotel receipt or missing receipt), that month's reimbursement will be adjusted accordingly, and the provider will be notified.
        - Providers may resubmit the reimbursement request with all required information by the 15th of the following month.
            - A re-submission that does not include all required documentation will be denied; there is no additional opportunity for resubmission.
    - Late reimbursement submissions or resubmissions will be denied.

    Example: A provider submits a reimbursement request for a July hotel stay by August 15th. The reimbursement request is missing an itemized hotel receipt. The provider will be notified by the BHD Administrator, and they have an opportunity to resubmit a reimbursement request by no later than September 15. This resubmission of the reimbursement request MUST include all required documentation. If any of this documentation is missing after the re-submission, the provider will not have an opportunity to resubmit again.

Receipt or Proof of Purchase Requirements

All receipts/proof of purchase must include:

- Date of purchase, and
- Amount, and
- Vendor name, and
- Itemization, and
- Participant name or CC number

If item descriptions are missing (e.g., Walmart receipts): Write a brief description of each item directly on the receipt, along with the participant's name or CC number.

Recurring bills (e.g., electric, cell phone, etc.): Include the statement/invoice showing participant's name and address; Provide payment confirmation.

Hotel stays: Include the hotel folio or itemized receipt showing all charges for each day; Hotel confirmations are not receipts and will be denied.

Gap Funding and Participant Transfers

The **new provider** is responsible for reviewing the funding history before using gap funding.

Note: The 12-month funding period is based on the participant's original program start date (does not reset upon transfer).

Gap Funding FAQs

Can it be used for someone else in the participant's household?

- **Yes.** Only if the other person is a dependent and/or child(ren) under the care of the participant.

Can it help with moving into a home?

- **Yes,** for application fees or deposits.
- **No** for moving truck or mover expenses.

Can it pay court-ordered fines or fees?

- **No.**

How long does a request take?

- The Gap Committee meets weekly.
- Missing documentation or incomplete request forms delay decisions.
- All requests must include:
    - Updated budget (all income, expenses and remaining balance).
    - Plan for covering recurring expenses in the future.

Does every Community Connect participant automatically get gap funding?

- **No.** Must meet criteria and exhaust other resources first. Community Connect is not meant to be a financial assistance type program that provides ongoing/monthly assistance.

If housing assistance ends, can gap funding pay rent?

- **Possibly** — must show how financial/housing goals were addressed before assistance ended and outline a forward plan.

Can gap funding pay overdue bills or monthly bills the participant can't afford?

- **Recurring bills** (cell phone, electric, storage, PO box) require Gap Committee review.

Can it pay for eye exams, glasses, or dental expenses?

- **Not in approved categories** — must be submitted to the committee for review.

Can it pay for prescription medications?

- **Not in approved categories** — must be submitted to the committee for review

What is a budget and why is it important?

- A budget is required when submitting an exception request and it serves as a valuable tool for managing income and expenses, ensuring that bills are covered. A budget is essential for planning purchases and making informed financial decisions. Supporting a participant with financial planning is the responsibility of the Care Coordinator and Peer Support and should be addressed proactively by the care team rather than waiting until a financial crisis occurs.

Glossary of Terms and Abbreviations

Authorization to Disclose Information form
A form that gives permission for a participant's private information- usually medical or personal records- to be shared with another person or organization.

Behavioral Health Division (BHD)
The North Dakota Department of Health and Human Services' Behavioral Health Division provides leadership for the planning, development, and oversight of the state's behavioral health system.

Best Practice
A method or practice that has shown to be most effective.

BHD Administrator
Employee of the Behavioral Health Division (BHD) supporting the Community Connect program by delivering technical assistance, training, regional leadership/collaboration, and reconciliation of monthly outcomes for providers.

Care Coordinator (CC)
Provides a source of connection and support for Community Connect participants as well as assisting participants with achieving motivation for long- and short- term goals while creatively problem-solving barriers. Serves as part of the care team.

Case Notes
Notes entered in the Provider Portal to record all interaction (actual & attempted) and other "work" done on behalf of a participant.

Community Connect
Community Connect is a community-based behavioral health program designed to assist participants with meeting their needs and goals through the provision of care coordination, recovery services and peer support services.

Community Connect Lead Administrator
Oversees the Community Connect program statewide and is the BHD Administrator's supervisor. This position assists with provider reviews and provides training and technical assistance.

Evidence Based Practices
Any practice that relies on scientific evidence for guidance and decision making.

Gap Funding
Available funding for participants to utilize with the assistance of their Care Coordinator or Peer Support Specialist to help fill gaps where other community resources are unavailable.

Outcomes
Identify participant results in the areas of housing, employment, recovery supports, and criminal justice involvement.

Peer Support Specialist (PSS)
An individual who uses their lived experience and skills learned through formal training to deliver services to promote mind-body recovery and resiliency, as well as serves as part of the care team.

Provider
The organization or agency that enters into an agreement with BHD to provide services to Community Connect participants.

Provider Agreement (PA)
The agreement and clarification of responsibilities between BHD and the provider.

Provider Portal
Online documentation system used for care plans, documentation, outcomes, participant identifying information, application, etc.

Reconciling
The process of vetting participant's outcomes and determining payment to the provider.

Reporting Period
A calendar month; starts on the 1st of the month and ends on the last day of the month.

Staffing
Refers to care team members discussing participant services or situations. It is an essential part of the program, providing an opportunity for collaboration among the entire care team to best support participant needs.

Weekly Services/Meetings
Based on a calendar week