

**2009-2011 Service Standards  
Waves 1-5  
(October, 2010)**

**General Revisions/Clarifications:**

<b>Service Standard</b>	<b>Revision/Clarification</b>
Chafee IL-Chafee Foster Care Independence Program	Billable Units Revised
Chafee IL-Transitional Services	Billable Units Established
Care Network	<p><b><u>Flexible Funding:</u></b></p> <p>There must be a documented need for the goods and/or services. Documentation of expenditure of funds must be maintained by the agency.</p> <p>If under \$500-either it be a part of the case plan or approval of the FCM Supervisor for the expense.</p> <p>If over \$500 – prior approval is mandatory from the Local Office Director or their designee.</p>
Child Advocacy Center	<p>Qualifications:</p> <ul style="list-style-type: none"> <li>• <b>Forensic Interviewer:</b> Bachelor’s Degree in social work, psychology, criminal justice, education or a related field or a Master’s Degree in Social Work or Forensic Science. A minimum of two (2) years of professional experience working with children and families where abuse and violence are identified issues is required. Requires professional experience in working with the criminal justice or child welfare system and has been or will be trained in a Forensic Interview technique.</li> <li>• <b>For a start-up Child Advocacy Center, the qualifications for the Forensic Interviewer are:</b> Bachelor’s Degree in social work, psychology,</li> </ul>

	<p>criminal justice, education or a related field or a Master’s Degree in Social Work or Forensic Science. A minimum of two (2) years of professional experience working with children and families where abuse and violence are identified issues is required. Requires professional experience in working with the criminal justice or child welfare system and has been or will be trained in a Forensic Interview technique before the contract period.</p>
<p>Diagnostic and Evaluation Services</p>	<p><b>Face to Face Time with the Client:</b> (Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)</p> <ul style="list-style-type: none"> <li>• Includes client specific face-to-face contact with the identified client/family during which services are defined in the applicable Service Standard are performed.</li> <li>• Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client family.</li> </ul> <p>Reminder: Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are built into the cost of the face to face rate and shall not be billed separately.</p>
<p>Domestic Violence, Home-Based Intensive Family Preservation Services, Home-Based Intensive Unification Services and Home-Based Family Centered Casework Services</p>	<p><b>Concrete Funds</b> -there must be a documented need for the goods and/or services. <b>Prior written approval is mandatory from the Local Office Director or their designee.</b> Documentation of expenditure of funds</p>

	must be maintained by the agency.
Home-Based Intensive Family Preservation Services, Home-Based Intensive Unification Services and Home-Based Family Centered Casework Services, Home-Based Family Centered Therapy Services	Generally added fidelity measures.
Home-Based Intensive Family Preservation Services, Home-Based Intensive Unification Services	<ul style="list-style-type: none"> <li>• Change maximum length of services from 28 days to 4-6 weeks</li> <li>• Change qualification of Supervisor to include Masters with experience (see Service Standards for details)</li> </ul>
Parenting/Family Functioning Assessment	<p>Billable Units:</p> <p>The hourly rate includes face to face contact with the identified client/family members and professional time involved in scoring testing instruments and preparing the assessment report.</p>
Substance Abuse Assessment, Treatment and Monitoring	<p>Minimum Qualifications:</p> <p>1) Revised licensure to read "...whose program is certified by the Division of Mental Health Administration..."</p> <p>2) Added to: "An alcohol and drug abuse counselor certified "by the Indiana Counselors Association on Alcohol or by the Drug Abuse (ICAADA), or by the Indiana Association for Addiction Professionals (IAAP)..."</p>
<p><b>Supervision</b>-all Service Standards-current language:</p> <p>"Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks."</p>	<p>In those instances where Face to Face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks <b>is not possible</b>, supervision may be allowed via web-cams located at the providers' site.</p>

**SERVICE STANDARDS  
WAVES 1-5  
(October 2010)**

**Rates Reflect 1/1/2010 10% Rate Reduction**

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**ADOPTION  
SERVICE  
STANDARDS**

**SERVICE STANDARD  
INDIANA DEPARTMENT OF CHILD SERVICES  
ADOPTION - CHILD PREPARATION**

**I. Service Description**

This preparation is to assist the local Department of Child Services (DCS) in assessing the adoption readiness of children in the custody of the State of Indiana. Upon assessment, the contractor will work to prepare the children for adoption. The child should be counseled about what adoption will mean to them, and make it clear that an adoptive family is a permanent family. This explanation also necessitates the painful realization that the biological family ties may be severed prior to the adoption.

Preparation of children or adolescents for adoptive placement may include but is not be limited to the following areas:

- 1) reconstruction and interpretation of child's history
- 2) weaving together the child's background so they understand their own unique life experience
- 3) grief and loss issues with biological and foster families (and others)
- 4) loyalty issues
- 5) what adoption means
- 6) listening to an adoptive child speak of their experience and feelings
- 7) sharing of feelings
- 8) knowing the difference between adoption and foster care

**Supportive Services**

Offering supportive services to the child and current care takers to help the child transition from a foster home to an adoptive placement. These services can be done in the foster home, in individual sessions or in group sessions.

Every child referred for child preparation services will begin a Lifebook or continue working on an existing Lifebook. The Lifebook is a means of documenting the child's life to date and is created for and with the child with the assistance of the child's case manager, therapist, foster parent, CASA, and/or other individual in the child's life. It is designed to capture memories and provide a chance to recall people and events in the child's life to allow a sense of continuity. The Lifebook also serves as a focal point to explore painful issues with the child that need to be resolved.

**II. Target Population**

- 1) Children who are free for adoption.
- 2) Children who have a permanency plan of adoption.

- 3) Children who have termination of parental rights initiated with an expected plan of adoption.

### **III. Goals and Outcome Measures**

#### **Goal #1**

Ensure that children in Indiana's custody are adequately prepared for adoption.

#### **Outcome Measures**

- 1) 100% of children referred for child preparation will complete an initial assessment which is to include a service plan within 30 days of the referral
- 2) 100% of children will have initiated a Lifebook within 60 days of the referral.
- 3) 100% of the local DCS offices referring a child for adoption preparation will receive written monthly reports and a discharge report within 15 days of the completion of the service.

#### **Goal #2**

Increase the child's understanding of adoption.

#### **Outcome Measures**

- 1) 90% of the children prepared over the age of 4 will verbalize their understanding and
- 2) acceptance of the adoption process.
- 3) 95% of the children prepared ages 4 to 10 will be able to draw a version of an
- 4) adopted family.
- 5) 95% of the children prepared over the age 10 will describe their ideal adoptive family.
- 6) 100% of the children prepared will have a Lifebook completed with their input.

#### **Goal #3**

Successful transition for the child and family to increase the probability of a successful adoption.

#### **Outcome Measures**

- 1). 90% of the children prepared will move into an adoptive home
- 2.) 95% of adoptions will be finalized within one year of placement.

#### **Goal #4**

DCS and child satisfaction with services

#### **Outcome Measure**

- 1.) 95% of children over the age of 10 will indicate comfort with the adoption process to the county through a satisfaction survey.
- 2.) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.

#### **IV. Qualifications**

**Direct Worker:**

Bachelor's degree in social work, psychology, sociology, or a directly related human service field.

**Supervisor:**

Master's degree in social work, psychology, or directly related human services field.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

In addition the worker must have:

- Knowledge of family of origin/intergenerational issues and child development.
- Knowledge of separation and loss issues
- Knowledge of child abuse/ child neglect and how these impact behavior and development.
- Knowledge of community resources, especially adoption friendly services in the communities families reside.
- Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
- Services must demonstrate respect for sociocultural values, personal goals, life style choices, and complex family interactions and be delivered in a culturally competent fashion.

#### **V. Billable Units**

**Hourly rate up to 24 hours (*additional hours must be approved by the referring DCS*):**  
**The hourly rate includes face to face contact with the identified client, collateral contacts, participation in the regional adoption team meeting and State SNAP Council meetings and professional time involved preparing the assessment report. This also includes support and matching services provided on behalf of the child which includes review of the child's case file; preparation for contacts; preparation of life book; transporting the child to various places of interest related to the child's past and time in foster care while in the provision of services; taking pictures as important to the child to reconstruct a timeline related to placements, people, pets, place of birth, etc.**

**The hourly rate requires participation in the regional adoption team meetings and State SNAP Council meetings either in person or by telephone. Mileage should not exceed the State rate of \$.40.**

**For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.**

**Translation or sign language:**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

**VI. Rates**

Hourly Maximum rate: \$31.50 (1/1/2010)

Translation or sign language rate: Actual cost

**VII. Case Record Documentation**

- 1) A completed, dated, signed DCS referral form authorizing service
- 2) Documentation of contacts with the child and activities related to the preparation with the child.
- 3) Documentation of the child preparation includes dates of sessions provided to the child and the material presented at each session.

**VIII. Service Access**

Services must be accessed through a completed, signed and dated DCS referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

***NOTE: All services must be pre-approved through a referral form from the referring DCS or a SNAP Specialist.***

**SERVICE STANDARD  
INDIANA DEPARTMENT OF CHILD SERVICES  
FAMILY PREPARATION**

**I. Service Description**

Preparation of the foster/adoptive/kinship home study for prospective families should follow the outline provided by the referring DCS from the State Child Welfare Manual. Providers should collect information, evaluate the family and home, then make a recommendation as to the ability of the prospective foster/adoptive/kinship parent(s) to meet the needs of children in Indiana's custody as a result of abuse or neglect. The assessment criteria must include but not be limited to the following areas:

- 1) Specific child(ren) to be placed in the home, if kinship preparation or completed for a specific child or children.
- 2) Specific child(ren) listed in the "Opening Hearts Changing Lives" Picture Book for children who wait for adoption and children who are listed as legal risk on the adoption website.
- 3) Child Behavior Challenges Checklist
- 4) Reference forms completed by four (4) of which one (1) may be a relative
- 5) Financial profile
- 6) Medical Report for Foster Care/Adoption
- 7) Application for Foster Family/Adoptive/Approved Relative Home
- 8) Background check for persons age 14 to 17:
  - State Limited Criminal History Check
  - Indiana State Juvenile History
  - Sex and Violent Offender Registry
  - Child Protection Services History (CCI)
  - Local law enforcement agencies (LEA) county sheriff records.
- 9) Background check for persons age 18 and older:
  - Fingerprint-based National Criminal History (includes Indiana State Juvenile History and fingerprint-based Indiana State Criminal History check)
  - Sex and Violent Offender Registry for Indiana and for every state in which the individual is known to have resided for the past five (5) years.
  - **Child Protection Services History-CPS records for all other states in which all individuals is known to have resided for the past five (5) years.(NOTE: or Indiana records, licensed child placing agencies (LCPAs) are unable to access this information and will need to send a copy of the Request for**
  - Child Protection Service (CPS) History Checks form to the local DCS office to obtain results.  
Local police/sheriff records and for every county/state in which the individual is known to have resided for the past (5) years.
- 10) Consent to Release Information for Foster Family Home License or Adoption
- 11) Outline for Adoption/Foster Family Preparation

Summary

The Child Welfare Manual is available at <http://www.in.gov/dcs/2413.htm>.

### **Family Assessment**

The Family Assessment Process includes the initial contact with a family, the application, several home visits at convenient times for the parent including evenings, weekends if necessary. The process includes compiling and sending out as well as processing the family's references, medical information forms, financial forms and all other necessary state forms. It also includes the family genograms, eco-map, and preparing other members of the family or household who will affect the success of an adoption because of their relationship to the family, such as a live-in grandparent or a relative who is always there during the day etc. Also included is using the challenges checklist as a learning tool to review common challenges the children have with the family and to gauge their degree of acceptance and to help the family self-evaluate to determine how this will impact them now and in the future and if special needs adoption is for them. The contractor also assists the family with pre-placement family support services as well as serving as advocate for the family throughout the adoption process and assist with matching.

The Family Preparation should include the family's feelings about adoption and experiences with parenting as well as pertinent issues specific to adoption. Preparation should also prepare adoptive parents in understanding the commitment they are making to provide a permanent home for the child or children they will be including in their family whether young children, adolescents, or sibling groups. The contractor will engage in a dialogue with family members, providing information on all aspects of child abuse and neglect, typical resulting behaviors, common characteristics of children in the system and assist the family in planning and foreseeing what is needed for their own specific successful parenting of these children. The contractor will explore with the family the types of children that they feel able to parent and the specific special needs that they can work with. The contractor will also make a recommendation about the family's ability to meet the needs of children in Indiana's custody. The assessment criteria must include but not be limited to specific children to be placed in the home, if a kinship preparation or one done for a specific child or children, and specific children listed on Indiana's website, who wait for adoption.

### **Foster and Kinship Care Families**

When the family preparation is complete, the contractor will provide a copy of the family preparation to the Department of Child Services (DCS) in the family's county of residence and/or the DCS with custody of child(ren) to be placed with the newly prepared family.

### **Foster/Adopt Families and Pre-Adoptive Families**

When the family preparation is complete, the contractor will share with the family a copy of the proposed summary and add the family's comments to the summary document and submit the entire case file to the referring DCS. The contractor will also provide a copy to the Regional Special Needs Adoption Program (SNAP) Specialist for the county of residence. The contractor will then present the family preparation at the adoption team meeting held in the region of the family's residence. The regional adoption team will recommend if the family is appropriate for consideration to adopt a special needs child. Families will be added to the Sharepoint website of approved families and their information will be shared with the other SNAP Specialists and contractors. An agency representative should also be

presenting the family at SNAP Council in Indianapolis. The Contractor will attend the regional adoption team meetings on a regular basis to hear updates on policy, and to hear presentations of available children that could be an appropriate match for their family.

The contractor may accompany the selected family to interview(s) for a specific child(ren) to offer support and feedback on the appropriateness of that particular child's placement in their family.

- Family assessment services must be completed within 60 days of receipt of the referral or within a time frame specified by the DCS at the time of referral.
- Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
- Services must demonstrate respect for socio-cultural values, personal goals, life style choices, and complex family interactions and be delivered in a culturally competent fashion.
- Services will be arranged at the convenience of the family and to meet the specific needs of the family.

## **II. Target Population**

- 1) Families who have successfully passed a criminal history check, FBI fingerprint check and successfully completed the Pre-Service Foster/Adoption/Kinship Parents/Caregiver Training, including Permanency training.
- 2) Families who are willing to parent a child or a sibling group of children, in Indiana's custody, who have been neglected and/or abused and are 2 to 18 years of age and/or have serious medical, emotional, developmental and behavioral challenges.
- 3) Families for who adoptive home update studies have been requested by the DCS.
- 4) ICPC requests for studies of Indiana families as potential placement for relative children from other states.

## **III. Goals and Outcome measures**

### **Goal#1**

Provide adoption home studies for families interested in adopting special needs children in a timely manner.

#### **Outcome Measures**

- 1) 95% of families referred will have their home study completed within 60 days of the referral.
- 2) 100% of home studies will be provided to the referring DCS within 14 days after the family is approved by the Regional and receipt of requested information.
- 3) 95% of families, who are approved by Regional SNAP Teams, will not need additional work done or will have the recommended additions or changes completed within 30 days as recommended by the Team.

### **Goal #2**

Ensure that the local DCS and SNAP are aware of each prepared and waiting family

#### **Outcome Measures**

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- 1) 95% of families completed home studies will be sent to SNAP Regional Teams for approval within 30 days of the completion of the home study.
- 2) 100% of prepared adoptive families will be presented at SNAP Regional Teams for approval.

#### Goal #3

Increase the number of adoptions of children.

##### Outcome Measures

- 1) 95% of families prepared for adoption will have an understanding of the special needs of a child(ren) that is being blended into their family through adoptive placement.
- 2) 75% of families will be supported through collaboration with the provider and DCS through the adoption finalization process within a year.

#### Goal #4

DCS and family awareness of available services

##### Outcome Measure

- 1) 95% of families will indicate comfort with the adoption process to the county.
- 2) 100% of families will be made aware of post adoptive services available to them, including respite care, support groups, newsletter etc.
- 3) DCS satisfaction will be rated level 4 and above on the Service Satisfaction Report.

### IV. Qualifications

#### **Direct Worker:**

Bachelor's degree in social work, psychology, sociology, or a directly related human service field and three years experience in Adoption.

#### **Supervisor:**

Master's degree in social work, psychology, or directly related human services field.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

In addition to:

- Knowledge of family of origin/intergenerational issues
- Separation and loss issues

- Knowledge of adoption specific issues and the needed characteristics for families to parent these children differently
- Knowledge of child abuse/ child neglect and how these impact behavior and development.
- Knowledge of community resources, especially adoption friendly services in the communities where families reside.

## V. Billable Units

**Hourly rate up to 12 hours (*additional hours must be approved by the referring DCS*):**

**The hourly rate includes face to face contact with the identified client/family members and professional time involved preparing the assessment report. Includes collateral support and matching services provided on behalf of the adoptive family which includes preparation for contacts, case conferencing, follow up with the family, SNAP Team presentation and SNAP Regional Council appearances and mileage not to exceed the State rate of \$.40.**

**Hourly rate (*up to 4 hours for adoptive home study updates and additional hours must be approved by the referring DCS*):**

**Includes face to face contact with the identified clients during which services as defined in the service standard are performed. Collateral contacts, travel time, mileage not to exceed the State rate of \$.40, scheduling of appointments, and report writing are included in this billable unit.**

**Contractors will be paid for their work without regard to approval or denial of the family preparation.**

**For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.**

### **Translation or sign language**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

## VI. Rates

Hourly Maximum rate: \$45.45 (1/1/2010)

Translation or sign language rate: Actual cost

## **VII. Case Record Documentation**

- 1) Documentation of contacts regarding foster parent interest in adopting children in their care or other children available.
- 2) Documentation of all contacts regarding adoptive families and a record of services provided to them with goals and objectives of the services and dates of service.
- 3) Documentation includes written home studies for all prospective families following the outline in the Child Welfare Manual.

## **VIII. Service Access**

Services must be accessed through a DCS referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

***NOTE: All services must be pre-approved through a referral form from the referring DCS FCM or DCS Service Consultant.***

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**PRE / POST PLACEMENT AND POST ADOPTION SERVICES**

**I. Service Description**

**Respite care for adoptive families**

Is to be provided in a licensed foster home. The child's family will supply their respite providers with emergency and back up emergency phone numbers, medical information, medications, behavioral, educational, nutritional information and clothing. The maximum number of respite care days per year is 30. The contractor will provide the county Department of Child Services (DCS) and the family a written report summarizing activities in which the child participated and behaviors the child (ren) exhibited during their respite stay.

**Home-based services**

Includes face to face individual and/or group counseling, written monthly progress reports, court testimony if required, and travel time. Mileage is included in the hourly rate.

**Support group services**

Should be provided no less than monthly and may be provided as often as weekly. These groups may serve families who provide foster/ kinship care, waiting adoptive families, families who have adopted, children who are in the adoption process and/or children who have been adopted. The support group leader will record the topic(s) of discussion and keep a sign in sheet for each support group.

**II. Target Population**

Home-based and office-based services, including Reactive Attachment Disorder (RAD) support, support group services, and respite care are to be provided to the following:

- 1) Families and their foster/kinship children who are in the custody of the State of Indiana.
- 2) Families and their pre-adoptive children who are in the custody of the State of Indiana.
- 3) Families and their adoptive children who were formerly in the custody of the State of Indiana.
- 4) Families and their adoptive children who were formerly in the custody of another State or adopted from a foreign country and now reside in Indiana. Families must provide a copy of their adoption decrees etc. and proof of the relationship with the other state (ICPC) or country (International Adoption).
- 5) Other adoptive families and their adoptive children. Families must provide a copy of their adoption decrees etc.

**III. Goals and Outcome Measures**

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#### Goal #1

Timely and ongoing intervention with family and referring case manager

##### Outcome Measures

- 1) 95% of all families that are referred will have face-to-face contact with the client within 10 days of the referral.
- 2) 95% of families will have a written service plan prepared and sent to the referring worker following receipt of the referral within 30 days of contact with the client.
- 3) 95% of all families will have quarterly written summary reports prepared and sent to the referring worker.

#### Goal #2

Minimize the number of disrupted foster/kinship/ pre-adoptive placements and adoption dissolutions.

##### Outcome Measure

- 1) 95% of pre/post adoptive parents will participate in supportive services that are recommended and available.
- 2) 95% of families and children requiring supportive services will maintain their pre-adoptive placement in a safe, family environment.

#### Goal #3

Educate and support adoptive parents on issues related to attachment, loyalty, grief, loss, separation, loyalty, claiming and entitlement of children who are adopted.

##### Outcome Measure

- 1) 100% of adoptive families requesting services will attend and participate in support group services.

#### Goal #4

DCS and family satisfaction with services

##### Outcome Measure

- 1) A satisfaction level of 4 and above should be the expected rate on the DCS Service Standards Satisfaction Evaluation.
- 2) 95% of the families who have completed home-based services should rate their supportive services "satisfactory" or above.

### IV. Qualifications

#### **Direct Worker:**

Bachelor's degree in social work, psychology, sociology, or a directly related human service field and three years experience in Adoption.

#### **Supervisor:**

Master's degree in social work, psychology, or directly related human services field.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

In addition:

- Knowledge of family of origin/intergenerational issues.
- Knowledge of child abuse, neglect, separation, loss, grief.
- Knowledge of attachment, claiming, entitlement and loyalty issues
- Knowledge of child and adult development.
- Knowledge of Indiana community resources.
- Ability to work as a team member
- Belief that with supportive resources clients can maintain their families.
- Adoption competency.

#### **V. Billable Units Face to face time with the client:**

##### **Face to face time with the client:**

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

***Reminder:** Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are built into the cost of the face to face rate and shall not be billed separately.*

For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8

to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.

**Support Group:**

Includes prep time, notification of participants, speaker costs and mileage for the speaker not to exceed the State rate.

**Respite Care**

Actual cost

**Translation or sign language**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

**VI. Rates**

Face to Face Maximum rate: \$73.80 (1/1/2010)

Translation or sign language rate: Actual cost

Respite Care Actual cost

**VII. Case Record Documentation**

Necessary case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS referral form authorizing service;
- 2) Documentation of ongoing contact with the referred families/children and referring agency;
- 3) Monthly written reports, or more frequently if requested, regarding the progress of the family/children provided to the referring agency.

**VIII. Service Access**

Services must be accessed through a Referral for Child Welfare Services Form. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved time period.

***NOTE: All services must be pre-approved through a Referral for Child Welfare Services Form from the referring DCS FCM or DCS Service Consultant.***

**CHAFEE**  
**INDEPENDENT**  
**LIVING**  
**SERVICE**  
**STANDARDS**

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**CHAFEE FOSTER CARE INDEPENDENCE PROGRAM**  
**(Revised 4/1/09)**

**I. Service Description**

The Chafee Foster Care Independence Program (CFCIP) provides independent living (IL) services that consist of a series of developmental activities that provide opportunities for young people to gain the skills required to live healthy, productive, and responsible lives as self-sufficient adults. Independent living services should be seen as a service to young people that will help them transition to adulthood, regardless of whether they end up on their own, are adopted, or live in another permanent living arrangement. IL services should be based on the Ansell Casey Life Skills Assessment following the youth's referral for services. Youth receiving IL services must participate directly in designing their program activities, accept personal responsibility for achieving independence, and have opportunities to learn from experiences/failures.

Services should be provided according to the developmental needs and differing stages of independence of the youth but should not be seen as a single event, or as being provided in a substitute care setting, but rather as a series of activities designed over time to support the youth in attaining a level of self sufficiency that allows for a productive adult life. Services should address all of the preparatory requirements for independent adulthood and recognize the evolving and changing developmental needs of the adolescent.

Youth, ages **16 through 18** will receive services that include individual guidance, case management, and soft skill independent living services as reflected in the Independent Living Plan (ILP). Transitional living services will be provided to youth when they turn 17½ or within six months of case dismissal due to aging out of foster care. Youth must be given an independent living assessment to determine the appropriate services. These services may include tutoring, self-esteem building, life interest explorations, and education in housing options, budgeting, money management, health care, transportation options, secondary and post-secondary education, and interpersonal relationship skills.

Youth ages **18-20** who have not reached their twenty first birthday and who have left foster care will be offered guidance on financial issues, assessment services, housing, health care, counseling, employment, education opportunities and other support services that are unique for the development of self-sufficiency. Youth leaving foster care or former foster youth requesting CFCIP independent living services must participate on a voluntary basis and sign an agreement with the service provider for case management services. This agreement outlines the services to be provided, the length of time expected for the service, and the plan for the youth's contribution. The youth must participate directly in designing their program activities, accept personal responsibility for achieving independence, and have opportunities to learn from experiences and failures. In addition,

the independent living plan must include an operational plan describing how the young adult is going to assume responsibility once assistance ends.

Independent Living Programs are designed to assist young people by advocating, teaching, training, demonstrating, monitoring and/or role modeling new, appropriate skills in order to enhance self-sufficiency. Services must allow the youth to develop skills based on experiential learning and may include the following based on the youth's needs as identified through the Independent Living assessment.

The independent living assessment must include a comprehensive, written assessment of the youth's strengths as well as areas of improvement. The Ansell-Casey Life Skills Assessment (ACLSA) at [www.caseylifeskills.org](http://www.caseylifeskills.org) is the **only** assessment tool approved for use. This assessment must be completed annually and shared with the youth, caregiver and referring agency within ten (10) days of completion.

### Educational Services

Service providers will provide instruction or monitor that the youth receives educational services that include but are not limited to the following:

- Coordination with the youth's school on their Individual Education Plan (IEP)/Individual Transition Plan (ITP) for youth in special education.
- Providing tutoring support as needed and assistance with GED preparation if applicable.
- Assistance with locating driver's education training.
- Assistance with transportation to College Goal Sunday program to assist the youth in understanding the financial aid process.
- Assistance with completing the Free Application for Financial Student Aid (FAFSA) and gathering needed documents.
- Assistance in the search for scholarships at the website of the State Student Assistance Commission of Indiana ([www.in.gov/ssaci](http://www.in.gov/ssaci)) as well as other websites and assist in the completion the required forms as well as gathering needed documents.
- Assistance with obtaining information on colleges or universities, including cost, by logging into the Department of Education's website [www.nces.ed.gov](http://www.nces.ed.gov). Additional information for Indiana schools and specialized vocational training programs may be found on the Education and Training Voucher (ETV) ([www.statevoucher.org](http://www.statevoucher.org)).
- Assistance in applying for 21<sup>st</sup> Century Scholars program and the appeal process if needed.
- Assistance in applying for the ETV program finds on the ETV website ([www.statevoucher.org](http://www.statevoucher.org)), if eligible, for secondary education opportunities.
- Provided information on post-secondary access and support services for former foster youth both in Indiana as well as outside Indiana (e.g.. Ball State University/Ivy Tech Guardian Scholars program; Indiana University Purdue University Indianapolis (IUPUI)/Ivy Tech ESP! Program; Nina Mason Scholars program at IUPUI/Ivy Tech Indianapolis).

### Vocational and Employment Services

Service providers will provide vocational and employment services, either directly or by referral that include but are not limited to the following:

- Transport the youth to the local Work One Center and assist the youth in requesting aptitude testing and resume writing
- Assistance in exploring career options, Job Corps, AmeriCorps, Vista, and the Armed Forces.
- Assist the youth in obtaining job services through the Work One Center and explore possible intern positions through this program.
- Assist the youth in exploring and applying for volunteer opportunities in the community.
- Assist the youth in obtaining and completing job applications and provide opportunities for the youth to practice interviewing for different types of employment.
- Training related to employment such as appropriate dress, expected work behavior, positive workplace interaction, arrival at work and returning from breaks on time, and other issues related to maintaining employment.
- Assist the youth in the use of all available community employment and training resources including on the job training, job coach if eligible for service, and helping the young person access them.
- Developing job leads in the private sector and working with employers who may employ young people, including internships, job mentoring, apprenticeship, summer employment programs and other supportive services.

### Health Services

Service providers will provide education or advocate for health services to the youth that include but are not limited to the following:

- Assist the youth in obtaining their Medical Passport from their FCM and ensuring that it contains current information related to their family health history, immunizations, operations, and childhood illnesses and includes the names of the youth's medical, mental health, and dental providers and their contact information.
- Transport the youth to visit the local community health clinic, mental health clinic, hospital emergency room, and urgent care facilities to familiarize the youth with the location of these facilities, services available and how to access services when needed.
- Provide education on obtaining a primary care physician and dentist and the importance of preventative medical and dental care to avoid urgent medical care facilities when possible.
- Provide age-appropriate education regarding basic hygiene and nutrition, medical and dental care, substance abuse prevention/intervention, pregnancy prevention, teen parenting education and sexually transmitted diseases and HIV prevention.
- Provide assistance with accessing formal individual and group counseling, including crisis counseling and family therapy and substance abuse treatment.

- Provide assistance with applying for Medicaid, State alternative or other insurance coverage for the youth and their children when applicable.

### Housing Services

Service providers will provide housing services that include but are not limited to the following:

- Arrange an interview and visit with apartment complex managers/landlords to allow the youth to understand the leasing process and view apartments in more than one location.
- Assist the youth in developing a budget to determine the amount of rent they are able to pay based on their income and other expenses.
- Provide education on tenant rights and responsibilities and the importance of following rules and regulation policies of the apartment complex or landlord.
- Explore with the youth the option of other housing arrangements such as host home with their current or former foster parents or relatives, not to include legal or biological parents, and shared housing with roommates.
- Arrange a visit or phone call with the youth to utility companies (electric, gas, water, phone) to gather information regarding the requirements of the company related to hook up charges, deposits, and the monthly cost of services.
- Provide education on how to avoid homelessness and arrange visits with the local homeless shelters, mental health day shelters, food pantries, and other services that are available in the event that the youth may ever become homeless.
- Provide education on the purpose of credit, the use of credit, maintaining good credit, and how credit can affect every facet of their adult lives.

### Life Skills and Social Skills Services

Service providers will provide life and social skills training that include but are not limited to the following:

- Ansell-Casey Life Skills Assessment (ACLSA) with the youth (and their caregiver for wards if possible) to identify the youth's strengths and needs.
- A written plan, which is strengths-based, developmentally appropriate, based on the ACLSA which involves the youth and significant persons in its development and builds on the young person's positive behaviors and personal strengths.
- Information regarding public assistance that is available for eligible applicants through the State such as TANF and food stamps, local food pantries, and township trustees.
- Opportunities to interact with other foster youth in small and large groups in learning activities related to independent living.
- Experiential learning opportunities in the areas of problem-solving, time management, conflict resolution, stress management, communication skills, interpersonal skills, community resources, support systems, and goal-setting.
- Experiential learning opportunities in accessing community resources such as 211, Department of Family Resources, local library, locating businesses or services in the yellow pages, knowledge locating businesses or services in the use of city, street, and state maps, etc.

- Familiarize the youth with available public transportation by accompanying them in purchasing tokens or passes and visiting frequently used destinations in order to reduce fear and apprehension.
- Assist the youth in making arrangements for taxi service or other arrangements to an appointment when public transportation is not available.
- Financial training including developing a budget, banking, the use of money orders, use of credit, cost of rent-to-own versus purchasing, understanding interest charges and cash advance services. Arrange a visit to a bank to gather information on checking and saving accounts and how to open and maintain the account.
- Take the youth to multiple shopping destinations to compare prices for personal care items, cleaning supplies, and food items to help develop a budget for monthly purchases.
- Assist the youth in planning a menu, reading a recipe, purchasing the food, and preparing a meal.
- Take the youth to the laundromat with their own soiled laundry and assist in the use of the facilities, supplies needed, money required for wash and dry loads, and time involved in this endeavor.
- Assist the youth in obtaining an original birth certificate, social security card, credit history, medical and mental health records, and school records for their own files.
- Assist the youth in obtaining a State ID card.
- Assist the youth in maintaining a life book (available through the youth's FCM) that includes their birth certificate, Social Security records, court orders relating to their CHINS or probation case, high school activities, family information including names of family members and location, placement information, photos of friends and school activities, and other information important to the youth.
- Education on the cost of purchasing and maintaining a vehicle as well as title, licensing and insurance costs.
- Education on tax documents received from employers, filing income taxes and maintaining financial records.
- Assist the youth in obtaining their free annual credit report from all three agencies ([www.ftc.gov/bcp/online/pubs/credit/freereports.htm](http://www.ftc.gov/bcp/online/pubs/credit/freereports.htm)) to ensure their credit will not be an obstacle to renting.

### Youth Development

Service providers will provide opportunities for social, cultural, recreational, and/or spiritual activities that:

- Are designed to expand the range of life experiences and are sensitive to the cultural needs of youth and youth with special needs.
- Form meaningful and growth-producing relationships with adults, families, peers, and significant others and assist youth in managing these relationships.
- Introduce various available recreational and social activities for leisure time.
- Offer experiential learning in communication skills and conflict resolution management.

- Introduces the youth to volunteer activities in the community.
- Encourage participation in youth conferences and other developmental opportunities, which include leadership activities.
- Encourage participation in the Youth Advisory Board.

## **II. Target Population**

### **Eligibility for case management services:**

- 1) Youth ages 16 to 21 who are in foster care\* as a CHINS or adjudicated a delinquent with a case plan establishing the need for independent living services.
- 2) Youth ages 16 to 21 who were formerly in foster care as a CHINS or adjudicated a delinquent between the ages of 16-18 that were returned to their own homes and remain a CHINS or adjudicated a delinquent with a case plan establishing the need for independent living services.
- 3) Youth age 18 to 21 who were formerly in foster care for a minimum of 6 months as a CHINS or adjudicated a delinquent between the ages of 16-18 under the supervision of the DCS and had a case plan establishing the need for independent living services.
- 4) Youth who are 18 to 21 who would otherwise meet the eligibility criteria above and who were in the custody of another state or were a “ward of another state” will be eligible if through the Interstate Compact for the Placement of Children there is a verification of wardship and all eligibility criteria from the state of jurisdiction.

Youth who turn 18 in foster care are exempt from the 6 month requirement indicated in the target population. For probation youth adjudicated a delinquent, the county of residence must have an interagency agreement between the court and DCS relating responsibilities of each party for meeting all state and federal mandates.

### **Eligibility for Room and Board assistance:**

Foster youth must have turned 18 years of age while in foster care\*. This includes:

- 1) Youth who move directly from foster care into their own housing at age 18 up to age 21.
- 2) Youth who leave care voluntarily at age 18 without accepting assistance but return prior to turning age 21.

\*Foster care is defined as 24-hour substitute care for children placed away from their parents or guardians and for whom the State agency has placement and care responsibility. Facilities that are outside the scope of foster care include, but are not limited to: detention facilities; psychiatric hospital acute care; forestry camps; or facilities that are primarily for the detention for children who are adjudicated delinquents.

Room and board expenses are considered as security deposits, rent, utility deposits and utilities. Utilities are limited to electric, gas, water and sewage. These funds are contingent upon availability as well as verification of the youth's eligibility for voluntary services by the IL Specialists. Room and board payments include a maximum of \$3,000 for assistance up to age 21. Youth may access this assistance as long as they continue to participate in case management services and receive SSI (Supplement Security Income through Social Security) or participate in a full or part time schedule of work (or are actively seeking employment) until the \$3,000 limit is exhausted. While receiving room and board funds, youth are expected to make incremental payments toward their own housing and utility expenses beginning in the third month of assistance and should be prepared to accept full responsibility by the sixth month unless there are extenuating circumstances. In cases where the youth is unable to accept full responsibility for their rent in the sixth month, approval must be received from the DCS IL Specialist to allow payment beyond the fifth month. Requests for an extension of this capped amount will be considered on a case-by-case basis by DCS Permanency Manager and/or a designee, based on availability of funds. Room and Board payments will only be made through a contracted service provider who is providing independent living case management services to the youth.

Youth receiving room and board assistance and planning to attend a post-secondary institution may access room and board funds to obtain off-campus housing prior to beginning their post-secondary program. Deposits for housing on campus may be made through room and board funding. Education and Training Voucher (ETV) funds are available for housing for youth attending post-secondary institutions. Those attending school full time or part time may access the ETV Program at [www.statevoucher.org](http://www.statevoucher.org). If eligible for ETV funds, housing assistance must be accessed through this program.

#### Housing Options:

Potential housing options may include host homes with foster families, relatives other than biological or adoptive parents, or other adults willing to allow the youth to reside in their home with or without compensation. Other housing options may include youth shelters, shared housing, single room occupancy, boarding houses, semi-supervised apartments, their own apartments, subsidized housing, scattered site apartments, and transitional group homes.

### **III. Goals and Outcome Measures**

#### Goal#1

Timely provision of services for the youth and regular and timely communication with referring worker

#### Outcome Measures

- 1) 95% of all youth that are referred will have face-to-face contact with the provider within 10 days of the referral.

- 2) 95% of youth will have an ACLSA completed within 30 days of referral and a written service plan prepared with the youth and provided to the FCM, Probation Officer or IL Specialist within 30 days of completion of the assessment.
- 3) 100% of all youth will have monthly written summary reports prepared and sent to the referring worker. Voluntary Services reports will be sent to the IL Specialist. All reports must be submitted by the 10<sup>th</sup> day of the month in the approved format (see section IX) or billing will not be permitted.

#### Goal #2

Increase the percentage of youth who have a safe and stable place to live.

##### Outcome Measures

- 1) 80% of youth receiving room and board assistance will have safe stable housing within 6 months of receiving room and board assistance.
- 2) 90% of youth being provided transition service will locate a place to live when their case is dismissed.

#### Goal #3

Increase the percentage of youth who receive services that assist in developing independence.

##### Outcome Measures

- 1) 80% of youth participating in voluntary services will be able to meet their living expenses within 6 months of the provision of services.
- 2) 80% of youth whose service plan includes an educational goal will achieve that goal.
- 3) 100% of youth will have contact information related to their dental, physical and mental health service providers.
- 4) 100% of youth leaving care will have their birth certificate, social security card, medical records, and educational records or will obtain them within six months of beginning voluntary services.

#### Goal #4

DCS and youth satisfaction with services

##### Outcome Measures

- 1) DCS satisfaction will be rated 4 and above out of a possible five (5) points on the Service Satisfaction Report.
- 2) 90% of the youth who have participated will rate the services "satisfactory" or above.

## IV. Qualifications

### **Direct Worker:**

Bachelor's degree in social work, psychology, sociology, or a directly related human service field.

### **Supervisor:**

Department of Child Services  
Regional Document for Child Welfare Services  
Term 1/1/09-6/30/011  
October, 2010

Master's degree in social work, psychology, or directly related human services field. Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

## **V. Billable Units**

### **Face to face time with the client:**

*(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)*

- Includes client specific face-to-face contact with the identified youth during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified youth.
- Includes Child and family Team meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/youth.
- Includes time in attendance for up to two representatives per agency at mandatory quarterly Regional Independent Living meetings.
- Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are to be included in the face to face rate and shall not be billed separately.

**For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.**

### **Translation or sign language:**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

### **Room and Board (eligible voluntary youth 18-21):**

Dollar for dollar cost of rental deposit, rent payments, utility deposits and utility payments. Utility deposits may include gas, electric, water and landline phone. Utility payments may include gas, electric and water.

### **Educational Groups:**

Group rate for youth referred for case management services including 3 to 12 participants. Siblings may participate in the same group.

**Emancipation Goods and Services (EG&S) not to exceed \$1000 (unless approved by the DCS Permanency Manager and/or designee):**

For DCS Wards/Probation youth: Goods and services required to ensure a safe and successful case closure for youth aging out of the system must be approved by the local DCS office on a dollar for dollar basis. The state approved form must be used to request needed funding for youth. Requests for items not listed on the EG & S form require pre-approval from the IL Specialist. The signature of the DCS Director or designee on the approved form provides approval for expenditure of the funds as does the emailed form with the email cover sheet attached to the form that was received from the DCS Director or designee.

For Non-Wards: The EG&S form may be signed by the IL Specialist serving the county in the region where the request originates or by the local DCS Director where the youth resides.

Note: This expenditure must be determined based on the specific needs of each youth, not on the amount available.

**VI. Rates**

Face-to-Face Maximum Rate:	<u>\$63.90</u> (1/1/2010)
Translation or sign language	Actual Cost
Room and Board	Actual Cost
Educational Groups	Budget must be completed
Emancipation Goods and Services	Actual Cost

**Case Record Documentation**

Necessary case record documentation for service eligibility for CHINS and probation youth must include:

- 1) Authorized DCS Referral
- 2) Case Plan indicating the need for independent living services;
- 3) Initial Ansell-Casey Life Skills Assessment and ongoing assessments every year during the service provision period;
- 4) Documentation of regular contact with the referred youth and the DCS;
- 5) Monthly written reports, or more frequently if requested, regarding the progress of the youth provided to the referring agency, and
- 6) A Chafee Supplement report at case dismissal.

Necessary case record documentation for service eligibility for youth over the age of 18 receiving voluntary services after dismissal of their CHINS and probation case must include:

- 1) Approved Chafee Independent Living Voluntary Services Application and Service Agreement;
- 2) Independent Living Plan;
- 3) Documentation of regular contact with the referred youth;
- 4) Monthly written reports on the required form regarding the progress of the youth provided to the IL Specialist serving the region by email. This report must include the youth's full name and ICWIS number. All reports must be turned in by the 10<sup>th</sup> of the month unless otherwise specified by the referring party.

### **VII. Service Access**

For Wards: Services must be accessed through a valid DCS or Juvenile Probation Service referral. Referrals are valid from the start date until the end date as identified on the referral form or until the youth's case is dismissed (if the case is dismissed prior to the end date of the referral). Providers must initiate a reauthorization for services to continue beyond the approved period.

For Non-Wards: Youth must apply for services using the Chafee Independent Living Voluntary Services Application and Service Agreement (State Form 52692). Authorization for these services may be provided by the local DCS or Juvenile Probation DCS office where the youth resides or by the IL Specialist serving the youth's county of residence. Eligibility for all youth receiving Voluntary IL Services must be verified by an IL Specialist prior to services being initiated.

### **VIII. Quarterly Regional IL Meetings.**

All contracted Chafee Providers will have at least one representative present at the Quarterly Regional IL Meeting in the regions which they serve.

### **IX: Required reports**

All providers must send a monthly list of all active clients to the IL Specialist serving the region. Progress reports and the monthly list of active clients are due by the 10<sup>th</sup> of each month.

Reports for wards are to be emailed to the referring Family Case Manager or Probation Officer, and reports for non-wards are to be emailed to the IL Specialist serving the region.

All reports must be typed and prepared in Microsoft Word or Adobe format. Reports must detail the amount of time spent with the youth and the goal the youth is working toward. The approved format is located on the website of the Department of Child Services at [www.in.gov/dcs](http://www.in.gov/dcs).

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**CHAFEE II SERVICES—MENTORING/LIFELONG CONNECTIONS**

**I. Service Description**

Research shows that strong, lifelong connections with caring adults are critical to the successful transition of foster and adjudicated youth to productive, self-sufficient adulthood. Appropriate relationships between youth and extended birth family members help youth develop positive, well-integrated identities, regardless of their permanency goals. Lifelong connections are particularly vital to youth who have no permanent home to go to when they leave care. Without the strong ties and safety net that lifelong connections provide, outcomes are very poor for transitioning youth.

In the past, IL services have included a mentoring component in which youth are matched with screened and trained adults who provide guidance, support, encouragement, listening, coaching, education, informal counseling and role-modeling for the youth. These mentors may also assist the youth in faith-based activities, recreation and sports, creative pursuits, and participation in civic service and community events. Although valuable, these mentoring relationships typically do not go far enough or last long enough to provide the support and commitment youth need to transition successfully to productive adulthood. Every youth leaving foster care or probation needs at least one lifelong connection with a committed caring adult who will be there for that youth through triumphs and challenges. A supportive adult agreeing to be a lifelong connection commits to a long-term relationship with the youth and in addition to providing the help a mentor might provide. A mentor is also likely to provide the following:

- A home for the holidays
- Help finding housing, educational opportunities, and/or a job
- Assistance with money and household management
- Assistance with health issues, relationship counseling, and/or babysitting if youth is a parent
- Advocacy, motivation, mentoring
- Emergency cash
- A place to do laundry, use a computer or phone
- Transportation, clothing, occasional meals.

In order to establish these lifelong connections, service providers will:

- Work with youth to determine with whom s/he would like to have a connection.
- Partner with youth's family case manager, probation officer, therapist and/or other professionals—as well as the youth's foster parents, if appropriate—to

develop a list of family members (and other supportive adults) and their contact information.

- Use family finding techniques including case mining, Internet searches, and telephone calls to family members to locate potential connections.
- Facilitate meetings between youth and potential connections to help them define and strengthen their relationship. This process may require lifelong connections worker to transport youth to/from meetings.
- Provide youth and adults with information and resources that will support this relationship. This may include training the adults to be aware of and know how to respond to specific issues or challenges the youth is facing.
- Solidify the relationship through a written certificate of commitment signed by both youth and connections and witnessed by service provider.
- Monitor and support the relationship over a 3 to 6 month period, as needed, to strengthen it. Monitoring by the service provider should include contact with the youth and the adult at least twice in the first month and monthly thereafter to assess how the relationship is developing and to troubleshoot any problems that arise.
- Refer youth and connections to other resources available in the community.

In the case of a possible placement with a connection before the foster youth has left care, the service provider will inform the family case manager that a connection may be a placement option for the youth. The service provider will also communicate to the family case manager any information that will help with the assessment process. The family case manager will then follow DCS procedures to assess and approve, if appropriate, the connection's home as a placement.

The service provider may seek mentors for the youth in addition to lifelong connections. In fact, in the search for lifelong connections, the service provider may also come across adults who cannot commit to being lifelong connections, but who can be mentors for the youth. Mentors, however, do not take the place of a supportive adult agreeing to a lifelong connection with the youth. Service providers will support and monitor the mentoring relationship as they would the lifelong connection (see above). Mentoring may include:

- One-on-one guidance, support and encouragement
- Meeting on a regular basis
- Listening, coaching, sponsoring and role-modeling
- Guiding youth to develop his/her interests
- Helping youth participate in community, civic and faith-based activities.

## **II. Target Population for Lifelong Connections/Mentoring**

Youth ages 16 to 21 are eligible who are or have been in foster care as a CHINS or adjudicated a delinquent with a case plan establishing the need for independent living services.

Youth who are 16 to 21 who would otherwise meet the eligibility criteria above and who were in the custody or a ward of another state, if through the Interstate Compact for the Placement of Children there is verification of wardship and all eligibility criteria from the state of jurisdiction.

Youth who have participated in the program but whose connections have failed can be re-referred for another 6 months of services to either rebuild failed connections or find and strengthen new ones.

### **III. Goal and Outcome Measure**

**Goal:** Ensure that all referred youth have a permanent family, or a permanent connection with at least one committed, caring adult who provides guidance and support to the youth as they make their way into adulthood. Multiple connections are ideal, since not every connection can provide all resources and support to a youth.

**Outcome measure:** 80% of all youth will have at least one lifelong connection (as documented by a signed certificate of connection) within 6 months of referral, and the remaining 20% of all youth will have a mentor. In the case of a connection leading to a legal placement, evidence of adoption or legal guardianship can take the place of the certificate of connection as proof of a lifelong connection.

### **IV. Qualifications**

#### **Direct Worker:**

Bachelor's degree in social work, psychology, sociology, or a directly related human service field.

#### **Supervisor:**

Master's degree in social work, psychology, or directly related human services field.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

For agencies providing general IL services as well as lifelong connections/mentoring, the youth's IL worker may also be his or her lifelong connections worker, providing both sets of services to the youth.

Adults who want to be lifelong connections for a youth must have a willingness to help transitioning youth. Once the adult and the youth agree that they would like to have a lifelong connection, the adult must be screened using CPS and criminal background checks, for any history that could pose a danger to the youth. For the

youth who is still a ward of the state, the service provider must get approval from the family case manager/probation officer before the youth can have unsupervised visitation with the connection.

Mentors must have a valid driver's license and minimum car insurance coverage, as well as a general interest in helping transitioning youth. Once the adult and the youth agree that they would like to have a mentoring relationship, the adult must be screened using CPS and criminal background checks, for any history that could pose a danger to the youth. For the youth who is still a ward of the state, the service provider must get approval from the family case manager/probation officer before the youth can have unsupervised visitation with the mentor.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

## **V. Billable Units**

### **Face to face time with the client:**

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.
- Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are to be included in the face to face rate and shall not be billed separately.

For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.

### **Translation or sign language:**

Services include translation for families who are non-English language

speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

## **VI. Rates**

**Budget summary must be submitted for rates.**

## **VII. Case Record Documentation**

Documentation for service eligibility for CHINS and probation youth must include:

- a. Case plan indicating the need for independent living services
- b. A completed, dated, signed DCS referral form authorizing service from the family case manager in CHINS cases or from a probation officer in delinquency cases
- c. Monthly written report to the referring agency that documents number of contacts with youth and number of contacts with potential connections, and describes results of family finding activities and progress in the relationship between the youth and connections
- d. A case summary at dismissal of case that documents number and type of connections made
- e. A copy of the certificate of connection.

In the case of youth over the age of 18, a signed voluntary services form must also be included.

## **VIII. Service Access**

For youth still in foster care, lifelong connections services must be pre-approved through a referral form from the referring DCS family case manager. For the adjudicated youth, lifelong connections services must be pre-approved through a referral form from the referring probation officer. In emergency situations, services may begin with verbal approval but must be followed by a written referral within 5 days. It is the responsibility of the service provider to obtain the written referral.

Former foster or adjudicated youth requesting lifelong connections services must participate on a voluntary basis and sign an agreement with the service provider to that effect.

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**CHAFEE FOSTER CARE INDEPENDENCE PROGRAM**  
**(Revised 4/1/09)**

**TRANSITIONAL SERVICES**

**I. Service Description**

Transition services are provided to prepare foster youth for housing and employment outside the confines of foster care and are provided to youth who are 17 years and 6 months of age who are expected to age out of care. This is a period of time for youth to build relationships with new people who will assist them in searching for employment, developing a budget to meet their housing needs, and to locate housing that is affordable and safe.

Transition planning begins at age 17, with a Transition Planning Conference scheduled by the youth's DCS family case manager (or Probation Officer) that includes the youth and those involved in the youth's life. Bringing together all those involved in the youth's case with their knowledge and resources is advantageous in helping the youth develop and carry out his/her transition plan. The conference should assist the youth in identifying their interests, possible career options, post-secondary education possibilities, and employment possibilities.

The second transition planning conference is to be reconvened at age 17½ to help the youth finalize their plans and to begin to take the necessary steps to bring them to fruition. Prior to this conference, a referral is to be made for youth in group homes, residential facilities, and transitional housing. Youth currently receiving independent living services should have their services intensified at this time to focus on housing and employment but no referral is required. During the period when transition services are being provided; IL services are to continue in the youth's placement.

Youth between the ages for 17 years and 6 months and 20 years who have a Case Plan Goal of Alternative Planned Permanent Living Arrangement ("APPLA") may be eligible for Transitional Housing. Transitional Housing may be defined as semi-supervised apartments, their own apartments, subsidized housing or scattered site apartments. Transitional Housing must be managed by a Licensed Child Placement Agency, group home or child caring institution. Youth in Residential Placements are not eligible for Transitional Housing.

When a referral is received for a youth placed in a group home, residential facility or transitional housing, the Chafee IL service provider should contact the youth's placement contact person and make arrangements to meet the youth and the youth's case manager in the placement. This meeting should be held to gain information from the youth about the type of employment the youth intends to pursue and housing options of interest to the youth.

### **Purpose of Transition Services**

- Relationship building with new worker
- Meet at least 1 time a month during months following referral and then weekly in the month prior to case dismissal
- Begin preparing to live independent of the system
- Determine employment interest if not employed or underemployed
- Assist in locating employment
- Purchase personal items needed for youth moving to BDDS housing. Case management will be minimal in this situation since BDDS will take over that role for the youth.

### **Purpose of Transitional Housing**

- Allow youth to experience interdependent living while continuing in care with supportive services
- Determine housing options based on potential earnings
- Locate housing
- Arrange with landlord to pay deposit & 1st month's rent on or after 18th birthday, upon DCS (Probation) case closure
- Pay deposits for utilities
- The youth should be allowed to participate in the process by taking the youth to the community to check out housing options. This may also give the youth an incentive to work toward the goal of independence. Permission must be obtained prior to the excursion from the placement facility and the youth's FCM.

## **II. Target Population**

### **Eligibility for transition services:**

- 1) Youth ages 17½ who are in transitional housing, group homes, or residential facilities as a CHINS or adjudicated a delinquent with a case plan establishing the need for independent living services who will remain in foster care until they turn age 18. Youth in these placements will continue to receive ongoing IL services from placement staff.
- 2) Youth receiving Chafee services due to their placement in a county foster home, relative home or court approved non-licensed placement will receive transition services beginning at age 17 ½ in addition to ongoing IL services as authorized by DCS referral.

### **Eligibility for transitional housing:**

- 1) Youth between the ages of 17½ and 20 who have a case plan goal set as APPLA
- 2) Youth actively participating in an educational or vocational program and/or employed

### **III. Goals and Outcome Measures**

#### **Goal#1**

Increase the percentage of youth who have a safe and stable place to live.

Outcome Measures:

- 1) 95% of youth ages 17½ – 20 with the case plan goal of APPLA will have an identified transitional housing option.
- 2) 90% of youth being provided transition service will locate a place to live when their case is dismissed.

#### **Goal #2**

Increase the percentage of youth who receive services that assist in developing independence.

Outcome Measures

- 5) 50% of youth participating in transition services will be employed prior to their case being dismissed.

#### **Goal #3**

DCS and youth satisfaction with services

Outcome Measures:

- 1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 90% of the youth who have participated will rate the services “satisfactory” or above.

### **IV. Qualifications**

Direct Worker:

Bachelor's degree in social work, psychology, sociology, or a directly related human service field.

Supervisor:

Master's degree in social work, psychology, sociology, or a directly related human services field.

Supervision/consultation is to include not less than one (1) hour of face-to-face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Services will be conducted with behavior and language that demonstrates

respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

## **V. Billable Units**

### **Face to face time with the client:**

*(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)*

- Includes client specific face-to-face contact with the identified youth during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified youth.
- Includes Child and family Team meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/youth.
- Includes time in attendance for up to two representatives per agency at mandatory quarterly Regional Independent Living meetings.
- Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are to be included in the face to face rate and shall not be billed separately.

**For hourly rates, partial units may be billed in quarter hour increments only.**

**Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a youth/client.**

### **Housing:**

Negotiated per diem to include case management, room and board, utilities, clothing and food.

## **VI. Case Record Documentation**

Necessary case record documentation for service eligibility for CHINS and probation youth must include:

- 7) Authorized DCS/Probation Referral
- 8) Case Plan indicating the need for independent living services;
- 9) Documentation of regular contact with the referred youth and the DCS;
- 10) Monthly written reports, or more frequently if requested, regarding the progress of the youth provided to the referring agency, and
- 11) A Chafee Supplement report at case dismissal.

## **VII: Required reports**

All providers must send a monthly list of all active clients to the IL Specialist serving the region. Monthly reports detailing services, goals, accomplishments and time spent with the youth will be given to the referral source by the 10<sup>th</sup> day of the month.

**FAMILY  
CENTERED  
SERVICES  
SERVICE  
STANDARDS**

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**HOME-BASED FAMILY CENTERED CASEWORK SERVICES**  
**(Revised 4/1/09)**

**I. Service Description**

Provision of home based casework services for families experiencing multiple problems. Home based casework is also available for pre-adoption and post-adoption services for adoptive families at risk or in crisis. Home based Caseworker Services (HCS) provides any combination of the following kinds of services to the families once approved by the DCS:

<ul style="list-style-type: none"> <li>• Home visits</li> <li>• Case planning</li> <li>• In-home supervised visitation</li> <li>• Coordination of services</li> <li>• Conflict management</li> <li>• Emergency/crisis services</li> <li>• Child development education</li> <li>• Domestic Violence education</li> <li>• Parenting education/training</li> <li>• Family communication</li> <li>• Assistance with transportation</li> <li>• Participation in Child and Family Team meetings</li> <li>• Family Reunification</li> </ul>	<ul style="list-style-type: none"> <li>• Advocacy</li> <li>• Family assessment</li> <li>• Community referrals and follow-up</li> <li>• Develop structure/time management</li> <li>• Behavior modification</li> <li>• Budgeting/money management</li> <li>• Meal planning/preparation</li> <li>• Parent Training with Children Present</li> <li>• Monitor progress of parenting skills</li> <li>• Community services information</li> <li>• Develop long and short term goal</li> </ul>
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**II. Service Delivery**

- 1) Services must include 24-hour crisis intake, intervention and consultation seven days a week and must be provided in the family's home, at a community site or (only if approved by DCS) in the office.
- 2) Services must include ongoing risk assessment and monitoring family/parental progress.
- 3) The family (families are self-defined) will be the focus of service and services will focus on the strengths of the family and build upon these strengths.
- 4) Services must include development of short and long term family goals with measurable outcomes.
- 5) Services will be time-limited and focused on limited objectives derived directly from the established DCS case plan.
- 6) Services must be family focused and child centered.

- 7) Services must include intensive in-home skill building and after-care linkage.
- 8) Services include providing monthly progress reports; requested supportive documentation such as case notes, social summaries, etc.; and requested testimony and/or court appearances including hearing and/or appeals; case conferences/staffing.
- 9) Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
- 10) Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life style choices, and complex family interactions and be delivered in a neutral valued culturally competent manner.
- 11) The caseload of the Home based Caseworker will include no more than 12 families at any one time.
- 12) Services will be provided within the context of the DCS practice model with involvement in Child and Family team meetings if invited (attendance at family team meetings will not be a separate payment point).
- 13) Each family receives comprehensive services through a single Direct Worker acting within a team, with team back up and agency availability 24 hours a day 7 days a week.

### **III. Target Population**

Services must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect, with moderate to high levels of risk and service needs according to the assessment matrix or
- 2) Children with a status of CHINS, and/or JD/JS, and their families, or
- 3) All adopted children and adoptive families

### **IV. Goals, Objectives and Outcome Measures**

#### **Goal #1**

Maintain timely intervention with the family and regular and timely communication with referring worker.

#### **Objectives**

- 1) DCS Referrals are made to the provider within 24-hours of determining that the family is in need of HCS.
- 2) DCS worker may assist provider in contacting the family and beginning the engagement process.
- 3) Provider assures that all additional referral information is received from DCS.
- 4) Direct Worker is available for consultation to the family 24-7.

#### **Outcome Measures:**

- 1) 95% of all families that are referred will have face-to-face contact with the client within 5 days of the referral or inform the referring worker if the client does not respond to requests to meet.

- 2) 95% of families will have a written treatment plan prepared and sent to the referring worker following receipt of the referral within 30 days of contact with the client.
- 3) 95% of all families will have monthly written summary reports prepared and sent to the referring worker.

## **Goal #2**

Improved family functioning

### **Objectives:**

Goal setting, and service planning are mutually established with the client and Direct Worker within 30 days of the initial face to face intake and a written report signed by the Direct Worker and the client is submitted to the DCS referring worker.

### **Outcome Measures:**

- 1) 75% of the families that were intact prior to the initiation of service will remain intact with no out-of-home, county paid placement for more than five days throughout the service provision period.
- 2) 60% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period.
- 3) 90% of the families served will not have new incidences of substantiated abuse or neglect throughout the service provision period.
- 4) 90% of families actively engaged in treatment and following treatment recommendations will not have incidences of recidivism through substantiated or indicated reports through DCS
- 5) Scores will be improved on the Risk Assessment and needs and strengths assessment instruments in ICWIS used by the referring DCS worker.

## **Goal #3**

DCS and family satisfaction with services

### **Objectives:**

- 1) At the least a random sample of families will complete the Service Satisfaction Survey at the conclusion of services.

### **Outcome Measures:**

- 1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) Clients will rate the services “satisfactory” or above.

## **V. Qualifications**

### **Direct Worker:**

Bachelor's degree in social work, psychology, sociology, or a directly related human service field.

**Supervisor:**

Master's degree in social work, psychology, or directly related human services field.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

In addition to:

- Knowledge of child abuse and neglect and child and adult development
- Knowledge of community resources and ability to work as a team member
- Belief in helping clients changes their circumstances, not just adapt to them.
- Belief in adoption as a viable means to build families.
- Understanding regarding issues that are specific and unique to adoptions such as loss, mismatched expectations and flexibility, entitlement, gratification delaying, flexible parental roles and humor.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

**VI. Billable Units**

Face to face time with the client (Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

*Reminder: Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are built into the cost of the face to face rate and shall not be billed separately.*

For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.

## **Translation or sign language**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

## **Concrete Services**

Concrete/advocacy services up to a lifetime cap of \$500 per family are available to be spent on a wide variety of things that reduce the likelihood of placement. Direct Workers help access needed items, supports and services that are essential and necessary to reduce the likelihood of placement. There must be a documented need for the goods/services, either in the case plan or as agreed on by the child and family team. **Prior written approval is mandatory from the local office director or their designee.**

Documentation of expenditure of funds must be maintained by the agency with a copy to the local office for client's record.

## **VII. Rates**

Face to Face Maximum rate: \$58.95 (1/1/2010)

Translation or sign language rate: Actual cost

Concrete Services: Actual Cost up to \$500

## **VIII. Case Record Documentation**

Case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS referral form authorizing services
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports no less than monthly or more frequently as prescribed by DCS.
- 4) Documentation of concrete/advocacy funds expended.

## **IX. Service Access**

Services must be accessed through a DCS referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

**A referral form from the referring DCS worker is required when changing the type of home based service.**

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**HOME-BASED FAMILY CENTERED THERAPY SERVICES**  
**(Revised 4/1/09)**

**I. Service Description**

Provision of structured, goal-oriented, time-limited therapy in the natural environment of families who need assistance recovering from physical, sexual, emotional abuse, and neglect. Other issues, including substance abuse, mental illness, personality/behavior disorder, developmental disability, dysfunctional family of origin, and current family dysfunction, may be addressed in the course of treating the abuse/neglect.

Professional staff will provide family and/or individual therapy including one or more of the following areas:

<ul style="list-style-type: none"> <li>• Family of origin/intergenerational issues</li> <li>• Family organization (internal boundaries, relationships, roles)</li> <li>• Stress management</li> <li>• Self-esteem</li> <li>• Communication skills</li> <li>• Conflict resolution</li> <li>• Behavior modification</li> <li>• Parenting Skills/Training</li> <li>• Substance Abuse</li> <li>• Crisis intervention</li> <li>• Strengths based perspective</li> <li>• Adoption issues</li> <li>• Child and Family team meetings</li> </ul>	<ul style="list-style-type: none"> <li>• Goal setting</li> <li>• Family structure (external boundaries, relationships, socio-cultural history)</li> <li>• Problem solving</li> <li>• Support systems</li> <li>• Interpersonal relationships</li> <li>• Supervised visitation</li> <li>• Family processes (adaptation, power authority, communications, META rules)</li> <li>• Cognitive behavioral strategies</li> <li>• Brief therapy</li> <li>• Family reunification</li> </ul>
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**II. Service Delivery**

- 1) Services will be provided face-to-face for the amount of time needed by each individual or family.
- 2) Services will be provided at times convenient for or necessary to meet the family's needs, not according to a specified work week schedule.
- 3) Services will be provided in the families' home or in the community environment when assisting with a particular learning task.
- 4) Services will be based on objectives derived from the family's established DCS case plan, Informal Adjustment, taking into consideration the recommendations of the Child and Family Team meeting.

- 5) Services will be time-limited. Providers must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
- 6) Services include providing any requested testimony and/or court appearances (to include hearing or appeals).
- 7) The family (families are self-defined) or individual will be the focus of service. Services will focus on the strengths of families and individuals and build upon those strengths
- 8) One (1) full time Home-Based Direct Therapy Worker may have a caseload of no more than 12 families at any one time. Services will be provided within the context of the DCS practice model with involvement in Child and Family team meetings if invited. A treatment plan will be developed and based on the agreements reached in the Child and Family Team Meeting.
- 9) Each family receives comprehensive services through a single Direct Worker acting within a team, with team back up and agency availability 24 hours a day 7 days a week.

### **III. Target Population**

Services must be restricted to the following eligibility categories:

- 1.) Children and families who have substantiated cases of abuse and/or neglect with moderate to high levels of risk and need, as well as moderate to high levels of service needs according to the DCS assessment matrix, and
- 2) Children who meet the requirements for CHINS, and or JD/JS, and their families  
or
- 3) Children and families who are currently in substitute care and who are in need of reunification/permanent placement services; and or,
- 4.)Any child who has been adopted, and adoptive families

### **IV. Goals, Objectives and Outcome Measures**

#### **Goals #1**

Maintain timely intervention with family and regular and timely communication with referring worker

#### **Objectives**

- 1) DCS Referrals are made to the provider within 24-hours of determining that the family is in need of Home Based Family Centered Therapy Services (HBFCT).
- 2) DCS worker may assist provider in contacting the family and beginning the engagement process.
- 3) Provider assures that all additional referral information is received from DCS.
- 4) Therapist is available for consultation to the family 24-7.

**Outcome Measures:**

- 1) 95% of all families that are referred will have face-to-face contact with the client within 5 days of the referral or inform the referring worker if the client does not respond to requests to meet.
- 2) 95% of families will have a written treatment plan prepared and sent to the referring worker within 30 days of the receipt of the referral.
- 3) 97% of all families will have monthly written summary reports prepared and sent to the referring worker.
- 4) Participation in Child and Family Team meetings when invited.

**Goal #2**

Development of positive means of managing crisis.

**Objectives**

- 1) Service delivery is grounded in best practice strategies, using such approaches as cognitive behavioral strategies, motivational interviewing, change processes, and building skills based on a strength perspective to increase family functioning.

**Outcome Measures:**

- 1) 90% of the individuals/families served will not be the subjects of a new investigation resulting in the assignment of a status of “substantiated” or “indicated” abuse or neglect throughout the service provision period.
- 2) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.

**Goal #3**

DCS and client satisfaction with service provided.

**Objective:**

- 1) At the least a random sample of families will complete the Service Satisfaction Survey at the conclusion of services.

**Outcome Measures:**

- 1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) Clients will rate the services “satisfactory” or above

**V. Qualifications****Direct Worker:**

Master's degree in social work, psychology, marriage and family therapy, or related human service field and 3 years related clinical experience or a masters degree with a clinical license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board, as one of the following. 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor.

**Supervisor:**

Master's degree in social work, psychology, or marriage and family or related human service field with a current license issued by the Indiana Social Worker, Marriage and Family Direct Worker or Mental Health Counselor Board as one of the following: 1) Clinical Social Worker, 2) Marriage and Family Direct Worker, 3) Mental Health Counselor

In addition to:

- Knowledge of family of origin/intergenerational issues
- Knowledge of child abuse/neglect
- Knowledge of child and adult development
- Knowledge of community resources
- Ability to work as a team member
- Belief in helping clients change, to increase the level of functioning, and knowledge of strength-based initiatives to bring about change
- Belief in the family preservation philosophy
- Knowledge of motivational interviewing
- Skillful in the use of Cognitive Behavioral Therapy
- Skillful in the use of evidence-based strategies

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

## **VI. Billable Units**

Face to face time with the client: (Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

Reminder: Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are built into the cost of the face to face rate and shall not be billed separately.

For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.

Translation or sign language Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

## **VII. Rates**

Face to Face Maximum rate: \$68.40 (1/1/2010)

Translation or sign language rate: Actual cost

## **VIII. Case Record Documentation**

Necessary case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS referral form authorizing service;
- 2) Documentation of regular contact with the referred families/children and referring agency;
- 3) Monthly written reports, or more frequently if requested, regarding the progress of the family/children provided to the referring agency.

## **IX. Service Access**

Services must be accessed through a DCS referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

**NOTE: All services must be pre-approved through a referral form from the referring DCS.**

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**HOME-BASED INTENSIVE FAMILY PRESERVATION SERVICES**  
**(Revised 4/1/09)**

**I. Service Description**

Intensive home based family preservation is seen as part of an array of home based services provided for children and families. The primary function of intensive family preservation is to engage the child (ren) and family, to take action to prevent removal of the child (ren), to increase safety, and to improve family functioning.

This is a categorical program able to help only one segment of the total range of families and children in need of support. The service is designed to offer short-term, crisis intervention; intense, family centered educational services within a continuum of care. The primary treatment emphasis is teaching skills to all family members, so that the family can learn to function more successfully on their own.

Intensive family preservation service is a cognitive behavioral approach that uses best practice strategies to motivate families to change, teaching skills, increasing access to personal, family, extended family, and community resources; to increase family functioning and child well-being

**II. Service Delivery**

- 1) Providing agency receives referrals 24 hours a day, 7 days a week. There is a verbal determination between DCS and the agency that intensive services are warranted, and there is agency availability for the service before the referral is sent. Waiting lists are not allowed for intensive services.
- 2) Caseload size is 2-3 families at one time for a Direct Worker.
- 3) Intensive services are limited to 4-6 weeks or ends sooner when the risk of placement or disruption has ended; timeframe starts the day of the initial face-to-face intake session.
- 4) The face to face intake must occur no later than the end of the day following the referral. However, there is a 72 hour timeframe (including the first day as part of the 72 hours) from the day of the referral, for the agency to refuse services, or end the intervention if it has been discovered within that 72 hour timeframe that intensive services are not possible due to: no family member willing and capable of engaging in service; the safety of the worker, or child (ren) cannot reasonably be assured; or it is determined through discussion between DCS and the provider that less intensive services will be more beneficial. If it is determined that services are not appropriate within these 72 hours, documentation of the reason and date of termination of intake must be provided to DCS. The provider is paid a per diem for the days the agency provided services within the 72 hour timeframe.

5) Goal setting, and service planning are mutually established with the client and Direct Worker with a written report signed by the Direct Worker and the client, submitted to the DCS referring worker within 7 days of the initial face to face intake. Communication between the Direct Worker and DCS is constant and documented as arranged between the two. Assessments including the North Carolina family Assessment Scale (NCFAS) are completed by the Direct Worker without the presence of the family.

6) Each family receives comprehensive services through a single Direct Worker acting within a team, with team back up and agency availability 24 hours a day 7 days a week.

7) Service primarily occurs in the family's home or natural environment.

8) Family functioning assessments, family's response, presenting problems according to DCS referral are factors included in the goal setting. Goals are behaviorally specific, measured, and attainable. The intervention addresses the family's needs and strengths to alleviate the risk of removal, and increase family functioning.

9) Safety is of paramount importance. If there are indications of safety concerns within the home, there is an obligation for the Direct Worker and DCS to communicate to address all safety concerns, and document steps taken to resolve the issues. If new incidences occur, the Direct Worker is to notify DCS immediately of the situation.

10) Direct Workers strategically vary session times, 3-5 times a week in-home sessions, for an average minimum of 10 hours of face-to-face contact per week, typically 20 hours per week of service. Largely framed as crisis intervention, service delivery is grounded in best practice strategies, using such approaches as cognitive behavioral strategies, motivational interviewing, change processes, and building skills based on a strength perspective to increase family functioning. Services are intense but brief.

11) Direct Workers and Supervisors will receive at least 12 hours ongoing annual training and education pertaining to families and service delivery to family preservation, as well as any new policies/procedures required by the Department of Child Services and/or new initiatives or statutory changes.

12) Child and family team meetings with DCS are included in the intervention with attendance as requested by DCS and the family (not a separate billable unit).

13) Regarding supervision:

- supervisors accompany new Bachelor level staff for at least the first three face to face sessions and Masters level with 2 yr experience for at least one.
- each family's case is reviewed through group and or individual consultation on a weekly basis;
- in-person team consultation meetings occur at least weekly;

- supervisors review all forms, reports, documentation, and oversees all necessary change;
- supervisors maintain constant direct contact with clients and
- supervisors are available 24/7 for clinical supervision.

14) A concluding session is conducted between the family and the Direct Worker, 1 or 2 weeks before the end of the intensive service in order to:

- assess changes / goal attainment;
- plan for maintenance of progress and
- help the family access personal, family and community resources.

15) Through a collaborative process, the family, the Direct Worker and DCS will determine if there are ongoing service needs, and if additional referrals are warranted from DCS for services other than intensive services.

**(Note: A new referral to intensive services is not possible without a 90 day interim between the end of intensive services and a new intensive service.)**

16) After the closure of the intensive case, a written summary report is prepared including second NCFAS scores, and submitted to the referring worker within 7 days of the end of intensive services.

17) At the termination of intensive services if future services are need, the provider should contact the local DCS office to discuss referral for Home-Based Family Centered Casework Services.

18) Confidentiality must be maintained. Failure to maintain confidentiality may result in termination of the service agreement.

### **III. Target Population**

Services must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect, with moderate to high levels of risk and service needs according to the assessment matrix; when there is “imminent risk of removal” of the child (ren) from the home, and
- 2) Children with the status of CHINS, and/or JD/JS, and their families or
- 3) All adopted children and adoptive families

### **IV. Goals, Objectives and Outcome measures**

#### **Goal #1:**

Maintain timely intervention with family and regular and timely communication with referring worker

**Objectives:**

- 5) DCS Referrals are made to the provider within 24-hours of determining that the family is in need of IFPS.
- 6) DCS worker may assist provider in contacting the family and beginning the engagement process.
- 7) Provider assures that all additional referral information is received from DCS.
- 8) Direct Worker is available for consultation to the family 24-7.
- 9) Direct Worker responds to family crises within one hour.

**Outcome Measures:**

- 1) 75% of families receive their first face to face visit no later than the end of the first day following the referral from DCS.
- 2) If the face to face is not possible within 24 hours, 95% of those records document the reason for not achieving this standard as being due to the family's schedule. Waiting lists are not allowed for intensive services.
- 3) 95% of written treatment plans/ assessments will be completed, and sent to the referring worker within-10 days of face-to-face intake contact with the client/family.

**Goal #2**

Improved family functioning

**Objectives:**

- 1) Direct Worker completes the initial NCFAS evaluation at the end of the first week.
- 2) Goal setting, and service planning are mutually established with the client and Direct Worker within 7 days of the initial face to face intake and a written report signed by the Direct Worker and the client is submitted to the DCS referring worker by day 10.

**Outcome Measures :**

- 1) Using the North Carolina Family Assessment Scales for measuring family functioning, 80% of families demonstrate improvement in at least one of the domains rated below baseline at intake.
- 2) Family safety is increased during the intervention. When the NCFAS safety domain is rated below baseline at intake, at least 80% of interventions show an increased rating in this domain at service closure.

**Goal #3**

Prevention of Out of Home Placement

**Objectives:**

- 1) Services are delivered to children and families in their own home or natural environment.
- 2) Services focus on teaching/skills-based approach.
- 3) Services are flexible and responsive to the needs of the family.

**Outcome Measures:**

1) At least 70% of the families that were intact at the initiation of service will remain intact with no out-of-home, county paid placement for more than five days throughout the service provision period, and will have avoided out of home placement 6 months following service closure.

**Goal # 4**

DCS and family satisfaction with services

**Objective:**

At the least a random sample of families will complete the Service Satisfaction Survey at the conclusion of services.

**Outcome Measures:**

- 1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) Clients will rate the services “satisfactory” or above.

**V. Qualifications**

**Direct Worker:**

Master's degree in social work, psychology, marriage and family therapy, or related human service field or a Bachelor's degree in social work, psychology, sociology, or related human service field with at least 2 years of direct social service experience.

**Supervision:**

Master's degree in social work, psychology, or marriage and family or related human service field with a current license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board as one of the following: 1) Clinical Social Worker, 2) Marriage and Family Therapist, 3) Mental Health Counselor or Master degree in social work, psychology, or marriage and family or related human service field and three years experience in child welfare or related human services.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

## **VI. Billable Units**

### **Concrete Services**

Concrete/advocacy services up to a lifetime cap of \$500 per family are available to be spent on a wide variety of things that reduce the likelihood of placement. Direct Workers help access needed items, supports and services that are essential and necessary to reduce the likelihood of placement. There must be a documented need for the goods/services, either in the case plan or as agreed on by the child and family team. **Prior written approval is mandatory from the local office director or their designee.**

Documentation of expenditure of funds must be maintained by the agency with a copy to the local office for client's record.

### **Intensive service period payment**

The per diem rate for the 4 – 6 week intervention for intensive home based preservation services begins the first day of direct service with the referred family.

Absence of the child(ren) from the family's care will not exceed more than 5 days of county/state/federal payment for placement during the 4-6 week intervention.

Termination of intensive services can occur if there is no family member willing to cooperate in treatment, the child (ren) has been removed, or the there is no longer imminent risk of removal. Otherwise services may continue within the time frame until the objectives of the intervention are met. Families may to be referred to continuing services as needed following the termination of intensive services.

**All agencies that receive a contract for Intensive Family Preservation and Intensive Family Reunification, must also have a contract for Home Based Family Centered Casework (HBFCC) Services. Therefore proposals must be written for both/all. If an agency wishes to provide the HBFCC services by sub-contract, please identify the sub-contractor. Intensive and less intensive services are seen within a continuum of care, to meet the evolving service needs of the family.**

### **Translation or sign language**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

## **VII. Rates**

Budget Summary must be submitted for rates.

## **VIII. Case Record Documentation**

Necessary case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS referral form authorizing service
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports as requested. Formats for written reports and forms will be designed collaboratively for use.
- 4) Documentation of concrete/advocacy funds expended.

## **IX. Service Access**

Services must be accessed through a DCS referral. Providers must initiate a reauthorization for services to change from intensive to other types of DCS monitored services.

The referral for intensive service covers a maximum of 4-6 weeks.

**Note: All services must be pre-approved through a referral form from the referring DCS.**

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**HOME-BASED INTENSIVE FAMILY REUNIFICATION**  
**(Revised 4/1/09)**

**I. Service Description**

Intensive home based family reunification is seen within an array of home based services provided for children and families to help them in the reunification process. Intensive reunification service is a short term, intense, crisis intervention utilized if after the child (ren) has been returned home, the child and family are demonstrating difficulties of such magnitude that without intensive crisis intervention the reunification will be jeopardized. Reunification is not a single event, it is a process which often calls for many forms of service. Forms of service might include home based services to prepare the child and family for reunification, or home based casework during the first months of the child returning home, or home based therapy. Intensive services are an example of a type of home based service to help children and families throughout the reunification process. Intensive reunification is a categorical program able to help only one segment of the total range of families and children in need of support.

Intensive family reunification service is a cognitive behavioral approach based on best practice strategies to motivate families to change, teaching skills, increasing access to personal, family, extended family, and community resources; to increase family functioning and child well-being.

**II. Service Delivery**

1) Providing agency receives referrals 24 hours a day, 7 days a week. There is a verbal determination between DCS and the agency that intensive services are warranted, and there is agency availability for the service before the referral is sent. Waiting lists are not allowed for intensive services.

2) Caseload size is 2-3 families at one time for a Direct Worker.

3) Intensive services are limited to 4-6 weeks from the initial face to face intake session, or ends sooner when the imminent risk of disruption has ended.

4) The face to face intake must occur no later than the end of the day following the referral. However, there is a 72 hour timeframe (including the first day as part of the 72 hours) from the day of the referral for the agency to refuse services, or end the intervention if it has been discovered within that 72 hour timeframe, that intensive services are not possible due to: no family member willing and/or capable of engaging in service, the safety of the worker, or child (ren) cannot be reasonably assured; or it is determined through discussion between the provider and DCS that intensive services are not appropriate. Documentation of the reason and date of termination of intake must be provided to DCS within 24 hours. The provider is paid a per diem for the days the agency

conducted the intake within the 72 hour timeframe. If it is a situation of safety, the provider is obliged to inform DCS within an hour of the documented incidence that safety issues must be immediately addressed.

5) Goal setting, and service plans are mutually established between the client and Direct Worker with a written report signed by the family and the Direct Worker, submitted to the DCS referring worker within 7 days of the initial face to face intake. Communication between the Direct Worker and DCS is constant and documented as arranged between the two. Assessments including the North Carolina family Assessment Scale (NCFAS-R) are completed by the Direct Worker without the presence of the family.

6) Each family receives comprehensive services through a single Direct Worker acting within a team, with team back up and agency availability 24 hours a day/7 days a week.

7) Service primarily occurs in the family's home or natural environment.

8) Family functioning assessments, family's response, presenting problems according to DCS referral are factors included in the goal setting. Goals are behaviorally specific, measured, and attainable. The intervention addresses the family's needs and strengths to alleviate the risk of reunification disruption, and increase family functioning.

9) Safety is of paramount importance. If there are indications about safety concerns within the home, there is an obligation for the Direct Worker and DCS to communicate to address all safety concerns, and document steps taken to resolve the issues. If new incidences occur, the Direct Worker is to notify DCS immediately of the situation.

10) Direct Workers strategically vary session times, 3-5 face to face home based sessions a week, for an average minimum of 10 hours per week, typically 20 hours per week. Largely framed as a crisis intervention, service delivery is based in evidence based practice using such approaches as cognitive behavioral strategies, and teaching skills to increase family functioning.

11) Supervisors and Direct Workers will receive at least 12 hours ongoing annual training and education pertaining to families and service delivery to family reunification, as well as any new policies/procedures required by the Department of Child Services and/or new initiatives or statutory changes.

12) Child and family team meetings with DCS are included in the intervention with attendance as requested by DCS and the family (not a separate billable unit).

13) Regarding supervision:

- Supervisors accompany new Bachelor level staff for at least the first three face to face sessions and Masters level with 2 yr experience for at least one.
- Each family's case is reviewed through group and or individual consultation on a weekly basis.

- In-person team consultation meetings occur at least weekly.
- Supervisors review all forms, reports, documentation, and oversee all necessary change.
- Supervisors maintain constant direct contact with clients.
- Supervisors are available 24/7 for clinical supervision.

14) A concluding session is conducted between the family and the Direct Worker, 1 or 2 weeks before the end of the intensive service in order to:

- assess changes / goal attainment,
- plan for maintenance of progress, and
- help the family access personal, family and community resources.

Through a collaborative process, the family, Direct Worker, and DCS will determine if there are ongoing service needs, and if additional referrals are warranted from DCS for services other than intensive services. **A new referral to intensive services is not possible without a 90 day interim between the end of intensive services and a new intensive service period.**

15) After the closure of the intensive case, a written summary report is prepared including second NCFAS-R scores, to be submitted to the referring worker within 7 days of the end of intensive services.

16) At the termination of intensive services if future services are need, the provider should contact the local DCS office to discuss referral for Home-Based Family Centered Casework Services.

17) Confidentiality must be maintained. Failure to maintain confidentiality may result in termination of the service agreement.

### **III. Target Population**

Services must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect, with moderate to high levels of risk and service needs according to the DCS assessment matrix; where reunification is jeopardized without intervention of intensive services, and
- 2) Children with a status of CHINS, and/or JD/JS, and their families or
- 3) All adopted children and adoptive families

### **IV. Goals, Objectives and Outcome measures**

#### **Goal #1**

Maintain timely intervention with family and regular and timely communication with referring worker

#### **Objectives:**

1. DCS referrals are made to the provider within 24-hours of determining that the family is in need of IFRS.

2. DCS worker may assist the provider in contacting the family and beginning the engagement process.
3. Direct Worker assures that all additional referral information is received from DCS.
4. Direct Worker is available for consultation to the family 24-7.
5. Direct Worker responds to family crises within one hour.

**Outcome Measures:**

- 1) 75% of families receive their first face to face visit no later than the end of the first day following the referral from DCS.
- 2) If the face to face is not possible within 24 hours, 95% of those records document the reason for not achieving this standard as being due to the family's schedule. Waiting lists are not allowed for intensive services.
- 3) 95% of written treatment plans/ assessments will be completed , and sent to the referring worker within 7 days of face-to-face intake with the client/family.

**Goal #2**

Improved family functioning Outcome Measures

**Objectives:**

**1. Direct Worker completes the initial NCFAS evaluation at the end of the first week.**

**2.** Goal setting, and service planning are mutually established with the client and Direct Worker within 7 days of the initial face to face intake and a written report signed by the Direct Worker and the client is submitted to the DCS referring worker by day 10.

**Outcome Measures:**

- 1) Using the North Carolina Family Assessment Scales-Reunification for measuring family functioning, 80% of families demonstrate improvement in at least one of the domains rated below baseline at intake.
- 2) Family safety is increased during the intervention. When the NCFAS-R safety domain is rated below baseline at intake, at least 80% of interventions show an increased rating in this domain at service closure.

**Goal #3**

Prevention of Reunification Disruption

**Objectives:**

1. Services are delivered to children and families in their own home or natural environment.
2. Services focus on teaching/skills-based approach.
3. Services are flexible and responsive to the needs of the family.

**Outcome Measures:**

1) At least 70% of the families that were intact at initiation of service will remain intact with no out-of-home, county paid placement for more than five days throughout the service provision period, and will have avoided out of home placement 6 months following service closure.

**Goal # 4**

DCS and family satisfaction with services

**Objective:**

At the least a random sample of families will complete the Service Satisfaction Survey at the conclusion of services.

**Outcome Measures:**

- 1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) Clients will rate the services “satisfactory” or above.

**V. Qualifications****Direct Worker:**

Master's degree in social work, psychology, marriage and family therapy, or related human service field or a Bachelor's degree in social work, psychology, sociology, or related human service field with at least 2 years of direct social service experience.

**Supervision:**

Master's degree in social work, psychology, or marriage and family or related human service field with a current license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board as one of the following: 1) Clinical Social Worker, 2) Marriage and Family Therapist, 3) Mental Health Counselor or Master degree in social work, psychology, or marriage and family or related human service field and three years experience in child welfare or related human services.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

## **VI. Billable Units**

### **Concrete Services**

Concrete/advocacy services up to a lifetime cap of \$500 per family are available to be spent on a wide variety of things that reduce the likelihood of placement. Direct Workers help access needed items, supports and services that are essential and necessary to reduce the likelihood of placement. There must be a documented need for the goods/services, either in the case plan or as agreed on by the child and family team. **Prior written approval is mandatory from the local office director or their designee.**

Documentation of expenditure of funds must be maintained by the agency with a copy to the local office for client's record.

### **Intensive service period payment:**

The per diem rate for the 4-6 week home based reunification intervention begins on the first day of direct service after the child (ren) has been returned to the home, to the parent's care. During the period of intervention, absence of the child (ren) from the home cannot exceed 5 days of paid placement by state/federal/county funds or the intensive service is terminated. Termination of intensive services can occur if there is no family member willing or capable of cooperating in treatment, the child (ren) has been removed, or there is no longer imminent risk of jeopardy to reunification. Otherwise services may continue within the time frame until the objectives of the intervention are met. Families are to be referred to continuing services as needed following the termination of intensive services.

**All agencies that receive a contract for Intensive Family Preservation and Intensive Family Reunification, must also have a contract for Home Based Family Centered Casework (HBFCC) Services. Therefore proposals must be written for both/all. If an agency wishes to provide the HBFCC services by sub-contract, please identify the sub-contractor. Intensive and less intensive services are seen within a continuum of care, to meet the evolving service needs of the family.**

### **Translation or sign language**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

## **VII. Rates**

Budget Summary must be submitted for rates.

## **VIII. Case Record Documentation**

Necessary case record documentation for service eligibility must include:

- 1.) A completed, signed and dated DCS referral form authorizing service.

- 2.) Documentation of regular contact with the referred families/children.
- 3.) Written reports as requested. Formats for written reports and forms will be collaboratively designed for use.
- 4.) Documentation of concrete/advocacy funds expended.

### **IX. Service Access**

Services must be accessed through a DCS referral. Providers must initiate a new authorization for services to change from intensive to other types of DCS monitored services.

Referrals for intensive services cover a maximum of 6 weeks.

**Note: All services must be pre-approved through a referral form from the referring DCS.**

**SERVICE STANDARD  
INDIANA DEPARTMENT OF CHILD SERVICES  
HOMEMAKER / PARENT AID**

**I Service Description**

Homemaker/parent aid provides assistance and support for parents who are unable to appropriately fulfill parenting and/or homemaking functions. Paraprofessional staff assists the family through advocating, teaching, demonstrating, monitoring, and/or role modeling new, appropriate skills for coping with the following areas:

- Time management
- Child care
- Child development
- Health care
- Community resources (referrals)
- Transportation
- Visitation with child(ren)
- Systems support
- Problem solving
- Isolation
- Discipline
- Family Reunification
- Resource management
- Safety
- Nutrition
- Housekeeping
- Parenting skills
- Housing
- Self esteem
- Interpersonal Problems
- Crisis Resolution
- Parent/child interaction
- Supervision

**Homemaker/Parent Aid expectations:**

- 1) Services will be provided in the family's home and in the course of assisting with transportation, accompanying the parent(s) during errands, job search, etc.
- 2) Services must be indicated by the established DCS case plan.
- 3) Provide transportation in the course of assisting the client to fulfill the case plan or informal adjustment program, with learning a particular task as specified in the service components, such as visitation, medical appointments, grocery shopping, house/apartment hunting, etc.
- 4) Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
- 5) Services must demonstrate respect for socio-cultural values, personal goals, life style choices, and complex family interactions and be delivered in a culturally competent fashion.
- 6) Provide any requested testimony, for court appearances (to include hearing or appeals), or when requested participate in Child and Family Team Meetings.
- 7) Services to families will be available 24-hours per day, seven days per week.
- 8) The family (families are self-defined) will be the focus of service.
- 9) Services will focus on the strengths of families and build upon those strengths.

- 10) One (1) full-time homemaker/parent aid can have a caseload of no more than 12 families at any one time.

## **II. Target Population**

### **Services must be restricted to the following eligibility categories:**

- 1) Children and families who have substantiated cases of abuse and/or neglect, with moderate to high levels of risk and service needs according to the assessment matrix
- 2) Children with a status of CHINS, and/or JD/JS
- 3) All adopted children and adoptive families

## **III. Goals and Outcome Measures**

### **Goal #1**

Timely intervention with family and regular and timely communication with referring worker

#### **Outcome Measures**

- 1) 95% of all families that are referred will have face-to-face contact with the client within 5 days of the referral or inform the referring worker if the client does not respond to requests to meet.
- 2) 95% of families will have a written plan prepared regarding expectations of the family and homemaker/parent aid and sent to the referring worker following receipt of the referral within 30 days of contact with the client.
- 3) 100% of all families will have monthly written summary reports prepared and sent to the referring worker.

### **Goal #2**

Improved family functioning

#### **Outcome Measures**

- 1) 90% of the families served will have resolved the problem that preceded the need for homemaker/parent aid services (such as living conditions, lice, unsafe environment, etc.)
- 2) Scores will be improved on the Risk Assessment and needs and strengths assessment instruments in ICWIS used by the referring DCS.

### **Goal #3**

DCS and family satisfaction with services

#### **Outcome Measure**

- 1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) Clients will rate the services “satisfactory” or above.

## **IV. Qualifications**

### **Minimum Qualifications:**

#### **Direct worker:**

A high School diploma or GED and is at least 21 years of age. Must possess a valid driver's license and the ability to use private car to transport self and others, and must comply with state policy concerning minimum care insurance coverage.

#### **Supervisor:**

Bachelor's Degree in social work, psychology, sociology, or a directly related human service field.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

#### **Qualities:**

- Ability to work as a team member
- Ability to work independently
- Insight into human behavior
- Patience
- Nonjudgmental
- Emotional maturity
- Knowledge of child development
- Understanding of family of origin/intergenerational issue
- Knowledge of community resources
- Belief that change is possible
- Ability to get along with others
- Strong organizational skills
- Thorough listener
- Exercise sound judgment
- Belief in family preservation philosophy
- Knowledge of child abuse and neglect

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

## **V. Billable Units**

### **Face to face time with the client:**

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.

- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

***Reminder:** Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are built into the cost of the face to face rate and shall not be billed separately.*

For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.

**Translation or sign language**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

**VI. Rates**

Face to Face Maximum rate: \$40.50 (1/1/2010)

Translation or sign language rate: Actual cost

**VII. Case Record Documentation**

Necessary case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS referral form authorizing service
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports no less than monthly or more frequently as prescribed by DCS.

**VIII. Service Access**

Services must be accessed through a DCS referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

**NOTE: All services must be pre-approved through a referral form from the referring DCS FCM or DCS Service Consultant.**

**FOSTER  
PARENT SERVICES  
SERVICE  
STANDARDS**

**SERVICE STANDARD  
INDIANA DEPARTMENT OF CHILD SERVICES  
FOSTER / ADOPTIVE / KINSHIP CAREGIVER TRAINING**

**I. Service Description**

The State of Indiana intends to contract with providers throughout the state to provide pre-service training for prospective families living in the State of Indiana. These families will be foster, adoptive or kinship families for children under the care and supervision of a local Department of Child Services (DCS) or under the care and supervision of another State Agency comparable to DCS. This training will also include in-service training, Adoption/Permanency, and First Aid/CPR/UP requirements.

**Pre-service Training**

The curriculum that is to be used is from the Institute for Human Services' "Foster, Adoption, Kinship Caregiver Training (FAKT) curriculum. When appropriate and if available, an introduction to foster parents supervising child visitation in their care should be included. The pre-service training is to be offered monthly in each region to ensure that pre-service training is offered on a regular, timely basis.

Provision of foster/adoptive/kinship caregiver training (FAKT), which includes 20 hours of pre-service training covering the competencies listed below:

- A. This will include permanency training for prospective foster, kinship, and adoptive parents.
- B. A monthly newsletter is to be provided to foster, adoptive, and kinship families to keep them informed of upcoming trainings and conferences as well as to provide them with educational information relative to children in their care.
- C. Pre-service training is to be provided to not less than 7 people or more than 30 people in a group. A waiver can be requested when less than 7 participants attend the training. A written request of waiver is sent to the Foster Care Consultant at Central Office for approval.
- D. The foster/adoptive/kinship caregiver training covers orientation and overview of the training and contains the following competencies:
  - 1) Teambuilding Competencies
  - 2) Family Systems and Abuse and Neglect Competencies
  - 3) Impact of Abuse and Neglect on Child Development Competencies
  - 4) Attachment, Separation, and Placement Competencies
  - 5) Discipline Competencies
  - 6) Cultural Issues in Placement Competencies
  - 7) Primary Families Competencies
  - 8) Sexual Abuse Competencies
  - 9) Effects of Care-giving on the Family Competencies

- 10) Permanency Issues for Children Competencies
- 11) Permanency Issues for Families Competencies
- 12) Connection and Disconnection of Children

### **In-Service Training**

Monthly in-service training will be provided for licensed DCS foster/kinship/adoptive families living in Indiana with topics that relate to fostering and/or adopting special needs children. The in-service trainings must be pre-approved by the FAKT Coordinator **OR** Central Office Foster Care Coordinator. Foster parents are required to obtain 10 hours of in-service training annually.

The in-service training contains information in the following areas:

- 1) Specialized and related classes as identified by the FAKT Coordinator.
- 2) Classes that meet a high need that have been identified by DCS **OR** the FAKT Coordinator.
- 3) Classes that address child development; proactive discipline and behavior management techniques; sexuality and sexual development and sexual abuse issues; abuse and neglect; attachment, separation, and placement; etc. and other topics as determined by the needs of foster, adoptive, and kinship parents.
- 4) Supervision of visitation between foster children and their biological parents (Any training material on this subject should be approved by DCS).

### **Other Training**

Other training (in-service training developed by subject matter expert):

- 1) Must submit curriculum for review/evaluation to FAKT Training Coordinator, Foster Care Consultant, **OR** DCS Regional Manager.
- 2) In-service training curriculum must be approved by FAKT Training Coordinator, Foster Care Consultant, **OR** DCS Regional Manager.

### **First Aid, CPR and Universal Precautions**

The provision of First Aid Training, CPR, and Universal Precautions Training (Blood Borne Pathogens, Transmission of Preventable Diseases) should include:

- 1) CPR training must include adult/child/infant CPR certified in a program on pediatric cardiopulmonary resuscitation and pediatric airway obstruction under the American Heart Association's Basic Life Support Course D or any other comparable course that provides the required training. American Heart Association, American Red Cross, American Safety and Health Institute, Medic First Aid/Pediatric First Aid (Adult, Child and Infant CPR inclusive), National Safety Council, and Heart Saver CPR state that they adhere to American Heart's Basic Course D's guidelines.
- 2) First Aid Training and Universal Precautions may be provided by any nationally accredited agency that provides this training to public and private

agencies such as Red Cross and American Heart Association. The trainer must be certified to provide these trainings.

## **II. Target Population**

- 1) Prospective foster parents who have passed a criminal history check or current foster parents of DCS. (County receives the application, runs the State background check and sends results along with the FAKT training request to the agency that will be doing the training. For county checks, a form is sent to the local Sheriff's office requesting the check and information is sent to the licensing agency.)
- 2) Prospective kinship families who have passed a criminal history check
- 3) Case managers and supervisors
- 4) Prospective or prepared adoptive parents who have passed a criminal history check

## **III. Goals and Outcome Measures**

### **Goal #1**

Increase the number of licensed foster/kinship parents and trained adoptive parents that are available to foster Indiana's abused and neglected children.

#### **Outcome Measures**

- 1) 90% of participants who start pre-service training will complete training sessions.
- 2) 95% of participants who complete pre-service training will become licensed.
- 3) 100% of adoptive parents will complete permanency training.
- 4) 100% of current foster/adoptive/kinship parents who start First Aid, CPR, and Universal Precautions training will complete.

### **Goal #2**

Increase the licensed foster parent's knowledge of child development and behavioral issues related to abuse and neglect, increase participants understanding of proactive discipline, sexuality and sexual development and understanding of sexual abuse.

#### **Outcome Measures**

- 1) 100 % of foster parents who become licensed will complete the required number of in-service training hours annually based on the type of license they hold.
- 2) 100% of current foster/adoptive/kinship parents will complete evaluations of the training attended.

### **Goal #3**

DCS and foster family satisfaction with services

#### **Outcome Measures**

- 1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 94% of the families who have participated in FAKT trainings will rate the services “satisfactory” or above.

#### **IV. Qualifications**

##### **Service Provider**

Must be knowledgeable of the State foster care program and training requirements, must have completed the Pre-service FAKT training, and must be skilled in determining, coordinating, and scheduling needed training and maintaining a database related to training hours.

##### **Minimum qualifications for persons providing pre-service training:**

- Complete the FAKT Training of Trainers Training (TOT) and participate in mentoring process as developed by the FAKT Training Coordinator
- Attend and complete Pre-service FAKT training
- Experienced in child welfare, foster parenting, foster parent training, or a directly related area
- Experienced as a group leader
- Recommended by DCS Regional Manager or their designee, or FAKT Training Coordinator

##### **Qualities of a trainer:**

- Has expertise in the topic being provided
- Understand own motivation, the child welfare system and the workers roles within it
- Positive attitude toward foster/adoptive/kinship parents
- Understand and identify with the needs of all members of the foster/adoptive/kinship care team (foster/adoptive/kinship parents, birth family, foster child, case manager, CASA/GAL, and service providers)
- Emotionally mature, non-judgmental attitude, and exercises sound judgment
- Empathetic and a thorough listener
- Strong communication and interpersonal skills
- Belief in family preservation philosophy

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

#### **V. Billable Units**

### **Coordination for training per hour**

Rates must include coordinator time, overhead including fringe benefits, materials, registration, general training materials, lending library materials, mileage not to exceed the state rate of \$.40 per mile, attendance at bi-monthly FAKT Coordinator meetings and other required training meetings (not to exceed 3 per contract year), evaluations, and other items as specified related to the business of providing the trainings listed below:

- **Pre-Service Training**
- **In-Service Training**
- **First Aid, CPR, Universal Precautions Training**
- **Cancelled Trainings due to lack of registrations** *(This rate should be based on the predicted amount of work that will be required in scheduling, locating a speaker and location, phone calls, and other time required to plan for training. No more than two cancelled trainings may be claimed with a maximum of 10 hours for each scheduled training that is cancelled due to lack of registrations or attendance.)*

### **Miscellaneous costs for the above named trainings**

Rates should include trainer prep time, training time, travel expense for the trainer, training specific materials, and refreshments. Trainer costs should be based on the amount of experience and qualifications of the person providing the services as well as the number of trainers needed. Travel expense for mileage is not to exceed the State rate of \$.40 per mile.

### **Billing for crossed-county foster parents**

If it is just a one time occurrence, an MOU is not required. If the LCPA sends foster parents to training regularly, a MOU is required and must be approved by the State. The FAKT Coordinators should send copies of the MOU to the Foster Parent Coordinator in Central Office.

Any amount billed to an LCPA would be subtracted from the amount billed to the State.

Each provider should submit their claims for the region they are contracted to serve and should also submit a county break-out sheet for the counties that services are provided.

When all counties are listed under each region, the billing should be submitted in the following format:

Each provider is set up in CMS for the regions they are contracted to serve but the contracts are “statewide”. Each provider should continue to submit their claims for the region they are contracted to serve. Continue to submit a county break-out

sheet for the counties you provided services in. If all participants are from a region that the coordinator serves, coordinators will take the cost of the training and divide it by the number of participants. The proportional cost would be charged to each region. If some participants are from regions that are not served by the coordinator, those participants would be billed to the region where the training was held. On the county expenditure form, the amount should be recorded under the county where they are licensed. The coordinator should track the total amount which has been billed to each region for training foster parents outside the region. These amounts should be reported regularly to the Regional Child Welfare Services Coordinators. Coordination time should be recorded under each county equally. If trainings cross months, the training amounts will need to be billed for each month. Providers will be permitted to have a summary page for training costs and keep timesheets in their office for audit purposes.

### **Billing for Coordinator Services**

Administrative fees are built into the coordinator hourly rate and should not be billed. It is not allowed to bill sick, personal, vacation or holiday pay separate as these should have also been built into your hourly rate that your coordinator is providing services. With Coordination services, only bill the time the Coordinator is actually working on the services as defined in the standards. The State allows billing for assistant coordinators when they are actually doing coordination work. They would, however, need to meet the qualifications for the coordinator in the service standards. We would need the same record keeping for time as the other coordinators keep.

### **Location costs**

Actual cost of rental space (if space is unavailable through a public facility at no cost).

### **Newsletter costs**

Includes developing the monthly newsletters, printing costs, and mailings. It is expected that the newsletter will be emailed when possible to reduce the cost.

### **Training of Trainers (TOT) cost**

TOT cost includes actual cost of attendance at TOT, mileage not to exceed the State rate of \$.40 per mile, and lodging if more than 50 miles from the training location. Actual cost of trainer for TOT that is provided by the service provider.

### **Translation or sign language**

Services include translation for families who are non-English language speaking or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

***For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the***

*following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours.*

## **VI. Rates**

Available payment points are as follows:

- FAKT Coordinator Services – per hour
- FAKT Training – Actual Cost (includes costs of trainers, training sites, supplies, and cancelled trainings)
- FAKT Training of Trainers – Actual Cost
- FAKT Newsletters – Actual Cost
- FAKT Interpreter Services – Actual Cost

**Budget Summary must be submitted for rates.**

## **VII. Case Record Documentation**

- 1) Documentation of coordination services such as securing trainers, setting up locations, etc.
- 2) Evaluation reports completed by the participants on a form provided by DCS at the end of each in-service training session.
- 3) Monthly reports provided to DCS Central Office Foster Parent Consultant regarding all other training provided on a form provided by DCS for this purpose.

## **VII. Service Access**

Training services can be accessed by persons interested in becoming a licensed foster/kinship foster home or adoptive parents either through their local DCS or FAKT Coordinator. An agency may not provide training to their own prospective foster/adoptive parents. This must be done by another qualified agency.

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**FOSTER FAMILY SUPPORT SERVICES**

**I. Service Description**

The Foster Family Support Coordinator (FFSC) will provide support services to local foster parents through a monthly or bi-monthly support group at the local DCS office which may include at least one training hour per meeting and bi-weekly phone contact. Child care should be provided if requested by foster families attending the support group meetings. Anyone providing childcare at support group meetings must pass a criminal history and CPS check.

The FFSC may be contracted to provide services on a part time or full time basis depending on the needs of the county. Working hours must be flexible and irregular in order to best meet the needs of the foster families. The FFSC may need to be available on weekends and evenings at times to provide assistance when situations arise that requires support services.

The FFSC will assist foster families in strengthening the relationship between the foster family and their foster children and promoting positive relationships between the foster families and the local DCS family case managers. The FFSC will work closely with the licensing Family Case Manager

The FFSC will assist in maintaining and strengthening the skills of local foster families. With support services available locally, foster families may be more willing to accept special needs children and older youth that come into care. By strengthening local foster homes, the DCS will be more able to maintain children in local foster homes. The following services will be provided by the FFSC:

- 1) Work with all licensed foster families by the county being served.
- 2) Work closely with the Licensing Family Case Manager in supporting the current foster families and working through situations involving other family case managers.
- 3) Serve as a liaison between the foster children's Family Case Manager and the foster family to work out any issues that may arise in order to preserve the child's placement and to develop and maintain a positive working relationship.
- 4) Develop a quarterly newsletter for foster parents and DCS staff to provide information regarding new staff at the DCS, upcoming topics for support meetings, and other pertinent information that needs to be decimated.
- 5) Provide refreshments and child care at monthly or bi/monthly support meetings.
- 6) Initiate at least monthly phone contact with foster families to allow foster parents to ask questions, request any needed information, and discuss any topic related to their foster children;
- 7) Facilitate a monthly/bi-monthly support group for foster parents to allow group discussion regarding fostering concerns and solutions and provide training

- sessions of topics requested by the foster parents (pro bono speakers/trainers should be recruited from the professional community that serve the foster children);
- 8) Invite prospective foster parents to the monthly/bi-monthly support group meeting.
  - 9) Provide monthly reports regarding contact with the foster families to the licensing family case manager. The report must contain all contacts with foster families, foster children, and family case managers and information regarding issues that were discussed and resolution to the issues. The report must also include information regarding the monthly or bi-monthly support meeting, attendance, and information regarding the training that was provided for in-service credit.
  - 10) Provide an annual report to the local DCS Regional Manager of the year's activities, progress, and areas that need improvement.
  - 11) Additional outcome objectives may be included. Process objectives may be included (i.e. how services are to be delivered).
  - 12) Provide foster parents with a certificate for training hours received signed by the presenter.
  - 13) Provide annual in-home visits with each foster family coordinating with the licensing family case manager either six month prior to or six months after the DCS annual home visit.

## **II. Target Population**

- 1) All foster and kinship parents licensed by the referring county DCS office.
- 2) Court ordered substitute caregivers and adoptive parents.

## **III. Goals and Outcome Measures**

### **Goal #1**

Retention of the current number of foster parents that are licensed

#### **Outcome Measures**

- 1) 95% retention of currently licensed foster families that continue to reside in the county.
- 2) 90% of licensed foster families participate in support meetings
- 3) 100% maintain contact with the foster family support worker.

### **Goal #2**

Develop an environment where foster families believe they are being heard and respected for the work they do.

#### **Outcome Measures**

- 1) 100% of foster families can report their belief that the DCS respects the work they do.
- 2) 10% increase in the number of foster families willing to accept special needs children and older youth based on the support received.

- 3) 95% of foster families that attend support group meetings complete their required in-service training timely.

#### Goal #3

DCS and foster family satisfaction with services

Outcome Measures

- 1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 94% of the families who have participated in Foster Family Support Services will rate the services “satisfactory” or above.

#### IV. Qualifications

##### **Direct Worker:**

Bachelor's degree in social work, psychology, sociology, or a directly related human service field.

##### **Supervisor:**

Master's degree in social work, psychology, or directly related human services field.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

##### **The FFSC must:**

- Possess clear oral and written communication skills
- Possess the ability to play the role of a mediator when necessary
- Possess the ability to confront in a positive manner and provide constructive criticism when necessary
- Demonstrate insight into human behavior
- Demonstrate emotional maturity and exercise sound judgment
- Be nonjudgmental
- Be a self starter
- Exhibit the ability to work independently
- Exhibit the ability to work as a team member
- Have strong organizational skills
- Must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
- Demonstrate respect for socio-cultural values, personal goals, life style choices, and complex family interactions and be delivered in a culturally competent fashion.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

## V. Billing Units

### Face to face time with the client:

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

*Reminder: Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are built into the cost of the face to face rate and shall not be billed separately.*

For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.

### Translation or sign language

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

## VI. Rates

Face to Face Rate: \$38.25 (1/1/2010)

Translation or sign language: Actual Cost

## VII. Case Record Documentation

- 1) Contact logs of all phone and face-to-face contacts with foster families, prospective foster families and DCS workers related to the foster families;
- 2) Support meeting sign in sheets if applicable;
- 3) Monthly reports regarding work with foster families that is provided to DCS; and

- 4) Copies of quarterly newsletters.

### **VIII. Service Access**

Service can only be accessed by licensed foster families, prospective foster families, or adoptive families as identified by DCS either verbally or in written form.

***NOTE: All services must be pre-approved through a referral form from the referring DCS FCM or DCS Service Consultant.***

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**FOSTER HOME STUDIES / UPDATES / RE-LICENSING STUDIES**

**I. Service Definition**

This is an information-gathering and evaluation of the family and home environment and making recommendations to DCS, provide foster home licensing studies, and or updates/re-licensing studies. Collects information and evaluates the family and home in some combination of the following areas:

- Income/expense records
- Expectations
- Family history
- Education
- Concerns
- Discipline methods
- Employment history
- References
- History of arrests
- Attitude of family
- Marital relationships
- Adoption/fostering preparation
- Parent/child relationships
- Attitude of community toward foster care
- Areas of tension/conflict
- Adoption/fostering
- Extended family
- Sibling relationships
- Support systems
- Reasons for applying
- Interests/activities/hobbies
- Applicants knowledge/experience with type of child
- Adequacy of home
- Compliance with law/regulation/policy
- Family health
- Case record requirement
- Children's school performance
- Children's behavior

➤ Religious/spiritual orientation

- 1) Services will be provided in the family's home or combination office/home.
- 2) Services must be completed within 60 days of receipt of the referral or by a time frame specified by DCS at the time of referral.
- 3) Services will be provided at the convenience of the family.
- 4) For Interstate Compact (ICPC) requests, the final approval of the home is the responsibility of DCS.
- 5) Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
- 6) Services must demonstrate respect for socio-cultural values, personal goals, life style choices, and complex family interactions and be delivered in a culturally competent fashion.

## **II. Target Population**

- 1) Families for who foster home licensing/updates/re-licensing studies have been requested by the DCS.
- 2) ICPC requests for studies of Indiana families as potential placement for relative children from other states.

## **III. Goals and Outcome Measures**

### Goal#1

Provide that foster care home studies/updates/re-licensing studies are completed timely.

### Outcome Measures

- 1) 98% of studies will be completed by DCS deadline within 60 days or unless otherwise specified.
- 2) 100% of studies will be completed by DCS instructions and accepted by them.

### Goal #2

DCS and foster family satisfaction with services

### Outcome Measures

- 3) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 4) 94% of the families who have participated in Foster Family Support Services will rate the services “satisfactory” or above.

## **IV. Qualifications**

### **Direct Worker:**

Bachelor's degree in social work, psychology, sociology, or a directly related human service field.

**Supervisor:**

Master's degree in social work, psychology, or directly related human services field.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

In addition to:

- Knowledge of family of origin/intergenerational issues.
- Knowledge of child abuse/neglect.
- Knowledge of child and adult development.
- Knowledge of community resources.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

**VI. Billable Units**

**Hourly rate (up to 8 hours for foster home studies and 4 hours for updates and re-licensing studies; additional hours must be approved by the referring DCS): Includes face to face contact with the identified clients during which services as defined in the service standard are performed. Collateral contacts, travel time, mileage not to exceed the State rate of \$.40, scheduling of appointments, and report writing are included in this billable unit.**

For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.

**Translation or sign language**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

**VI. Rates**

Hourly Maximum rate: \$45.90 (1/1/2010)

Translation or sign language rate: Actual cost

## **VII. Case Record Documentation**

- 1) A completed, dated, signed DCS referral form authorizing service;
- 2) Documentation of contact with DCS workers, referred foster families, or others related to the requested study; and
- 3) Copy of the completed study.

## **VIII. Service Access**

**NOTE: Service can only be accessed through a DCS FCM or DCS Service Consultant referral.**

**OTHER SERVICE**

**SERVICE**

**STANDARDS**

**SERVICE STANDARD  
INDIANA DEPARTMENT OF CHILD SERVICES  
CARE NETWORK SERVICE STANDARD**

**I. Service Description**

Care Network encompasses the part of the system of care that focuses on coordinating, integrating, facilitating and monitoring services for children with behavioral health needs who are in the child welfare or juvenile justice system.

This system of care is based on a comprehensive spectrum of services which are organized into a coordinated network to meet the multiple and changing needs of children with severe emotional disturbances and behavioral challenges and their families.

Services in the system of care should be comprehensive, incorporating a broad range of services and supports, individualized, provided in the least restrictive appropriate setting coordinated at the system and service delivery levels, involve youth and families as full partners and emphasize early identification and intervention. Core values of a system of care are that services are child centered and family focused, community based and culturally competent.

Services include providing any requested testimony and/or court appearances including hearings or appeals.

Services within the network will include but are not limited to the following:

1) Behavioral Health Services

- Behavior Management Services
- Crisis Intervention
- Day Treatment
- Evaluation / Testing Services
- Family Assessment
- Family Therapy
- Group Therapy
- Individual Therapy
- Parenting/ Family Skills Training Groups
- Special Therapy
- Substance Abuse Therapy- Group
- Substance Abuse Therapy- Individual
- Family Preservation – home based services

2) Mentor Services- hourly

- Case Management

- Clinical Mentor
- Educational Mentor
- Life Coach/ Independent Living Skills Mentor
- Parent and Family Mentor
- Recreational/Social Mentor
- Supported Work Environment
- Tutor

### 3) Other Services

- Consultation with Other Professionals
- Team Meetings
- Transportation

### 4) Psychiatric Services- hourly

- Assessments Outpatient
- Medication Follow-up/ Psychiatric Review

### 5) Respite Services

- Crisis Respite
- Planned Respite
- Respite-Residential or Hospital 23 Hour

### 6) Supervision Services

- Community Supervision
- Intensive Supervision

## **II. Specific Responsibilities**

### 1) The Care Network Facilitator conducts the following activities for the system of care:

- Evaluates and interprets referral packet application and completes a strength-based assessment with child and family and the Child and Adolescent Needs and Strengths Assessment (CANS);
- Schedules and facilitates in coordination with the DCS Family Case Manager (FCM) family/child specific team meetings;
- Address need for and develop, revise and monitor in a crisis plan with family and team members;
- Monitor progress by communicating with the family and child, as well other team members through no less than monthly team meetings;
- Maintains comprehensive reports based on services and assessments while providing information to FCM and team members every 30 days, reassess child using CANS every 6 months;
- Makes recommendations to team members based on monthly assessments and service reports;

- Assist the family and child with gaining access to services and assuring that families are aware of available community-based services and other resources such as Medicaid State Plan services, Vocational Rehabilitation programs, educational, and public assistance programs; mental health and addiction services as indicated;
- Monitor use of service and engage in activities that enhance access to care, improve efficiency and continuity of services, and prevent inappropriate use of services;
- Monitor health and welfare of the child/youth;
- May provide crisis intervention.

2.) Providing agency receives referrals 24 hours a day, 7 days a week. There is a verbal determination between DCS, the family and the agency that services are warranted, and there is agency availability for the service before the referral is sent.

3.) The face- to- face intake must occur no later than the end of the day following the referral.

4.) Assessments including the goal setting and service plan are mutually established between the client, care facilitator and FCM with a written report signed by the family and care facilitator, submitted to the DCS referring worker within 7 days of the initial face-to-face intake and every 30 days thereafter. Communication between the care facilitator and DCS is constant and documented as arranged between the two.

5.) Each family receives access to services through a single care facilitator acting within a team, with availability 24 hours a day 7 days a week.

6.) Family functioning assessments, assessments of caretakers needs through the CANS, the family's response, presenting problems according to DCS referral are factors included in the goal setting. Goals are behaviorally specific, measured and attainable.

7.) Safety is of paramount importance. If there are indications about safety concerns within the home there is an obligation for the care facilitator and DCS to communicate to address all safety concerns, and document safety steps taken to resolve the issues. If new incidences occur, the care facilitator is to notify DCS immediately of the situation.

8.) Confidentiality must be maintained. Failure to maintain confidentiality may result in termination of the service agreement. Appropriate release forms will be requested and signed by family members and DCS before information is shared with team members or others.

### **III. Target Population**

Services must be restricted to cases where severe emotional disturbances and/or behavioral problems have been documented within the following eligibility categories:

- 1) Children and families with a case type of Informal Adjustment (IA) with moderate to high levels of risk and service needs according to the DCS assessment matrix; and,
2. Children with a status of CHINS, and/or JD/JS (Juvenile Delinquency/Juvenile Status); or,
3. All adopted children and adoptive families

#### **IV. Goals and Outcome measures**

Goal #1: Provide high quality care which results in improved outcomes for the child and family.

##### **Improved child and family functioning**

- A.) Improved school functioning from case opening to closure
  - An increase in scores as found on grade reports in 85% of cases
  - Decrease in absenteeism/truancy as reflected by attendance reports in 85% of cases
  - A decrease amount in behavior reports in 85% of cases
  - A decrease in suspension/expulsion reports in 85% of cases
- B.) Improved records with the child welfare and juvenile justice system
  - 85% of families with no further substantiated incidences of child abuse or neglect, which results in removal of the child from the home during involvement
  - 85% of families show improvement and child(ren) remain at home.
- C.) Progress in service coordination plan
  - Measured by monthly team report and Care Facilitator plan of care
- D.) Fewer days in out of home placement (the provider will track and report as a part of evaluation the number of continuous days in placement for each child).
  - Information submitted will be evaluated by DCS against DCS data.
- E.) 50% of the children and families will have statistically significant improvement in any life domain on the CANS (functioning, behavioral health systems, risks, caretaker needs and strengths, child strengths)

#### **V. Qualifications**

##### **Supervisor**

1. Master's Degree in Social Work, Psychology, Marriage and Family Therapy, or related Human Services field; and,
2. A current license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board as one of the following:

- Clinical Social Worker
- Marriage and Family Therapist
- Mental Health Counselor

### **Care Network Facilitator**

1. Bachelor's Degree in Social Work or related Human Service field; and,
  2. Minimum of three years of clinical/management experience in human service field; and,
  3. Demonstrated 2 or more years of clinical intervention skills; and,
  4. Demonstrated skill in fiscal management activities, team building and development.
- Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

The Care Network Facilitator assures care is delivered in a manner consistent with strength-based, family centered, and culturally competent values, offers consultation and education to all providers regarding the values of the model, monitors progress toward treatment goals and assures that all necessary data for evaluation is gathered and recorded.

### **VI. Billable Units**

The Care Network Facilitator and team will determine what services a child/family needs and what they may be eligible for and can use flex funding when services cannot be accessed through other available State contracts. Services recommended by the Continuum of Care Facilitator that don't have other state contracts will have the ability to be reimbursed on a dollar for dollar basis with flexible funding.

- Requested testimony and/or court appearances including hearings or appeals as requested and approved by the DCS.

**Face to Face time with the client** (Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family):

- 1) Includes any client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- 2) Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- 3) Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.
- 4) Time spent with service providers on behalf of the client/family to plan and monitor services and progress.

**Reminder:** *Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time, no show and planning, and report writing for family meetings. These activities are built into the face to face rate and shall not be billed directly.*

**For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are rounded to the nearest quarter hour using the following guidelines:**

**8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.**

**Flexible Funding:**

There must be a documented need for the goods and/or services. Documentation of expenditure of funds must be maintained by the agency.

If under \$500-either it be a part of the case plan or approval of the FCM Supervisor for the expense.

If over \$500 – prior approval is mandatory from the Local Office Director or their designee.

**Translation or sign language:**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client - dollar for dollar amount.

**VII. Rates**

Face to Face Maximum Rate: \_\_\_\_\_

Translation or Sign Language Rate: Actual Cost

Flexible Funding: Actual Cost

Provider must provide a budget summary for Face to Face Rate.

**VIII. Case Record Documentation**

Documentation of services will be maintained and updated at least monthly by the curriculum of care facilitator. Records are confidential and may only be shared with participating team members unless informed consent is obtained from the child/youth's parent or guardian.

Necessary case record documentation for service eligibility must include:

- 1) A DCS referral form; and,

- 2) Documentation of regular contact with the referred families/children and referring agency; and,
- 3) Written monthly reports regarding each case facilitation that has been referred.

## **IX. Service Access**

Services must be accessed through a DCS referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

**NOTE: All services must be pre-approved through a referral form from the referring DCS FCM or DCS Service Consultant.**

## SERVICE STANDARD

### INDIANA DEPARTMENT OF CHILD SERVICES CHILD ADVOCACY CENTER (Revised 6/09)

#### I. Service Description

The Child Advocacy Center (CAC) facilitates a multidisciplinary team approach to the investigations of allegations of child abuse and neglect. Teams of professionals, include law enforcement, child protective services, prosecution, medical and mental health, victim assistance, and child advocacy. The CAC must be a designated legal entity responsible for program and fiscal operations. The CAC must be a child appropriate facility, which maintains focus on the child and helps to ensure that systems designed to protect children are able to do so effectively through culturally competent policies and practices. The purpose is to enhance the response to suspected child abuse cases by combining the expertise and professional knowledge of various investigative agencies and other professionals. Those involved in the CAC share a core philosophy that **child abuse is a multifaceted community problem and that no single agency, individual or discipline has the necessary knowledge, skills or resources to serve the needs of children and their families.**

The Child Advocacy Center **shall** provide the following:

Recorded interviews of child abuse victims in safe, child-friendly surroundings to avoid multiple interviews, reduce the trauma of disclosure, and preserve statements for court purposes. It consists of one or a series of developmentally appropriate, forensic interviews by a specially trained forensic interviewer who builds trust and rapport with the child while taking care not to suggest words or answers that are not the child's own. Other professionals may observe interviews and participate as appropriate by using a one way glass window, bug-in-the-ear system or remote camera/television or some similar method of communication. Team discussion and information sharing regarding the investigation, case status and services needed by the child and family are to occur on a routine basis. The CAC must develop and implement a system for monitoring case progress and tracking case outcomes for team components. **Copies of interviews and reports will be given to local DCS offices. In the cases of prosecution, a report is required to be given to local DCS offices.**

The Child Advocacy Center **may** provide any or all of the following:

- **Forensic medical exams, offered on-site or by a consulting physician, utilizing specialized equipment necessary for accurate diagnoses.**

- Mental health professionals with special knowledge, skill and experience in this field provide therapy for child victims of abuse and their families. Services include individual, family and group therapy, crisis intervention, and consultation to the child's school.
- Play Therapy to allow children to work through worries and troubles and gain understanding and mastery of the world around them. This is a powerful means for children to overcome experiences of victimization and to acquire a sense of safety and appropriate personal power.
- Case review and tracking which includes follow-up calls to clients for up to two years to offer services and to assure that family conditions remain stable.
- Family Advocacy, crisis intervention, support/advocacy and counseling for victims and their families during the investigative and deposition process.
- Educational Programs  
Free abuse awareness and prevention training to the community. Programs may include recognizing signs and symptoms of child abuse, methods for abuse prevention, body safety and the intricacies of the child protection system.
- Provide support groups for non-offending parents in cases of alleged child sexual abuse in a manner that they can act responsibly to protect and support the alleged child victim.

## **II. Target Population**

Every child in Indiana alleging abuse may benefit from a multidisciplinary team approach to investigations in a safe, child friendly environment within a reasonable traveling distance.

Services must be restricted to the following eligibility categories:

- 1) Families and children for whom a child protection service investigation has been initiated.
- 2) Families and children for whom the children have been adjudicated a CHINS or have an Informal Adjustment

## **III. Goals**

### Goal #1

To provide a child and family friendly facility to which DCS and LEA may bring (or send) children and families for a forensic interview after a child's disclosure of abuse

#### Outcome Measures

- 1) Maintain a log of children interviewed
- 2) Maintain a log of MDT members using the facility
- 3] Maintain and/or provide multidisciplinary team members with a copy of the recorded interview according to established protocols

### Goal #2

Provide a comprehensive multidisciplinary, developmentally and culturally appropriate responsive environment to prevent trauma to children during interviews.

Outcome Measures

- 1) Conduct interviews in the language of the child
- 2) Provide multidisciplinary partners appropriate training to ensure proper interviewing
- 3) Provide translators for child or family if one is necessary. This translator should be a non-family member of the client if possible.
- 4) Make provisions for hearing impaired child or family member if one is necessary. This translator should be a non-family member of the client if possible.

Goal #3

Maintain open communication, information sharing and case coordination with community professionals and agencies involved in child protection efforts.

Outcome Measures:

- 1) Record interviews for sharing, as necessary, with community professionals (law enforcement, child protection services, prosecution, medical and mental health, victim assistance, and child advocacy) working with the child and non-offending family members.
- 2) Track interviews and services and coordinate with all professionals involved with the children and non-offending family members on an as needed basis.

Goal #4

Aid multidisciplinary team members educate non-offending caregivers on their role in the investigative process.

Outcome Measures

- 1) Help non-offending caregivers understand the legal and child protective systems
- 2) Assure non-offending caregivers understand their role is to support the child and not to gather facts independent of the multidisciplinary assessment/investigation.
- 3) Assist non-offending family members with regard to their lost of income or financial support, sudden change of lifestyle, and divided

Goal #5

Satisfaction with services

Outcome Measures

- 1) DCS satisfaction will be rated 4 and above on the Program Progress Report
- 2) 90 % of children reported feeling that the Child Advocacy Center was a child friendly/child appropriate facility.
- 3) 90 % of parents who filled out the evaluation reported satisfaction with the safety and positive or neutral effect on their child's anxiety.

## **IV. Qualifications**

### **Minimum qualifications:**

Centers minimally will have a director and support staff, as needed. In addition, centers may maintain a staff of trained volunteers who assist in the provision of Center program services under the supervision of Center staff.

- **Executive Director:** Bachelor's Degree or related experience preferred as required by center's board of directors.
- **Forensic Interviewer:** Bachelor's Degree in social work, psychology, criminal justice, education or a related field or a Master's Degree in Social Work or Forensic Science. A minimum of two (2) years of professional experience working with children and families where abuse and violence are identified issues is required. Requires professional experience in working with the criminal justice or child welfare system and has been or will be trained in a Forensic Interview technique.
- **For a start-up Child Advocacy Center, the qualifications for the Forensic Interviewer are:** Bachelor's Degree in social work, psychology, criminal justice, education or a related field or a Master's Degree in Social Work or Forensic Science. A minimum of two (2) years of professional experience working with children and families where abuse and violence are identified issues is required. Requires professional experience in working with the criminal justice or child welfare system and has been or will be trained in a Forensic Interview technique before the contract period.

**DCS will fund the persons (Forensic Interviewers) who are in place at the time the contract is effective (January 1, 2009) this first time. After that, candidates must meet the qualifications.**

- **Interns** must complete orientation training and will be supervised by the executive director.
- **Volunteers:** Must complete volunteer orientation training. Volunteers may be supervised by center staff.

**There will be two (2) Interview rates.** One interview rate, called the **CAC interview** will include all services that are provided as a part of the child forensic interview and assessment/investigation. The second Interview rate will be for usage of the Child Advocacy Center by the local DCS office and will be called the **DCS interview**. All billed time must be associated with a family/client. Payment for services will be based on actual allowable costs. Grantees will bill monthly on these payment points: This cost may include:

- Forensic interview
- Family meeting with multidisciplinary team prior to and/or post interview
- Family advocacy
- Center staff time for case coordination and child supervision
- Case tracking
- Recording costs associated with the interview
- Team training
- Court preparation and testimony
- On- site medical examination as necessary

- Mental health counseling, play therapy

Billing records shall include the following information:

- Center case number
- Date of interview
- Names of child or children
- Name of parent/mother
- Name of DCS caseworker/s
- Name of interviewer
- Any other information required by the State

**Translation or sign language**

Services including translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client.

**VI. Rates:**

CAC Interview Rate: \_\_\_\_\_

DCS Interview Rate: \_\_\_\_\_

Translation or sign language rate: Actual Cost

**A Budget Summary must be submitted for both rate determinations.**

**VII. Service Access:**

Services must be accessed through a DCS Family Case Manager or DCS Service Consultant referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved time period.

**NOTE: All services must be pre-approved through a DCS Family Case Manager or DCS Service Consultant referral form. In emergency situations, services may begin with a verbal approval but must be followed by a written referral form within 5 days. It is the responsibility of the service provider to obtain the written referral.**

**SERVICE STANDARD  
INDIANA DEPARTMENT OF CHILD SERVICES  
CHINS PARENT SUPPORT SERVICES**

**I. Service Description**

The CHINS Parent Support Worker (CPSW) will provide support services to parents who have children in foster care, this includes absent parents, and parents whose children were previously in foster care and remain a CHINS. The CPSW will assist families in strengthening the relationship with their children and promoting positive relationships between the families and the local DCS family case managers and others involved in their children's case. In the case of the absent parent the CPSW may help in the location, engaging and support of the absent parent. The CPSW may be contracted to provide services on a part time or full time basis depending on the needs of the county.

The CPSW will facilitate a monthly/bi-monthly support group for parents to allow group discussion regarding concerns related to their children and assist in maintaining and strengthening the skills of participating families. Individual family support may be provided for those families who are unable to function appropriately or understand the material in the group setting. Individual support of families can be for the caretaker or the absent parent. Services to locate and engage the absent parent can be supported through this service standard.

Use family finding techniques including case mining, Internet searches, and telephone calls to locate absent parent. Protocols for searching must be followed. **Contact the Deputy Director for Program and Services to arrange training from State Staff on the use of family finding techniques.**

**Family support group meetings must provide:**

- 1) information regarding the CHINS legal process including court procedures, parental participation requirements, court ordered services, visitation with the children, reimbursement of cost for services, and other aspects related to the legal process;
- 2) the expectations of the family related to participation in court ordered services and visitation with the children, attendance at court, appropriate dress for court, and other aspects related to the legal process;
- 3) information regarding the parent's rights and the CHINS proceedings, the length of time children may be in care prior to a permanency procedure, and termination of parental rights;
- 4) role of the Court Appointed Special Advocate or Guardian ad Litem,
- 5) interactive activities including pre and post tests related to the CHINS process, parental rights, parental participation, reimbursement for cost of services, permanency, termination of parental rights and other issues related to CHINS case to assist in the learning process and to ensure that learning is taking place,

- 6) an informal environment for parents to discuss issues that brought them to the attention of the DCS and develop suggestions that may assist in resolving these issues as a group, and;
- 7) educational programs using speakers recruited from the local professional community to assist and educate the families in areas such as:
  - abuse and neglect,
  - increasing parenting skills,
  - substance abuse,
  - anger management,
  - advocacy with public agencies including the children's schools, and;
  - issues of interest to the parents related to their needs and the needs of their children.

## **II. Target Population**

**Services must be restricted to the following eligibility categories:**

- 1) Children and families who have substantiated cases of abuse and/or neglect, with moderate to high levels of risk and service needs according to the assessment matrix
- 2) Families who's children has the status of CHINS, and/or JD/JS
- 3) Absent parents of children who have the status of CHINS and/or JD/JS

## **III. Goals and Outcome Measures**

### **Goal #1**

Educate parents regarding CHINS process and expectations of the parents involved.

#### **Outcome Measures**

- 1) 90% of parents participating can verbalize their rights and expectations related to the CHINS proceedings.

### **Goal #2**

Develop an environment where families believe they are being heard.

#### **Outcome Measures**

- 1) 90% of families participating verbalize their ability to provide input and make recommendations at the meetings.

### **Goal #3**

DCS and family satisfaction with services

#### **Outcome Measures**

- 1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.

- 2) 90% of the families who have participated in Family Support Services will rate the services “satisfactory” or above.

#### **IV. Qualifications**

**Direct Worker:**

Bachelor's Degree in social work, psychology, sociology, or a directly related human service field.

**Supervisor:**

Master's degree in social work, psychology, or related human services field.

**The CPSW must:**

- Possess clear oral and written communication skills
- Possess the ability to play the role of a mediator when necessary
- Possess the ability to confront others in a positive manner and provide constructive criticism when necessary
- Demonstrate insight into human behavior
- Demonstrate emotional maturity and exercise sound judgment
- Be non-judgmental
- Be a self starter
- Have strong organizational skills
- Must respect confidentiality. (Failure to maintain confidentiality may result in immediate termination of the service agreement.)
- Demonstrate respect for socio-cultural values, personal goals, life style choices, and complex family interactions and be delivered in a culturally competent fashion.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

#### **V. Billing Units**

**Group rate**

Groups are defined as a minimum of three (3) with no more than twelve 12 participants. The rate must include preparation time, report writing, contacting families, and face-to-face contact in group with participating families.

**Face to face time with the client:**

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

***Reminder:*** Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are built into the cost of the face to face rate and shall not be billed separately.

For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.

#### **Translation or sign language**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client.

#### **VI. Rates**

**Budget Summary must be submitted for rates.**

#### **VII. Case Record Documentation**

**Necessary case record documentation for service eligibility must include:**

- 1) A completed, dated, signed DCS referral form authorizing service
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports as requested but no less than quarterly

#### **VIII. Service Access**

Service can only be accessed by families as identified by DCS either verbally or in written form. Any verbal recommendation from DCS must be documented in writing by the service provider with the date of referral and name of DCS staff person making the referral.

***NOTE:*** All services must be pre-approved through a referral form from the referring DCS FCM or DCS Service Consultant.

**SERVICE STANDARD  
INDIANA DEPARTMENT OF CHILD SERVICES  
COUNSELING-INDIVIDUAL / FAMILY**

**I. Service Description**

Provision of structured, goal-oriented therapy on the issues related to the referral for family members who need assistance recovering from physical abuse, sexual abuse, emotional abuse, or neglect. Other issues, including substance abuse, dysfunctional families of origin, etc., may be addressed in the course of treating the abuse or neglect.

Professional staff provides individual, group, and/or family counseling with emphasis on one or more of the following areas:

- Conflict resolution
- Behaviors modification
- Support Systems
- Interpersonal Relationships
- Communication Skills
- Substance Abuse
- Parenting Skills
- Problem solving
- Stress Management
- Self-Esteem
- Goal-setting
- Domestic Violence Issues
- School Problems
- Family of origin/inter-generational issues

- 1) Services are provided at a specified (regularly scheduled) time for a limited Period of time.
- 2) Services are provided face-to-face in the counselor's office.
- 3) Services must be compatible with the established Department of Child Services (DCS), Informal Adjustment, or a CHINS Case Plan.
- 4) Counselor must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
- 5) Services must demonstrate respect for socio-cultural values, personal goals, life style choices, and complex family interactions and be delivered in a culturally competent fashion.
- 6) Services include providing any requested testimony and/or court appearances including hearing and/or appeals.
- 7) Services must be provided at a time convenient for the family.
- 8) Services will be time-limited.
- 9) Written reports will be submitted monthly to provide updates on progress and recommendation for continuation or discontinuation of treatment.

**II. Target Population**

**Services must be restricted to the following eligibility categories:**

- 1) Children and families who have substantiated cases of abuse and/or neglect, with moderate to high levels of risk and service needs according to the assessment matrix

- 2) Children with a status of CHINS, and/or JD/JS
- 3) All adopted children and adoptive families

### **III. Goals and Outcome Measures**

#### **Goal #1**

Assessment/Treatment initiated quickly after referral

#### **Outcome Measures**

- 1) 85% of clients referred for treatment will have an appointment take place within 12 business days of the receipt of the referral.
- 2) 95% of clients referred will have a treatment plan in place within 30 days of initial appointment.

#### **Goal #2**

Timely reports regarding progress

#### **Outcome Measures**

- 1) 100% of all progress reports will be submitted monthly or as requested by the referring DCS.

#### **Goal #3**

Development of positive means of managing crisis.

#### **Outcome Measures**

- 1) 90% of the individuals/families served will not be the subjects of a new investigation resulting in the assignment of a status of “substantiated” or “indicated” abuse or neglect throughout the service provision period.
- 2) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.

#### **Goal #3**

DCS and client satisfaction with service provided.

#### **Outcome Measure**

- 1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 90% of clients will rate services as satisfactory or above on satisfaction survey.

### **IV. Qualifications**

#### **Direct Worker:**

Master's degree in social work, psychology, marriage and family therapy, or related human service field and 3 years related clinical experience or a masters degree with a clinical license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board, as one of the following: 1)

Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor.

**Supervisor:**

Master's degree in social work, psychology, or marriage and family or related human service field with a current license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board, as one of the following: 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

In addition to:

- Knowledge of child abuse and neglect and child and adult development
- Knowledge of community resources and ability to work as a team member
- Beliefs in helping clients change their circumstances, not just adapt to them.
- Belief in adoption as a viable means to build families.
- Understanding regarding issues that are specific and unique to adoptions such as loss, mismatched expectations and flexibility, entitlement, gratification delaying, flexible parental roles and humor.

**V. Billable Units**

**Face to face time with the client:**

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

*Reminder: Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are built into the cost of the face to face rate and shall not be billed separately.*

**For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.**

**Per person per group hour:**

When DCS clients are referred to groups where most of the clients are non-DCS referrals. This is available when the nature of the group or the geographic location does not support a group composed of primarily DCS clients.

**Translation or sign language**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

**VI. Rates**

Face to Face Maximum rate:            \$65.90 (1/1/2010)

Translation or sign language rate:    Actual cost

**VII. Case Record Documentation**

Necessary case record documentation for service eligibility must include:

- 1) A completed dated, signed DCS referral form authorizing service
- 2) Documentation of regular contact with the referred families/children and referring agency;
- 3) Written reports no less than monthly or more frequently as prescribed by DCS.

**VIII. Service Access**

Services must be accessed through a DCS referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

***NOTE: All services must be pre-approved through a referral form from the referring DCS FCM or DCS Service Consultant.***

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**CROSS-SYSTEM CARE COORDINATION**  
**(Revised June 15, 2010)**

**I. Service Description**

The provision of services is for youth with severe emotional disturbances and behavioral challenges that are involved in multiple care systems and are involved with the Department of Child Services and/or Juvenile Probation. Cross-system care coordination is designed to facilitate child and family teams comprised of youth, families, their natural support persons, local systems, agencies, and community members. These teams design individualized service and resource plans based on the needs of the youth.

Services in this system of care should be comprehensive, incorporating a broad range of services and supports, individualized, provided in the least restrictive, appropriate setting coordinated at the system and service delivery levels involve youth and families as full partners and emphasize early identification and intervention. Core values of a system of care are, that services are child centered and family driven, community based and culturally competent.

The services provided are comprehensive and will include cross-system coordination, case management, safety and crisis planning, comprehensive strength-based discovery and assessment, activities of daily living training, assistance to the FCM in the facilitation of the child and family team process, and family and child centered care. Support is provided and facilitated with community providers who can provide mentoring services, respite services, transportation services, community supervision, placement services, education services, therapies, social/recreational opportunities, specialized camps, independent living services, psychiatric services, psychological evaluations, medical needs services, parent support groups, mentoring and education, and medication management.

This service is based on the belief that children and their families are remarkably resilient and capable of positive development when provided with community-centered support, truly defined by what is in the best interest of the child. It is meant to provide a single comprehensive system of care that allows children in the child welfare and/or juvenile probation system(s) that experience emotional disturbances and their families to receive culturally competent, coordinated, and uninterrupted care.

The services provided to the clients and covered in the per child allotment rate will include but are not limited to the following:

- 1) Behavioral Health Services
  - Behavior Management Services
  - Crisis Intervention

- Day Treatment
- Evaluation / Testing Services
- Family Assessment
- Family Therapy
- Group Therapy
- Individual Therapy
- Parenting/ Family Skills Training Groups
- Special Therapy
- Substance Abuse Therapy- Group
- Substance Abuse Therapy- Individual
- Family Preservation – home based services

2) Mentor Services- hourly

- Case Management
- Clinical Mentor
- Educational Mentor
- Life Coach/ Independent Living Skills Mentor
- Parent and Family Mentor
- Recreational/Social Mentor
- Supported Work Environment
- Tutor

3) Other Services

- Consultation with Other Professionals
- Team Meetings
- Transportation

4) Psychiatric Services- hourly

- Assessments Outpatient
- Medication Follow-up/ Psychiatric Review

5) Respite Services

- Crisis Respite
- Planned Respite
- Respite-Residential or Hospital 23 Hour

6) Supervision Services

- Community Supervision
- Intensive Supervision

7) Residential Services

**II. Specific Responsibilities**

- 1.) The Care Coordinator has the specific responsibilities for the following:
  - Evaluates and interprets referral packet information and completes a strength based assessment with child and family and the Child and Adolescent Needs and Strengths Assessment (CANS).
  - Assist the Family Case Manager (FCM) in convening the family members, service providers and other child and family team members to form a collaborative plan of care with clearly defined goals.
  - Addresses need for and develops, revises and monitors crisis plan with family and team members.
  - Ensures that parent and family involvement is maintained throughout the service period.
  - Maintains ongoing dialogue with the family and providers to assure that the philosophy of care is consistent and that there is progress toward service goals. Evaluates the progress and makes adjustments as necessary.
  - Maintains central file consisting of treatment summaries, payment and resource utilization records, case notes, legal documents and releases of information.
  - Facilitates the closing of the case and oversees transition to any ongoing care.
  - Uses resources and available flex funding to assure that services are based specifically on the needs of the child and family.
  - Able to deliver strength based, family centered, culturally competent services.
  - Able to interpret psychiatric, psychological and other evaluation data, and use that information in the formation of a collaborative plan of care.
  - Able to complete all documentation using a computerized clinical record.
  - Creativity, flexibility and optimism about the strengths of children and their families.
  
- 2.) Providing agency receives referrals 24 hours a day, 7 days a week. There is a verbal determination between DCS and the agency that services are warranted, and there is agency availability for the service before the referral is sent.
  
- 3.) The face- to- face intake must occur no later than the end of the day following the referral.
  
- 4.) Assessments including the goal setting and service plan are mutually established between the client, care coordinator with a written report signed by the family and care coordinator, submitted to the DCS referring worker within 7 days of the initial face-to-face intake. Communication between the care coordinator and DCS is constant and documented as arranged between the two.
  
- 5.) Each family receives access to services through a single care coordinator acting within a team, with availability 24 hours a day 7 days a week.

6.) Family functioning assessments, family's response, presenting problems according to DCS referral are factors included in the goal setting. Goals are behaviorally specific, measured and attainable.

7.) Safety is of paramount importance. If there are indications about safety concerns within the home there is an obligation for the care coordinator and DCS to communicate to address all safety concerns, and document safety steps taken to resolve the issues. If new incidences occur, the care coordinator is to notify DCS immediately of the situation.

8.) Confidentiality must be maintained. Failure to maintain confidentiality may result in termination of the service agreement.

### **III. Target Population**

Services must be restricted to cases where severe emotional disturbances and/or behavioral problems have been documented within the following eligibility categories:

- 1) Children and families with a case type of Informal Adjustment (IA) with moderate to high levels of risk and service needs according to the DCS assessment matrix; and,
- 2) Children with a status of CHINS, and/or JD/JS (Juvenile Delinquency/Juvenile Status); or,
- 3) All adopted children and adoptive families
  
- 4) Or where DCS has determined to expand the target population in a limited area, as a pilot, to assess the value of cross-system care coordination in one or several different target populations, such as medically fragile or developmentally delayed children. In this case, all the same contractual and service standard obligations will apply except to the extent that they are inconsistent with the needs or capabilities of the expanded population. Services will still require pre-approval through a DCS Family Case manager or DCS Service Consultant referral, which will note any deviations from the usual service array, specific care coordinator responsibilities, child and family functioning goals or qualifications for supervisors or care coordinators. The deviations may eliminate, modify or add to the usual requirements as dictated by the needs and capabilities of the expanded target population. DCS acknowledges that expansion of the target population may alter the community providers used to provide comprehensive care.

### **IV. Goals and Outcome Measures**

Goal #1: Provide high quality care which results in improved outcomes for the child and family.

#### **Improved child and family functioning**

##### **A.) Improved school functioning**

- An increase in scores as found on grade reports in 85% of cases

- Decrease in absenteeism/truancy as reflected by attendance reports in 85% of cases
- A decrease in behavior reports in 85% of cases
- A decrease in suspension/expulsion reports in 85% of cases
- The Care Coordinator Treatment Plan level rating decreases in severity in 85% of cases

B.) Improved records with the child welfare and juvenile justice system

- 85% of families with no further substantiated incidences of child abuse or neglect, which results in removal of the child from the home during involvement
- 85% of families with no further substantiated incidences of child abuse or neglect, which results in removal of the child from the home for a period of six and twelve months from dis-enrollment
- 85% of children with no further substantiated incidences of delinquency, runaway or truancy charges, or violation of terms of probation which results in placement failure during enrollment
- 85% of children with no further incidences of delinquency, runaway or truancy charges, or violation of terms of probation which results in placement failure for a period of six and twelve months from dis-enrollment.

C.) Improved CANS scores

- 50 % of the children and families will have statistically significant improvement in any life domain on the CANS (functioning, behavioral health systems, risks, caretaker needs and strengths, child's strengths)

D.) Progress in Service Coordination Plan

- Measured by monthly team report and Care Coordinator Treatment Plan
- Level rating in 100% of cases

**Increased family autonomy**

A.) Decrease in number of paid providers

- Measured by service usage and payment data in 100% of cases

B.) Caregiver Strain Questionnaire

- Decrease in Caregiver Strain measured by Questionnaire at intake, every 6 months until discharge and 12 months after discharge in 100% of cases

**V. Qualifications**

**Supervisor**

1. Master's Degree in Social Work, Psychology, Marriage and Family Therapy, or related Human Services field; and,
2. A current license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board as one of the following:
  - Clinical Social Worker

- Marriage and Family Therapist
- Mental Health Counselor

**Care Coordinator**

1. Bachelor’s Degree in Social Work or related Human Service field; and,
  2. Minimum of three years of clinical/management experience in human service field; and,
  3. Demonstrated 2 or more years of clinical intervention skills; and,
  4. Demonstrated skill in fiscal management activities, team building and development
- Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

The Care Coordinator assures care is delivered in a manner consistent with strength-based, family centered, and culturally competent values, offers consultation and education to all providers regarding the values of the model, monitors progress toward treatment goals and assures that all necessary data for evaluation is gathered and recorded.

**VI. Billable Units**

Billable units will be based on four levels of service and are based on intensity with Level 1 being the least intense and Level 4 with the most intense. **Attach to your program narrative the definition of your levels of service of intensity and their components.** The assessment period will help determine the appropriate tier based on CANS scores, other criteria, and collateral information. Billable rates will include all costs associated with services and placement.

Due to economies of scale, the cost associated with serving each youth decreases as the number of youth served increases. As a result, the case rates vary based on the number of youth enrolled and the level of service. Rate will be defined as a monthly rate and daily rate based on the other criteria.

\*Note that Medicaid MRO is used to pay for care coordination and some services when possible.

**VII. Rates (1/1/2010)**

**Per Youth per Month**

<b>Levels</b>	<b>150 Youth</b>	<b>225 Youth</b>	<b>300 Youth</b>
<b>1</b>	\$1,408.50	\$1,343.70	\$1,278.90
<b>2</b>	\$2,502	\$2,437.20	\$2,372.40
<b>3</b>	\$3,861	\$3,893.50	\$3,731.40
<b>4</b>	\$5,850	\$5,785.20	\$5,720.40

### **Per Youth per Day**

<b>Levels</b>	<b>150 Youth</b>	<b>225 Youth</b>	<b>300 Youth</b>
<b>1</b>	\$46.31	\$44.17	\$42.05
<b>2</b>	\$82.26	\$80.13	\$77.99
<b>3</b>	\$126.94	\$124.80	\$122.68
<b>4</b>	\$192.33	\$190.20	\$188.06

If the number of youths to be served and the cost associated are different from above then a budget summary must be submitted.

### **VIII. Case Record Documentation**

Necessary case record documentation for service eligibility must include:

- 1.) A completed, signed and dated DCS referral form authorizing service.
- 2.) Documentation of regular contact with the referred families/children
- 3.) Written reports as requested. Formats for written reports and forms will be collaboratively designed for use.

### **IX. Service Access**

Services must be accessed through a DCS Family Case Manager or DCS Service Consultant referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a new reauthorization for services to continue beyond the approved time period.

**NOTE: All services must be pre-approved through a DCS Family Case Manager or DCS Service Consultant referral form.**

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**DIAGNOSTIC AND EVALUATION SERVICES**  
**(Revised 4/1/09)**

**I. Services Description**

Diagnostic and assessment services will be provided as requested by the DCS for parents, other family members, and children due to the intervention of Child Protective Services because of alleged physical, sexual, or emotional abuse or neglect and/or the removal of children from the care and control of their parents. Required information will be included in the referral form from the DCS identifying the reason for involvement with the family and specific information needed in order to assist the family in remedying the problems that brought the family to the attention of child protective services. Requested services may include: psychological evaluation, drug/alcohol testing, Minnesota Multiphasic Personality Inventory-2 (MMPI-2), or other testing instruments.

**II. Target Population**

Services must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect, with moderate to high levels of risk and service needs according to the assessment matrix
- 2) Children with a status of CHINS, and/or JD/JS
- 3) All adopted children and adoptive families

**III. Goals and Outcomes**

Goal #1

Timely receipt of evaluations.

Outcome Measure

- 1) 90% of the evaluation reports will be submitted to the referring DCS case manager within twenty one (21) days of the last appointment or testing completed with the client.
- 2) 100% of the participating families will receive by face-to-face visit, whenever possible, a written copy of the agreed upon plan within five (5) working days following the family meeting and will provide written documentation of receipt of the plan.

Goal #2

Obtain appropriate recommendations based on information provided.

Outcome Measure

- 1) 100% of reports will meet information requested by DCS.
- 2) 100% of reports will include recommendations for treatment, needed services or indicate no further need for services.

Goal #3

Client satisfaction with service provided.

Outcome Measure

- 1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.

#### **IV. Qualifications**

**Direct Worker:**

Master's degree in social work, psychology, marriage and family therapy, or related human service field and 3 years related clinical experience or a masters degree with a clinical license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board, as one of the following: 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor.

**Supervisor:**

**Doctorate** degree in social work, psychology, or marriage and family or related human service field with a current license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board, as one of the following: 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

#### **V. Billable Unit**

The hourly rate includes face to face contact with the identified client/family members and professional time involved in scoring testing instruments and preparing the assessment report.

Face to face time with the client:

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

Reminder: Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are built into the cost of the face to face rate and shall not be billed separately.

**For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.**

#### **Translation or sign language**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

#### **VI. Rates**

Face to Face Maximum rate: \$87.30 (1/1/2010)

Translation or sign language rate: Actual cost

#### **VII. Case Record Documentation**

Necessary case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS referral form authorizing services
- 2) Documentation of regular contact with the referred families/children and referring agency; and
- 3) Written reports no less than quarterly or more frequently as prescribed by DCS.

#### **VIII. Service Access**

Services must be accessed through a DCS referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

***NOTE: All services must be pre-approved through a referral form from the referring DCS FCM or DCS Service Consultant.***

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**DOMESTIC VIOLENCE INTERVENTION SERVICES**  
**(Revised 4/1/09)**

**I. Service Description**

These populations (batterer, survivor or child) may be selected for service delivery of Domestic Violence services. Services may be provided comprehensively with service delivery including the batterer, survivor and child. The provider may accomplish comprehensive services through subcontracting and the provider is responsible for the reporting and coordinating of services to all 3 populations. Domestic Violence intervention services shall not exist in isolation, as it is only one component of a coordinated community response to domestic violence. Services shall maintain cooperative working relationships with local programs (domestic violence batterer programs, survivor programs, shelters, law enforcement, advocates, legal services, etc.) Services shall be structured, goal-oriented, time-limited individual/group services and casework/victim advocacy services.

Group is the preferred service modality for the batterer. However, access to individual services is available. The Exclusion Criteria section provides guidelines for exceptions to this service modality. Also, communication is vital between the provider of batterer services and the victim, given the propensity of batterers to present well in group but continue to abuse.

**Definition of Domestic Violence**

(ICADV Definition) A pattern of assaultive or coercive behavior, including physical, sexual, or psychological attacks, as well as economic coercion, that adults or adolescents use against an intimate partner. Intimate partners include spouse, former spouse, those living or having lived as if a spouse, those having a child in common, those having a past or current sexual relationship, or a past or current dating relationship.

*\*Definition from the Indiana Coalition Against Domestic Violence and the Resource Center (ICADV)*

Child safety and ending violence takes precedence over saving relationships. The service focus shall be: child safety, survivor safety, increasing the survivor and child's functioning emotionally and physically including life skills, batterer accountability, providing the batterer skills to change abusive behavior, and ending physical, sexual and psychological violence.

The provider shall establish a written policy requiring that all staff have a duty to warn and protect survivors, partners, children and others against whom the batterer has made a threat of violence. This policy will detail the criteria for determining when a duty to warn arises, and the procedures staff are expected to follow.

Services include providing any subpoenaed/court ordered testimony and/or court appearances (to include hearing or appeals).

The provider must be available to respond for crisis intervention as needed.

Services will be provided within the context of the Department of Child Services' practice model with involvement in Child and Family team meetings if invited. A service plan will be developed and based on the agreements reached in the assessment and the Child and Family Team Meeting. Separate service plans will be developed for the batterer, survivor and the child.

Services must be available to participants who have limited daytime availability. The provider must identify a plan to engage the participant in the process, and a plan to work with non-cooperative participants including those who believe they have no problems to address.

Provider must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the contract.

**Service Description includes Child Services, Survivor Services, Batterer Services, Batterer Remaining in the Home, Support Groups and Interventions to Exclude from Services:**

**A. Child Services**

Safety Plans

(Note: the child must be willing and able to use the plan, and have the ability to opt out of any step in the plan if needed)

Comprehensive safety plans that are age and developmentally appropriate will be developed based on the assessment and will contain both long-term and short-term plans. Plans at a minimum will:

- Include input from the non-abusive parent and be age appropriate
- Include input from the child when appropriate
- Identify safe places to go inside/outside of the home during violence
- Identify where to meet if exiting the home is necessary
- Identify how and when to use the phone for help
- Identify how to stay safe during an argument/violence

Assessment

Within 24 hours after initiation of services, children will receive an initial assessment of needs when DCS indicates imminent risk/immediate safety concerns, or no later than 72 hours. Assessments shall include but are not limited to:

- Safety and risk factors for the child
- Child abuse/neglect
- Medical/dental care

- Food/shelter/clothing
- The parent/child relationship
- Screening for other co-occurring issues (substance abuse, mental health issues, behavioral issues, social impairment, educational impairment, etc.)

### Service Plans

Comprehensive service plans will be developed and based on the assessment will contain both long-term and short-term goals. Plans at a minimum will:

- Reflect underlying needs and goals
- Build on realistic possibilities and options
- Promote positive behavior patterns and positive self image
- Emphasize that the violence is not the child's fault and violence is not the fault of the survivor
- Teach strategies for managing and reducing the effects of domestic violence
- Critical thinking skills to enhance the child's ability to identify the batterer's controlling behaviors
- Be tailored to the child's strengths, needs, risks, available resources and unique circumstances

### Advocacy and Support Services

Supportive services shall be provided as needed and as consistent with the assessment and service plan. Services shall emphasize personal growth and development. Services shall include but are not limited to:

- Crisis intervention
- Educational/developmental resources and services
- Links to community resources
- Legal Advocacy
- Personal Advocacy
- Housing advocacy
- Medical advocacy
- Information and referral
- Transportation

### Service Modality

Services should be provided in the method consistent with the assessment and service plan and may occur through individual or group services, play services or group play services, family services, support groups and casework/victim advocacy services.

Group services for children are to occur in weekly sessions 1 hour in length. Number of weekly sessions will be determined by the provider and DCS based on the child's individual needs. Class size minimum of 7 and is not to exceed 20 participants. A waiver can be requested when less than 7 participants attend the

training. A written request of waiver is sent to the Director or his designee at the Department of Child Services local office for approval.

### Group Curriculum Content

Group curriculum will be age appropriate and shall include but is not limited to, the following:

- Promote open discussion of experiences with violence for integration into the child's understanding
- Help the child understand why their caregivers fight
- Violence is not the child's fault and violence is not the fault of the survivor
- Help the child understand and cope with their emotional responses to domestic violence
- Teach identification and labeling of feelings to help the child express his or herself.
- Explore the child's attitudes and beliefs about families and family violence
- Teach how to effectively manage anger
- Explore self concept and boost self-esteem
- Teach the cycle of domestic violence
- Critical thinking skills to enhance the child's ability to identify the batterer's controlling behaviors

## **B. Survivor Services**

### Safety Plans

Comprehensive safety plans will be developed based on the assessment and will contain both long-term and short-term plans. Plans at a minimum will:

- Prepare the parent to promote their safety in various circumstances, including those calling for emergency re-location
- Plan how the parent will create a safe, nurturing and stable environment for the child

### Assessment

Within 24 hours after initiation of services, survivors will receive an initial assessment of needs when DCS indicates imminent risk/immediate safety concerns, or no later than 72 hours. Assessments shall include but are not limited to:

- Safety and risk factors for the survivor and their child(ren)
- Medical/dental care
- Legal assistance
- Food/shelter/clothing
- Parenting needs and the parent/child relationship
- Screening for other co-occurring issues (substance abuse, mental health issues, etc.)

### Service Plans

Comprehensive service plans will be developed based on the assessment and will contain both long-term and short-term goals. Plans at a minimum will:

- Reflect underlying needs and goals
- Build on realistic possibilities and options
- Emphasize that the violence is not the survivor's fault
- Respond to the needs of their child(ren)
- Help the parent recognize the impact of domestic violence on the child
- Assist the survivor in creating a safe, nurturing and stable environment for the child long-term that includes the use of formal and informal supports.
- Be tailored to the survivor's strengths, needs, risks, available resources and unique circumstances
- Skills to assist the survivor in interacting with the batterer on issues dealing with the best interest of the child, in circumstances where face to face contact is necessary (visitations, school/athletic events etc.)

An aftercare plan will be developed identifying and promoting the continued use of informal and community supports, increasing the likelihood that services will be accessed after case closing.

#### Advocacy and Support Services

Supportive services shall be provided as needed and as consistent with the assessment and service plan. Services shall emphasize personal growth, development, situational change and helping to gain confidence in personal abilities. Services shall include but are not limited to:

- Housing assistance and housing readiness
- Management of legal needs
- Employment education and preparedness
- Educational resources
- Linking to community resources

#### Service Modality

Services should be provided in the method consistent with the assessment and service plan and may occur through individual and/or family services, marital/couples services, support groups and casework/victim advocacy services.

Group services are for survivors of the same gender and occur in weekly sessions 1.5 hours in length. Number of weekly sessions will be determined by the provider and DCS based on the survivor's individual needs. Class size minimum of 7 and is not to exceed 20 participants. A waiver can be requested when less than 7 participants attend the training. A written request of waiver is sent to the Director or his designee at the Department of Child Services local office for approval.

#### Group Services Curriculum Content

Group curriculum shall include but is not limited to, the following topics:

- Explore the survivor's attitudes and beliefs about families and family violence
- Explore self concept and boost self-esteem
- Emphasizing violence is not the survivor's fault
- Teach the cycle of domestic violence
- Teach the impact of violence on their child's development
- Build parenting competence
- Provide a safe place to discuss parenting fears and worries
- Enhance parenting and disciplinary skills
- Enhance social and emotional adjustment
- Skills to assist the survivor in interacting with the batterer on issues dealing with the best interest of the child, in circumstances where face to face contact is necessary (visitations, school/athletic events etc.)

### **C. Batterer Services**

#### The Appropriate Use of Provider Contacts with the Survivor in the Context of Batterer Services

The provider performing survivor contact will have observed a minimum of 26 batterer intervention sessions and the observation of sessions must be conducted so as to include an entire curriculum. The purpose of contact with the survivor shall be limited to the following:

- Informing the survivor of the batterer's entry in, removal or completion of group services.
- Outlining group content and service procedures.
- Answering any questions about the service program and clarify any misinformation that may have been given.
- Inviting the survivor to make future contact with any information, questions, concerns or reports of violence and re-offenses or violations of the participant contract/agreement that may arise.
- To ascertain survivor safety.
- To follow up on suspected participant re-offense.
- Encouraging the survivor to utilize the availability of domestic violence outreach, advocacy, emergency shelter services or to attend support groups or orientations for survivors.
- Sharing provider concerns/evaluations/observations of the batterer's in group participation. Caution the survivor to not assume the batterer's good conduct or completion of the service program is a predictor of future positive change or nonviolent choices.
- Discussing safety planning.
- Warning the survivor of any threats of violence made by the batterer or provider reason to believe there is an unacceptable risk of violence.

#### Protocol for Contacts with the Survivor in the Context of Batterer Services

Contact with the survivor should only be made by a trained victim advocate who is not providing direct services to the batterer.

The service provider will establish and follow written rules regarding the method of survivor contact. Contact refers to any mail, phone, e-mail, or face-to-face contact, direct or indirect, with any survivor of any batterer participating in group services *before, during or after the batterer's enrollment in group.*

Contact rules shall include but are not limited to the following:

- Take steps to ensure that mail, telephone and other communication is as secure as possible against intrusion by the batterer or others.
- Inform the survivor of her/his right to confidentiality and ability to consent to disclosure of her/his report. Caution the survivor to consent to disclosure only if she/he has a safety plan and believes disclosure will not reduce her/his safety.
- Inform the survivor prior to inviting them to share information, that any information regarding suspected child abuse cannot be confidential and must be reported to the legal system.
- Inform the survivor that neither the provider staff nor the legal system can guarantee their safety, and neither can they guarantee that disclosure of their report will not result in a violent reaction by the batterer.
- Inform the survivor that a witness statement or complaint to the legal system cannot be made confidentially or anonymously, yet they may receive help in determining the timing and method by which the batterer is confronted.
  - Reporting statements made by the survivor to the legal system is equivalent to confronting the batterer. When by law the provider must report an incident without survivor consent, the survivor will be allowed time for safety planning.
- Document in writing the survivor's consent or lack thereof, as well as the survivor's wishes regarding the use of any information they have given.
- Assume the survivor has denied consent to disclose their report to anyone, including the group facilitator, unless they have specifically stated otherwise and disclosure wishes are documented in writing.
- The batterer shall not be confronted regarding information from the survivor when the service provider in consultation with victim advocates have reason to believe confrontation will create an unacceptable risk of retaliation abuse.
- Do not pressure or convince the survivor to make a report or agree to the disclosure of information or confrontation of the batterer, or to agree to make a report or take any action that they may feel is not in their best interests.
- Assume the survivor may accurately or inaccurately relay to the batterer what was said by provider staff during survivor contact.

- Do not offer the survivor services, communication, mediation or reunification with the batterer participating in group services.

### Assessment

Within 24 hours after initiation of services, batterers will receive an initial assessment of needs when DCS indicates imminent risk/immediate safety concerns, or no later than 72 hours. Assessments shall include but are not limited to:

- Batterer's past and current use of physical and sexual violence, including other abusive behaviors, within and outside of intimate relationships
- History of violence within family of origin
- History of use, possession of, or access to weapons
- Lethality risk assessment
- Criminal history
- Pending court actions
- Current or former partners
- Threats of taking the child
- Access to the survivor
- Substance abuse assessment
- History of mental illness, including threats or ideations of homicide
- Learning disabilities, literacy and special language needs

### Exclusion Criteria

Individuals who are found through the assessment to be unable to benefit from group services must be provided other appropriate services. Individuals to be excluded are those who are a threat to the safety of group participants as they are likely to be seriously violent or disruptive, those with psychiatric symptoms or serious developmental delays preventing participation or those with a medical condition that is the primary cause of violence, such as brain injury. Excluded individuals may enter the program at a later date in the event the reasons for exclusion have been alleviated.

### Service Plans

Comprehensive service plans will be developed based on the assessment and will contain both long-term and short-term goals. Plans at a minimum will:

- Reflect underlying needs and goals
- Build on realistic possibilities and options
- Emphasize batterer accountability for violence
- Respond to the needs of their child(ren)
- Help the batterer recognize the impact of domestic violence on the child
- Assist the batterer in creating a safe, nurturing and stable environment for the child long-term that includes the use of formal and informal supports.

- Be tailored to the batterer's strengths, needs, risks, available resources and unique circumstances, in regards to referrals made to services that are separate from batterer services
- Skills to assist the batterer in interacting with the survivor on issues dealing with the best interest of the child, in circumstances where face to face contact is necessary (visitations, school/athletic events etc.)

An aftercare plan will be developed identifying and promoting the continued use of informal and community supports, increasing the likelihood that services will be accessed after case closing.

### Participant Agreement

Batterers shall sign a contract including but not limited to, the following:

- I will not abuse anyone else or myself for duration of program. This includes verbal, emotional and psychological abuse, threats of suicide, and threats of violence. I will inform the provider of what happened and I will openly talk about the situation and accept responsibility for my behavior.
- I agree that the reason I am in batterer services is to learn to not be violent or abusive. I will not be violent or abusive in this group or in my personal life.
- I will participate openly, honestly and actively in group discussions and will follow through with all group assignments.
- I will abide by all group rules, including attendance.
- I will seek appropriate services if additional problems arise (e.g. drug abuse, mental health issues), and I will cooperate with if the group facilitator requests that I obtain an assessment for any of these problems.
- I will provide the correct address and phone number of the survivor and will notify the group facilitator of any changes. I give the group facilitator and other individuals working with him/her permission to give out the following information to the survivor: 1) When I start and stop the program, 2) Referral information to services, and 3) safety options, and any other information pertinent to safety.
- I understand that I may not be informed of any communication that takes place between the survivor and the group facilitator and I waive any right to have access to or be informed of the nature, content or existence of any such communication.
- I understand that safety to others and to myself is priority and will be enforced by the group facilitator.
- I understand that all suspected child abuse and neglect will be reported as defined by Indiana law.
- I understand that all suspected battery, neglect or exploitation of an endangered adult will be reported as required by Indiana law.
- I have received and understand the service provider's policies and procedures.

### Exceptions to Confidentiality

Batterers shall sign a written waiver of confidentiality at the time of intake. The waiver may include an end date, but an exception must be included in the text of the waiver that extends the waiver beyond the end date where necessary. This is to prevent the participant from avoiding legal consequences for criminal or violent acts or in order for the provider to respond to a court subpoena for information or testimony. The waiver shall give the service provider permission to:

- Make reports
- To testify
- To otherwise communicate as needed
- To reveal file and other information regarding the batterer to each of the following:
  - DCS, as the referral source
  - The court, lawyers, prosecutor, police, probation
  - The survivor or designated advocate
  - Administrative and professional personnel who need information for record-keeping, monitoring, or professional development
  - Any entity or person to whom the service provider is legally bound to report suspected abuse or neglect of a child
  - Any person whose safety appears to be at risk due to the participant's potential for violence and lethality, in order for the service provider to fulfill its duty to warn or protect

### Curriculum Content

The central focus of curriculum will remain on batterer responsibility and accountability for their beliefs and actions. It will actively challenge all abusive behaviors and survivor blaming. Curriculum delivery should be designed to accommodate new participants in an ongoing group and to ensure no participant misses curriculum content. Curriculum shall reflect an awareness of cultural diversity. Curriculum used or developed by service providers will include but is not limited to, the following:

- Definition of domestic violence.
- Forms of abuse, including:
  - physical, sexual, emotional
  - economic manipulation or domination
  - property destruction
  - stalking
  - terroristic threat
  - acts jeopardizing the well-being and safety of partners, children, pets, other family members and friends
- The dynamics and tactics of power and control, and the cycle of violence.
- Relationship between substance abuse, mental illness and acts of violence, with a distinction that there is not a cause and effect relationship.

- Gender roles; beliefs in male entitlement and male privilege and rigid sex-role stereotypes.
- Identifying and challenging cultural and social influences that promote, sustain or excuse abusive behavior.
- Batterer's responsibility for past and future abusive behaviors and the need to avoid survivor blaming.
- Current Indiana state law and practice regarding domestic violence.
- Adverse legal and social consequences for batterers.
- Identifying and challenging the batterer's personal values and beliefs that promote, sustain or excuse abusive behavior.
- Participant will identify, confront, and change abusive and controlling behaviors.
- Long-term and short-term effects of abuse on the survivor and on children who are witnesses and/or survivors.
- Empathy for the survivor and child's experience.
- Equality and power-sharing in relationships
- Cooperative and non-abusive forms of communication and conflict resolution
- Non-violent alternatives and techniques for achieving non-abusive and non-controlling conduct.
- Nonviolence planning; identification of danger signs violence may occur and how to prevent them
- Relapse prevention plan that provides alternatives to all forms of abuse and includes input from the batterer.
- Skills to assist the batterer in interacting with the survivor on issues dealing with the best interest of the child, in circumstances where face to face contact is necessary (visitations, school/athletic events etc.)

#### Service Modality

Group services for adult batterers of the same gender. Group is without survivor participation. Twenty-six (26) sessions 1.5 hours in length. Class size minimum of 7 and is not to exceed 20 participants. A waiver can be requested when less than 7 participants attend the training. A written request of waiver is sent to the Director or his designee at the Department of Child Services local office for approval.

#### Criteria for Satisfactory Completion

The service provider will provide criteria in writing for satisfactory completion of services. At a minimum the provider will include the following criteria for completion of services:

- Attendance at weekly group sessions and all other required service periods
  - Attendance shall be recorded by the group facilitator.
  - Three (3) unexcused absences are permitted. In the event any absences are consecutive or 4 classes total classes are missed, the batterer shall be dismissed from services.

- The batterer shall be on time for each group session. If the batterer leaves class he/she may not return and shall be counted absent.
- Cooperation of program rules and conditions throughout services
  - Failure to comply with rules and conditions shall be documented. Non-compliance more than 3 times shall result in expulsion from the group.
- Cessation of violence and other abusive and controlling conduct while a participant in the program
- Adherence to the participant's agreement
  - Failure to comply with the participant agreement shall be documented. Non-compliance more than 3 times shall result in expulsion from the group.
- Compliance with court orders
- Accepting responsibility for abusive and controlling behavior and ceasing to blame the survivor
  - As evidenced by an assessment of the batterer
- Recognition of the adverse effects of their abusive and controlling behavior
  - As evidenced by an assessment of the batterer

*Note: The batterer may pursue other service methods after satisfactory completion of group services. The batterer should only be included in marital/couples or family services if the batterer has done extensive work to change violent behavior and there is proof of progress. The batterer should not be included in marital/couples or family services if there is reason to be concerned about the survivor/child's safety or wellbeing.*

#### Expulsion from Program

The service provider will develop guidelines in writing for expulsion so that decisions are uniform and predictable and so that discrimination does not occur against participants based on race, class, age, physical handicap, religion, educational level, ethnicity, national origin, sexual orientation or gender. The provider will immediately notify DCS of the expulsion of any batterer.

Guidelines shall include, but are not limited to:

- Continued or renewed physical or sexual assaults, threats, stalking or repeated or severe psychological abuse
- Threats or violence to program staff or group participants
- Bringing weapons or illegal substances to program property
- Failure to comply with the attendance policy, group rules or other program rules and conditions
- Failure to comply with the participant agreement
- Violation of any judicial orders pertaining to violence, the safety of the survivor and/or children or the intervention process

Non-compliance with the agreement, court orders or with group rules will be documented in writing.

*Note: Batterers may be re-enrolled in group on an individual basis at the provider's discretion in consultation with the referring FCM.*

#### Collaboration

Batterer services must work in collaboration with local programs that serve survivors of domestic violence, law enforcement, the Indiana Coalition Against Domestic Violence and the Resource Center (ICADV) and others. Collaboration shall include:

- Measuring effectiveness of the services by outcome measures
- Being an active participant in local coordinated community response efforts

*\*Adapted from the Indiana Coalition Against Domestic Violence and the Resource Center (ICADV)*

#### **D. Batterer Remaining in the Home**

Service standards regarding the *assessment, service planning, advocacy and support services and service modality* will remain the same as prescribed above for the child, survivor and batterer when the batterer lives in the same home as the survivor and child.

The following standards regarding safety planning will be used:

#### Child

(Note: the child must be willing and able to use the plan, and have the ability to opt out of any step in the plan if needed)

Comprehensive safety plans that are age and developmentally appropriate and will be developed based on the assessment will contain both long-term and short-term plans. Plans at a minimum will:

- Include input from the non-abusive parent and be age appropriate
- Include input from the child when appropriate
- Identify safe places to go inside/outside of the home during violence
- Where to meet if exiting the home is necessary
- How and when to use the phone for help
- How to stay safe during an argument/violence
- Family/friends code word or emergency signal
- Boundaries regarding what not to tell the batterer

#### Survivor

Comprehensive safety plans will be developed based on the assessment and will contain both long-term and short-term plans. Plans at a minimum will:

- Prepare the survivor to promote their safety in various circumstances

- Plan how the survivor will create a safe, nurturing and stable environment for the child
- Identify the batterer's triggers as warning signs and identify how to stay safe during an argument
- Identify safe areas of the house with exits to use when violence is threatened
- An escape plan for use if needed, which may include:
  - A transportation plan
  - Pre-packed luggage in a safe place inside or outside of home
  - Access to hidden money, check books or savings books, even if in small amounts
  - Access to legal documents such as a driver's license, birth certificates, social security cards
- Family/friends code word or emergency signal

#### Batterer

Comprehensive safety plans will be developed based on the assessment and will contain both long-term and short-term plans. Plans at a minimum will:

- Plan how the batterer will create a safe, nurturing and stable environment for the child
- Identify the batterer's triggers as warning signs and include nonviolent alternatives
- Require participation in batterer's intervention services
- Address the violence as a choice of the batterer.

#### **E. Support Groups**

The provider shall offer a support group for survivors and children. The group facilitator shall be a Direct Worker 1. Survivor groups shall be held separately from Child groups. Child groups should be age appropriate. The purpose of the group is for members to provide each other with various types of help, usually nonprofessional and nonmaterial, for a particular shared, usually burdensome, characteristic. The help may take the form of providing and evaluating relevant information, relating personal experiences, listening to and accepting others' experiences, providing sympathetic understanding and establishing social networks. Groups should increase self-esteem, teach healthy ways to express feelings and resolve conflicts and provide tools to form healthy relationships.

#### **F. Interventions to EXCLUDE from services:**

(Note: the following interventions are to be excluded in all situations, including when the batterer lives in the same home as the survivor and child)

- Group services that involves mixed gendered participants.
- Interventions that blame the survivor or consider violence as a mutually circular process.
- Interventions that rely on or coerce survivor/child participation or communication.

- Interventions that identify poor impulse control or psychopathology as the primary cause of violence.
- The batterer should only be included in services for the survivor/child if the batterer has done extensive work to change violent behavior. The batterer should not be included in services for the survivor/child if there is reason to be concerned about the survivor/child's safety.
- Ventilation techniques and other services that encourage the expression of rage, such as punching pillows and primal screams.
- Batterer services should not be substituted with services for substance abuse, addictions, anger management and/or mental illness. Batterer group services should be completed before the batterer becomes involved in other service programs, *except* when the batterer has been assessed with a chronic substance abuse or mental health problem that warrants intervention and these services shall be kept separate from group batterer services.
- Individual services for the batterer is not an appropriate intervention *except when the batterer meets exclusion criteria and cannot benefit from group services.*
- Group services for children who have been severely traumatized, regardless of age. These children have more complex needs and are better served by individual services.
- Interventions that encourage the provider to become an advocate or witness on behalf of the batterer or further the interests of the batterer in legal matters.
- Negotiating or mediating for the batterer with the survivor in any way.

## **II. Target Population**

Services must be restricted to cases where domestic violence has been documented within the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect, with moderate to high levels of risk and service needs according to the DCS assessment matrix; where reunification is jeopardized without intervention of intensive services, and
- 2) Children with a status of CHINS, and/or JD/JS, or
- 3) All adopted children and adoptive families.

## **III. Goals and Outcome Measures**

### **Goal #1: DCS and family satisfaction with services**

Outcome Measure: 90 % of the families who have participated in Domestic Violence Services will rate the services "satisfactory" or above.

Outcome Measure: DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.

**Goal #2 Timely intervention with family where DCS indicates imminent risk/immediate safety concerns, and regular and timely communication with referring worker**

Outcome Measure: 100 % of families receive their first contact (telephone, mail or face to face) no later than the end of the first day following the referral from DCS. If face to face contact is not made within three days the DCS referral source will be notified.

Outcome Measure: 100 % of written service plans/ assessments will be completed, and sent to the referring worker within 7 days of face-to-face intake with the client/family.

**Goal #3: survivor/child improved safety and safety skills**

Outcome Measure: 100 % of victims know how to plan for their continued safety.

Outcome Measure: 95 % of victims report having an increased understanding of their legal rights.

Outcome Measure: 90 % of victims report they know how to access short and long-term resources that meet their emotional and safety needs.

Outcome Measure: 95 % of victims report an increased knowledge of services available.

**Goal #4: Improved functioning**

Outcome Measure: 100 % of victims report an increased knowledge and understanding of domestic violence and its effect on their children.

Outcome Measure: 90 % of children report an improved understanding and ability to cope with their emotional responses to domestic violence.

Outcome Measure: Improved family functioning as indicated by no further incidence of the presenting problem, during program participation, in 90% of the families.

**Goal # 5: Documentation, completion, and conception of Batterer services**

Outcome Measure: 100 % of no-show alerts will be provided to referring worker

Outcome Measure: 100 % of referred clients will have a service plan developed following the assessment with the service plan provided to the referring worker within 10 days of completion.

Outcome Measure: 90% Intervention prevents further physical injury to victim during program participation.

Outcome Measure: 80 % Intervention prevents re-arrest during program participation.

**IV. Service Delivery**

### Direct Worker 1

Services provide any combination of the following kinds of services to the client:

- 1) Education and skills-based Support Group for batterer, survivor and/or child
- 2) Assistance with transportation
- 3) Coordination of services
- 4) Advocacy
- 5) Community services information and assistance obtaining services
- 6) Community referrals and follow up
- 7) Family assessment
- 8) Child development education
- 9) Domestic violence education
- 10) Parenting education
- 11) Parent training with child present
- 12) Monitor progress of parenting skills
- 13) Supervised visitation
- 14) Budgeting and money management
- 15) Participation in Child and Family Team Meetings
- 16) Family reunification

### Direct Worker 2

Provides any combination of the following kinds of services to the client:

- 1) Group Services for the batterer, survivor and/or child
- 2) Safety Planning
- 3) Individual and Family Services
- 4) Cognitive behavioral strategies
- 5) Family of origin/Intergenerational issues
- 6) Family structure and organization (internal boundaries, relationships, roles, socio-cultural history)
- 7) Stress management
- 8) Self-esteem
- 9) Communication skills
- 10) Conflict resolution
- 11) Behavior modification
- 12) Problem solving
- 13) Goal setting
- 14) Support systems
- 15) Parenting skills/training
- 16) Supervised visitation
- 17) Substance abuse
- 18) Crisis intervention
- 19) Participation in Child and Family Team Meetings
- 20) Family reunification

## **V. Qualifications**

*Note: there will be no discrimination of race, class, age, religion, ethnicity, national origin, sexual orientation or handicaps in hiring of employees or in providing services to batterers.*

**Direct Worker 1:**

Services may be provided as needed by personnel with a Bachelor's degree in social work, psychology, sociology, or a directly related human services field. Knowledge of current Indiana state law and practice regarding domestic violence. Minimum 2 years professional field experience working with family violence.

**Direct Worker 2:**

Bachelor's degree in social work, psychology, marriage and family or a related human services field. Minimum 3 years professional field experience in family violence services. Or Master's degree in social work, psychology, marriage and family or a related human services field. Minimum 2 years professional field experience in family violence services. Knowledge of current Indiana state law and practice regarding domestic violence.

**Supervisor:**

Bachelor's degree in social work, psychology, marriage and family or a related human services field. Minimum 5 years professional field experience in family violence services. Or Master's degree in social work, psychology, marriage and family or a related human services field. Minimum 2 years professional field experience in family violence services. Knowledge of current Indiana state law and practice regarding domestic violence.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

**Educational and Training Requirements for Providers of Batterer Services:**

- 1. Co-Facilitator:** To qualify to co-facilitate a batterer program with a qualified program Supervisor/Trainer or Facilitator, an individual must show:
  - a. Evidence of 60 hours of formal training. A minimum of 40 hours of this training must be specific to domestic violence. The remaining 20 hours shall include evidence of training in each of the following areas of group facilitation skills: cultural diversity, substance abuse, and mental health.
  - b. Evidence of observing a minimum of 26 different batterer program sessions.
  - c. The observation of sessions must be conducted so as to include an entire 26 session curriculum.

- 2. Facilitator:** To qualify to facilitate a batterer program an individual must show:
- a. Evidence of meeting all the requirements of a Co-facilitator.
  - b. 100 hours of formal training. A minimum of 60 hours of this training must be specific to domestic violence. The remaining 40 hours shall include evidence of training in each of the following areas of group facilitation skills: cultural diversity, substance abuse, and mental health.
  - c. Evidence of co-facilitating a minimum of 26 additional batterer program sessions with a Supervisor/Trainer.

- 3. Supervisor:** To qualify to supervise a batterer program, an individual must show:
- a. Evidence of meeting all the requirements of a Facilitator.
  - b. 120 hours of formal training. A minimum of 80 hours of this training must be specific to domestic violence. The remaining 40 hours shall include evidence of training in each of the following areas of group facilitation skills: cultural diversity, substance abuse, and mental health.
  - c. Evidence of facilitating a minimum of 26 additional batterer program sessions as a Facilitator under a Supervisor/Trainer.

- 4. Trainer:** To qualify to train staff or others related to batterer program work, an individual must show:
- a. Evidence of fulfilling the requirements of a Supervisor.
  - b. Have a minimum of 3 years experience as a supervisor (or the equivalent thereof).

*\*Adapted from the Indiana Coalition Against Domestic Violence and the Resource Center (ICADV)*

### **Continuing Education for Providers of Batterer Services:**

Individuals must show evidence of participating in a minimum of 10 hours of formal continuing education specific to domestic violence annually to maintain their status as a qualified service provider.

*\*From the Indiana Coalition Against Domestic Violence and the Resource Center (ICADV)*

### **Worker qualities:**

Personnel have the competencies and support needed to:

- Engage, empower and communicate effectively, respectfully and empathetically with families from a wide range of backgrounds, cultures and perspectives
- Assess risks and safety
- Develop safety plans
- Recognize and address barriers to ending and/or escaping abuse or accessing services

- Recognize the presence of medical or health problems
- Recognize and respond to the co-occurrence of domestic violence, substance use conditions and mental health conditions
- Manage stress and intervene in crisis situations
- Set appropriate boundaries with survivors
- Understand relevant legal and civil rights issues
- Coordinate services and collaborate with other providers
- Follow reporting mandates

*\*Adapted from the Council On Accreditation (COA)*

Personnel providing services in a group setting have the competencies and support needed to:

- Engage and motivate group members
- Educate group members
- Understand group dynamics
- Lead discussions
- Facilitate group activities

*\*Adapted from the Council On Accreditation (COA)*

Personnel who work directly with children or with survivors who have children, are knowledgeable about:

- Child development
- Possible effects of witnessing domestic violence
- Signs and symptoms of, and reporting requirements for, child abuse and neglect
- Collaborating with child protective services
- Non-violent discipline methods

*\*Adapted from the Council On Accreditation (COA)*

Personnel have an understanding of the laws pertaining to domestic violence. At a minimum the provider will be familiar with the following:

- State domestic violence laws and the response by the criminal justice systems
- Civil protection orders and restraining orders
- Court and probation policies and local law enforcement prosecution regarding domestic violence cases.

## **VI. Ethical Standards**

### Ethical Standards

All providers and administrators shall agree to and sign the following ethical standards, and retain this documentation in the provider's personnel file:

## Ethical Standards

The term “provider” for this section applies to all staff and volunteers who work with batterers, including facilitators, co-facilitators and supervisors/trainers.

AS A BIP PROVIDER OR ADMINISTRATOR, I DO AFFIRM THAT:

1. **I will make victim safety my first priority in working with those who batter.**
2. **I will make accountability of those who batter and program accountability my second priority.**
  - (a) I will immediately report to all appropriate legal authorities
    - Any additional violence (which includes but is not limited to physical violence, stalking, criminal trespass, and invasion of privacy) admitted to by a program participant.
    - Any suspected neglect or abuse of a child.
    - Any additional violence by a program participant sworn to by a third person, where such reporting will not further endanger the victim or witness.
  - (b) I will help prevent the unethical or unskilled practice of program intervention. I will report to the appropriate authorities any practice of program intervention by untrained or unqualified persons and any unethical conduct or unprofessional modes of practice by other program providers.
3. **I will collaborate with advocates against domestic violence in the design and overseeing of our program’s work.** I will welcome independent advocates to oversee, observe, and give feedback about the Program and services provided. I will participate in a coordinated community response against domestic violence. I will respect the limits of present knowledge in my public statements and not make any claims that are not substantiated by valid studies and statistics developed in collaboration with independent survivor advocates.
4. **I will conduct myself in my personal and professional life in a manner consistent with the principles of nonviolence and sobriety.** I will be vigilant regarding my own power and control issues, seeking to identify and change any sexist, racist, and homophobic attitude in my personal belief system. I will not use physical violence or tactics of abuse. If I have been physically violent, I will document completion of a certified program. I will be violence-free in my own life for three years prior to facilitating in a program. I will not abuse drugs, including prescription drugs, or alcohol. I will be alcohol and drug free when performing program services. If I have an addiction problem (including substance, gambling and sexual addictions), I will undergo services and attain sobriety as a precondition to providing services. I will immediately disclose to the manager of my program if I am arrested for or have been convicted of any related charge, including, but not limited to, battery, domestic battery, stalking, criminal trespass, invasion of privacy, abuse or neglect of a child or protected adult, or any charge involving drugs, alcohol, gambling, pornography or other sex-related crime.
5. **I will avoid personal, professional, or business relationships that conflict with the interest of the program and those it serves.**

I will never engage in a relationship with a present or past program participant, a partner or ex-partner of a participant, or a family member of a participant that would in any way compromise their health and well-being or the complete integrity of the program, or that could impair professional judgment, or increase the risk of exploitation. I will avoid even the appearance of impropriety. I will not engage in any behavior with any of these persons that I would be unwilling to disclose fully to my colleagues, legal authorities, and the public. Specifically, I will not engage in sexual or romantic activities with participants, survivors, partners, or their family members for at least two years after last professional contact, and even then, not where such behaviors could reasonably contribute to the suffering of any person or the impairment of the program intervention effort. I will avoid working with participants who have close relationships with members of my family or significant business associates. I will not accept gifts or benefits from participants that might impair the integrity of the relationship or might invite special treatment.

6. **I will treat all program participants, their partners, and survivors fairly.** I will not discriminate because of race, class, age, religion, educational attainment, ethnicity, national origin, sexual orientation, or economic condition. I will act to guarantee that all persons, especially the needy, the disadvantaged, and those outside the cultural and language mainstream, have equal access to program resources and services. I will charge fees that are fair, reasonable, and consistent with a participant's ability to pay. I will fully explain from the beginning all program rules and policies affecting fee payment, enrollment, program standard, discharge, and completion. I will apply consistent program rules to all participants.
7. **I will protect the confidentiality of participants, their partners, families, and survivors, subject to the primary duty of survivor safety.** In doing so, I will follow the rules established by state and federal law, and by my program.
8. **I will protect and enhance the professionalism, dignity, and integrity of the program.** I will never participate in lessening program quality or duration for pecuniary or personal reasons. I will not offer services, testimony, or public pronouncements outside the recognized boundaries of my competency. I will not misrepresent my qualifications, education, experience, affiliations, or memberships.

*\*Adapted From the Indiana Coalition Against Domestic Violence and the Resource Center (ICADV)*

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**Date**

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**Signature: Provider**

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**Printed: Provider**

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**Signature: Witness**

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**Printed: Witness**

Department of Child Services  
Regional Document for Child Welfare Services  
Term 1/1/09-6/30/11  
(June 15, 2010)

## VII. Billable Units

### Face-to-face time with the client

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

Face-to-face time Includes:

- Client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Crisis intervention and other goal directed interventions via telephone with the identified client family.
- Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

*Reminder: Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are built into the cost of the face to face rate and shall not be billed separately.*

**For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.**

**Translation or sign language** Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

### Concrete Services

Concrete funds of up to \$500 maximum per family are available to be spent on a wide variety of things that reduce the likelihood of placement. Services help access needed items, supports and services to reduce the likelihood of the child's placement. There must be a documented need for the goods and/or services. Prior written approval is mandatory from the Local Office Director or their designee. Documentation of expenditure of funds must be maintained by the agency.

## VIII. Rates

Face to Face Family Services Rate: \_\_\_\_\_  
(2 or more members of the same family)

Face to Face Individual Services Rate: \_\_\_\_\_

Face to Face Group Services Rate: \_\_\_\_\_

Face to Face Case Management Rate: \_\_\_\_\_

Face to Face Group Case Management Rate: \_\_\_\_\_

Translation or Sign Language Rate: Actual Cost

Budget summary must be submitted for rate determination.

### **IX. Case Record Documentation**

Necessary case record documentation for service eligibility must include:

- 4) A completed, dated, signed DCS referral form authorizing service
- 5) Documentation of regular contact with the referred families/children
- 6) Written reports provided no less than quarterly or more frequently as prescribed by DCS.

### **X. Service Access**

Services must be accessed through a DCS referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved time period.

***NOTE: All services must be pre-approved through a DCS referral form. In emergency situations, services may begin with a verbal approval but must be followed by a written referral within 5 days. It is the responsibility of the service provider to obtain the written referral. Providers must have the ability to respond to referrals and to provide services 24 hours a day, 7 days a week.***

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**FUNCTIONAL FAMILY THERAPY**  
**(Revised 4/1/09)**

**I. Service Description**

Functional Family Therapy (FFT) is an empirically-grounded, family-based intervention program for acting-out youth between 11-18, whose problems range from conduct disorder to alcohol/ substance abuse, and their families. A major goal of Functional Family Therapy is to improve family communication and supportiveness while decreasing the intense negativity. Other goals include helping family members adopt positive solutions to family problems, and developing positive behavior change and parenting strategies. Further information on FFT can be found at <http://www.fftinc.com> or <http://www.ncjrs.org/pdffiles1/ojdp/184743.pdf>.

**FFT is designed to increase efficiency, decrease costs, and enhance the ability to provide service to more youth by:**

- 1) Targeting risk and protective factors that can change and then programmatically changing them;
- 2) Engaging and motivating families and youth so they participate more in the change process;
- 3) Entering each session and phase of intervention with a clear plan and by using proven techniques for implementation; and
- 4) Constantly monitoring process and outcome.

The program is conducted by FFT trained family therapists through the flexible delivery of services by one and two person teams to clients in the home and clinic settings, and at time of re-entry from residential placement. Service providers must adhere to the principles of the FFT model. FFT requires as few as 8-12 hours of direct service time for commonly referred youth and their families, and generally no more than 26 hours of direct service time for the most severe problem situations. Sessions are spread over a 3-month period or longer if needed by the family. Therapists must engage the family (as many members as reasonably feasible) through a face to face contact within 14 days of the referral and obtain their willingness to participate. FFT emphasizes the importance of respecting all family members on their own terms as they experience the intervention process. Therapists must be relationally sensitive and focused, as well as capable of clear structuring, in order to produce significantly fewer drop-outs and lower recidivism.

Empirically grounded and well-documented, FFT has three specific intervention phases. Each phase has distinct goals and assessment objectives, addresses different risk and protective factors, and calls for particular skills from the therapist providing treatment. The phases consist of:

- **Phase 1: Engagement and Motivation**  
During these initial phases, FFT applies reframing and related techniques to impact maladaptive perceptions, beliefs, and emotions and to emphasize within the youth and family, factors that protect youth and families from early program dropout. This produces increasing hope and expectation of change, decreasing resistance, increasing alliance and trust, reduced oppressive negativity within the family and between the family and community, increased respect for individual differences and values, and motivation for lasting change.
- **Phase 2: Behavior Change**  
This phase applies individualized and developmentally appropriate techniques such as communication training, specific tasks and technical aids, basic parenting skills, and contracting and response-cost techniques.
- **Phase 3: Generalization**  
In this phase, Family Case Management is guided by individualized family functional needs, their interaction with environmental constraints and resources, and the alliance with the therapist to ensure long-term support of changes. FFT links families with available community resources and FFT therapists intervene directly with the systems in which a family is embedded until the family is able to do so itself.

Each of these phases involves both assessment and intervention components. Family assessment focuses on characteristics of the individual family members, family relational dynamics, and the multi-systemic context in which the family operates. The family relational system is described in regard to interpersonal functions and their impact on promoting and maintaining problem behavior. Intervention is directed at accomplishing the goals of the relevant treatment phase. For example, in the engagement and motivation phase, assessment is focused on determining the degree to which the family or its members are negative and blaming. The corresponding intervention would target the reduction of negativity and blaming. In behavior change, assessment would focus on targeting the skills necessary for more adaptive family functioning. Intervention would be aimed at helping the family develop those skills in a way that matched their relational patterns. In generalization, the assessment focuses on the degree to which the family can apply the new behavior in broader contexts. Interventions would focus on helping generalize the family behavior change into such contexts.

Program certification must be obtained and maintained through utilizing Functional Family Therapy certified trainers to train a site supervisor and therapists. Program fidelity must be maintained through adherence to using a sophisticated client assessment, tracking and monitoring system and clinical supervision requirements.

## **II. Target Population**

**Services must be restricted to the following eligibility categories:**

- 1) Children and families who have substantiated cases of abuse and/or neglect, with moderate to high levels of risk and service needs according to the assessment matrix
- 2) Children with a status of CHINS, and/or JD/JS
- 3) All adopted children and adoptive families

### **III. Goals and Outcome Measures**

#### Goals #1

Services are provided timely as indicated in the service description above.

#### Outcome Measures

- 1) 100% of referred children and families are engaged in services within 14 days of referral.
- 2) 100% of children and families being served have an assessment completed at the beginning of each phase.
- 3) 100% of children and families being served have a clear plan developed immediately following the assessment.
- 4) Progress reports are provided to the referring worker. Monthly.

#### Goal #2

Improved family functioning as indicated by no further incidence of the presenting problem

#### Outcome Measures

- 1) 90% of the children and families served will not have new incidences of substantiated abuse or neglect throughout the service provision period.
- 2) 90% of children and families actively engaged in treatment and following treatment recommendations will not have incidences of criminal or status charges while the agency is actively involved.
- 3) Scores will be improved on the Risk Assessment instruments in ICWIS used by the referring DCS or Youth Level of Service Inventory (YSLI) used by referring Juvenile Probation Officer.

#### Goal #3

DCS and client satisfaction with service provided.

#### Outcome Measures

- 1) Juvenile Probation/DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 90% of clients will rate services as satisfactory or above on satisfaction survey.

### **IV. Qualifications**

**Direct Worker:**

Master's degree in social work, psychology, marriage and family therapy, or related human service field and 3 years related clinical experience or a masters degree with a clinical license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board, as one of the following: 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor.

**Supervisor:**

Master's degree in social work, psychology, or marriage and family or related human service field with a current license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board, as one of the following: 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor.

**Both Direct Worker and Supervisor must complete FFT certified training.**

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

**V. Billable Units**

**Face to face time with the client:**

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

*Reminder: Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are built into the cost of the face to face rate and shall not be billed separately.*

**For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.**

#### **Translation or sign language**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

#### **VI. Rates**

Face to Face Maximum rate: \$161.55 (1/1/2010)

Translation or sign language rate: Actual cost

#### **VII. Case Record Documentation**

Necessary case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS referral form authorizing service
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports no less than quarterly or more frequently as prescribed by DCS.

#### **VIII. Service Access**

Services must be accessed through a Juvenile Probation/DCS referral unless otherwise specified. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the Juvenile Probation/DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

***NOTE: All services must be pre-approved through a referral form from the referring DCS FCM or DCS Service Consultant.***

**SERVICE STANDARD  
INDIANA DEPARTMENT OF CHILD SERVICES  
PARENT EDUCATION**

**I. Service Description**

Parenting education is the provision of structured, parenting skill development experiences. Being a parent is rewarding and challenging and there are not easy answers. Education regarding parenting, discipline and child development is a means to provide parents whose children are “at risk” or have been abused or neglected with tools to assist them in the lifelong task of disciplining, understanding, and loving their children. Parent education is provided in a group setting except for those instances where a family is unable to function appropriately or understand the material in the group setting. Many curriculums such as STAR Parenting Program and Systematic Training for Effective Parenting (STEP), Strengthening Families and Celebrating Families are available to provide this education. Regardless of the curriculum that is used, the following components must be addressed:

Child development

- Nurturing
- Self-control
- Setting limits
- Child’s temperament
- Heredity and Environment
- Birth Order
- Gender roles
- Child’s desire to belong
- Children as observers
- Power and Revenge
- Inadequacy
- Beliefs and feelings
- Encouragement
- Listening and talking
- Owning the problem
- Natural and logical consequences and choices
- Family meetings
- Responding vs. reacting to behavior
- Parenting style
- Age appropriate expectations
- Communicating with teens
- Child abuse and neglect

**II. Target Population**

**Services must be restricted to the following eligibility categories:**

- 1) Children and families who have substantiated cases of abuse and/or neglect, with moderate to high levels of risk and service needs according to the assessment matrix
- 2) Children with a status of CHINS, and/or JD/JS
- 3) All adopted children and adoptive families

**III. Goals and Outcome Measures**

**Goal#1**

Ensure that parents participating in the classes are provided with an opportunity improve parenting skills.

**Outcome Measures**

- 1) 100% of the families participating will sign attendance sheets at each session attended.

**Goal #2**

Strengthen and increase the parent's ability to provide for the emotional, physical, and safety needs of their children.

**Outcome Measures**

- 1) 100% of parents participating will complete a pre-test at the initial session.
- 2) 100% of parents participating will complete a post-test at the conclusion of the sessions.
- 3) 90% of the parents completing 75% of the sessions taking the pre and post tests will score higher on the post test.

**Goal #3**

DCS and family satisfaction with services

**Outcome Measures**

- 1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 94% of the families who have completed home-based services will rate the services "satisfactory" or above.

**IV. Qualifications**

**Direct worker (Paraprofessional):**

A high School diploma or GED and is at least 21 years of age. Must possess a valid driver's license and the ability to use private car to transport self and others, and must comply with state policy concerning minimum care insurance coverage.

**Supervisor (Professional):**

Bachelor's Degree in social work, psychology, sociology, or a directly related human service field.

Direct worker and Supervisor must have direct training in the Parent Education curriculum they are teaching.

**In addition to:**

- Knowledge of child abuse and neglect
- Knowledge of child and adult development and family dynamics
- Ability to work as a team member
- Strong belief that people can change their behavior given the proper environment and opportunity
- Belief in helping families to change their circumstances, not just adapt to them.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

**V. Billable Units**

**Face to face time with the client:**

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

*Reminder: Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are built into the cost of the face to face rate and shall not be billed separately.*

**For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.**

### **Group rate**

Groups are defined as:

- Minimum of three (3) to maximum of twelve (12) unrelated participants.

### **Per person per group hour**

When DCS clients are referred to groups where most of the clients are non-DCS referrals. This is available when the nature of group or the geographical location does not support a group composed of primarily DCS clients.

### **Translation or sign language**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

## **VI. Rates**

Face to Face Maximum rate: \$34.20 (1/1/2010)

Translation or sign language rate: Actual cost

**Budget summary must be submitted for all other rates.**

## **VII. Case Record documentation**

### **Necessary case record documentation for service eligibility must include:**

- 1) A completed, dated, signed DCS referral form authorizing service
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports no less than quarterly or more frequently as prescribed by DCS.

## **VIII. Service Access**

Services must be accessed through a DCS referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

**NOTE: All services must be pre-approved through a referral form from the referring DCS FCM or DCS Service Consultant.**

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**PARENTING / FAMILY FUNCTIONING ASSESSMENT**  
**(Revised 4/1/09)**

**I. Service Description**

**Testing and Interviews Required**

Parenting/family functioning assessment must include an interview with the adults and children being assessed in their current environment (such as: own home, relative's home, motel room, jail, etc.); completion by adults of standardized test(s) to include a parenting inventory (such as Parent-Child Relationship Inventory; Adult Adolescent Parenting Inventory-2; Family Assessment Device, Version 3; Family Assessment Measure Version III (FAM-III); and/or the Child Abuse Potential Inventory and /or another Standard Risk Assessment Instrument; observation of the parent(s) relationship with the child(ren); completion of an eco-map and/or genograms and a tour of the proposed home environment noting any needs or challenges.

If issues of substance abuse are prevalent during the investigation, a drug/alcohol assessment must also be completed which should include a clinical interview focusing on substance abuse issues and completion of the Substance Abuse Subtle Symptom Inventory (SASSI-3) or another substance abuse assessment tool.

Parenting and family functioning assessments shall include two separate appointments held on different days scheduled at the convenience of the client (to include evenings and weekends).

Failure to maintain confidentiality may result in immediate termination of the service agreement.

**Written Report**

All written reports must include the recommendations regarding services/treatment at the beginning of the report followed by information relating to specific categories. The written assessment must be prepared to include the following:

- 1) identifying information,
- 2) history of significant events, medical history, history of the children (including educational history),
- 3) family socio-economic situation, including income information of the parents and child(ren)
- 4) family composition, structure, and relationships
- 5) family strengths and skills
- 6) family motivation for change
- 7) description of home environment,
- 8) summary of any testing completed,
- 9) summary of collateral contacts,

- 10) assessment of relationship between parent(s), and child(ren), and
- 11) assessor's assessment of the client's ability to safely parent the children.

If assessing parents in separate households, a separate written report must be provided on each parent. The report must also include current issues that jeopardize reunification with either parent if separate as well as a description of ongoing issues that need to be addressed even if the children remain in the home or are returned to the home.

**If a substance abuse assessment was completed, the written report will also include the following:**

- 1) results of the SASSI and any other diagnostic instruments used results and interpretations of the interview data including the DSM-IV diagnosis, and
- 2) recommendations for treatment needs.

## **II. Target Population**

**Services must be restricted to the following eligibility categories:**

- 1) Children and families who have substantiated cases of abuse and/or neglect, with moderate to high levels of risk and service needs according to the assessment matrix
- 2) Children with a status of CHINS, and/or JD/JS
- 3) All adopted children and adoptive families

## **III. Goals and Outcomes**

### **Goal #1**

Timely receipt of report (service must commence within 3 working days of receipt of the referral)

Outcome Measures

- 1) 90% of the evaluation reports will be submitted to the referring DCS case manager within twelve (12) working days of the last appointment or testing completed with the client.

### **Goal #2**

Obtain appropriate recommendations based on information provided.

Outcome Measures

- 1) 100% of reports will meet information requested by DCS.
- 2) 100% of reports will include recommendations for treatment, needed services or indicate no further need for services.

### **Goal #3**

DCS and client satisfaction with service provided.

## Outcome Measures

- 1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 90% of clients will rate services as satisfactory or above on satisfaction survey.

## IV. Qualifications

### **Direct Worker:**

Master's degree in social work, psychology, marriage and family therapy, or related human service field and 3 years related clinical experience or a masters degree with a clinical license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board, as one of the following: 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor.

### **Supervisor:**

Master's degree in social work, psychology, or marriage and family or related human service field with a current license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board, as one of the following: 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

## V. Billable units

**The hourly rate includes face to face contact with the identified client/family members and professional time involved in scoring testing instruments and preparing the assessment report.**

### **Face to face time with the client:**

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.

- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

**Reminder:** *Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are built into the cost of the face to face rate and shall not be billed separately.*

For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.

**Translation or sign language**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

**VI. Rates**

Face to Face Maximum rate: \$78.75 (1/1/2010)

Translation or sign language rate: Actual cost

**VII. Case Record Documentation**

**Necessary case record documentation for service eligibility must include:**

- 1) A completed, dated, signed DCS referral form authorizing services;
- 2) Documentation of regular contact with the referred families/children and referring agency; and
- 3) Written reports no less than quarterly or more frequently as prescribed by DCS.

**VIII. Service Access**

Services must be accessed through a DCS referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

***NOTE: All services must be pre-approved through a referral form from the referring DCS FCM or DCS Service Consultant.***

**SERVICE STANDARD  
INDIANA DEPARTMENT OF CHILD SERVICES  
SEX OFFENDER TREATMENT;  
VICTIMS OF SEX ABUSE TREATMENT**

**I. Service Description**

Sex offender specific treatment is designed to improve public safety by reducing the risk of reoccurring sexually based offenses. It is an intervention carried out in a specialized program containing a variety of cognitive behavioral and psycho-educational techniques that are designed to change offense supportive beliefs and attributions, improve handling of negative emotions, teach behavioral risk management, and promote pro-social behavior. Because programming will rely on a containment approach, providers shall work closely with local service and treatment agencies to enhance the community's response to sexual offending. Along with sexual offender specific treatment, containment teams shall be established for each referral in order to ensure consistency in service delivery and decision-making and foster collaboration. Programming will provide services to children and their families who are referred by the Department of Child Services, the local Juvenile Court, and/or the local Juvenile Probation Department.

All referred cases shall follow a continuum that provides the following:

- 1) **Risk and needs assessment for sexual offenders: (emergency and non-emergency)**  
Assessments must include the following components: Youth, family and community strengths; cognitive functioning; social/developmental history; current individual functioning; current family functioning; delinquency and conduct/behavioral issues; substance use and abuse; mental health assessment; sexual evaluation; community risk and protective factors; awareness of victim impact; external relapse prevention systems including informed supervision amenable to treatment and treatment recommendations. It must also include an assessment of risk using the ERASOR (Estimated Risk of Adolescent Sexual Offender Recidivism).
- 2) **Risk and needs assessment for victim sex abuse assessment (emergency and non-emergency)**  
Assessments must include the following components: Presenting issue; history of abuse; familiar history; social/developmental history; developmental competence; sexual evaluation; substance use and abuse; assessment of risk in home, community risks and protective factors; youth, family and community strengths; treatment recommendations.
- 3) **Containment Teams for offenders**  
Traditional supervision practices do not adequately address the unique challenges and risks that sexually maladaptive youth pose to the community. Therefore it is expected that the provider will establish a "network" of family members, friends,

teachers, coaches and any other community members or professionals who are committed to the success of the youth, to provide intensive monitoring of the youth in the home, school and community. This monitoring will occur 24 hours a day while the youth receives treatment.

- 4) Treatment must include individual, group and family components for both sex offenders and victims of sex abuse including the following:
  - a. Case-specific treatment components through individual therapy including addressing personal history of sexual victimization and behavioral techniques designed to modify deviant sexual arousal if appropriate
  - b. Core treatment modules through group therapy including: psycho-education about the consequences of abusive behavior; increasing victim empathy, identifying personal risk factors, promoting healthy sexual attitudes and beliefs; social skills training; sex education; anger management and relapse prevention as appropriate
  - c. Parent components including: engendering support for treatment and behavior change; encouraging supervision and monitoring; teaching recognition of risk signs and promoting guidance and support to their teenager.
  - d. Relapse prevention if appropriate
  - e. Polygraph testing if appropriate
  - f. Family and victim support services
  - g. Compliance monitoring and reporting

Further, service providers shall strive to enhance the community's awareness of the dynamics of sexual abuse by providing the following:

- a. Community awareness projects
- b. Interdisciplinary training

## **II. Target Population**

Services must be restricted to the following categories:

- 1) Youth, under the age of eighteen (18), experiencing sexually maladaptive behaviors, who are under the supervision of the local Division of Child Services, the local Juvenile Probation Department, and/or the local Juvenile Court. Family members are included in services.
- 2) Children who are victims of a sex offense and their families.
- 3) Children and families who meet the requirements for CHINS 6; or
- 4) A family with a child (offender or victim) at imminent risk of placement.
- 5) Probation youth shall be included if they meet the criteria of 1, 2, 3 and/or 4 and the required case record documentation (referral, case plan and risk assessment) is provided to the local DCS for case processing.

## **III. Goals and Outcome Measures**

Goal #1:

Timely initiation of services with the family.

Outcome Measures

- 1) Emergency Assessments: Initial recommendations must be provided to the referring worker within 48 hours of the assessment with a full assessment report to the worker within 72 hours of the assessment (by email).
- 2) Non-Emergency Assessments: A full assessment report must be available within fourteen calendar days of the referral (by email).
- 3) Treatment: The initial treatment plan including measurable goals, specific steps to be taken to meet those goals and estimated timeframes for completing each goal must be sent to the referring worker within fifteen calendar days of the first face-to-face contact with the client (by email).
- 4) Monthly progress must be completed and sent to the referring worker by email by the 10<sup>th</sup> of each month for the previous month. Reports must contain progress made since the previous report in each goal.

Goal #2:

Programming shall include a “full service” response including, but not limited to all of the components identified in the service standards.

Outcome Measures

- 1) A clinical audit undertaken by a DCS employee will find documentation relating to all of the required components.

Goal #3:

A Containment Team shall be implemented for each family referred to services. The Team approach will allow for families to participate in the decision making process regarding their family.

Outcome Measures

- 1) 100% of all children/families referred for treatment will have a fully functional network in place within 60 days of the initial face-to-face contact and will thereafter meet monthly to review the adolescent’s progress, strengths and needs.
- 2) 100% of these meetings will have minutes prepared with action steps identified together with person(s) responsible for completing those steps. These minutes will be included with the monthly progress reports sent to the referring workers.

Goal #4:

Service providers shall work closely with local service and treatment agencies in order to enhance the community’s response to sexual offending.

Outcome Measures

- 1) Selected providers will develop and promote quarterly community education opportunities regarding child/adolescent sexual abuse issues.

Goal #5:

Youth participating in the program will have no behavioral issues and/or probation violations.

Outcome Measures

- 1) 90% of youth/families participating in the program will not have any delinquency charges and/or probation violations during the treatment phase.
- 2) 75% of youth who successfully complete the program will not have any delinquency charges and/or probation violations within 12 months of completing the program.

#### **IV. Qualifications**

Minimum qualifications: Master's degree in a behavioral health science. Service providers will only utilize professionals who are specifically trained and are licensed practitioners. Training can occur through the University of Louisville, KY, Ohio University, OH, the Indiana Association for Juvenile Sex Offender Practitioners, or an equivalent recognized credentialed authority.

Further, staff members shall be knowledgeable of the dynamics surrounding child abuse/neglect, be knowledgeable of child and adult development and family dynamics, and also knowledgeable of community resources.

#### **V. Billing Units**

##### **Face to face time with the client:**

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

*Reminder: Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are built into the cost of the face to face rate and shall not be billed separately.*

**For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.**

##### **Translation or sign language:**

Department of Child Services  
Regional Document for Child Welfare Services  
Term 1/1/09-6/30/11  
(June 15, 2010)

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

### **Polygraphs**

Polygraphs must be purchased from a licensed provider. Polygraphs are a unit rate and the provider must tell what their rates are. The intent of the polygraph is for the sex offender only.

## **VI. Rates**

**Face to Face Rate:** \_\_\_\_\_

**Polygraphs:** **Actual Cost**

**Translation or Sign Language:** **Actual Cost**

**Budget Summary must be submitted for rates.**

## **VII. Case Record Documentation**

Necessary case record documentation for service eligibility must include:

- 1) A DCS referral form, **Juvenile** Court Order, or written referral from the Juvenile Probation Department;
- 2) Documentation of regular contact with the referred families/children and referring agency;
- 3) Written reports regarding each assessment;
- 4) Written minutes regarding each containment team meeting.
- 5) Written monthly progress reports

## **VIII. Service Access**

Referrals will be submitted via a DCS service referral, Juvenile Probation Department written referral (with written notification to the DCS with corresponding case processing information and/or the Court Order of the Juvenile Court (with written notification to the DCS with corresponding case processing information. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS, Juvenile Court, or Juvenile Probation Department. Providers must initiate a reauthorization for services to continue beyond the approved period.

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**VISITATION FACILITATION-PARENT / CHILD / SIBLING**

**I. Service Description**

**It is the fundamental right for children to visit with their parents and siblings.** The relationship developed by the child with the parent is one of bonding, dependency, and being nurtured, all of which must be protected for the emotional well being of the child. It is of extreme importance for a child not to feel abandoned in placement by either the child's parents or by other siblings, and for a child to be reassured that no harm has befallen either parent or siblings when separation occurs.

Visit facilitation will be provided between parents/children and/or siblings only who have been separated due to a substantiated allegation of abuse or neglect. Visitation allows the child an opportunity to reconnect and reestablish the parent/child/sibling relationship in a safe environment. It is an excellent time for parents to learn and practice new concepts of parenting and to assess their own ability to parent through interaction with the child. Supervised visitation allows the DCS to assess the relationship between the child and parent and to assist the parent in strengthening their parenting skills and developing new skills. In situations where reunification is not the goal for the family and siblings are separated, sibling visitation may be provided under this service.

The visitation provider provides a positive atmosphere where parents and children may interact in a safe, structured environment. Visitation may be held in a visitation facility; neutral sites such as parks, fast food restaurant with playground, or shopping malls; child's own home or relative's home; foster home; or other location as deemed appropriate by the referring DCS and other parties involved in the child's case taking into consideration the child's physical safety and emotional well being.

**Referral process**

In order for positive and productive visitation to occur, a referral form (*in addition to the IV-B referral form*) will be provided by the visitation facility for completion by the child's case manager to obtain information such as:

- 1) desired/allowable location of visits (such as facility, neutral space, foster home, own, home, etc.), length of visits, number of visits requested per week,
- 2) placement of the child and contact information,
- 3) who may participate in visits with contact information and relationship to child,
- 4) who is restricted from visits,
- 5) level of supervision requested (such as in-room, drop-in during visit, audio monitored, video monitored, semi-supervised, unsupervised, etc),
- 6) what is expected of the parents or other approved person(s) regarding prior preparation related to bottle feeding, meals and snacks, change of clothes if needed, diapers and wipes, etc.,
- 7) restricted activities, if any, and

- 8) consequences when parents do not attend visits as planned and agreed upon (this may include no showing or being consistently late or consistently leaving early);
- 9) circumstances under which visits may be limited or terminated (such as parent or child has head lice, parent under influence of mood altering substance, parent's intimidating or threatening behavior, inability of parent to manage children's behavior in structured setting, etc.); and
- 10) other information pertinent to the visits.

The referral form will provide adequate information for the visitation facility to develop a visitation plan with input from the child's placement and biological/legal parents and foster parents to activate the referral.

Upon receiving the referral from the DCS, the agency will contact all parties to set up the visits taking into consideration the ability of the parent to attend based on work schedules and the foster parent or relative caregiver ability to ensure attendance of the child. Every attempt must be made for visitation to be scheduled within 5 working days of receipt of the referral. All cancelled visits by the parent or visit facilitator must be reported to the referring DCS as soon as possible after the decision to cancel indicating who cancelled and the reason for cancellation.

### **Visit Observation and Reporting**

Professional and/or paraprofessional staff will assist the family by monitoring, strengthening, teaching, demonstrating, and/or role modeling appropriate skills in the following areas:

- Establishing and/or strengthening the parent-child relationship
- Instruction parents in child care skills such as feeding, diapering, administering medication if necessary, proper hygiene
- Teaching positive affirmations, praising when appropriate
- Providing instruction about child development stages, current and future
- Teaching age-appropriate discipline
- Teaching positive parent-child interaction through conversation and play
- Providing opportunities for snack and meal prep with children present
- Responding to child's questions and requests
- Teaching safety regarding age-appropriate toys, climbing, running, jumping, or other safety issues depending on the environment
- Managing needs of children of differing ages at the same time
- Helping parents gain confidence in meeting their child's needs
- Identifying and assessing potentially stressful situations between parent and their children
- Giving parents an opportunity to decide whether they are willing and able to pursue reunification

**At each visit, the visitation facilitator will accurately document for the referring DCS the following information:**

- 1) date, location, and level of supervision of visit;

- 2) those in attendance at the visit;
- 3) time of arrival and departure of all parties for the visit;
- 4) greeting and departure interaction between parent and child/ren;
- 5) positive interactions between parent and child;
- 6) planned activities by the parent for visit;
- 7) interventions required, if any and parent's response to direction provided with regard to interventions;
- 8) ability and willingness of parent to meet child's needs as requested by child or facilitator;
- 9) recommendation regarding level of supervision of follow up visits based on on-going demonstration of ability by the parents and comfort level of the child/ren;
- 10) tasks given to the parent to be completed prior to or at the next visit, etc.

**Additionally, the following items apply:**

- 1) Visitation staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
- 2) Family Case Managers will be notified by phone immediately when inappropriate behavior occurs with either parent in a visit that affects the ability of the visit to continue or the safety of the child.
- 3) Services must demonstrate respect for sociocultural values, personal goals, life style choices, and complex family interactions and be delivered in a culturally competent fashion.
- 4) Attendance at case conferences may be required as well as testimony and/or court appearances at review or permanency hearings for the child.
- 5) Documentation regarding subjective information must be followed by examples of the situation for clarification. The documentation of the visit must be provided to the referring DCS no less than 3 days following the visit.
- 6) Provider understands that documentation will be shared with the child's parents, foster parents or other placement of the child, the child's therapist, and other parties in the case to assist in decision making regarding decreased or increased levels of supervision and reunification.

## **II. Target Population**

**Services must be restricted to the following eligibility categories:**

- 1) Children and families who have substantiated cases of abuse and/or neglect, with moderate to high levels of risk and service needs according to the assessment matrix
- 2) Children with a status of CHINS, and/or JD/JS

## **III. Goals and Outcome Measures**

### Goal #1

Department of Child Services  
Regional Document for Child Welfare Services  
Term 1/1/09-6/30/11  
(June 15, 2010)

Ensure that all children removed from their parents have the opportunity to visit their parents/siblings on a regular basis.

Outcome Measures

- 1) 90% of the families will actively and appropriately participate during visits.

Goal # 2

Strengthen and increase the parent's ability to provide for the emotional and physical needs as well as the safety of their children.

Outcome Measures

- 1) 85% of parents served will recognize and respond to their children's cues regarding their needs and wants.
- 2) 85% of the parents provide an emotionally stable and safe level of care to meet the needs of their children during visits.
- 3) 90% of parents will arrive with previously requested items by the visit facilitator for the children such as diapers, food, etc. and be prepared a meal or snack if expected.

Goal # 3

Provide accurate and timely information in the child's case so that informed decisions may be made regarding reunification and permanency for the child.

Outcome Measures

- 1) 98% of visitation reports will be received weekly by the DCS of the visitation or immediately when inappropriate behavior occurs with either parent.

Goal #4

DCS and family satisfaction with services

Outcome Measures

- 1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 94% of the families who have completed home-based services will rate the services "satisfactory" or above.

#### **IV. Qualifications**

##### **Direct Worker (Paraprofessional):**

A high school diploma or GED; one (1) year full-time experience in child care in an organized setting or experience as a parent and is at least 21 years of age.

##### **Direct Worker (Professional):**

Bachelor's degree in social work, psychology, sociology, or a directly related human service field.

##### **Supervisor:**

Master's degree in social work, psychology, or directly related human services field.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

## **V. Billable Units**

### **Face to face time with the client:**

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

*Reminder: Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are built into the cost of the face to face rate and shall not be billed separately.*

**For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.**

### **Translation or sign language**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

## **VI. Rates**

Face to Face Maximum rate: \$46.80 (1/1/2010)

Translation or sign language rate: Actual cost

## **VII. Case Record Documentation**

**Necessary case record documentation for service eligibility must include:**

- 1) A completed, dated, signed DCS referral form authorizing service
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports no less than quarterly or more frequently as prescribed by DCS.

## **VIII. Service Access**

Services must be accessed through a DCS referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

***NOTE: All services must be pre-approved through a referral form from the referring DCS FCM or DCS Service Consultant.***

# **ADDICTIONS**

**SERVICE STANDARD  
INDIANA DEPARTMENT OF CHILD SERVICES  
DRUG TESTING AND SUPPLIES  
(Revised 1/13/09)**

**I. Service Description**

These services are designed for individuals who are suspected of drug and/or alcohol use by DCS workers and Probation Officers and require immediate testing. The vendor must provide all required supplies and courier services to transport all specimens, test results, and testing materials to and from any location within the referring county.

**The FCMs may administer saliva/oral fluid (swabs) only. Probation Officers are not prohibited by DCS from the administration of drug tests.**

**The types of drug screens included, but are not limited to, saliva/oral fluid, hair follicle, and urine.**

Services include providing any requested testimony and/or court appearances (to include hearing or appeals), including chain-of-custody and/or testing procedures/results on an as needed basis.

The vendor shall provide Initial Testing and Gas Chromatography/Mass Spectrometry Confirmation (GC/MS) Testing or other federally approved testing methods which may include LC/MS/MS or GC/MS/MS (when the Initial Tests indicate a positive result) for any location within the referring county.

The Vendor shall ensure proper legal chain-of-custody procedures are maintained and comply with departmental procedure, state and federal law. The vendor shall also ensure complete integrity of each specimen tested and the respective test results. Receiving, transfer and handling of all specimens by laboratory personnel shall be fully documented using the proper chain-of-custody.

Testing shall not be conducted on any specimen without a legal chain-of-custody. All specimens found to be "Adulterated" or "Contaminated" shall be treated as an Invalid Specimen. Any specimen without a valid chain-of-custody is to be destroyed. The submitting location shall be notified in writing when a specimen has been rejected due to an invalid chain-of-custody or any other integrity problem. Monthly reports shall document how many random samples were taken minus how many "Adulterate" or "Contaminated" specimens there were for the month. (Note: This does not apply to oral fluid testing.)

**Initial Testing**

All sample collections drug screens will be observed sample collections screens. Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Propoxyphene, and Methamphetamine. The agency will be expected to provide reports that state the

minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation.

For urine screens, testing for creatinine levels shall be conducted on all samples. The vendor shall also insure testing for total Cannabinoids per mg of creatinine using spectrophotometer technology. The Vendor shall insure testing for specific gravity on all samples with a creatinine level below 20 mg per deciliter. The Vendor shall also insure the administration of a nitrite test on any specimen that contains no creatinine and has a specific gravity test of 1.000.

Initial screening shall be conducted utilizing an enzyme immunoassay method. Testing should occur for the following substances utilizing the cut-off levels listed below:

<b>DRUG</b>	<b>URINE</b>	<b>ORAL FLUID</b>	<b>HAIR LEVELS*</b>
<i>Amphetamines</i>	<i>1000NG/ML</i>	<i>20NG/ML</i>	<i>500PG/MG</i>
<i>Cannabinoids</i>	<i>50NG/ML</i>	<i>1NG/ML</i>	<i>1PG/MG</i>
<i>Benzodiazepines</i>	<i>300NG/ML</i>	<i>10NG/ML</i>	<i>200PG/MG</i>
<i>Methamphetamine (including ECSTACY(MDMA), ADAM(MDA))</i>	<i>1000NG/ML</i>	<i>20NG/ML</i>	<i>500PG/MG</i>
<i>Opiates</i>	<i>2000NG/ML</i>	<i>10NG/ML</i>	<i>200PG/MG</i>
<i>Cocaine</i>	<i>300NG/ML</i>	<i>5NG/ML</i>	<i>500PG/MG</i>

*\*Hair uses = PG/MG = weight*

*\* For all other substances tested use recommended laboratory cutoff levels*

All negative samples held by the laboratory will be retained for one week. A retention time extension may be requested based upon need.

### **Confirmation Testing**

Confirmation Testing shall be conducted utilizing GC/MS or LC/MS/MS Technology on all samples initially testing POSITIVE. The following cut-off levels shall be utilized:

<b>DRUG</b>	<b>URINE</b>	<b>ORAL FLUID</b>	<b>HAIR LEVELS*</b>
<i>Amphetamines</i>	<i>500NG/ML</i>	<i>10NG/ML</i>	<i>300PG/MG</i>
<i>Cannabinoids</i>	<i>15NG/ML</i>	<i>.5NG/ML</i>	<i>.05PG/MG</i>
<i>Benzodiazepines</i>	<i>100NG/ML</i>	<i>1NG/ML</i>	<i>50PG/MG</i>
<i>Methamphetamine (including ECSTACY(MDMA), ADAM(MDA))</i>	<i>500MG/ML</i>	<i>10NG/ML</i>	<i>300PG/MG</i>
<i>Opiates</i>	<i>150NG/ML</i>	<i>5NG/ML</i>	<i>200PG/MG</i>
<i>Cocaine</i>	<i>150NG/ML</i>	<i>1NG/ML</i>	<i>50PG/MG</i>

*\*Hair uses = PG/MG = weight*

*\* For all other substances tested use recommended laboratory cutoff levels*

All positive samples shall be frozen and maintained for 365 days by the laboratory. A retention time extension may be requested based upon need.

In situations where the source of the methamphetamine present in any specimen may come into question, the vendor must perform a d-1-isomer differentiation. This service is to be offered at no additional cost to the Department of Child Services and performed when requested by DCS.

**Results Notification**

The vendor shall notify the Department of Child Services and/or Probation of testing results via email on vendor letterhead. The results will also be sent by U.S. mail to the referring agency as well. The vendor shall gain approval from DCS for any changes in the results notification system.

The referring agency will be notified of negative test results within 24 hours of the test. The specified time frame is from delivery to the testing laboratory to the time of notification. Positive test results will be provided within 72 hours of the test.

For urine tests, diluted results must be reported on the result form.

**Courier System**

The vendor will coordinate all courier services to transport all specimens, test results, and testing materials to and from any location within the referring county. Deliveries shall be made during regular working days, normally between the hours of 8:00 am and 5:00pm unless otherwise indicated. The vendor shall be responsible for the cost of all courier services provided under the contract.

The vendor shall provide courier services that maintain the legal chain-of-custody, throughout the State of Indiana within 24 hours of request of pick up. The vendor shall provide postage paid mailers or next day delivery services for utilization at any location that desires to use this method as an alternative to the courier services. This shall be at no additional charge to DCS.

The vendor’s courier system shall provide documented, legal chain-of-custody throughout the State of Indiana which includes, or is similar to, the following:

Vendor Courier	Operates Statewide/Same Day Delivery
Airborne Express	Operates nationwide providing next day delivery.
NOW Carrier	Operates throughout the State of Indiana providing same day delivery.
Direct Delivery	Operates throughout Central Indiana/Same Day Delivery.

**Training**

Prior to implementation, the vendor must provide training to the referring agency. The initial training shall be completed within six weeks of contract activation. The vendor will be responsible for conducting "Train the Trainer" sessions with appropriate staff of the referring agency. This will include universal precautions as well. This training will allow trained staff to train others in the county. The trainers will receive a training manual and all of the necessary handouts, videos or other material to accomplish all further training of staff.

### **Technical Support**

A toll free 800 number will be available to all DCS local offices, in the State of Indiana to contact for technical support. Technical support staff and laboratory technicians shall be available during normal working hours via the 800 number, to provide technical assistance at no additional cost.

### **Supplies**

The vendor shall provide the following supplies:

- 1) Sample containers
- 2) Specimen donor labels
- 3) Evidence security tape
- 4) Evidence bags
- 5) Evidence chain-of-custody forms with seals
- 6) Swabs
- 7) All supplies required for mailing or next day delivery
- 8) Any additional supplies necessary for referring specimens to the laboratory.

## **II. Target Population**

Services must be restricted to the following eligibility categories:

- 1) Parent(s) of children for whom a CPS assessment has been initiated
- 2) Children and parent(s) who have substantiated cases of abuse and/or neglect
- 3) Children with a status of CHINS, and/or JD/JS
- 4) Minor children suspected of drug use prior to adjudication

## **III. Goals and Outcome Measures**

### **Goal #1**

Services are provided timely as indicated in the service description above.

### **Outcome Measures**

- 1) 100% of courier services will be provided within a 24 hours of a request for pick up.

- 2) 100% of referring agencies will be notified of negative test results within 24 hours of the test.
- 3) 100% of referring agencies will be notified of positive test results within 72 hours of the test.

#### Goal #2

Services are provided as indicated in the service description above.

#### Outcome Measures

- 1) 100% of proper legal chain-of-custody procedures will be maintained and will comply with Departmental Policy, State and Federal law.
- 2) 100% of all specimens will be tested for illegal drugs or prescription medication if the client does not have a valid prescription. Amphetamines Cannabinoids Benzodiazepines Opiates, Cocaine, and Meth utilizing the cut-off levels listed above.
- 3) 100% of supplies will be provided to referring counties upon request.

#### **IV. Qualifications**

A laboratory participating in DCS drug testing must comply with all applicable Federal Department of Health and Human Service, and, under these federal requirements, are subsumed [Substance Abuse and Mental Health Services Administration](#) (SAMSHA), or College of American Pathology (CAP), or Clinical Laboratory Improvement Act (CLIA) requirements.

#### **V. Billable Units**

##### **Rejected or Unfit Specimens**

**The provider cannot claim for the handling of rejected specimens or those otherwise unfit for testing.**

##### **Drug Screens**

Actual cost of the screens. The provider is to present a list of the drug screens available with the total cost of each drug screen or set of drug screens. The DCS will specify which drug screen or screens they are authorizing for each client on the authorizing referral form.

The billable units will include the following:

- 1) Monthly Report
- 2) Retention of positive samples as required by other standard.
- 3) Technical Support
- 4) Training
- 5) Cost of Courier System

Grantees will bill monthly based on these payment points:

### **Drug Tests and Supplies**

Actual Cost

### **Screen, Confirmation and Test Kit**

(Court costs and supplies must be rolled into Actual Cost)

### **Collection Cost**

Actual Cost

### **Supplies**

Actual Cost (Supply list with proposal)

### **Translation or sign language**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

## **VI. Rates**

Grantees will bill monthly based on these payment points:

Drug Tests and Supplies (Actual Cost)

Screen, Confirmation and Test Kit (court costs and supplies must be rolled into Actual Cost)

Collection Cost (Actual Cost)

Supplies: Actual Cost (Supply list with proposal)

Translation or sign language: Actual Cost

## **VII. Case Record Documentation**

Necessary case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS referral form authorizing service
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports no less than quarterly or more frequently as prescribed by DCS.

## **VIII. Service Access**

Services must be accessed through a DCS referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

**NOTE: All services must be pre-approved through a referral form from the referring DCS FCM or DCS Service Consultant.**

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**EMERGENCY/MOBILE DRUG SCREENS/TESTS**  
**(Revised 1/13/09)**

**I. Service Description**

These services are designed for individuals who are suspected of drug and/or alcohol use by DCS workers and probation and require screening immediately. The agency must have the capacity to respond to Emergency and Mobile screen referrals twenty-four (24) hours per day, seven days per week, including all holidays, including after-hours, weekends, and holidays. Emergency screen referrals may be completed at the bidding agency facility. Mobile screen referrals will require the provider to travel to any location within the referring County to complete the screen with the DCS referring worker.

It is expected that the referring worker and provider will work together to make arrangements to collect the screen in no more than twenty-four (24) hours of the first contact attempt from the referring worker.

**The types of drug screens included, but are not limited to, saliva/oral fluid, hair follicle, and urine.**

Services include providing any requested testimony and/or court appearances (to include hearing or appeals).

All sample collections drug screens will be observed sample collections screens. Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Propoxyphene and Methamphetamines. The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation.

**Initial Testing**

All sample collections drug screens will be observed sample collections screens. Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Propoxyphene, and Methamphetamine. The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation.

For urine screens, testing for creatinine levels shall be conducted on all samples. The vendor shall also insure testing for total Cannabinoids per mg of creatinine using spectrophotometer technology. The Vendor shall insure testing for specific gravity on all samples with a creatinine level below 20 mg per deciliter. The Vendor shall also insure the administration of a nitrite test on any specimen that contains no creatinine and has a specific gravity test of 1.000.

Initial screening shall be conducted utilizing an enzyme immunoassay method. Testing should occur for the following substances utilizing the cut-off levels listed below:

<b>DRUG</b>	<b>URINE</b>	<b>ORAL FLUID</b>	<b>HAIR LEVELS*</b>
<i>Amphetamines</i>	<i>1000NG/ML</i>	<i>20NG/ML</i>	<i>500PG/MG</i>
<i>Cannabinoids</i>	<i>50NG/ML</i>	<i>1NG/ML</i>	<i>1PG/MG</i>
<i>Benzodiazepines</i>	<i>300NG/ML</i>	<i>10NG/ML</i>	<i>200PG/MG</i>
<i>Methamphetamine (including ECSTACY(MDMA),</i>	<i>1000NG/ML</i>	<i>20NG/ML</i>	<i>500PG/MG</i>

ADAM(MDA)			
Opiates	2000NG/ML	10NG/ML	200PG/MG
Cocaine	300NG/ML	5NG/ML	500PG/MG

\*Hair uses = PG/MG = weight

\* For all other substances tested use recommended laboratory cutoff levels

### **Confirmation Testing**

Confirmation Testing shall be conducted utilizing GC/MS or LC/MS/MS Technology on all samples initially testing POSITIVE. The following cut-off levels shall be utilized:

<b>DRUG</b>	<b>URINE</b>	<b>ORAL FLUID</b>	<b>HAIR LEVELS*</b>
Amphetamines	500NG/ML	10NG/ML	300PG/MG
Cannabinoids	15NG/ML	.5NG/ML	.05PG/MG
Benzodiazepines	100NG/ML	1NG/ML	50PG/MG
Methamphetamine (including ECSTACY(MDMA), ADAM(MDA))	500MG/ML	10NG/ML	300PG/MG
Opiates	150NG/ML	5NG/ML	200PG/MG
Cocaine	150NG/ML	1NG/ML	50PG/MG

\*Hair uses = PG/MG = weight

\*For all other substances tested use recommended laboratory cutoff levels

In situations where the source of the Amphetamine present in any specimen may come into question, the vendor must insure the performance of a d-1-isomer differentiation. This service is to be offered at no additional cost to the Department of Child Services and performed when requested by DCS.

The Vendor shall ensure proper legal chain-of-custody procedures are maintained and comply with DCS Procedure, State and Federal law. The vendor shall also ensure complete integrity of each specimen tested and the respective test results. Receiving, transfer and handling of all specimens by personnel shall be fully documented using the proper chain-of-custody.

The vendor shall insure that all laboratories used for drug testing purposes must comply with all applicable Federal Department of Health and Human Service, and, under these federal requirements, are subsumed [Substance Abuse and Mental Health Services Or Administration](#) (SAMSHA), The College of American Pathology (CAP), or Clinical Laboratory Improvement Act (CLIA) requirements.

Testing shall not be conducted on any specimen that does not have a legal chain-of-custody. All specimens found to be “Adulterated” shall be treated as an Invalid Specimen. Any specimen without a valid chain-of-custody is to be destroyed. The submitting location shall be notified in writing when a specimen has been rejected due to an invalid chain-of-custody or any other integrity problem.

Reporting requirements:

- Provider agency will be required to send email notification of positive and negative results to the referring worker within 24 hours of receipt of results and to mail original copies of all results within 24 hours of receipt of results from the laboratory.
- Email notification must be sent to the referring worker within 24 hours of all “failed attempts”.
- Notification to the referring worker and termination of the referral after two (2) consecutive “failed attempts”.
- Diluted results must be reported on the result form.

## **II. Target Population**

Services must be restricted to the following eligibility categories:

- 1) Parent(s) for whom a CPS assessment has been initiated
- 2) Children and parent(s) who have substantiated cases of abuse and/or neglect
- 3) Children with a status of CHINS, and/or JD/JS
- 4) Minor children suspected of drug use prior to adjudication

## **III. Goals and Outcome Measures**

### **Goal #1**

Drug screens and their results will be provided to the referring worker in a timely fashion.

#### **Outcome Measures**

- 1) 100% of positive reports will be reported verbally by phone, voice mail or email within 24 hours of receiving results of the drug screen from the laboratory.
- 2) 100 % of written sample reports will be mailed or faxed to the referring worker within 24 hours of receipt of laboratory results.

### **Goal #2**

Failed attempt forms based on two failed attempts of sample collection.

#### **Outcome Measures**

- 1) 100% of failed attempt alerts will be provided to referring worker within 24 hours following each failed attempt.

## **IV. Qualifications**

Sample collection does not require the services of a certified drug abuse counselor. The person providing this service must be highly trained in sample collection and the chain of custody procedures to document the integrity and security of the specimen from time of collection until receipt by the laboratory.

## **V. Billable Units**

**The provider cannot claim for the handling of rejected specimens or those otherwise unfit for testing.**

### **Drug Screens**

Actual cost of the screens. The provider is to present a list of the drug screens available with the total cost of each drug screen or set of drug screens. The DCS will specify which drug screen or screens they are authorizing for each client on the authorizing referral form.

Grantees will bill monthly based on these payment points:

### **Initial Test:**

Services include the collection of sample specimen and ensuring that the chain of custody procedure is followed to maintain the integrity and security of the specimen from time of collection until receipt by the laboratory. This will be billed for all tests that are negative.

### **Confirmation Testing (lab processing)**

Services include the collection of the specimen. This confirmation testing charge shall include confirmation of positive results for one or more substances in the same sample. Ensuring that the testing of specimens and the chain of custody procedure is followed to maintain the integrity and security of the specimen from time of delivery to the testing laboratory to the results notification.

### **Failed Attempts:**

- 1) Includes attempted scheduled sample collections with the identified client/family for which the client/family does not appear. Upon the second consecutive attempt, the provider must contact the referring DCS worker/Probation Officer to determine if continuation of drug testing services is appropriate.
- 2) Includes attempted unscheduled home visits if such visits are requested by the DCS via the Referral Form, the DCS Case Plan, or subsequent DCS Progress or Case Notes.
- 3) Wait time for a failed attempt must be no less than 30 minutes. A note must be left to inform the client/family that a contact attempt was made.
- 4) "Failed Attempts" are to be billed per occurrence.

### **Translation or sign language**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

## **VI. Rates**

Grantees will bill monthly based on these payment points:

Initial Test: Actual Cost  
Confirmative Testing: Actual Cost  
Failed Attempts: Actual Cost  
Translation or sign language: Actual Cost

## **VII. Case Record Documentation**

Necessary case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS referral form authorizing service
- 2) Documentation of contacts with the referred families/children including failed attempts.
- 3) Written reports as described in the service standard.

## **VIII. Service Access**

Services must be accessed through a DCS referral. Referrals are valid for a maximum of two sample collection attempts unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

**NOTE: All services must be pre-approved through a referral form from the referring DCS FCM or DCS Service Consultant.**

**SERVICE STANDARD  
INDIANA DEPARTMENT OF CHILD SERVICES  
RANDOM DRUG TESTING  
(Revised 1/13/09)**

**I. Service Description**

Random screens are designed for individuals who may or may not meet the criteria for substance abuse and may or may not actively participate in drug treatment services. Each random screen referral shall consist of no more than twenty-four (24) screens to be completed over a period not to exceed six (6) months, with a maximum of three (3) screens per week as indicated by the referral form. It is expected that the referring worker and provider agency will work together to develop a plan to determine the appropriate duration (up to 6 months) of each referral. A second referral will be required if an excess of twenty-four (24) screens per referral are necessary.

The service provider must identify a plan to engage the client in the process, a plan to work with non-cooperative clients including those who believe they have no problems to address as well as working with special needs clients such as those who are mentally ill or developmentally delayed.

**The types of drug screens included, but are not limited to, saliva drug screen/oral fluid based drug screen, hair follicle, and urine.**

Services include providing any requested testimony and/or court appearances (to include hearing or appeals).

All sample collections drug screens will be observed. Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Phencyclidine, Methadone, Creatinine (urine only), Propoxyphene, Oxycodone, and Methamphetamines. The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation.

Initial Testing

All sample collections drug screens will be observed sample collections screens. Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Propoxyphene, and Methamphetamine. The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation.

For urine screens, testing for creatinine levels shall be conducted on all samples. The vendor shall also insure testing for total Cannabinoids per mg of creatinine using spectrophotometer technology. The Vendor shall insure testing for specific gravity on all samples with a creatinine level below 20 mg per deciliter. The Vendor shall also insure the administration of a nitrite test on any specimen that contains no creatinine and has a specific gravity test of 1.000.

Initial screening shall be conducted utilizing an enzyme immunoassay method. Testing should occur for the following substances utilizing the cut-off levels listed below:

<b>DRUG</b>	<b>URINE</b>	<b>ORAL FLUID</b>	<b>HAIR LEVELS*</b>
<i>Amphetamines</i>	<i>1000NG/ML</i>	<i>20NG/ML</i>	<i>500PG/MG</i>

<i>Cannabinoids</i>	<i>50NG/ML</i>	<i>1NG/ML</i>	<i>1PG/MG</i>
<i>Benzodiazepines</i>	<i>300NG/ML</i>	<i>10NG/ML</i>	<i>200PG/MG</i>
<i>Methamphetamine (including ECSTACY(MDMA), ADAM(MDA))</i>	<i>1000NG/ML</i>	<i>20NG/ML</i>	<i>500PG/MG</i>
<i>Opiates</i>	<i>2000NG/ML</i>	<i>10NG/ML</i>	<i>200PG/MG</i>
<i>Cocaine</i>	<i>300NG/ML</i>	<i>5NG/ML</i>	<i>500PG/MG</i>

*\*Hair uses = PG/MG = weight*

*\* For all other substances tested use recommended laboratory cutoff levels*

### Confirmation Testing

Confirmation Testing shall be conducted utilizing GC/MS Technology on all samples initially testing POSITIVE. The following cut-off levels shall be utilized:

<b>DRUG</b>	<b>URINE</b>	<b>ORAL FLUID</b>	<b>HAIR LEVELS*</b>
<i>Amphetamines</i>	<i>500NG/ML</i>	<i>10NG/ML</i>	<i>300PG/MG</i>
<i>Cannabinoids</i>	<i>15NG/ML</i>	<i>.5NG/ML</i>	<i>.05PG/MG</i>
<i>Benzodiazepines</i>	<i>100NG/ML</i>	<i>1NG/ML</i>	<i>50PG/MG</i>
<i>Methamphetamine (including ECSTACY(MDMA), ADAM(MDA))</i>	<i>500MG/ML</i>	<i>10NG/ML</i>	<i>300PG/MG</i>
<i>Opiates</i>	<i>150NG/ML</i>	<i>5NG/ML</i>	<i>200PG/MG</i>
<i>Cocaine</i>	<i>150NG/ML</i>	<i>1NG/ML</i>	<i>50PG/MG</i>

*\*Hair uses = PG/MG = weight*

*\* For all other substances tested use recommended laboratory cutoff levels*

In situations where the source of the Amphetamine present in any specimen may come into question, the vendor must insure the performance of a d-1-isomer differentiation. This service is to be offered at no additional cost to the Department of Child Services and performed when requested by DCS.

The Vendor shall ensure proper legal chain-of-custody procedures are maintained and comply with departmental procedure, state and federal law. The vendor shall also ensure complete integrity of each specimen tested and the respective test results. Receiving, transfer and handling of all specimens by personnel shall be fully documented using the proper chain-of-custody.

The vendor shall insure that all laboratories used for drug testing purposes must comply with all applicable Federal Department of Health and Human Service, and, under these federal requirements, are subsumed [Substance Abuse and Mental Health Services Administration](#) (SAMSHA) or The College of American Pathology (CAP), or Clinical Laboratory Improvement Act (CLIA) requirements.

A letter to all referred clients will be required within three (3) calendar days of referral with instructions for contacting the agency immediately to begin screens. It is expected that the first screen will be collected within seven (7) calendar days of referral and each subsequent screen will be random. One or more toll free phone lines for clients to call daily to determine the day their screen is to be required. Agency must have a plan in place to modify the phone messages every day by 5 a.m., instructing clients whether to report that day for a screen or call again the next day.

**Note: It is expected that the referring worker and provider agency will work together to develop a plan to administer random testing for clients who do not have access to public transportation or telephone.**

The agency shall update the referring worker, by phone or email, within ten (10) calendar days of the date the referral was sent regarding the status of the referral. Agencies should inform the referring worker of the date the client completed their first screen or, if the client has not contacted the agency to complete their first screen, a consultation with the referring worker should be held to determine the next steps of services.

It is expected that the referring worker and provider agency will work together to develop a plan to determine the appropriate duration (up to 6 months) of each referral. All random screen referrals shall include no more than twenty-four (24) screens and are to be completed over a period of no more than six (6) months. A second referral will be required if an excess of twenty-four (24) screens per client are necessary.

### **Results Notification:**

The vendor shall notify the local Department of Child Services Office/ Probation Officer of testing results via email on vendor letterhead. The results will also be sent by U.S. mail to the referring county as well. The vendor shall gain approval from DCS for any changes in the results notification system.

The referring worker and DCS (if not the referral source) will be notified of positive test results within 24 hours of receiving test results from the testing laboratory. Negative test results will be provided within 72 hours of receiving test results from the testing laboratory.

No-show alert forms will be provided by the contracted agency to the referring worker within 24 hours of the client's failure to show. Failure to show may result in an administrative discharge. Any client who is administratively discharged must request a new referral from the referring worker to begin receiving services again.

The referring location shall be notified in writing if the specimen has been rejected due to an invalid chain-of-custody or any other integrity problem.

For those employing urine tests diluted results must be reported on the result form.

Testing shall not be conducted on any specimen that does not have a legal chain-of-custody. All specimens found to be "Adulterated" shall be treated as an Invalid Specimen. Any specimen without a valid chain-of-custody is to be destroyed. The referring location shall be notified in writing when a specimen has been rejected due to an invalid chain-of-custody or any other integrity problem. Monthly reports shall document how many random samples were attempted and completed minus how many "Adulterate" specimens there were for the month.

## **II. Target population**

Services must be restricted to the following eligibility categories:

- 1) Parent(s) for whom a CPS assessment has been initiated
- 2) Children and parent(s) who have substantiated cases of abuse and/or neglect
- 3) Children with a status of CHINS, and/or JD/JS
- 4) Minor children suspected of drug use prior to adjudication

## **III. Goals and Outcome Measures**

#### Goal #1

Drug screen results will be provided to the referring worker in a timely fashion.

#### Outcome Measures

- 1) 100% of positive reports will be reported verbally by phone, voice mail or email within 24 hours of receiving results of the drug screen from the lab.
- 2) 100 % of written sample reports will be mailed or faxed to the referring worker within 24 hours of receipt of laboratory results.

#### Goal #2

100% of “No Shows” alerts will be provided to referring worker within 24 hours of failed attempts.

### **IV. Qualifications**

Sample collection does not require the services of a certified drug abuse counselor. The person providing this service must be trained in sample collection and the chain of custody procedures to document the integrity and security of the specimen from time of collection until receipt by the laboratory.

### **V. Billable Units**

#### **Rejected or Unfit Specimens**

**The provider cannot claim for the handling of rejected specimens or those otherwise unfit for testing.**

#### **Drug Screens**

Actual cost of the screens. The provider is to present a list of the drug screens available with the total cost of each drug screen or set of drug screens. The DCS will specify which drug screen or screens they are authorizing for each client on the authorizing referral form.

Grantees will bill monthly based on these payment points:

#### **Initial Test**

Services include the collection of sample collections specimens and ensuring that the chain of custody procedure is followed to maintain the integrity and security of the specimen from time of collection until receipt by the laboratory. This will be billed for all tests that are negative.

#### **Confirmation Testing (lab processing)**

Services include the collection of the specimen. This confirmation testing charge shall include confirmation of positive results for one or more substances in the same sample. Ensuring the testing of specimens and that the chain of custody procedure delivery to the testing laboratory to the results notification.

#### **Translation or sign language**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

### **VI. Rates**

Grantees will bill monthly based on these payment points:

Initial Test: Actual Cost  
Confirmation Testing: Actual Cost  
Translation or sign language: Actual Cost

## **VII. Case Record Documentation**

Necessary case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS/Probation referral form authorizing service
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports as stated in this service standard.

## **VIII. Service Access**

Services must be accessed through a DCS Family Case Manager or DCS Service Consultant referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

***NOTE: All services must be pre-approved through a referral form from the referring DCS FCM or DCS Service Consultant.***

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**RESIDENTIAL DETOXIFICATION**

**I. Service Description**

Safe, humane detoxification from alcohol and other drugs is an important step in the recovery process. Detoxification is a short-term residential service for persons withdrawing from the effects of prolonged alcohol or drug consumption. Services shall continue only until the client recovers from the effects of acute intoxication. Detoxification shall always include supervision, and may also include counseling and/or medical care. Three immediate goals of detoxification shall be included, to provide a safe withdrawal from the drug(s) of dependence and enable the patient to become drug free, to provide withdrawal that is humane and protects the patient's dignity, and to prepare the patient for ongoing treatment of his or her alcohol and other drug (AOD) dependence

The vendor shall provide withdrawal that is humane and protects the patient's dignity. A caring staff, a supportive environment, sensitivity to cultural issues, confidentiality, and the selection of appropriate detoxification medication (if needed) are all important to providing humane withdrawal.

The program will prepare the patient for ongoing treatment of his or her AOD dependence. During detoxification, patients may form therapeutic relationships with treatment staff or other patients, and may become aware of alternatives to an AOD-dependent lifestyle. Detoxification is an opportunity to offer patients information and to motivate them for longer term treatment.

Detoxification facilities shall provide living accommodations in a structured environment for individuals who require twenty-four (24) hour per day supervision while withdrawing from toxic levels of consumption. Services will be available continuously twenty-four (24) hours a day, seven (7) days per week. Counseling services will be provided to motivate clients to accept referral for continued care for alcohol and drug dependence.

Detoxification clients will be monitored by qualified, experienced staff 24 hours a day. On staff physician and nurses shall supervise the process and coordinate services as needed. Each client shall also be assigned a counselor to work with during their stay. When they are able to, detoxification clients will be encouraged to participate in educational groups, group counseling sessions, and to work individually with their counselor.

During the detoxification process, every effort should be made to engage clients in longer-term treatment designed to promote recovery from alcoholism and other addiction. An individualized treatment plan will be developed, for each client with his or her counselor, in order to learn to identify and cope with relapse potentials and to create a plan for maintaining freedom from drug or alcohol use after discharge.

Services include providing any requested testimony and/or court appearances (to include hearing or appeals). Clients will be accepted into the program within twelve (12) hours of the referral or sooner if an emergency exists. Each client will spend approximately two to six days in the detoxification program.

Length of stay is determined for each individual in attendance.

Services provided during the detoxification period include:

- 1) Medical services
- 2) Counseling
- 3) Family/Collateral contacts
- 4) Visitation arrangements with children
- 5) Aftercare planning

### **Discharge**

Each discharge plan should include discussions on the client's diagnosis, progress and recommendations for further treatment. Best practice will have client discharged only when the next step of the treatment plan is available immediately or in a short time frame.

The referring county shall receive a copy of the discharge summary within 7 days of the client's discharge.

### **II. Target Population**

**Services must be restricted to the following eligibility categories:**

- 1) Children and/or child's guardian who have substantiated cases of abuse and/or neglect, with moderate to high levels of risk and service needs.
- 2) Children with a status of CHINS, and/or JD/JS
- 3) All adopted children and adoptive families

### **III. Goals and Outcome Measures**

#### **Goal #1: Timely initiation and reporting**

- 1) 100 % of services initiated within 12 hours of referral.
- 2) 100 % of discharge summary reports will be received within 7 days of client's discharge.

#### **Goal #2: Effective treatment for individuals**

- 1) 90% of clients will participate in continuing care upon completion of detoxification.

#### **Goal #3 DCS and Family satisfaction with services**

- 1) 90% of the families who have participated in Residential Detoxification will rate the services "satisfactory" or above.
- 2) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.

### **IV. Qualifications**

## Licensed Physician:

A licensed physician shall be identified as the program's medical director. The vendor shall be licensed and certified by the Indiana Division of Mental Health and Addiction according to state law. The Indiana DMHA licensure and certification rules and regulations are at: <http://www.in.gov/fssa/dmha/4553.htm>  
Another helpful link is How to Become a Certified/Licensed Provider at:  
<http://www.in.gov/fssa/dmha/4560.htm>

## Therapists and Counselors:

It is expected that all therapists and counselors shall have a degree and be licensed/certified by an organization approved by the Indiana Division of Mental Health and Addiction. They shall receive pertinent ongoing training. Indiana DMHA approved addiction counseling is at:  
<http://www.in.gov/fssa/dmha/4517.htm>

## V. Billable Units

Primary payer for this service is Medicaid and private insurance. This is not intended as a co-pay or secondary payer but as payer of last resort.

Per Diem cost for each client placed in the program.

## Court Time on case

Services include providing any requested testimony and/or court appearances including hearings or appeals. Includes up to one hour for preparation of a DCS requested and approved court testimony. The provider may bill up to one hour per day for testimony in client/family specific court hearings as requested and approved by the DCS.

## Translation or sign language

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

## VI. Rates

Daily rate/per diem \_\_\_\_\_

Court cost \_\_\_\_\_

Translation or sign language Actual cost

**Budget summary must be submitted for rate determination.**

## VII. Case Record Documentation

Necessary case record documentation for service eligibility must include:

- 4) A completed, dated, signed DCS referral form authorizing service
- 5) Documentation of regular contact with the referred families/children

- 6) Written reports no less than quarterly or more frequently as prescribed by DCS.

### **VIII. Service Access**

Services must be accessed through a DCS referral. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

***NOTE: All services must be pre-approved through a DCS FCM or DCS Service Consultant referral form.***

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**SUBSTANCE ABUSE ASSESSMENT, TREATMENT, & MONITORING**  
**(Revised 1/27/09)**

**I. Service Description**

Drug addiction is a complex illness. It is characterized by compulsive, at times uncontrollable drug craving, seeking, and use that persist even in the face of extremely negative consequences. For many people, drug addiction becomes chronic, with relapses possible even after long periods of abstinence. Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society. Treatment does not need to be voluntary to be effective. Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions.

Substance abuse negatively affects a parent's social, emotional and physical functioning. Their ability to provide for their children will be impaired and poses a risk to child development, safety and/or well being. Recognizing the "cloak of secrecy" that often surrounds these families, efforts must be made to open lines of communication and be sensitive to a variety of sources in verifying substance abuse and corroborating the effects on children.

**Assessment**

Effective treatment attends to multiple needs of the individual, not just his or her drug use. To be effective, treatment must address the individual's drug use and any associated medical, social, psychological, vocational, and legal problems. A face-to-face clinical interview must take place with each referred individual. In-person sessions provide the ability to provide immediate attention to individuals who may be a danger to themselves or others. Tremors, needle marks, dilated pupils, exaggerated movements, yellow eyes, glazed or bloodshot eyes, lack of eye contact, a physical slowdown or hyperactivity, appearance, posture, carriage, and ability to communicate in person are vital components to the clinical interview.

**The substance abuse assessment must include:**

- 1) Any associated medical, psychological and social history of the client,
- 2) An in-depth drug and alcohol use history with information regarding onset, duration, frequency, and amount of use; substance(s) of use and primary drug of choice; associated health, work, family, person, and interpersonal problems; driving record related to drinking or drug use; past participation in treatment programs,
- 3) Standardized assessment tool for drug/alcohol abuse such as Substance Abuse Subtle Screening Inventory (SASSI), Addiction Severity Index (ASI) Teen Addiction Severity Index (T-ASI), ASI Lite, or the Addiction Society of Medicine Placement Patient Criteria Revised Version II(ASAM PPII), Drug Abuse Screening Test (DAST), Substance Abuse Relapse Assessment (SARA), etc.,
- 4) Results of urine screen with the requested drug panel.

Reports on non-emergency referrals must be delivered within 30 days of the completion of the assessment. For emergency assessments, it is expected that a verbal report will be provided to the referring office within 72 hours and a written report provided within 14 days after the completion of the assessment with the client. It is expected that a client with a history of homelessness, frequently changing employment and/or instability in caring for their children will be addressed realistically regardless of an admission of substance abuse.

Recommendations regarding the client's needs must be provided on each assessment. This information should be used to develop an individualized treatment plan with specific strategies for coping with high-risk situations, slips, and relapses.

### **Treatment & Monitoring**

There are many addictive drugs. Treatments for specific drugs can differ and varies depending on the characteristics of the patient. Problems associated with an individual's drug addiction can vary significantly. People who are addicted to drugs come from all walks of life. Many suffer from mental health, occupational, health, or social problems that make their addictive disorders much more difficult to treat. Even if there are few associated problems, the severity of addiction itself ranges widely among people.

A variety of scientifically based approaches to drug addiction treatment exists. Treatment prescribed for all clients must be evidenced based. Drug addiction treatment can include behavioral therapy (such as counseling, cognitive therapy, or psychotherapy), medications, or their combination. Behavioral therapies offer people strategies for coping with their drug cravings, teach them ways to avoid drugs and prevent relapse, and help them deal with relapse if it occurs. When a person's drug-related behavior places him or her at higher risk for AIDS or other infectious diseases, behavioral therapies can help to reduce the risk of disease transmission. Case management and referral to other medical, psychological, and social services are crucial components of treatment for many patients.

Change does not happen all at once. Much of the early change process takes place internally as a person weighs whether change is worth the time and effort required. Treatment must help the client to identify the events that typically precede their substance use, as well as the consequences that may reinforce that use. Individual and/or group treatment to assist the client toward change may include any or all of the following:

- Consciousness raising
- Self-revelations
- Weighing pros and cons
- Environmental reassessment
- Problem solving
- Stimulus control-triggers
- Stress
- Assertiveness
- Refusal skills
- Thought management
- Cravings and urges
- Alternatives to using
- Social Support
- Identifying needs and resources
- Goal Setting
- Relapse Prevention Planning
- Role play
- Role clarification

Following the assessment of each client, the service provider must inform the referring worker of the expected number of treatment sessions to be provided to each client. The service provider must contact the referring worker by phone or email to relay important information regarding the client such as active drug use that affects parenting abilities as situations develop. Copies of treatment plans, progress reports with

recommendations for each court hearing and discharge summaries with prognosis and recommendations must be provided to the referring worker in a timely manner. If self-help groups (such as AA/NA) are part of the support of treatment process, the service provider must provide a means to document and verify attendance at such programs. Aftercare plans must be identified for all clients completing outpatient services.

Services must be available to clients who have limited daytime availability. The service provider must identify a plan to engage the client in the process, a plan to work with non-cooperative clients including those who believe they have no problems to address as well as working with special needs clients such as those who are mentally ill or developmentally delayed.

No-show alert forms will be provided by the contracted agency to inform the referring worker of the client's failure to attend sessions based on five no-shows and ten no-shows. After ten no-shows, the client will be administratively discharged. Any client who is administratively discharged must request a new referral from the referring worker to begin receiving services again.

## **II. Target Population**

**Services must be restricted to the following eligibility categories:**

- 4) Children and families who have substantiated cases of abuse and/or neglect, with moderate to high levels of risk and service needs according to the assessment matrix
- 5) Children with a status of CHINS, and/or JD/JS
- 6) All adopted children and adoptive families

## **III. Goals and Outcome Measures**

### **Goal #1**

Timely receipt of report to prepare for services/court.

Outcome Measures:

- 1) For non-emergency assessments: 100% of the written reports will be received by referring worker 14 days after the completion of the assessment with the family.
- 2) For emergency assessments: 100% of Verbal reports will be received by the referring worker within 72 hours; written report received by the referring worker 14 calendar days after the assessment with the family.

### **Goal #2**

Recommendations relevant and based on documentation in the body of the report.

Outcome Measures:

- 1) 100% of recommendations prepared as a result of the assessment are appropriate based on interviews, observations, review of other records, and completion of test instruments.
- 2) Abstinence or decrease use of alcohol or drugs.
- 3) Improvement of work or improvement of educational status
- 4) Stable living situation.
- 5) Decrease involvement with the criminal justice system

### **Goal #3**

Drug screens will be provided to the referring worker in a timely fashion.

Outcome Measures:

- 1) 100% of positive reports will be reported verbally by phone, voice mail or email within 24 hours of receiving the results of the urine screen. Written reports of the urine screen will be mailed/faxed to the referring worker within 24 hours of receipt of laboratory results.

Decreasing evidence of illicit drugs in drug screens.

#### Goal #4

No-show alert forms based on five no-shows and ten no-shows will be provided to the referring worker.

Outcome Measures:

- 1) 100% of no-show alerts will be provided to referring worker immediately following the select number of no-shows. After 10 no-shows, the client will be discharged from services.
- 2) Retention – Improvement in length of stay in treatment.

#### Goal #5

Referring worker will be provided treatment plan and sessions needed for progress to occur for each client referred.

Outcome Measures:

- 1) 100% of referred clients will have a treatment plan developed following the assessment with the treatment plan provided to the referring worker within 10 days of completion.

#### Goal #6

DCS and client satisfaction with services

Outcome Measures:

- 1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 80% of the clients who have completed substance abuse assessment and treatment services will rate the services “satisfactory” or above.

## IV. Qualifications

Minimum Qualifications:

- 1) Master’s degree in social work, counseling or psychology with at least three years experience providing substance abuse services and a current license issued by the Indiana Social Worker, Marriage and Family Therapist and Mental Health Counselor Board, as one of the following: 1) Clinical Social Worker, 2) Marriage and Family Therapist, or 3) Mental Health Counselor or whose program is certified by the Division of Mental Health Administration to provide addiction services, or
- 2) An alcohol and drug abuse counselor certified by the Indiana Counselors Association on Alcohol or by the Drug Abuse (ICAADA), or by the Indiana Association for Addiction Professionals (IAAP), or by the National Association of Alcoholism and Drug Abuse Counselors Certification Commission (NAADAC), or by the International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse (ICRC), or by the National Board of Certified Counselors, Inc and Affiliates/Master Addictions Counselor (NBCC).
- 3) Sample collection does not require the services of a certified drug abuse counselor. The person providing this service must be highly training in sample collection and the chain of custody procedures to document the integrity and security of the specimen from time of collection until receipt by the laboratory.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

## **V. Billable Units**

### **Face to face time with the client:**

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

***Reminder:** Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are built into the cost of the face-to-face rate and shall not be billed separately.*

For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.

### **Per person per group hour**

When DCS clients are referred to groups where most of the clients are non-DCS referrals. This is available when the nature of the group or the geographic location does not support a group composed of primarily DCS clients

**For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.**

### **Drug Screens**

Actual cost of the screens. The provider is to present a list of the drug screens available with the total cost of each drug screen or set of drug screens. The DCS will specify which drug screen or screens they are authorizing for each client on the authorizing referral form.

### **Translation or sign language**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

## **VI. Rates**

Face to face Maximum Rate: \$106.20 (1/1/2010)

Budget summary must be submitted for other rates.

## **VII. Case Record Documentation**

Necessary case record documentation for service eligibility must include:

- 7) A completed, dated, signed DCS referral form authorizing service
- 8) Documentation of regular contact with the referred families/children
- 9) Written reports no less than quarterly or more frequently as prescribed by DCS.

## **VIII. Service Access**

Services must be accessed through a DCS referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

***NOTE: All services must be pre-approved through a referral form from the referring DCS FCM or DCS Service Consultant.***

# **PREVENTION SERVICES**

## **SERVICE STANDARDS**

**SERVICE STANDARD  
INDIANA DEPARTMENT OF CHILD SERVICES  
CAMP SERVICES-PREVENTION & INTERVENTION**

**I. Service Description**

These services are designed to provide Indiana’s Children with a safe and nurturing environment while respecting their dignity and individuality and helping children to reach their full potential.

The purpose of these services is to enrich the lives of children and build tomorrows that will allow children served to make a lasting contribution to society. This is not for treatments such as wilderness and boot camps.

Examples:

Sports camps

Day camps

Overnight camps

Camps should be committed to a safe and nurturing environment with caring, competent adult role models, and should provide healthy and developmentally-appropriate experiences. Camps should also allow children the opportunities for leadership and personal growth, provide discovery experiential education, learning opportunities, and excellence and continuous self-improvements for Indiana Children.

It is expected that the referring source and provider will work together to make arrangements for children to attend camp. The provider will monitor the progress of the children attending camp and report to referring source as appropriate, and agreed on prior to camp experience.

**II. Target Population**

Services must be restricted to the following eligibility categories:

<b>Target Population - Prevention</b>	<b>Target Population - Intervention</b>
<ul style="list-style-type: none"> <li>• Children and families for whom a child protection services investigation has not been substantiated</li> <li>• Families that have been referred by a community partner or who self refer due to a determination that, with timely, effective and appropriate prevention support services, family functioning can be improved and child abuse and neglect prevented</li> </ul>	<ul style="list-style-type: none"> <li>• Children and families who have substantiated cases of abuse and/or neglect, with moderate to high levels of risk and service needs according to the assessment</li> <li>• Children with a statue of CHINS, and or JD/JS</li> <li>• All adopted children and adoptive families</li> </ul>

**III. Goals and Outcome Measures**

## **Prevention:**

### **Goal # 1 Prevent families from entering the DCS system**

*Outcome measure:* 100% of families participating in camps will report no involvement with CPS

### **Goal #2 Youth will attend camps on a consistent basis**

*Outcome measure:* 100% of youth referred will report regular attendance and participation in camp activities

### **Goal #3 Family satisfaction with services**

*Outcomes measure:* 100% of families who have participated will rate the services “satisfactory” or above

## **Intervention:**

### **Goal #1 Timely intervention with the family and regular communication with camp personnel**

*Outcome measure:* 100 % of all referred youth will have face to face contact with camp personnel to verify camp attendance and participation

### **Goal #2 Family satisfaction with services**

*Outcome measure:* 100% of families who have participated will rate the services “satisfactory” or above

## **IV. Staff Qualifications**

Staff should adhere to national and state health and safety standards that include first aide and CPR training. In the area of special needs, staff should have the appropriate certifications to work with targeted special needs children. Current certifications must be maintained on file at the camp. For expired certifications, the date of scheduled re-certification courses may be listed when staff is registered to attend camp.

## **VI. Camp Qualifications**

Camps are encouraged to have American Camp Association (ACA) accreditation. All camps must meet local, state and federal laws, regulations, and policies that govern their particular operation.

## **VII. Criminal Background Checks**

For camp providers, a “background checks” will consist of the following criminal (or juvenile) and civil history checks:

1. Fingerprint-based National Criminal History which includes Indiana State Juvenile History and fingerprint-based Indiana State Criminal History check.
2. Sex and Violent Offender Registry
3. Child Protection Service History
4. Local law enforcement agencies (LEA) county sheriff records

## **VIII. Billable Units**

The billable unit for camp will be the actual cost of the camp experience.

## **Translation or sign language**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

## **IX. Rates**

Camp Rates: Actual cost  
Translation/Sign Language: Actual Cost

A provider does have the option of submitting an RFP to become a contracted provider with the State of Indiana. In the event that an RFP is submitted by the provider, a budget summary must be submitted for rate determination.

### **a. Case Record Documentation**

Necessary case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS referral form, or a prevention referral form authorizing service
- 2) Documentation of contact with the referred families/children
- 3) Written reports frequently as prescribed by referring source
- 4) In the event of absenteeism by client, the provider must contact the referring source to determine if continuation of services is appropriate.

### **b. Service Access**

Services must be accessed through a DCS Family Case Manager or DCS Service Consultant referral form. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by DCS. Providers must initiate a reauthorization for services to continue beyond the approved time period.

**Note: All services must be pre-approved through a DCS Family Case Manager or DCS Service Consultant referral form.**

**SERVICE STANDARD  
INDIANA DEPARTMENT OF CHILD SERVICES  
COMMUNITY PARTNERS FOR CHILD SAFETY**

**I. Service Description**

The purpose is to provide a secondary child abuse prevention service that can be delivered in every region in the state. This service will build community supports for those families that are identified through self-referral or other community agency referral to a service that will connect families to the resources needed to strengthen the family and prevent child abuse and neglect. It is intended that through the delivery of prevention services that the need for referral to Child Protective Services will not be necessary.

Community partners include, but are not limited to: schools, social services agencies, health care providers, public health, hospitals, child care providers, community mental health agencies, local DCS offices, child abuse prevention agencies like Healthy Families and local Prevent Child Abuse Councils, Youth Services Bureaus, Child Advocacy Centers, faith-based community, Twelve Step Programs. In general, each community defines its own partnerships. However, Local Offices of the Department of Child Services are required by the Director of DCS to be a partner. DCS must be a partner because Child Protective Services Investigators frequently identify families that could benefit from services, but do not have a substantiated case of child abuse. It is believed that if these families receive supportive services that they are less likely to have a substantiated case of child abuse in the future.

**Communities for Child Safety Grantees must deliver the following outcomes to the community/region as defined below to families:**

- A Community Partnership Project Manager is recruited and hired by the agency. The Project Manager develops and initiates the program effort as identified by the Regional Service Council and is qualified by credentials to be the Project Manager of the Community for Child Safety Program.
- An identified group of community partners.
- The partners must assume multiple roles including: referral source, provider of supportive services to a specific family (ies), potential provider of funding for the program as a whole or as a support to identified specific families, service administration and/or governance.
- Maintain the agency/community mission, vision, and goals.
- Strategy for governance that can be the Regional Service Council or an independent governance council as chosen by each region and approved by the Regional Service Council. That at a minimum includes: a governing or managing board, board committees that assure program integrity, desired outcomes and trends that affect/impact outcome, training and curriculum for training, assessment and planning, sustainability including funding. Governance membership must include community partners and other identified community leaders.
- Identify a strategy for establishing a consumer advisory board. Must include parents that have successfully completed the program and parents that live in the community.
- Maintain service delivery site, number of staff needed to continue service delivery, administrative efforts necessary to continue to accept referrals and serve families.
- Provision of on-going training for staff development, service delivery, community collaboration and partnerships. Curriculum will be selected by DCS.

**Communities for Child Safety Grantees must deliver the following services to identified families:**

- On-call staff availability for crisis intervention counseling and referral if needed
- Strengths-based, family focused assessment to identify families' stability, safety, and strengths. The intake or assessment tool used for this may be selected by the grantee.
- The "Parenting Inventory for Community Partners" will be used to measure improvement in family functioning.
- Development of family service plans that include no more than 3 active goals that families identify as goals. The development of these plans may include a solution-focused family case conference in which all persons chosen by the family are involved in the conference. Members present may assist with planning and goal development.
- Referrals to resources and supports in the community.
- Support and advocacy services to families.
- Development of classes and support groups for families as identified and needed (parenting skills building, life skills development, and self improvement).
- Participation and involvement in neighborhood and community events that support families.
- Development of relationships with agencies in the community that support families through referral of families, funding to the agency as a whole or to specific families within the program, and that , in general, will act as a partner in the delivery of services .
- Voluntary enrollment of referred families.
- Provision of home based family visitation program through which workers provide supportive services.
- Referred families will have a documented form of attempted contact from the agency within 5 working days from the date of referral.
- Families will work on each identified goal and accomplish one goal at a time; that goal can be replaced as long as there are no more than 3 goals.
- Service delivery will be as long as it takes to meet the goals identified by the family. During the service delivery time family must be actively engaged in goal accomplishment. Family may voluntarily withdraw from the program.
- Families will be terminated from the program within 10 days of reaching their goals.
- Families may be re-referred as many times as necessary as long as there is no substantiated case of abuse or neglect.
- Families will **not** have a substantiated case of abuse or neglect during their time in this program. If they have a substantiated case, the Local Office of Department of Child Services will determine the services needed by this family by the coercive intervention of the court, and this family will no longer receive services from this voluntary program.
- Parents who have successfully completed the program may be engaged as partners in service delivery to other families.

## **II. Service Delivery Requirements**

- Must identify one provider (administrative entity) to oversee service delivery in each region.
- Must employ a Project Manager to develop the partnerships, service delivery mechanisms, and governance.
- Must identify community partners that shall be actively involved as partners as established earlier in the service standard (section I, paragraph 2).
- Must establish governance that can be the Regional Service Council or an independent governance council as chosen by each region and approved by the Regional Service Council.
- Must establish a consumer advisory council.

- Must have a plan for delivery of staff and community training from a curriculum approved by DCS. DCS will approve any training plan that incorporates training on the assessment tool chosen by the agency for intake purposes. The assessment tool that has been chosen is the “Parenting Inventory for Community Partners”. This will be used to measure improvement over time. The agency is also expected to provide or arrange for training for home visitation programs like: domestic violence, addictions, mental health, home visitor safety, specific interventions, basic home visitor skills, and engaging families. DCS will not pay for this kind of training since it is intrinsic to home visitation services. It is further assumed that if an agency is awarded a contract for Community Partners for Child Safety that the agency will be knowledgeable about home visitation programs as well as types of training needed for these programs. If, through the course of the contract, it is determined that training is needed that is not available, the agency should notify the DCS staff consultant. Arrangements will be made to incorporate the training at The Institute for Strengthening Families, offered by DCS twice per year. It is also possible that training can be made available to staff through the contract with Indiana University that is used by Healthy Families staff and made available through e-learning modules. More information will be available on this in the future.
- Must be a home visitation program.
- Must have a plan for recruiting and identifying staff as family referrals increase.
- Must have a plan for receiving and tracking referrals.
- Must have a plan for attempting to conduct face to face contacts within 5 working days from date of referral.
- Must have a plan for engaging families to participate in voluntary services.
- Must know the services available in the community and be prepared to subcontract for those services if necessary and arrange for services if not available. For example, if parenting classes are identified as a need, there is sufficient funding in the reimbursement to develop and deliver these services. It is, however, anticipated that the home visitor will assist the family in meeting its goals without referral to other agencies; however, it is recognized that in some regions, it may be less expensive to subcontract for services due to travel costs. It is also likely that in some cases, agencies that are within the county/city/neighborhood will be more familiar to families and therefore, more likely to succeed in assisting families in meeting their goals.
- **Work with Partnertude, a database system to develop a plan for gathering and aggregating quantitative and qualitative data identified by DCS. These data will be required for quarterly reporting to DCS. At a minimum, grantees will be expected to gather the following information:**
  - \* Date of referral
  - \* Date of consent
  - \* Date of assessment and assessment data
  - \* Date(s) of face-to-face contact(s).
  - \* Family goal(s)
  - \* Date goal was met

As each event occurs, all data will be entered into Partnertude within 5 working days. Specific client files will contain assessment tools, goal(s) identified in the family service plan and other kinds of family-specific detail. This information will be collected and reported to DCS as soon as service delivery begins by the agency. This information will be entered into the state Partnertude data system. Information about the data system will be shared with providers as soon as specific data elements are identified. Reports will be obtained from Datatude, Inc., the vendor that has been selected to develop and monitor the Community Partners program. There will be no need for written reports. The provider will assure that all the data elements are completed in the state data system. Ultimately, even monthly claims may be submitted based on the information in this system.

- Must be willing to accept assistance from the DCS appointed persons responsible for the development of this service.

### **III. Target Population**

#### **A. Services must be restricted to the following eligibility categories:**

- 1) Children and families for whom a child protection service investigation has not been substantiated
- 2) Families that have been referred by a community partner or who self refer due to a determination that, with timely, effective, and appropriate prevention support services, family functioning can be improved and child abuse and neglect prevented.
- 3) Families that do **not** meet the criteria for Healthy Families participation.

#### **B. For purposes of evaluation, upon completion of services people/families will be classified as belonging to one of three categories of services:**

- 1) Information and referral (I&R),
- 2) Seven face-to-face contacts or less
- 3) Eight face-to-face contacts or more

### **IV. Goals**

#### Goal #1

Prevent CPS referrals and prevent families from entering the DCS system.

#### Outcome Measures

- 1) All data will be recorded in Partnertude.
- 2) 100% of referred families will receive information about Community Partners. A referred family that requests only speaking with an agency to get their questions answered or for a referral to other community resources, shall be documented as a telephone or face to face contact.
- 3) 90% of families referred will receive a telephone call or a drop by contact within 5 working days of referral. (Documentation of all service activities is required).
- 4) 75% of families will have a minimum short term services to consist of at least one referral to Community Partners and/or community resources.
- 5) 50% of referrals will engage in home based services: have a face to face contact, a signed family consent form, a completed initial assessment, and at least one identified goal.
- 6) 90% of the families participating in home based or community based service (has consent) will have a service plan that identifies at least one goal but no more than 3 active goals.
- 7) A) 90% of families with 8 or more face-to-face contacts will have a second assessment of family functioning  
  
B) 75% of families will show improvement in family functioning after a minimum of 8 face-to-face contacts.  
  
C) 75% of families with consent will accomplish at least one goal as identified in the family service plan.

- 8) 75% of families receiving 8 or more face-to-face contacts will not have a substantiated child abuse case following the 8<sup>th</sup> contact for a period of 12 months after discharge.
- 9) 100% of participants who become clients of the agency will be terminated within 10 working days after final goal completion and when the family agrees that services are no longer needed.

## Goal #2

Regional Service Council (RSC) and family satisfaction with services

Outcome Measures

- 1) RSC will rate the services as “satisfactory” or above if 75% of families receiving 8 or more face-to-face contacts do not have a substantiated case of child abuse following the 8<sup>th</sup> contact for a period of 12 months after discharge.
- 2) 75% of families receiving 8 or more face-to-face contacts, will demonstrate improvement in family functioning as measured by the Parenting Inventory for Community Partners or other standardized tool approved by the Department of Child Services.
- 3) 90% of the families who have participated in prevention activities will rate the services “satisfactory” or above (using a uniform client satisfaction survey).

## V. Required Activities

The Community Partners for Child Safety Program is intended to be a community-based program with design flexibility at the local level. However, it is imperative that some program elements be required. This section identifies program requirements.

- Upon completion of services, people/families will be documented in one of three categories of services for outcome analysis: (1) Information and referral (I&R), (2) seven face-to-face contacts or less or, (3) eight face-to-face contacts or more.

## VI. Qualifications

### Minimum qualifications:

- 1) Project Managers are preferred to have a Masters Degree in social work or in a related human service field and 2 years of social work experience; project managers may have a Bachelors Degree in social work or a related human service field with 5 years experience in social work.
- 2) Neighborhood Liaisons (or case managers) are preferred to have Bachelors Degree in social work or in a related human services field and two years experience in working with families and children. Case managers may have education equivalent to a year above secondary education and 2 years experience in social work or a related human services field.
- 3) Parent Partners may work on a part time basis. A parent partner is preferred to be a parent who has successfully completed the program and is needed to mentor and assist other parents enrolled in the program. The parent partner may have a secondary degree or a GED equivalent, but these educational requirements may be waived if the parent partner is judged by the Project Manager to have the skills

necessary to engage parents in the successful completion of their goals.

4) Administrative support staff may have a high school diploma or GED equivalent.

## **VII. Billable Units**

### **1. Program Development**

Payment for services will be based on actual allowable costs. Grantees will bill monthly based on these payment points:

- .1-personnel
- .2-other
- .3-contracts
- .4-supplies
- .5-equipment
- .6-buildings/lands
- .7-indirect cost
- .8-travel

### **2. Service Delivery to Families**

Grantees must accept and adopt the DCS “Framework for Child Welfare Service Provision” in all contact with families. This model must be integral to the agency culture. Families and family identified support individuals/agency representatives will be involved in decisions that assist the family in meeting its needs. Community partner agencies will not tell families what to do but will facilitate family recognition of needs and solutions / goals to meet those needs.

## **VIII. Potential Funding**

- Kids First Fund
- Community-Based Child Abuse Prevention (CBCAP)
- Child Welfare Services Account
- IVE Waiver Savings
- Title IVB Part II Family Support
- FamilyandChildrenFund

**Service Standard**  
**Indiana Department of Child Services**  
**Respite Care as a Prevention Service**

**I. Service Description.**

Respite is a temporary interval of rest or relief from emotional exhaustion for parent(s), or caregivers of children, who are at risk of abuse and neglect. Respite care can be both crisis (emergency) and planned and in the case of preventative respite care, the service will originate with the onset of a crisis situation facing the caregiver. Care giving services may be in a free standing facility or given in or away from the child's home and may be for a few hours or extend to several weeks. Well planned and carried out respite services reduces stress and promotes the safety , well-being, and stability of families.

**II. Target Population.**

Indiana children from birth to age 16 who are at risk of abuse and/or neglect due to the onset of adverse circumstances facing the child's caregiver(s).

Children meeting the following conditions are **not** candidates for respite care:

- Children with the status of CHINS and/or JD/JS.
- Children with diagnosed emotional or behavioral disorders.
- Children with medical conditions that require constant monitoring.
- Children actively infected with a communicable disease.
- Children whose caregivers have alternative means of child care.

**III. Goals and Outcome Measures.**

Goal 1. Increased preservation of families through prevention services.

- A. Reduced number of reports of child abuse and neglect.
- B. Reduced number of CHINS-

Goal 2. The provision of respite service within a reasonable timeframe of a request for services.

- A. 100% of requests for services will be addressed within 4 hours of the call/referral for crisis respite and the next business day for planned respite.

Goal 3 Increased public awareness of the need for respite care and respite care providers in reducing child abuse and neglect.

- A. Increased number of respite care providers
- B. Increased usage of respite care

**IV. Qualifications.**

**Administrative Standards:**

1. Service providers shall have an organizational staffing chart that shows the lines of authority and communication channels.

2. A program director shall be appointed the responsibility to plan, staff and manage the provision of respite services.
3. Each employee shall receive a copy of the agencies personnel policies and practices.
4. The service provider shall comply with federal and state laws and regulations safeguarding client information and the personnel system shall comply with all applicable laws, statutes, regulations and equal employment opportunity mandates.
5. The service provider shall have a participant record system that includes, but is not limited to:
  - A written policy on the confidentiality and protection of records which states the use and conditions for removal of records, conditions for release of information and client authorization for release of information not otherwise authorized by law.
  - A written policy providing for the retention and storage of records as required for audit purposes and in the event the program discontinues operation.
  - Maintenance of records on the premises in a manner that is confidentially secure.
6. The service provider shall assure accessibility of services to persons with disabilities.
7. The service provider shall obtain and retain adequate insurance to guard against liabilities.
8. The service provider shall provide timely orientation to its employees that transmit the values philosophy and mission of this agency.
9. The service provider shall inform staff of laws, policies, procedures and individual reporting responsibilities regarding abuse, neglect and mistreatment of the person being cared for prior to the actual service delivery.
10. The service provider shall periodically assess the need for specific staff training programs.
11. The service provider shall have an evaluation system.
12. Have policies and procedures that address:
  - Program mission and philosophy.
    - Types of service.
    - Standards of care for children receiving services.
    - General emergency procedures.
    - Family and child rights and responsibilities.
    - Family confidentiality.
    - Program entry and departure procedures.
    - Record keeping.
    - Medication administration.
    - Transporting children.
    - Staff behavior and expectations.
    - Staff communication.
    - Staffing ratios and job descriptions.

**Program Standards:**

**Service Providers shall:**

- Match children with respite providers who meet their needs, therapeutic or medical, and are familiar with their daily routines, preferred foods and activities.
- Maintain caseloads of agency worker at a reasonable number to ensure professional service to clients.
- Provide clear admission and discharge procedures which includes that a child will only be released to a person listed in the plan of care and the caregiver should call the agency immediately if they sense a safety risk.

- Provide information on the plan of care to respite providers.
- In emergency/crisis respite situations the agency shall have age appropriate interventions to help the child cope with the trauma and stress of the situation. This should be documented in the plan of care.
- Highly discourage corporal punishment and recommend, encourage, and if necessary, teach the use of disciplinary methods such as time outs, redirection and positive reinforcement.
- Limit number of children in respite home to 5 with no more than two under the age of 2. Exceptions can be made for sibling groups, if worker evaluates the provider home and recommends that a higher number of children can be provided quality care. This should be documented in the case file. If a child has therapeutic or medical special needs the number of children in a providers care should be evaluated and documented.
- Conduct satisfaction surveys with the family of the child in respite, the caregivers and the child if over 7 years old and able to respond.
- Offer training opportunities to staff and caregivers and keep a current list of other pertinent community trainings available.
- Maintain a 24 hour contact phone number with an on-call staff available.
- Provide caregiver with an on-call number and the child's health care contact information and known allergies.
- Be responsive to families needs. Families should have a choice of provider if possible and be able to request a change in provider.
- Instruct caregivers to report to the agency promptly any accidents, health problems or changes in appearance or behavior of a child in care.
- Have a method to assure client (child/child's family and caregiver) input on matters pertaining to program activities.

**Caregivers providing respite care shall meet the following standards:**

- Be at least 18 years of age, documented by birth certificate or driver's license.
- Be free of communicable diseases and/or other conditions that would pose safety or health risk to care recipients, documented by a signed statement.
- Documentation from a medical service provider may be requested.
- Possess the ability to follow directions and keep records, when required, of tasks being performed, documented by observation.
- Have adequate training for the level of child they care for.
- Have the ability to perform tasks/activities of the service to be provided, documented by written evidence of previous experience, competency –based testing, and training.
- Be a responsible, mature individual of reputable character who exercises sound judgment and displays the capacity to provide good care for children. This to be documented by competency-based testing, training or education, written evidence of previous experience.
- Possess the ability to communicate effectively with the person being cared for - documented by demonstrated ability.
- Shall not have been convicted in any jurisdiction for abuse, neglect, or any other crime that might pose a safety or health risk to the person receiving care. This is to be documented by a fingerprint analysis and criminal background check administered by the local police department and the Indiana State Police and a check of the Sex Offender Registry.
- Three written references shall be provided by someone who has known the caregivers family for more than a year.

- Care providers should respect the culture, race, ethnicity, language, religion and sexual orientation of the children they provide respite for.

### **Respite services may be delivered in various settings:**

- 1) Child(ren) needing respite services are taken to a respite caregiver's home
- 2) Respite caregivers may go to the child(ren)'s home to deliver services
- 3) Child(ren) may be taken to a respite care center

### **Caregiver's Home Standards:**

When respite is in the caregiver's home the worker must submit a written statement that the home meets the following standards.

- The home shall be clean and maintained in a sanitary condition.
- The home shall have adequate heating, ventilation and lighting.
- The home shall be equipped with at least one smoke detector per floor and a minimum of one fire extinguisher per home.
- The home shall have a safe drinking water supply.
- Each child shall have a comfortable and clean place to rest or sleep.
- Potential hazards such as guns, medicines, etc. shall not be accessible to the child.
- The home shall have a method for communication such as a telephone.
- The home shall have a first aid kit.
- Caregiver's pets must not negatively effect a child in the home.

### **When the respite caregiver goes into the family home, the home must have the following:**

- The caregiver will have access to a working phone.
- The caregiver will have information regarding domestic violence situations or other dangerous situations regarding the family or the home.
- The caregiver will have a list of emergency numbers pertinent to the local area as well as the contact information for the parents and the agency on-call number.
- The caregiver will be familiar with the plan of care.

### **Center-based respite care:**

Center-based respite care is care that is provided in a residential care facility licensed by the state. Facilities providing respite care services are required to follow applicable licensing and certification rules.

### **Program Evaluation:**

Each respite service provider shall conduct an internal evaluation at least annually of its operation and services. A written report of the evaluation must be kept on file. The evaluation shall include:

- Review of the performance of the program director and all staff.
- Review of the extent to which the program assisted clients (children and caregivers).
- Measurement of the achievement of goals and objectives.
- Assessment of the cost effectiveness of the program.

- Assessment of the relationship of the program to the rest of the community service network.
- Recommendations for improvement, corrective action of problem areas, and future program directions.

**Ideally the program would evaluate the following for best practice:**

- Reasons families are seeking service.
- Impact of services on family stress and quality of life.
- Family requests for service changes, expansion, and new service development.
- Family involvement in services.
- Program cost-effectiveness.
- Impact of the services on the community.
- Special activities (public awareness; fundraising).

**V. Billable Units.**

**1. For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.**

2. Administrative cost to be paid on a monthly basis to support voluntary respite services.

**VI. Rates.**

Budget summary must be submitted for rate determination .

Case management: budget summary must be submitted for rate determination method.

**VII. Service Delivery.**

Respite services should be family friendly and easy to access. It should be clear what families need to do to receive services. The service options should be developed so that a variety of needs can be met and is flexible and responsive to the changing needs of families as possible.

Service providers must be able to accept calls 24 hours a day, seven days a week and during holidays. Once a call has been received, contact with the client must be initiated within four hours if there is a crisis situation and during the next business day if it is for planned respite.

Non business hours: Designated service provider staff shall receive calls via phone, cell phone or pager contact and will notify supervisory staff of the need for emergency care. Contact will be initiated with the client to arrange an intake at the service provider office, clients home, hospital or any other safe place.

Prevention respite services will be administered by Community Partners for Child Safety (CPCS) agencies.

**VIII. Case Record Documentation.**

Service providers shall maintain the following in a client case file:

- Dates of service and any reimbursement.

- Plan of care that meets the child's needs and identifies essential information to maintain the health, safety and welfare of the child, including any known allergies.
- Notes on behaviors, diet, routine, recreation and leisure activities (likes and dislikes) and any assistance needed for daily living skills if not age appropriate.
- A list of emergency contacts and phone numbers for child and a written agreement with the family regarding arrangements for emergency care. This should be signed by the parent and agency representative.
- An assessment of the client's needs relevant to the provision of respite services (client being both child and caregiver).
- Documentation of accidents, health problems or changes in appearance or behavior of a child in care and any follow up if it occurs.
- A discharge plan that includes the client's status (child and caregiver), recommendations for continuing care, referrals to community services agencies, and necessary follow-up when the client leaves the program.

## **IX. Service Access.**

Service requests may come from the respite service seeker, from the Police, CPS, Emergency Room, or other community organizations or faith based organizations. The service is then initiated and agreed upon by the child's parent or guardian.

Agencies should distribute information regarding the program to hotlines, mental health facilities, hospitals, law enforcement, community programs, religious institutions, schools, public/private agencies or any other entity that would be a referral/information source for a family in need of respite.

**PROBATION  
SERVICES  
(Primarily)**

## **SERVICE STANDARD**

### **INDIANA DEPARTMENT OF CHILD SERVICES**

#### **DAY TREATMENT/DAY REPORTING PROGRAM**

##### **I. Service Description**

Day Treatment/Day Reporting programs provide intensive supervision to children exhibiting a pattern of delinquent behavior. The primary functions of Day Treatment/Day Reporting can include intensive supervision, utilizing a cognitive behavior change approach, to prevent the removal of the child from the home, to increase community safety, and to improve family functioning.

Day Treatment/Day Reporting programs can vary in the intensity and length of supervision and service hours the child and family receive.

The Day Treatment service is designed to provide an environment in which each child can develop the skills necessary for successful living, and to alter the previous environment of the child so that newly acquired skills are encouraged and old inappropriate behaviors are discouraged. Family involvement is highly encouraged or required for successful completion of the program. The service also addresses the educational needs of the individual child, based on an assessment of their academic progress.

The Day Reporting service provides daily supervision and structured activities for youth whom require more intensive oversight, as an alternative to secure detention. This program serves pre- or post-adjudicated youth.

##### **Day Treatment**

Providing agency receives referrals from the Department of Child Services FCM or the DCS Service Consultant. Upon receipt of a referral, the provider will respond to the referral source within two business days regarding the receipt of the referral. Provider will conduct an interview with the child and family within 5 business days of the referral and notify the referral source regarding acceptance into the program within 24 hours after the interview. (This requirement is null and void if the referral source determines eligibility for program acceptance).

Service delivery can range from 1-180 days, at 4-10 hours per day. Per Diem may not be billed if there is not at least 20 hours of face to face contact per weekly. Service delivery may be extended beyond 180 days if approved by Department of Child Services.

Services shall include, but are not limited to: Individualized educational planning, life skills training (including work readiness if appropriate), and community service projects.

Services shall also include a minimum of 6 hours per week of cognitive based instruction in a curriculum that demonstrates best practices of model programs. The use of role playing and interaction to teach new skills may be utilized. Services can address thinking errors, anger management, substance abuse, and other mental health needs identified by the provider and referral source.

Pre- and post-tests for evaluation and progress must be utilized.

Provider must also include a component that requires family involvement for a minimum of one hour per week. This may be in the form of a parenting support group or parenting instruction.

Provider will communicate progress to the referral source at least once per month in the form of a written progress report and monthly attendance in program, including number of contact hours. Provider will attend all Court review hearings and provide written progress reports to the Court at each review hearing.

### **Day Reporting**

Providing agency receives referrals from the Department of Child Services FCM or DCS Service Consultant. Upon receipt of a referral, the provider will respond to the referral source within two business days regarding the receipt of the referral. Provider will conduct an interview with the child and family within 5 business days of the referral and notify the referral source regarding acceptance into the program within 24 hours after the interview. (This requirement is null and void if the referral source determines eligibility for program acceptance).

Service delivery can range from 1-180 days, at 4-10 hours per day. Per Diem may not be billed if there is not at least 20 hours of face to face contact per weekly. Service delivery may be extended beyond 180 days if approved by Department of Child Services and by order of the Court.

Services shall include, but are not limited to: Intensive supervision, educational planning assistance, and community/recreational activities.

Provider will communicate progress to the referral source and monthly attendance in program, including number of contact hours. Provider will submit written progress reports to the Court at each hearing to review placement.

## **II. Target Population**

Services must be restricted to the following eligibility categories:

- Children who have substantiated cases of abuse and/or neglect, with moderate to high levels of risk and service needs according to the assessment matrix; when there is “imminent risk of removal” of the child (ren) from the home; or

- Children alleged to be a delinquent child or adjudicated a delinquent child with moderate to high levels of risk to re-offend and/or a risk to be removed from the home.

### **III. Goals and Outcome measures**

#### **Day Treatment**

Goal #1: Reduce the risk of repetitive delinquent behavior.

1. 100% of children in the Day Treatment program will receive a minimum of 6 hours per week of cognitive based instruction to successfully complete the program.
2. 50% of children will successfully complete the program with a reduction of the risk to re-offend based on a validated risk assessment tool.

Goal #2: Prevent removal from home or community.

1. 70% of parents will participate in required family activities as identified by the individual program.
2. 70% of children who successfully complete the program will have exhibited improved family relationships.
3. 70% of families that were intact at the initiation of service will remain intact with no out-of-home, county paid placement for more than five days throughout the service provision period, and will have avoided out of home placement 6 months following service closure.

Goal #3: Enrollment in education programming

1. 100% of children will be enrolled in some type of educational programming during their involvement in the program.
2. 70% of children will be enrolled in an education program three months after the program completion.

Goal # 4: Provide opportunities for the child to make meaningful contributions to their community.

1. 100% of children will be given opportunities to participate in employment, community, and recreational activities during their involvement in the program.
2. 70% of children will be employed or involved in community activities three months after program completion

#### **Day Reporting**

Goal #1: Provide supervision as an alternative to incarceration

1. 75% of youth will not return to secure detention while in the program.

2. 100% of youth will receive intensive supervision and participate in other activities while in the program.

Goal # 2: Provide opportunities for the child to make meaningful contributions to their community.

1. 100% of children will be given opportunities to participate in employment, community, and recreational activities during their involvement in the program.

2. 70% of children will be employed or involved in community activities three months after program completion

Goal #3: Enrollment in education programming

1. 100% of children will be enrolled in some type of educational programming during their involvement in the program.

2. 70% of children will be enrolled in an education program three months after the program completion.

#### **IV. Qualifications**

##### **Direct Worker:**

Program Coordinator must be a person with Bachelor's degree in criminal justice, sociology, psychology, social work or related field.

##### **Supervision:**

Program Supervision must be a person with Master's degree in criminal justice, social work, psychology, Social Work or related field.

Overall supervision of the Day Treatment program must be provided by a person with a Master's degree in Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

#### **V. Billable Units**

Per Diem cost for each client placed in the program. This per diem includes all costs of program including court appearances.

##### **Translation or sign language**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

**VI. Rates:**

Day Treatment Per Diem: \_\_\_\_\_

Day Reporting Per Diem: \_\_\_\_\_

Translation/Sign Language: Actual Costs

**Budget Summary must be submitted for rate determination.**

**VII. Case Record Documentation**

Necessary case record documentation for service eligibility must include:

- 1) A completed, dated, signed referral form authorizing service
- 2) Documentation of regular contact with the referred families/children
- 3) Copies of monthly reports/Court reports

**IX. Service Access**

Services must be accessed through a DCS Family Case Manager or DCS Service Consultant referral. Referrals are valid for a maximum of twelve months (12) unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved time period.

**NOTE: All services must be pre-approved through a DCS Family Case Manager or a DCS Service Consultant referral form.**

## **SERVICE STANDARD**

### **INDIANA DEPARTMENT OF CHILD SERVICES**

#### **QUALITY ASSURANCE FOR CHILDREN IN RESIDENTIAL PLACEMENT**

##### **I. Service Description**

Quality Assurance services will be provided for DCS and Probation children currently in residential placement to assist the local DCS and Probation offices to determine if the needs of the children are being met by the placement or to find a placement that more suitably meets individual needs and to decrease costs for children in residential care; children at-risk of residential placement will be evaluated to locate a placement that can meet the child's needs at an acceptable cost.

These quality assurance services will consist of, but may not be limited to, specific evaluations completed with regard to educational needs, psychiatric needs, medical needs, etc. to be sure that each child is receiving the quality of services specified by said agency or to assure each child is "matched" with a provider that can best meet the individual needs of the child.

##### **II. Target Population**

Children that are either at-risk of residential placement or already in placement.

##### **III. Goals and Outcomes**

Goal #1: Decrease in number of children placed in residential care

1. Numbers of children in residential placement will be monitored, compared to placement numbers of previous years with a goal of 25% decrease in the number of children placed by the end of the contract period.

Goal # 2: Children will be maintained in lower levels of care

1. The level of services needed by individual children and provided by their placements will be monitored through visits with the facility and FCM to assess effectiveness of treatment and to ensure treatment progress, with the goal of 25% of children in residential placement being stepped down to treatment that continues to meet their needs by the end of the contract period. The educational, physical and mental health needs of children in placement will be monitored to ensure appropriate levels of response to these needs.

### Goal #3: Decrease cost of children in residential placement

1. By monitoring the treatment needs and progress of children during residential placement, they will be moved to less restrictive and less costly placements that will lead to a decreased length of stay in placement. Referral to alternate funding sources, such as Department of Education, Division of Mental Health and Addictions, Division of Disability, Aging and Rehabilitation Services and Bureau of Developmental Disability Services will be made and monitored to decrease DCS placement costs. Data will be kept on the cost of children in placement and compared to previous years to demonstrate at 25% reduction in overall placement costs during the contract period.

### Goal # 4: Development of additional services within the local community

1. Through meetings with local DCS staff, service providers and facility staff more programs will be developed to meet the needs of children that are either being considered for placement or that are already in placement, to allow them to remain or return to the community and still have their individual needs met. Data on children being served in the local community will reflect at 25% increase in local services.

## **IV. Qualifications**

Master's degree in social work, psychology or marriage and family therapy and 3 (three) years of related clinical experience.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued culturally competent manner.

## **V. Billable Units**

### **Hourly rate for face-to-face services with the client**

Client is defined as the child/family members of a child at-risk or placement or in placement, facility staff of the residential placement, services providers and DCS or Probation staff

Face-to-face contact may be to conduct assessments, staff children being referred and discuss proposed or alternate placements, visit children in placement, meet with service providers and facility staff to develop programming specific to the child and includes professional time involved in scoring testing instruments and preparing the assessment report. (Note: routine report writing, scheduling of appointments and travel time is not included in face-to-face time. These activities are to be built into the costs of face-to-face and shall not be billed separately.)

Includes crisis intervention and other goal-directed interventions via telephone with the identified client.

**For hourly rates, partial unites may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes= .25 billable hours, 23 to 37 minutes= .50 billable hours, 38 to 52 minutes= .75 billable hours, 53 to 60 minutes= 1.00 billable hours. All billed time must be associated with an identified client.**

## **VI. Case Record Documentation**

**Necessary case record documentation for service eligibility must include:**

- 1) A completed, dated and signed DCS referral form authorizing services
- 2) Written report of contact made with child, facility staff, DCS or Probation staff or service provider staff to include summary of meeting content
- 3) Data to support that the goals of decreased number of placements, lower cost of placements, lower levels of care and increased number of local services are being met

## **VII. Service Access**

Services must be accessed through a DCS referral form. Referrals are valid for a maximum of 12 (twelve) months unless otherwise specified by DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

***NOTE: All services must be pre-approved through a DCS FCM or DCS Service Consultant referral form***

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**TRANSITION FROM RESTRICTIVE PLACEMENTS (TRP)**

**I. Service Description**

TRP is a provision of services to assist in transition from most the restrictive to a less/least restrictive placement. A Transition from Restrictive Placement (TRP) is a court-ordered program for youth adjudicated a CHINS or JD/JS. The purpose of the program is to prevent a return of the youth to a more restrictive setting/placement. TRP must include the following kinds of services to the youth and family:

- Therapeutic/clinical interventions to address the service needs of the youth and family. Therapeutic interventions must be based on an evidence-based model such as Functional Family Therapy (FFT), Multisystemic Therapy (MST), Parenting with Love and Limits (PLL), etc.
- Home-based services including but not limited to the following:
  - Home-based family therapy
  - Case management services
  - Home assessment
  - Coordination of services, with special emphasis on education and employment services
  - Educational transition services
  - Vocational services
  - Drug/alcohol screening & monitoring
  - Conflict management
  - Emergency/crisis services
  - Child development education
  - Domestic violence education
  - Parenting education/training

- Family communication
- Assistance with transportation
- Family reunification
- Family assessment
- Community referrals and follow-up
- Behavior modification
- Budgeting/money management
- Other services as deemed appropriate based on the needs of the youth and family
  - Services must include 24-hour access to crisis intervention seven days a week and must be provided in the family's home, at a community site, or in the office.
  - Services must include ongoing risk assessment and monitoring family/parental progress.
  - Services must include development of goals with measurable outcomes.
  - Provider must complete an intake interview with the family within five calendar days after receipt of the referral.
  - Provider must provide home-based therapy services to the family during the time the youth is incarcerated to identify and address any issues that may hinder the youth's success upon his/her return home.
  - Provider must maintain monthly contact with the youth's placement agency during the time the youth is in the more restrictive placement to ensure that the transition plan remains consistent between both agencies.
  - Provider must participate in an initial meeting with the youth's FCM or probation officer, youth, and family within 48 hours of release.
  - Provider must complete the Child and Adolescent Needs and Strengths (CANS) assessment within 30 days of release from the correctional facility, if not completed at the time of discharge from the more restrictive placement, and every six months thereafter. If no CANS was completed prior to the youth being admitted to the more restrictive placement, the service provider is responsible for completing the assessment within 2 weeks of the placement in a less restrictive placement. .
  - Provider must conduct a minimum of two (2) face to face visits per week with the youth during the first thirty (30) days of release from a more restrictive placement. The level of supervision after that period of time will be determined by the team but will never be less than 1 face to face visit per week.

- When appropriate the provider may require the youth to submit to at least one random drug screen within fourteen (14) days of changing from a more restrictive placement. This may be done through probation or another approved vendor.
- Provider must maintain frequent contact with the FCM/probation officer and notify the FCM/probation officer in writing of non-compliance issues. The provider must also develop a recommendation for the FCM/probation officer as to a suitable therapeutic intervention.
- The family will be the focus of service and services will focus on the strengths of the family and build upon these strengths.
- Services must be family focused and child centered.
- Services must include intensive in-home skill building and after-care linkage.
- Services include providing monthly progress reports in a format approved by the Court, participation in team meetings, and providing requested testimony and/or presence at court hearings.
- Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
- The caseload of the therapist/case manager will include no more than ten (10) workload units per therapist. Youth being supervised in the community are weighted at 1 workload unit.

## **II. Target Population**

Services must be restricted to the following eligibility categories:

- 1) Children with a status of CHINS and/or JD/JS who have been placed in a restrictive setting.

**Transition From Restrictive Placements (TRP) can be provided to CHINS or probation youth who are transitioning out of residential or group home placement. A residential or group home provider should never bill TRP and a per diem at the same time. Community providers could bill TRP while a youth is still in a residential or group home placement if that youth will be transitioning within 30 days.**

**Please note, the following is in effect for all new referrals beginning 3/1/2010:**

**For JDJS youth who are committed to the Department of Corrections, this service shall commence no sooner than 60 days prior to discharge.**

## **III. Goals and Outcome Measures**

**Goal #1:** To improve the transition for youth back to their home by providing therapeutic services to the youth and family

### Outcome Measures

Department of Child Services

Regional Document for Child Welfare Services

Term 1/1/09 to 6/30/11

- 1) Based on the CANS Assessment, 100% of participants will have an individualized service plan developed. (For Probation only)
- 2) 95% of families will participate in home-based counseling during the youth's period of placement.
- 3) 90% of the youth will have a minimum of 2 face to face visits each week from their case manager/therapist during the first 30 days following their placement from a more restrictive to a less restrictive placement.

**Goal #2:** To reduce routine barriers by providing direct assistance with transition issues

Outcome Measures

- 1) 90% of all participants will have a state-issued ID or driver's license by the completion of the program.
- 2) 90% of all participants will actively participate in an education program.
- 3) 100% of participants not involved in an educational program will be employed and/or participating in a formal employment assistance program.

**Goal #3:** To develop a system of community supports for each youth that will continue after completion of the program.

Outcome Measures

- 1) 100% of the youth in the program will establish at least one community-based support that will continue to provide assistance and/or direction following completion of the program.

**IV. Qualifications**

**Case Manager:**

Bachelor's degree in social work, psychology, sociology, or a directly related human service field required.

**Therapist:**

Master's degree in social work, psychology, marriage and family therapy, or related human service field and 3 years related clinical experience or a masters degree with a clinical license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board, as one of the following: 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor.

**Supervisor:**

Master's degree in social work, psychology, or marriage and family or related human service field with a current license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board, as one of the following: 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

The staff person must possess:

- Knowledge of community resources and ability to work as a team member
- Understanding regarding issues that are specific and unique to youth transitioning back into the community following a period of incarceration

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life style choices, and complex family interactions and be delivered in a neutral valued culturally competent manner.

**V. Billable Units****Face to face time with the youth and/or family**

(Note: Members of the client family are to be defined in consultation with the family and approved by the Juvenile Court. This may include persons not legally defined as part of the family).

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes probation meetings or case conferences initiated and approved by Probation for the purposes of goal directed communication regarding the services to be provided to the client/family.

***Reminder: Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are built into the cost of the face to face rate and shall not be billed separately.***

For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.

**Translation or sign language**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

**VI. Rates**

Face to Face rate: \_\_\_\_\_

Translation or sign language rate: Actual cost

**VII. Case Record Documentation**

Necessary case record documentation for service eligibility must include:

- 1) A completed, signed, and dated referral form authorizing services
- 2) A court order ordering the TRP program
- 3) Documentation of regular contact with the referred families/children
- 4) Written reports no less than monthly or more frequently as prescribed referral by the source.

**VIII. Service Access**

Services must be accessed through a DCS Family Case Manager or DCS Service Consultant referral form. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by DCS. Providers must initiate a reauthorization for services to continue beyond the approved time period.

**Note: All services must be pre-approved through a DCS Family Case Manager or DCS Service Consultant referral form.**

**SERVICE STANDARD**  
**INDIANA DEPARTMENT OF CHILD SERVICES**  
**TRUANCY TERMINATION**

**I. Service Description**

The purpose of Truancy Termination services is to provide school drop-out prevention education, job readiness skills services, parent education, and family support services to youth and his/her family in order to reduce recidivism of delinquent youth and truants.

**Family Support Services**

Family support workers are to work with family members to identify reasons for youth's truancy and barriers to regular and positive school attendance as well as work with the school and Probation Officers to identify solutions and interventions necessary to ensure school attendance, increase youth's involvement in the school, and improve academic performance. Accomplishing these objectives may require the support worker to attend parent/teacher conferences and attend classes with the student. The support worker shall provide services in the areas of parent education and crisis intervention, including direct services. The support worker will be present as the Juvenile Court directs, including, but not limited to the Initial Hearing, where the worker will meet with the youth and family and complete the preliminary intake. The purpose of the preliminary intake is to gather basic information and provide a brief overview of participation in the program. The support worker is responsible for providing weekly written reports and to attend and be prepared to present at subsequent court hearings, written progress reports regarding each family's circumstances, participation in the program, school attendance rates, examples of school involvement, and academic performance. These reports shall reflect ongoing collaboration and cooperation among the family support workers, school social workers, and Probation Officers.

The family support workers shall conduct and complete comprehensive intake and assessment for each referral to create a Family Development Plan (FDP). The FDP will be shared with school social workers and Probation Officers to ensure that youth attends school and is favorably progressing academically.

**Training Modules**

Training modules consist of six (6) weekly skills-based classes in which the youth and parents are required to attend and complete. The family support worker will assess competence of knowledge of all program graduates, identify youth and families who may benefit by additional tutoring to strengthen their knowledge of skills and strategies in areas taught. Assessment of areas for continued improvement will be shared with school social workers, Probation Officers, and Juvenile Court.

**Youth Modules**

The following youth modules of Skills Based programming will be taught:

- "You are Somebody with Someplace to Go"/Personal Hygiene
- Truancy/College Awareness
- Conflict Resolution

- Relationships (peer to peer and peer to parent)
- Social Pressures and Substance Abuse
- Decision Making, Time Management, and Goal Setting

#### Parent Modules

The following parent modules of Skills Based programming will be taught:

- Role as a parent and self-esteem
- Understanding child growth and development/Sibling Rivalries
- Communication and listening skills/Relationships
- How to use effective discipline/Problem solving
- Anger management/Conflict resolution/Stress maintenance
- Teaching morals, values, and respect/How to prepare and manage a budget

Subsequent to the completion of the training modules the family support worker shall continue to work with the school social workers, probation officers, and the Juvenile Court to monitor families' well-being to ensure youth attend school. The support worker will conduct monthly activities designed to connect youth and families with positive sources of ongoing encouragement (i.e. career fairs, family dinners, age appropriate sports and/or entertainment events, etc.).

## II. Target Population

Services must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect, with moderate to high levels of risk and service needs according to the assessment matrix
- 2) Children with a status of CHINS, and/or JD/JS
- 3) All adopted children and adoptive families

## III. Goals and Outcomes

### Goal #1

Ensure youth and parents participating in the modules are provided with the opportunity to learn the importance of regular school attendance.

### Outcome Measures

- 1) 85% of youth and parents referred by the Juvenile Court shall complete six (6) skills-based modules.
- 2) 85% of those families completing the modules shall demonstrate increased knowledge resulting from participation in the skills-based modules.

### Goal #2

Increase regular school attendance of youth completing the program.

- 1) 75% of youth completing the six week modules will attend school regularly through the term of this contract.

### Goal #3

Juvenile Court and client satisfaction with services

#### Outcome Measures

- 1) Juvenile Probation/DCS satisfaction will be rated 4 and above on the Services Satisfaction Report.
- 2) 90% of clients will rate services as satisfactory or above on the satisfaction survey.

## IV. Qualifications

Training Facilitator (Paraprofessional):

A high school diploma or GED and is at least 21 years of age. Must possess a valid driver's license and the ability to use private car to transport self and others, and must comply with state policy concerning minimum care insurance coverage.

Family Support Worker:

Bachelor's Degree in social work, psychology, sociology, or a directly related human service field.

Supervisor (Professional):

Bachelor's Degree in social work, psychology, sociology, or directly related human service field plus three (3) years related experience.

Supervision/consultation is to include not less than one (1) hour of face-to-face supervision/consultation per twenty (20) hours of direct client services provided, nor occur less than every two (2) weeks.

## V. Billable Units

Roll all costs into Face to Face or Group rate.

### Group rate

Groups are defined as a minimum of three (3) with no more than twelve (12) participants. The group rate must include preparation time, report writing, contacting families, and face-to-face contact in group with participating families.

### Face-to-face time with the client :

(Note: Members of the client family are to be defined in consultation with the family and approved by the Juvenile Court. This may include persons not legally defined as part of the family).

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

*Reminder: Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are built into the cost of the face-to-face rate and shall not be billed separately.*

**For hourly rates, partial units may be billed in quarter our increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.**

#### **Translation or sign language**

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client.

#### **VI. Rates**

Face to Face rate: \_\_\_\_\_

Group rate: \_\_\_\_\_

Translation or Sign Language Rate: Actual Cost

Budget summary must be submitted for rates determination.

#### **VII. Case Record Documentation**

Necessary case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS referral form authorizing service
- 2) Documentation of regular contact with the referred families/youth
- 3) Written reports no less than weekly or more frequently as requested by the Juvenile Court

#### **VIII. Service Access**

Services must be accessed through a Juvenile Probation/DCS referral unless otherwise specified. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the Juvenile Probation/DCS. Providers must initiate a reauthorization for services to continue beyond the approved period.

**NOTE: All services must be pre-approved through a Juvenile Probation/DCS FCM referral form.**

**SERVICE STANDARD  
INDIANA DEPARTMENT OF CHILD SERVICES  
TUTORING/LITERACY CLASSES**

**I. Service Description**

Tutoring/literacy and math services will be provided to raise the academic performance of school aged youth to a level consistent with state education standards.

Services shall be provided in a manner that is age and developmentally appropriate, and consistent with the child's academic ability and learning style, interpersonal characteristics and special needs. Children will be connected as appropriate with both formal and informal community supports, services and activities that promote their literacy skills. The child's characteristics such as race, culture, ethnicity, language and personal history including child abuse and neglect will be considered when choosing or designing program interventions, materials and curriculum. The provider will develop an education plan to address the child's literacy and math needs.

A variety of activities and lessons shall be available to afford choice. Activities and lessons shall promote literacy skills and academic development and should demonstrate well-planned, flexible and responsive services. Services should include regular use of external resources such as libraries, museums and community educational sites. Services may also incorporate the use of video games and computers. The use of television and videos shall be strictly limited to a minimal portion of the child's participation. Video games, computers, television and videos should be age and developmentally appropriate, supportive of the child's educational goals, and should be monitored at all times.

The provider will develop a plan to engage the child and caregiver in the process, as well as the educator, and this plan will accommodate persons who are difficult to engage. The provider will clearly and frequently communicate and coordinate the child's education plan goals with the caregiver and educator.

**Treatment Modality**

Tutoring/literacy and math services shall be provided through direct one-on-one sessions or in small groups of 2 to 4 children who are matched by ability. Sessions shall be provided at least twice a week and may be up to 60 minutes in duration, depending upon the age of the child and type of activity. Services should occur in locations that promote learning, are large enough for the child to concentrate without being disturbed by others, and allow for meaningful and direct assistance. Services may take place after school, on weekends and/or during the summer.

Tutoring/literacy and math services shall incorporate evidence-based strategies that improve student achievement. Sessions shall be divided into segments, including: 1) an opening activity to set the stage, 2) activities based on individual learning goals, 3) opportunities to develop and

practice skills, and 4) a closing activity. All sessions shall include opportunities for the child to experience success and to progress. The provider may suggest home activities as appropriate.

### **Assessment**

The provider will ensure the child receives an initial assessment in order to determine child specific learning needs, no later than 10 days after being referred to services to promote the timely initiation of services. The provider will make reasonable attempts to discover previous assessments and to utilize the findings of those assessments in conjunction with the provider's own assessment. Assessments shall include the use of standardized tools to obtain a baseline measurement and will at a minimum identify the following:

- Learning disabilities and/or impairments in cognitive functioning due to child abuse or neglect or involvement with child welfare services
- Academic strengths and needs
- Level of ability compared to expected grade level

Services will be provided within the context of the Department of Child Services' practice model with involvement in Child and Family team meetings if invited. An education plan will be developed and based on the agreements reached by means of the assessment and Child and Family Team Meeting (CFTM). Services will be in coordination with the child's Individualized Education Plan (IEP) if present, and the provider should participate in IEP conferences with educators.

### **Education Plan**

Comprehensive education plans will be developed based on the assessment and will contain both long-term and short-term goals. Plans at a minimum will:

- Include input from the child, caregiver and the educator
- Reflect underlying needs and goals
- Be tailored to the child's strengths, needs, available resources and unique circumstances
- Build on realistic possibilities and options
- Identify strategies for lessening the effects of disabilities and/or impairments in cognitive functioning due to child abuse or neglect, if present
- Promote reading and math achievement at a level consistent with state education standards
- Be consistent with the child's Individualized Education Plan (IEP), if one is present
- Support and/or build upon what the child is learning through their primary education program
- Respond flexibly to the child's changing needs

The provider will evaluate the child's progress toward achieving identified goals and will regularly incorporate the use of standardized performance measurement tools to track progress and adjust tutoring/ and literacy and math activities. The provider will assist the child and caregiver in realizing ways of generating and maintaining gains. The provider will document progress and participation.

The Books for Youth Program, sponsored by the Indianapolis Colts, the Indiana Department of Child Services and the Indianapolis Marion County Library will be accessed by providers in participating counties.

Services must be available to participants who have limited daytime availability.

Services include providing any requested testimony and/or court appearances (to include hearing or appeals).

Provider must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the contract.

## **II. Target Population**

Services must be restricted to the following eligibility categories:

- 1) School aged children who have substantiated cases of abuse and/or neglect and have been identified as needing tutoring/ literacy and math services
- 2) Children with a status of CHINS, and/or JD/JS, or
- 3) All adopted children.

## **III. Goals and Outcome Measures**

### **Goal#1**

Timely provision of services for the youth and regular and timely communication with referring worker.

Outcome Measures:

- 1) 95% of all youth referred will have face-to-face contact with the provider within 10 days of the referral.
- 2) 95% of all youth will have a written education plan within 30 days of the referral.
- 3) 100% of all youth will have monthly written summary reports prepared and sent to the referring worker.

### **Goal #2**

Child has improved academic and/or literacy performance

Outcome Measures:

- 1) 90% of children improve academic and/or literacy performance as evidenced by pre and post-testing
- 2) 90% of children improve overall school performance as measured by grade point average or other standard indicators
- 3) 100% of children participate actively in the goals of their education plan as evidenced by provider documentation

#### Goal #4

DCS and youth satisfaction with services

Outcome Measures:

- 1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 90% of the youth who have participated will rate the services “satisfactory” or above.

#### IV. Qualifications

##### **Direct Worker:**

Tutoring services may be provided by workers with a Bachelor's degree or at least 60 hours of post secondary credit hours in education, social work, psychology, or a related field. Intermediate computer skills (e-mail, internet, word processing, etc.) and knowledge of state education standards are preferred. Workers are required to pass a state background check.

##### **Supervisor:**

Bachelor's degree in education, social work, psychology, or a related field and 5 years experience tutoring children. Knowledge of state education standards is required.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

##### **Worker Qualities:**

Providers working directly with children have the competencies and support needed to:

- Engage, empower and communicate effectively, respectfully and empathetically with children and families from a wide range of backgrounds, cultures and perspectives
- Develop plans to meet the child's literacy needs
- Recognize and identify the presence of cognitive impairments due to child abuse and neglect and learning disabilities
- Collaborating with other disciplines and community resources

- Advocate for the child during Child and Family Team Meetings and Individualized Case Plan (IEP) conferences

Providers working directly with children are knowledgeable about:

- Child development
- Behavior management
- Learning disabilities
- Possible effects of child abuse and neglect on cognitive functioning
- The Individualized Education Plan (IEP) and its use in education
- Educational resources within the community
- Tutoring techniques

## V. Billable Units

**All other costs must be into Face to Face or group.**

### **Group Rate:**

Groups are defined as a minimum of three (3) with no more than twelve (12) unrelated participants. The rate must include preparation time, report writing, contacting families, and face-to-face contact in group with participating families.

**Face-to-face time with the client** (Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family):

Face-to-face time includes:

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

**Reminder:** *Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are built into the cost of the face to face rate and shall not be billed separately.*

**For hourly rates, partial units may be billed in quarter hour increments only. Partial units to be billed are to be rounded to the nearest quarter hour using the following guidelines: 8 to 22 minutes = .25 billable hours, 23 to 37 minutes = .50 billable hours, 38 to 52 minutes = .75 billable hours, 53 to 60 minutes = 1.00 billable hours. All billed time must be associated with a family/client.**

**Translation or sign language** Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

## **VI. Rates**

**Group:** \_\_\_\_\_

**Face-to-Face:** \_\_\_\_\_

**Translation or Sign Language:** Actual Cost

Budget summary must be submitted for rate determination.

## **VII. Service Delivery**

Provider staff caseloads shall support the achievement of child outcomes. Caseloads should be based on the qualifications, competencies and experience of the worker, and the level of supervision needed, as well as on service volume, including the work and time required to accomplish job responsibilities.

## **VIII. Case Record Documentation**

Necessary case record documentation for service eligibility must include:

- 7) A completed, dated, signed DCS referral form authorizing service
- 8) Documentation of regular contact with the referred families/children
- 9) Written reports provided no less than quarterly or more frequently as prescribed by DCS.

## **II. Service Access**

Services must be accessed through a DCS Family Case Manager or DCS Service Consultant referral. Referrals are valid for a maximum of twelve (12) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved time period.

***NOTE: All services must be pre-approved through a DCS Family Case Manager or DCS Service Consultant referral form***