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MANDATORY POLICIES

Attachment 1

Private Provider Contract Agencies Will Adhere to the Following DCS Policies. (All collateral attachments to these policies also must be reviewed)			
#	Policy Name	Contact	Comments
http://www.tn.gov/youth/dcsguide/policies/chap1/1.4.pdf	Incident Reporting	Family and Child Well-being	Cross-reference with 31.2
http://www.tn.gov/youth/dcsguide/policies/chap9/9.4.pdf	Confidential Child-Specific Information	DCS General Counsel	
http://www.tn.gov/youth/dcsguide/policies/chap9/9.5.pdf	Access and Release of Confidential Child-Specific Information	DCS General Counsel	
http://www.tn.gov/youth/dcsguide/policies/chap14/14.24.pdf	Child Protective Services Background Checks	Office of Child Safety	
	Best Practice Guide for Adoption	Foster Care and Adoption	
http://www.tn.gov/youth/dcsguide/policies/chap15/15.5.pdf	Registering and Maintaining Status of Children with REACT	Foster Care and Adoption	
http://www.tn.gov/youth/dcsguide/policies/chap15/15.8.pdf	Preparing Adoption Records for Archives	Foster Care and Adoption	
http://www.tn.gov/youth/dcsguide/policies/chap15/15.11.pdf	Adoption Assistance	Foster Care and Adoption	
http://www.tn.gov/youth/dcsguide/policies/chap16/16.3.pdf	Desired Characteristics of Resource Parents	Foster Care and Adoption	
http://www.tn.gov/youth/dcsguide/policies/chap16/16.4.pdf	Resource Home Approval	Foster Care and Adoption	

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http://www.tn.gov/youth/dcsguide/policies/chap16/16.8.pdf	Responsibilities of Approved Resource Parents	Foster Care and Adoption	
http://www.tn.gov/youth/dcsguide/policies/chap16/16.11.pdf	Shared Resource Homes	Foster Care and Adoption	
http://www.tn.gov/youth/dcsguide/policies/chap16/16.27.pdf	Resource Parent Fourteen-Day Removal Notice and Right to Appeal	Foster Care and Adoption	
http://www.tn.gov/youth/dcsguide/policies/chap16/16.38.pdf	Face-to-Face Visitation with Dependent and Neglected and Unruly Children in DCS Custody	Foster Care and Adoption	
http://www.tn.gov/youth/dcsguide/policies/chap16/16.43.pdf	Super Unsupervised Visitation Between Child-Youth, Family and Siblings	Foster Care and Adoption	
http://www.tn.gov/youth/dcsguide/policies/chap16/16.51.pdf	Interdependent Living Plan	Foster Care and Adoption	
http://www.tn.gov/youth/dcsguide/policies/chap19/19.1.pdf	Suicide-Self Harm Intervention	Medical and Behavioral Health	
http://www.tn.gov/youth/dcsguide/policies/chap19/19.8.pdf	Referral to Division of Mental Health Adult	Medical and Behavioral Health	

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http://www.tn.gov/youth/dcsguide/policies/chap20/20.7.pdf	TENnderCARE Early Periodic Screening Diagnosis and Treatment Standards (EPSDT)	Medical and Behavioral Health	
http://www.tn.gov/youth/dcsguide/policies/chap20/20.8.pdf	Reproductive Health Education and Services	Medical and Behavioral Health	
http://www.tn.gov/youth/dcsguide/policies/chap20/20.12.pdf	Dental Services	Medical and Behavioral Health	
http://www.tn.gov/youth/dcsguide/policies/chap20/20.15.pdf	Medication Administration-Storage and Disposal	Medical and Behavioral Health	
http://www.tn.gov/youth/dcsguide/policies/chap20/20.18.pdf	Psychotropic Medication	Medical and Behavioral Health	
http://www.tn.gov/youth/dcsguide/policies/chap20/20.19.pdf	Communicable Diseases	Medical and Behavioral Health	
http://www.tn.gov/youth/dcsguide/policies/chap20/20.22.pdf	HIV and AIDS	Medical and Behavioral Health	
http://www.tn.gov/youth/dcsguide/policies/chap20/20.24.pdf	Informed Consent	Medical and Behavioral Health	
http://www.tn.gov/youth/dcsguide/policies/chap20/20.25.pdf	Health Information Records and Access	Medical and Behavioral Health	

Attachment 1 – Mandatory Policies

MANDATORY POLICIES

Attachment 1

http://www.tn.gov/youth/dcsguide/policies/chap20/20.59.pdf	Medication Error Guidelines	Medical and Behavioral Health	
http://www.tn.gov/youth/dcsguide/policies/chap21/21.14.pdf	Serving the Educational Needs of the Child/Youth	Educational Services	
http://www.tn.gov/youth/dcsguide/policies/chap21/21.16.pdf	Rights of Foster Child with Disabilities and IDEA	Educational Services	
http://www.tn.gov/youth/dcsguide/policies/chap21/21.18.pdf	Notification to School Principals of Certain Delinquency Adjudications	Educational Services	
http://www.tn.gov/youth/dcsguide/policies/chap21/21.19.pdf	Education Passport	Educational Services	
http://www.tn.gov/youth/dcsguide/policies/chap21/21.20.pdf	Non-Traditional Educational Settings	Educational Services	
http://www.tn.gov/youth/dcsguide/policies/chap25/25.10.pdf	Behavior Management	Family and Child Well-being	
http://www.tn.gov/youth/dcsguide/policies/chap27/27.1.pdf	Use of Mechanical Restraints	Family and Child Well-being	Also 31.15, in revision
http://www.tn.gov/youth/dcsguide/policies/chap27/27.2.pdf	Seclusion	Family and Child Well-being	
http://www.tn.gov/youth/dcsguide/policies/chap27/27.3.pdf	Physical Restraint	Family and Child Well-being	
http://www.tn.gov/youth/dcsguide/policies/chap31/31.2.pdf	Responsibilities Regarding Runaways, Absconders and	Office of Inspector General	Cross-reference with 1.4 Incident Reporting

Attachment 1 – Mandatory Policies

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	Escapees		
http://www.tn.gov/youth/dcsguide/policies/chap31/31.7.pdf	Building, Preparing and Maintaining Child and Family Teams	Child Permanency	

POLICIES FOR INFORMATION

Attachment 2

Private Provider Contract Agencies will use these DCS Policies for Reference and Information			
#	Policy Name Click on policy to view	Contact	Comments
1.33	Research Proposals	Office of Performance and Quality Improvement	Policy references using children in research.
12.1	Return to Home Placement: Youth Adjudicated Delinquent	Juvenile Justice	Note agencies must request passes through DCS and include summary of youth's progress in the monthly summary report. Note any new contact information regarding the pass in the monthly reports. DCS makes release requests. Providers should participate in the release CFTM.
12.5	Passes For Youth Adjudicated Delinquent	Juvenile Justice	
14.15	Reporting False Allegations of Child Sexual Abuse	Office of Child Safety	Use 1-877-237-0004 to report child abuse/neglect.
14.20	Notice of Child Fatality Near Fatality	Office of Child Safety	Notify DCS.
14.25	Special Child Protective Services Investigations	Office of Child Safety	SIU investigates allegation in provider placements.
16.2	MEPA/IEPA Inter – Ethnic Placement Act	Child Permanency	Note statutory requirements, prohibitions and possible sanctions.
16.20	Expedited Custodial Placements	Foster Care and Adoption	Providers may not make expedited placements.
16.21	DCS Employees as Resource Parents	Foster Care and Adoption	DCS employees cannot parent DCS custodial children for private agencies.
16.23	Resource Home Case Files	Foster Care and Adoption	

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16.29	Resource Home Board Rates	Foster Care and Adoption	Providers cannot pay their resource families any less than the DCS board rates.
16.31	Permanency Planning For Children/Youth in DCS Custody	Child Permanency	Providers should: Participate in Permanency Planning, Develop treatment plans based on the perm plan, Provide information for the FCRB to DCS through monthly reports, Receive notice on hearings and FCRBs from DCS and are encouraged to attend and help ensure children 12 and older also attend.
16.32	Foster Care Review and Quarterly Progress Reports	Child Permanency	
16.33	Permanency Hearings	Child Permanency	
16.39	Subsidized Guardianship	Child Permanency	These cases are limited and typically will only apply in PPLA case of youth 14+, who have been with a family a year or more. It is important to prepare provider families that once the child leaves care through SPG, that child is no longer a part of the agency and the payment the family receives will only be what is approved through the SPG agreement.
16.48	Conducting Diligent Search	Foster Care and Adoption	Providers should communicate any new/known relative/kin contact information to DCS so that they (DCS) may follow-up.
16.52	Eligibility for Interdependent Living and Voluntary Post-Custody Services	Family and Child Well-being	See Interdependent Living Section.
16.53	Identifying and Accessing Interdependent Living Services	Family and Child Well-being	
16.54	Provision of Voluntary Post-Custody Services to Young Adults	Family and Child Well-being	

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16.55	Post Secondary Scholarships: Educational and Training Vouchers and State Funded Scholarship	Family and Child Well-being	See Interdependent Living Section.
16.56	Interdependent Living Direct Payment Allowance http://www.tn.gov/youth/dcsguide/policies/chap16/16.56.pdf	Family and Child Well-being	
20.3	Reporting Suspected TennCare Fraud or Fiscal Abuse	TennCare Policy	
20.9	Court Advocate Program	Department of Personnel	
24.10	Title VI Program and Complaint Process	Department of Personnel	
24.11	Grievance Procedures For Youth in DCS Group Homes	Juvenile Justice	
24.13	Access to Legal Counsel For Youth in DCS Group Homes	Juvenile Justice	
31.15	Transportation of Children/Youth by Regional and Field Services Employees	Regional Services	
32.	<u>HIPAA</u> http://www.tn.gov/youth/dcsguide/policies/chap32/32.1.pdf	Special Counsel	

Attachment 3 - DCS Forms			
#	Form Name	Requirement	Policy Reference
0741	Database Search Results	Mandatory Form	14.24
0695	REACT Child Entry Information	Mandatory Form	15.5
0696	REACT Child Status Information	Mandatory Form	15.5
0677	Closed Adoption Case Record Face Sheet	Mandatory Form	15.8
0422	Mailing and Acknowledging Case Record, Record Materials and Forms	Mandatory Form	15.8
0460	Intent to Adopt and Application for Adoption Assistance	Mandatory Form	15.11
0674	Special or Extraordinary Rate Request	Mandatory Form	15.11
0431	Monthly Family Income and Expenditures	Equivalent Accepted	16.3, 16.4
0678	Resource Parent Medical Report	Equivalent Accepted	16.3, 16.4
0690	Resource Home Study Verifications Checklist	Equivalent Accepted	16.4
0691	Fingerprint Card Information	Equivalent Accepted	16.4
0687	Internet Records Clearance	Equivalent Accepted	16.4
0676	Home Safety Checklist	Equivalent Accepted	16.4
0427	Child's Medical Record	Equivalent Accepted	16.4
0673	Resource Parent Oath of Confidentiality	Equivalent Accepted	16.4
0670	Oath to Report Suspected Child Abuse or Neglect and to Abide by Child Safety Restraint Laws	Equivalent Accepted	16.4
0553	Discipline Policy	Equivalent Accepted	16.4
0697	REACT Family Entry Information	Mandatory Form	16.4
0675	Resource Family Cover Sheet	Equivalent Accepted	16.8

Attachment 3 - DCS Forms			
#	Form Name	Requirement	Policy Reference
0630	Resource Home Prescription Medication Record	Mandatory Form	16.8, 20.15
0689	Health Services Confirmation and Follow up Notification	Mandatory Form	16.8
0692	Resource Home Mutual Reassessment	Mandatory Form	16.8
0707	Resource Parent Annual Medical Self Report	Mandatory Form	16.8
0685	Resource Family Update Checklist	Equivalent Accepted	16.8
0706	Absconder/Runaway/Escapee Checklist		16., 31.2
0698	REACT Family Status Information	Mandatory Form	16.8
0773	Resource Home Addendum	Equivalent Accepted	16.8
0672	Shared Resource Home Authorization	Mandatory Form	16.11
0450	Notice of Removal of a Child from a Resource Home	Mandatory Form	16.27
0403	Appeal for Fair Hearing	Mandatory Form	16.27
0583	Waiver of Right to Appeal	Mandatory Form	16.27
0594	Visitation Observation Checklist		16.43
0544	Resource Home Placement Checklist		16.46
	TennCare Medical Appeal, available on TennCare web site		16.46
0543	Well-Being Information and History		20.7
0708	EPSDT Physical Examination	Used by YDC, Level IV and RTC. All other locations/levels use the Health Department document	20.7
0628	Request for Prior Approval of PRN Psychotropic Medication	Mandatory Form	20.7

Attachment 3 - DCS Forms			
#	Form Name	Requirement	Policy Reference
0206	Authorization for Routine Health Services for Minors		20.7
0593	Medication Observation Record	Equivalent Accepted	20.15
0627	Informed Consent for Psychotropic Medication	Mandatory Form	20.24
0629	Psychotropic Medication Evaluation	Mandatory Form	20.24
0158	Notification of Equal Access to Programs and Services and Grievance Procedures		24.10
0636	Title VI Complaint		24.10
BI-0083	TBI Missing/Wanted Person Report		31.2
0156	Violation Report		31.2
0706	Runaway/Escapee Checklist		31.2
0705	Absconder Recovery		31.2
0749	Penalty Letter for Harboring		31.2
0761	Independent Living Program Review Request	Mandatory Form	16.52, 16.54, 16.56
0778	Application for Post Custody Services	Mandatory Form	16.54
0559	Authorization for Release of Child-Specific Information from DCS and Notification of Release	Mandatory Form	16.54
0542	Research Involving Study of Existing Records or Data	Mandatory Form	6.1
0334	Request for Access to human Subjects or Records, which may involve Informed Consent	Mandatory Form	6.1
0541	Request for Information	Mandatory Form	6.1

Resource Home Eligibility Team (RHET) Protocol:

<http://www.tn.gov/youth/dcsguide/policies/chap16/RHETProtocol.pdf>

Foster Parent's Bill of Rights

Resource Parents Bill of Rights

The Tennessee General Assembly enacted *The Foster Parents Rights Act* in 1997 as an amendment to *Tennessee Code Annotated, Title 37, Chapter 2; Part 4*.

<http://tennessee.gov/youth/fostercare.htm>

TennCare Services for Children in Custody

TennCare Funding for DCS contract agency services

The per diem funding for contract agency behavioral residential and continuum services are provided in whole or in part by TennCare funding depending on the service/level of care. Please note that the contract for DCS provider agencies contains information regarding the obligations of TennCare providers.

Providers shall not access TennCare services through the TennCare MCC (Managed Care Companies) that are covered under the per diem of services as set forth in this provider manual. Accessing TennCare services on behalf of a child in your agency that are covered under the DCS contract agency per diem constitutes TennCare fraud.

The custodial child served in DCS Contract agencies has a right to appeal those behavioral residential services. This appeal process is described below in the Section “Notice of Action regarding DCS administered TennCare Services.”

TennCare Coverage

The overwhelming majority of children entering DCS care will be eligible for TennCare. Exceptions include persons who are undocumented immigrants (however, these persons may qualify to receive emergency care in hospital settings) and children assigned to Youth Development Centers, operated by the Department of Children’s Services.

Children in detention are eligible for TennCare, if not assigned to be transferred to a Youth Development Center.

TennCare Covered Services

Children in DCS custodial care receive all health services from the assigned MCO for custodial children, TennCare Select. TennCare Select manages health service, including medical and behavioral health.

However, children in custody receive residential behavioral services through DCS. Hospital services are not considered residential behavioral health services. Dental care is provided through Dentaquest, and pharmacy services are managed by SXC, the TennCare Pharmacy PBM.

TennCare covers all medically necessary EPSDT services for children 21 and under. For resources regarding covered services, refer to the TennCare website, <http://www.tn.gov/tenncare/members.html>. The DCS Well Being Health Advocate Representative may also provide technical assistance regarding TennCare services.

TennCare Eligibility /Enrollment for Children in Custody

When children enter DCS custody, a TennCare Select DCS enrollment form is sent to TennCare Select and the child is enrolled in immediate eligibility. This is to facilitate the initial EPSDT TENNderCare appointment, as well as emergent medical needs that may be identified.

A Primary Care Provider (PCP) is selected by DCS when the enrollment form is sent; TennCare Select confirms the PCP assignment or assigns a PCP if there was not a preference.

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The family services worker (FSW) must make changes to the PCP assignment; providers may contact the FSW if changes in PCP assignment are needed.

TennCare Select will also verify private insurance information if listed, and notify the department if a child does have other insurance..

The DCS family services worker (FSW) completes a IV-E/ Medicaid eligibility application, which is provided to the DCS Child Welfare Benefit Worker who determines eligibility for benefits through Department of Human Services polices and the DHS ACCENT information system. After 45 days, the immediate eligibility expires.

TennCare cards are issued by TennCare Select; 2 cards are mailed to the child's FSW. A TennCare card should be made available to the child's placement caregiver.

The DCS Child Welfare Benefit Worker is responsible for re-determinations of eligibility while children are in DCS custody.

Upon exit from care, DCS will obtain an address for where the child will live. This address will be entered into the TennCare database, and a Request for Information will be sent to the child/youth at the address provided. The Request for Information (a green application) must be completed for the child/youth and provided to DHS. DHS will then keep the TennCare eligibility open until that Request for Information application is processed and eligibility is redetermined.

Initial EPSDT TENNderCare appointment

Policy (EPSDT 20.7) requires that the child be taken for a screening within 30 days of entry into care; appointments are made as soon as feasible, but not later than 7 calendar days after the child's entry into care. The family service workers requests immunization records, and information regarding immunization, as well as the Well Being history and information form is provided to the child's placement/caretaker.

EPSDT screenings are provided by the state Health Departments (available in each county) or designated providers who are knowledgeable about foster care and Medicaid requirements of EPSDT screening components.

Under Federal EPSDT regulations, screening visits consist of a comprehensive health and developmental history, an unclothed physical exam, vision and hearing screenings, appropriate immunizations, laboratory tests, and health education. The purpose of these visits is to identify physical, mental, or developmental problems and risks as early as possible and to link children to needed diagnostic and treatment services.

The Pediatric Symptom checklist (PSC) and the PEDS are incorporated into the above initial screening provided through the Department of Health or designated providers. A summary sheet indicating the completed components of the screening, and findings of the screening, is provided by the Health Department or designated provider to the child's assigned PCP (primary care provider) with a copy to the Department's Well Being team.

The regional Well Being team member (nurse) reviews the completed components and findings of the screening, making specific recommendations for follow up care identified to the family service worker. The FSW should provide the results of the EPSDT and the identified follow up services with the child's placement/caretaker to coordinate these health services.

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Note that Components not completed generally include immunizations (when those records are not yet available to DCS or the EPSDT provider) and instances when a component is not completed due to illness related to the screening element. Children are referred for services relating to screening components that were not completed (i.e. child had ear infection; referral is made and then hearing screening was completed).

Annual EPSDT

Policy (EPSDT 20.7) requires that children receive EPSDT according to the periodicity schedule. EPSDT screenings are scheduled and accessed according to the periodicity schedule of the EPSDT program at least annually, and as required for children under 2. Reports are provided to regional DCS programs monthly of all children who have a screening that will be needed in the next 60 days, as well as a report of children who have/have not met their annual screening.

Dental Screenings

Policy (Dental 20.12) requires that children three (3) and older receive an initial dental examination by a dentist within 30 days of coming into custody unless the child/youth has had a dental exam within the last 6 months. DCS coordinates with Doral Dental to ascertain past dental care. Each child/youth in DCS custody who is three (3) years of age or older must receive a dental examination and cleaning every six (6) months or as recommended by a dentist. Young children, age six months to three years or age, can be seen by a dentist if they need an oral health assessment or if an oral health problem is suspected.

Mental Health Assessment

If a child presents with mental health concerns an appointment for a mental health assessment should be made with a clinician or a community mental health center. The EPSDT TENNderCare screening may identify a mental health concern, or the CFTM or the caregiver may identify this. The mental health assessment serves as a more focused EPSDT TENNderCare screening for mental health services, and is an important first step in the determination of mental health services. Recommended services should be coordinated with the serving agency.

Health Services Confirmation and Follow Up Form Documentation of Health Services Follow UP services

When a child receives any type of health service (*except for the EPSDT screening*), the Health Services Confirmation and Follow up form (CS-0689), should be given to the TennCare provider with a request that the form be completed or the information provided.

DCS tracks services received, and additional services needed, through the Health Services Confirmation and Follow Up form. All services can be documented on this form: medical, dental, and behavioral.

DCS contract agencies should request TennCare providers complete the form on children receiving services, and provide the form to DCS. This can be provided to the FSW or faxed directly to the DCS regional SAT coordinator in the Well Being division. The Regional SAT Coordinator will ensure that the information is input into the current child welfare information system/SAT, and provided to the DCS case manager.

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The Health Confirmation and Follow up form allows a provider to indicate follow up services identified. The cycle of identifying health services, and confirming a child's access to health services, continues as indicated in this tracking process.

This completed form or information should be provided to
The form may be used to provide information to Contract Agencies, foster parents, and DCS about the services received by children in their care.

The FSW should print and provide to the placement/caregiver a copy of the Client Health Summary from the current child welfare information system when face to face visits are made. This summary provides all health services that have been entered into the current child welfare information system, and serves as a health passport.

Access and Advocacy

Well Being Teams in the Tennessee child welfare program serve to support family service workers, resource parents, and DCS contract agency providers with recommendations and technical assistance for children and families served by DCS (Department of Children's Services). The supports provided by the Well Being teams work collaboratively to reinforce permanency and safety.

Each of the 12 DCS regions has a Well Being team, which includes the following staff:

- ✓ Psychologist
- ✓ Nurse
- ✓ Health Advocate Representative
- ✓ Services and Appeals tracking coordinator
- ✓ Interdependent Living Specialist
- ✓ Educational Specialist
- ✓ CANS (Child Adolescent Needs & Strengths) Field Assessor
- ✓ MSW (Masters of Social Work)

Well Being teams are responsible programmatically for the system of support for well being services in their region. They provide targeted technical assistance on specific cases from pre-custodial stages through transition to permanency. They serve as consultants on cases where the treatment, educational, or transition needs require specialized assistance.

Well Being teams also make referrals to the COEs (Centers of Excellence) for assessments, as well as guidance in the development of treatment planning.

DCS contract provider agencies may contact Health Advocacy units to coordinate care or for technical assistance.

Well Being Triage

Interdisciplinary Triage Review

Well Being teams meet weekly or bi-weekly (*depending on size and regional needs*) regarding the children that have entered care in their region. All disciplines of the well being team are included in this interdisciplinary review of the child and their presenting needs.

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The FSW and TL (team leader, supervisor of the FSW) are included in the meeting, which is made available telephonically. The team is informed of additional information which has been received, and a determination about the need for additional information is also addressed.

Recommendations about treatment needs health needs, placement, educational needs and interdependent status are discussed, and action steps are assigned. For example, follow up to a school for records, and managing a prescription refill might be issues identified as action steps.

These recommendations should be included in the CFTM and coordinated with the placement/caregiver.

Care Coordination for Children in Custody Receiving Inpatient Psychiatric Services

DCS coordinates inpatient psychiatric hospitalization with TennCare Select. DCS is notified when children in custody are authorized for a hospital stay so that informed consent and discharge planning may be coordinated.

Children admitted for psychiatric care are presumed to be returning to their placement. DCS contract agencies should coordinate care with the acute facility and DCS. Contract agencies should ensure that the child has clothing, and that persons authorized to visit have the information about visitation made available to them. Contract Agencies should coordinate as needed with the DCS case manager and Well Being team.

Private Insurance: Coordinating Health Care When a Child Has Other Insurance in Addition to TennCare

When a child has private insurance, the other insurance benefits must be coordinated with TennCare. TennCare is the “payor of last resort.” Other insurance is primary to TennCare. It is best if the child accesses a PCP or other providers that take both the primary insurance and TennCare Select. If this is not possible, it is necessary to go to the primary carrier’s PCP or provider, and that provider will need to bill TennCare for the difference in any payment, equal to what TennCare Select would have paid. The provider cannot set aside what TennCare Select would have allowed and accept payment for the difference between what the primary insurance paid and the billed amount. That is considered Medicaid fraud.

Child and Family Team Meetings: Permanency Planning

- ***Notice Provisions***

Child and Family Team Meetings

The Child and Family Team meetings are the primary decision-making and case-planning tool used by all case management staff. (Policy 31.7)

Child and family team meetings are held for the purposes of developing the permanency plan. The DCS contract agency serving a custodial child is a team member and should be included in CFTM meetings. Policy 31.7 provides details regarding the CFTM process and guidelines.

Placement decisions are made at Child and Family Team meetings

Child and Family Team Meetings (CFTM) are held to determine service needs for children in DCS custody, including placement. The placement may be residential care that is a DCS-

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administered TennCare covered services. As indicated earlier, a TennCare funded behavioral health service to be provided by a DCS contract agency requires a Notice of Action to effectuate TennCare appeal rights.

Residential services that are DCS-administered TennCare services are as follows:

- Foster Care Medically Fragile
- Level 2 Continuum Foster Care
- Level 2
- Level 2 Continuum
- Level 2 Special Needs
- Level 2 Special Population
- Level 3
- Level 3 Continuum
- Level 3 Continuum Special Needs
- Level 4
- Level 4 Special Needs
- Interdependent Living

Persons attending CFTM when placement decision is to be made

When a placement decision will be discussed, the following persons must be invited to attend the CFTM:

- Child if over 14
- Biological parent (s) *if no TPR*
- Guardian
- Foster parent
- Child's attorney or Guardian ad Litem
- Residential Service Provider.

Note that any member of the child and family team may initiate a CFTM to address an issue or concern that has arisen. The purpose of this CFTM is to pull together only the members of the child and family team necessary to address the concern(s). (Policy 31.7)

Notice of Action regarding DCS administered TennCare Services

A Notice of Action setting forth the determination made regarding placement must be provided to each of the persons indicated above where a placement determination is discussed.

The facilitator of the CFTM shall provide to all participants of the CFTM, at any CFTM when placement services are discussed, a copy of the template Notice of Action, with the TennCare Appeal form attachment. The CFTM summary requires that participants sign indicating that they have received the TennCare Appeals information.

The facilitator must inform the participants that they have a right to appeal a determination made about a residential service. The facilitator must inform the participants that a completed Notice of Action specific to the determination made in the CFTM will be provided to the participants after the meeting.

The facilitator should make sure that addresses of all participants are obtained, and this information is provided to case managers for entry into the current child welfare information

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system. Addresses of all participants should be entered into the current child welfare information system to ensure that the Notice of Action can be sent following the CFTM.

Notices of Action are completed in the current child welfare information system, and mailed to the NOA participants from Central Office NOA.

Notice of Action is provided to TennCare Consumer Advocates

Special Grier provisions require that notices be provided to TennCare Consumer Advocates to review and determine whether appeals should be filed on behalf of children to ensure the timely receipt of TennCare services. Advocates receive notice of NOAs that are available in the current child welfare information system, and are provided access to the Permanency Plan for children for whom an NOA is generated. Under the TennCare agreement and Grier provisions, the Advocacy Contractor will conduct a substantive review of procedures followed and services rendered, and will monitor implementation of the determined services and may file an appeal as needed to effectuate the rights of the child.

Special Grier provisions also require that the TennCare Consumer Advocates receive the Serious Incident Reports (SIRs) and Monthly Treatment plans for children in Continuum provider placements. Currently the Serious Incident reports are provided electronically through the child welfare tracking system. Agencies do not have to send Incident Reports to Advocates. They receive them electronically.

Right to appeal DCS administered TennCare Service

Those receiving a *Notice of Action* may appeal the action by filing a *TennCare Medical Care Appeal* form, which will be sent to the TennCare Solutions Team. Appeals must be made to the TennCare Solutions unit within thirty (30) days of the notice to deny, delay, reduce, suspend or discontinue. The TennCare Medical Appeal form can be found at: <http://www.tn.gov/tenncare/mem-appeal.html>.

Advocacy for TennCare Health Services: Filing Appeals for children in custody

TennCare provides all medically necessary services for children. These services are administered through the Managed Care companies, and included medical, behavioral, pharmacy, and dental services.

If a DCS contract agency provider has concerns regarding access to a TennCare service, they may contact the DCS Well Being Health Advocate Representative for technical assistance. The Health Advocate Representative will coordinate with the TennCare Managed Care Company and will file an appeal as needed.

When a TennCare managed care company denies, reduces, suspends, terminates, or discontinues a TennCare service, a written notice should be provided. For children in DCS custody, these TennCare notices of adverse action should be sent to the Central Office Health Advocacy division by the TennCare Managed Care Companies. DCS then follows up and files an appeal if the service has not been received. If a DCS contract agency receives a Notice of Adverse Action, please notify the applicable regional well being health advocate representative so a TennCare appeal may be filed.

Retaliatory Actions Prohibited

Individuals involved with children/youth in care are encouraged to exercise their right to appeal. DCS employees are strictly prohibited, under any circumstances, from taking any action or threatening to take any action whatsoever against an individual based upon that individual's filing of an appeal.

When appeals are filed on behalf of a child in custody

The Regional Well Being Health Advocate Representative coordinates all TennCare appeals within the region, both in filing appeals, and in responding to appeals filed regarding DCS TennCare funded residential behavioral services.

The Well Being Health Advocate Representative will contact the DCS contract agency as needed to coordinate the response.

Referrals to Legal counsel for children in Care

DCS maintains a contract for the provision of legal services related to TennCare appeals for custodial children.

Legal services are provided related to the resolution or preparation of a hearing resulting from a TennCare Appeal through the Tennessee Association of Legal Services.

The Legal Contractor may request any additional assessment information as needed to provide legal representation and to otherwise effectuate the rights of the child/youth. DCS contract agencies shall reasonably cooperate with the Legal Contractor in providing records and testimony as reasonably needed by the Legal Contractor to provide legal representation and to otherwise effectuate the rights of the child/youth.

Appeal of Child & Family Team Meeting (CFTM) Decision

The Child and Family Team Meeting (CFTM) model is the main decision-making tool used by the Department, private provider agencies and families to review and discuss case management related issues. It is possible that disagreements could occur regarding decisions made by the team. A protocol for the appeal of CFTM decisions has been developed to address this issue. If Child and Family Teams are functioning as they should, *it will rarely be necessary to appeal CFTM decisions.*

It is the intent of the Department to maintain the integrity, structure and decision-making authority within the Child and Family Team. Effective teaming requires that every team member's perspective is heard and considered before a consensus is reached. This consensus indicates a resolution that can be conditionally endorsed by all team members, but does not necessarily reflect each individual team member's opinion. However, if a decision is made by the team that is contrary to what a provider believes to be in the best interest of the child, the provider may appeal that decision. Regions also will have the right to appeal a decision made by a provider that is contrary to the CFTM decision-making. Providers will not be penalized for exercising this appeal right.

The appeal of a CFTM decision can be requested to resolve the following issues *only*:

- A child's type of placement;
- A child's level of care; and,
- Continuation of a child's current services.

Families and private provider agencies will continue to have the right to appeal CFTM decisions through the TNCARE appeal process as defined by Grier V. Betts.

Each child will remain in his or her current placement throughout the appeal process, and all members of the team must understand the placement plan before leaving the meeting.

Provider Appeal Process - Regional Level

The provider must document their contention that the CFTM decision is contrary to the best interest of the child and family by using the Request for Appeal form. In order to ensure an efficient review of matters relating to a child, the following procedure will be followed:

1. The provider's intention to appeal should be announced to the team before the meeting is concluded. However, all parties will be afforded one (1), 24-hour business day cycle after the adjourning of the CFTM in which to lodge their request for appeal. The provider will contact the CFTM facilitator. If the CFTM did not require a facilitator, the Family Service Worker (FSW) for the case will be contacted.
2. Within one (1) business day of the CFTM, the facilitator (or if the facilitator is not present, the FSW) will notify the Team Coordinator (TC) for the case that an appeal has been requested. The TC will then contact the provider either in person or by conference call.

If the issue can be resolved, the TC will communicate the decision to the CFTM members associated with the case. The TC and Team Leader (TL) will ensure the implementation of the decision via the FSW.

3. If, after two (2) business days, resolution cannot be reached at the TC level, the Deputy Regional Administrator or the RA should then be engaged. The Deputy RA or RA then will have two (2) business days in which to conduct a review of the case which includes contact with the provider agency making the appeal.

If resolution is reached at this level, the Deputy RA/RA will communicate the decision to the TC and in writing to the provider agency. The TC will then inform the CFTM members associated with the case. The TC will ensure the implementation of the decision via the FSW.

***Note:** The Deputy RA or Regional Administrator may not delegate this responsibility unless there are unique and extenuating circumstances that prevent him/her from overseeing the review. In such a case, the Executive Director for Regional Support for that area of the state would either review the case themselves or identify the

appropriate Director-level staff within DCS to complete the review and oversee the resolution of the issue. The time frame of two (2) business days for completion of review by the RA is unchanged in this circumstance.

If all the above-outlined steps in the regional process fail to produce a resolution, the provider may initiate further review in the form of a state level appeal. The procedure for this process is outlined below.

Regional Appeal Process

The region must document their contention that the CFTM decision is contrary to the best interest of the child and family by using the Request for Appeal form. In order to ensure an efficient review of matters relating to a child, the following procedure will be followed:

1. The region's intention to appeal should be announced to the team before the meeting is concluded. However, all parties will be afforded one (1), 24-hour business day cycle after the adjourning of the CFTM in which to lodge their request for appeal. The region will contact the CFTM facilitator. If the CFTM did not require a facilitator, the Family Service Worker (FSW) for the case will be contacted.
2. Within one (1) business day of the CFTM, the facilitator (or if the facilitator is not present, the FSW) will notify the Team Coordinator (TC) for the case that an appeal has been requested. The TC will then consult with the RA on the appeal to the provider's decision. The RA will have two business days to review the information and convene a discussion with the provider regarding the provider's decision.
3. If the meeting does not conclude satisfactorily the RA can appeal to Central Office for a decision utilizing the same appeals process afforded to providers.

Appeal Process - State Level

This process will allow a CFTM decision to be reviewed by a Central Office multidisciplinary team. The Central Office multidisciplinary team's decision is final and all parties will comply with the recommendations. The Central Office multidisciplinary team will comprise of the: DCS Child Psychiatrist, Director of CPPP, Director of Foster Care and Adoption and Director of Child Permanency or their designees.

The steps for requesting and conducting a State Level Appeal are as follows:

1. The private provider/region must notify the CFTM facilitator (or the FSW assigned to the case in question) of their intention to request a State Level Appeal immediately after the Regional Appeal is completed.
2. The provider/region will forward the Request for Appeal and supporting documentation to the CPPP PBC Assistant Director and the Team Leader of the DCS Family Services Worker assigned to the case. This must be submitted within two (2) business days of the regional and private provider agency appeal meeting. The Team Leader will ensure either the Regional Administrator or the Executive Director for Regional Support as well as the Family Services Worker receives a copy of the Request for Appeal including all supporting documentation. The Team Leader will also ensure that any additional case-related information is forwarded to the Assistant Director of PBC within one (1) business day from receipt of the Request for Appeal.
3. The PBC Assistant Director will review the materials submitted and send to the Central Office multidisciplinary team.
4. During this appeal, the Central Office multidisciplinary team will review the materials submitted, hear both the Department and the private provider agency's position and make a determination. This decision will be made verbally during the meeting and followed up with a written explanation via the last section of the Request for Appeal form.
5. The DCS representative will notify the Family Service Worker of the results of the appeal. The FSW will then notify all members of the team of the outcome of the appeal.
6. Information gathered through the appeals process will be shared with the Director of Permanency and Planning for ongoing training and development of the CFT.

DCS reserves the right to reconsider appeal decisions made through the above process at the request of the DCS Commissioner.

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The Child and Family Team Meeting (CFTM) model is the main decision-making tool used by the Department, private provider agencies and families to review and discuss case management related issues. It is possible that disagreements could occur regarding decisions made by the team. A protocol for the appeal of CFTM decisions has been developed to address this issue. If Child and Family Teams are functioning as they should, *it will rarely be necessary to appeal CFTM decisions.*

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The appeal of a CFTM decision can be requested to resolve the following issues *only*:

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- Continuation of a child's current services.

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Each child will remain in his or her current placement throughout the appeal process, and all members of the team must understand the placement plan before leaving the meeting.

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The provider must document their contention that the CFTM decision is contrary to the best interest of the child and family by using the Request for Appeal form. In order to ensure an efficient review of matters relating to a child, the following procedure will be followed:

1. The provider's intention to appeal should be announced to the team before the meeting is concluded. However, all parties will be afforded one (1), 24-hour business day cycle after the adjourning of the CFTM in which to lodge their request for appeal. The provider will contact the CFTM facilitator. If the CFTM did not require a facilitator, the Family Service Worker (FSW) for the case will be contacted.
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appropriate Director-level staff within DCS to complete the review and oversee the resolution of the issue. The time frame of two (2) business days for completion of review by the RA is unchanged in this circumstance.

If all the above-outlined steps in the regional process fail to produce a resolution, the provider may initiate further review in the form of a state level appeal. The procedure for this process is outlined below.

Regional Appeal Process

The region must document their contention that the CFTM decision is contrary to the best interest of the child and family by using the Request for Appeal form. In order to ensure an efficient review of matters relating to a child, the following procedure will be followed:

1. The region's intention to appeal should be announced to the team before the meeting is concluded. However, all parties will be afforded one (1), 24-hour business day cycle after the adjourning of the CFTM in which to lodge their request for appeal. The region will contact the CFTM facilitator. If the CFTM did not require a facilitator, the Family Service Worker (FSW) for the case will be contacted.
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3. If the meeting does not conclude satisfactorily the RA can appeal to Central Office for a decision utilizing the same appeals process afforded to providers.

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This process will allow a CFTM decision to be reviewed by a Central Office multidisciplinary team. The Central Office multidisciplinary team's decision is final and all parties will comply with the recommendations. The Central Office multidisciplinary team will comprise of the: DCS Child Psychiatrist, Director of CPPP, Director of Foster Care and Adoption and Director of Child Permanency or their designees.

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2. The provider/region will forward the Request for Appeal and supporting documentation to the CPPP PBC Assistant Director and the Team Leader of the DCS Family Services Worker assigned to the case. This must be submitted within two (2) business days of the regional and private provider agency appeal meeting. The Team Leader will ensure either the Regional Administrator or the Executive Director for Regional Support as well as the Family Services Worker receives a copy of the Request for Appeal including all supporting documentation. The Team Leader will also ensure that any additional case-related information is forwarded to the Assistant Director of PBC within one (1) business day from receipt of the Request for Appeal.
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6. Information gathered through the appeals process will be shared with the Director of Permanency and Planning for ongoing training and development of the CFT.

DCS reserves the right to reconsider appeal decisions made through the above process at the request of the DCS Commissioner.

LICENSURE MATRIX

The following is a list of residential program settings licensed to serve children and youth within the State of Tennessee. This list is simply a guideline provided to assist you in determining the correct license type for your program. Please note it is the responsibility of each vendor to coordinate with the appropriate licensing entity to ensure proper licensing is obtained for each program site; including sub-contracted sites. Verification of appropriate licensing must be submitted prior to contract.

Please contact the following offices with any questions regarding licensing requirements:

DCS Education Division	(615) 741-9211
DCS Division of Licensing	(615) 532-5640
MHDD Office of Licensure	(615) 532-6590

Setting	Type of License/Link to Standards	Licensing Agency	Education
Residential Program serving 1-6 children (Non-Mental Health)	Family Boarding Home http://www.state.tn.us/sos/rules/0250/0250-04/0250-04-02.pdf	DCS	Public School
Residential Program serving 7-12 children (Non-Mental Health)	Group Care Home http://www.state.tn.us/sos/rules/0250/0250-04/0250-04-02.pdf	DCS	Public School and access to approved in-house school site* that will not necessitate a placement move.
Residential Program utilizing individual resource homes and/or any combination of Group Care Homes and Family Boarding Homes	Child Placing Agency http://www.state.tn.us/sos/rules/0250/0250-04/0250-04-09.pdf	DCS	Public School and access to approved in-house school site* that will not necessitate a placement move.
Residential Program serving 13 or more children (Non-Mental Health). Applies also to smaller programs on contiguous properties where total combined population exceeds 12	Residential Child Care Agency http://www.state.tn.us/sos/rules/0250/0250-04/0250-04-05.pdf	DCS	Public School and access to approved in-house school site* that will not necessitate a placement move.
Any residential program serving more than 1 pregnant youth (may be a supplemental license)	Maternity Home http://www.state.tn.us/sos/rules/0250/0250-04/0250-04-07.pdf	DCS	Public School
Juvenile Detention Center	Juvenile Detention Center http://www.state.tn.us/sos/rules/1400/1400-03.pdf	DCS	Program must provide education benefit. Must notify local school system of special education students.
Mental Health Residential Treatment Program (Non-Hospital Setting)	Residential Treatment Facility http://www.state.tn.us/sos/rules/0940/0940-05/0940-05-37.pdf	MHDD	Approved in-house school site*.
Mental Health Residential Treatment Program (Hospital Classification)	Mental Health Hospital Facility http://www.state.tn.us/sos/rules/0940/0940-05/0940-05-16.pdf	MHDD	Approved in-house school site*.
Alcohol and Drug Treatment Facility	Residential Rehabilitation Treatment Facility http://www.state.tn.us/sos/rules/0940/0940-05/0940-05-45.pdf	MHDD	Approved in-house school site*.
Residential Program serving MR students in a community setting	Mental Retardation Residential Habilitation Facility http://www.state.tn.us/sos/rules/0940/0940-05/0940-05-24.pdf	MHDD	Approved in-house school site*.

***Approved in-house school site** is a non-public school approved by Tennessee Department of Education as a Category 1, 2, 3, or 7 that is also recognized the DCS Education Division.

EDUCATIONAL STANDARDS FOR DCS PROVIDERS

DCS Policy 21.14 Serving the Educational Needs of the Child/Youth

<http://www.tn.gov/youth/dcsguide/policies/chap21/21.14.pdf>

DCS Policy 21.16 Rights of Foster Child with Disabilities and IDEA

<http://www.tn.gov/youth/dcsguide/policies/chap21/21.16.pdf>

DCS Policy 21.18 Notification to School Principals of Certain Delinquency Adjudications

<http://www.tn.gov/youth/dcsguide/policies/chap21/21.18.pdf>

DCS Policy 21.19 Education Passport

<http://www.state.tn.us/youth/dcsguide/policies/chap21/21.19.pdf>

DCS Policy 21.20 Non-traditional Educational Settings

<http://www.tn.gov/youth/dcsguide/policies/chap21/21.20.pdf>

A. Needs Assessment--The provider will ensure that the educational needs of students are thoroughly assessed.

Commentary: The provider will obtain and review previous educational records for each student. Children who are eligible for special educational services must be identified, and the agency must ensure that those services are provided.

B. Enrollment in Local Schools Systems--The provider will ensure that children and youth will be enrolled in the local school system rather than an in-house school as defined in departmental policy (DCS Policy 21.20).

Commentary: There is a presumption that children in state custody should be educated in the public schools whenever possible. Children and youth who have an identified and documented treatment need that prohibits placement in public school may attend an in-house educational program in a contracted treatment center for a short period of time. Regular reviews of the students' progress should be conducted so that they may return to public school at the appropriate time.

C. Records Transfers and School Changes--The provider will develop a process to ensure a quick transfer of records, information, and individual support when children change schools.

Commentary: A quick transfer of records from one school to another is vital to the new school. When records are delayed or not sent, students may be placed in inappropriate classes, may not receive credit for work completed, may be forced to repeat classes and state-mandated tests, and may not receive special education services.

D. Changes in Educational Placement--The provider will monitor and limit changes in a student's educational placement in order to avoid disruptions in the learning process.

Commentary: "School mobility has been shown to have a significant negative effect on children's academic progress and opportunities for educational success." Legal Center for Foster Care and Education, *Fact Sheet: Educational Stability and Continuity for Children and Youth in Out-of-Home- Care* (Washington, D.C.: American Bar Association, 2007).

E. Enabling Success in School--The provider will use clinical experts and other student support providers to work to enable a child’s success in school.

Commentary: Many students in custody in DCS schools or contracted in-house schools have needs that require them to see professional clinicians (or other support providers) in order to make progress toward returning home and attending public schools. Since students spend a great deal of time in school, staff should understand the needs of students, should have assistance in handling these needs, and should realize that these needs will likely manifest themselves in the classroom. Both students and staff should have access to trained professionals and other support staff to help them deal with difficult issues.

F. Supporting Learning Needs The provider will use school-based and school-focused services to support the specific learning and transitional needs of children in custody.

Commentary: Students in the care of the Department of Children’s Services may at times need additional support services in order to function effectively in the public schools. DCS is committed to working in collaboration with local school systems to benefit the students in its care.

G. Parental Involvement in Educational Planning The provider will ensure that parents/guardians are involved in the educational planning and educational activities of students.

Commentary: Unless the court has terminated parental rights, a student’s parents are to be involved in the planning of the child’s education program. This is a “best practice” since reunification is often the goal for students in custody. In addition, both federal and state laws require parents to be invited by the school to participate in meetings for students eligible to receive special education services.

H. Behavioral Problems

Commentary: When notified by a resource parent that a child/youth is having behavioral problems at home and/or school significant enough to cause a future disruption of the child/youth’s placement, the family services worker must contact the DCS Well-Being Unit immediately to request assistance in obtaining in-home wraparound services for the child/youth and resource family. TennCare refers to these services as intensive mental health case management, CTT (Continuous Treatment Team), or CCFT (Comprehensive Child and Family Treatment), and they are available to children/youth in DCS custody who are in Level 2 placements or below. For recurring public school discipline problems (10 days or more day of out of school suspensions in one school year), the regional DCS education specialist or DCS education attorney may also be contacted for assistance.

I. Suspension/Expulsion from Public School

Commentary: When a child in DCS custody is suspended for ten (10) or more days, the regional DCS education specialist should be consulted for assistance. DCS is committed to ensure all custodial children receive educational services and continue with their pre-custodial educational goals. It is the responsibility of all involved parties to support each child’s school placement and educational plan.

1. In the rare instance that a child/youth has been excluded from public school and cannot be readmitted in another public school setting (such as in zero-tolerance instances), a CFTM shall be convened within but no later than five (5) calendar days and **must** include the regional DCS education specialist. At this meeting, alternative education arrangements shall be developed for the child. This will include delegation of case management tasks and a fiscal plan to ensure payment for all educational services.
2. If the child receives special education services or Section 504 accommodations and is suspended for 10 or more days, notify and involve the regional DCS education specialist.

3. If the child/youth is moved to another placement location without the convening a CFTM or without the consensus of the CFTM, DCS shall not reimburse the provider for the costs of the educational arrangement (if applicable) until a CFTM is held and consensus is achieved.
4. The agency will document all contacts to the FSW to request a CFTM. Documentation will be copies of faxed or emailed requests.
5. Upon return to public school, state law requires that certain adjudications be reported to school principals. See Policy 21.18 *Notification to School Principals of Certain Delinquency Adjudications* for a list of reportable offenses and for the procedures for notifying principals.

J. Provider Agency and DCS In-house School Placement/Attendance

1. Determination of placement

The child/youth's treatment plan must document treatment needs that would interfere with public school attendance. The following reasons are some examples of why a child/youth would be unable to attend public school and consequently need to be served in an in-house school:

- current identified alcohol and drug treatment issues that require a self-contained treatment program;
- identified sexual offending treatment issues that require a self-contained program;
- zero-tolerance issues that prohibit enrollment despite involvement and efforts of the educational specialist and/or the DCS attorney;
- placement in wilderness programs in which the treatment regime is so integrally related to the educational program that attendance at public school would disrupt treatment;
- a crisis requiring intensive supervision due to community or child-safety treatment needs, or a crisis such that the child is at imminent risk of disruption of placement; or
- public school placement would cause the youth to lose academic credits (such determination will be made through a CFTM and will include a best interest of the child analysis)

2. Procedures for in-house school attendance

- If the child/youth requires an in-house educational program, the child/youth may be in that educational setting up to thirty (30) total days.
- Prior to the end of the thirty (30) day limit, the agency where the child is attending school must contact the child's educational specialist to convene a staffing. The staffing may include the DCS family services worker, agency representative(s), the resource parents, any individual with educational rights, a DCS attorney, a Well-Being Unit staff member, and other professionals as necessary and appropriate. In-house school staff must invite a representative from the local education agency. A target date for entry into public school will be established. The DCS staffing team will have the responsibility for reviewing the child's progress in order to enroll the child in public school at the earliest possible date.
- During the staffing, a consensus should be reached regarding the educational services that would best meet the needs of the child/youth and his/her treatment plan. If the consensus indicates that the child/youth should continue to receive services at an in-house school or other alternative to public school, the treatment team will establish the specific treatment issues that require the child/youth to be in the in-house school and provide a review and target date for completion of the treatment and projected date for transition to public school. The reasons for such placement and the goals of such educational services must be included in the documentation along with an expected duration or time frame.
- If no consensus regarding the most appropriate educational setting is reached during the staffing, the FSW and the education specialist will, within three (3) days of the meeting, present the case

directly to the regional administrator for a decision. NOTE: When a child is being considered for placement in public school, the CFTM should determine if the child has any of the adjudications listed in DCS Policy 21.18 that would require a notification to the public school. The CFTM should consult the regional education specialist before placing any student with these adjudications in public school.

K. In-house School Requirements When circumstances require student enrollment in an in-house school, the provider will ensure that the educational program is substantially similar to that provided to other students in the school district.

Commentary: Students in contracted in-house schools must be able to continue to make progress toward graduation with a GED, a regular diploma, a diploma of specialized education, or a high school certificate. In order to do so, the contracted in-house school must provide an educational program that is approved by the Tennessee State Department of Education (DOE) and is recognized by DCS to offer educational services to students in its custody. All new schools will complete an In-House School Proposal. Thereafter, each school will complete an In-House School Compliance Document to demonstrate continued compliance with the specified educational standards. These standards include, but are not limited to, the following:

1. All in-house schools will be approved by the Tennessee State Department of Education (DOE) as Category I, II, or III, VII.
2. All teachers will be qualified according to state requirements, and at least one full-time special educator shall be among the teaching staff.
3. Direct service providers in the on-grounds school will have
 - educational and experiential backgrounds that enable them to participate in the overall treatment program and to meet the emotional and developmental needs of the children served; and
 - personal characteristics and temperament suitable for working with children with special needs.
4. Educational personnel will facilitate school transfers and provide consultation as needed to professionals in off-campus educational settings. Each school will have one staff member designated as “school liaison” having the following duties:

To Assist the In-House School

- Meet with newly arriving students to determine educational history
- Assist in collecting and transferring student’s educational records
- Assist student’s treatment team to plan appropriate educational placement and objectives
- Train other facility staff in areas related to education
- Document student’s educational progress regularly in both the on-site school and public school (credits, transcripts, report cards, IEPs)
- Assist students in accessing community and educational resources outside of the formal school setting
- Request DCS to schedule necessary Child and Family Team Meetings (CFTMs) to meet Brian A. requirements

To Assist the Public Schools

- Serve as contact for public schools
- Assist in collecting and transferring student’s educational records
- Assist public schools in developing IEPs, behavior management plans, and crisis intervention plans
- Act as curriculum advisor for students transferring to public school
- Attend all meetings involving the student’s education
- Contact regional educational specialist if disciplinary hearings are held in the LEA and if a student is suspended/expelled for 10 or more days.
- Become familiar with local school board policies and procedures that will impact students
- Attend professional conferences as required or as needed

5. Educational plans will be developed for each student and will be coordinated in a manner that maximizes the impact on his/her educational and treatment goals.
6. The agency will identify a public school liaison and a process for interaction with the public schools focusing on the development of good relationships and effective communication with the local school system.
7. Educational texts and curriculum materials shall be current, state approved, and rotated at regular intervals.
8. The organization will provide students with an educational program designed to lead to a Tennessee high school diploma or General Equivalency Diploma (GED).
9. The organization will provide or arrange tutoring, mentoring, and college preparation, as necessary.
10. The school will provide
 - 6.5-hour school day as required by the Tennessee State Department of Education, and
 - a school schedule that will allow a high school student to earn at least five (5) credits during a given school year.
11. Teachers in the on-grounds school will receive a minimum of thirty (30) hours per year of approved in-service activities as required by the Tennessee Department of Education.
12. Teachers in the on-grounds school will be evaluated using the Framework for Evaluation and Professional Growth as required by the Tennessee State Department of Education in order for teachers to maintain licensure.
13. Students will be provided access to computers and library/research materials comparable to those provided to students in public schools.
14. The on-grounds school will provide a summer school program that includes an academic component.
15. The agency and on-grounds school will provide special education and related services for individual students as required by the Individuals with Disabilities Education Act (IDEA) and the state of Tennessee. For example, the facility and programs will be accessible to students with disabilities; students will be screened upon entry at the agency to determine if they are eligible for special education services; psycho-educational evaluations will be conducted within legal timelines; instructional and related services will be provided to eligible students by appropriately licensed special educators; child-find procedures will be implemented; and trained surrogate parents will be assigned when necessary.
16. Documentation as to compliance with this Section (K) will be provided in the in-house school proposal. Throughout the year, regional educational specialists will conduct monitoring visits at the in-house schools and will file reports with the DCS Education Division. If noncompliance with any of these standards is indicated, the provider will be requested to take immediate steps to correct the deficiency. Failure to address the deficiency may result in an in-house school not being allowed to educate DCS students.

L. Training for Resource Parents/School Liaisons/Family Service Workers

1. Each resource parent is required to have two (2) hours of in-service training per year on education services/issues for the child/youth in DCS custody.
2. Each agency family services worker/DCS family services worker/agency school liaison working in the area of foster care is also required to have two (2) hours of in-service training per year on educational services/issues.
3. Training may be made available through the regional training coordinators and the DCS regional education specialists and DCS education attorneys.

M. Alternative Education Placements

1. The following categories of youths may be eligible for approval of an exception to public school attendance so that they can be enrolled in alternative education programs:
 - youth aged 17 and up who are eligible and for whom it is appropriate to take the GED
 - youth eligible for and desiring enrollment in vocational or journeyman training
 - youth who have graduated from high school or achieved a GED.
2. Home schooling and private school placements may be other alternatives. These are appropriate only under certain situations and may occur only with the permission of the DCS Director of Education. FSWs should notify the regional Educational Specialist when home schooling or private school placement is being considered by a Child and Family Team.

N. Emergency Shelters/Primary Treatment Centers (PTC)

1. If a child/youth is placed in an emergency shelter or a PTC, attempts should be made to keep him/her in his/her former school if doing so is in the child's best interest. The CFTM will determine the child's best interest regarding school placement location.
2. If a child/youth is placed in an emergency shelter and is not able to attend public school, this time period (30 days for a shelter) must be used as an educational assessment period by the agency. The agency's staff in conjunction with the school liaison will develop an education plan to allow the child/youth to complete remedial or ongoing schoolwork during the remainder of his/her stay.
3. At the end of the placement in the emergency shelter, agency staff and DCS education staff will provide to the DCS family services worker any recommendations for future evaluations and educational programs.

O. Education Plan for Children Placed Temporarily

Commentary: If the child/youth is in a temporary, emergency type of placement, it is the department's expectation that the child/youth remain in his/her former school if doing so is in the child's best interest. The local school system is obligated to provide transportation for children falling within the McKinney-Vento Homeless Education Act of 2001. The DCS family services worker, in consultation with any involved agency family services worker, will:

1. advocate for enrollment, transportation (if needed), and other services under McKinney-Vento for those DCS children who are McKinney-Vento eligible;
2. utilize the public school system's McKinney-Vento liaison;
3. seek help from the regional education specialist or DCS attorney if needed;
4. collaborate with school systems and contract providers regarding transportation to ease the burden on the involved school system(s) where feasible;
5. in the event of a dispute with the school, request that the resource parent transport the child back and forth to school until his/her placement is made in a more permanent setting. (If the resource parent is unable for legitimate reasons to transport the student, DCS will provide an alternative.)

P. Availability of Educational Staff and Attorneys--The provider will ensure that educational staff and attorneys are available to assist case management staff in advocating on behalf of students in state custody.

Commentary: Each DCS region has been assigned an educational specialist and an educational attorney to advocate for students in state custody. The educational specialists should be the first contact for agencies that need assistance with any part of a student's educational program. The educational specialists will work in conjunction with the DCS Education Office to ensure that appropriate educational services are provided to all students in custody. As necessary, the educational attorney shall assist students, agencies, and other DCS educational staff with legal issues surrounding the student's instructional program.

INFORMED CONSENT PROVIDER INFORMATION 050608



Healthcare Consent Guidelines for Youth in DCS State Custody

*You are seeing a youth in the legal custody of the Tennessee Department of Children's Services. Unless the parents' rights have been terminated, DCS is merely the legal custodian – **not** the youth's legal parent or guardian. The parent(s) or guardian(s) have the legal authority to determine healthcare when their youth is in DCS custody. DCS policy is to involve the youth's parent or legal guardian in healthcare decision-making for the youth when possible and in the best interest of the youth. The DCS representative who is present at this appointment will be able to inform you of the guardianship status of the youth and persons responsible for making healthcare decisions.*

EMERGENCY HEALTHCARE (medical and behavioral) - The parent/legal guardian, DCS case manager, contract agency caseworker, or foster parent determine consent at the time care is needed. A licensed physician may perform emergency medical or surgical treatment on a youth without consent if the physician has a good faith belief that delay of care would result in serious threat to life or serious worsening of the youth's medical condition.

ROUTINE HEALTHCARE (medical and behavioral) - The parent/legal guardian, DCS staff or foster parent present determine consent (as representative of the legal custodian) for *ordinary and routine care*. *Extraordinary or non-routine* treatment will require the parent/legal guardian to determine care. If the parent/legal guardian is unavailable, DCS staff will consult their legal counsel for assistance in determining appropriate steps for consent. This may involve a hearing in juvenile court for the judge to order the extraordinary or non-routine medical care.

Note - If the youth is 14 years of age or older, Tennessee law presumes that they have the maturity to decide medical care, but this is determined on an individual case basis by the provider.

SURGERY - The parent/legal guardian determines consent. If the legal guardian cannot or will not be available or if termination of parental rights has occurred, then the DCS Regional Nurse has the responsibility of determining consent for *ordinary and routine surgery*. *Extraordinary surgical procedures* will require an order of the juvenile court (if the parent/legal guardian is unavailable or parental rights have been or are being terminated).

PSYCHOTROPIC MEDICATION - The parent/legal guardian determines consent if the youth is less than 16 years of age. The parent/legal guardian or legal custodian for a youth 15 years of age and under can consent to disclosure of the youth's confidential information. DCS has asked that the parent be present for this appointment or available by telephone to decide the care of the youth. If the parent cannot or will not be available to determine consent or if termination or parental rights has occurred or is in process, then the DCS Regional Nurse has the responsibility of determining consent. He or she is available by telephone (the number can be provided to you by the DCS representative present). The appropriate informed consent form may be faxed to him/her (again the number will be provided) for signature prior to initiation of medication usage. **The DCS Regional Nurse, as the representative of the legal custodian and acting in place of the parent**, may contact you with questions concerning diagnosis, nature and purpose of proposed treatment, risks and benefits of proposed treatment, alternative

treatments, risks and benefits of alternative treatment, and risks and benefits of receiving no treatment.

Note - If the youth is 16 years of age or older, he or she has the same rights as adults with respect to outpatient and inpatient mental health treatment medication decisions, and confidential information (TCA 33-8-202). The youth has the right to determine parent involvement, including any use of medication. An outpatient facility or professional may provide treatment and rehabilitation without obtaining the consent of the parent, legal guardian, or legal custodian. We ask that appropriate DCS documents indicating the youth's consent to treatment be forwarded to the DCS Regional Nurse or Youth Development Center Nurse for tracking purposes.

EXCEPTIONS to parent/legal guardian/legal custodian determination of medical care

- Youth 16 years of age or older for mental health treatment
- “Mature” 14 year old youth, determined on individual case basis by provider
- Treatment of juvenile drug abuse, a physician may use his/her own discretion in notification of the youth's parents
- Prenatal care of a minor, a physician may use his/her discretion in notification of the youth's parents
- Contraceptive supplies and information
- Treatment of sexually transmitted diseases
- Emergency medical or surgical treatment

TREATMENT REFUSAL by parent/legal guardian or youth (14 years of age or older)

You, as the health care provider, in consultation with DCS will determine:

- if the treatment or procedure is medically necessary,
- if the youth may be harmed if he/she does not receive the treatment or procedure, and
- if DCS determines that the treatment is necessary to protect the youth from harm,

THEN DCS will contact the local DCS attorney regarding the need for judicial intervention.

We hope these guidelines are informative and helpful in your care of this youth and we thank you for the clinical services you are providing.

Guide to Search Policy

Provider Level of Care	Search Level Allowed				
	Non-Invasive Searches			Invasive Searches	
	Observation	Visual review of pockets	Wands or metal detectors	Pat Downs	Clothing Search
DETENTION CENTERS	A	A	B, C	B, C	C
PRIMARY TREATMENT CENTERS	A	A	B, C	B, C	
EMERGENCY SHELTERS	A	A			
FOSTER CARE (LEVEL 1)	A	A			
MEDICALLY FRAGILE FOSTER CARE	A	A			
FOSTER CARE THERAPEUTIC	A	A			
INDEPENDENT LIVING	A	A			
LEVEL 2	A	A	B, C		
LEVEL 3	A	A	B, C	B, C	C, D
LEVEL 2 SPECIAL NEEDS	A	A	B		
LEVEL 3 SPECIAL NEEDS	A	A	B	B	
LEVEL 4	A	A	B	B, C, D	C, D
LEVEL 2 SPECIAL POPULATIONS	A	A			E

Search Criteria A: All programs are allowed this level of search at any point.

Search Criteria B: Circumstances in which a child has been out of the range of normal staff or DCS supervision.

Search Criteria C: Pat down searches when the child has had contact with other family members or other children that are not DCS charges or participants in the program in which as child is placed.

Search Criteria D: Searches if a child engages in suspicious activity which would indicate possible concealed contraband.

Search Criteria E: Clothing searches may be performed when warranted by unsupervised contact with persons outside the treatment setting.

DCS PRACTICE MODEL

The Practice Model

- **Family Engagement**

Our work promotes the full participation of families in the child welfare system. Child welfare work, while focused primarily on its legal mandate to ensure child safety, must engage families and be responsive to them. Family-centered and solution focused activities are used. Workers and other staff show genuineness, empathy and respect for families. Communications are honest, straightforward and culturally sensitive. A family's experience of the child welfare system is one of engagement from the first moment that a worker knocks on the family's door to the last interaction at case closure.

- **Teaming**

A team is created or expanded at the inception of a family's child welfare case. The team includes the family, children and youth, their extended network of informal supports, community partners, formal supports and service providers, resource families and child welfare agency staff. The team becomes a cohesive unit whereby all members understand their roles, rely on each other and hold each other accountable. This team moves with a family and child during their involvement in child welfare with membership growing and changing based on family, child and youth needs. Once the child welfare case is closed, the non-child welfare agency team members continue to support the family to reduce the likelihood that the family will again need child protective services.

- **Assessment and Understanding**

Teams work together to discover family and child strengths and underlying needs, risks and safety concerns and future goals. Through this joint discovery process, team members have a clear and shared understanding of the family and child. Assessments can be both formal and informal and information is shared among team members. The assessment process is on-going with new information being used to update team members about progress. The shared understanding of the family promotes a unified, consensus-driven approach to decision-making and planning.

- **Decision-making and Planning**

Teams meet regularly - as needed and at specific points in the child welfare continuum - to make decisions and develop plans thereby ensuring that all information and possibilities have been considered. Planning is focused on providing a clear roadmap for achieving goals and objectives that is known to, understood by and agreed upon through consensus by all team members. Decisions and plans are individualized to match each family's specific strengths, needs, risks and safety concerns.

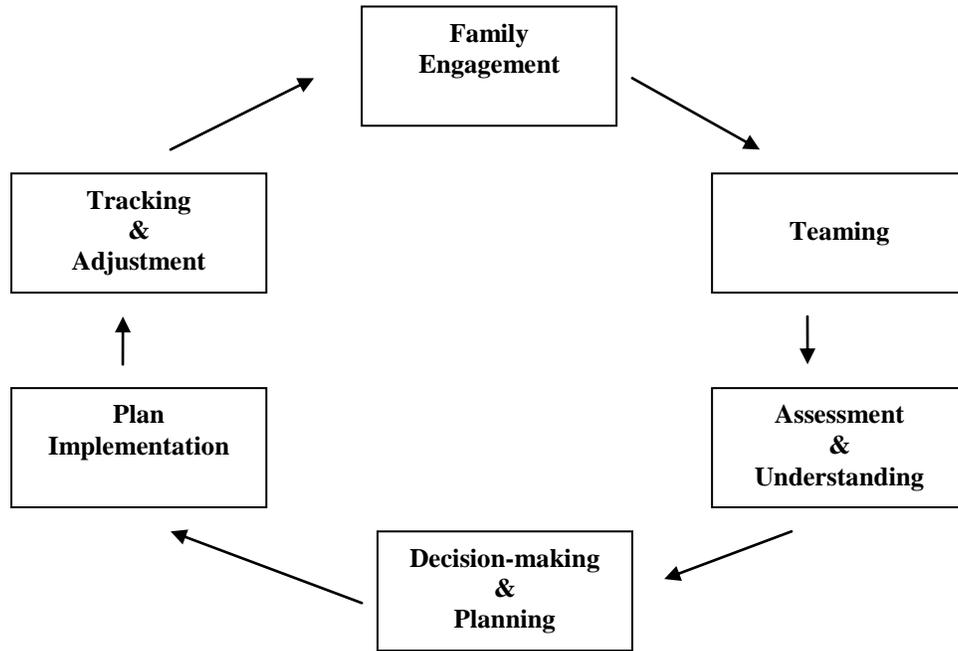
- **Plan Implementation**

The team works together to implement the plan at an intensity and level of competency that will ensure successful safety, permanency and well-being. Team members are responsive in a timely manner to the commitments made during the decision-making and planning meetings. Supports and services remain sequenced and coordinated throughout plan implementation. The team provides on-going support and encouragement to the family.

- **Tracking and Adjustment**

Through the on-going tracking of the plan and its implementation, the team determines and communicates about what's working well and what's not working. Adjustments are made to services and supports to make them more responsive. Team meetings are called as necessary to update the plan based on changing needs and progress.

A visual representation of the practice model is in Figure 1 below.



PACC

PSYCHIATRIC ACUTE CARE COORDINATION (PACC)

The Department has established the following guidelines for provider agencies whenever a child, in the care of a provider, experiences an acute psychiatric hospitalization episode:

- As much as possible ensure that some adult known to the child is present upon admission to the hospital to assure the child's well-being;
- Provide clothing/hygiene needs of child upon admission to hospital;
- Provide any pertinent records to hospital regarding child's current/past medical care;
- Provide ongoing visitation/contact with child during hospital stay;
- Notify DCS case manager of admission; coordinate visitation for child with family or others as appropriate;
- Participate in treatment and discharge planning;
- Make sure that medications dosages and other follow up treatment is understood;
- Coordinate discharge transportation with DCS Case Manager;
- Coordinate hospital follow-up appointments with DCS Case Manager;
- Inform placement of treatment needs and work with placement as needed to integrate child back to daily routine;
- Contact school as needed and coordinate for missed schoolwork.

NOTE:

An acute psychiatric hospitalization episode is not a reason to disrupt a child from his/her placement. All disruptions from a placement MUST be decided within the context of a Child & Family Team Meeting. It is the expectation that the child will return to his/her placement once the child is stabilized.

REGIONAL ADMINISTRATOR (RA) TO RA APPROVAL PROTOCOL

- Provider will contact Region's Placement Gatekeeper when RA to RA approval is needed. Gatekeeper will, in turn, contact the RA of the Region requesting the approval. RA will then contact appropriate RA to give approval. Provider will be notified regarding status of approval. This process will take place within a 24 hour time frame. A three person chain of command will be given to the provider in order to directly contact Regional Representatives if they have not heard back from the Gatekeeper in a timely manner (at least 3 hours). After the 24 hour time frame has transpired and there has been no final response from the Region, the provider will contact Judy Cole or Mildred Lawhorn to seek approval. Providers will supply contact numbers to RA as well in order to facilitate communication.
- A template has been developed to be utilized by provider and Region in order to facilitate communication of appropriate information.
- **No** RA to RA approval is needed if there are **no** other custodial children in the home. The RA to RA will only be required when there is another custodial child/ren in the home. The RA(s) with custodial children in the home will be contacted for approval. The RA of the Region the home is in will **not** be contacted for approval unless that RA has a custodial child in the home.
- A PER will still be required to place a child outside of the Region. This process will be utilized to ensure the safety/best interest of the child to be placed in the home as well as the safety/best interest of the biological/adopted children already in the home. The CFTM process will also be utilized to assess the dynamics of the home and address the safety/best interest of all the children in the home including biological and adopted children when placement is being considered. Lastly, the DTO/SA/SR spreadsheet will be utilized to monitor the ongoing safety of all high risk children in their placements.
- An appeal process will be utilized if provider does not agree with the decision of the RA. Executive Directors for regional support will be the first level of appeal. If needed, the Deputy Commissioner will be the final level of appeal.
- The Regions request providers make sincere good faith attempts to recruit homes in Regions where there are insufficient number of homes to meet a region's needs.

Facility and Group Care IV-E Compliance Protocol

<http://www.state.tn.us/youth/dcsguide/policies/chap4/Facility&GroupCareIVEComplianceProtocol.pdf>

IV-E Eligibility Compliance

Effective March 01, 2011

- I. Providers are responsible for maintaining and ensuring the approval of all resource homes under their purview in accordance with policy.
- II. The following responsibilities will move under the Green PQTS effective immediately:
 - All Technical Support to providers on the TFACTS Resource Home module;
 - All provider resource home inquiries with validation errors;
 - Reactivation of a resource home;
 - Transfer of resource homes from one agency to another;
 - Data corrections in TFACTS related to provider resource homes;
 - Freezing and unfreezing of resource homes; and,
- III. RHET's sole function will be to determine IV-E compliance only.
- IV. Initial - Beginning March 01, 2011 RHET will have a 14-day turn-around for reviewing initial packets for compliance.
 - The home is fully approved in TFACTS;
 - All adult and minor household members are identified in TFACTS;
 - The complete RHET packet is scanned and available in TFACTS on or prior to the home's approval date;
 - All documents and the dates on each document are clear on the scan;
 - All charges listed in the criminal history must have a final disposition;
 - All waivers have been obtained regarding all criminal charges with appropriate signatures and dates;

NOTE: Misdemeanor offenses require Provider Program Director's signature and felony offenses require DCS Executive Director of Permanency's signature for a waiver to be granted.
 - Criminal checks are completed on all legal names (first and last name) for initial assessments;

If DCS is unable to initially review the home within the 14-day period and an error is noted, the Department will not assess penalties beyond the 14-day period. Provider agencies will be accountable for any penalty days accrued beyond one business day of notification of the error as well as for the 14-day review period itself. A business day is a day where DCS offices are open and business day ends at 5:00 pm central time.

Examples:

1. A home is newly approved on the 1st of the month. A packet is submitted and a child is placed on that date. DCS reviews the packet on the 18th and notifies the agency there is an error. The agency resolves the error and provides the supporting information on the next business day. The agency will be responsible for 14 days of penalties for being out of compliance but not for the 4 extra days it took for the information to be reviewed beyond the 14-day review period.
2. A home is newly approved on the 1st of the month. A packet is submitted and a child is placed on that date. DCS reviews the packet on the 18th and notifies the agency there is an error. The agency resolves the error and provides the supporting information on the 24th. The agency will be responsible for the initial 14 days of penalties and an additional five (5) days of penalties due to the amount of time it took the agency to resolve the error after notification. The agency will not have to pay for the 4 extra days it took for the information to be reviewed beyond the 14-day review period.

Best Practice Suggestion: On initial homes providers will have the option of developing policy that would delay the placement of children in a new home for 14 days after the home has been approved in TFACTS. In doing so, providers will minimize the potential for penalty since the home would have been reviewed by both parties prior to any placements.

Re-activated Homes should follow the protocol as directed in Protocol for Re-Activation and Re-Classification of Resource Homes which is attached to policy 16.4 and 16.8. The 14-day review period also applies in these situations.

V. Re-Assessed Resource – Beginning March 01, 2011 RHET will have a 14-day turn-around for reviewing Re-Assessment packets for compliance:

- The home is fully approved in TFACTS;
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Examples:

1. A home is due to be re-assessed on the 1st of the month and the family has an active placement. DCS reviews the home information on the 18th and notifies the agency there is an error. The agency resolves the error and provides the supporting information on the next business day. The agency will be responsible for 14 days of penalties for being out of compliance but not for the 4 extra days it took for the information to be reviewed beyond the 14-day review period.
2. A home is due to be re-assessed on the 1st of the month and the family has an active placement. DCS reviews the home information on the 18th and notifies the agency there is an error. The agency resolves the error and provides the supporting information on the 24th. The agency will be responsible for the initial 14 days of penalties, plus five (5) additional days of penalties due to the amount of time it took the agency to resolve the error after notification. The agency will not have to pay for the 4 extra days it took for the information to be reviewed beyond the 14-day review period.

Best Practice Suggestion: Providers are responsible for ensuring re-assessments are processed timely. This suggestion is designed to give one example of a structure that could be put in place that would minimize the potential for penalty.

Providers approve resource homes twenty (20) days prior to approval due date. RHET has 14 day turn-around for reviewing packets for compliance. This allows for 6 days to make any corrections determined by RHET's review for compliance

If there was any non-compliance determined it would be completely corrected prior to the actual due date in TFACTS. Neither the provider nor DCS would have to reimburse IV-E dollars.

- VI. RHET will document in TFACTS when the resource home's review is completed within the 14 day period.
- RHET will record the Received Date for the RHET Packet as the date the provider saved the packet to the home study;
 - RHET will record in the Comments Section on the RHET Checklist page the date the home was initially reviewed and if it met the 14 day review period.
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Examples:

1. A home is due to be re-assessed on the 1st of the month and the family has an active placement. DCS reviews the home information on the 18th and notifies the agency there is an error. The agency resolves the error and provides the supporting information on the next business day. The agency will be responsible for 14 days of penalties for being out of compliance but not for the 4 extra days it took for the information to be reviewed beyond the 14-day review period.
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IN-SERVICE TRAINING TOPICS

- Group Dynamics
- Effective Supervision
- Effective Communication
- Time (task) Management
- Conflict Management
- Strength-based Case Management
- Grief and Loss
- How to Work with Birth Parents
- Parenting and Engaging Teens
- How to Parent Sexually Abused Children
- Challenges to Building Trusting Relationships
- Holistic Approach to Behavior Management
- Burnout and Stress Management
- Nutrition and Behavior
- Learning Styles
- Cultural Awareness
- Working with the Education System
- Child Trauma
- Crisis Intervention/ De-escalation
- Mental Health Diagnosis and Treatment Strategies
- Working with Sexually Reactive Youth
- Child Sex Abuse
- Child Development
- Grief and Loss Associated with Entering Foster Care
- JJ Curriculum (For All)
- Positive Discipline