THE CITY OF PHILADELPHIA

DEPARTMENT OF HUMAN SERVICES

PERFORMANCE AND SERVICE STANDARDS FOR

General Foster Care

Effective July 1, 2012
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I. INTRODUCTION

The standards and expectations set forth in this document represent a baseline level of services that direct service level staff will deliver to dependent children, their birth/legal parents, and foster/kinship caregivers (resource families). While they incorporate regulatory requirements promulgated by the Pennsylvania Department of Welfare, they also include non-regulatory standards for best practice referenced in Pennsylvania Child Welfare Practice Standards, the Five County Service Description and Contract Requirements, Philadelphia Department of Human Services Children and Youth Division Policy Manual and the Council of Accreditation Family Foster Care Standards. These Standards ensure that children and their families will receive high-quality services while simultaneously allowing providers the flexibility to address the individual needs of children and families to maximize the achievement of permanency, safety and well being for each child.

In order for providers to achieve these standards, both CYD and provider agencies must comply with federal and state statutes and regulations, as well as policies in the Philadelphia Department of Human Services Children and Youth Division Policy Manual, and DHS will monitor compliance through the Streamlined Standards (Attachment A).

A. DEFINITIONS

Foster Family Care: Family Foster Care (FFC) is a planned, goal directed service which includes 1) the provision of 24 hour care for children in an approved foster home (no more than six youth, including natural children); 2) the provision of services to birth/legal parents (and other potential permanent caregivers) aimed at achieving permanency for children through reunification with birth/legal parents, adoption, or permanent legal custodianship; 3) the provision of services directed at preparing youth age 12 years and older for independent functioning through the acquisition of skills that promote or enhance self sufficiency as an adult.

Kinship Care: Kinship Care is a planned, goal directed service which includes 1) the provision of 24 hour care for children in an approved foster home (no more that six youth, including natural children) with kin; 2) the provision of services to birth/legal parents (and other potential permanent caregivers) aimed at achieving permanency for children through reunification with birth/legal parents, adoption, or permanent legal custodianship; 3) the provision of services directed at preparing youth age 12 years and older for independent functioning through the acquisition of skills that promote or enhance self sufficiency as an adult.

Kin refers to any individual who has a relationship with the child or the child’s family. This individual is related to the child through blood or marriage, is a godparent as recognized by an organized church, is a member of the child’s tribe or clan, or has a significant positive relationship with the child or child’s family.

Safety: The condition of being free from immediate (imminent) harm or threat of danger. Safety is the particular set of conditions that positively or negatively describe the
physical and emotional well-being of children. A child may be considered safe when there are no threats of immediate harm present or when protective capacities in the family can adequately manage foreseeable threats of harm (DPW Bulletin 3490-00-02).

**Outcomes**

**Notes:**
- Any exit within 30 days (i.e. 30 days or less) of initial placement will not be classified as an outcome. These placements will not count toward the annual caseload served when calculating outcomes.

**Permanency Outcomes:** These outcomes are exits from DHS custody to permanent home settings through reunification, adoption, and permanent legal custodianship (PLC). Permanency is best achieved in the briefest amount of time that allows for responsible decision-making and solid, reasonable changes on the part of family members to eliminate repeated dependency. Permanency outcomes that last less than 12 months will be subtracted from the agency's total number of permanency outcomes during the contract year in which the children returned into care. If reunification, adoption, and permanent legal custodianship have been ruled out, a child exiting DHS care and achieving an Independence Outcome (defined in section VI) will be counted as a permanency outcome when documentation is submitted by the provider (within 30 days of the child's exit from PBC and in any event not more than 30 days after the end of the fiscal year) and approved by DHS.

**Non-Permanency Outcomes (NPO):** Generally, any movements to higher levels of care\(^1\) or out of the agency (transfers, runaways) that last 90 days or more are considered non-permanent outcomes.

**Neutral Outcomes:** Cases transferred in order to consolidate sibling groups within foster care at another agency, babies who leave foster care to be placed with their mothers in mother/baby placements, children leaving foster care to be with a parent in a residential facility but who are still committed to DHS, appropriate exits from foster care to medical foster care placements, and youth aging out of the system\(^2\) without achieving an Independence Outcome will be treated as neutral exits.

**Quality Outcomes:** Outcomes that do not necessarily impact the movement of cases from the contract, but are important measures of program quality and well-being of children. They include but are not limited to:
- Safety: substantiated reports of abuse and neglect while in foster care and in the first year after permanency is achieved.
- Stability:
  - the level of placement stability for children, including placement moves within a provider’s system of care, in a given period
  - the level of caseworker stability (e.g. number of different workers assigned) in a given period.

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1 *Higher level of care* includes residential treatment facility, institution, group home, supervised independent living, treatment foster care, or any DHS placement service other than General Foster Care. For non-mother/baby placements, higher level of care also includes mother/baby placements.

2 See Section VI Permanency, Part D Independence Outcomes for additional requirements regarding youth aging out of the system.
Sibling placements: the proportion of siblings who are placed together.
Geography: percentage of children placed in their home service region and average distance between foster care placement and parent’s, legal caregiver’s, or identified permanent resource’s home. In the event that provider and DHS agreed that it was in a child’s best interest to place the child outside of the home service region and the provider documents this agreement to DHS, the placement will not be held against the provider in decision making regarding this quality outcome.
Permanency disruptions: permanency disruptions that occur within a year will be tracked as a measure of service quality.
Transfers from Foster to Kinship Care: when possible, children will be placed with kin to preserve family connections. Appropriate transfers from foster to kinship care will be tracked as a measure of service quality.

These are not the only measures of quality used by DHS to determine the quality of service provision. They are considered quality outcomes because they are quantitative and not subjective.

Clients
A child or youth receiving FFC or Kinship Care services is the primary client. The provider agency will direct social work services to and on behalf of the child. Provider agency will direct social work service to and on behalf of other individuals based on the goal of the child.

A. A child who is appropriate for FFC or Kinship Care meets the following criteria:
   1. Falls within the definition of child in PA. Reg. §3680.4
   2. Meets the criteria for identified level of care (i.e. general, medical, mother/baby) through DHS screening process

B. Birth/Legal Family
Provider agency will provide direct social work services to and on behalf of members of the birth/legal family relative to the goal of the primary client. These services will be consistent with the Family Service Plan. The members of the birth/legal family may include:
   1. Birth/legal/adoptive parents (excluding individuals who are subject to a judicial finding that reasonable efforts do not have to be undertaken to reunify them with the child in FFC or Kinship Care)
   2. Significant adults
   3. Siblings

C. Resource Caregiver: An adult or family unit recruited trained and supported to serve children and families receiving services from the provider agency. Resource families may be emergency placement families, foster families, adoptive families, kinship families, or respite families.
   1. Must meet all regulations in PA. Regs. §3700
   2. Identification of kinship resources at initial placement will be the responsibility of CYD following guidelines outlined in CYD Policy Manual §4400 and §5200 and the Referral and Assessment Document.
   3. Persons who are culturally and linguistically skilled to care for the children being
referred.

D. Provider’s Role and Responsibility Relative to Children in the Birth/Legal Family
   1. When visiting the birth/legal family’s home, the provider will fulfill the responsibilities required of a mandated reporter in relation to children living with the birth/legal family.
   2. If provider believes that the children remaining in the home require more intensive oversight to ensure their safety and well-being, the provider will request in-home services both orally and in writing within 24 hours of the assessment.

B. GOALS

The goals of FFC and Kinship Care are multiple and should be achieved simultaneously.

1. Safety: Child safety is the preeminent goal of the child welfare system. The safety of the child will be addressed at all stages of provider involvement including during the provision of general foster care services and during the planning for reunification or other permanency options for the child. Safety plans put into place to establish and maintain safety will be documented in the case record.

2. Permanency: Services will ensure a permanent, legally assured family for the child through the child's return to his/her legal family, the child's adoption, or the child's placement with a permanent legal custodian. Such permanency is best achieved in the briefest amount of time that allows for responsible decision-making and concrete, reasonable changes on the part of the family to eliminate repeated dependency.

3. Well Being: Services will ensure that the child's physical needs are met and that the child's emotional, social and intellectual potential are maximized. Services will be provided in a manner that recognizes and values each child's own immediate and extended family as well as his/her ethnic, racial, and religious heritage. Whenever possible, children should be placed with their siblings.

4. Stability: Given the extremely disruptive experience of separation from their family and the frequently chaotic life experiences of many youth, stability of foster care placement is critical for children. Appropriate recruitment and training of resource parents, careful matching of children and families and viable, accessible supports for resource families should be in place to avoid multiple foster family placements. However when it is in the children's best interest to move to another placement setting, they will be moved to a more appropriate setting in a manner to maximize their safety and well-being.

C. TERMS AND CONDITIONS

DHS agrees to enter into a performance contract with the provider agency for the provision of Family Foster Care and Kinship Care.

DHS may adjust a provider agency’s contract size based on systemic or provider agency-specific factors including those noted below.
1. **a. Systemic and agency-specific administrative reasons for contract adjustment which could result in either an increase or decrease in an agency’s contract/payment:**

   1) A material change in intake: An increase or decrease in the number of children entering general foster care/kinship care could result in contract adjustments for all provider agencies or could be applied differentially among agencies based on relative performance of agencies with respect to permanencies, stability and/or quality outcomes and/or for reasons including those noted under sections II and III below.

   2) To address issues or correct errors as they come to the attention of DHS.

**b. Process for systemic and administrative agency-specific contract adjustment:**

   1) Criteria for these types of adjustments will be applied consistently among agencies.

   2) Financial adjustments will fairly reflect the services provided.

   3) DHS will provide 30 days written notice to providers of any contract adjustments.

2. **a. Agency-specific reasons resulting in an increase in contract/payment:**

   1) Acceptance of additional referrals in excess of the contracted number of placements through the secondary match or any other means will result in an increase in contract amount.

**b. Process for implementing adjustment for contract/payment increases:**

   1) Criteria for adjustment will be applied consistently among agencies and discussed with the provider prior to any action.

   2) DHS will provide 30 days written notice to provider of adjustments.

3. **a. Agency-specific reasons for contract adjustments that could result in a decrease in the agency’s contract/payment**

   1) Rejection of referrals Non-permanencies in excess of allowable standard.

   2) Quality of care deficits related to the primary clients' safety and well-being including substantiated reports of abuse and neglect.

   3) Performance deficits compared to contract expectations and/or other agencies related to the achievement of permanency outcomes, the number of non permanency outcomes, or other indicators of quality including those set forth in the section titled Quality Outcomes.

**b. Possible consequences related to quality of service concerns**

DHS may take any of the following steps to address quality of service concerns:

1) Placing the agency on hold or partial hold status.

2) When a provider agency is placed on hold or partial hold status, the agency may not receive referrals, with the exception of add-on siblings or other trumps when appropriate.

3) When a provider agency is placed on hold or partial hold status, its contract may be gradually downsized as permanency outcomes are not replaced by new referrals.
4) Setting intake below the full intake level.
5) Transferring cases to another provider agency.
6) Adjustment of the size of the contract.

c. Process for Implementing Contract Adjustments Based on Quality of Performance Concerns:
1) Criteria for adjustment will be applied consistently among agencies and discussed with the provider prior to any action.
2) DHS will provide 30 days written notice to provider of adjustments. The notice will include the reason(s) for the adjustments. If a provider agency for which quality of service concerns resulted in the agency being placed on hold status, having intake set below full levels, or having cases transferred improves performance with respect to the reason(s) for adjustment, it may be given the opportunity to resume full referral status in the next contract period.

DHS reserves the right to take rapid action to reassign cases when there are emergency or safety concerns.

Reconciliation process:
DHS will develop a reconciliation process for performance data. Child-specific data with respect to each of the performance expectations will be shared with agencies. Permanency and non-permanency outcomes will be reviewed, analyzed and reconciled with agencies semi-annually. Agencies will be sent reconciliation materials with a list of all permanency outcomes and non-permanency outcomes achieved and will have at least five (5) business days to respond with any additions, deletions, or corrections. DHS will then verify the additions/deletions by reviewing FACTS and any documentation submitted by the agency. DHS may hold a reconciliation meeting with each agency to review these data. DHS will not review new information submitted by the agency more than two business days after the agency’s reconciliation deadline.

Transfers between Family Foster Care and Kinship Care
The number of children in each agency who transferred between Family Foster Care and Kinship Care, and vice versa, within the agency, will be reconciled semi-annually. These transfers do not count as referrals.

Placement Categories

Within Foster Family Care, specific categories have been identified for the purposes of purchasing services. These categories and service codes are subject to change. At present, the categories are as follows:

1. Kinship Care and Foster Family Care are planned, goal directed services which include 1) the provision of 24 hour care for children in an approved foster home (no more than six youth, including natural children); 2) the provision of services to birth/legal parents (and other potential permanent caregivers) aimed at achieving permanency for children through reunification with birth/legal parents, adoption, or permanent legal custodianship; 3) the provision of services directed at preparing youth age 12 years and older for independent functioning through the acquisition of skills that promote or enhance self sufficiency as an adult.
a. Level II

b. Level III

c. College Board Extension Level differs in that the youth lives on campus and returns to the foster or kinship home for school breaks.

d. Maternity Foster Care differs in that the youth is pregnant and requires pre-natal care and preparation for parenting.

2. Medical Foster and Kinship Care are services for dependent children with medical or physical conditions that require medical treatment plans.
   a. This planned, goal directed service includes 1) the provision of 24 hour care for children in an approved foster home (no more than six youth, including natural children); 2) the provision of services to birth/legal parents (and other potential permanent caregivers) aimed at achieving permanency for children through reunification with birth/legal parents, adoption, or permanent legal custodianship; 3) the provision of services directed at preparing youth age 12 years and older for independent functioning through the acquisition of skills that promote or enhance self sufficiency as an adult.

3. Mother/baby Kinship and Foster Care are services for dependent teen mothers and their children.
   a. This planned, goal directed service includes 1) the provision of 24 hour care for youth in an approved foster home (no more than six youth, including natural children); 2) the provision of services to the teen mother's birth/legal parents (and other potential permanent caregivers) aimed at achieving permanency for youth through reunification with birth/legal parents, adoption, or permanent legal custodianship; 3) the provision of services directed at preparing youth age 12 years and older for independent functioning through the acquisition of skills that promote or enhance self sufficiency as an adult.

4. Emergency Foster Care is Foster Family Care of a short-term nature for dependent children who require immediate emergency placement. Referrals for this type of care will be made outside normal Central Referral Unit hours, including evenings, weekends, and holidays.
   a. This service includes 1) the provision of 24 hour care for children in an approved foster home (no more than six youth, including natural children); 2) the provision of services to birth/legal parents (and other potential permanent caregivers); 3) coordination with DHS to plan for the needs of the children after the emergency placement.

Other
All agencies with this contract must adhere to all federal and state statutes and

3 Level Three is being phased out beginning 7/1/2012.
4 As of May 2005, these hours are 8:30 am to 7 pm, Monday through Friday. DHS may extend or change referral hours with 30 days advance written notice to providers.
regulations and the Philadelphia Department of Human Services’ Children and Youth Division Policy Manual. Compliance with regulations and policy and the requirements set forth herein will be monitored by DHS’s Provider Relations and Evaluation of Programs Unit through the Streamlined Standards (Attachment A).

The provider agency will use its judgment and discretion as to the mix of children placed in an individual foster home. It is expected, however, that such decisions will be based on the capabilities, training and experience of the resource caregiver and most importantly, on what is deemed most appropriate for the individual child who is placed and the children already placed in the home. Whenever possible, sibling groups are to be maintained in the same foster home.

II. PERFORMANCE EXPECTATIONS

Permanency and Stability:
On an annual basis, performance outcomes will be measured against Federal benchmarks for permanency timeliness and stability. Baseline data will be analyzed to determine additional contractual performance expectations.

Referral:
Agencies will accept all appropriate referrals

All cases are expected to have continuity in caregivers and remain within the agency for case management unless a change is deemed by the agency and the DHS case manager to be in the best interests of the child.

DHS may take corrective action, including transferring cases to high performing agencies or reducing intake if it has documented performance or safety concerns as referenced under the Terms and Condition Section of this contract.

III. REFERRAL AND ADMISSION

An agency will receive referrals based on the youth’s level of need (i.e. emergency, medical, mother/baby) or relationship with the agency (based on DHS’ referral trump\(^5\) process). The agency agrees to conform to the case referral process detailed in Attachment B. This collaborative agreement establishes principles for case referral (appropriate and timely referral, quicker movement into stable placement, equitable case distribution, geographic assignment, and consolidation) and details an agreed management and clinical process consistent with those principles. This document supersedes the referral section 5.2b in the General Contract provisions for FFC and Kinship care.

A. REFERRAL ACCEPTANCE EXPECTATIONS
An agency must have the capacity to place any child appropriate for foster care referred during DHS referral hours (as of May 2005, these hours are 8:30 am to 7 pm, Monday

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5 Trumps are based on relationships with the referred youth or a family member.

FY 2013
through Friday). DHS may extend or change referral hours with 30 days advance written notice to all providers. Agencies are expected to accept referrals made during DHS referral hours. Agencies with a DHS contract for Emergency Foster Care (placements outside regular DHS Referral hours (see above) will respond immediately to placement requests.

Agencies will develop the capacity to place all appropriate referrals, including children requiring placement on a same-day/ emergency basis as necessary. All children who are found appropriate for foster care will be accepted without regard to age, race, religion, sexual orientation or gender.

Agencies are not prohibited from setting up collaborative processes or subcontracting for emergency resources. In designing and operating its foster care system, the agency must adhere to all licensing rules and policies.

IV. SERVICE PLANNING

The provider will engage in a mutual, ongoing service planning process with DHS, birth/legal parents, children, extended family, and resource caregivers that builds on the strengths and addresses identified needs outlined in an assessment. The full service planning process must occur a minimum of every six (6) months, but will also occur as family circumstances change. The actions or tasks stated should be negotiated on an incremental basis, cover a short period of time, and recognize the family's ability to comply with a specific task. The provider will have a shared leadership role and decision making authority in the service planning process.

In service planning, DHS and the provider will be guided by law, regulation, DHS policy and the DHS Framework for Individualized, Need-Based Child Welfare Practice.

Attachment C, Working Model for Defining the Roles of DHS and Private Providers, sets forth the expected roles and responsibilities of DHS and the private provider agency with respect to service planning and delivery. Additional detail is set forth below.

A. DEVELOPING THE INITIAL PLACEMENT PLAN

1. Placement Case Transition Meeting:
   Initial placement of a child with a new provider agency requires an initial visit /meeting scheduled as soon as possible, preferably before the initial court hearing, but not later than ten working days after placement. Whenever possible and appropriate, this meeting will be held in the resource family home. The provider, DHS (intake and/or family region staff), the birth/legal parent(s), resource caregiver and child will participate in the meeting. If a provider from another general foster care agency was involved immediately prior to the placement, that provider will be invited to participate in the meeting.

   6 Exception: for emergency kinship care referrals where the initial home assessment is completed by a contracted assessment provider, the transition meeting will take place within 60 calendar days after placement.

FY 2013
a. DHS will:
   1) Ensure that the meeting occurs. The purpose of the meeting is to:
      a) begin to establish a relationship among those involved in the child’s care, especially between the parents and the resource family;
      b) initiate the birth/legal parents into the placement process;
      c) obtain information regarding the child, and his/her developmental, medical, and educational needs;
      d) stress the importance of parent’s and kin’s involvement with the child and provider worker;
      e) help parents to understand that the placement is temporary measure, and that if reunification does not occur within allotted time frames, the next best permanent plan for the child will be developed; and
      f) establish a date for the Family Service Plan/Individual Service Plan Meeting.

b. The private provider will:
   1) Discuss with the family the implications of the concurrent planning process in concrete and factual terms; in a culturally sensitive manner; and in a language the family understands, including specific time frames and alternate goals that maximize child safety and permanence.

2. Identification of Adult Relatives
In accordance with DHS’ Policy on Identification and Notification of All Adult Relatives of a Child’s Removal from Parent/Guardian:

a. DHS will:
   1) Use due diligence to identify and notify all adult relatives within 30 days of a child’s removal from parents.
   2) Give relatives the opportunity to be considered as resources for permanency, placement, and/or life connections.

b. The private provider will:
   1) Gather information on as many adult relatives and kin as possible within 30 days of the placement of a child who was removed from his/her parents, using the form provided by DHS.
      a) Adult relatives are defined as family members age 21 or older, related by birth or marriage to a parent of the child in placement, including those removed to the 1st, 2nd, and 3rd degree, on the maternal and paternal sides. This includes all parents, step-parents, adult siblings, aunts, uncles, grandparents, great grandparents, great aunts and uncles, and first cousins.
   2) Send information gathered at the time of placement to the DHS worker within three calendar days.
   3) Send any additional information gathered after the first 30 days of placement to the DHS worker within seven calendar days.

3. Family Service Plan (FSP) and Child Permanency Plan (CPP) Completion and Review
DHS will:
- Complete the initial FSP/CPP within 30 days of placement.
- Organize the process of FSP/CPP revisions, which must occur within 30
days for every new placement or change in placement notwithstanding the
semi annual review cycle. Subsequent FSP/CPP reviews and revisions
must be completed semiannually based on the six month anniversary of
the family’s DHS Accept for Service (AFS) date.
- Notify parents, legal custodians, service providers, children over 14 and all
their legal counsel of the FSP/CPP no less than 15 working days prior to
the FSP/CPP meetings and prepare participants for the meeting.
- Provide parents and/or legal custodians and children 14 and older with a
copy of the ‘Notice of Right to Appeal’ and notify the provider of appeals
and of the outcomes of appeals to FSP/CPP.
- Furnish the provider with a copy of the initial FSP/CPP within five working
days of its completion.
- Support and advance service plan changes recommended by the provider
as long as they do not violate law, regulation or DHS policy.

The private provider will:
- Ensure that ISP addresses goals outlined in FSP.
- Furnish DHS with input to the FSP/CPP.
- Inform all required parties, including DHS, in advance of any
contemplated changes affecting services to the child and family that could
result in revisions to the FSP/CPP, e.g. changes in placement services,
placement location, visitation plans, etc.
- Ensure that a worker who will have ongoing responsibility for the case is
assigned promptly enough to take part in the family service planning
meeting and to assist with the preparations for the meeting.
- Complete a transition plan to be included in the CPP of any youth age 16
or older (as of the FSP date) who has a goal of APPLA (Another Planned
Permanent Living Arrangement) or Placement with a Fit and Willing
Relative, using the form provided by DHS, in accordance with DHS Policy.
  a. Revise the transition plan for each subsequent FSP.
  b. Submit the transition plan to DHS 30 days prior to the FSP review.
  c. Within 90 days prior to the anticipated exit, submit to DHS the final
version of the transition plan for all youth exiting care to
independence between age 18 and 21.

4. Individual Service Plan (ISP)
Note that ISP meetings should take place, whenever possible, at the same time as
FSP/CPP meetings.

a. DHS will:
  1) Participate in the development of the ISPs and any revisions for each
child in placement by (1) attending the FSP/ISP meetings and (2) signing
off on the ISPs developed and submitted by the provider agency.

b. The private provider in accordance with FSP/CPP will:
  1) Design and implement the initial ISP for the child in accordance with state
regulations and provide copies to the appropriate parties no later than 30 days after the 85-29 placement date.

2) After the initial ISP, review and revise the ISP in a joint FSP/ISP meeting no later than by the six-month anniversary of the AFS date.

3) Submit the reviewed and revised ISP to DHS not more than 30 calendar days after the six month AFS date.

4) Notify DHS of any changes affecting the delivery of services to the birth/legal parent(s), child and resource family, e.g. visitation, placement location, service needs, out-of-state vacations, etc.

5) Ensure that the child and family are aware of the expectation placed on them in the ISP, that they sign off on the ISP, and that they receive a copy of the ISP.

6) Ensure that foster parents are aware of the expectations in the ISP.

7) Periodically review the child and family's situations to assess progress in meeting goals in the ISP. This progress will be documented and forwarded to DHS in the form of a Quarterly Report.

8) Solicit feedback and input from the child and family on meeting ISP goals.

9) Determine what changes need to be made to the service delivery goals as delineated on the ISP.

10) Include a visitation plan in the ISP which reflects the visitation schedule in the CPP. This visitation plan will include at least one monthly face to face visit with all siblings in placement.
   a) Include the following in the plan: visitation frequency, location, participants, and, if needed, name of person(s) who will supervise visits.
   b) Attempt to locate all siblings and include them in the visitation plan. Sibling visits may take place at the same time as parent/guardian visits.
   c) Contact the DHS worker to coordinate visitation planning for any siblings placed with different agencies.
   d) Encourage other types of contact between siblings who are not placed together (e.g. emails, letters, and telephone calls).
   e) Encourage visits, emails, letters, and telephone contact between children in placement and their siblings who are not in placement.

11) For all youth age twelve (12) and older, information obtained from the youth’s Ansell-Casey Life Skills self-assessment will be utilized to design an age-appropriate life skill curriculum that will be integrated into the youth’s ISP.

12) For all youth age twelve (12) and older, information obtained from the youth through the Youth Resource Interview and Youth Resource List will be integrated into the youth’s ISP.

13) For all youth age fourteen (14) and older who are at risk of failing a course or program and/or have received a final or interim grade of D or F in a class, information obtained from the Academic or Training Program Progress Improvement Plan form will be incorporated into the youth’s ISP.

5. Family Group Decision Making
   a. Providers will participate in the Family Group Decision Making (FGDM) process.
b. Providers will integrate objectives and tasks from the FGDM plan into the Individual Service Plan (ISP).

B. MODIFYING THE SERVICE PLAN

Both DHS and the provider case managers will attend and participate in all planning meetings, and will ensure that plans are adjusted when needed. DHS and the provider will communicate on an ongoing basis to ensure effective participation in service planning. At a minimum, the provider and DHS will review/discuss progress toward case goals on a quarterly basis.

DHS and the provider will share responsibility for inviting and preparing participants for the review meeting, dividing up responsibility for contacting individuals based on existing relationships and available time. DHS and the provider will work together to ensure that the meeting is held at a time and in a place conducive to team members being present.

Whenever possible, service planning decisions will reflect the agreement of the family team. In certain instances, if there is not agreement, the team will involve supervisors, administrators, and directors when they are needed in order to decide difficult practice issues, resolve system problems, or mediate conflicts within the team that could obstruct progress on the case.

1. DHS will:
   a. Call the plan review meeting when necessary (either in response to significant case events, or to ensure that no more than six months go by without a review).
      1) If the private provider or another team member requests a meeting, the DHS worker will contact the team to schedule the meeting within ten days. The meeting will occur within thirty days of the request.
   b. Facilitate the review meeting.
      1) If the team is unable to reach agreement, support and advance private provider position unless that position violates law, regulation or DHS policy.
   c. Write up and distribute revised FSP.
   d. Request expedited court hearings, in accordance with Family Court policies, to facilitate goal changes based on agreed upon decisions.

2. The provider will:
   a. Recommend changes in the plan.
   b. Request that the DHS worker convene a case planning meetings with DHS, birth/legal parent(s), resource caregiver, or child to discuss progress toward goals, goal changes, and changes in the service plan when necessary to facilitate child safety, permanency, well being, or stability.
   c. If necessary, assist the primary client and members of the family or other individuals based on the goals of the primary client with transportation to and from the meeting.
   d. Write and distribute the revised ISP.

C. PREPARING FOR AND TESTIFYING IN COURT
DHS and the provider will work together to meet their joint obligation to present to the court complete and accurate information and recommendations based on the permanency plan for the child.

1. DHS will:
   a. Arrange for administrative review and/or petition Court for placement/dispositional review hearings at least once every six months.
   b. Consistently and aggressively advocate for timely hearings.
      1) When the private provider requests a court hearing, DHS will within five working days work with the Law Department to request an expedited hearing in accordance with Family Court policies.
   d. Notify the provider and other appropriate parties verbally and in writing in a timely manner (as soon as possible) when any court proceeding or Permanency Status Review meeting has been scheduled.
   e. Assume primary responsibility and take the lead for the Department’s testimony and recommendations in court, based on agreed upon decisions in service planning meetings.
   f. Provide copies of documents relevant to the hearing/review to the provider at least 5 working days prior to the hearing/review.
   g. At the hearing, utilize providers’ experience and expertise when advocating for agreed upon recommendations developed prior to the hearing.

2. The provider will:
   a. Support the Department’s preparation by providing full, timely information in advance of the court proceeding.
   b. Participate in all court hearings and pre-hearing conferences whenever notified prior to the hearing and testify when requested to do so. The provider will have the opportunity to request authorization for services related to safety, permanency, and well being at the pre-hearing conference.
   c. May request an expedited court hearing, in accordance with Family Court policies, when circumstances warrant.
   d. Inform DHS of known interactions with the legal representative of the child and legal family. Provide transportation for the primary client to and from court hearings.

D. ASSESSMENT TOOLS: The Behavioral Observation Checklist (BOC) and Family Resource Scale (FRS) were suspended as of March 2011. They will be replaced with new assessment tools. Instructions and requirements for providers will be distributed upon finalization.

E. SAFETY PLANNING: Child safety must be assessed by the provider and DHS at every contact with child and family. If child is determined unsafe, the provider and DHS must develop a plan that will ensure the child's immediate safety. Provider and DHS will alert each other immediately if child is found to be unsafe. This assessment of safety and development of a safety plan must be documented in the case record in accordance with CYD Policy, including the Policy on the Safety Assessment Process during Investigations/Assessments and for Ongoing In-home Services, issued
February 5, 2008.

F. PARENTAL SEARCH: Provider will initiate and document efforts to locate absent parents every six months in accordance with CYD Policy, including the Policy on Diligent Search Efforts for Missing Parents of Children in Placement, issued May 2, 2008.

G. EARLY INTERVENTION ASSESSMENT: Provider will screen all children in care under age five for Early Intervention Service needs, as per requirements set forth in Policy and Procedure Guide issued 10/27/06, effective 11/1/06⁷, Re: Revised Policy and Procedure Guide for Accessing Early Intervention services for Children Under Age 5.

1. For all children between four months and 60 months of age, the provider will facilitate completion of the Ages and Stages Questionnaire (ASQ).
   a. The ASQ will be completed within thirty days of the accept-for-service date.
   b. The ASQ will be administered according to the following interval schedule:
      1) Children ages 4 months – 24 months must have the ASQ administered every 2 months
      2) Children ages 25 – 36 months must have the ASQ administered every 3 months
      3) Children ages 37 – 60 months must have the ASQ administered every 6 months
   c. The Social and Emotional Questionnaire (ASQ-SE) will be administered every 6 months for all children ages 6 months - 60 months.
   d. If ASQ/ASQ-SE results indicate one or more areas of developmental delay, the provider will inform the child’s legal family within seven days and request consent for multidisciplinary evaluation and Early Intervention services. Provider will refer children to ChildLink (or other service provider as appropriate) for multidisciplinary evaluation as needed.
      1) Providers will notify CYD if parents/caregivers refuse to consent to evaluation or services.
      2) Providers will document Early Intervention referrals and subsequent services in Individual Service Plans and Quarterly Reports.
   e. The ASQ/ASQ-SE form, including the information summary sheet, will be in the case file, and a copy of the information summary sheet will be sent to the assigned DHS social worker within seven days of the date the ASQ was administered. Scores and assessment-specific information will be entered in P-Web.
   f. The ASQ replaces the Behavioral Observation Checklist (BOC) for children ages 60 months and younger.

2. ASQ/ASQ-SE screenings that produce a qualifying score indicating that a child is at risk of developmental delay must be referred for early intervention supports and services, which includes multidisciplinary evaluations. Children will be referred under the following circumstances:
   a. Children whose ASQ screening results in a qualifying score.

⁷ Updated policy issued 1/25/12
b. Children, birth to 5 years old, regardless of ASQ screening results, with the following high risk conditions:

1) Medical Conditions
   a) History of admission to a Neonatal Intensive Care Unit (NICU)
   b) Failure to Thrive (FTT)
   c) Cerebral Palsy
   d) Progressive neurological disorders
   e) Trisomy 21 (Down) or other syndromes typically associated with developmental delays
   f) Other complex health care needs that may have required multiple or lengthy hospital stays
   g) Technology dependent

2) Social-Emotional Conditions
   a. Appear to be emotionally withdrawn
   b. Lethargic
   c. Flat emotional presentation (never happy or angry)
   d. Caregivers report toddler has feeding problems, for example, shoves food in his/her mouth to point of choking, is never full, and hoards food
   e. Frequent nightmares
   f. Fearful
   g. Often irritable
   h. Present with sexualized behaviors

H. HEALTH ASSESSMENT: Provider will complete a health information assessment to assist them with gathering and tracking important health information to ensure coordination and continuity of services. This information will include immunizations, medical, dental, and behavioral health services, names and locations of medical service providers, medications, special medical equipment, and known allergies.

The provider will:
1. Complete the information form in P-Web prior to the development of the first FSP.
2. Update the form annually based on the Accept for Service cycle.
3. Make additional updates under the following circumstances:
   a) Whenever there is a change in medication.
   b) Whenever there is a change to the youth’s health status that has a significant impact on their health care needs.
      1) Conditions such as a cold or flu and routine dental care do not require an update.
   c) When youth 18 and older are in the six month review cycle prior to discharge from care, as part of their transition plan.
4. Give a copy of the form to the birth/legal parents if the goal is reunification
5. Use the information to develop ISP objectives that address identified medical and behavioral health needs.

I. DISCHARGE AND AFTERCARE PLANNING: Discharge and Aftercare planning will involve all members of the service planning team, including the family, DHS, provider, and advocates, and will take place prior to the Permanency Hearing. Discharge and
Aftercare planning will be part of the regular service planning process.

V. SERVICE DELIVERY: Ongoing Services to Assure Safety, Well-being, Stability and Permanency

In delivery of services, DHS and the provider will be guided by law, regulation, DHS policy and the DHS Framework for Individualized, Need-Based Child Welfare Practice (Practice Framework).

Attachment C, Working Model for Defining the Roles of DHS and Private Providers, sets forth the expected roles and responsibilities of DHS and the private provider with respect to service planning and delivery. Additional detail is set forth below.

The provider will operationalize the Family Service Plan (FSP) by coordinating, delivering, and monitoring services in accordance with the Individual Service Plan (ISP) on an ongoing basis to assure safety, well being, stability and permanency for the child. The provider will coordinate services that are timely, culturally sensitive, and assessed for appropriateness. The services detailed below may be used to advance any or all of these multiple goals simultaneously.

Depending on the needs of the child and family (which change over time), any or all of these types of services may be provided for any case at any time.

A. CASE MANAGEMENT

Case management includes all those services performed by provider agency staff on behalf of the legal family, the child, and the foster family. These services include:

1. All oral and/or written contacts designed to:
   a. Seek out appropriate services for or on behalf of primary client, the birth/legal family, and foster family.
   b. Obtain, schedule and arrange for such services.
   c. Obtain progress reports and insure that services are appropriately meeting the primary client’s needs.
   d. Facilitate and monitor client’s use of services in an effort to promote independent use of such services.

2. Safety: Child safety must be assessed by provider and DHS at every contact with child and family. If child is determined unsafe, the provider and DHS must develop a plan that will ensure the child's immediate safety. Provider and DHS will alert each other immediately if child is found to be unsafe. This assessment of safety and development of a safety plan must be documented in the case record in accordance with DHS Policy Manual 5222.3.
   a. Provider will meet with child in the foster home within 72 hours of placement.
   b. Provider will have face-to-face contact with child at least twice per month or as often as required by Court order (never with a gap of more than 30 days) to assess and monitor child safety. At least once a month this contact will be made in the foster home.
c. The provider will ensure adherence to PA. Reg. §3700.67, Safety Requirements for Foster Homes.

d. The provider will ensure adherence to PA. Reg. §3680.43, Agency Discipline.

e. The provider will ensure adherence to PA. Reg. §3680.21, Reports of unusual incidents and child abuse.

3. Visitation - the provider shall:

a. Facilitate visits in the most natural and least restrictive setting possible between the child and the birth/legal parent(s) in accordance with visitation plan, including evening and weekend visits as needed. Visits must occur not less than once every two weeks, unless otherwise indicated. When the goal is reunification, best practice strongly indicates that birth/legal parents and children should be given the opportunity to visit at least weekly, and DHS strongly encourages this practice whenever possible.

b. Visit the family’s home prior to the unaccompanied home visit by the child to assess the safety of the home and take all reasonable efforts to ensure the child is safe during visits. At least one contact per quarter should occur in the birth/legal family’s home whenever appropriate.

c. Notify DHS of any apparent unsafe conditions in the family home whenever they are found. Monitor the well-being of other children in the home and to report any protective service issues to the DHS case manager.

d. Implement a progression of visitation plans based on an assessment of risk and safety factors; the developmental needs of the child; inclusive of siblings, extended family and resource family as related to service plan goals. Planned visits will be structured to provide an opportunity for parents to participate in routine child care activities and/or learn parenting skills to assure the safety of child and achieve timely permanency.

e. Assist the family in obtaining financial assistance and arranging transportation when necessary to ensure that visitation can occur.

f. Facilitate visits in the most natural and least restrictive setting possible between the child and siblings in accordance with the visitation plan in the ISP. Face-to-face sibling visits must occur at least twice per month unless doing so would be contrary to a child’s safety or wellbeing.

1) Visits must be scheduled so that they do not disrupt the children’s educational or therapeutic activities.

2) Visits can take place during naturally occurring life events such as birthday celebrations, school events, performances, and events within the resource family.

3) The provider will encourage other types of contact between siblings who are not placed together (e.g. emails, letters, and telephone calls).

4) The provider will encourage visits, emails, letters, and telephone contact between children in placement and their siblings who are not in placement.

5) Sibling visits may take place at the same time as parent/guardian visits.

6) The provider will make ongoing efforts to place siblings together whenever possible.
4. Youth Resource Interview:
   a. The provider must coordinate and facilitate a Youth Resource Interview with youth within thirty (30) days of placement for all youth age twelve (12) and older. The provider should also conduct a Youth Resource Interview with children under twelve when deemed appropriate by the provider. The Youth Resource List must be reviewed and updated prior to the FSP Meeting every six months. The Youth Resource Interview is used to obtain information from youth using the Youth Resource List, which will be integrated into the youth’s FSP and ISP. The Youth Resource List is designed as an ongoing dialogue between the provider and youth to identify discuss and document visitation resources, family reunification objectives, sibling relationships and former caregivers.

   b. Visitation Resources – Identify potential resources for visitation in order to maintain family and community connection, keeping in mind that the definition of family is individualized (e.g. biological/legal family members, including biological/legal parents or caregivers, siblings and extended family; involved caregivers and friends).

   c. Family Reunification Objectives – Review the reunification goal, identify the person with whom the child will reunify, discuss the challenges and needs that may be potential barriers to achieving reunification and encourage and support the youth’s input regarding reunification.

   d. Sibling Relationships – If a youth has siblings, understand where they are placed and encourage and support contact and visitation.

   e. Former Caregivers – Identify former caregivers or previous placements and discuss the experience of those placements with the youth.

B. SERVICES TO MEET CHILD’S NORMAL DEVELOPMENTAL NEEDS

1. Shelter: The child will be provided shelter in an approved foster care setting that meets all state regulations. The provider will ensure that all youth placed in foster care have independent sleeping arrangements (crib or bed as developmentally appropriate) not shared with adults or other children. The provider agency will provide cribs to foster homes as needed.

2. Supervision: Provider will maintain a cadre of trained and supervised resource caregivers to provide appropriate supervision to the child on a 24 hour/7 day a week basis.

   a. Respite Care:

   **Definition:** Respite Care is a short term change in placement location that helps resource caregivers with childcare situations that may arise. For example, the caregivers may need medical treatment, need to travel to attend to a sick family member, or benefit from a short time away from the youth to allow them to recharge and become better prepared to handle the normal day-to-day challenges of parenting. Respite care is used with the intention of returning the child to his/her previous placement. Respite care may last up to seven days before a new placement location is determined (Exception:
planned foster parent absence or child enrichment activity of up to 14 days).
If return of the child to the original placement is not planned at the time of the
movement, this is considered a placement location change, not a respite care
placement, and the provider will notify DHS in writing that the child has had a
change in placement location (using the Request for Change form or other
written notification as required).

Respite Care may only be provided by a certified foster parent (full foster
home approval in compliance with all state regulations). Planning for all
children and youth in resource homes, whether foster or kinship, should
include identifying respite resources in advance to avoid the need to place
children or youth in unfamiliar settings. Resource caregivers may consider
having a respite caregiver stay at the certified foster or kin home to provide
the respite. In this case, all required clearances must be complete and up to
date for the respite caregiver. This may be a particularly appealing option for
foster and kinship caregivers who can identify someone with whom the
children and youth already have a relationship; it also avoids their physical
move.

Families may also identify visitation resources for events such as an
overnight visit. These could include biological and resource family friends,
classmates, etc. Visitation opportunities should be discussed at the FSP and
ISP meetings to allow all parties (parents, child advocate, DHS worker,
provider worker, etc.) an opportunity to discuss and identify potential
resources for events such as sleepovers. Prior to overnight visits, the
provider must work with DHS to complete oral ChildLine clearances and a
complete home inspection including a Safety Check that observes the
sleeping areas, working smoke detectors, and fire extinguishers. All
overnight visits require notification to the child advocate and parents. If the
parent is not in agreement, the court must be notified and permission granted
before the overnight visits can take place.

Visitation in this context refers to people other than parents or permanency
resources. If the identified contact becomes a permanency option or ongoing
visitation resource for the child, the provider must pursue full certification of
the home.

Respite Plan:
A Respite Plan will be developed and included in the initial ISP and updated
in each Quarterly Report thereafter for each child in care. This plan will
include the caregiver’s name and address for planned respite foster care.
After the initial ISP, respite plans within Quarterly Reports will list actual dates
of respite used during the prior three months.

Notification:
All non-emergency placement moves, including respite not documented on
the ISP and Quarterly Report, require 15 days prior written notice to the DHS
worker, supervisor, child’s parents and child advocate. Use of emergency
respite care requires notification within one business day to the DHS worker,
supervisor, child’s parents and child advocate of the unplanned move.
Notification of child’s parents and child advocate must be in writing, with a copy to the DHS worker and supervisor. Notice to DHS is preferred by email, but may be by phone call, followed up by a copy of the letter sent to the child’s parents and advocate.

3. **Food:** The provider will ensure that the child is provided with food (at a minimum three meals and snacks) that meets nutritional needs, including any special dietary needs.

4. **Clothing:** The provider agency will ensure that the child has clothing (outer and under garments) which are seasonably and fashionably appropriate. Clothing should accommodate any special medical needs/physical condition, and not distinguish the child from other members of the community in which the child resides. The provider agency will have a prescribed program for the purchase, care, and maintenance of clothing that applies equally to all children. All clothing should be purchased new with the child, when appropriate, having choice in the selection. All clothing purchased for the child will become the property of the child.

5. **Health/Medical:** The provider, in collaboration with the CYD, birth/legal family, the resource family, and the child, will ensure that health care needs of the child are met in accordance with state regulations including physical, dental, ophthalmologic, hearing, behavioral and developmental needs.

   a. Providers will share all medical information available, including the child’s health assessment form, with the resource caregivers and ensure that the caregivers adequately understand the identified health care needs and are able to address them.
   
   b. The provider agency must obtain necessary approval from parent and/or DHS. DHS will obtain **court consent** for medical treatment when parents are not available.
   
   c. If the child’s goal is reunification, the provider will facilitate parents’ participation in physical health office visits for the child when appropriate.
   
   d. The provider will ensure that a newly placed child continues to see their current Primary Care Provider (PCP) and any specialists whenever possible.
   
   e. The provider will monitor compliance with medication regimens and assist with transportation, when needed, to medical and behavioral health appointments.
   
   f. The provider agency will ensure that the child has culturally appropriate hygiene and personal care products.

6. **Educational/Vocational:** DHS and the provider must consider educational stability and continuity for children at every point in the life of the case, document decisions which affect a child’s education, and maintain current education information in the case record. DHS and the provider should advocate on behalf of the child for educational stability.

   A child’s educational placement must be considered when making decisions
about where the child will live. When a child enters placement, the child must remain in his/her current school unless there is a documented reason why it is not in the child’s best interests. Provider agencies are required to provide to foster parents all educational information available on the child placed in their care.

a. Enrollment: The provider will ensure the child does not miss school due to placement. The child will either continue attending the school attended prior to placement or the provider will ensure that the child is enrolled on the next school day post-placement. If enrollment does not occur within four weeks, legal advocacy will be obtained.

b. Monitoring: The provider will monitor the child's participation in the educational/vocational program. Provider and/or resource caregiver will attend all meetings/conferences regarding the child's progress in educational/vocational programs. Provider will encourage participation of birth/legal caregivers in meetings/conferences. The provider agency will coordinate the availability and use of educational supports and activities. The provider will forward all report cards and will notify DHS when the report card indicates three or more unexcused absences. The provider will also notify the DHS worker when the youth is failing to perform at an appropriate level in school, training, and/or employment activities or has received a grade of D or F in any subject.

1. Academic Improvement Plan: When a youth age fourteen and up is at risk of failing a course or program and/or has received a final or interim grade of D or F in a class, the provider will develop a plan for improvement using the Academic or Training Program Progress Improvement Plan Form. This plan will be developed with the youth within seven business days of receipt of a report of the youth’s unsatisfactory progress.

   a. Information about this plan will be incorporated into the youth’s subsequent ISP. Copies of the completed Improvement Plan form will be placed in the youth’s case record and mailed or faxed to the DHS worker upon completion.
   
c. Transportation: The provider is responsible to ensure that the child is transported to and from school.
   
d. Missing school: The provider will avoid making appointments during school hours. Other than court hearings, the provider will arrange for the child to attend appointments outside school hours. If it is necessary to schedule an appointment during school hours, the provider will document the reasons for doing so in progress notes in the case record.
   
e. Preschool aged children: The provider will arrange for developmental activities or programs as set out in the FSP/CPP and ISP.

7. Recreation and Social Activities: The provider will attempt to ensure that the child participates in age appropriate recreational, social, and cultural activities that will contribute to the child’s development. The activities should be designed to meet the individual needs of the child and when appropriate, should be detailed in the ISP.
8. **Utilization of Community Resources**: In accordance with FSP/CPP, the provider will advocate, facilitate and monitor the child’s birth/legal family’s use of community resources in an effort to promote independent use of the resources.

9. **Life Skills Education**: Provider will deliver, as indicated in the FSP/CPP, practical education and training to family unit, either in or outside their homes, which is needed to perform the activities of daily living, including but not limited to, child care and parenting education, home management skills, and related to functions which promote life skills development. Services must be related to and must be designed to promote the earliest possible reunification of the family unit if that is the goal.

   a. While the development of independent functioning skills must be an ongoing process and, therefore, addressed at least informally, for all children, general foster care for adolescents aged 12 and older must address in a formal way the acquisition of those skills that will promote or enhance self sufficiency as an adult. The provider agency must detail the life skills training opportunities afforded the youth in the ISP.

   b. Life skill training should include but not be limited to the following topics;
   - Food purchase, preparation, and storage
   - Budgeting and money management
   - Housing
   - Decision making and self-reliance
   - Employment and job ethics
   - Use of health care resources
   - Sex education, including information about sexually transmitted diseases and AIDS
   - Family Planning
   - Substance Abuse

   c. Providers will facilitate completion of the **Ansell-Casey Life Skills Assessment (ACLSA)** by all youth in care ages twelve (12) and older and their resource caregivers within thirty (30) days of placement and prior to each subsequent ISP. Information obtained from the youth’s self-assessment will be utilized to design an age-appropriate life skill curriculum that will be integrated into the youth’s ISP. The ACLSA tool is designed to facilitate an ongoing conversation among the youth, provider worker and the biological/legal family or caregiver. The ACLSA assists with recognizing the youth’s strengths and challenges, supports further discussion of the areas of greatest disagreement (i.e. scoring discrepancies between the youth’s score and another involved party’s score), and facilitates service planning by addressing goals that are in alignment with the youth’s needs. Additionally, the ACLSA can be completed by other people involved in the youth’s life (e.g. biological/legal parent, teacher, counselor, case worker, etc) as a means to provide comparison to the youth’s own assessment, thereby encouraging an ongoing conversation that will assist with service planning.

   1) This comprehensive strengths-based and youth centered assessment covers nine (9) life skills domains:
2) The following assessment supplements are designed for special populations and their needs:
- Pregnancy
- Biological/legal parents or caregivers of Infants (ages 0-24 months)
- Biological/legal parents or caregivers of Young Youth (ages 2-6 years)
- American Indian
- Education
- Homeless Youth
- LGBTQ Youth
- Youth Values

3) The provider will administer the initial Ansell-Casey Life Skills Assessment (ACLSA) to all youth age twelve (12) and older upon entry into the program (within the first thirty days of placement). The ACLSA must be administered in conjunction with each ISP. The provider will facilitate completion of the ACLSA by the youth’s resource caregiver according to the same schedule.

The provider must review the results of the assessment tool with the youth to determine key areas of strength and the areas of development where the youth might need additional training. Youth must have opportunities to learn and master developmentally appropriate skills that move them toward maturity, autonomy, and self-sufficiency.

The provider must provide life skills instruction to all youth (age 12 and older) utilizing the Ansell-Casey Life Skills Guidebook. This instruction may take the form of individual or group sessions but must always be tailored to the needs of each youth as identified in their ACLSA and outlined in the youth’s Learning Plan. The provider may choose to have this function performed by the youth’s case managers or by specialized staff.

Using the ACLSA, the provider must encourage and facilitate increasing independence, as developmentally appropriate, for every youth receiving services. The provider must help youth to take progressive responsibility for accessing community resources for health care, education, employment, recreation, and
transportation. In addition, youth must be taught how to develop supportive relationships and networks in their communities.

The provider will facilitate training and monitor the resource family’s promotion of youth’s independent living skills education and training. The provider will ensure that children ages 16 and older are referred to the Adolescent Initiative Program in their area (in Philadelphia, this will be the Achieving Independence Center).

C. SOCIAL WORK CASE MANAGEMENT

Case management in this context, is a planned face to face contact between provider agency worker/caseworker and any member of triad or clients that is directed to the resolution of an issue or set of issues related to the goals and objectives articulated in the FSP/CPP and ISP. Case management may occur in a variety of settings in accordance with the provisions of this document.

1. Case Management with the Birth/Legal Family

When reunification is the goal, provider agency will conduct a face-to-face meeting at least once monthly with members of the birth/legal family in accordance with the FSP/CPP and ISP for the following purposes:

- To facilitate the parents’ growth and development.
- To hasten reunification by resolving the problems that resulted in the child’s placement.
- To assess and re-assess the validity and appropriateness of reunification as a goal.
- To insure that visitation is goal-directed and beneficial, not detrimental to the child.

When reunification is no longer the goal, provider agency will continue to relate to the birth/legal family for the following purposes:

- To facilitate the parents’ growth and development.
- To re-assess the validity and appropriateness of the goal.
- To ensure the highest level of parent-child contact consistent both with the child’s safety and developmental needs.

2. Case Management with the Child

The provider agency primary worker will have face-to-face contact at least twice per month or as often as required by Court order (never with a gap of more than 30 days) and will visit the child in the foster home at least once monthly to assess and monitor safety and well-being. The provider worker will assess the use of independent sleeping arrangements (crib or bed as developmentally appropriate, not shared with adults or other children) for children age two and under on all home visits and verify that the family has a safe sleeping arrangement. The provider will document this assessment in case notes.

Examples of relevant topics for discussion during these visits include:

- Clarification and acceptance of the role of the social worker.
• Clarification and acceptance of the role of the foster parents.
• Relationship issues with the other children in the foster home.
• Use of limits imposed by the foster parents.
• Understanding the need of placement.
• Relationship with legal family.
• Interaction in the community.
• Progress (or lack of) toward attainment of Service plan goals/objectives.

3. Case Management to Foster/Resource Parents

Provider agency will visit the foster parent at least once per month to facilitate their care of the foster child. Examples of relevant topics for discussion are:

- Understanding the nature of the child and family’s problems and the general context in which the child was placed.
- Ensuring the continuity of the foster care placement.
- Handling emergency or other difficult situations.
- Accessing community and human service resources (e.g., health and education) for the child.
- Supporting the treatment plan and understanding relationships with legal parents.
- Promoting normative development.

On a quarterly basis, the Provider worker will educate caregivers with children age 5 and under or children with cognitive impairments regardless of age, about the following safe bathing practices:

- Check the temperature of the water to make sure it is appropriate
- Never leave a child unattended in the bath
- Monitor a child in the bath; do not leave the child in the care of a member of the family other than the certified caregiver (e.g. another foster child or the caregiver’s child)

This information will also be given to the caregivers whenever a child age 5 and under or a child with cognitive impairments regardless of age is placed in the resource home.

VI. PERMANENCY

Reunification is the preferred permanency outcome, and providers are expected to direct services to children and their birth/legal families in support of reunification. If reasonable efforts have been made and reunification has been determined to be inappropriate, adoption must be vigorously pursued. If adoption is ruled out, Permanent Legal Custodianship (PLC) should be pursued. If these three permanency options have been ruled out, providers are expected to prepare children for independent living and to work toward the achievement of a successful Independence Outcome.

A. REUNIFICATION

Whenever possible, reunification is the preferred permanency option for children. The
agency provides casework and other services to the family to assess their potential for attaining a minimum standard of parenting. These services shall be directed at rehabilitating and stabilizing family relationships so that the child may return to the family under a DHS permanency goal of reunification. Good assessment and goal planning is essential to explore the possibility of reunification as early as possible. The birth/legal family, the foster/resource family, and the child all need assistance preparing for reunification.

To ensure the stability of reunifications, a reunification that does not last for at least 12 continuous months from the date of the court order returning the child(ren) home will not count as a permanency outcome and the agency will be expected to reassume care for the child(ren). The disruption will be subtracted from the agency's permanency count.

B. ADOPTION

Agencies are responsible for ensuring the completion of all work toward adoption finalizations. In accordance with SWAN standards, child profiles must be completed within 90 days of termination of parental rights and the goal change to adoption. Funding is outlined in Section XI.

At the time of finalization, agencies will make families aware of post-permanency services available through SWAN.

To ensure the stability of adoptions, an adoption that does not last for at least 12 continuous months from the date of the court order finalizing the arrangement will not count as a permanency outcome. The disruption will be subtracted from the agency's permanency count.

Shared Adoptions: if a child is moved to a pre-adoptive home in a different agency (adoptive subsidy has started) the sending agency can request a permanency credit at the time of the move by using the reconciliation process. If the pre-adoptive placement breaks down prior to finalization and within 12 months of the child leaving the agency, the agency will accept the child back (pending foster care eligibility) and the permanency credit will be deducted from the agency’s total.

C. PERMANENT LEGAL CUSTODIANSHIP (PLC)

When reunification and adoption have been ruled out, PLC should be pursued, in accordance with eligibility requirements and procedures set forth in DHS policy.

Services to assist the child in preparation for PLC will be provided by the agency through this contract. Funding is outlined in Section XI.

To ensure the stability of PLC arrangements, a PLC that does not last for at least 12 continuous months from the date of the court order returning the child(ren) home will not count as a permanency outcome and the agency will be expected to reassume care for the child(ren). The disruption will be subtracted from the agency's permanency count.
D. INDEPENDENCE OUTCOMES

For children exiting DHS care and for whom reunification, adoption and PLC have been ruled out, the provider will prepare the child for a successful transition to independence.

All youth who age out of the system will have the following at the time of their discharge: original/official copy of birth certificate, Social Security card or established legal residency/citizenship with appropriate documentation, and photo identification in the form of a State Non-driver’s Photo ID or Driver’s License.

Providers will submit Independence Outcome forms and documentation applicable to each criterion for all youth who age out of Foster or Kinship Care. The form and documentation will be submitted within thirty (30) days of the youth’s exit from care.

A successful Independence Outcome, as defined below, will be counted as a permanency towards the provider’s performance expectations when documentation is submitted by the provider (within thirty (30) days of the child’s exit from PBC and in any event not more than thirty (30) days after the end of the quarter in which the youth exited) and approved by DHS.

All of the criteria listed below must be satisfied and youth must be exiting care (age 18 or older)\(^8\):

- Youth will have been referred to the Adolescent Initiative Program in their area at age sixteen (16) or upon entering the agency’s care.
  - In Philadelphia, this will be the Achieving Independence Center.
- Youth has original/official copy of birth certificate.
- Youth has Social Security card or youth’s legal residency/citizenship is established and current and youth has records.
- Youth has photo identification in the form of State Non-driver’s Photo ID or Driver’s License.
- Youth has a current resume.
- Youth has identified three (3) employment references and has their contact information.
- Youth has obtained: i) a high school diploma; or ii) a GED certificate; or iii) completed an approved vocational - technical school at the time of discharge or by the end of the contract year. Exceptions to this general rule follow:
  - A youth who enters care at age sixteen (16) years or older will:
    - If the youth is in care for at least one year, advance at least one grade level per year for each year in care OR if the youth has an Individualized Education Program (IEP), meet the goals identified in the IEP.
    - If the youth is in care less than one year, meet appropriate, agreed-upon educational goals identified in the FSP/ISP or in the IEP if applicable.
- Youth has enrolled in a post-secondary program (college, vocational or technical

\(^8\) A youth exiting foster care but remaining on Board Extension to attend and live at college is eligible for an Independence Outcome if all other criteria are met. A youth exiting foster care for SIL will be eligible for a neutral outcome if the Independence Outcome criteria are met.
Youth lives in a usual (non-shelter), safe and sustainable (financially and otherwise) living arrangement.

Youth has access to appropriate and affordable health care services.

Youth has selected local health care options and has been oriented to accessing selected options.

Youth has copies of medical records/history, including immunizations/inoculations.

Youth has a positive relationship with a caring adult.

If a youth is pregnant or parenting children of his/her own, an additional parenting criteria must be met in order to qualify for an Independence Outcome. This includes: completion of a parenting program, and submission of a brief plan addressing resources for child care, financial support of the child, and pre-natal care (when applicable).

VII. FOSTER PARENT RECRUITMENT AND SCREENING

A. RECRUITMENT AND SCREENING

Provider agency will recruit and screen individuals who meet state regulation requirement and the provider agency’s requirements.

B. ELIGIBILITY REQUIREMENTS

Foster parents and homes must fulfill all applicable state regulations. In addition, foster parents should exhibit a sincere desire to care for children and possess the mental, emotional, social, moral and financial capacities to work in collaboration with the provider agency to meet the needs of children and their families. If a child with additional needs is placed in a foster home, the provider agency is expected to assure that the foster family is capable of addressing those needs, is willing to receive more advanced training as deemed appropriate by provider agency, and is willing and able to work intensively with the child and legal family according to programs established by provider agency.

C. ORIENTATION

In accordance with state regulations, the provider agency will provide an orientation for new foster parents before placing any children with them. In addition to the topics listed in the state regulations, provider agency will provide training in the following areas: the identification and prevention of child abuse and child sexual abuse; infection control procedures; Safe Sleeping, using materials from the Maternity Care Coalition; and safe bathing.

D. TRAINING

Provider agencies will provide all on-going training as required in the state regulations. Foster parents will also participate in three hours of training on the Ansell-Casey Life Skills Assessment in addition to training required in the state regulations.
DHS encourages agencies to provide foster parent training in accordance with Statewide Adoption and Permanency Network (SWAN) benchmarks in order to facilitate concurrent planning.

VIII. DOCUMENTATION OF SERVICE DELIVERY

A. CLIENT CASE RECORDS

The provider agency will establish and maintain a case record for each child placed in foster care under its aegis in accordance with state regulations.

The case record will include items required by State Regulation 3680.32. In addition, the case record will include documentation of all activities performed in support of the goals of the FSP/CPP and ISP.

Case recordings must contain, at a minimum, the following:

- Date, length, participants, specific purpose and specific outcome of each contact with or on behalf of clients.
- Documentation that the purposes and outcomes of such contacts related to alleviating/ameliorating those elements, past and present, in the client situation that precipitated the client’s coming to the attention of the DHS and/or that are impeding the attainment of goals (i.e., that the contacts are related to the goals and objectives of the FSP/CPP and ISP).
- Documentation that the contacts made and services delivered relate to the service activities included herein.

Case records will contain:

- The initial Ages and Stages Questionnaire (ASQ/ASQ-SE) and subsequent ASQ/ASQ-SE’s according to the age-based interval schedule for all children up to age 5.
- A copy of the youth’s initial Ansell-Casey Life Skills Assessment (ACLSA) upon entry and all subsequent ACLSA’s submitted in coordination with the ISP review.
- A copy of ACLSA’s completed on the youth by the resource caregiver upon entry and subsequently, in coordination with the ISP review.
- A copy of the youth’s Learning Plan as developed through the ACLSA.
- An initial copy of the Youth Resource List completed within thirty (30) days of placement and all subsequent Youth Resource Lists submitted in coordination with the ISP Review.
- Any Academic or Training Program Progress Improvement Forms completed within seven (7) business days of receipt of notification that the youth has performed below expectations in education or training activities (including, but not limited to, the receipt of grades of D or F in any subjects).

The client case record must also include a section on the legal family in accordance with State regulations. This section should include:

- Documentation regarding family’s visits with child (location, time, missed visits and reasons, efforts to facilitate visits) as specified in Bixler v. White.
- Documentation regarding all sibling visits, including location, date, missed visits and reasons, and efforts to facilitate visits.
- A copy of the form used to gather information on adult relatives and kin upon the placement of a child who was removed from his/her parents.
- Contacts with other community resources and social service agencies on behalf of family and the monitoring of such services.
- Significant events in lives of family members (births, deaths, marriages, divorces, changes in living arrangements and status of siblings).

**B. FOSTER FAMILY RECORDS**

The provider agency will establish a foster family file in accordance with state regulations. In addition, the foster family record will include the following:

- Original application and updated personal information.
- Orientation and Training Schedule and Attendance.
- List of children placed in home including dates of placements and discharges.
- Awards and commendations.
- Foster home approval and child relocation appeals.
- CY-47's filed against foster parents, if indicated.
- Disciplinary actions.
- List of approved substitute caretakers.
- A chronology of the use of the foster home as a placement setting (names of children, outcome of placement and conditions under which placement terminated).

**IX. REPORTING REQUIREMENTS**

**A. PROVIDER AGENCY RESPONSIBILITY**

1. **Documentation of Quality Monthly Visits**
   a. The provider worker will submit one Quality Monthly Visit form per month to the DHS worker through P-Web.
      1) The form will be submitted within the first 10 days of the month following the quality visit (i.e. if the visit was in April, the form will be entered in P-Web by May 10).

2. **Quarterly Reports**
   The provider agency will submit quarterly reports on each child’s progress in placement.
   a. The Quarterly Report must include: progress on specific short-term service planning goals, including goals from the Ansell Casey Life Skills Guidebook, significant revisions on goals and/or strategies, any changes to the permanence plan and the transition/discharge plan and documentation of sibling visits, including dates.
   b. The 1st Quarterly Report is due to DHS 1 month before the 3 month anniversary date of the DHS Accept for Service (AFS) Date. This quarterly report will span a time period that is less than one full quarter.
   c. The 2nd Quarterly Report is due to DHS 1 month before the 6 month...
anniversary date of the DHS AFS date.

d. The 3rd and 4th Quarterly Reports are each due to DHS 1 month before the respective 9 month and 12 month anniversary dates of the DHS AFS date.

3. Unusual Incident and HCSIS Reports
   The provider agency will notify DHS, orally and in writing of any fatality or incident, as required by state regulations, including but not limited to 55 Pa. Code 3680.21, and state and DHS directives, including but not limited to the Policy and Procedure Guide dated February 23, 2010, “Using and Responding to the Safety Alert Tool for Families Receiving In Home Services and the Home and Community Services Information System (HCSIS) Reports for Children in PA placements.” In addition, an unusual incident report is required in the event of suicide behaviors and the death of a foster family household member.

   All unusual/critical incidents must be reported orally to the DHS within 24 hours of the incident to be followed by a written report submitted within 5 calendar days of the occurrence of the incident.

4. School Change Notification
   When a child changes schools, the provider worker will notify the DHS worker and copy the DHS supervisor within one business day of the school change.

B. DHS RESPONSIBILITY

1. DHS Contacts with Child and Legal Family
   DHS will:
   - Notify the provider agency in advance of all scheduled DHS contacts with the child or birth/legal family.
   - Inform the provider agency of its direct contacts and interactions with children and birth/legal families.
   - Furnish the provider agency with information regarding the outcomes of DHS contacts with the child or birth/legal family including any change in the family situation that may affect the child’s care and services to the birth/legal family.

2. DHS Visits to Placement Setting
   DHS will notify the provider agency in advance of its scheduled visits to placement settings.

3. DHS-Unusual/Critical Incident Reports
   DHS will notify the provider agency of unusual/critical incidents relating to the child’s family that may impact on the delivery of services to the child.

X. PERSONNEL

A. PROVIDER AGENCY RESPONSIBILITY

1. Assignment of Personnel
a. Recruitment/Screening/Training
Provider agency will recruit and screen potential individuals for social work positions in accordance with state regulations.

Case workers will receive training in accordance with state regulations. In addition, they are to receive training in the identification and prevention of child and sexual abuse, suicide prevention and intervention, and life skills for adolescents, including the use of the Ansell-Casey Life Skills Assessment.

b. Supervision
Each case worker will receive supervision at least one time each week. Case workers with at least 3 years experience and who are certified by provider agency as advanced can receive less supervision but in no instance less than twice a month.

c. Education Requirements
- The Program Director has a Master’s degree and 2 years experience in the administration of human service programs.
- The Program Supervisor has a Master’s degree in social work or a related field. Related fields are limited to sociology, psychology, counseling, criminal justice, education, divinity, or public health administration.
- The Program Case Manager has a Bachelor’s degree in social work or a Bachelor’s degree in a related field. Related fields are limited to sociology, psychology, counseling, criminal justice, education, divinity, or public health administration.

d. Notification to DHS
Provider agency will assign a primary worker for the child not later than the day of placement and will inform DHS of all personnel involved with the management of placement services for each child. The names and telephone numbers of the primary worker and his/her supervisor must be reported to the DHS and supervisor. All changes in personnel should be reported to DHS within two (2) weeks of the change.

B. DHS RESPONSIBILITY

1. Notification of Assigned Personnel
DHS will furnish the provider agency with a listing of DHS personnel involved with the management of placement services for each child or youth in placement. This listing will include names and telephone numbers of the case manager, supervisor of the case manager and the staff person to whom the supervisor reports. DHS will notify the provider agency of all changes in these personnel within two (2) weeks of each change.

2. Communication with Provider Agency Personnel
DHS will channel its client service delivery input requests for direction in the following order: provider agency caseworker, supervisor of caseworker, and administrator of the provider agency. DHS will not contact or give direction for service delivery to other
than those listed above except with prior provider agency approval, except in cases of emergency.

XI. FINANCE AND BILLING PROCEDURES

Family Foster Care and Kinship Care

Payments will be divided into four parts, detailed below:
1. Administrative component
   a. Baseline case management
   b. Placement Capacity Enhancement/Emergency Resources
   c. Resource Caregiver Recruitment and Certification
   d. Permanency worker
   e. Resources for stability
2. Foster parent payments to be passed through to foster parents
3. Adoption and PLC Funding
   a. Child Profiles
   b. Child Preparation
   c. Adoption Payments
   d. PLC Family Profiles

Further, DHS agrees to provide to private agencies equal access to all publicly funded services.

Administrative Component
(Figures noted below are annualized.)

Administrative payments will be made to the agency on a monthly basis. Baseline case management funding is provided to provide case management services and services to meet normal developmental needs. The changing demands of the case situation should drive this service delivery, consistent with applicable law, regulation, DHS policy and this contract’s requirements.

Placement Capacity Enhancement funds may be used flexibly by providers to enable them to handle emergency placement referrals. Providers are expected to be able to meet the needs of children entering on an emergency basis.

Recruitment funds are to be used to support foster parent recruitment specialists.

Funding is provided to support a portion of a permanency worker for each team. Permanency workers are expected to provide a full range of support to case carrying staff. Agencies are expected to combine this funding with the funding received through Adoption and PLC Funding to support a permanency worker on every team.

Resources for stability and well-being are provided to enable agencies to craft individualized plans targeted to support a subset (estimated at two children) of each caseload most in need of more intensive supports with the goal of preventing their movement into higher levels of care. Planning for these expenditures should be guided by the domains noted in Attachment D. These funds may not be used to provide
services that are covered by Community Behavioral Health. Similarly, agencies should exhaust other potential funding sources prior to spending these funds.

Foster Parent Payments
DHS shall pay the private agency foster parent payments to pass through to caregivers. This amount will fluctuate based on the number of care days provided during the month.

The agency agrees and warrants that it shall pay to the foster caregiver a board rate no less than the rate paid to the agency by the DHS. As of 7/1/2012, this is $21.25 per day.

The Agency is required to provide information (including location codes and dates) necessary for DHS to complete an 85-29 each time a child is placed, moved, or discharged from the agency. Each month the Agency is also required to review its bill for accuracy and complete a billing change request and submit it to DHS.

Adoption and PLC Funding
Timelines for completion of these services will be in compliance with state regulation and Statewide Adoption and Permanency Network (SWAN) benchmarks unless otherwise required by court.

Child Profiles
 Agencies are expected to complete or ensure the completion of child profiles for every child for whom parental rights have been terminated as well as for other children identified by DHS. Agencies may subcontract with other providers for this work. Payment for Child Profiles will be made through SWAN.

Child Preparation
Children may be identified to participate in child preparation services to prepare them for permanency. Services will be delivered by agencies certified by SWAN to perform this service.

Payment for Adoptions
Agencies are expected to complete or ensure the completion of the components necessary for a completed adoption, including family profiles, child placement if needed, child-specific recruitment if needed, and finalization. PBC agencies may complete their own adoption work or subcontract with another agency for the completion of this work. All payment for adoption components will be made through SWAN.

PLC Family Profiles
Agencies must complete a Family Profile in preparation for PLC in the format promulgated by DHS. Payment for PLC Family Profiles will be made in accordance with DHS standards and SWAN benchmarks.

Payment for all child and family profiles includes completion of the original profile and up to two updates within three years. Agencies will not invoice more than once in a three year period for the same child or family.
ATTACHMENT B

FOSTER CARE REFERRAL AND ADMISSION
Family Foster Care and Kinship Care
Including Medical, Mother/baby, Maternity
and Emergency Foster Care

CONTENTS
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INTRODUCTION
To improve the process of case referral to private agencies, agencies will receive referrals on a family based, geographic, rotational basis. An agency will accept cases referred to them consistent with the stipulations of this contract. The agency agrees to conform to the standards of the revised referral process. The agreement establishes principles for case referral (appropriate and timely referral, geographic alignment, family case consolidation and case coordination) and details an agreed management and clinical process consistent with those principles. Agencies not under the Performance Based Contracting model for General Foster Care will not receive geographic rotation referrals.

The assignment process supports the following goals:

Appropriate and timely case assignment: The referral and assessment process should be designed to ensure that a child needing to be placed in substitute care receives, as soon as possible, the most appropriate level of service to maximize the child’s safety, stability, and well-being. Timely and appropriate referral is not only best practice for children, it promotes the sound use of scarce system resources, particularly the use of foster homes. An appropriate placement decision occurs when accurate information about a child and his/her family is obtained and analyzed prior to DHS making a placement decision.

Quicker movement into a stable placement: Direct referral enables the child to be placed into a stable foster placement more quickly upon entry into the substitute care...
It is essential that children be afforded increased stability by decreasing the moves they experience while in the substitute care system.

**Equitable case distribution:** Rotational referral permits the equitable distribution of cases across all agencies. The more rapid initiation of service, greater continuity of care and higher quality of case planning contribute to improved outcomes for children and their families.

**Geographic Referral:** Geographic referral (consistent with Ongoing Service Regions) will be accommodated to the extent practical. Geographic referral improves relationships with service providers in communities, eases the logistics of care, and reduces the disruption of a child's familial, educational, social, and community connections.

- Agencies have been afforded the opportunity to indicate preferred geographic areas for case referral.
- For Family Foster Care, geographic referral is based on the parent's/legal caregiver's home community, not on the site of the placement and/or agency location. For Kinship Care, geographic referral is based on the placement location, consistent with past practice.

**Consolidation:** The policies of referral are driven by principles designed to improve the clinical appropriateness of case assignment and case services. They tie together under a single agency the entire family, linking siblings with agencies already serving the family. In addition, new cases will be referred with the assumption that the agency can serve the sibling group in one home. When that cannot happen, the agency must post the sibling group on the secondary match system in order to find an agency that can place all the newly referred children in the same home unless there are documented overriding clinical reasons to place the family apart. If the provider believes that there are clinical reasons to separate siblings, they will coordinate with the clinical management team of the Center for Child and Family Well-being and Community Behavioral Health to make a final determination.

**Trumps to the Automated Rotational Assignment System:** The following circumstances will determine when a referral is made based on circumstances other than geography:

1. Relationship with sibling
2. Relationship with child
3. Prior relationship with family
4. Language need

When a trump determines the selection of an agency for a referral, the CRU will identify the trump in the referral documents that are faxed to the agency.

DHS will monitor the Automated Rotational Assignment System for accuracy and efficiency and will adapt it to meet changing system dynamics as needed.

**Acceptance of Referrals:** Agencies are expected to accept referrals made during DHS
referral hours. (As of May 2005, these hours are 8:30 am to 7 pm, Monday through Friday. The 5pm to 7pm period is defined as Extended CRU Hours). DHS may extend or change referral hours with 30 days advance written notice to all providers. Agencies with a DHS contract for after business hour referrals will accept referrals outside regular CRU hours (defined as of May 2005 as between the hours of 7 pm and 8:30 am and on weekends and city holidays).

**Characteristics of Children Served in Foster Care Settings**

When DHS has determined that foster care is the least restrictive setting needed to meet a child's needs, it may refer to agencies any such child, for whom it has legal responsibility, who falls within the parameters of the population served under the contract. All children who are found appropriate for general foster care will be accepted without regard to age, race, religion, sexual orientation or gender.

A child/youth who has a diagnosis of Intellectual and Developmental Disability generally meets the criteria for foster care unless the degree of his/her developmental disability requires that he/she requires: 1) significant supervision and personal care services not typically needed by someone the same age, 2) significant coordination of individualized special education, developmental and vocational services, or 3) specially trained foster parents.

**Criteria for Referral to General Foster Care**

_A child must not be excluded from general foster care because of a behavior problem /mental health disorder that is resolved or is under control._

For those children who are experiencing the behaviors noted below who have been evaluated within the past 60 days, the evaluation must clearly indicate that the behavior(s) noted below are resolved or under control prior to the child's referral to general foster care.

For those children who are experiencing the behaviors noted below who have not been evaluated in the last 60 days, the CRU Screening Unit will coordinate with a senior care manager from Community Behavioral Health (CBH) to review the child’s behavioral health history and determine if an evaluation is necessary prior to admission to general foster care. The CRU Screening Unit and CBH will then arrange for the appropriate type of evaluation and make a determination as to whether the child should be referred to general foster care.

1. has engaged in a homicidal act or ideation;
2. has experienced a suicide attempt;
3. has experienced a pattern of loss of contact with reality;
4. has engaged in impulsive sexual acting out that endangers self or others;
5. has engaged in fire setting and has been determined to be an active and continuing risk based on a fire setting evaluation;
6. has been actively drug dependent (as opposed to occasional or previous use);
7. has committed injury causing or aggravated assault to self, others, or animals; OR
8. has had a Child and Adolescent Needs and Strengths Assessment (CANS) within the last 90 days that indicates the need for a higher level placement.

Eligibility for general foster care is based on the child’s behaviors. Deferred adjudication, dual adjudication, or pending delinquent charges do not necessarily exclude a dependent child from general foster care.

RECONSIDERATION PROCESS WITHIN THE FIRST 60 DAYS OF PLACEMENT

If during the first 60 days after placement, the provider believes that a child with any of the above listed behavioral/mental health disorders was referred because 1) the child’s behavioral health record was not found at the time of referral and current behaviors suggest the need for evaluation and possible higher level of care, or 2) the child’s behavior/mental health disorder manifested in placement and an evaluation supports transitioning the child to a higher level of care, or 3) a previously unknown medical condition that would qualify the child for Medical Foster Care becomes known and affects placement to the extent that level of care is reexamined, the provider will submit a Reconsideration Memo along with any documenting information to the Reconsideration Liaison as soon as possible.

If a child manifests a behavior/mental health disorder within the first 60 days of placement, the provider will coordinate with CBH to obtain an evaluation to determine community treatment needs. If the evaluation suggests the need for a different type of placement, the CRU Screening Unit will arrange for a CANS or RTF teaming as appropriate. In all cases, DHS will make a final determination with respect to the appropriateness of the placement in no more than ten working days of receipt of documentation from the provider. Providers will make all possible attempts, with the assistance of CBH and DHS’ Center for Child and Family Well-being, to stabilize children without moving them during this process.

If the Reconsideration is approved, the CRU screening unit will withdraw the referral unless, by mutual agreement, adequate care is being provided or appropriate additional services can be developed. When that is not the case, a referral to the appropriate level of care will be initiated within one business day of the reconsideration approval and the child will be placed in an appropriate level of placement as soon as possible, and in any event within 30 days of the receipt of documentation from the provider of above-noted behaviors.
The Short Stay Policy will apply in any case *(see page 52)* where a child leaves an agency within 30 days of referral.

In situations in which the agency disagrees with the CRU staff determination, the case will be referred to the CRU Administrator for resolution. If there remains disagreement, the Director of the Center for Child and Family Well-being will make a final determination. In all cases, DHS will make a final determination with respect to the appropriateness of the placement within four working days of receipt of documentation from the provider of above-noted behaviors.

If the Reconsideration is approved, DHS will withdraw the referral unless, by mutual agreement, adequate care is being provided or appropriate additional services can be developed and the agency agrees to serve the child. The provider can agree to provide services outside the general foster care contract under an existing DHS contract, if applicable.

A movement of a child where a Request for Reconsideration was submitted within 60 days of referral and Reconsideration was approved as outlined in this section will not be considered a negative quality indicator.

**ASSESSMENT OF KINSHIP PLACEMENTS FOR SAFETY AND HABITABILITY**

Pursuant to applicable state regulations and DHS policy, prior to placing a child in a kinship care home, the DHS worker and/or a DHS contracted kinship assessment provider will undertake the following steps to assess the appropriateness of the placement:

**Facility:** The DHS worker will conduct an on-site visual inspection of the home and will not place or maintain children in homes that do not have all of the following:

- Running water
- Operable toilet, sink and tub
- Electricity
- Operable heating system
- Operable smoke detectors on each level of the residence
- Operational fire extinguisher
- Appropriate sleeping area for the child and a separate bed for each child
- Household chemicals, weapons and medications properly secured
- No obvious structural damage which could be detrimental to the child's health or safety (ex: exposed electrical wiring, falling plaster)

**Caregiver:**

Prior to placing a child in a kinship care placement, DHS and/or a DHS contracted kinship assessment provider will conduct an assessment as set forth in CYD policy, including the following steps:
• DHS will obtain an oral ChildLine clearance, and an online State Police clearance. Consistent with directives set forth in state law and DHS policy, children may not be placed in homes in which any resident is a perpetrator of a founded report of child abuse or neglect within the previous 5 years. Children may not be placed on an emergency basis in homes in which any resident is a perpetrator of an indicated case of child abuse or neglect.

• DHS will clear household members in FACTS. Consistent with DHS policy, no child may be placed on an emergency basis in a home where there is history of involvement with DHS that suggests any threat to the child’s safety.

• DHS and/or a DHS contracted kinship assessment provider will assess caregiver’s ability to meet the child’s needs and assure child’s safety and well-being.

• DHS and/or a DHS contracted kinship assessment provider will apprise caregivers of the alternatives for supporting children (own resources, TANF/SSI, DHS foster care subsidy)

• DHS and/or a DHS contracted kinship assessment provider will apprise kinship caregivers of their rights and responsibilities as a kinship caregiver.

The referring DHS worker and/or a DHS contracted kinship assessment provider will document the results of the safety inspection and the steps set forth under the Facility and Caregiver sections above on the prescribed form. Documentation will be forwarded by the CRU to the provider agency at the time of referral if the assessment was completed by DHS. If the assessment was completed by a contracted assessment provider, documentation will be given by the contracted assessment provider to the placement provider no later than the date of the transition meeting.

If, after receiving a kinship care referral from DHS, the provider determines that the facility does not meet safety standards required by State regulation and DHS policy and there is reasonable likelihood that the home can be brought into compliance, the provider will take reasonable steps to bring the home into compliance, through appropriate collaboration with DHS’ CYD Chain of Command. If necessary during the first 60 days of the placement, the provider may move the child into a temporary respite placement while working with DHS to bring the home into compliance. The DHS case manager must be notified of any such move, and an 85-29 must be initiated by the provider and completed by the CRU data entry staff for any move lasting more than 24 hours.

If the provider determines that the facility and/or caregiver is out of compliance with State regulation and/or DHS policy, the provider will document the nature of the non-compliance with respect to applicable regulations and will notify DHS’ Provider Relations and Evaluation of Programs (PREP) Unit as soon as possible and not later than the 30th day of placement. DHS and the provider will work together to bring the facility and/or caregiver into compliance. If in the process of working toward compliance, it becomes evident that the facility and/or caregiver cannot be brought into compliance by the 60th day of placement, the provider will work with DHS to move the child into another kinship or family foster care home. No later than 15 days in advance...
of the move, the provider must notify the child’s parents in writing of the placement change and forward a copy of the notification to the DHS case manager.

When a child in kinship or foster care placement is moved to a new kinship care home, the provider will conduct the safety assessment and the steps noted in the Facility and Caregiver sections above and fully certify the home before moving the child, except that the DHS case manager will obtain the oral ChildLine clearance, will obtain the online State Police clearance, and will clear household members in FACTS.

When a youth planning to step down from a Group Home is referred for a planned kinship care placement, a kinship care provider will be identified through the rotational assignment system. DHS will obtain oral ChildLine clearances, online State Police clearances, and clear household members in FACTS. The kinship care provider will begin the kinship home assessment within 72 hours of accepting the referral. The provider will fully certify the home before the youth can be moved into the home. If the home cannot be fully certified or the youth cannot be moved into the home, the kinship care referral will be withdrawn and the Group Home will retain responsibility for planning the youth’s next steps. If, subsequently, a foster home is needed, a foster care agency will be identified through the rotational assignment system. The kinship care provider will collaborate closely with the Group Home provider and attempt to certify the home in a timeframe consistent with the youth’s readiness to transition to kinship care.

**REFERRAL PROCESS**

1. DHS/CYD determines there is a need for placement;
2. The referring DHS case manager completes a referral form in the electronic case management system (ECMS);
3. CRU clerical logs the request;
4. CBH care manager reviews the referral form and contacts the DHS case manager for clarification as needed;
5. CRU screener reviews the referral form, contacts the DHS case manager for clarification as needed, and determines if the case meets the criteria for general foster care (based on behavioral health history and all other available information). If the behavioral health history indicates the need for a CANS, the CANS will be administered prior to referral.
6. If appropriate, CRU refers the case to an agency;
   a. if not appropriate, the case remains with CRU and the DHS case manager; the child will be referred to an appropriate alternative placement;
7. CRU calls the agency referral liaison (regular or duty intake after hours) and faxes/e-mails the referral packet (including Referral Form, any current psychiatric or psychological evaluations, and/or CANS Assessment). All providers will have phone messaging capabilities, and if not available at the time of the initial CRU
call, agency referral liaison will call back within 60 minutes. Providers will ensure that the CRU has current phone numbers for supervisors and/or executive staff, which may be used by the CRU to reach the provider agency in exceptional situations, such as to facilitate the referral of a sibling of a child already served by the agency. DHS staff will provide a telephone number where they can be reached, if the referral is not made during regular business hours.

a. Agencies with a DHS contract for after business hour referrals (defined as between the hours of 7 pm and 8:30 am and on weekends and city holidays) will respond immediately to placement requests.

b. When providers accept kinship care referrals, they will visit the kinship home within 72 hours of the referral. If an agency believes that it will not meet this expectation, the agency will reject the referral. (Exception: for emergency kinship care referrals where the initial home assessment is being completed by a contracted assessment provider, the placement provider will be required to attend the transition meeting but will not be required to visit the home within 72 hours.)

8. CRU gives the agency the referring DHS case manager’s name, phone number and location for direct coordination;

9. CRU contacts the referring DHS case manager and supervisor and gives the agency name, referral liaison’s name, phone number, and pager number;

10. Referring DHS case manager contacts agency as soon as possible and in any event by the end of the working day after agency’s acceptance of referral, and agency and DHS referring case manager coordinate placement into an agency home. If the placement does not occur or if the child runs away or otherwise exits placement within 30 days of referral, the provider will notify the CRU and the referral will be backed out and replaced (See Short Stay Policy, page 52).

11. If DHS determines that the foster home is no longer needed, the CRU or the DHS case manager will contact the foster parent and provider agency worker within one hour of the determination.

12. Payment authorization
   a. The 85-29 is authorized when the CRU data entry staff is contacted by the DHS case manager to confirm the placement;
   b. In cases where the child is already in placement at the time of referral (some kinship care cases), the 85-29 should be completed by the CRU referring worker upon referral.
      1) For emergency kinship care referrals where the initial home assessment is being completed by a contracted assessment provider, the date of the transition meeting will be the 85-29 placement date for the PBC kinship care service provider.

13. CRU will complete all data elements in the tracking system to confirm admission; and

14. As appropriate, the DHS intake worker (if applicable), the assigned DHS worker and the provider agency worker (including admissions staff if appropriate) attend placement case transition meeting and the initial court hearing. Additional case
Referral of Cases New to Placement

1. An agency must accept all appropriate referrals made during DHS referral hours upon request by CRU staff. The provider agency must provide access to an appropriate placement resource, including a same-day/emergency placement resource if necessary. If an agency receives a referral for a child who is in shelter or another placement, the agency is expected to assume responsibility for housing that child within 24 hours. When an agency accepts a kinship care referral, the agency will visit the home within 72 hours of the referral. (Exception: for emergency kinship care referrals where the initial assessment is being completed by another agency, the placement agency will be required to attend the transition meeting but not be required to visit the home within 72 hours of the referral.)

2. Agencies must be prepared to attend the initial preconference/adjudicatory court hearing within 10 days of the case’s entry into foster care. The DHS referring case manager will notify the agency of the hearing time and date as soon as the DHS worker is notified if it is not known at the time of referral. (Exception: for emergency kinship care referrals where the initial home assessment is being completed by a contracted assessment provider, the placement agency will continue to be required to attend any court hearings scheduled after the transition meeting but will not be required to attend court hearings scheduled prior to the transition meeting.)

3. Agencies must accept foster care referrals where they are currently serving the family (add-on cases) provided the child is appropriate for foster care. Agencies are expected to place siblings within a single home and assign the case to a single agency worker.

4. Agencies that cannot secure an appropriate placement for a child within their system or that cannot place all siblings together are responsible for identifying an appropriate placement within another agency (Secondary Match). The CRU must approve the placement before the child is moved.

5. If a sibling group is split between Kinship and Family Foster Care, the agency receiving the Family Foster Care referral must also accept the cases placed in the Kinship Care home. Such cases will be referred to the same agency (though will not necessarily be moved to the same home, unless the kinship placement disrupts) in order to consolidate case management with one agency.

6. Upon acceptance of the child and family, the provider agency will:
   - Review all of the materials and information available on the child and family.
• Interview the child and family to obtain their input.
• Obtain input from the prospective foster parent
• Assess all of the information gathered to determine the child’s and family’s strengths and problems areas or special needs.

7. Agencies must ensure that the foster parents are aware of the expectations placed on them. Agencies must complete the Individual Service Plan [this operationalizes the Family Services Plan (FSP)] of the children referred within 30 days of entry into care. The FSP and ISP should be completed at the same time.

**Referral of Transferred Foster Care Cases**

Same as referral of new placements (above) except:

1. If a child disrupts from his/her current placement and the siblings are split between homes or agencies, agencies will use this as an opportunity to consolidate the children in one home or with one agency (with approval of DHS case manager). It will be considered a neutral outcome for an agency to transfer a case to the same level of care at another foster care agency in order to consolidate siblings. The transfer will be considered an intake for the receiving agency.

2. If an agency determines it is in the best interest of the children to consolidate siblings and a consolidated placement is available, with approval of the DHS case manager, the agency will consolidate the sibling group. It will be considered a neutral outcome for an agency to transfer a case to the same level of care at another foster care agency in order to consolidate siblings. The transfer will be considered an intake for the receiving agency.

3. As for new placement cases, for transferred cases CRU will provide information on the Referral Form, the Safety Risks from the Safety Assessment and any current psychiatric/ psychological evaluations and CANS assessments. Additional information contained in the transfer packet will be shared at the time of referral to the extent possible.

4. The provider sending the child will provide the transfer packet to the new provider. If this packet is not forwarded or is not complete, the new provider will contact the DHS case manager for the information, which will be provided not later than the placement case transition meeting. The transfer packet includes:
   • Referral Form
   • Medical consent order form
   • Redetermination of Medical Assistance Eligibility
   • Immunizations record or authorizations
   • Most recent FSP and ISP
   • Court Disposition/ court dates
   • Court Orders
   • Education Records, if available
   • Birth Certificate, if available
Name and phone number of the child’s lawyer, if available
Name and phone number of the parents’ lawyer(s), if known
CANS (if one exists)

Note: in some cases, such as when an agency has been ordered off a case by the court due to poor performance, there may not be a complete transfer packet available.

The new provider may call for a placement case transition meeting within ten (10) working days of case transfer. If this meeting is convened, the DHS case manager is required to attend. The attendance of the provider sending the child is at the request of the new provider.

REFERRAL INFORMATION

Pre-Referral: Prior to referral of a child for foster care, the DHS case manager will engage in a diligent search of existing records, including but not limited to county children and youth records (in home services, treatment foster care, residential care, previous FFC/Kinship placements). In coordination with CBH, the CRU screening unit will conduct a search of Community Behavioral Health records (from BRAHMS); make a determination with respect to the need for a CANS based on the behavioral health history; and determine whether a child has any of the behaviors which would make them candidates for a higher level of placement.

See the sections titled Characteristics of Children Served in General Foster Care and Assessment of Kinship Placements for additional pre-referral responsibilities.

Referral: DHS CRU will provide a placement referral form, which contains basic identifying information, at the time of initial referral. It includes:
1. Name;
2. Date of birth or approximate age;
3. Gender;
4. Race;
5. Accept for Service Date;
6. Accept for service reasons;
7. Primary language or documentation of primary mode of communication for the hearing or visually impaired;
8. Any identified special behavior/emotional issues;
9. Child medical information, known medical needs or physical handicaps;
10. Current location of child;
11. Known information on parents or other relevant family members and siblings;
12. Safety Risks from Safety Assessment;

In addition to the Placement Referral Form, the following will be shared at the time of
referral:
1. Current psychiatric/ psychological evaluations/CANS, if applicable;
2. For kinship care referrals, documentation of assessment of kinship care facility and of clearances and briefing of kinship caregivers (Exception: for emergency kinship care placements where the initial home assessment is being completed by a contracted assessment provider, this documentation will be provided by the assessment provider to the PBC placement provider at the transition meeting);
3. Additional information will be shared as available.

Post-referral: If, at the time of referral, the above information is not complete, it will be provided by the DHS referring worker to the agency not later than the placement case transition meeting. In addition, not later than the placement case transition meeting, the DHS referring worker will provide the following:

1. ACCESS/ MCO Medical Card;
2. If the child was previously served by DHS:
   a. Initial and most recent FSP;
   b. Most recent discharge summary; and
   c. Most recent quarterly report
3. Medical consent/ order forms.

In any event, all information must be provided to the agency within 10 days of referral (See above exception for emergency kinship placements, where documentation will be provided by the contracted assessment provider to the placement provider at the transition meeting).

DHS will systemically address referral concerns through workgroups and other means as necessary.

SHORT STAY POLICY
When a child is in placement for 30 days or less, the referral will be backed out from the referral count. This exit will not be classified as a permanency or a non-permanency.

SECONDARY MATCH FOR GENERAL FOSTER CARE (WITHIN 60 DAYS OF INITIAL REFERRAL)

If an agency receives a general foster care referral and is unable to secure an appropriate placement for the child within its own system, the agency is expected to utilize secondary match, an internet based computer referral system accessible to all general foster care agencies. If an agency receives referrals for a sibling group but cannot place all the children in one home, the agency must post the children on the secondary match system. The agency must post the children within two business days
of placing them in separate homes – if the agency locates a home which can take all the siblings before another agency has requested the children, the original agency can withdraw the posting and place the children in its foster home.

Agencies that have an appropriate home will respond to that referral (first consideration is given to the agencies serving the child’s siblings, if any). Once agreement has been reached by the agencies and the match is approved by the CRU, the case will be transferred.

If no alternative placement is identified within 15 working days, the referral will be removed from the secondary match system and retained by the original agency. The agency may request an extension to allow a case to remain on the secondary match system for longer than 15 working days.

Secondary match process:
- The initial agency inputs the secondary referral into internet system;
- Any agency that has an appropriate home responds to the secondary referral;
- Within system parameters (e.g. siblings placed in home, available home within school catchment area, available home within geography), the initial agency determines the most appropriate match;
- The new placement is approved by the CRU;
- When the child is moved, CRU is notified to transfer the case (the case referral will be deleted from the first agency and will be assigned to the second agency) and the 85-29 is entered.
- CRU will fax agency the Fax Cover Transmittal Sheet for Referral and Service Authorization.
- If the transfer occurs within 20 days of the referral, the new provider is responsible for completion of the Individual Service Plan. If the transfer occurs between days 21 and 30 after the referral, the provider that is sending the child is responsible for completion of the Individual Service Plan.

DHS will closely track the level of secondary referral. The appropriate level of secondary referral will be reviewed periodically.

**PLACEMENT MOVES**

**All Placement Moves**

If a child is moving to another placement setting, the provider agency that is sending the child will work in conjunction with the DHS case manager to ensure that:

- The legal family is aware of the reasons for the move in advance with fifteen (15) days notice, as required under *Bixler v. White*.
- The legal family has the opportunity to accompany the child on a pre-placement visit, when appropriate.
- The child is aware of the reasons for the move.
• The child has as much choice and input as possible and appropriate in selecting the new placement setting.
• The child has a pre-placement visit whenever possible and appropriate.
• Agencies are authorized to move a child’s placements within their agency as long as it is within general foster care and with prior notification of the DHS case manager. Agencies should note, however, that placement stability is seen as a quality indicator.

**Placement Moves (less than 60 days from initial referral)**

Placement moves within 60 days of initial referral are generally handled through the secondary match system, as outlined in the section titled *Secondary Match for General Foster Care (within 60 days of initial referral)*. See also sections titled *Characteristics of Children Served in Foster Care* and *Assessment of Kinship Placements*.

**Placement Moves (61+ days from initial referral)**

Stability is an important measure of the quality of care an agency is providing, since instability has negative consequences for children. When it is in the best interest of the child, the agency and the DHS case manager have a shared responsibility to discuss why they believe another substitute care arrangement is necessary and to identify an alternative placement.

When a child needs to change placements, the agency is to search within its own system for an appropriate foster home match for the child (siblings are to be placed together). The agency has the authority to move children within its own general foster care system, with advance notification of the DHS case manager. The emphasis will be on placing children with their siblings. If another substitute care arrangement is necessary, the agency will first attempt to identify relatives who are willing and able to provide care and carry out the service plan (including serving as a permanency resource) for the child. If a relative is identified, the agency may make the re-placement. If no relative resource exists, the agency is responsible for identifying an appropriate foster care placement from within its general foster care system.

If an agency cannot secure an appropriate placement within its own system, it is responsible for identifying an appropriate placement with another agency utilizing the secondary match system (first consideration is given to the agencies already serving the child’s siblings, if any). The process will operate as outlined for new cases, except that the referral will not be deleted from the first agency and will instead be considered a non-permanency outcome (except as noted below).

When a child disrupts from his/her current placement and siblings are split between homes or agencies, agencies will use this as an opportunity to consolidate siblings in one home or with one agency. Similarly, when siblings are split between homes or agencies, and the agency determines it is in the best interest of the child and family to
consolidate siblings and a consolidated placement is available, with approval of the DHS case manager, the agency should consolidate the sibling group. It will be considered a neutral outcome for an agency to transfer a case to a Foster or Kinship Care placement at another agency in order to consolidate siblings.

DHS has the responsibility of securing higher-level placements if necessary, and will do so as soon as possible and in any event within 30 days of the date the agency provided DHS with notice and documentation of the possible need for a higher level of care. If, after stepping up, the child gets stepped down within 90 days, the agency must take the child back. In that situation, the non-permanency outcome that had been charged to the agency is subtracted.

UNPLANNED DISCHARGES

Unplanned discharges (i.e. discharges outside of the agency within the same level of care or to a different level of care not pursuant to a mutually agreed upon service plan) are disfavored. An agency is expected to work in good faith with DHS to stabilize the existing placement and/or plan together for a placement move in order to avoid such discharges. No discharge can take place without first resorting to the procedures set out under the Placement Moves sections above.

If despite these efforts, an unplanned discharge is deemed necessary by the provider agency, the provider agency must provide written notice to the DHS case manager and the CRU. DHS will secure the new substitute care setting within 30 days of receipt of notice including both (1) and (2) below from the provider.

The written notice must contain the following: (1) reason for the discharge including detailed description of events that precipitated the discharge and actions taken in response to the events, including an explanation of why the unplanned discharge could not be avoided; and (2) a discharge summary that has sufficient detail to facilitate future planning for the child including psychiatric or psychological evaluations necessary for such planning; and (3) a copy of a request for a CANS if the provider has reason to believe a higher level of care is necessary.

If the unplanned discharge is due to the child’s having a psychiatric episode or due to the child’s committing a crime within the jurisdiction of the provider agency, the agency and DHS are required to take immediate action (i.e., committing to a hospital or obtaining intervention services).

TRANSPORTATION OF THE CHILD

For referrals made during business hours (8:30 am to 5 pm), the private agency receiving the case is responsible for placing the child in their foster home. The private
agency worker will meet the DHS referring worker and the child at the DHS offices unless by mutual agreement alternative plans are made.

If referrals are made after business hours (5 pm to 8:30 am), the DHS referring worker will transport the child to the designated home of the agency assigned unless the agency agrees to transport the child.

If there is a need for a secondary match, the agency who was initially referred the case is responsible for transporting the child to the DHS-approved secondary match placement unless the secondary match agency agrees to transport and place the child.
ATTACHMENT C

Philadelphia Department of Human Services
Working Model for Defining the Roles of DHS and Private Providers

Preface

The purpose of this working model is to promote safety, permanency, and well-being for children in the legal custody of DHS. The model applies to all cases of children in placement toward the achievement of the goals the Department has set for its work with children and families, namely

- To protect children from abuse and neglect.
- To provide them with stability and timely permanency in their lives.
- Where possible through the provision of services that strengthen families, to permit children to live with their own families.
- To enable children to achieve success in school and become stable, gainfully employed adults.

The Department’s Framework for Individualized Needs-based Child Welfare Practice (Practice Framework) provides the guide for decision-making and the filter through which decisions about the achievement of goals for individual families must pass.

The principles underlying the specific responsibilities described in this document are as follows:

- DHS is holding providers accountable for achieving permanency for all children in placement. It must give providers sufficient flexibility and authority to achieve those results.
- At the same time, DHS remains legally and ethically responsible for the safety, permanency, and well-being of every child in its care, and must act consistently to promote these outcomes.
- The potential for tension between these two fundamental points - providers needing flexibility and sufficient authority to achieve permanency for children in placement with DHS upholding its ultimate legal responsibility to ensure safety, permanency and well-being of children in its care - can best be minimized, if not eliminated, through a continuing effort by both parties to collaborate with and support one another in reaching agreement on sound and timely permanency decisions for all children in out of home care.
- DHS and private providers are not the only essential actors in this effort. We must work together with the key people in a child’s life – parents, their natural supports such as friends and relatives, foster parents, other service providers and advocates assisting the family – in order to develop good service plans and make good permanency decisions.
- In all of these efforts, we should try to reach consensus, consistent with applicable law, regulation, and DHS policy.
The failure to reach consensus cannot be a reason for inaction or delay. The team will involve supervisors, administrators, and directors when they are needed in order to decide difficult practice issues, resolve system problems, or mediate conflicts within the team that could obstruct progress on the case. We must have a process for resolving disputes that is efficient, fair, and tied to our goals and practice standards. (Such a dispute resolution mechanism is detailed in another document.)

Developing the Initial Placement Service Plan
(both the Family Service Plan and the plans for individual children)

DHS has lead responsibility for the planning process: organizing the effort, facilitating the meeting, and writing and distributing the Family Service Plan. The private provider will participate in the initial and all subsequent planning meetings and prepare the ISP.

Shared Responsibilities of DHS & Private Provider

- Develop the service plan together with a team that also includes the parent(s) and child(ren) old enough to participate; the family’s natural supports (e.g. relatives, close friends) whom they choose to invite; foster parents; attorneys and other advocates, and other key service providers.
- Attend and participate in the service planning meeting; provide relevant information and assessments.
- Ensure that parent and child (as appropriate) attend the meeting; assist with transportation as necessary.
- Work together to ensure that the meeting remains focused on reaching consensus around a realistic, individualized, strengths-based plan that addresses critical needs.
- Work together to ensure that the viewpoints of all team members are expressed and considered during the review meeting.

Additional DHS Responsibilities

- Take the lead in organizing the team meeting.
- Invite participants to attend and prepare participants for the initial meeting.
- Ensure that the meeting is held at a time and in a place conducive to team members being present.
- Facilitate the meeting.
- Write up and distribute to all parties the resulting Family Service Plan.

Additional Private Provider Responsibilities

- Ensure that a worker who will have ongoing responsibility for the case is assigned promptly enough to take part in the family service planning meeting and to assist with the preparations for the meeting.
- Write up and distribute to all parties the Individual Service Plan for each child.
Implementing the Service Plan

The private provider has lead responsibility for implementing the service plan.

Shared Responsibilities of DHS & Private Provider
- Communicate regularly on service plan implementation issues.

Additional Private Provider Responsibilities
- Implement the service plan. This includes connecting the primary client, and other family members in support of the goals of the primary client, to appropriate services through referral, advocacy, and active participation. Provide transportation assistance when necessary.
- If the provider cannot access needed services (e.g. housing, behavioral health, or medical services) for a client directly and in a timely manner, contacts both the DHS worker and the relevant DHS Support Center for assistance.
- Begin needed services quickly.
- Implement the safety plan.
- Implement the visiting plan, including visits outside normal business hours, as needed by family members.
- Maintain frequent, regular contact with the primary client, and with members of the family or other individuals as required to achieve the goals of the primary client.

Additional DHS Responsibilities
- Serve as a resource to assist with plan implementation when needed – typically
  - when the private provider needs help accessing services from another public agency or contracted private agency;
  - when there are safety concerns that must be reinforced with the client;
  - when it is necessary to influence the Juvenile Court.
- When seeking to access services from another public agency, the DHS case manager will:
  - alert the provider about the results of this effort within ten working days of the request, and
  - utilize DHS’s Support Centers (including the Education Support Center, Policy and Planning, Quality Improvement, and the Center for Child and Family Well-being which includes the Health Management Unit).

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10 The child receiving FFC, kinship care or other placement services is the primary client. DHS and provider agencies will direct social work service to and on behalf of the child and family members and other individuals based on the goal of the child.
• DHS’s Support Centers will document requests and their outcomes, and will use this information to identify and remedy systemic barriers.
• Provide direct services as a backup in the event of emergency if the private provider agency can’t be reached; when this happens, follow up with private provider worker to debrief and turn the direct service role back to him or her.

**Monitoring the Service Plan**

**Monitoring is a joint responsibility of DHS and the private provider.**

**Shared Responsibilities of DHS & Private Provider**

• Have regular and frequent11 communication to ensure that both are aware of progress and problems in the case. The private provider worker keeps the DHS worker up to date, and the DHS worker is pro-active in seeking out this information.
• Involve supervisors, administrators, and directors when they are needed in order to decide difficult practice issues, resolve system problems, or mediate conflicts within the team that could obstruct progress on the case.

**Additional Responsibilities of DHS**

• Monitor the progress of the plan, through
  o periodic and planned in-person contact with the adults and children being served. (Unannounced visits may sometimes be necessary, in which case DHS will coordinate with the provider in accordance with DHS policy.)
  o phone consultation with the private provider, collaterals, and family.

**Additional Responsibilities of Private Provider**

• Through regular12 in-person contact with the primary client and family, ensure child safety and well-being, that the plan is being followed, and that progress is being made towards permanency goals.
• Provide ongoing progress updates to DHS/team members.

**Modifying the Service Plan**

DHS has lead responsibility for the planning process: organizing the effort, facilitating the meeting, and writing and distributing the revised Family Service Plan. With respect to the substance of the plan, DHS will coordinate and engage the entire service planning team, supporting and advancing

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11 At least monthly
12 As defined by contract, for PBC general foster care at least biweekly with child in placement and, when goal is reunification, monthly with family (see Service Description for additional detail).
provider position unless that position violates law, regulation, or DHS policy.

**Shared Responsibilities of DHS & Private Provider**

- Ensure that plans are adjusted when needed – not only at six-month intervals, but also in response to key events in the lives of the clients and to the success of the plan. When something critical happens and new services are needed, or when the plan isn’t working, it must be modified, even if it was reviewed a short time previously.
- Attend and participate in all service plan review meetings.
- Communicate with each other in advance of the meeting to ensure that both workers have the information they need to participate effectively in the service plan review.
- Inform each other promptly in advance of the meeting if either worker believes that a major change in the plan (e.g. a change in the permanency goal) should be made. Have sufficient discussion of the rationale for such a change, and provide sufficient information and evidence concerning it, to minimize the likelihood of conflict between DHS and the private provider in the FSP meeting and facilitate the achievement of consensus; if necessary, involve supervisors, administrators, and directors in assisting with this process.
- Invite and prepare participants in the review meeting, dividing up responsibility for contacting individuals based on existing relationships and available time.
- Ensure that the meeting is held at a time and in a place conducive to team members being present.
- Work together to ensure that meetings remain focused on reaching consensus around an individualized, strengths-based plan addressing critical needs.
- Work together to ensure that the viewpoints of all team members are expressed and considered during the review meeting.

**Additional DHS Responsibilities**

- Call the plan review meeting when necessary (either in response to significant case events, or to ensure that no more than six months go by without a review).
  - If the private provider or another team member requests a meeting, the DHS worker will contact the team to schedule the meeting within ten days. The meeting will occur within thirty days of the request.
- Facilitate the review meeting.
  - If the team is unable to reach agreement, support and advance private provider position unless that position violates law, regulation or DHS policy.
- Write up and distribute revised FSP.

**Additional Private Provider Responsibilities**

- Request that the DHS worker call a meeting when the private provider worker believes that one is needed because of important changes in case circumstances or because the plan isn’t working. (If a crisis makes it important
that the meeting be held quickly, and the DHS worker isn’t immediately available, consult with the DHS supervisor and or administrator in order to begin preparations for the meeting.)

- Recommend changes in the plan (both changes in the needed services and changes in the permanency goal) when the private provider worker believes they are necessary, and after appropriate supervisory consultation within the private provider agency.
- If necessary, assist the primary client and members of the family or other individuals based on the goals of the primary client with transportation to and from the meeting.
- Write up and distribute revised ISP.

**Preparing for and Testifying in Court**

*Shared Responsibilities of DHS and Private Provider*
- Work together to meet their joint obligation to present to the court complete and accurate information and recommendations based on the permanency plan for the child. DHS and the provider will speak with one voice in court.

**Additional DHS Responsibilities**
- Notify the provider verbally and in writing, in a timely manner (as soon as possible) when any court proceeding or Permanency Status Review meeting (i.e. Permanency Roundtable) has been scheduled.
- With the assistance and involvement of the Law Department, prepare the Department’s testimony and recommendations to the court consistent with decisions made through the service planning process. Organizes materials, prepares written reports, and delivers the Department’s testimony.
- Attend court proceedings. If the assigned social worker is unavailable, the supervisor will attend.
- At the hearing, utilize providers’ experience and expertise when advocating for agreed upon recommendations developed prior to the hearing.
- Consistently and aggressively advocate for timely hearings.
- When the private provider requests a court hearing, DHS will within five working days work with the Law Department to request an expedited hearing.

**Additional Private Provider Responsibilities**
- Support the Department’s preparation by providing full, timely information in advance of the court proceeding. This includes an obligation to be clear about opinions and recommendations regarding desired results, so DHS is not surprised by information or opinions expressed during the hearing.
- Attend court proceedings; testify when requested to do so. If the assigned social worker is unavailable, the supervisor will attend.
- Attend and participate in Permanency Status Review meetings (i.e. Permanency Roundtables).
- When circumstances warrant, request that the DHS case manager petition for an expedited court hearing.
- Provide transportation for the primary client to and from court hearings.
ATTACHMENT D

RESOURCES FOR STABILITY and WELL-BEING

Resources to Promote Stability and Well-Being

Resources for stability may not be used to provide services that are covered by Community Behavioral Health (CBH). Similarly, agencies should exhaust other potential funding resources prior to spending these funds.

The following examples of child-focused responses listed below are for the purpose of stimulating thinking in the context of an individual plan for the child and the family. This is NOT a recommended list NOR is it inclusive. It is based on the types of concrete and practical assistance that a family caring for a child with serious emotional disturbance might need.

<table>
<thead>
<tr>
<th>Life Domains</th>
<th>Examples of Possible Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safety.</strong> Does the child have proper supervision? Is anyone in the family safe? Is anyone a current danger to themselves or the community?</td>
<td><strong>the foster family and child may need...</strong></td>
</tr>
<tr>
<td><strong>DHS and the child welfare worker assure the ongoing safety of the situation, however...</strong></td>
<td>In-school mentors/shadows, Locking cabinets or drawers, Smoke detector/Alarm system/Motion sensors, Escape ladder/Fencing, Recreational helmets and other safety equipment, First aid training and kits</td>
</tr>
<tr>
<td><strong>Family.</strong> Do the child and family have regular routines (bedtimes and meals) that are functional? Do family members have a way to communicate with one another? Are family roles and responsibilities clear to all members?</td>
<td><strong>the foster family and child may need...</strong></td>
</tr>
<tr>
<td><strong>The assigned worker in regular visits assesses the family function, however...</strong></td>
<td>Parenting education, Communication training, Magazine subscriptions, Alarm clocks, Scheduling assistance</td>
</tr>
<tr>
<td><strong>Social and Recreational.</strong> Do family members have friends and access to their supports? Does the family have an opportunity to socialize with one another? Do they have fun and relax together? Do they socialize with others outside of the family?</td>
<td><strong>the foster family and child may need...</strong></td>
</tr>
<tr>
<td><strong>The assigned worker and the therapist will support a healthy family environment, however...</strong></td>
<td>Family recreation toys/games, Family or Child Activity fees, Family outings, Regularly scheduled respite, Daycare, Babysitting/respite, Movie rentals or passes, Camps</td>
</tr>
<tr>
<td><strong>Educational and Vocational.</strong> What will it take to ensure a viable education for the child? Are there specific learning issues that need to be addressed? Is there access to employment opportunities for the child? What sort of future planning is in place?</td>
<td><strong>the foster family and child may need...</strong></td>
</tr>
<tr>
<td><strong>The local school and the assigned worker, will help the child achieve educational and</strong></td>
<td>Desk and chair, Tutoring/accelerated learning classes or educational testing, Developmental toys, equipment (e.g., Hooked on Phonics), Art classes and supplies, special fees for recitals, Tools or other vocational equipment, Books, workbooks, including life skills like cooking, Transportation or uniforms for vocational training, e.g., bicycle</td>
</tr>
</tbody>
</table>
| Vocational Goals, however... | Alarm clock  
Driving lessons and insurance  
Graduation expenses  
Scientific calculator  
Magazine subscription  
School photos |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural and Spiritual. Are there connections to a spiritual and cultural community? Are there any language barriers? Are there specific traditions or mores that the worker needs to be aware of?</td>
<td></td>
</tr>
<tr>
<td>The assigned worker will have working knowledge of the culture and spirituality connections of the child, however...</td>
<td></td>
</tr>
</tbody>
</table>
| The foster family and child may need...  
Camps  
Mentors  
Activity fees  
Gifts for special occasions |
| Emotional and Psychological. Are there unresolved issues that impede interactions? Is there a diagnosis that needs intervention and management? Has the child and family developed positive ways to cope with strong thoughts and feelings? Overall, do behaviors lead to success? Are there substance abuse issues that need to be addressed? |
| Community Behavioral Health (CBH) will be responsible for the delivery of all direct clinical services however... |
| The foster family and child may need...  
Communication devices  
Behavior incentives/allowances  
Punching bag/Stress balls  
Hair-care, dental work related to public presentation |
| Health and Medical. Are health care needs met? |
| DHS provides Medical Assistance, however... |
| The foster family and child may need...  
Health or medical expenses not covered by MA |