Saint Francis Texas

-Providing healing and hope to children and families-

SAINT FRANCIS COMMUNITY SERVICES IN TEXAS, INC.
PLACEMENT PROVIDER MANUAL

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About Us

Saint Francis Ministries, Inc. is a 501(c)3 nonprofit organization *providing healing and hope to child and families in ways others believe impossible.* From a boy's home in Ellsworth, Kansas, in 1945 to now, we serve some of the most vulnerable children and families in seven states and three Central American countries. We approach each interaction with respect, understanding, compassion, and integrity as we engage children, families, and adults in their journey of healing.

Saint Francis Ministries serves over 19,000 children and families each year. We have been licensed and in good standing as a Child Placing Agency since 1970 and Joint Commission accredited since 1974, earning the Gold Seal of Approval for health care quality and safety in behavioral health care.

Saint Francis Community Services in Texas, Inc. (Saint Francis Texas) is one of the nine subsidiaries of Saint Francis Ministries, Inc., providing services in Region 1. Saint Francis Texas is dedicated to the protection, nurturing, and healing of all children in body, mind, and spirit. Saint Francis Texas welcomes the opportunity to provide important and life-changing services to children from all walks of life.

Mission

Saint Francis, providing healing and hope to children and families.

Vision

Saint Francis will be recognized nationally and internationally for transforming lives and systems in ways others believe impossible.

1.0 Provider Network

Providers choosing to partner with Saint Francis Community Services in Texas, Inc. (hereafter referred to as SFCS) in serving vulnerable and valued children are one of the most critical supports a foster child can have. Out-of-home placement can support the healing process while at the same time assisting in the reunification process.

SFCS utilizes General Residential Operations (GROs) and Child Placing Agencies (CPAs) that comply with the Department of Family and Protective Services (DFPS) licensure requirements and meet residential childcare licensing minimum standards. SFCS will work with providers that have a current DFPS agreement and/or are in the process of becoming contracted or are not currently contracted through DFPS.

The SFCS Provider Manual adheres to and complies with DFPS Minimum Standards. It is the expectation of SFCS that all subcontractors adhere to the aforementioned regulations and standards. Please refer to the following websites for further information:

- Child Care Licensing Minimum Standards
  https://hhs.texas.gov/doing-business-hhs/provider-portals/protective-services-providers/child-care-licensing/minimum-standards
- Community-Based Care
  https://www.dfps.state.tx.us/Child_Protection/Foster_Care/Community-Based_Care/default.asp

SFCS has been awarded the contract to provide this continuum of services to children, youth, and families in Region 1. A Single Source Continuum Contractor (SSCC) is responsible for finding foster homes or other living arrangements for children in state care and providing them a full continuum of services. DFPS began expanding the community's role to meet the challenges of serving children in foster care under Foster Care Redesign. Originally, a SSCC was responsible for:

- Developing foster care capacity;
- Building a network of providers;
- Engaging the community to help.
- Foster care placement services; and
- Coordinating and delivering services to children in foster care and their families.

In 2017, the Texas Legislature directed DFPS to expand the model to include both foster care and relative or “kinship” placements and give the SSCC sole responsibility for case management – rather than sharing that responsibility with DFPS.

As Community-Based Care expands statewide, Child Protective Services (CPS) will shift its focus to providing high-quality oversight of foster care and services for children and families. The SSCC will be responsible for case management and services that move children from foster care or kinship care into a permanent home.

Community-Based Care allows the SSCC and the community more flexibility to innovate. This increased flexibility comes with greater responsibility and accountability for outcomes such as safety, permanency, and well-being.

Source: https://www.dfps.state.tx.us/Child_Protection/Foster_Care/Community-Based_Care/default.asp

1.2 Substitute Care

There is a tremendous responsibility placed on any individual, family, or agency choosing to serve a child in a substitute care capacity. Substitute care is needed from the time a child is removed from his or her home and placed in CPS conservatorship until the child returns home safely or is placed in another permanent living arrangement.

After receiving a court order, CPS legally assumes responsibility for the child who has been removed from the home, being appointed conservatorship, and subsequently contracts with SFCS with authorization to provide placement and services for that child. This authority affords SFCS the opportunity to manage his or her care or act as agents of the state.

When a child is placed in substitute care, SFCS and the child's substitute caregiver (kinship, fictive kin, child placing agencies (CPAs) or residential facilities) work together to ensure parental responsibilities are met on behalf of the child.

The goals of substitute care are to ensure that a child receives:

- Protection from abuse and neglect; and
- Care that is consistent with his or her needs for safety, well-being, belonging, and achievement of positive permanency.

The objectives of substitute care are to:

- Provide temporary, planned placements for a child at risk of abuse or neglect;
- Provide or arrange for social, therapeutic, medical, and educational services appropriate to the child's needs; and
- Make reasonable efforts to achieve positive outcomes for the child, which includes reunification with his or her family, transferring conservatorship to another appropriate adult, or finding an adoptive parent.

Reasonable efforts to reunite a child with his or her family include:

- Assessing each child's and family's situation;
- Developing, implementing, and supporting a service plan to change the conditions that have placed the child at risk and prepare the child and family for the child's return; and

- Finding a permanent placement for the child if the child cannot be safely reunited with his or her family.

1.3 Subcontractor Application Process

Agencies choosing to partner with SFCS are able to access the following website and complete the steps below to prequalify as a Network Provider:

1. Understand SFCS mission, vision, and values.
2. Apply online at https://saintfrancisministries.org/texas-partner-application/. This will enable your agency to become prequalified to provide services with the SFCS Network. In the event you cannot complete online, please complete the fillable document Application to Partner (Texas Region 01) and submit via email along with all attachments to TXProviderRelations@st-francis.org.
3. Review the Provider Services Agreement.
   a. GRO Provider Services Agreement
   b. CPA Provider Services Agreement
      Treatment Foster Care Statement of Work
      Adoption Services Addendum
   c. SIL Provider Services Agreement
4. Complete the Request to Provide Services form and submit via email to TXProviderRelations@st-francis.org.

Once we have received and evaluated your Application to Partner and Request to Provide Services, we will contact you for further discussion. The final step to prequalify is the extension of a contract by SFCS, which must be signed and returned.

1.4 Subcontractor Application Packet

Providers who wish to contract with SFCS to provide services to our clients must submit the following packet of information before a draft contract and rate exhibit are prepared:

- Completed Application to Partner (from section 1.3)
- Completed Request to Provide Services Form (from section 1.3)
- All applicable RCCL Licenses
- DFPS contract and/or contracts with other SSCCs
- List of any/all Medicaid Provider Numbers
- All accreditations and certifications

- All liability insurance certificates
- Formal grievance/resolution procedure
- Written QA/QI Plan
- Internally prepared financial statements
- Any audited, reviewed, or complied statements from an outside source

1.5 Provider Workgroups

SFCS recognizes and appreciates the difference between the needs and supports found in our communities. A flow of constant, strong communication between the SSCC and Providers is imperative to facilitate the effective delivery of services to children, youth, and families. Provider workgroups will convene at least quarterly with the expectation that at least one (1) representative from each subcontracting agency will be in attendance. Workgroups are designed to create opportunities to share information and to explore challenges that will influence the design of a stronger community-based system that is child-centered and family-focused.

1.6 Enhancing Service Capacity

SFCS will work in partnership with Providers to address gaps in services and placement capacity within Region 1. SFCS will support joint recruitment activities within the Network based on placement needs identified in the Foster Care Needs Assessment Report* completed by DFPS. These recruitment efforts will be aimed at developing the complete array of placement services needed within the catchment area.

*https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2019/2019-08-06_Foster_Care_Needs_Assessment.pdf

Provider workgroups will identify gaps in placement resources and will develop and plan strategies to engage each community to develop additional resources. Additionally, Provider workgroups will address other service areas of need and present plans to engage communities to create, develop, and provide the needed services. The SFCS Quality Improvement (QI) team will review all Providers' recruitment plans and patterns during annual reviews.

1.7 Child Placing Agencies

1.7.1 Ethical Family Transfer Process

During the term of the contract with the SSCC and up to one (1) year after the contract ends, no verified family of the Provider will be contacted by staff, volunteers, subcontractors, or affiliated entities of another Network Provider for the purpose of recruitment or transfer to that Provider agency. This standard applies even when one organization is planning to close its operations or is placed on placement hold by Residential Child-Care Licensing (RCCL) and wishes to release its homes to other agencies. In these situations, the organization may request that SFCS send a list of Providers with contact information to the affected foster parents, allowing them to make their own contacts and decisions about transferring verification.

If a verified family contacts another agency for information about a potential transfer or submits an application to change verification, the agency contacted shall inform the family of this Ethical Family Transfer Process and direct the family to discuss their concerns with their original verifying agency. The contacted agency must also inform the original verifying Provider within five (5) business days of contact regarding the date of the family's contact for a request to transfer.

The contacted agency may have no further contact with the family for at least 30 days, or until they have received a release and closing summary from the previous verifying Provider, whichever occurs first, to allow sufficient time for that Provider to meet with the family to resolve any outstanding issues that may be present.

If the family still wishes to make a transfer, the original verifying Provider shall transfer the family's verification information to the Provider with whom the family wishes to transfer, with a Closing Summary/Release Form signed by an administrator of the agency no later than 30 days after receiving notification.

Foster families and Providers are encouraged to contact SFCS if families are solicited *in an unethical manner,* directly or indirectly, to make a transfer to another Provider.

SFCS has a number of remedies it may consider when this Ethical Family Transfer Process has been violated, including withdrawal of an agency's Provider Services Agreement and notification of appropriate licensing boards regarding a pattern of unethical practice by Child Placing Agency Administrators and Licensed Social Workers. SFCS will continue to emphasize and encourage the development of new foster family resources for children in our catchment area by developing the trust and cooperation between and among Providers within the currently existing Provider Network.

1.7.2 Interagency Home Transfer Procedure

When a foster home has been approved for transfer by the receiving or new Provider agency, the receiving agency will notify the SFCS Permanency and Reunification Department by email at TXReg1Perm@st-francis.org no later than five (5) days prior to the intended transfer date. If more than one family is transferring, the receiving agency will provide as much notice as possible, but no later than 10 days prior to the intended transfer date.

The following information must be provided in the email request:

- Name of the home(s)/foster parent(s) transferring;
- Name(s) of the child(ren) in the home transferring;
- The specific placement forms necessary for each child; and
- The intended transfer placement date.

The SFCS Permanency and Reunification will assign a Child Case Manager who will be responsible for obtaining and/or completing any placement paperwork necessary and sending an email to all parties upon receiving confirmation that the transfer has taken place.

Once the home(s) has officially transferred and been entered in the CLASS system, the placing agency should notify the assigned SFCS Child Case Manager. SFCS will then verify the information in IMPACT and CLASS to verify that each home has transferred. Upon verification of the official transfer, SFCS will notify all parties that the transfer is considered official and will provide an effective date for placement paperwork.

By 5 pm the next business day, the assigned SFCS Child Case Manager, in collaboration with the Provider Case Manager, will provide all necessary placement paperwork and a confirmation email to all parties (CPS, CASA, CPA, Attorneys, etc.) and complete appropriate documentation as necessary.

1.8 Training

SFCS believes that cultivating healthy relationships is essential to the healing process. Preparing and training staff and foster parents to be in an environment where children struggle with the realities of life is critical to offering opportunities to heal. Each Provider has the right to design their own training for developing the knowledge and skills essential to care for children in the child welfare system. In collaboration with DFPS and subcontractors, SFCS will define and develop strategies to maximize training opportunities for all Providers in Region 1. SFCS seeks to aggressively integrate best practices and new evidence-based practices within the Provider Network. As a part of the Annual Audit, SFCS will monitor staff and foster family trainings.

SFCS expects that each Provider will ensure that their staff and caregivers/foster parents have the minimum required trainings for minimum standards licensing requirements and national accreditation (if applicable) to perform all duties as expected in the Provider Services Agreement, the Operations Manual, and this Provider Manual. This includes the following:

- A Provider's personnel must acknowledge being informed of the agency's most current Disaster and Emergency Response Preparedness Plan (DERPP) on an annual basis.
- The following trainings **are required** for Provider's personnel and all caregivers/ foster parents:
    - Emergency Behavior Intervention (8 hrs. pre-service);
    - Abuse and Neglect Prevention & Reporting (1 hr. annually);
    - FPS Medical Consenter (annually, if applicable);
    - Trauma-Informed Care (8 hrs. pre-service and 2 hrs. annually);
    - Normalcy (2 hrs. pre-service and annually);
    - Cultural Competency training (3 hrs. annually);
    - Recognizing and Reporting Child Sexual Abuse: A Training for Caregivers (1 hr. annually); and
    - Any additional trainings identified by SFCS or DFPS to meet requirements.
- Foster Parents must receive information on Texas Health Steps.

2.0 Placements

SFCS prioritizes placing children close to their families, friends, relatives, school, and home community. Placements are made in the least restrictive environment appropriate to meeting the needs of the child and will not be delayed or denied based on race, color, or national origin.

SFCS uses CareMatch, which is the official placement-matching algorithm tool used to locate the best potential placement options for children. Within this algorithm, the CareMatch tool uses the Texas Provider Gateway* (TPG), the database where providers enter all relevant capacity and current openings within their respective agency. It is important that providers enter all data into TPG and ensure daily that it is up to date.

*https://www.texasprovidergateway.org/

Pursuant to DFPS expectations, SFCS provides all required documentation and known information within each placement referral, including Application for Placement, relevant and available assessments, etc. SFCS is committed to working with all provider placement departments for the successful coordination of services.

The SFCS Placement Services Department is responsible for accepting, assigning, managing, and tracking incoming referrals from DFPS. The Director of Placement Services will oversee a Placement Services Supervisor and Placement Coordinators. The Placement Services Department will accept referrals from DFPS for residential childcare 24 hours per day, seven (7) days per week, 365 days per year.

2.1 Types of Placement

A placement need may be generated from the following types of circumstances.

2.1.1 Initial Placements:

Initial placements will be considered an emergency placement and must be identified by SFCS within four (4) hours. SFCS has the responsibility to accept all referrals for paid foster care (**no reject**) made by DFPS and will continue to meet the individual needs of children referred (**no eject**) until DFPS determines the individual is no longer eligible for the SSCC's services. The SFCS Placement Coordinator will match the child with the most appropriate and least restrictive placement based on the information provided by DFPS at the point of referral and information entered in TPG.

2.1.2 Emergency Placement:

An emergency placement is appropriate when DFPS makes a referral to SFCS for a child or youth who is in immediate need of paid foster care placement and services and is not currently served by SFCS. Therefore, the process outlined below will be used for all emergency removals, as well as any child requiring immediate paid placement and services.

Once a placement has been identified as a potential best match, the Placement Coordinator will call the Provider who must respond back with acceptance or non-acceptance of the placement

and any concerns the agency has about the potential placement **within one (1) hour** of notification of placement need.

2.1.3 Non-Emergency Placement:

A non-emergency placement is appropriate when DFPS makes a referral to SFCS for a child or youth already in DFPS conservatorship who is moving to a paid placement in the SFCS Provider Network.

For new referrals to SFCS that are classified as non-emergency, the SFCS Placement Coordinator will identify the potential placement option(s) for the child, again through the CareMatch system, and will help facilitate pre-placement visits for children with potential caregivers as appropriate. The child will be involved in the placement decision as appropriate to their age and level of understanding. Whenever possible, the SFCS Placement Coordinator will contact the Provider from which the child will be moved to gather relevant information. The process outlined below will be used for all non-emergency placements.

Once a placement has been identified as a potential best match, the SFCS Placement Coordinator will call the Provider who must respond back with acceptance or non-acceptance of the placement and any concerns the agency has about the potential placement **within two (2) business days** of notification of placement need.

2.1.4 Placement Change:

Placement changes will take place with children/youth that are placed in a paid placement setting within the SFCS Network and require a new placement within the same Network. A placement change can be either an emergency move, such as a disruption stemming from a safety concern, or a non-emergency move, such as a move to place siblings together or to place a child closer to home.

In the case of a request from DFPS for a placement change, SFCS will request a joint staffing with DFPS, when needed, to discuss barriers and strategies to prevent placement changes whenever possible and appropriate. SFCS and the Provider will offer placement stabilization services to attempt to avoid a disruption. If these strategies are not effective or warranted, the CareMatch database will again be utilized to identify potential placement option(s) for the child and to schedule pre-placement visits for the child with potential caregivers, as appropriate. Each child will be involved in this decision-making process as appropriate to their age and level of understanding.

Providers may not make their own placement changes without prior approval from SFCS. This includes placing children in respite only to later become a placement, arranging placement with a DFPS caseworker without a proper referral to SFCS, as well as other types of sub-moves. As soon as a provider learns that a placement change may be needed, the provider should contact their SFCS Child Case Manager to set up a staffing.

2.2 24/7/365 Contact Requirements

The Provider will need to ensure that the SFCS Placement Department has updated contact information for staff who are responsible for making placements during business hours as well as after-hours and weekends. The Provider is responsible for being available for placement referrals and for physical placement of the child(ren) 24 hours per day, seven (7) days per week, 365 days per year.

SFCS may contact several agencies at one time due to the timeframes involved in making placements, so an initial contact from SFCS does not guarantee that placement will be made with your agency. The best match identified within the above timeframes will be considerations in SFCS' final decision for placement recommendation to DFPS. Once the process for DFPS approval has been completed, the SFCS Placement Coordinator will work together with the Provider case manager, the family, and DFPS to determine placement date/time and transportation arrangements.

2.3 Habilitative or Primary Medical Needs

After a placement has been recommended by SFCS and approved by DFPS for children who have habilitative or primary medical needs, DFPS, with the assistance of the Placement Services Coordinator, will coordinate a telephone staffing with the chosen caregivers, the Provider case manager, medical staff (if applicable), the DFPS Well-Being Specialist, DFPS Supervisor and Program Director, Regional DFPS Nurse, and STAR Health staff to:

- Discuss the specific needs of the child or youth;
- Discuss the expectations of placement; and
- Develop a plan to move the child or youth and establish services in the new placement.

The staffing should occur prior to the child or youth arriving in his or her new placement, but no later than two (2) business days after the child or youth's placement. It will be the responsibility of the Provider case manager to ensure that the services for the child are implemented in a timely manner, as outlined in the plan.

2.4 Institutional Setting

DFPS-Licensed Institutions for children with intellectual and developmental disabilities (IDD) include:

- State-Supported Living Centers;
- State Hospitals, Home and Community-Based Services (HCS) Residential Placements, Nursing Facilities; or
- Intermediate Care Facilities for the Intellectual Disabilities/Related Conditions (ICF/IID-RC).

The current Provider case manager and caregiver(s) should work collaboratively with SFCS and DFPS to assess the child or youth's specific needs and attempt to exhaust all least-restrictive placement options before recommending the child or youth's placement in one of these institutions. The Provider case manager and caregiver(s) will have important information about the child or youth to

assist in this assessment. In addition, the Provider case manager should ensure that the child or youth is informed and prepared for this transition.

Note: SFCS works in collaboration with DFPS, as these providers are not in our contracted network.

2.5 Verified Kinship Giver

When SFCS receives a referral for a kinship caregiver to be licensed for paid foster care or for adoption of a Region 1 child, SFCS will work with Network Provider agencies within the identified family's county of residence to make a referral to become licensed foster parents.

When the Provider has completed the verification process with a family, they will notify the SFCS Kinship Child Case Manager at TXReg1Kinship@st-francis.org, the Conservatorship Specialist (CVS worker), and the DFPS Kinship worker that the family has been submitted to CLASS as an approved foster home. DFPS will make the referral in IMPACT. A plan for the child's official placement start date will be coordinated with DFPS and the Provider. Official placement will not occur until approved by SFCS. SFCS will enter the placement into IMPACT, and placement process protocol will be followed.

The Provider will work with the family, SFCS, and DFPS to assist the family as needed through the Permanency Care Assistance Process. Further information about Permanency Care Assistance can be found here: https://www.dfps.state.tx.us/Child_Protection/Kinship_Care/pca.asp

2.6 At Time of Placement

In addition to the DFPS caseworker, the Provider case manager/designee, and caregiver must be present to receive the child(ren) at the time of placement. When a child is entering paid care, either by emergency removal or a new entry, the DFPS removal worker will complete the following forms and provide them at placement. In addition, if the child is in the SFCS network, the SFCS Child Case Manager will be providing the following forms to the Provider, prior to or at placement:

- Placement Summary (Form 2279);
- Placement Authorization (Form 2085fc);
- Placement Documentation (Form 1509);
- Medical Consenter (Form 2085b); and
- Education Decision-Maker (Form 2085e).

SFCS will supply the Provider case manager with information received to assist with daily care of the child, such as the Application for Placement or the Alternative Application for Placement of Children in Residential Care and the Removal Affidavit. It may be 30 to 45 days from the date of placement before these documents are received.

2.7 Placement Decisions

SFCS will utilize information gathered in the referral data/packet about the child's needs that will assist with assessment of the most appropriate placement, including information from the child's

record, such as information from the birth family, DFPS caseworkers, IMPACT system, previous providers and caregivers, professionals providing services, historical records, current assessments, court records, and other resources. Once known information is reviewed, the SFCS Placement Coordinator will evaluate the least restrictive placement type needed and review with the supervisor, if needed.

The SFCS Placement Coordinator will then use CareMatch to identify appropriate placement resources based on information entered into TPG. This process prioritizes close proximity to the child's removal location, family, siblings, school of origin, or others with whom the youth may be reunifying. CareMatch will rank potential placements for a child(ren), taking into account the characteristics and performance history of potential homes, geographic distance and school district boundaries, and the characteristics of the child obtained from the initial assessment and referral information.

The SFCS Placement Coordinator will use this information to guide decision-making about the most appropriate placement. For this reason, Providers will be asked to work closely with SFCS in identifying an appropriate placement and in recruiting and developing additional resources throughout Region 1.

2.7.1 Sibling Groups

Each child in a sibling group will be assessed for their individual needs, but also the needs of the sibling group as a whole. If their needs differ greatly and require different types of specialized services, maintaining sibling connections will be prioritized as placement decisions are considered. All attempts will be made to involve children, when appropriate, in the placement decision. It is up to the Provider to make sure that all sibling connections are maintained in accordance with DFPS requirements.

Placing siblings together reduces the stress and behavioral issues in most cases and reduces trauma for children being removed from their families. SFCS will continue to search for placement where siblings can remain together.

2.8 Placement Resource Profiles

SFCS will require our Network Providers to verify *daily* information on capacity and availability and to update TPG if changes have occurred, thus providing an actual representation of available placement options. Utilizing a "live" system that accurately identifies available placement options throughout Region 1 and out-of-region Network Providers will allow the SFCS Placement Coordinator to make decisions that reflect the best interests of the child. By utilizing real-time placement information from TPG and CareMatch, SFCS will identify the most appropriate placement early in the process so that the best match can be made.

SFCS understands the importance of continuity of procedure and service provision across the continuum of care. The standard resource profile in TPG used for matching purposes in CareMatch will be utilized for all placement resources where an SFCS child is to be placed. This profile has information regarding the placement resource, such as location, demographics, type of resource (basic, therapeutic, etc.), capacity (openings and placements), preferences of age range and sex, quality indicators (utilizes trauma-informed principles, structured home environment, one parent

stays at home, advocates for education, facilitate transportation or visits, etc.), behaviors that the resource feels comfortable working with/preferred (home accepts LGBTQ youth), etc. SFCS requires this information to be entered into TPG for each placement resource in the Network.

Failure to update TPG may result in placement resources not being selected for placement. Providers that do not update their capacity and availability according to the guidelines listed above are subject to placement holds and/or restrictions.

2.9 Pre-Placement Staffing

SFCS may hold a pre-placement staffing for non-emergency moves and placement changes to ensure that all the child's interested parties have an opportunity to share and discuss relevant information in support of SFCS' search for the best possible placement option. The pre-placement staffing will be coordinated and facilitated by SFCS. The Provider case manager and current caregiver will be invited and will be expected to attend either in-person or by phone. The Provider is responsible for the transportation of the child/youth to all pre-placement staffings.

If the pre-placement staffing is warranted or believed to be beneficial, a child (based on cognitive ability and maturity level) must be given an opportunity to participate. If he/she cannot or chooses not to attend, the child's voice in the decision-making and planning process should be represented by either the Provider case manager or the caregiver(s). The Provider case manager will provide the child or youth with alternative methods of participation, such as:

- Writing them down in a letter to be read during the staffing;
- Drawing them in a picture to be shared during the staffing;
- Verbalizing them in a video to be played during the staffing;
- Utilizing technology such as FaceTime or Skype; and/or
- Verbalizing them to a designated person (such as the Provider case manager or DFPS caseworker, current caregiver, or CASA volunteer) to be addressed at the staffing.

If older youth are unable or decline participation, in addition to the above methods of including their voice in the process, the Provider case manager will:

- Ascertain the reason for the decline;
- Ensure that the youth fully understands the purpose of the staffing; and
- Ensure that the youth understands the importance of having a voice in planning for their future.

SFCS, DFPS, and the Provider case manager will share and exchange copies of all external documentation gathered thus far related to the child or youth's needs, including, but not limited to, birth certificates, social security cards, medical/dental reports or records, school records, assessments, evaluations, and other relevant documents.

2.10 Respite

SFCS encourages the use of overnight respite to provide stability and support for the child and placement providers. ***Respite is for the family, not for the child***. It is SFCS' expectation that placement providers utilize natural supports to provide respite and exhaust all options to ensure respite occurs. It is the CPA's responsibility to locate respite for children placed within their foster care home program. SFCS Placement Services will not be responsible for locating respite care services. A lack of respite care resources will not be considered a viable reason for a disruption.

Notification of the respite must be given to the SFCS Child Case Manager via email at least 24 hours prior to respite occurring. If respite is planned to exceed seven (7) nights, placement providers must notify the SFCS Child Case Manager seven (7) days prior to respite occurring.

2.11 Placement Stability

Every child is entitled to placement stability. Placement disruptions negatively impact the child's emotional, behavioral, and physical health, as well as his/her ability to develop and maintain healthy relationships. Through policy and in practice, SFCS and the Providers will integrate best practices and evidence-based models of care, such as wraparound and trauma-informed interventions to maintain and preserve placements in the least restrictive settings.

SFCS will track all placement changes in CareMatch, will review a child's response to services, and will assist in authorizing services to support stability.

Note: SFCS will periodically assess Providers in placement stability within network, factoring in discharges, capacity growth, and ability to meet the placement needs of Region 1.

2.11.1 Ice Breakers

An agency's ability to provide the appropriate tools to foster home families and residential facilities to care for children also contributes to enhancing placement stability. One such tool is an "icebreaker," a meeting that case management staff facilitate between birth and foster parents. The icebreaker meeting creates an opportunity for biological and foster parents to meet and engage in open communication concerning a child's wellbeing. It is the expectation that foster families participate in this activity.

Note: The icebreaker process is a Stage 2 function; however, SFCS wants providers to begin understanding, learning about, and preparing for this process.

2.11.2 Case Management Monitoring

The monitoring of placement stability occurs during regular communications between DFPS, the Provider, and the SFCS Child Case Manager. Foster families and residential providers are encouraged to take advantage of frequent interactions with SFCS Case Management teams. Although any and all communication is appreciated regarding the care of a child, constant communication, including face-to-face interactions, emails, and phone calls, create the opportunity to address concerns and challenges.

2.11.3 Placement Stability Staffings

When a child is having behavioral or emotional problems and is at risk of disrupting placement, the Provider case manager can request a Placement Stability Staffing. The Provider should notify the SFCS Child Case Manager via email or per phone call of the potential placement disruption.

A Placement Stability Staffing includes a conference call in which professionals and caregivers discuss the challenges they are facing. Members include, but are not limited to, the family, child, case management, supervisor, foster care worker, residential case manager, foster parent, residential staff, and foster parent, and the conference call will be facilitated by the Clinical Utilization Specialist.

After reviewing the current stability status of the child, a plan of action with assigned tasks will be distributed to participants. The Provider case manager will consult with their clinical staff to review interventions and strategies and develop a child- and family-centered placement stability plan when appropriate. These plans will focus on providing support, additional training and coaching, and increased monitoring.

A Placement Stability Staffing is highly encouraged prior to submitting discharge on a child.

2.12 Discharge/Disruption

SFCS considers a discharge successful when it is planned, when it is to a less restrictive setting, or when reunification with the family occurs. However, if the child is a danger to him or herself or others and cannot be helped through additional supervision and support in their current placement, the Provider will submit a placement change through the Placement Team via email at TXReg1Placement@st-francis.org, and notify the SFCS Child Case Manager and DFPS caseworker, in compliance with their Provider Services Agreement.

Prior to requesting the removal of a child, the Provider case manager will be required to provide documentation defining efforts to maintain placement over the last 30 days, as well as to participate in the development and implementation of a transition plan appropriate to the child's best interests. Exceptions will be made for emergency removals as defined by SFCS. By contractual agreement, the Providers will be expected to deliver foster parent support services to minimize placement disruptions, including contact (with child and caregiver) within one (1) business day and not to exceed 72 hours of any placement, as well as on-going support for crisis intervention.

All Providers will be required to create a "Disruption Mitigation Process" to review and evaluate alternatives to potential disruptions. All crisis situations will be promptly responded to by the Provider 24 hours per day, seven (7) days per week, 365 days per year. Providers will be expected to have a crisis response plan that will work quickly to de-escalate the crisis and quickly advance to an action plan that ensures the stability of the placement.

As appropriate, the SFCS Child Case Manager will support the Provider in convening support services to ensure ongoing needs are provided.

Upon physical discharge of a child, the following will need to be provided to SFCS:

- Placement Summary (Form 2279);

- Education Portfolio; and
- Child's personal possessions.

2.12.1 Discharge Form

When requesting a placement change, the Provider case manager will complete the SFCS Residential Child Care Discharge Form and will forward it to the SFCS Placement Team via email at TXReg1Placement@st-francis.org. SFCS will track reasons for discharge, and as such, the Provider is to identify on the form the top two (2) reasons why the child is being discharged. This form gives information that will assist with understanding the reasons for discharge and will provide recommendations for a future placement that will increase the child's opportunity to attain a stable placement. In addition, the Provider case manager will notify SFCS when a child is discharged to any positive permanent placement by using the same form.

SFCS may remove a child whenever SFCS determines it is in the best interest of the child due to allegations of neglect and abuse in the current placement. SFCS will be in contact with DFPS for any recommendations in the event of an open investigation.

Time frames for discharge are detailed on the SFCS Residential Child Care Discharge Form as follows:

- For an **Emergency Discharge**, within 24 hours of the child being admitted for psychiatric treatment or charged and detained.
- For a **Non-Emergency Discharge**, upon deciding to discharge the child.

Provider shall complete and submit the SFCS Residential Child Care Discharge Form for any placement change after the child's initial placement, including movement from one foster home to another within the same CPA.

All discharges will be effective beginning the date received by the SFCS Placement Services Department, via the TXReg1Placement@st-francis.org email.

2.12.2 Discharge Types

The following types of discharges are documented using the SFCS Residential Child Care Discharge Form.

24-Hour Discharge Notice
A child or youth is arrested, and the child is in jail or a juvenile detention facility, and the Provider is not willing to allow the Child to return to the operation following release from jail or juvenile detention.

A child or youth placed in a foster home is admitted to a psychiatric hospital because the child poses a danger to self or others, or exhibits volatile, self-injurious, or inappropriate behaviors that the caregiver is not equipped to manage and the provider is not willing for the child to return to the placement after stabilization.

A child or youth placed in a GRO that does not provide treatment services is admitted to a psychiatric hospital because the child poses a danger to self or others, or exhibits volatile, self-injurious, or inappropriate behaviors that the caregiver is not equipped to manage and the provider is not willing for the child to return to the placement after stabilization.

A child or youth placed in a GRO-ECS ONLY services is admitted to a psychiatric hospital because the child poses a danger to self or others, or exhibits volatile, self-injurious, or inappropriate behaviors that the caregiver is not equipped to manage and the provider is not willing for the child to return to the placement after stabilization.

10-Day Discharge Notice – GRO-ECS

This type of notice is for a GRO-Emergency Care Services (ECS), when the GRO-ECS has determined that it is no longer in the child's best interest to remain at the facility, or that the GRO-ECS cannot meet the needs of the child. After receiving notification, SFCS will remove the child within 10 calendar days.

14-Day Discharge Notice

A psychiatrist, licensed psychologist, physician, LCSW or LPC who has provided treatment services to the child has provided documentation showing that the child consistently exhibits behavior that cannot be managed within the Provider's licensed Programmatic Services. SFCS will consult with the Provider to determine a plan for removing the child within 14 calendar days.

30-Day Discharge Notice

It is no longer in the child's best interest to remain at the Provider's facility, or the Provider cannot meet the needs of the child.

Exception to 14-Day or 30-Day Discharge Notice

If a youth placed in a GRO offering Treatment Services is admitted to a psychiatric hospital and the facility does not plan for the child to return to the facility following stabilization, the Provider may request an exception to the 14-Day or 30-Day Discharge Notice.

For SFCS to consider an exception, the Provider must demonstrate good faith efforts to serve the youth in the facility by discharging the child back to their facility *at least two (2) times* prior to the exception request. The Provider must complete due diligence and demonstrate that all resources have been exhausted that would support the child in the placement. This includes STAR Health options, creative solutions, resources from CPS and/or SFCS, including but not limited to, education specialists. The Provider's clinical team is also required to meet with the psychiatric hospital's clinical team prior to considering an exception.

The following are circumstances that an exception would be considered for a child to not return to the GRO RTC or GRO offering Treatment Services once stabilized and ready for discharge from psychiatric hospitalization:

- Safety concerns for the child, other children in the placement, and/or staff.

- If the Provider is not equipped to manage the child's specific and unique needs and/or behaviors. (Examples include medical needs, significant change in behavioral needs, change in diagnosis.)
- Child's absolute refusal to return. Motivational interviewing is required prior to considering this exception.

Timeframes for Exception Process:

The licensed administrator for the operation must send a request to the SFCS Placement Director. The exception request must include:

- Dates of the child's hospitalization;
- Dates the child returned to the operation;
- Services provided to the youth to support him/her following stabilization; and
- The reason the Provider is unable to meet the child's needs.

The SFCS Placement Director will review the exception request within three (3) business days and notify the Provider, in writing, of the decision to grant or not grant the exception.

If the SFCS Placement Director approves exception, child will be discharged from placement within 24 hours.

2.13 Rate per Service (Level of Care)

SFCS is currently utilizing Youth for Tomorrow (YFT) to determine **R**ate per **S**ervice (**L**evel of **C**are) for children. This process will continue until determined by SFCS and our Providers through a Rate per Service Committee. SFCS, with feedback from the Provider **N**etwork and through this committee, will move towards a Client Screening and Caregiver Response Tool. In the interim, SFCS will continue to use YFT.

In order to request a Rate per Service (Level of Care), the Provider will:

- Request a Service Level Request Approval Form from the SFCS Child Case Manager; and
- Submit supporting documents to help@yft.org and include TXReg1YFT@st-francis.org.

Once SFCS receives the Rate per Service (Level of Care), the SFCS Child Case Manager will notify the Provider case manager within two (2) business days.

2.13.1 Review Process

Children who qualify for basic rate of service will be reviewed every 365 days, unless a higher Rate for Service (Level of Care) is needed by the Provider and SFCS. Children with therapeutic rates of service will be reviewed every 90 days.

The SFCS Permanency and Reunification Team receives monthly spreadsheets with children placed with therapeutic rates of service that need to be reviewed within the next month.

2.13.2 Rate per Service (Level of Care) Expectations

SFCS will primarily place children in family-like settings at Basic, Moderate, Specialized, Intense, and Intense-Plus, as determined by objective information gathered and level of care determined by YFT. If a child's Rate per Service (Level of Care) is deemed Intense or Intense-Plus, a General Residential Operation (GRO) or Residential Treatment Center (RTC) will be a placement option. SFCS will review all Moderate, Specialized, Intense, and Intense Plus every ninety (90) days. SFCS expects foster families to support the child in the stabilization of behaviors and to be leveled down within the same foster home without disruption. Network Providers shall provide the care necessary to ensure safety and opportunities to heal for the children and youth accepted at the following Rate per Service (Level of Care):

Basic Service Level
The Basic Service Level consists of a supportive setting, preferably in a family, that is designed to maintain or improve the child's functioning, including:

1. Routine guidance and supervision to ensure the child's safety and sense of security;
2. Affection, reassurance, and involvement in activities appropriate to the child's age and development to promote the child's well-being;

3. Contact, in a manner that is deemed in the best interest of the child, with family members and other persons significant to the child to maintain a sense of identity and culture; and
4. Access to therapeutic, habilitative, and medical intervention and guidance from professionals or paraprofessionals on an as-needed basis to help the child maintain functioning appropriate to the child's age and development.

*Characteristics of a child who needs **Basic Services**:*

A child needing basic services is capable of responding to limit-setting or other interventions. The child needing basic services may include:

- A child whose characteristics include one or more of the following characteristics:
    - Transient difficulties and occasional misbehavior;
    - Acting out in response to stress, but episodes of acting out are brief; and
    - Behavior that is minimally disturbing to others, but the behavior is considered typical for the child's age and can be corrected.
- A child with developmental delays or Intellectual or Developmental Disabilities (IDD) whose characteristics include minor to moderate difficulties with conceptual, social, and practical adaptive skills.

<u>Moderate Service Level</u>
The Moderate Service Level consists of a structured supportive setting, preferably in a family, in which most activities are designed to improve the child's functioning, including:

1. More than routine guidance and supervision to ensure the child's safety and sense of security;
2. Affection, reassurance, and involvement in structured activities appropriate to the child's age and development to promote the child's well-being;
3. Contact, in a manner that is deemed in the best interest of the child, with family members and other persons significant to the child to maintain a sense of identity and culture; and
4. Access to therapeutic, habilitative, and medical intervention and guidance from professionals or paraprofessionals to help the child attain or maintain functioning appropriate to the child's age and development.

In addition to the description in subsection above, a child with primary medical or habilitative needs may require intermittent interventions from a skilled caregiver who has demonstrated competence.

*Characteristics of a child who needs **Moderate Services**:*

A child needing moderate services has problems in one or more areas of functioning. The children needing moderate services may include:

- A child whose characteristics include one or more of the following:
    - Frequent non-violent, anti-social acts;
    - Occasional physical aggression;
    - Minor self-injurious actions; and
    - Difficulties that present a moderate risk of harm to self or others.
- A child who abuses alcohol, drugs, or other conscious-altering substances, whose characteristics include one or more of the following:
    - Substance abuse to the extent or frequency that the child is at-risk of substantial problems; and
    - A historical diagnosis of substance abuse or dependency with a need for regular community support through groups or similar interventions.
- A child with developmental delays or Intellectual or Developmental Disabilities (IDD), whose characteristics include:
    - Moderate to substantial difficulties with conceptual, social, and practical adaptive skills to include daily living and self-care; and
    - Moderate impairment in communication, cognition, or expressions of affect.
- A child with primary medical or habilitative needs, whose characteristics include one or more of the following:
    - Occasional exacerbations or intermittent interventions in relation to the diagnosed medical condition;
    - Limited daily living and self-care skills;
    - Ambulatory with assistance; and
    - Daily access to on-call, skilled caregivers with demonstrated competence.

Specialized Service Level

The Specialized Service Level consists of a treatment setting, preferably in a family, in which caregivers have specialized training to provide therapeutic, habilitative, and medical support and interventions, including:

1. 24-hour supervision to ensure the child's safety and sense of security, which includes close monitoring and increased limit setting;
2. Affection, reassurance, and involvement in therapeutic activities appropriate to the child's age and development to promote the child's well-being;
3. Contact, in a manner that is deemed in the best interest of the child, with family members and other persons significant to the child to maintain a sense of identity and culture; and
4. Therapeutic, habilitative, and medical intervention and guidance that is regularly scheduled and professionally designed and supervised to help the child attain functioning appropriate to the child's age and development.

In addition to the description above, a child with primary medical or habilitative needs may require regular interventions from a caregiver who has demonstrated competence.

*Characteristics of a child who needs **Specialized Services**:*

A child needing specialized services has severe problems in one or more areas of functioning. The children needing specialized services may include:

- A child whose characteristics include one or more of the following:
    - Unpredictable non-violent, anti-social acts;
    - Frequent or unpredictable physical aggression;
    - Being markedly withdrawn and isolated;
    - Major self-injurious actions to include recent suicide attempts; and
    - Difficulties that present a significant risk of harm to self or others.
- A child who abuses alcohol, drugs, or other conscious-altering substances, whose characteristics include one or more of the following:
    - Severe impairment because of the substance abuse; and
    - A primary diagnosis of substance abuse or dependency.

- A child with developmental delays or Intellectual or Developmental Disabilities (IDD), whose characteristics include one or more of the following:
    - Severely impaired conceptual, social, and practical adaptive skills to include daily living and self-care;
    - Severe impairment in communication, cognition, or expressions of affect;
    - Lack of motivation or the inability to complete self-care activities or participate in social activities;
    - Inability to respond appropriately to an emergency; and
    - Multiple physical disabilities including sensory impairments.
- A child with primary medical or habilitative needs whose characteristics include one or more of the following:
    - Regular or frequent exacerbations or interventions in relation to the diagnosed medical condition;
    - Severely limited daily living and self-care skills;
    - Non-ambulatory or confined to a bed; and
    - Constant access to on-site, medically skilled caregivers with demonstrated competencies in the interventions needed by children in their care.

Intense Service Level

The Intense Service Level consists of a high degree of structure, preferably in a family, to limit the child's access to environments as necessary to protect the child. The caregivers have specialized training to provide intense therapeutic and habilitative supports and interventions with limited outside access, including:

1. 24-hour supervision to ensure the child's safety and sense of security, which includes frequent one-to-one monitoring with the ability to provide immediate on-site response;
2. Affection, reassurance, and involvement in therapeutic activities appropriate to the child's age and development to promote the child's well-being;
3. Contact, in a manner that is deemed in the best interest of the child, with family members and other persons significant to the child, to maintain a sense of identity and culture;
4. Therapeutic, habilitative, and medical intervention and guidance that is frequently scheduled and professionally designed and supervised to help the child attain functioning more appropriate to the child's age and development; and

5. Consistent and frequent attention, direction, and assistance to help the child attain stabilization and connect appropriately with the child's environment.

In addition to the description above, a child with developmental delays or Intellectual or Developmental Disabilities (IDD) needs professionally directed, designed, and monitored interventions to enhance mobility, communication, sensory, motor, and cognitive development, and self-help skills.

In addition to the description above, a child with primary medical or habilitative needs requires frequent and consistent interventions. The child may be dependent on people or technology for accommodation and require interventions designed, monitored, or approved by an appropriately constituted interdisciplinary team.

*Characteristics of a child who needs **Intense Services**:*

A child needing intense services has severe problems in one or more areas of functioning that present an imminent and critical danger of harm to self or others. The children needing intense services may include:

- A child whose characteristics include one or more of the following:
    - Extreme physical aggression that causes harm;
    - Recurring major self-injurious actions to include serious suicide attempts;
    - Other difficulties that present a critical risk of harm to self or others; and
    - Severely impaired reality testing, communication skills, cognitive, affect, or personal hygiene.
- A child who abuses alcohol, drugs, or other conscious-altering substances whose characteristics include a primary diagnosis of substance dependency in addition to being extremely aggressive or self-destructive to the point of causing harm.
- A child with developmental delays or Intellectual or Developmental Disabilities (IDD), whose characteristics include one or more of the following:
    - Impairments so severe in conceptual, social, and practical adaptive skills that the child's ability to actively participate in the program is limited and requires constant one-to-one supervision for the safety of self or others; and
    - A consistent inability to cooperate in self-care while requiring constant one-to-one supervision for the safety of self or others.
- A child with primary medical or habilitative needs that present an imminent and critical medical risk whose characteristics include one or more of the following:

- Frequent acute exacerbations and chronic, intensive interventions in relation to the diagnosed medical condition;
- Inability to perform daily living or self-care skills; and
- 24-hour on-site, medical supervision to sustain life support.

Intense-Plus Service Level

Intense-Plus Services consist of a high degree of structure to support the child in his or her environment while intervening as necessary to protect the child. The caregivers have specialized training specific to the characteristics of the child, and the therapists on staff have professional licensure or graduate level education to provide therapeutic services and intense therapeutic supports and interventions, including:

1. 24-hour supervision to ensure the child's safety and sense of security, which includes constant one-to-one monitoring during waking hours by an employee who is trained on the child's therapeutic interventions and is able to provide immediate on-site response.
2. Participation in individual and/or group therapy sessions that are research-supported, reimbursable by Medicaid, and readily available in the community, including but not limited to specialized therapies such as Eye Movement Desensitization and Reprocessing Therapy, Applied Behavior Analysis (certified), Treatment for Anorexia/Bulimia/Eating Disorders, and others as appropriate;
3. Use therapeutic programs that are documented as either well supported, supported, promising practice or evidence based and are appropriate to the child's age and development to promote the child's well-being. Therapy must address trauma and the behaviors resulting in the need for intense plus level of care;
4. Contact with siblings, family members, and other persons significant to the child in order to maintain a sense of identity and culture;
5. Provision of services to help the child learn or improve skills and functioning for daily living;
6. Medical intervention and therapy that is structured daily and professionally designed and supervised to help the child attain functioning more appropriate to the child's age and development addressing the behaviors resulting in the need for intense plus services;
7. Consistent and constant direction, intervention, and structured support to help the child attain stabilization and connect appropriately with the child's environment.

8. A child with intellectual or developmental disabilities will receive professionally directed, designed, and monitored interventions to enhance mobility, communication, sensory, motor, cognitive development, behavioral and self-help skills.

*Characteristics of children who need **Intense Plus Services**:*

A child needing intense plus services has severe problems in **two (2) or more areas** of functioning that present an extreme, imminent and critical danger of harm to self or others. The children needing intense plus services may include a child whose characteristics include more than one of the following:

- Extreme and reoccurring episodes of physical aggression that causes harm;
- Extreme and reoccurring episodes of sexually aggressive behaviors;
- Assaultive, homicidal, suicidal, recurring major self-injurious actions;
- Chronic runaway behaviors;
- Severely impaired reality testing, communication skills, and cognition;
- A child who abuses alcohol, drugs, or other conscious-altering substances whose characteristics include a primary diagnosis of substance dependency or abuse in addition to being extremely aggressive or self-destructive to the point of causing harm;
- A child with eating disorders causing concerns for health and well-being;
- A child with intellectual or developmental disabilities, whose characteristics include:
    - Impairments so extreme in conceptual, social, and practical adaptive skills that the child's ability to actively participate in the program is limited and requires constant one-to-one supervision for the safety of self or others; and
    - A consistent inability or unwillingness to cooperate in self-care while requiring, constant one-to-one supervision for the safety of self or others;
- A child who is actively psychotic and has acted out on the psychosis;
- A child who is a survivor of human or sex trafficking;
- A child with chronic criminal behaviors that result in current or recent involvement with the justice system; and/or
- A child who has displayed animal cruelty in the last 90 days.

Intense-Plus Requirements:

1. Offer placement for individual children.

2. Provision of individual and/or group therapy. The therapies must be research-supported, reimbursable by Medicaid, and readily available in the community, including but not limited to specialized therapies such as Eye Movement Desensitization and Reprocessing Therapy, Applied Behavior Analysis (certified), Treatment for Anorexia/Bulimia/Eating Disorders, Sex Offender Treatment, and others as appropriate.
3. Continued care for a child following psychiatric or medical hospitalization.
4. Provision of discharge planning, including recommendations for care and intervention strategies and availability for ongoing phone calls with the caregiver for three months to begin during placement transition. Intense Plus Service Level will be reviewed every 90 days by YFT.
5. Initial determination for Intense Plus will be determined by YFT and not through a service level waiver.

2.13.3 Level of Service Change Process

If the child has been approved to be leveled down/up, the SFCS Child Case Manager will notify the placement provider with a letter via email providing them with a two (2) business day notice that the child's Rate of Service (Level of Care) will be changed.

The SFCS Child Case Manager will make appropriate changes to the Rate of Service (Level of Care) in CareMatch to ensure proper payment.

Placement providers will have seven (7) calendar days to dispute the child's level of service and will work with the SFCS Child Case Manager who will defer to the YFT Dispute Resolution Process. The SFCS Director of Permanency and Reunification can approve variances on a case-by-case basis.

If a dispute is not received by the SFCS Child Case Manager within seven (7) calendar days, the Rate per Service (Level of Care) change cannot be disputed again for 90 days.

2.14 Safety Plan

A safety plan will be completed by the Provider when a child poses imminent danger to themselves or others, or to mitigate risk and safety threats in the home or facility. The Provider will notify the SFCS Child Case Manager of any safety plans completed or currently in place in the home or facility. The written plan is then to be sent by email to the SFCS Child Case Manager by noon (12 pm) the following business day.

Upon request by SFCS at the time of admission or when a behavior triggers a critical incident, SFCS expects a safety plan to be completed as an immediate response to address the safety of the child and others. Behaviors that would require that a safety plan be submitted would include but are not limited to:

- Alleged perpetrator of animal abuse;
- Alleged victim of human trafficking;
- Alleged perpetrator of Child Sexual Aggression;
- Arrest of a child in foster care;
- Attempted suicide;
- Child is an alleged perpetrator or victim of a criminal assault of any kind;
- Criminal behavior;
- Drug/alcohol use/abuse;
- Fire setting;
- Frequent AWOL;
- Physically aggressive;
- Property destruction;
- Psychiatric emergency/screened for acute care;
- Runaway or missing from placement;
- Safety of environment;
- Self-injury;
- Sexual acting out/offender; and/or
- Use of illegal drugs.

3.0 Service Delivery

A foster home or residential facility is expected to provide 24-hour care to children who are in out-of-home placement to meet their needs, namely in the areas of safety, permanency, and well-being. Services provided in the home/facility will support the healing process as a part of the permanency goal and will include, but are not limited to, supervision, food, shelter, age-appropriate daily living skills instruction, transportation, recreation, and supporting parent/child interactions (when not prohibited by court order).

3.1 Participation and Implementation

The placement provider will also be expected to participate in and support the implementation of case plan tasks and objectives that may include but not be limited to the activities listed below.

3.1.1 Accessing Community Services

Providers are expected to develop a supportive relationship with each child entrusted to their care. The supports needed to care for a child are directly related to the assessed needs of each child and often will need to be accessed through naturally occurring community supports. In an effort to address the challenges present in the life of a child, placement providers are expected to partner with SFCS in accessing community services as recommended by the SFCS Child Case Manager, DFPS, clinical staff and/or as identified in the case plan. These supports will directly promote and support goals directed at achieving permanency in accordance with Texas Minimum Standards for leisure and normalcy activities.

3.1.2 Academic Success of Children/Youth in Care

Providers will ensure children are enrolled in and attend an accredited Texas Public School within two (2) days of placement (DFPS Policy 4114.32), unless an exception has been granted in writing by the DFPS Education Specialist (e.g., for private schooling, homeschooling, or temporary school absence due to physical or mental condition). Educational stability will be a critical factor when identifying placements.

Providers also will ensure that preschool age children will be provided access to appropriate early childhood education programs. Children between 3 and 5 years of age will attend a pre-kindergarten program offered through the local public school district or an early childhood education program offered through Head Start, unless an exception has been granted by DFPS.

Within five (5) calendar days of the child's enrollment, verification of the child's school enrollment will be provided by the Provider to the SFCS Child Case Manager, and documentation of such notification will be recorded in the child's record. In compliance with the Texas Education Code §29.012, the Provider will notify the school district in which the school is located for all children 3 years of age or older. For eligible children under age 3, SFCS will require that the Provider set up a Texas Health Steps exam to evaluate developmental health. If a disability or developmental delay is suspected, a referral will be made to Early Childhood Intervention (ECI) within 30 days of placement.

SFCS understands the Provider serves a critical role in ensuring the educational stability and success of children and youth in paid placement. The Provider is responsible for monitoring and documenting each child's educational progress and stability, and in collaboration with the DFPS Educational Specialist, facilitating the coordination of educational services on behalf of the child, and addressing issues impeding the provision of appropriate education-related services.

The education service plan for each child will identify the child's educational needs and any additional support services necessary to meet those needs. For children requiring special education or Section 504 services, the Provider will consult with the DFPS Educational Specialist and the DFPS Developmental Disability (DD) Specialist to ensure needs are met.

A current/accurate Education Portfolio is essential to monitoring a smooth transfer if the child must move from one school to another, which includes proper educational placement and services and ongoing monitoring of a child's academic progress. The Provider will ensure copies of all required documentation (e.g., report cards, transcripts, standardized tests scores, school withdrawal documentation, immunization records, medication needs, correspondence to and from the school, copy of the birth certificate) are included in the portfolio, with original documentation being maintained in the child's case file. The Provider will ensure the Education Portfolio is reviewed and updated as needed, on a monthly basis, and that documentation is reflected in the child's record.

For children receiving special education or Section 504 services, additional documentation will be maintained. Examples include: Admissions, Review, and Dismissal (ARD) meetings, results of Full Individual Evaluation (FIE), Individual Education Plan (IEP) updated annually, current Individual Family Service Plan (IFSP), documentation of services provided under Section 504, and Individual Transition Plan (ITP) or Summary of Performance for youth in grades 9-12. The Provider will coordinate with the SFCS Child Case Manager to ensure copies of needed documents are submitted to the child's school within 30 days of enrollment (if a change in school occurs). The Education Portfolio will be updated quarterly and discussed during monthly reviews with the caregiver.

A child's educational success is influenced by including biological parents and providers. However, the roles of caregivers in the educational process can be confusing. In many cases, biological parents maintain decision-making rights even after the child is removed from the home. It is important to empower the biological parent as an educational advocate. The role of a caregiver is equally important in the educational processes, specifically if a child has a disability and an Individual Education Plan (IEP).

3.1.3 Medical/Dental/Vision and CANS Requirements

Network Providers must access all medical, dental, vision, and behavioral healthcare services for children in substitute care referred to Network Providers by the SSCC through STAR Health Network Providers.

A person consenting to medical care for a child must participate in each appointment set for the child with the healthcare provider, in accordance with Texas Family Code §266.004. The Provider is responsible for transportation of the child/youth to all medical, dental, vision, and behavioral healthcare appointments.

Participation must be in-person or, if appropriate and acceptable to the Provider, by telephone. The level of participation depends on the nature of the medical care the child is receiving; the medical consenters must attend any appointments in-person when a child may be prescribed psychotropic medications. Healthcare providers may have varying requirements for participation. Medical consenters must discuss their expectations for participation with healthcare providers.

Providers are required to use the DFPS Medical/Dental/Vision Examination Form (2403). The doctor must complete the form at a child's medical, dental, or vision appointment. The form is filled out jointly by the person taking the child/youth to the appointment (usually the caregiver) and doctor/dentist. Within three (3) business days after the child's appointment, the Provider will send the completed Examination Form (2403) to both the SFCS Child Case Manager and the DFPS caseworker.

The Provider case manager will ensure that youth ages 16 to 22 are advised of their right to request to become their own Medical Consenter. Documentation of this conversation will be noted in the youth's record.

No later than the second (2nd) business day after a child's caregiver receives a STAR Health denial letter, the Provider will email a scanned copy of the denial letter and the date of such receipt to the SFCS Child Case Manager for assistance.

Providers will maintain records of all health care services in accordance with SSCC policies and Residential Child Care Licensing (RCCL) requirements. Providers must ensure a 3-Day Medical Exam is completed for each child within three (3) business days of placement as per 3 in 30 requirements. This will be followed by a 30-Day Texas Health Steps Examination.

Initial CANS Assessment will be completed within 21 to 30 days for children ages 3 years or older, initiated by the Provider's certified CANS assessor. A list of STAR Health providers can be found here: https://www.fostercaretx.com/for-members/find-a-provider.html It is the responsibility of the Provider to ensure STAR Health CANS Assessments are completed annually. Providers must follow the Texas Health Steps schedule for subsequent medical/dental/vision appointments.

Therapeutic children with a Rate per Service (Level of Care) Moderate or higher, in the SSCC system, are required to have CANS assessments every 90 days. Provider's staff or subcontractor must complete the CANS training and pass a test demonstrating competency in order to be certified to administer the CANS assessment tool. Staff or subcontractor must retrain and retest annually to remain in compliance. It is the Provider's responsibility to ensure staff or subcontractor who administer CANS maintain their certification.

Once a CANS assessment is completed, it will need to be provided to the SFCS Child Case Manager within three (3) business days.

Note: SFCS Child Case Managers will be conducting CANS assessments in collaboration with the Provider until the end of Quarter 2 in 2020.

For any child that is placed who is under the age of 3 and is suspected of having a disability or developmental delay, the medical provider will need to refer the child to ECI within three (3) days of placement and document it in the child's record.

3.1.4 Accessing Mental Health Services Initiated and Authorized by SFCS Clinical Staff

Providers must access Medicaid through STAR Health for Medicaid Covered Behavioral Health Services, unless the court orders DFPS to provide behavioral health services for the child from a Provider outside of the Network. The Provider must use community resources to obtain Behavioral Health Services not covered by Medicaid. SFCS Child Case Managers will assist the Provider in locating services as needed. In the event that community resources are not available for Behavioral Health Services and/or Medicaid does not cover the services, the Provider shall be financially responsible for providing Behavioral Health Services.

3.1.4.1 Psychiatric Hospitalization

Providers are to notify SFCS **immediately** of any psychiatric hospitalization by emailing TXReg1IR@st-francis.org as soon as a child is admitted, but no **later than 12 hours** after being admitted. The email will need to include:

- Name of the child/youth;
- Date and time of the hospitalization
- Name and location of the Psychiatric Hospital where the child/youth was admitted; and
- Any other pertinent information, such as an authorization code or identifying code to be able to get information about the child including what precipitated the hospitalization.

Note: If hospitalization ends in a discharge, the Provider should notify the SFCS Child Case Manager and email TXReg1Placement@st-francis.org.

SFCS encourages Providers to see psychiatric hospitalization as a last resort and utilize wraparound services through Local Mental Health Authority (LMHA), unless a child is a threat to themselves or others. However, SFCS understands that sometimes psychiatric hospitalization is necessary. SFCS encourages Providers to not see psychiatric hospitalizations as an end to placement but rather, in these instances, to encourage Providers to reach out to the SFCS Child Case Manager and the team of professionals surrounding the child to ensure all services and supports necessary are in place so the child can return to their placement upon discharge.

If a placement change is needed, the provider must provide SFCS with a discharge notice as soon as possible so that planning can be made in a timely manner.

Note: A discharge notice does not substitute as a serious incident report or a notification of hospitalization.

3.1.4.2 Psychotropic Medication Appointments

The Provider must ensure that all caregivers and employees who serve as medical consenters for a child (who is prescribed psychotropic medications) facilitate an office visit with the prescribing physician, physician's assistant, or nurse practitioner in the STAR Health Network **at least once every 90 days** to allow the practitioner to appropriately monitor the side effects of the drug, determine whether the drug is helping the child achieve the treatment goals, and determine whether continued use of the drug is appropriate.

In the event that a DFPS staff member is designated as the medical consenter for a child, the Provider must ensure that the DFPS staff member has notice and is able to attend any appointments in-person in which a psychotropic medication may be prescribed, as well as all medication review appointments.

The Provider is responsible for ensuring that any medical consenter representing the agency has the most recent DFPS training and documentation in their record to function in this capacity.

3.1.4.3 Consenting to Psychotropic Medication

When a healthcare provider initially prescribes a psychotropic medication, the Provider will ensure that all caregivers or employees who serve as medical consenters for a child:

1. Notify the SFCS Child Case Manager, in writing, of any initial psychotropic medications and subsequent dosage changes by the next business day;
2. Complete and sign the Psychotropic Medication Treatment Consent (Form 4526) with the healthcare provider; and
3. Provide a copy of the form to the SFCS Child Case Manager within three (3) business days. Form 4526 is not required for changes in dosage or for refills of the same medication.

3.1.5 Transitional Living Services

Using a multidisciplinary approach, SFCS, DFPS, and the Provider will work together to prepare and support foster youth in DFPS conservatorship who are transitioning from substitute care to adulthood. SFCS seeks support form Providers as we utilize a multidisciplinary approach involving the youth, the family, Network Providers, and natural supports, including biological families, churches, and community partnerships.

The Provider will ensure that youth ages 16 and older obtain a Driver's License or State ID as part of the youth's preparation for adulthood. Efforts to obtain these will be documented in the client record and provided to the SFCS Child Case Manager.

3.1.5.1 Transition Plan Development

The Transition Plan is enhanced over time until the youth leaves substitute care or ages out of care. The Plan must address the issues that are important for the youth as he or she leaves care and enters the adult world. SFCS, DFPS, and the Provider will work together to initiate the discussion and development of the youth's Transition Plan.

During a service planning meeting (or 90-day review) when a youth turns 14, the DFPS case worker will:

- Introduce the Transition Plan (Form 2500) and Circles of Support (COS) process to the youth; and
- Inform the youth that a Family Group Decision Making (FGDM) staff member will discuss COS with them further.

The Provider case manager will ensure that the Transition Plan is discussed at all subsequent service planning meetings.

3.1.5.2 Circles of Support (COS)

Circles of Support (COS) will be generally coordinated and facilitated according to current DFPS policy after a youth turns 16 years old. SFCS and the Provider will work jointly with DFPS Family Group Decision-Making (FGDM) staff and the DFPS caseworker to engage youth, family, and other caring adults in the COS or subsequent service planning meetings.

SFCS and the Provider will work with the youth, the caregivers, and other significant individuals to identify caring adults and other lifelong connections that can be sustained once the youth transitions to adulthood.

The Provider must participate in the COS or subsequent service planning meeting and will also ensure that the youth attends.

When the youth declines a COS, the Provider will schedule a subsequent service planning meeting instead. The Provider will discuss the elements of the Transition Plan (Form 2500) with the youth and record discussion of the Service Plan document (i.e., goals, strengths, fears, etc.).

The Provider will continue to discuss and document the Transition Plan and progress with the youth over time during face-to-face visits, subsequent service planning meetings (90-day reviews), and COS.

3.1.5.3 Preparation for Adult Living (PAL)

SFCS will ensure the development and delivery of PAL Life Skills Training utilizing the curriculum topics established by DFPS. As part of the delivery of PAL training, within 30 days of new placements and when the youth turns 14 years old, the Provider will ensure that the youth and caregiver complete the Ansell-Casey Life Skills Assessments (ACLSA) and that its interpretation is shared and discussed with the youth and caregiver. The ACLSA will identify the youth's strengths, needs, and goals, which will be documented in the youth's service plan.

SFCS will refer the youth for PAL services no later than the youth's 16th birthday; the Provider must ensure the youth receives the referral and attends PAL services. The Provider must work with the caregiver to ensure that the youth are made available and have transportation to participate in PAL services, including the following:

- The completion of PAL training;
- The provision of identified services to assist with their transition to adulthood; and
- Assistance with applying for and securing services to aid in their transition to adulthood.

On the 10th day of the month following the month of service, the Provider will submit a monthly report to the SFCS Child Case Manager referencing the Life Skills Training that the youth received. The submitted report must include:

- The youth's status;
- The youth's progress;
- Completion of PAL training;
- Services provided to the youth to assist with their transition to adulthood; and
- Assistance provided to the youth with applying for and securing services to aid in their transition to adulthood.

The Provider will document the youth's progress and status of PAL Life Skills Training as well as experiential life skills learning in the child's service plan. The Provider is responsible for transportation of the youth to all life skills and experiential trainings/activities.

Providers must ensure for all children/youth that caregivers:

- Teach Basic Living and Social Skills;
- Maximize opportunities for learning through the use of Experiential Life Skills Activities;
- Provide access to Experiential Life Skills Activities provided by community resources;
- Promote the ability to appropriately care for themselves and function in the community;
- Assist youth ages 14 or older who have a source of income to establish a savings plan and, if available, a savings account to manage independently; and
- Assist youth ages 18 up to 22 years of age who have a source of income to obtain a savings or checking account with a Financial Institution (in accordance with Texas Finance Code §201.101).

3.1.5.4 Supervised Independent Living (SIL)

Supervised Independent Living (SIL) placement settings are living arrangements offered through the Extended Foster Care program that allow young adults to reside in a less restrictive, non-traditional foster care setting while continuing to receive casework and support services to become independent and self-sufficient.

At the youth's 17th birthday, the SFCS Child Case Manager, in conjunction with the Provider and CPS Caseworker/PAL Worker, will provide information to the young adult regarding SIL. CPS may coordinate a meeting with the Provider and the young adult to provide information to the youth about their SIL options.

To be eligible for SIL, young adults must be able to live independently in a setting with minimal-to-no supervision. Through conversations with the young adult and the initial assessment, the young adult will be placed in the setting which best meets his or her needs. In order to maintain placement in the SIL program, young adults must comply with the Voluntary Extended Foster Care Agreement (Form 2540). Young adults can move through the settings offered based on behaviors, enhancement of skills, or overall progress made in the young adult's current setting.

If the youth chooses SIL services either in Region 1 or outside of Region 1, the SFCS Child Case Manager contacts the CPS worker with the transitional living placement recommendation for their approval.

3.1.5.5 Extended Care and Return to Extended Care

SFCS, DFPS, and the Provider will work together to identify youth for either Extended Care or Return to Extended Care programs. The Provider will ensure that participation in the Extended Care or Return to Extended Care programs will be discussed and planned with the youth during regularly scheduled service planning meetings (such as 90-day reviews), during the youth's Circle of Support or Transition Plan Meeting, or upon the youth's request.

If a youth appears to be eligible and is interested in Extended Care or Return to Extended Care, the Provider will assist the youth in completing the Voluntary Extended Foster Care Agreement (Form 2540) within 30 days prior to the youth's 18th birthday and provide the completed form to the SFCS Child Case Manager.

The SFCS Child Case Manager will provide the information to DFPS for the approval process. DFPS will determine eligibility according to current Extended Care Guidelines. Once approved or denied, SFCS will notify the Provider, and the Provider will notify the caregiver and the youth of the approval or denial.

If approved, the Provider will ensure that the youth is assisted in maintaining necessary documentation for the Extended Care program.

If a caregiver or Provider becomes aware of a youth who is interested and eligible for Return to Extended Care, the same process will be followed.

3.1.5.6 National Youth in Transition Database (NYTD)

DFPS will take the lead on identifying youth (ages 17, 19, and 21) who will participate in surveys for the National Youth in Transition Database (NYTD). SFCS will inform the Provider of the youth who will participate in NYTD surveys via email with a subject line of "NYTD Survey Participant."

Note: The Provider will ensure youth 17 years of age and older are registered for the NYTD in the event they are chosen to participate in the survey.

Once notified, SFCS and the Provider will assist DFPS in obtaining NYTD surveys from identified youth. SFCS will maintain current contact information for youth placed within their Provider Network and inform DFPS when updated information becomes available.

3.1.5.7 Aftercare and Follow-Up

SFCS and the Provider value the importance of seeing our youth not just age out of the foster care system, but age into a new community full of opportunities and life as a young adult.

Before the youth discharges from foster care, an aftercare plan will be developed by the Provider along with the SFCS Child Case Manager, focusing on the youth's preferences and independent living needs. The aftercare plan will include a termination of service evaluation and assessment of "unmet" needs. Together, the SFCS Child Case Manager and Provider will establish a support system for the youth to devise goals and objectives, meeting the "unmet" needs to monitor an ongoing structure for a smooth discharge and transition into adulthood.

A list of aftercare providers can be found at:
https://www.dfps.state.tx.us/Child_Protection/Youth_and_Young_Adults/Preparation_For_Adult_Living/aftercare.asp

3.1.7 Birth Family Interaction

SFCS expects each Provider to support the reunification of the child with their birth family as directed by the DFPS and SFCS Child Case Management Teams. Providers support the reunification process by facilitating and encouraging authorized, consistent, and frequent interactions and visits between children and their birth parents. Biological parents are to be treated with respect for their strengths in the care of their children.

3.1.8 Adoptive Resources

Should a child's case plan change to adoption, SFCS expects Providers to support DFPS and SFCS Case Management decisions regarding the adoptive process and that they will support their foster families during the adoption of a child placed in their care. Permanency decisions are made in the best interest of the child. Providers will work SFCS to implement the appropriate transition plan. All communications pertaining to permanency with potential adoptive families will be directed with the authorization of the SFCS Child Case Manager.

3.1.9 Sibling Interaction

SFCS expects all Providers to work diligently in the placement of siblings, since separation is considered a last resort. When placement in the same home is not possible, a visitation plan is developed by SFCS through the Case Planning Document, to keep siblings connected until arrangements can be made to place all the siblings together.

Providers are expected to support sibling interaction through encouragement, flexibility, and provision of transportation for sibling visitation.

3.1.9.1 Frequency of Visitation

Providers in conjunction with DFPS must provide frequent visitation between siblings. Frequent visitation is defined as visits that occur at least weekly. Sibling visits should occur weekly if they are not placed together; distance is not an approved exception to this requirement.

Efforts to accomplish this may include:

- Utilizing caregivers and relatives for transportation and supervision;
- Providing transportation services such as bus passes;
- Allowing visits at locations outside of a DFPS office;
- Allowing overnight visits between siblings at their respective placements; and/or
- Working with other regions and residential provider staff to coordinate transportation.

If the Provider in conjunction with DFPS cannot arrange weekly face-to-face visitation, they must promote other forms of contact, such as:

- Phone calls and texts;
- Letters;
- Social media contact; and/or
- Video conferences, Skype, or FaceTime.

3.1.9.2 Exceptions

Providers in conjunction with DFPS must ensure frequent visitation occurs unless one of the following exceptions apply:

- The court orders otherwise; and/or
- DFPS has determined and documented in the Child's Plan of Service (CPOS) that frequent visitation or ongoing interaction between siblings would not be in the child's best interest, and the court has not ordered this visitation to occur.

Texas Administrative Code §700.1327 External Link

A supervisor must approve any exceptions not ordered by the court. Upon request, Providers will be expected to participate in the 90-day sibling separation staffing.

3.2 Visitation

It is the Provider's responsibility to ensure transportation to the initial visit, which should occur within five (5) calendar days of removal. Prompt visitation between children and their parents early in the case is critical to ensuring more timely permanency occurs. The Provider will respect the right of both children and their parents to have visitation as long as behavior remains safe throughout.

Additionally, it is the Provider's responsibility to ensure that ongoing visitation occurs between children and their parents as outlined in the service plan, **including transportation to the visits**.

3.3 Initial Coordination Meeting

The Initial Coordination Meeting (ICM) is a collaborative process that focuses on the unique, individualized needs of the child and outlines services to address those needs. The Provider is expected to participate in the ICM. The ICM process seeks to share all relevant information about a

child in DFPS conservatorship who required a new emergency placement within the SFCS Provider Network. Relevant information includes assessments, evaluations, medical reports, recommended services, and all other information that pertains to the child's individual needs. During the ICM, the child's initial and concurrent permanency goals will be identified. The ICM takes the place of the traditional removal staffing.

3.3.1 Initial Coordination Meeting Process

Within seven (7) days of a new emergency placement in the home or facility, DFPS will host, coordinate, and participate in the ICM. The ICM may be extended up to three (3) days if an emergency placement occurs on a holiday or weekend day (Friday, Saturday, and Sunday) or inclement weather prevents the ICM from occurring as scheduled. All other extensions to an ICM must be approved by the DFPS Program Administrator. At minimum, the following participants will be notified by DFPS of the upcoming ICM: The SFCS Child Case Manager, DFPS removal worker and supervisor, DFPS conservatorship worker and supervisor, DFPS FGDM Specialist or coordinator, Provider case manager, and other DFPS staff or subject matter experts as needed.

Note: It is the SFCS Child Case Manager's responsibility to notify the Provider about the need for an ICM.

SFCS, DFPS staff, and the Provider will share and exchange copies of all external documentation gathered thus far related to the child's needs, including but not limited to, the removal affidavit, immunization records, birth records, birth certificates, social security cards, medical/dental reports or records, school records, assessments, evaluations, etc.

The first or subsequent service planning meeting date will be identified by the Provider prior to ending the ICM.

3.4 Service Planning

Child service plans will be developed through a service plan meeting. Child service plans must be developed with the child/youth in accordance with Texas Family Code timeframes and applicable licensing standards. Primary and concurrent permanency goals for the child will be reviewed at each service plan meeting.

The Single Case Plan model will be followed for Service planning in Region 1. Whenever possible, sibling groups will have combined service plan meetings, which may require additional time allotted for the meeting.

The Provider will ensure that service plans are developed within established timeframes according to the Single Case Plan model. Child and youth service planning is a collaborative and inclusive process between SFCS, DFPS, the Provider, the child, and the family that focuses on developing and reviewing plans to meet the individualized and unique needs of the child. Service planning with children and youth will occur with all children placed within the SFCS Network.

3.4.1 Service Planning Meeting Process

The Initial Child Service Plan meeting (ICSP) will be conducted by DFPS no later than the 30th day. The Provider will need to be present at the ICSP meeting and have the plan completed and

submitted to the SFCS Child Case Manager no later than the 35th day. The meeting to develop both the Family Plan and the Child Plan will be coordinated and facilitated by DFPS FGDM staff. The Provider will participate in the 7-day ICM at which time the date/time of the Service Plan meeting will be identified. DFPS will be responsible for coordination of this meeting, including sending the required 14-day notice to all required parties, including the biological family. If the SFCS Child Case Manager receives a 14-day notice, they will inform the Provider.

Service planning meeting participants will generally include, at a minimum, the child or youth's parents and the parents' attorney (who must be invited when the parents have been invited), child(ren) or youth, family members, the current caregiver, Provider, SFCS Child Case Manager, DFPS conservatorship worker and/or supervisor, legal representatives (e.g., CASA, Guardian ad litem, etc.), other relevant professionals and other persons identified in the case who can contribute to service planning with the child. During the Service Plan meeting, the Provider will complete the child's Service Plan except for the sections designated to be completed by DFPS staff.

The Provider will ensure that the child's Service Plan incorporates, at minimum, and is consistent with:

- Permanency Planning and Permanency Goals identified by DFPS;
- The child's needs (i.e., educational, cultural, religious, language, recreational, etc.);
- CANS Assessment of the child's strengths and needs;
- Any (short-term and long-term behavioral goals) established by the Child's team;
- Components of a Child's Individual Education Plan (IEP) and the Individual Transition Plan (ITP) that are both developed by the schools;
- Admission, Review, and Dismissal (ARD) committee, if appropriate;
- Components of the CPS Transition Plan for youth 16 to 22 years of age to include results of the Ansell-Casey Life Skills Assessment (ACLSA) when applicable; and
- Early Childhood Intervention (ECI) Individual Family Service Plan (IFSP) if applicable.

The Provider will ensure that the Conservatorship Specialist (CVS) worker and SFCS Child Case Manager are provided a copy of the completed and signed Plan within five (5) days of DFPS approval of the Plan.

3.4.2 Child Service Plan Schedule and Responsibilities

For children receiving basic (non-therapeutic) Rate for Service (Level of Care), the first review will be completed at the fifth (5th) month Permanency Conference coordinated and facilitated by CPS. CPS will ensure that a 14-day notice is sent to all required parties. If the SFCS Child Case Manager receives a 14-day notice, they will inform the Provider.

Following the first review, all subsequent reviews for children in temporary conservatorship, regardless of service level, will be completed every 120 days and will be coordinated and

facilitated by the Provider. This will include sending a 14-day notice to all required parties as previously identified. The venue for the meeting should take individual circumstances of the biological family and foster parents into consideration. In-person attendance by all is encouraged, but phone or virtual participation may be the most appropriate option in some instances.

For children in permanent managing conservatorship, subsequent reviews of the plan of service would take place 180 days for children receiving basic (non-therapeutic) Rate for Service (Level of Care) and 120 days for children receiving therapeutic services for moderate levels or higher. All subsequent reviews will be coordinated and facilitated by the Provider. This will include sending a 14-day notice to all required parties as previously identified. The venue for the meeting should take individual circumstances of the biological family and foster parents into consideration. In-person attendance by all is encouraged, but phone or virtual participation may be the most appropriate option in some instances.

When to Review the CPOS:

Child's Legal Status	Service Level	When to Review the CPOS
Temporary managing conservatorship (TMC)	Any level	Every 120 days
Permanent managing conservatorship (PMC)	Basic	Every 180 days
Permanent managing conservatorship (PMC)	Moderate or higher	Every 120 days

For children receiving therapeutic Rate for Service (Level of Care), the Provider will coordinate and facilitate a 90-day review of the plan in order to meet licensing standards. The Provider will also participate in the 5-month review coordinated and facilitated by DFPS FGDM staff when the Family Plan is also reviewed.

All future reviews for children receiving therapeutic services will be coordinated and facilitated every 90 days by the Provider in order to meet Minimum Standards. This will include sending 14-day notice to all required parties.

The Provider will ensure that all service planning meetings will be hosted in a venue that allows for maximum participation either in-person or virtually. The venue for the meeting should take individual circumstances of the biological family and foster parents into consideration. In-person attendance by all is encouraged, but phone or virtual participation may be the most appropriate option in some instances.

Providers are responsible for maintaining the client's documentation in the client record, to be included but not limited to, admission and placement paperwork, service plans and assessments, medical/ dental/vision exams, psychotropic/psychological/psychiatric evaluations, daily/weekly/monthly notes, educational/recreational schedules, court reports, etc. It is the Provider's responsibility to ensure there are daily/weekly/monthly notes in the client record with documentation in reference to milestones, activities, behaviors, serious incidents, visits, appointments, etc., that could impact the client's therapeutic needs, placement stability, and Rate for Service (Level of Care).

To view the DFPS policy on case planning, visit:
https://www.dfps.state.tx.us/handbooks/CPS/Files/CPS_pg_6200.asp

3.5 Child and Family Assessments

SFCS will hold itself and Providers responsible for completing assessments using an inclusive model of care that is family-focused, strengths-based, trauma-focused, and culturally respectful. As indicated by research, children and families' active participation in every aspect of the treatment planning process is central to placement stability and permanency.

SFCS values individual uniqueness and firmly believes that families know what they need better than anyone. Rather than relying solely on case history, SFCS recognizes that children and families are the experts on their own lives, and this will be communicated throughout the assessment process. SFCS will draw from children and families' accounts of their own histories to develop a culturally competent understanding of needs and strengths. Assessments will drive service plan development and inform the appropriateness of placement and permanency goals.

3.6 Court Requirements

The Provider will comply with all court orders regarding the provision of paid placement and/or purchased services for children, youth, and families served by the Provider.

Services that are ordered by the court and fall outside the purchase of service criteria of this Agreement will be reviewed by the SSCC and Provider on a case-by-case basis to determine rate of payment and parameters of services to be provided by the Provider.

It is important not only for provider staff to understand all court orders/requirements, but also for caregivers to have a clear understanding of the judicial process. Caregivers are encouraged to attend court hearings and provide youth with the opportunity to attend court hearings related to his/her individual case. We believe the youth's voice should be heard by the court systems, and the Provider should make every reasonable effort for the child to attend.

Note: If it is determined that it is not in the best interest of the child/youth to attend a court hearing, the absence must be approved by DFPS and the court, and then documented in the child's/youth's record.

Court orders will be reviewed and documented in the following instances: Intake Assessments, Individual Service Plans, Monthly Contact Notes, Permanency Planning Documentation, and Provider Progress notes when appropriate. There will be continued monitoring of court requirements, such as visitation, permanency goals addressed in the youth's Individual Service Plan, and continued contact with DFPS to monitor the Provider is meeting all court requirements.

3.6.1 Court Hearings

The Provider must ensure children attend court hearings, unless excused by the presiding judge prior to the court hearing. Attendance may occur through video conference and/or teleconference when appropriate and approved by the court. Attendance at Adversary Hearings (14-day hearings) is generally not expected, unless the child's attorney ad litem requests the

child's attendance. If the child/youth is expected to attend, the Provider is responsible for transportation to all court hearings.

The Provider must identify and ensure attendance of the most appropriate staff (e.g., Provider case manager) with personal knowledge of the case at all court hearings unless excused by the presiding judge. The Provider must also attend all other court preparation meetings as requested by DFPS, CASA, the attorney ad litem, or other members of the judiciary.

The Provider must notify the SFCS Child Case Manager who will be attending court within two (2) business days of notification of court hearing. If an emergency court hearing is scheduled, then the Provider will share the attendee list as soon as possible.

If date and time of a court hearing is announced during court, DFPS considers this formal notice to SFCS and the Provider. Therefore, whoever is present (the Provider, the Caregiver, or SFCS staff) must notify the other parties by the next business day.

If an emergency court hearing is scheduled, then the Provider and SFCS will determine the attendee list as soon as possible and SFCS will immediately notify DFPS.

The Provider will also notify the SFCS Child Case Manager immediately of any service of legal process (e.g., subpoena, summons, discovery notices) delivered to the Provider agency, employees, caregiver, or child/youth related to the child's court case or any contract compliance issues.

3.6.2 Court Reports

DFPS holds ultimate responsibility and ownership of all information contained in court reports submitted to the court. However, the Provider will be expected to ensure that DFPS has the most recent and up to date information on the child, their needs, and services that are being provided in preparation for the court report.

The Provider must maintain a copy of the most up-to-date court report in the client record from within the past six (6) months or be in compliance with their accrediting organization, if any.

3.7 Adoption

In order to ensure placement stability, SFCS will be contracting with the Provider to deliver services to children placed with adoptive families prior to consummation of the adoption. The Provider is responsible for managing all services (including but not limited to monthly post-placement supervision) to prepare and support adoptive placements. The Provider will provide documentation of these services to SFCS Child Case Manager.

DFPS adoption staff will provide monthly supervision of children who are placed with adoptive families until consummation is achieved and DFPS is dismissed as the child's conservator.

SFCS will take the primary lead on all adoption recruitment and matching activities for referred children in DFPS conservatorship in the Region 1 Community Based Care catchment area. DFPS adoption staff will continue to be responsible for all legal and court activities, including the termination of parental rights and in all court hearings giving or withholding consent to adoption,

waiving service to adoption hearings, authorization for and authorization of post-adoption subsidies and services.

3.7.1 Recruitment

SFCS will be fully responsible for all general and child-specific recruitment activities for adoption-motivated homes for children from and referred to Region 1. This will include various recruitment tools such as Heart Gallery, Wednesday's Child, TARE, maintaining child profiles, and handling any general or child-specific inquiries that may be received by CPS.

The SFCS Child Case Manager will have primary responsibility for adoption activities and will manage and track all child specific inquiries.

3.7.2 Home Studies

The SFCS Permanency and Reunification Team will ensure that home studies on all potential adoptive homes (including kinship homes) are conducted and approved by the Provider.

If a potential adoptive family is referred to SFCS for an adoption home study, SFCS will refer the family to Providers in the family's geographical area that have expressed interest in completing adoption home studies and will provide these options to the family. Once the family chooses a Provider, SFCS will send an email to the Provider as the adoption home study referral and will provide via email any supporting documentation, such as a kinship home assessment or previously completed home studies completed, if available.

3.7.3 Home Selection and Staffing

The SFCS Child Case Manager will coordinate and host a selection staffing with DFPS, CASA, ad litem, guardian ad litem, the Provider, and current foster parents, as appropriate.

SFCS will present recommended home studies to participants prior to the staffing for review. A decision regarding selection of a family will be made during the staffing.

Once an adoptive home is approved, the SFCS Child Case Manager will provide all appropriate redacted information to the prospective family (e.g., psychological evaluation, service plans, Health, Social, Educational, and Genetic History report) once received from DFPS.

When the prospective family agrees to proceed with the adoption process, DFPS will complete redaction within 15 business days and provide SFCS a copy of the redacted file. When an adoptive home recommendation is denied, SFCS will continue the recruitment of adoptive homes to find a match for the child.

3.7.4 Presentation Staffing

After the prospective family has reviewed the child's redacted case file, the SFCS Child Case Manager will ensure a Presentation Staffing is held with the prospective family, current placement, CASA, ad litem, guardian ad litem, Provider, and DFPS. A Presentation Staffing is an opportunity for the prospective family to ask questions, for the current family to discuss the child's daily care, and for the attendees to collectively develop an appropriate transition plan.

The transition plan will include adoption preparation activities, pre-placement visits, and a discussion of services to be in place prior to the placement. If the prospective family elects to not accept a child, the Provider must notify the SFCS Family Finder by close of business the following business day.

3.7.5 Placement of the Child

When placement of the child with the adoptive family is determined, the SFCS Child Case Manager will work together with the Provider and the adoptive family to coordinate pre-placement visits and facilitate the physical placement of the child/youth in the home

4.0 Additional Provider Requirements

4.1 Trauma Informed

Decades of work in the field of trauma have heightened awareness of the need for those working in child welfare to adopt trauma-informed practices. Individual trauma results from an event, series of events, or a set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

SFCS expects all sub-contractors caring for youth in the child welfare system to develop an understanding of trauma and develop trauma-specific practices. An agency that is trauma-informed:

- Realizes the widespread impact of trauma and understands potential paths for recovery;
- Recognizes the signs and symptoms of trauma in clients, families, staff and others involved with the system; and
- Responds by fully integrating knowledge about trauma policies, procedures, and practices and seeks to actively resist re-traumatization.

During annual site visits, SFCS staff will review documentation that ensures all staff receive basic training on trauma, its impact, and strategies for trauma-informed approaches.

4.2 Client's Rights

Providers will:

- Ensure all children have been given a written copy of the DFPS Rights of Children and Youth in Foster Care (DFPS Form 2530) at the time of placement and at the time of any placement change to a new foster home;
- Support the rights listed in the DFPS Rights of children and youth in Foster Care;
- Not deny or restrict, through action or policy, any of the rights listed in the DFPS Rights of children and youth in Foster Care;
- Provide services to children who are deaf or hard of hearing that ensure effective communication;
- Make reasonable efforts to ensure services provided to children and families are offered in the individual's primary language; and
- Deliver services in a manner that is relevant to the culture of children and families served.

4.3 Conflict Resolution

There may be times when SFCS and a Provider do not agree on a case decision affecting a child. Appropriate resolution measures will be taken to make the best possible decisions for the child.

4.3.1 Case-Specific Conflict Resolution

SFCS staff and Provider staff (who are most knowledgeable about the issue in dispute), along with the SFCS Supervisor and the Provider Supervisor, will work together to resolve case-specific issues informally. This will be accomplished through an objective, solution-driven discussion or meeting. If a mutually agreeable solution is not achieved in three (3) business days, either Supervisor can notify the other Supervisor that they plan to involve their chain of command. The disputed issue will be elevated to the SFCS Department Director and the next level within the Provider agency for resolution. If the dispute is not satisfactorily resolved, it will be elevated in writing to the Regional Vice President of SFCS.

As a part of the review, the philosophy and goals of Community Based Care will be reviewed and used as a guideline for the ultimate resolution. The Provider must ensure continuity of services, as defined by the SFCS Contract and the SFCS Provider Manual for the child or family involved while seeking to resolve the case-specific dispute. The issue will be resolved at this level and a final decision will be distributed back to the requesting staff by email with supporting points for the decision.

There also may be times when SFCS and the Provider may not agree on a case decision made by DFPS. In those cases, SFCS and DFPS will follow a similar conflict resolution process outlined in the Protocol Manual.

4.3.2 Non-Case-Specific Conflict Resolution

Examples of non-case-specific issues that a Provider may dispute include, but are not limited to, the following:

- Decisions not to contract with Providers;
- Referral practices;
- Rate for Service (Level of Care) determinations; and/or
- Payment.

The Provider must ensure continuity of services to the affected child while seeking to resolve non-case-specific disputes, as defined by the SSCC Provider Services Agreement and the SFCS Provider Manual.

Supporting documentation will be sent by email to the SFCS Regional VP with the subject line of “Dispute Resolution.” The issue will be resolved at this level, and a final decision will be distributed back to the requesting staff by email with supporting points for the decision.

4.4 Complaints and Concerns

SFCS employs a Customer Care Representative (CCR) to facilitate responses to complaints and concerns. Any consumer/client, Provider, DFPS employee, or community stakeholder can register a complaint or concern directly with SFCS by sending an email to TXCustomerCare@st-francis.org or call 1-866-671-4735 and ask for Customer Care. The CCR will document and present the complaint/concern to the appropriate supervisor and track it to ensure it is addressed in a timely manner.

A quarterly summary report of complaints and concerns will be generated and sent to the SFCS Regional Vice President, the SFCS Vice President of Performance Improvement and Risk Management, and SFCS leadership personnel.

4.5 Conflict of Interest

SFCS has an ethical obligation not to enter into any relationship which poses a possible conflict of interest. We expect the same from the Providers in the network. A conflict of interest is a situation in which a person has a private or personal interest sufficient to appear to influence the objective exercise of his or her duties in the best interest of SFCS, our mission, or our clients as a Board member, advisory committee member, paid consultant, employee, or subcontractor.

Providers, including Board members, advisory committee members, paid consultants, employees, community partners, and subcontractors, are required to fully disclose any potential conflict of interest.

Provider employees shall be trained in Policy and Procedures and are required to fully disclose any potential conflicts of interest to their immediate supervisor as well as their Human Resources (HR) representative to be investigated and bring resolution to the actual, potential, or perceived conflict. The employee will be advised of the resolution accordingly.

For subcontractors (Providers) or community partners, should a potential, actual, or perceived conflict of interest arise, the party will notify SFCS immediately. Once SFCS is made aware of the conflict, it will be reported to the SFCS Regional Vice President to be further investigated and bring resolution to the actual, potential, or perceived conflict.

4.6 Transportation

It is the responsibility of Providers to ensure caregivers transport to all visits as well as all medical/dental, counseling, educational, and other appointments. If a caregiver is unable to transport, it is the responsibility of the agency to arrange for alternative transportation. SFCS will only provide transportation on a case-by-case basis and only after due diligence has been completed on the part of the Provider. If a Provider is unable and/or unwilling to ensure transportation will occur, the Provider must contact the SFCS Director of Permanency and Reunification to explain the circumstances and gain approval for SFCS to transport.

Note: If a home is unwilling or refuses to transport, and the agency does not have a backup transportation plan in place, SFCS may place that home on hold or restrict the types of placements the home is able to take.

4.7 Risk Management and Reporting

Within 24 hours of knowledge of critical incidents, as defined by the Provider Services Agreement, including licensing investigations, licensure board reports and investigations, suspected fraud or fraud investigations, and violations that occur within the Provider's business, must be reported to SFCS by the Provider at TXReg1IR@st-francis.org. The Provider must have operational procedures and mechanisms in place to ensure staff are knowledgeable of, and respond immediately to, conditions or situations that may pose a threat to child safety as soon as possible or in accordance with DFPS Minimum Standards.

4.7.1 Crisis Response

Providers are expected to have staff available, accessible, and able to manage a crisis immediately and in the manner needed to support the child(ren). Any emergency concerns will need to be brought to the immediate attention of the SFCS Child Case Manager or after-hours on-call staff at **(806) 381-3753**. Emergencies are defined as follows:

- Critical medical or mental health treatment;
- Placement is in substantial non-compliance with applicable placement standards and agreements such that the health, safety, or welfare of the child is endangered;
- Involvement with law enforcement including the removal of the child for safety reasons; and/or
- Pending investigation of an allegation of abuse or neglect of a child by the foster parent(s)/staff or any other person residing in the home of the foster parent(s)/residential facility.

A Critical/Significant/Unusual Incident will need to be completed within the timeframes set in subsection 4.7.2 below.

4.7.2 Critical/Significant/Unusual Incidents

Nothing in this section shall be deemed or construed to replace or eliminate any obligation to report child abuse or neglect, sexual abuse or exploitation, or abandonment required of Provider or a Provider employee or other person by DFPS Minimum Standards 749.503, by a contract with Provider, or by terms of employment by Provider.

SFCS requires all providers to report all critical/significant/unusual incidents as determined by the DFPS criteria to the SFCS Child Case Manager during business hours or after-hours on-call at **(806) 381-3573**.

4.7.2.1 Critical Incident
A Critical Incident is defined as the following:

- Child Death

- Child Near Death
- Incident Which May Draw Public, Legislative, or Media Attention

4.7.2.2 Significant Incident

A Significant Incident is defined as the following:

- Alleged abuse or neglect
- Alleged perpetrator of animal abuse
- Alleged victim of human trafficking
- Arrested for a juvenile offense
- Attempted suicide
- Birth
- Child is an alleged perpetrator or victim of a criminal assault of any kind
- Death of a parent/primary caregiver (provide date of death)
- Emergency change in placement
- Pregnancy
- Provider staff or incidents in which staff safety was seriously compromised
- Psychiatric emergency/screened for acute care
- Runaway or missing from placement
- Safety of environment
- Serious physical illness
- Unanticipated medical attention that requires treatment beyond first aid
- Use of illegal drugs
- Work related serious staff injury or death
- Child sexual aggression

4.7.2.3 Unusual Incident

An Unusual Incident is defined as the following:

- Aggressive or assaulting behavior
- Any sexual contact between children
- Breach of privacy or confidentiality
- Discharge against medical advice
- Law enforcement contacted

- Medication/Pharmacy concern (list medications involved in description)
- Minor injury of client
- PRN Injection
- Restraint
- Seclusion
- Unauthorized treatment
- Unprofessional conduct by staff or contract staff

4.7.3 Reporting Protocols

The Provider or its employees will follow the verbal report with a written notification sent electronically within 12 hours of the critical/significant/unusual incident to SFCS at TXReg1IR@st-francis.org. The Provider's written critical, significant, or unusual incident report is to be made using the Provider's Critical/Significant/Unusual Incident Report form.

4.7.4 Steps of Action

When a caregiver, placement staff, or provider observes, or is involved in, or is advised of a critical/significant/unusual incident or potential incident, proceed through the following steps:

1. Take immediate action as needed (e.g., safety, emergency procedures, first aid).
2. Decide if emergent assistance from anyone is needed.
3. Contact appropriate individuals (e.g. Parents, SFCS, Police, Fire Department, On-Call, Case Manager).
4. Complete a Critical/Significant/Unusual Incident Report within12 hours and email to SFCS at TXReg1IR@st-francis.org.
5. Mandated reporters must report allegations of abuse and neglect to the DFPS Abuse & Neglect Hotline at 1-800-252-5400, as pursuant to DFPS requirements.

4.7.5 Critical Incident Review

Understanding the behaviors of a child while in placement is essential to providing the best services to children and families. When a Critical Incident transpires, Providers are expected to communicate efficiently and effectively with the assigned SFCS Child Case Manager. All concerns and responses will need to be documented on either critical/significant/unusual incident reporting forms.

Upon request, SFCS personnel may request a Critical Incident Review of events that have jeopardized the safety of youth in the care of SFCS. Key agency representatives are requested to complete a systematic review of the situation, planning, and/or training that will minimize the likelihood of similar incidents.

A Critical Incident Review shall include, at minimum:

- Review date;
- Date and time of incident;
- Staff involved;
- Description of incident;
- Identify harm or potential harm to the child(ren); and
- Precautions taken to minimize future incidents.

A Critical Incident Review shall include, but may not be limited to, the following incidents:

- Medication management concerns;
- Behavior management challenges resulting in harm to children; and/or
- Missed medical or mental health appointments.

The intent of a Critical Incident Review is to evaluate and make corrections to the system when required.

Upon learning of investigations by DFPS, the Provider will notify SFCS immediately by emailing TXReg1IR@st-francis.org. If the allegation indicates a situation that threatens the well-being of a child, the foster family or residential facility may be put on a placement hold.

SFCS will notify the Provider of the hold by email within 24 hours of the hold being placed. SFCS will not resume placement with the foster family or residential facility under investigation before receiving the following documentation:

- All DFPS Findings (licensing violations or child abuse/neglect investigations);
- Documentation that a Critical Incident Review has occurred; and
- Steps the Provider has taken to correct the situation that resulted in the on-hold status.

Each Provider will be required to keep a file for each child in placement, and the file should include the documentation noted on the SFCS Joint Monitoring Tool.

4.8 Disaster and Emergency Response Preparedness Plan

Providers shall submit a Disaster and Emergency Response Preparedness Plan (DERPP) to SFCS within 30 days of executing the Provider Services Agreement. The Plan shall include provisions for pre-disaster records protection, alternative accommodations for child(ren)/youth in substitute care, supplies, and a recovery plan in the event of an actual emergency.

DERPP shall be completed in accordance with the SFCS Provider Manual and the Provider Services Agreement. A Provider's staff and caregivers must be trained annually in order to be informed of any updates to the Provider's DERPP. In the event of an emergency, SFCS may exercise oversight authority over the Provider in order to assure implementation of the agreed emergency relief provisions.

All youth placed in the care of Providers, either within or outside of the Region 1 catchment area, will have location-specific plans for ensuring their children's safety. Each contracted Provider must have written plans and procedures for handling potential disasters and emergencies, such as fire, severe weather emergencies, transportation emergencies, and state declared emergencies.

These plans must include:

- Procedures for relocating children to a designated safe area or alternate shelter (including specific procedures for evacuating children who are under 24 months of age, who have limited mobility, or who otherwise may need assistance in an emergency, such as children who have mental, visual, or hearing impairment, or a medical condition that requires assistance); and
- Procedures to ensure medications and equipment will be made available to children with special needs and/or medical conditions.

Providers and caregivers must know the procedures for meeting disasters and emergencies, including evacuation procedures, supervision of the children, and contacting emergency help.

5.0 Quality Improvement/Continuous Quality Improvement

SFCS will maintain a high level of stakeholder and customer satisfaction through quality assurance (QA) and continuous quality improvements (QI) in service delivery and outcome reporting. This will be accomplished by developing, documenting, and maintaining a comprehensive quality management program guided by best practices.

5.1 Administrative Review of Providers

Onsite reviews are conducted at least annually with subcontracting Providers, and the results are shared with DFPS as needed. The review is completed by the SFCS Provider Relations staff and/or the SSCC Joint Monitoring staff, including a review of relevant documentation demonstrating the program is operating and in good standing. Staff may review policies and procedures and/or records of SFCS client or caregiver/foster family files. SFCS staff may tour the Providers' facilities to monitor the environment of care. Through the review of documentation, SFCS will determine if Providers are offering the services outlined in program descriptions. SFCS also reviews copies of licenses, accreditations, certifications, all recent survey results, and copies of current liability insurance coverage.

Onsite reviews may be announced or unannounced as determined by SFCS Provider Relations. For announced visits, the Provider will be notified via email at least 24 hours in advance. Unannounced visits will be conducted during the Provider's normal business hours.

SFCS Provider Relations and/or SSCC Joint Monitoring staff will meet with the Provider to go over identified issues and coordinate the review, which will include an entrance and exit interview. The entrance interview will include the purpose, scope, and activities planned for the review. SFCS Provider Relations and/or SSCC Joint Monitoring staff will be the point of contact for the Provider regarding the onsite review.

The Provider should be prepared to make the following documents available, including but not limited to:

- Policy and Procedure Manual;
- Personnel records;
- Caregiver/Foster Home records;
- Client records;
- Financial records; and
- RCCL history and documentation.

A walk-through of the facility may be completed. The walk-through is to evaluate the safety and security of clients, the training of staff, and provision of services. This walk-through could include interviews with staff and clients.

Files reviewed may include client or caregiver/foster parent records. Any documentation reviewed as part of the onsite review is confidential and will be securely stored. SFCS Provider Relations and/or SSCC Joint Monitoring staff will require a private space to review files. If a safety concern is discovered, it will be addressed with the provider and immediate action will be taken as needed.

When the onsite review is completed, SFCS Provider Relations and/or SSCC Joint Monitoring staff will review the preliminary results with the provider during the exit interview. Following the onsite review, within 30 days, the Provider will receive a monitoring report, which is a summary of the review from SFCS Provider Relations and/or SSCC Joint Monitoring staff.

If concerns of non-compliance are cited during an onsite review, the Provider may be requested to develop a Performance Improvement Plan (PIP) that includes a timeline and dates for resolution of the concerns. This request will be included in the monitoring report. If it is determined that a PIP is not required, this will be stated within the monitoring report. The PIP will be due within 30 days of receipt of the monitoring report. The SFCS Provider Relations Director will review the submitted PIP and either approve the plan or request revisions from the Provider. If necessary, SFCS Provider Relations will conduct a follow-up review within four (4) to six (6) months (or sooner if indicated in the PIP) to ensure unsatisfactory performance findings are corrected.

5.2 Quality Assurance (QA)

The SFCS QA team will report outcomes and trends quarterly. The outcomes selected for monitoring will be directly related to the performance outcomes of the Provider Services Agreement and/or those that affect the safety/care of a child in provider homes/facilities or show indications of problems with the organization's standard of care. Providers are held accountable to performance and outcome standards through performance-based agreements, which include requirements of the Provider Services Agreement.

Data is gathered from record reviews, Information Technology (IT) systems, and reports. Data is then analyzed and examined for inaccuracies or errors before being summarized and organized into reports for tracking and trending. Reports are distributed to SFCS leadership and Providers.

Each Provider will be expected to participate in a quarterly review of the outcomes and trends during individual quarterly meetings as requested by the SFCS Director of Provider Relations. SFCS may request a PIP to address concerns identified through data review. Meetings may be scheduled more frequently to address risk trends noted. Data will be tracked to guide and monitor PIP activities to ensure improvements are being made.

Additional QA/QI activities may be implemented, or activities may be modified to address needs and to ensure quality services are provided to children and families.

5.3 Random Facility Environmental Surveys

SFCS Provider Relations staff will perform scheduled and random walk-throughs of any residential program providing services to SFCS clients. These walk-throughs will evaluate the facility for security, safety, training of staff, restraint or seclusion policies/processes, and treatment services. At the completion of any walk-through, SFCS Provider Relations staff will complete an exit process with facility staff to communicate any concerns and create action plans to address any deficiencies.

5.3.1 Oversight and Monitoring of Subcontract Providers

Providers will be held accountable through performance-based agreements, which detail the scope, requirements, and parameters of the Provider Services Agreement. Additionally, because SFCS will encourage Providers to be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or Joint Commission or any other approved accreditation bodies, and support them in their efforts to achieve this milestone.

Providers will be required/encouraged to develop and implement internal quality management processes and participate in SFCS' monitoring processes. Through the Continuous Quality Improvement (CQI) process, SFCS will work closely with Providers to ensure accountability and provide the necessary oversight and training to ensure that the Provider meets the conditions of their contract.

5.4 Accountability to Performance and Outcome Requirements

SFCS holds Providers accountable to administrative and service performance standards. Contractual measures are established to drive the Provider Services Agreement, which in turn could reduce the frequency of onsite monitoring.

Performance and outcome measures will be discussed at least quarterly during Network Provider meetings. Risk management meetings with specific providers will occur in response to risk trends noted through data collection. The QI/Contract staff will work closely with the Provider leadership to ensure that all parties are aware of serious incidents and are prepared to work together to mitigate future risk.

A risk management report will be provided to Provider leadership at intervals negotiated with the QA/Performance Improvement Department. The risk management report will include a list of serious events within the Network, recent policy violations, and corrective action plans. The report will also include a narrative on trends in safety and risk issues in foster homes and facilities.

The organizational SSCC Quality Improvement approach is simple: Providers must meet clear levels of contractual performance or immediately execute plans to meet performance expectations. If any Provider does not meet DFPS expectations, SFCS will quickly launch a comprehensive plan to improve performance in the identified areas.

5.5 Outcomes

The SFCS QA team will report outcomes and trends quarterly. This may include:

- Children/youth are safe from abuse and neglect 100% of the time;
- Children/youth have stability in their placements;
- Children/youth attend court hearings; and/or
- Children/youth remain in their school of origin.

6.0 Information Technology (IT)

6.1 Technical Contact

Each Provider must specify a technical contact that is familiar with program operations and relevant technology systems used within the organization. The technical contact's responsibilities include the following:

- Serve as liaison between the Provider and SFCS technical staff;
- Request the creation and deactivation of user accounts for SFCS software systems;
- Respond to periodic reports verifying the Provider's active user accounts;
- Request training and support for the Provider's staff in the use of SFCS software systems; and
- Report any technical problems related to SFCS software systems.

6.2 Required Data

Providers are required to submit timely data including the following:

- Client data, such as assessments, demographics, health information, medications, critical incidents, plans of care, and documents pertinent to client cases;
- Resource information such as addresses, contact information, licensing information, members of the household, and preferences relating to the types of children to be placed; daily bed vacancies; and
- Other data pertinent to outcome metrics, Provider contract performance, or quality of care.

6.3 Methods of Data Submission

In keeping with state requirements, the CANS Assessment must be entered in the statewide CANS system at https://ecans.org.

The Texas Provider Gateway (TPG), accessed at www.texasprovidergateway.com, will allow Providers to share information with each of the SSCCs from one (1) location. Providers will be asked to share:

- Resource information (members, location, contact information, preferences, daily bed vacancies, etc.)
- Placement End information (date child leaves the resource home, reason for placement end), when available;

- Performance Management Evaluation Tool (PMET) data; and
- Any other information as identified.

Providers will have the option of either maintaining the data directly in the TPG or sending the information electronically from their own system to the TPG. For those wanting more details to enable their system's communication directly with the TPG, technical assistance can be provided upon request.

6.3.1 Support

SFCS will provide periodic webinars and onsite training for Providers. Recorded webinars, manuals, and other useful information will be posted on the Saint Francis Ministries website at https://www.saintfrancisministries.org. These trainings and support can also be requested from the SFCS Child Case Manager.

During business hours, SFCS provides live phone support at **(806) 553-5106** or by email at TXProviderRelations@st-francis.org to assist Providers with technical issues related to any SFCS software.

6.3.2 CANS Certifications

Provider staff or CANS Administrators must complete the online CANS training at www.schoox.com/academy/CANSAcademy/register and pass a test demonstrating competency in order to be certified to administer the CANS Assessment tool. To maintain the CANS Certification, Provider staff and/or CANS Administrators must retrain and retest annually. It is the Provider's responsibility to ensure that the CANS Administrators maintain certification.

6.3.3 Requesting Logins to SFCS Systems

If you are a Provider needing access to TPG for the first time, you will need to choose an administrator for your agency and send the following to TXProviderRelations@st-francis.org:

- The full name of the individual; and
- The individual's email address.

Once your agency has a TPG Administrator, that person will be able to create additional logins for your agency.

Note: The Provider is responsible for ensuring that each authorized user is appropriately trained on the protection of confidential information per contract requirements. The Provider's TPG Administrator is responsible for deactivating logins to the TPG when an employee is terminated or transferred.

6.7 Securing Email and Fax Communication

Prior to transmitting confidential information by email, Providers are responsible for ensuring that their email system utilizes Transport Layer Security (TLS) to provide an encrypted channel of

communication between email servers. TLS is an attractive alternative to third-party email encryption systems because encryption occurs automatically in the background without requiring the receiving party to log into a third-party system to access the email. If a Provider is not certain whether their email system uses TLS, they should check with their IT professionals. SFCS will accept emails through third-party encryption services but has a strong preference for using TLS instead.

Providers are also responsible for ensuring privacy of communications received by fax. DFPS and SFCS require physical security around fax machines to prevent unauthorized access to confidential information. SFCS encourages the use of secure digital faxing services, which deliver faxes to a secure email account.

6.8 Data Collection and Reporting

Providers shall be responsible for forwarding all appropriate records relating to the services required by the Provider Services Agreement, the SSCC Contract, or applicable law, rule or regulation, preparing and attending to, in connection with the services, all reports, claims, and other correspondence necessary or appropriate under the circumstances to SFCS on a timely basis.

7.0 Financial Services Procedures and Submissions

7.1 Finance and Billing Procedures

SFCS will follow the process outlined in Article 5 of the Provider Services Agreement and any addendums to the agreement for payments and payment disputes. Questions that arise should be sent to the SFCS Finance Department at: zzcspayablesTX@st-francis.org.

7.2 Initial Payment for Foster Care Services

New placements: Providers will be paid by SFCS for all new placements that have been referred by SFCS after January 6, 2020.

Legacy transfers: Providers will be paid by SFCS for Region 1 legacy children/youth beginning on the date the legacy children/youth are transferred into the SFCS Network.

7.3 Payment Terms

Article 5 of the Provider Services Agreement states that Providers will be paid for pre-authorized placements for each month's services by no later than the 25th day of the next month. For example, Providers would be paid for their December foster care services by no later than January 25th. However, SFCS will make every effort to pay Providers earlier than the 25th whenever possible.

Providers will receive one (1) payment each month for all services provided (e.g., foster care, adoption, etc.).

SFCS does not require or need Providers to send a bill or invoice for paid services. Payments will be based on placement data from CareMatch. SFCS may withhold payment for disputed services and begin the disputed service reconciliation process described in Article 5 Section 1.4 of the Provider Services Agreement.

All Providers will be paid electronically by direct deposit. The Provider's bank account will show that the deposit is from Saint Francis. A Direct Deposit Authorization Form and an IRS Form W-9 will be sent to all Network Providers to complete and return once the Provider application and contract process has been completed.

7.4 Service Payments

SFCS will pay the Providers for services at the fee-for-service rates shown in Exhibit A of the Provider Services Agreement (or applicable addendums for rate changes) and according to the limitations in this section.

Providers will receive payment for each day a youth is in pre-authorized placement, with the exception that no payment will be made for the day that a child leaves care. SFCS will pay the provider for up to 14 days of foster care in the following circumstances unless your agency is identified at an Emergency Shelter, which is five (5) days of:

- Psychiatric hospitalization;

- Medical facility hospitalization;
- Runaway;
- Unauthorized placement;
- Temporary placement/visit in own home;
- Locked facility, jail, juvenile detention center; and/or
- Short-term substance abuse placement.

Under the above-referenced circumstances, SFCS would pay the Provider for days of care on behalf of a child who is no longer in that Provider's care in order to reserve space for the child's anticipated return to the same placement at a date in the near future.

The maximum duration of continued payments to the Provider during a child's absence is subject to the limitations set forth in this section. Payments to the Provider for care during a child's absence will only be made if each of the following conditions are met:

1. The Provider plans to return the child to the same placement at the end of the absence;
2. The Provider agrees to reserve space for the child's return for as long as payments are made in the child's absence; and
3. SFCS will not pay the Provider for days of foster care when children and/or youth reside in the following non-DFPS paid placements:
    - Nursing home placement
    - Intermediate care facilities for persons with Intellectual or Developmental Disabilities (IDD) (ICFMR)
    - State Supported Living Centers (SSLC)
    - Placed with a non-licensed relative caregiver
    - Pre-consummated adoptive placement
    - Texas Youth Commission facility or Texas State Hospitals
4. In the event a Provider does intend to take a child back after temporary absence the discharge process will need to be followed.

7.5 Adoption Service Payments

SFCS will pay the Providers for Adoption Placement and Adoption Post-Placement services. The fees for these services are included in the Provider Services Agreement Adoption Addendum.

Providers will be required to send an invoice and adoption document packet to the SFCS Data Team at DataManagementTXReg1@st-francis.org for Adoption Placement Services, if applicable, and Adoption Post-Placement Services. The invoice and document packet must be received by SFCS

within 30 days from the date of service. For Adoption Placement Services, the date of service is the date of the adoptive placement as shown on the DFPS Adoptive Placement Agreement. For Adoption Post-Placement Services, the date of service is the date the adoption decree or final adoption order is signed by the judge.

7.5.1 Adoption Placement Document Packet: Checklist of Required Documents

This will include, at minimum:

- A copy of the signed CPS Service Authorization Form 2054 (with a date of adoptive placement within the period of the Begin Date and the Termination Date and have the correct 88F service code); and
- A copy of the approved and signed DFPS Adoptive Placement Agreement for each child.

7.5.2 Adoption Post-Placement Document Packet: Checklist of Required Documents

This will include:

- A copy of the signed CPS Adoption Service Authorization Form 2054 (with dates inclusive of the day following the adoptive placement to the date of consummation as Begin Date and the Termination Date. Must also have the correct 88G service code);
- A copy of the approved and signed DFPS Adoptive Placement Agreement for each child;
- A copy of the file stamped petition for adoption (stamp must be clearly visible on first page);
- A copy of the signed **and notarized** court report for the adoption proceedings (DFPS requires the court report to be notarized in order to release the funds for the adoption services – court reports that are not notarized *will not be accepted*); and
- A copy of the adoption decree signed by the Judge, noting:
    - Decrees must have the Judge's signature.
    - Decrees with the stamp "Original signed by Judge" on the signature line will not be accepted. DFPS requires the Judge's signature in order to release the funds for the adoption services.

To request a copy of the CPS Adoption Service Authorization Form 2054, please contact SFCS by email at DataManagementTXReg1@st-francis.org.

Once received, the SFCS Data Management team will review the document packet to ensure all documents have been received, notify the Provider of payment approval, and send to SFCS Finance for payment processing. Upon verification, the SFCS Adoption Specialist will email the

approved invoice to zzcspayablesTX@st-francis.org for payment. Upon review of the information, the SFCS Accounting will reply to the Provider with a payment date so they are aware of when to expect it.

7.6 Extended Foster Care Service Payments

SFCS will pay the Providers for Extended Foster Care Services. Extended Foster Care Services that are provided in a licensed CPA or GRO placement are paid at normal Foster Care daily rates, which are shown on the fee schedule included in the Provider Services Agreement. There is a separate daily rate fee schedule for Extended Foster Care Services provided in a Supervised Independent Living (SIL) program. The fees for these services are included in the SIL Provider Services Agreement.

In order for Providers to be paid for Extended Foster Care Services and SIL Services, the following conditions must be met:

- The Extended Foster Care agreement signed by the youth must be on file.
- The provider must be able to provide documentation on a periodic basis demonstrating that the youth is:
    - Regularly attending high school or enrolled in a program leading toward a high school diploma or Graduate Equivalency Diploma (GED), up to the youth or young adult's 22nd birthday;
    - Regularly attending an institution of higher education or a post-secondary vocational or technical program, up to the youth or young adult's 21st birthday. These can remain in care to complete vocational-technical training classes regardless of whether or not the youth or young adult has received a high school diploma or GED certificate. (40 TAC§700.316);
    - Actively participating in a program or activity that promotes or removes barriers to employment, up to the youth or young adult's 21st birthday;
    - Employed for at least 80 hours per month, up to the youth or young adult's 21st birthday;
    - Incapable of doing any of the above due to a documented medical condition, up to the youth or young adult's 21st birthday (40 TAC §700.316); and
    - Accepted for admission to a college or vocational program that does not begin immediately. In this case, the youth or young adult's eligibility is extended three and a half (3.5) months after the end of the month in which the youth or young adult receives his/her high school diploma or GED certificate.

7.7 Payment Reports for Providers

Upon sending monthly payment to the Providers, SFCS's Finance Staff will create a payment report for each Provider showing the details of the Provider's direct deposit payment. The payment report will show the Provider agency name, children's names, children's PID, Rate per Service (Level of Care), dates of care, the services that were provided, and amounts paid for each child.

SFCS has created a file for each active Provider that is receiving payments at www.box.com. The payment report for each Provider will be uploaded to their file within two (2) business days of payment being made. Once uploaded, each Provider will be able to login to their file and download the payment report.

When the Provider Agreement is signed, SFCS Provider Relations will request contact information for billing/payment details. This person will be given access to their organization's file on www.box.com with viewer/uploader status. At any time, a Provider can contact SFCS to change the staff that have access to their file. For any questions about accessing or downloading information from www.box.com, please contact zzcspayablestx@st-francis.org.

7.8 Payment Discrepancy Resolution Process

The Provider will reconcile the payment from SFCS to the Provider's records. If any discrepancies are noted, the Provider will initiate the following process within 30 days of receiving payment:

1. Providers will send all information on payment discrepancies via email to TexReg1Recon@st-francis.org or by uploading to www.box.com. Information should include child's name, child's PID and/or date of birth, amount paid, amount expected, and description of the discrepancy (e.g., SCFS paid at a basic rate and should have paid at a moderate rate). SFCS will acknowledge receipt of the payment discrepancies within two (2) business days.
2. SFCS will perform a good faith review of any documents submitted. Within 10 business days of receipt of notice of payment discrepancies, SFCS will alert the Provider of all payment corrections that will be made, based upon a good faith review or any documents submitted by the Provider and SFCS's own documentation or records.
3. Should the Provider have disputes beyond this initial reconciliation, SFCS's Chief Financial Officer (CFO) and the Provider's Chief Financial Officer (CFO), or their designees, shall confer in a CFO conference to resolve, settle, or compromise the dispute. The parties shall complete the CFO conferencing process within 30 days of completion of the payment discrepancy resolution process described above.
4. SFCS shall take all action reasonable and necessary to comply with the requirements of the Provider Services Agreement and ensure payment for the services thereunto.

7.8.1 Payment After Resolving Disputes

If SFCS, after conferring as provided herein with the Provider about the disputed payment, concludes it is responsible for paying for a service or some part of it, SFCS shall make its payment to the Provider in the next monthly payment following the month in which SFCS concluded it was liable for payment.

7.8.2 Return of Funds

If SFCS, after conferring as provided herein with the Provider about the disputed payment, concludes the Provider is responsible for repaying for a service or some part of it, SFCS shall recoup this payment from the Provider in the next monthly payment following the month in which SFCS overpaid the Provider for services.

In the event that SFCS first discovers an overpayment has been made to the Provider, SFCS will make the appropriate adjustments to the following month's payment report and payment will be recouped in that month's payment.

If SFCS does not expect the Provider to have any payments in the following month, SFCS will request a check be made out to SFCS in the amount of the overpayment as reimbursement. Payment will be made to SFCS within 30 days of the request.

7.9 Monitoring for Minimum Pass-Through Rate Compliance

SFCS monitors its CPA Providers for compliance with the minimum pass-through rate, which is required by the SSCC Master Contract and any addendums to the agreement for payments and payment disputes. The Minimum Pass-Through Rate to the foster parents is shown in the most recent Rate Addendum to the Provider Service Agreement. This annual monitoring is performed by the SFCS Director of Finance.

Each year, one month is randomly selected for monitoring. A Provider payment report by Provider and by client is created in the SSCC client data management system for the selected month. Ten percent (10%) of each Provider's placements or two placements, whichever is greater, are randomly selected for the pass-through payment monitoring. Once the sample of placements has been created, each Provider is contacted with the list of randomly selected foster homes. For the selected month, we request that the Providers send us the calculation of the foster parents' payment and also proof that the foster parents received the payment.

Once the Providers have complied with our request, we use the Minimum Pass-Through Rate Monitoring Tool to evaluate each foster parent's payment, and to verify that all Providers have complied with the minimum pass through rate requirement. If we determine that a foster parent has been paid incorrectly, the issue is presented to the billing contact of the Provider and proof of a corrected payment to the foster parent is requested and required. If a Provider fails to comply with the request for the foster parent payment information and/or fails to comply with the Minimum Pass Through Rate requirement, it is reported to the SFCS Chief Operating Officer (COO) in order to pursue a remedy with the Provider.

7.10 Monitoring for Financial Viability

SFCS may monitor the financial viability of the Providers when it deems appropriate to do so. SFCS will utilize standard financial measures, and the monitoring will be performed by a SFCS Provider Relations team member in collaboration with the SFCS Director of Finance and the results of this monitoring will be submitted to the SFCS COO and CFO.

According to the SFCS Provider Services Agreement, Providers must send their unaudited financial statements to SFCS on an annual basis, within 90 days of the Provider's fiscal year-end. These financial statements shall include Balance Sheet and Income Statement (or Statement of Activities and Changes in Net Assets). If the financial statements of the Provider have been audited or reviewed by an independent certified public accountant, then audited financial statements accompanied by the auditor's management letter or a financial review report are to be provided to SFCS within nine (9) months after the Provider's fiscal year-end.