FY 2012 Room, Board and Watchful Oversight

Minimum Standards for Child Placing Agencies and Child Caring Institutions

Division of Family and Children Services

Office of Provider Management

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The FY 2012 RBWO Minimum Standards are effective July 1, 2011.

The Office of Provider Management recognizes that certain standards will require time for providers to come into full compliance. For example, providers may need planning time to create new policies or protocols. Additionally, certain new standards may only apply to new placements starting after July 1st. Please be assured that all reasonable allowances will be made during monitoring reviews and support provided to ensure that providers understand and can adhere to the standards, particularly newly created or revised standards.

Thank you for your continued service to children and families.

Please direct any questions, comments or requests for technical assistance to the appropriate OPM Monitoring Team Manager for your region. A staff contact list is located in the Appendix.

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Introduction to RBWO Minimum Standards

RBWO Minimum Standards for Child Caring Institutions and Child Placing Agencies

The mission of the Division of Family and Children Services (DFCS) Foster Care program is to strengthen families, protect children from further abuse and neglect and to assure that every child has a permanent family. The private provider community is an important and integral part of DFCS's ability to achieve its mission. The Room Board and Watchful Oversight (RBWO) Minimum Standards follows and support the DFCS mission and provide guidance to Child Caring Institutions (CCI) and Child Placing Agencies (CPA) contracted with DFCS.

The RBWO Minimum Standards apply to all providers with the exception of sections which apply specifically to CCI's or CPA's. Compliance with all Office of Residential Child Care (ORCC) rules and regulations are required of all providers that have entered into a contract with DFCS.

RBWO Minimum Standards are focused on securing positive permanency, health and education outcomes for children and to reduce risks to their welfare and safety. Providers must aim to provide the best care possible for the children in their care; observing the Standards is an essential part, but only a part, of the overall responsibility to safeguard and promote the welfare of each individual child placed. The Standards are presented as "minimum" requirements rather than as best practices. Thus, providers should strive to exceed these minimum requirements.

Having Minimum Standards does not mean that providers must standardize their services. The Standards are designed to be applicable to a wide variety of different types of RBWO provider programs and to enable, rather than prevent, providers to develop their own particular best practice approaches to meeting the safety, permanency and well-being needs of children[1] placed.

The Standards are intended to be qualitative, in that they provide a tool for judging the quality of care provided and are also designed to be measurable. The Office of Provider Management (OPM) will monitor providers against these standards during its annual comprehensive reviews and through randomly occurring Safety Reviews. During monitoring visits, OPM will look for evidence that the requirements are being met. Provider practices which exceed the requirements of the Minimum Standards will also be identified and documented in the OPM monitoring report.

There are six broad areas comprising the Standards. They are as follows:

- **Safety;**
- **Quality of Care;**
- **Permanency Support;**
- **Family Foster Homes;**

[1] The word child or children refers to anyone in RBWO care. The terms "youth" or "adolescent" refers to those aged 14 years to 21 years.

- **Child Caring Institutions; and**
- **General Administrative Matters.**

Additionally, standards for Independent Living and Transitional Living Programs are included.

Room, Board and Watchful Oversight (R.B.W.O.) is the provision of lodging, food, and attentive responsible care to children. Providers shall be responsible for the provision or acquisition of services to ensure that each child's physical, social, emotional, educational/vocational, nutritional, spiritual/cultural and permanency needs are met. These services are defined as follows:

1. **Physical** – all health services pertaining to the body (medical and dental). Includes medication monitoring, documenting and administering by staff or foster parents trained in medication dispensing.

2. **Social** – the provision of an environment in which the child's relationships with peers, staff, significant others, and community are improved through the use of recreational and leisure activities.

3. **Emotional** – a support network that implements recommendations of treatment providers; provides access to treatment; and recognizes behaviors such as anger, negative and positive stress, often accompanied by physiological or psychological changes.

4. **Educational/Vocational** – enrollment of youth in an accredited educational school system; monitoring of progress and support of the youth's education by participation in student support team (SST) meetings, Individual Education Planning (IEP) meetings, parent/teacher conferences and disciplinary meetings. Opportunities for participation in school related extra-curricular activities. For those youth who have completed high school or who have achieved a high school diploma or GED, access to academic or vocational classes/opportunities that will prepare them to lead self-sufficient lives.

5. **Nutritional** – the provision or acquisition of food services to ensure healthy physical and emotional development which is inclusive of the child's religious, cultural, and health needs in accordance with the United States Department of Agriculture (USDA) guidelines for servings per child. Please refer to ORCC's policy section 290-2-6-.21 & section 290-2-5-.17 for guidelines on food consumption and preparation.

6. **Spiritual/Cultural** – awareness, sensitivity, and competence in understanding the child and family's religious values, belief system, mores, customs, training, social growth or development.

7. **Permanency** – providing the child with continuous and guided interaction with family members and significant others for the purpose of transitioning the child back to the home and community. Where return home is not possible, working to secure another permanent option for the child. Permanency planning begins at the admission process and continues through discharge.

SAFETY

Standard 1 –Safety of Children in Care
The safety of children in care is paramount; no child will be abused or neglected in foster care.

1.0 Providers must have policy and procedures in place to promote the safety and welfare of children and to ensure that children are protected from abuse and neglect.

1.1 Providers (which includes all staff, caregivers, volunteers etc.) will adhere to the requirements of the Taylor vs Ledbetter Consent Decree which prohibits the improper punishment of children in care. Improper punishment includes any physical or emotional act to deliberately inflict pain to the body or which creates undue fear, anxiety or feelings of humiliation or degradation.

1.2 Staff and caregivers must understand the Mandated Reporting law and procedures to report concerns about abuse and neglect.

a. Providers must immediately notify the DFCS county office where the provider is located as well as the custodial county of any child involved when there is an allegation or suspicion of abuse, neglect, or corporal punishment of any child/children being served.
b. The provider must cooperate fully with DFCS and those investigating and prosecuting the alleged maltreatment of children, including providing access to the records, staff, facilities, and foster parents as dictated by the circumstances of the particular case.
    i. Such investigations will necessitate unannounced visits to various sources, including foster homes, facilities, staff, victims, other residents, schools, neighbors and other collateral contacts.
    ii. The provider must comply with the recommendations of the investigation's report and must implement and maintain any required follow-up regarding the safety and well-being of the child/children in care.

1.3 Providers must comply with DHS standards regarding criminal records and other background checks for employees, caregivers, students and volunteers.

1.4 Providers must identify the child's vulnerabilities and develop an individualized service plan to maintain the child safely in his/her living environment. As new vulnerabilities are identified, the plan must be reviewed and updated to ensure that emerging needs are met.

1.5. Providers must have a process for identifying individual triggers, coping behaviors, calming measures, interventions, and effective behavior management / prevention strategies for each child in order to de-escalate and avoid full-blown crises.

a. Staff and/or foster parents should be trained to identify danger signals, potential triggers, and possible medical emergencies for the child.
b. Decisions about the child's long-term or continued placement in the program should not be made during a crisis.

1.6 Providers will have two monthly contacts with children placed. At least one of the visits must be a Purposeful Visit and occur in the residence (foster home or CCI). (Information on Purposeful Visitation is available at www.gascore.com).

1.7 Children and caregivers must be visited by the provider within one week of a new placement and more frequently in the early stages of any placement or when there are particular issues which warrant more frequent contact.

1.8 Providers must ensure that children in their care are protected from bullying by other children placed and staff.

1.9 Providers (staff and caregivers) must create an atmosphere where bullying is known to be unacceptable.

1.10 Providers must have a policy on bullying, which includes the following: a definition of bullying, types of bullying, training for staff and caregivers, measures to prevent bullying, responses to and reporting of bullying.

1.11 Providers must identify an agency staff person or subcontracted agency representative to receive reports from children in R.B.W.O. placements about any concerns, grievances or complaints. The *child ombudsmen* must not have any direct care or oversight responsibility for the child. All children in the program shall receive clear communication regarding the identification of the ombudsmen and the method to be used to contact this individual. The contact process should reflect the age and developmental abilities of the children being served.

1.12 Providers must notify OPM whenever there is a Significant Event relating to the provider's operation or to the care or protection of children in its care. Notification must be made as soon as possible but within one business day via GA Score. Additionally, based on circumstances and the severity of situations, providers should use good judgment in determining which Significant Events should also be reported verbally to OPM.

1.13 Providers must notify OPM immediately when there has been a significant injury or death of any child placed in any facility, group home, or foster home operated by the provider, whether or not the injured or deceased child is in the custody of the Department. Notification must be reported verbally to OPM followed by input into the GA Score system.

1.14 Providers must have and follow their protocol for children who are considered runaways or otherwise absent without permission.

Standard 2: Safe and Appropriate Behavior Management

Use of corporal (physical or emotional) punishment is strictly prohibited.

2.0 Providers are prohibited from using or authorizing the use of corporal punishment with any child in the Department's custody.

2.1 Providers must have a behavior support and intervention policy that reinforces the banning of all physical or emotional punishment. Providers must ensure, through

appropriate training, that staff and caregivers are aware of the corporal punishment prohibition and follow the policy prohibiting the use of corporal punishment with any child in the Department's custody.

2.2 Providers must establish practices to manage children who exhibit difficult or aggressive behaviors and ensure that their staff and caregivers are trained to understand such behaviors and can safely respond.

2.3 Providers must ensure that staff and caregivers understand and have the necessary skills to carry out the agency's behavior management policies. The behavior management strategy or practice must be effective and appropriate for the types of children served, understood by staff and caregivers, and explained to children.

2.4 If corporal punishment is used with any child in the Department's custody, the incident must be reported to county CPS and the provider must take appropriate actions to prevent a recurrence. Providers must cooperate fully with the Department in assessing alleged incidents of the use of corporal punishment.

2.5 If the provider is a CPA and corporal punishment has occurred in a foster home placement operated by the provider, the provider agrees that the Department may choose, in its sole discretion, to move a child from the provider's foster home and/or to discontinue use of the foster home placement for children in the Department's custody.

2.6 As a result of a corporal punishment incident, if children in the Department's custody remain in the foster home, the provider must develop a corrective action plan with the foster parent, which must be signed by all parties involved and monitored to make sure the foster parents are in compliance. Children must be removed and the home closed to DFCS placements if any of the following apply:

a. The foster parents are not amenable to change or correct their disciplinary practices, or to Department intervention;
b. The incident of corporal punishment had a direct impact on the safety and well-being of a child, or posed a serious risk to the safety of a child; or
c. A second incident of corporal punishment occurs in the foster home placement.

2.7 If the provider is a CCI and an instance of corporal punishment occurs, an organizational corrective action plan must be submitted (even if the staff person in question is terminated) and approved by OPM . A corrective action plan for an individual staff member is acceptable when:

a. it is the first incident involving the staff member;
b. the staff person is amenable to change and it is clearly documented that the individual has demonstrated a willingness to use appropriate disciplinary practices going forward; and
c. the incident of corporal punishment has not posed a serious risk that directly impacts the child's safety and well-being.

If one or more of the preceding conditions does not apply, the provider must ensure that the staff person in question no longer has any direct or indirect contact with the child population where DFCS is responsible for their care, custody or control of.

2.8 Providers must develop and implement policies and procedures describing their Behavior Management Plan. Behavior Management is defined as those principles and techniques used to assist a child in facilitating self-control, addressing inappropriate behavior, and achieving positive outcomes in a constructive and safe manner. The policies and procedures for Behavior Management shall include a description of the principles and techniques that are approved for use, as well as any techniques that are prohibited. In addition, such policies and procedures shall set forth the types of children served in accordance with the program purpose, the anticipated problems of the children, and acceptable methods of managing such problems.

Policies and procedures must indicate that the following forms of Behavior Management are prohibited:

a. Assignment of excessive or unreasonable work tasks that are not related to the resident's misbehavior;
b. Denial of meals or hydration;
c. Denial of sleep;
d. Denial of shelter, clothing, or essential personal needs;
e. Denial of essential program services;
f. Verbal abuse, ridicule, or humiliation;
g. Manual holds, chemical restraints, or mechanical restraints when not used appropriately by adequately trained staff in accordance with policy, ORCC rules and regulations and all applicable guidelines as emergency safety interventions;
h. Denial of contact, communication and visits with approved family members and other visiting resources.
i. Seclusion, when not used appropriately and in accordance with policy and ORCC rules and regulations and all applicable guidelines as an emergency safety intervention;
j. Children in care shall not be permitted to participate in the behavior management of other children or to discipline other children, except as part of an organized therapeutic self-governing program in keeping with accepted standards of practice that is conducted in accordance with written policy and by designated staff.

2.9 Behavior Management shall be used in accordance with the child's Individual Service Plan (ISP), agency policies and procedures, and licensing rules and regulations.

2.10 Referrals to Law Enforcement, including the Department of Juvenile Justice (DJJ), local police or sheriff's departments, and the juvenile court, may not be a part of the routine Behavior Management Plan. Law Enforcement should be used only for emergencies when the Behavior Management Plan is unsuccessful. Calming measures, preventive and behavior management strategies identified for the child must be utilized without success before Law Enforcement is involved. If appropriate, an emergency safety intervention must also be utilized without success before Law Enforcement is involved. Intervention by Law Enforcement is appropriate only if the child's behaviors escalate to the point of exceeding the ability of properly trained staff to manage the child safely and the issues poses a physical danger to the child, staff, or other children.

2.11 An emergency safety intervention (ESI) plan may not be a component of a provider's Behavior Management Plan. It is a plan for the manner in which staff will respond

when the Behavior Management Plan is unsuccessful and a child escalates to a point that requires implementation of an emergency safety intervention.

2.12 ESI may not be utilized by CPA staff or foster parents. CPA providers must establish protocols and supports that assist foster parents in developing or strengthening their skills in managing children who exhibit difficult or aggressive behaviors. Foster parents must be trained and supported to safely and appropriately respond to behavioral issues.

2.13 CCI providers (who use ESI) must ensure that all direct care staff are trained in the provider's ESI protocol within 90 days of the employment start date. ESI training must be approved by ORCC. Provider staff must be trained in the proper use of emergency safety interventions before they are allowed to use them and may be used only when a child exhibits a dangerous behavior reasonably expected to lead to immediate physical harm to the child or others and less restrictive means of dealing with the injurious behavior have not proven successful or may subject the child or others to greater risk of injury.

2.14 Providers must have written policies for the use of any emergency safety interventions that will be authorized, a copy of which shall be provided to and discussed with each child and the child's parents/or legal guardian prior to or at the time of admission. The policies and procedures must indicate whether any form of manual holds will be a part of that emergency safety intervention plan. Policies and Procedures for emergency safety interventions shall include:

a. Provisions for documentation of an assessment at admission and at each annual exam by the child's physician or authorized medical professional that there are no medical issues that would be incompatible with the appropriate use of emergency safety interventions on that child. Such assessment and documentation must be re-evaluated following any significant change in the child's medical condition;
b. Provisions for the documentation of each use of an emergency safety intervention including:
    i. Date and description of the precipitating incident;
    ii. Description of the de-escalation techniques used prior to the emergency safety intervention, if applicable;
    iii. Environmental considerations;
    iv. Names of staff participating in the emergency safety intervention;
    v. Any witnesses to the precipitating incident and subsequent intervention;
    vi. Exact emergency safety intervention used;
    vii. Documentation of the 15 minute interval visual monitoring of a child in seclusion;
    viii. Beginning and ending time of the intervention;
    ix. Outcome of the intervention;
    x. Description of any injury arising from the incident or intervention;
    xi. Summary of any medical care provided.

2.15 Policies and Procedures for emergency safety interventions shall include the following regarding manual holds:

a. Provisions for prohibiting manual hold use by any employee not trained in prevention and use of emergency safety interventions;

b. Provisions for assessing and monitoring the child's behavior after an emergency safety intervention has been used;
c. Provisions for reporting incidents of emergency safety interventions to the ORCC as required by the rules and regulations under which the provider is licensed;
d. Provision for review of emergency safety interventions by a staff member responsible for quality assurance and ensuring that staff are correctly using the interventions;
e. Provision for the use of a manual hold with any child whose primary method of communication is sign language, allowing the child to have his/her hands free from restraint sufficiently during the intervention to communicate for brief periods except when such freedom may result in physical harm to the child or others.
f. Provisions that specify when manual holds are authorized to be used, which staff are authorized to use them, a description of the holds that are approved by the provider, the time limit allowed on any manual hold, and the policies on documenting the holds;
g. Provision for continuous monitoring during manual holds of the child's breathing, verbal responsiveness, and motor control.

2.16 Policies and procedures for emergency safety interventions must include the following prohibitions:

a. Manual holds may not be used to prevent runaways unless the child presents an imminent threat of physical harm to self or others or is specified in the child's service plan;
b. Manual holds shall not be used by staff that are not trained and authorized by the provider to utilize the manual holds or by staff that are unfamiliar with the child's medical and psychological conditions;
c. Children in care shall not be allowed to participate in emergency safety interventions of other children in care;
d. Emergency safety interventions utilizing prone restraints require at least two trained staff members to carry out the hold;
e. Emergency safety interventions shall not include the use of any restraint or manual hold that would potentially impair the child's ability to breathe or has been determined to be inappropriate for use on a particular child due to a documented medical or psychological condition.

2.17 If the use of a seclusion room is a part of the provider's emergency safety intervention plan, then policies and procedures must include a description of the circumstances under which seclusion may be used and the policies and procedures governing its use. These policies and procedures must include the following:

a. If seclusion is used, procedures must be in place requiring seclusion of more than 30 minutes duration being approved by the Director or Designee. No child shall be placed in a seclusion room in excess of one hour within any twenty-four hour period without obtaining authorization for continuing such seclusion from the child's physician, psychiatrist, or licensed psychologist and documenting such authorization in the child's record.
b. A seclusion room shall only be used if a child is in danger of harming himself /herself or others.
c. A child placed in a seclusion room shall be visually monitored at least every 15 minutes.

d. A room used for the purposes of seclusion must meet the following criteria:
   i. Room shall be constructed and used in such way that the risk of harm to the child is minimized;
   ii. Room shall be equipped with a viewing window on the door so that staff can monitor the child;
   iii. Room shall be lighted and well ventilated;
   iv. Room shall be a minimum of 50 square feet in area; and
   v. Room must be free of any item that may be used by the child to cause physical harm to himself/herself or others.

e. No more than one child shall be placed in a seclusion room at a time.

f. A seclusion room monitoring log shall be maintained and used to record the following information: child's name, reason for seclusion, time placed in seclusion, name and signature of staff who conducted visual monitoring, signed observation notes, and time of child's removal from seclusion.

2.18 All forms of behavior management and Emergency Safety Intervention must be limited to the least restrictive appropriate method.

2.19 Provider policies and procedures will include the requirements and method of training that will be used for orientation and ongoing training of staff regarding behavior management and Emergency Safety Interventions. All training shall be clearly documented in the staff member's personnel record.

2.20 Within 24 hours of an incident of restraint or seclusion or other serious behavior management issue, a staff debriefing must occur and a debriefing with the child must also occur. Debriefing provides an opportunity for staff and children to discuss their feelings and perceptions about the issue and establish a plan for the future.

Quality of Care

Standard 3: Comprehensive and Family-Centered Services

Provider service planning and delivery is comprehensive and family-centered; children, families, DFCS and other stakeholders have the opportunity to participate in all aspects.

3.0 Every child must have a ISP that is strength-based and reflective of assessment findings. It must promote the welfare, permanency, education, interests and health needs of the child and address emotional and psychological needs. Assessments, service plans, and service delivery must reflect and be tailored to the needs, strengths and resources of the child and family. The issue of permanency must be addressed in every service plan. All ISP's must be in accordance with recognized professional child welfare standards; shall provide for the participation of the family in the plan; and shall be appropriate given the child's needs.

3.1 The provider must carefully and immediately assess the needs of all children placed and develop a 7-Day ISP within seven days of admission. The 7-Day ISP is an extension of the admissions assessment whereby immediate safety, health and placement adjustment

needs are considered and a plan developed to address immediate needs. The 7-Day ISP sets goals and objectives through the first 30 days of placement.
The 7-Day should address at a minimum immediate placement issues such as:

- Increased Placement Supervision or Contacts by Case Support Worker or HSP
- Precautions or Other Safety Measures
- Immediate needs related to:
  - Health (including medication management)
  - Behavioral Management
  - Educational/Vocational
  - Personal/Social
  - Family Visitation/Contact
  - Placement Adjustment
  - Scheduled Court, FTMs or other Case Related Appointments

The 7-Day ISP must be submitted to the child's County DFCS Case Manager within 5 business days of completion.

3.2 The first comprehensive ISP is due by the 30th day of the placement. Providers will update ISPs at least every six months or whenever needs assessments warrant a change in the service plan. Providers must set a timeframe for regular, periodic review of the ISP. The review should involve the child, family, DFCS and other stakeholders as appropriate. Provider must submit to DFCS Case Manager within 5 business days.

3.3 General requirements of providers regarding service planning include:

a. Each ISP identifies the needs of the child, the steps and measures to meet those needs.
b. Family members are included in the development of the ISP.
c. Family members and the child help to define their goals and outcomes, with input from the custody holder. There are times when DFCS or the courts will require that certain issues be addressed in the service plan.
d. DFCS, parents or other people who are significant in the child's life are given adequate information and assistance to enable participation in service planning.
e. Cultural, ethnic or religious identity is taken into account when determining individual plans. Decisions are consistent with cultural, ethnic and religious values and traditions relevant to the child.
f. Both needs and strengths are identified and linked in the assessment and service plan.
g. Service plans are tailored to the needs and strengths of each child and family and are a mix of traditional and non-traditional services.
h. Family members, local case managers and other caring adults are included in the service plan reviews.
i. When returning to family is not possible, the provider works with the custodial agency to pursue adoption or transition to another permanency option. For older teens the emphasis is on the development of independent living skills and achieving the optimum level of family involvement that is possible.

3.4 Children are given an opportunity and assistance to participate in decisions and planning that affect them, taking into account their age and understanding.

3.5 Decision making and planning are based on a detailed and thorough assessment and are clear in respect to the reasons for decisions or plans. Both are documented and communicated to the appropriate family members and DFCS.

3.6 A copy of the ISP is provided to the child (when developmentally and age appropriate), any caregiver of the child and DFCS.

3.7 The provider must maintain records to document the provision of services:

a. Providers must permit authorized representatives of the Department access to all records and information at any time.
b. The case record must contain a monthly summary of the services provided to the child and the progress being made by the child in achieving the goals as outlined in the ISP.

3.8 The provider must ensure that all services to the child and the family that are identified in the child's ISP are implemented and documented.

3.9 Each ISP is managed by a case support worker or HSP who ensures that the requirements of the plan are implemented in the day-to-day care of the child.

3.10 Children and young people are supported and encouraged to maintain and strengthen connections with their birth families, especially their parents and siblings. Children are provided with practical support to maintain contact with parents, family and other significant people unless expressly prohibited by DFCS.

Standard 4: Appropriateness of Admissions

Providers admit for care only those children for whom the admission evaluation indicates that the provider can meet the child's needs.

4.0 Providers must ensure that children are placed in accordance with their individual needs, taking into account the closeness of the placement to the child's home and community, sibling's location, relative resource and the least restrictive setting. Providers must ensure that siblings who enter placement at or near the same time shall be placed together unless it is not in the best interest of the child.

4.1 Providers must only accept referrals for children with program designations for which they have been approved.

4.2 Providers must have clear criteria for admissions and must evaluate each referral for service against those criteria. Providers must have a written intake process which includes the steps and processes used to evaluate the appropriateness of admissions and support the decision made.

4.3 Providers will give DFCS notice of its decision to accept or reject referrals upon receipt of complete admissions packet as soon as possible, but no longer than two calendar days. Placement of children accepted for admission should occur as soon as possible or within a timeframe negotiated with the DFCS case manager.

4.4 For children referred by Fulton or Dekalb County, these admission decisions must be made via written notice within 8 hours of the referral. For children admitted, they must be placed within 23 hours of the approved admission.

4.5 Providers must admit all children accepted for emergency admission within 23 hours of the time the provider receives the referral information.

4.6 Providers must ensure that CCI admissions or foster home placement matches provide a safe environment for children which includes emotional, psychological, physical and environmental safety, and takes into consideration their age and any specific needs of the child.

4.7 Providers must have and follow their admission protocol for children placed in CCIs or in foster homes. The admissions protocol must outline the provider’s process for incorporating the child into the milieu or foster family and include an introduction to the program (orientation) and such things as family rules and operations.

4.8 Providers must comply with the following placement conditions and requirements regarding each of the identified care settings:

Foster Homes

a. No child will be placed in a foster home if that placement will result in more than three (3) foster children in that home or, a total of six (6) children in the home, including the foster family’s biological and/or adopted children, without the written approval of the DFCS Social Services Director.
b. No child will be in a placement that will result in more than three (3) children under the age of three (3) residing in a foster home.

Group Care or CCI Settings

a. No child under six year (6) of age will be placed in a group care setting without the express written approval of the state DFCS Social Services Director based upon his or her written certification that the individual child has exceptional needs which cannot be met in any foster home placement or other facility.

b. No child between the ages of six (6) and twelve (12) years of age in the custody of Fulton or DeKalb County will be placed in a group care setting without the express written approval of the state DFCS Social Services Director based upon his or her certification and specific finding that the individual child has needs which can be met by the particular group care setting and that the particular group setting is the least restrictive placement that can meet such needs.

c. For the other 157 counties, no child between the ages of six (6) and twelve (12) years of age will be placed in a group care setting without the express written approval of the Regional Director or Designee based upon his or her certification and specific finding that the individual child has needs which can be met by the particular group care setting and that the particular group setting is the least restrictive placement that can meet such needs.

d. No child under six (6) years or six (6) years through twelve (12) years that has been appropriately certified for a group care setting will be placed in any group care setting that has a capacity in excess of twelve (12) children. This will not apply to a child who is under six years of age and who is also the son or daughter of another child placed in a group care setting.

4.9 Where co-placement of siblings is not possible, providers must assist the Department in ensuring that regular contact between siblings in care is maintained.

4.10 Providers must have a plan for admissions, which includes having a qualified staff on call, seven days a week, 24 hours a day, to receive and assess admissions.

4.11 CPA providers must have a plan and policy regarding caregivers on accepting evening and weekend placements.

4.12 Providers who offer MWO services must include Psychological Residential Treatment Facilities (PRTF) step-downs as part of their inclusion criteria. CPA's with MWO program designations must have a plan to develop foster homes that accept PRTF step-down placements.

4.13 Providers must not use race, ethnicity or religion as a basis for a delay or denial in placement of a child, either with regard to matching a child with a family or with regard to placing a child in a CCI.

4.14 Providers must maintain a list in GA+SCORE of all admission requests and decisions made based on referrals to the agency where an admissions application was received. Inquiries made to the provider where an admissions application was not received should not be included on the list. The list must include the requesting county name, case manager's name, child's name, child's program designation, presenting issue and reason for accepting or denying admission.

Standard 5: Placement Stability

Children in care should have placement stability through permanency; moves in care are minimized.

5.0 A Family Team Meeting (FTM) should be conducted when potential disruption of a child's placement is threatened or imminent, including children returning from runaway or hospitalizations where they will not return to the same placement. Providers must alert DFCS of the need to hold an FTM when children in their care may experience a placement disruption. Providers must participate in these FTMs as invited by DFCS.

5.1 Providers must have a policy which addresses the importance of placement stability and how the agency will preserve placements, where the placement remains in the best interest of children, in its institutions or foster homes. Included in the policy, providers will have and follow a protocol on identifying and preserving placements that are at risk of disruption.

5.2 The decision for placement disruption is made only after all possible interventions to maintain the child in care have proven unsuccessful. Decisions about the child's long-term or continued placement in the program should not be made during a crisis. At best, a

decision to discharge a child from a provider's placement should be made by mutual discussion between the provider and the Department concerning the child's situation, either in a face-to-face or telephone conference.

5.3 For placement disruptions that occur within 60 days of placement or admission to the provider, providers will document a review of the initial placement decision and identify any changes needed in the admissions review or placement matching process.

5.4 Providers will have and follow their protocol on addressing foster parents who have patterns of ejecting children within 60 days of placement or where other disruption patterns are identified.

5.5 DFCS must be provided with at least 14 calendar day notice of the need to move a child from a CCI or CPA foster home unless there is an impending threat of harm to the child or others.

5.6 In all cases where discharge is determined to be in the best interest of the child but due to safety issues a 14 day notice cannot be provided, a minimum of 72-hour notice shall be given prior to discharge. If the 72-hour notice is not possible, the reasons for the failure to notify in advance must be documented in the child's record.

5.7 Providers must ensure that no child will be moved from one placement site or home to another without prior approval of DFCS and the execution of a new institutional placement agreement as appropriate. For children in the custody of Fulton or DeKalb counties, an FTM may be required prior to placement changes.

5.8 Providers must ensure that in situations where a child's discharge is the result of a determination that the placement is not safe or appropriate for the child or other children, any remaining child(ren) must be removed unless there is another written agreement with DFCS to correct the situation.

5.9 A Discharge Summary must be provided to the DFCS case manager at the time of the placement move from the provider. The Discharge Summary must include general information covering the child's placement, progress, challenges and recommendations for services and supports the child will need to be successful at home or in the next placement. If the discharge is as a result of a placement disruption, the Discharge Summary must also include the following:

i. The circumstances leading to the disruption;
ii. The actions that were taken by the agency to prevent the disruption;
iii. The reasons for disruption decision;
iv. The services and supports the child will need to be successful in the next placement; and
v. Details of the child's transfer from the CCI or foster home to the DFCS case manager or other placement.

5.10 If a child is discharged on an emergency basis (less than 14 day notice to DFCS), the Discharge Summary must be provided to the DFCS case manager within 5 business days of the discharge.

5.11 If a child is discharged because he is a threat to himself or others, the provider will accompany him to the receiving agency or person. Provider staff must remain with the child until admission is complete or the child's custodian arrives and takes responsibility. If the police or sheriff is transporting the child, the provider must send staff to the receiving point who will remain there until the admission is complete or the child's custodian arrives.

Standard 6: Meeting Well-Being Needs

Children's social, emotional, physical, mental and educational needs are regularly assessed and needs met.

6.0 Providers must regularly assess the behavioral, social, emotional, psychological and physical needs of children placed and develop an initial ISP to address the child's needs. Providers must ensure that all well-being services identified in the ISP are provided and must document the frequency and results of the services.

6.1 Providers must ascertain the health status of children at admission and take immediate steps to address emergency health care needs. Each ISP must include a health plan component which covers health history and needs.

6.2 The ISP must include the provision of routine medical and dental services according to Medicaid's Early Prevention and Screening Diagnostic Test (EPSDT) standards, including at a minimum, the components identified in the Georgia Health check program and any related health services required by the ORCC rules and regulations.

The EPSDT is as follows:

a. Ages zero through six months: All children between the ages of zero to six months shall receive no less than three periodic EPSDT/Georgia Health Check Program health screenings.
b. Ages six months through 18 months: All children between the ages of six months through 18 months shall receive no less than four periodic EPSDT/Georgia Health Check Program health screenings performed at approximate three month intervals.
c. Ages 18 months through five years: All children between the ages of 18 months through five years shall receive no less than one periodic EPSDT/Georgia Health Check Program screening performed every six months.
d. Ages six years and over: All children of six years of age and older shall receive no less than one periodic EPSDT/Georgia Health Check Program health screenings performed every year.
e. All children shall receive any follow-up treatment or care as directed by the physician who administered the periodic EPSDT/Georgia Health Check Program health screening.
f. All children age three (3) and over shall receive at least two annual dental screening per year and shall receive any and all treatment as directed by the child's assessing dentist.

6.3 CCI providers must ensure that all children in care are given all medications as prescribed.

I. Providers must have a medication management policy that includes managing medication refusal.
II. The provider shall designate, authorize and train staff to hand out and supervise the taking of medications.
III. The provider staff will maintain a thorough record of all medications taken by children in the program including the required documentation that medication was handed out by the authorized staff and taken by the children for whom it was prescribed.
IV. Providers must have and follow their policy on managing medication refusals.

6.4 CPA providers must provide and document training regarding the Agency's policies and procedures for handling medical emergencies (conditions or situations which threaten life, limb, or continued functioning), and managing the use of medications by all children in care.

6.5 Providers must ensure that the following apply to the dispensing of psychotropic medications:

a. No child will be given psychotropic medication unless its use is in accordance with the goals and objectives of the child's service plan.
b. Staff and/or foster parents shall be trained in detecting side effects of any medication prescribed for use by children in care.
c. Psychotropic medications shall be prescribed by the physician who has responsibility for the diagnosis and treatment of the child's condition necessitating the medication. The prescribing physician shall review continued use of psychotropic medications every sixty days.
d. Psychotropic medications shall be used in concert with other interventions that will contribute to remediation of the problem and reduce the reliance on medication alone.
e. Psychotropic medication shall only be given to a child as ordered in the child's prescription. A provider shall not permit medications prescribed for one child to be given to another child.

6.6 Providers must maintain a first aid kit and instructions manual in each unit, cottage, and/or foster home. The first aid kit shall contain scissors, tweezers, gauze pads, adhesive tape, thermometer, assorted band-aids, antiseptic cleaning solution, and bandages.

6.7 Providers must not admit a child unless an educational program commensurate with the educational and vocational needs of the child can be provided.

6.8 Clear educational objectives should be developed for every child and should be a part of the ISP.

6.9 Providers must ensure that children are enrolled in a public school system or a GaDOE/LEA approved residential facility school within 2 days of placement. Providers must ensure that children have no more than five (5) unexcused absences per school year.

6.10 Providers will ensure that appropriate educational services are provided and shall include the following:

a. Documentation of the child's academic progress;
b. Documentation of each child's attendance, courses and grades at the time of withdrawal from school;
c. Immediate referral by the R.B.W.O. provider of the child to the appropriate educational agency, with the goal of placing each child in the educational program appropriate for his/her needs within 48 hours of admission to the R.B.W.O. provider;
d. Monitoring of the child's educational progress through regular contact with the local school personnel;
e. Participation in the annual Individualized Educational Plan (IEP) review and ensuring that any child determined to be eligible for special education has an IEP;
f. Ensuring that every child age 14 and older receiving special education services has an IEP that includes a section on Transition Services and that those services are being provided;
g. Notifying and inviting parents/guardians to attend any school-related conferences;
h. Ensuring that any child who is experiencing difficulty in school is considered for assistance through the Student Support Team (SST);
i. Providing and/or accessing vocational course work for each child determined to be eligible for vocational education and training;
j. Providing and/or accessing GED preparation classes for each child who meets the state and local eligibility standards in order to quality for GED testing; and
k. For providers with on-grounds schools, the school programs must be operated in accordance with all requirements of the State Department of Education (see state law O.C.G.A. Section 20-2-133) and all applicable state and federal guidelines.

6.11 For youth not enrolled in secondary education, providers will ensure that the youth has programming that focuses on the development of life skills, basic academic skills, GED preparation, and/or vocational skills. Vocational Services include provision or access to the following menu of services:

a. Counseling and guidance.
b. Referral and assistance to obtain services from other agencies.
c. Job search and placement assistance.
d. Vocational and other training services.
e. Transportation, if needed.
f. On-the-job or personal assistance services to teach good work habits.
g. Interpreter services.
h. Occupational licenses, tools, equipment, initial stocks and supplies.
i. Technical assistance for self-employment.
j. Rehabilitation assistive technology.
k. Supportive employment services.
l. For those youth who are not job-ready, opportunities to do structured and regular volunteer work.

6.12 For youth who are considering dropping-out of school or pursuing a GED, providers must follow the policy outlined in the DFCS Social Services Policy, 1011.7, Educational Needs of the Child (see appendix for link to Social Services Policy).

6.13 Providers must provide or arrange for tutoring or other academic assistance for children who are not achieving academically (i.e. performing below grade level, failing one or more classes and/or standardize test reveal deficiencies in any academic subject).

6.14 Providers must facilitate the provision of psychiatric services appropriate for the needs of all children.

6.15 Providers must coordinate community supports and service/treatment elements needed by the children served. This includes the provision or arrangement of transportation.

6.16 Providers must use Medicaid Rehab option (MRO) providers and/or private providers who have been pre-approved by the Department.

6.17 Providers must maintain up to date records on all MRO services provided to children.

6.18 Providers must coordinate with the External Review Organization (ERO) for short-term placements in PRTFs.

6.19 Providers must ensure that a purposeful visit (ECEM- Every Child Every Month) face to face occurs at least monthly in the home/residence with children placed. The documentation of the visit must be uploaded via the SHINES Portal within 48 hours of the visit. The documentation must include the following:

a. The developmental progress of the child
b. Progress on one or more ISP goals
c. The child's involvement in the permanency case plan
d. Issues pertinent to safety, permanency and/or well-being
e. Any concerns or red flags
f. Any need for follow-up or next steps.

6.20 Providers must incorporate the principles of trauma-informed knowledge into the daily living environments in CCI's and provide trauma-informed training to foster parents.

6.21 CCI providers must ensure that children have adequate, season-appropriate clothing suitable for the child's age, gender, size and individual needs. Children should be involved in shopping and selecting their clothing whenever possible. Funding for clothing is included in the CCI per diem.

6.22 CPA providers must regularly assess children's clothing needs. Funding for clothing is not included in the CPA per diem. The DFCS case manager should be notified--- when children do not have adequate, season-appropriate clothing suitable for the child's age, gender, size and individual needs -- to determine if the child is eligible for a clothing allowance. CPAs should also consider creating community or other resources to address clothing issues.

Standard 7: Least Restrictive and Most Appropriate Placements

Children should be placed in the most appropriate and least restrictive living arrangement.

7.0 Providers must initiate the step-down process for children to less restrictive placements as they meet their service goals and their needs change. Providers must notify the DFCS case manager and OPM at **opmrequests@dhr.state.ga.us** for a review of the child's program designation as indicated. Step-downs may occur within a provider's own service continuum or to other providers who offer the less restrictive and/or less intensive services.

7.1 CCI providers must re-assess the appropriateness of restrictive placements at least every three months but as frequently as assessments warrant and initiate step-downs as indicated.

7.2 Providers must ensure that children in their care are placed appropriately based upon their current needs.

Permanency Support

Standard 8: Achieving Permanency

Providers will assist DFCS in achieving permanency for children.

8.0 Providers must work in partnership with DFCS to facilitate visits between the child and family, which include transportation of the child placed with the provider to visit.

8.1 Provider's role in permanency is to provide supportive services to assist DFCS in achieving permanency for children. Permanency support services include identifying, documenting and partnering with DFCS to address the following:

- Defining and linking interventions to barriers to achieving permanency;
- Teaching the child and family the skills to live successfully in a family setting;
- Assertively reaching out to "hard-to-reach" or "resistant" families;
- Helping siblings maintain or reconstitute their relationship through phone contact and visitation;
- Identifying extended family or other caring adult connection who may be able to provide permanency or support for the child and family;
- Providing the parents and guardians with strategies to manage their own stress, as well as manage their child's challenging behaviors;
- Working with DFCS to arrange for family therapy, family support and skill-building activities for the family;
- Operating on the principle that family contact is a right, not a privilege;
- Supervising family visitation, coordinating unsupervised transitional family visitation, coordinating and monitoring visiting schedule and plan;
- When reunification is not possible, working with DFCS to pursue adoption or transition to another permanency option;

- Helping children who will not be returning home to have the optimal level of involvement with their families; and
- Other strategies as dictated by individual cases.

8.2 When permanency is achieved, the provider must work with DFCS , families, treatment providers and other stakeholders to transition children into the permanent placement.

8.3 Providers must attend/participate when invited to an FTM, Multi-Disciplinary Team (MDT) meetings, Juvenile Court Reviews, Citizen Panel Reviews, and transitional discharge planning meetings as requested by the Department.

8.4 Providers must have contact with the child's birth parents, guardian or other permanency person (EPEM—Every Parent Every Month) in order to support the DFCS case plan. The frequency, type, mode and purpose of the contacts must be negotiated with the DFCS case manager. Within the 1st 30 days of placement, providers must communicate with DFCS to understand each individual child's permanency plan, the DFCS EPEM plan and to establish the provider's EPEM plan. The provider's EPEM plan should be updated when the ISP is updated, when the DFCS case plan or EPEM plan is changed or when events dictate.

Standard 9: Planned Discharges and Continuity of Care

Discharges are planned and coordinated with families, DFCS and other stakeholders.

9.0 Discharge planning must begin at the beginning of admission to the provider and is reflected in the initial ISP. Placement disruptions are unplanned changes whereas discharges are planned transitions to less restrictive placements, more appropriate placements or to permanency.

9.1 The DFCS case manager and the provider including any subcontractors must participate in a team meeting prior to discharge for all children placed by Fulton or Dekalb County.

9.2 The Discharge Summary must be provided to the DFCS case manager at the time of the discharge. The Discharge Summary must includes general information covering the child's placement, progress, challenges and recommendations for services and supports the child will need to be successful at home or in the next placement.

9.3 If a child is discharged on an emergency basis (less than 14 day notice to DFCS or the provider), the Discharge Summary must be completed within 5 business days of the discharge.

9.4 The Department may, in its sole discretion, remove a child from a placement at any time.

Standard 10: Preparation for Independent Living

Adolescents receive independent living skills in preparation for self-sufficiency.

10.0 Providers who care for youth ages 14 years and up will develop Individualized Skill Plans based upon the Ansell Casey Life Skills Assessment (ACLSA). The

individualized skill plan is a supportive component to the DFCS Written Transitional Living Plan (WTLP). The individualized skill plan must be updated every six months.

10.1 Providers must ensure that youth complete the ACLSA at ages 14, 16 and 17 ½ years and annually for youth ages 18 to 21 years. An ACLSA is required to develop the Individualized Skill Plan. When administering the ACLSA, providers must use the appropriate code (which is based on the child's custodial county region). The list of ACLSA codes is located in the appendix.

10.2 Providers must provide a monthly Independent Living report on each youth's progress on the Individualized Skill Plan to the DFCS IL Coordinator by the 10th day of the following month. (A copy of the form is located in the appendix.)

10.3 Providers must provide adolescents ages 14 years and older with daily living skills that include such things as menu planning, grocery shopping, meal preparation, dining decorum, kitchen cleanup and food storage, home management, and home safety.

10.4 Providers must provide independent living services to support the youth's Individualized Skills Plan directly and/or ensure that youth participate in county or other independent living services. Independent Living programming includes:

- Housing and community resources to assist youth in making a positive transition to the community. Includes housing, transportation, and community resources.
- Money management to help youth make sound decisions, both now and in the future. Includes exploring beliefs about money and information about savings, income tax, banking and credit, budgeting and spending plans, and consumer skills.
- Self-care to include skills to promote a youngster's physical and emotional development: personal hygiene, health, drugs and tobacco education, and information about human sexuality and making safe choices.
- Social Development focusing on relating to others now and in the future. Includes personal development, cultural awareness, communication and relationships education and training.
- Work and study skills to address the skills needed to help youngsters complete their educational programs and pursue careers of interest. Includes career planning, employment, decision making and study skills.

10.5 Providers must ensure that the daily lives of children provide opportunities, appropriate to the age and needs of the child, for development of knowledge and skills needed for future independent living.

Family Foster Homes

Standard 11: CPA Family Foster Homes Meet DFCS Minimum Standards[2]

All family foster homes must meet safety, well-being and quality of care standards.

11.0 CPA foster homes must meet the minimum approval standards for fostering parenting as outlined in Social Services Policy 1014. Foster homes may not receive placements prior to complete family information being entered into GA SHINES.

11.1 CPAs must approve and re-approve foster homes using the standards and requirements outlined in Social Services Policy 1014 and 1015. Only foster parents in full approval status, which includes all criminal history and child protective services safety checks, may foster children in DFCS custody.

11.2 CPAs must ensure that prospective caregivers are drug screened per Social Services Policy 1014.25 using a drug testing laboratory. A list of acceptable laboratories may be accessed at http://www.spa.ga.gov/agencyservices/recruitment/collectionSites.asp . This list is not exhaustive but may assist providers who do not already have a laboratory identified.

11.3 CPAs must have a written description of their pre-service and on-going training program for caregivers. The training program should be reviewed and updated periodically to reflect the changing needs of children and families. The pre-service training program must be approved by DFCS.

11.4 Providers must ensure that caregivers participate in relevant annual training that at least meets the requirements of Social Services Policy 1014.28. CPAs must have a standard format for approving independent study and for measuring and documenting the learning that has taken place.

11.5 Caregivers must complete a pre-service training and a provider orientation to foster parenting as a part of the initial approval process.

11.6 Providers must incorporate the principles of trauma-informed practice into foster parent on-going training (A free trauma curriculum for foster parents can be obtained at The National Child Traumatic Stress Network www.nctsnet.org).

11.7 Foster parent homes must be located close enough to the agency to allow for their involvement in all aspects of the program including pre-service and in-service training, formal and informal support networks, home visits by the case support worker both planned and in emergencies, and participation in all activities related to the development and implementation of the child and family plan.

11.8 CPAs must ensure that caregivers have a copy of the Foster Parent Bill of Rights and receive an explanation of the grievance process.

11.9 CPAs must ensure that caregivers are provided with information on their Right To Be Heard during court reviews, hearings and other information in accordance with

[2] Providers may use DFCS forms or their own comparable forms to meet requirements.

O.C.G.A. 15-11-58 (p). Such information must be provided during pre-service training and annually during on-going training. It must be documented in the foster parent's training record.

11.10 CPAs must ensure that their foster parents who provide services to foster children in the custody of DFCS are paid timely (as outlined in the provider's foster parent manual or other agreement with caregivers) and at a minimum the rate equal to the DFCS foster parents.

11.11 CPAs must ensure that children are removed from foster homes and will not be placed in foster homes where there has been a finding by the Department that the foster parent is the perpetrator of substantiated abuse or neglect or whose violation of a DFCS policy has threatened the safety of the child. The only exception is where the home has been determined by the DFCS state office review to be in the best interest of the child/children in the home. A written waiver must be in the case file as well as a plan of correction to alleviate the safety concerns.

11.12 CPAs must ensure that the number of children placed in their foster homes complies with the following requirements:

a. No child in the custody of DFCS may be placed in a foster home if that placement will result in more than three (3) foster children in that home or, a total of six (6) children in the home, including the foster family's biological and/or adopted, children without the written approval of the DFCS Centralized Services Director.
b. No child in the custody of DFCS may be placed in a foster home if that placement will result in more than three (3) children under the age of three (3) residing in a foster home.

11.13 CPAs must ensure that the number of children placed or approved to be placed in a foster home will not displace the foster family's children or other members living in the household from reasonable and expected accommodations (i.e.. bed, personal space and privacy). CPAs must ensure that placements also comply with the following requirements:

a. Only bedrooms shall be used as sleeping space for children.
b. Each non-related child must have a separate bed.
c. A maximum of two (2) children may sleep in a double or larger bed if they are siblings, the same sex and under age 5 years. Preferably all children will have separate beds however. Infants must always be in a separate bed or crib.
d. No child shall sleep in a bed with an adult. Infants may not sleep in a bed with anyone.
e. A child over one (1) year of age cannot sleep in the bedroom of an adult.
f. Preferably, a maximum of three (3) children will share a bedroom. The suitability of children sharing a room must be thoroughly assessed and based on the background/history of the children and the space.
g. Children age five (5) years and older and of different sexes shall not share a bedroom.

In all instances, the suitability of children sharing rooms or beds (as in item C) must be thoroughly assessed and re-assessed as circumstances dictate.

11.14 Placements should be made after careful consideration of how well the prospective foster family will meet the child and family's needs. CPAs must document the process for making the decisions regarding foster home placements, including discussions with DFCS and the families of children already in the home, in the foster family's file. Proximity to family, including siblings, and home community must be considered in the placement matching decision. Placements must provide nurturing homes, which promote the abilities, contribution and competencies of children and young people in everyday life taking into consideration their age and development. Documentation of the placement decision must be recorded in the case file of the child being placed, as well as that of the child or children already in the home.

11.15 A caregiver must be provided the right to refuse placement of any child the parent feels is inappropriate for the home or presents a potential safety risk for other children in the home.

11.16 During the first 30 days of placement, providers must assess with the caregivers the necessity of securing sharps, medications, cleaning supplies or other items that may pose a hazard or danger based upon the individual child's needs. Alternatively, providers may have a blanket policy that requires that all sharps, cleaning supplies and other items that may pose hazard or danger to the safety or well-being of children be locked up and inaccessible to children and youth.

11.17 The provider, including the caregiver, must be willing to work with the child's family, when applicable, and other caring adults in the child's life, e.g. extended family, former foster parents, CASA's, etc. including assisting with, arranging, or providing transportation for visits and helping the child maintain sibling ties.

11.18 CPAs must conduct an in-home visit within the first week of placement. CPAs must increase visitation during the first thirty days of placement, to ensure the adequacy of the placement match, monitor the in-home implementation of the case plan and to develop strategies to assist the child in being successful in the home, school and community. Some of this time should be spent interacting with the child alone and meeting with the child and the foster parent.

11.19 During home visits, the case support worker must talk privately with each child placed to ascertain the child's individual perspective, safety, well-being and any concerns. Information gathered must be documented in the case record.

11.20 Caregivers must have 24 hour access to the provider. Foster parents must know how to contact the provider during nights and weekends.

11.21 Caregivers must have access to respite care, both planned and crisis. Respite homes must be approved by the agency or another agency as fully approved foster homes.

11.22 Prior to the child being placed, providers must ensure that their caregivers receive available information concerning children placed including family history, medical, dental, physical, mental health and educational needs prior to the child being placed. Providers must ensure that complete and accurate updated information is provided to the caregivers as information becomes available.

11.23 Caregivers must be provided with a foster parent manual which outlines standards, policies and expectations of caregivers. The DFCS Foster Parent Manual which is available on the DFCS website (see appendix for link) may be used or the provider may create a comparable version.

11.24 If a CPA determines that a caregiver has violated a safety, behavior management, quality of care, well-being or other such policy, the violation must be reported and screened by the County DFCS Child Protective Services Unit. Whether or not it is investigated by CPS, providers must assess the issue and develop a Corrective Action Plan with the caregiver following the policy outlined in SS Policy 1115.33. Please note that reporting to OPM applies if the policy violation is also a Significant Event which impacts the safety or well-being a child.

11.25 CPAs must ensure that foster parents who accept placements of infants are informed about the general dangers of infant co-sleeping (with adults or other children) and the DFCS policy which prohibits infants in care from sleeping in the same bed with anyone. CPAs should regularly inquire about infant sleep arrangement including naptimes during home visits and remind caregivers about taking precautions to prevent infant sleep related deaths and injuries.

Child Caring Institutions

Standard 12: Child Caring Institutions

CCIs provide safe, quality, appropriate and effective programming.

12.0 CCIs must have a procedural manual which contains its statement of purpose, programs, policies, procedures, guidance to staff and other operational information.

12.1 The CCIs location, design and size are in keeping with its purpose and function. The CCI must have sufficient space to meet the needs of children placed.

12.2 CCIs must provide home-like accommodations whenever possible. CCIs must be decorated, furnished and maintained in a home-like manner appropriate for the number, gender mix and abilities of the children placed. Pictures and posters will reflect the cultures of children and families being served and should create a home-like atmosphere. The interior and exterior of the CCI must be safe and in a good state of structural and decorative repair.

12.3 The building and grounds and/or campsites must be designed and maintained to meet the needs of the children and families, and to assist staff in fulfilling their responsibility to provide supervision and oversight of children.

12.4 The building, grounds and/or campsites must be maintained in a condition to ensure the health and safety of the children served. Hazardous items will not be openly accessible to children and youth. The building and grounds will be kept clean and free from trash, debris and pests. Ceilings, walls, and floors will be maintained and kept clean and free from graffiti, dirt, or stain buildup.

12.5 Providers must have a plan for regular maintenance and upkeep of the building, furniture, and grounds. Resources must be available to repair damages and unanticipated repairs to the buildings and furnishings as needed.

12.6 Each child placed must have a suitable bed, bedding, storage for personal items. Children must be able to personalize their bedrooms to the extent possible.

12.7 Each child must have a space to complete homework assignments and study.

12.8 Bath, showers and toilets must be of a number and standard to meet the needs of the children placed.

12.9 Upon admission, children must be provided with an orientation about the CCI, services they can expect, information on how they will be cared for and who they are likely to share the home with and other information which would orient the child to the placement. The orientation must be documented in the child's records.

12.10 In the initial and subsequent ISP, it should clearly indicate the assessed needs of the child, the objectives of the placement and how these objectives will be addressed on a daily basis which includes efforts to be made by the direct care staff and HSP.

12.11 Providers must actively promote the involvement of all children in the placement's social group, counters isolation of individuals, nurtures friendships between children and supports children who for any reason do not readily "fit in" with the group.

12.12 Providers must have a process for ensuring that the opinions and views of children on the operations of the placement are ascertained on a regular and frequent basis and given due consideration. Children are given the opportunity to meet with staff individually and in groups to discuss the general running of the home, to plan activities and to share their views.

12.13 Providers must ensure that children's privacy is respected and information is handled in a confidential manner. Provider's must ensure that staff know how to deal with and share information which they are given in confidence by the child or others.

12. 14 Providers must ensure that children are provided with adequate quantities of suitably prepared food and drink having regard to their needs and wishes and as appropriate children have the opportunity to shop for and prepare their own food.

12.15 Providers shall ensure that nutritional "grab and go" snacks are available and accessible to the children in the program. To the extent possible, providers will ensure that children are able to obtain and or prepare snacks and drinks for themselves at reasonable times during the day.

12.16 The selection, preparation, and serving of food will be guided by the nutritional, social, cultural, religious, and health needs of the children served.

1. Food should be appetizing and attractively served. The dining area should be pleasant.
2. Meals should occur at regularly scheduled times. The atmosphere should be relaxed with opportunities for children to engage in conversation. In small group home settings, there should be enough chairs for all the children to eat together.
3. Meals should include some of the food preferences of the children of different cultural and ethnic groups
4. Children may be encouraged to eat; they may not be forced.
5. Snacks should be offered after school and at other times as appropriate.
6. Children should have a voice in menu planning.
7. Children should be given opportunities to participate, with supervision, in food shopping and preparation.
8. Unless there are dietary or therapeutic restrictions, children should be allowed to have more than one helping.
9. For those children with special dietary needs, a professional nutritionist or a dietitian must be available for consultation on menu planning, portions, and preparation. The dietitian or nutritionist should be aware of the particular needs of children who have experienced neglect and deprivation.

12.17 Providers must ensure that children's clothing and personal needs are met.

12.18 Providers must ensure that there are ample opportunities for children to participate in a range of appropriate leisure activities.

12.19 Providers will have a program of indoor and outdoor recreational and leisure activities.

12.20 In addition to providing activities on site, the provider shall utilize the community's cultural, social, and recreational resources whenever possible and appropriate. If children are participating in a community program, the provider must ensure that the program has sufficient and appropriate supervision for the children in attendance or provider staff will supplement the supervision as necessary to achieve an adequate level.

12.21 Leisure and recreational activities will be incorporated in each child's service plan. Children's strengths, needs, and interests should be addressed when developing recreational and leisure activities. Recreation and leisure activities must provide opportunities for children to participate in both group and individual events. Providers must ensure that all activities are appropriate for the ages of the children being served.

12.22 Recreational equipment must be in good condition. Games and supplies must be useable and in good condition.

12.23 Providers must have adequate space to allow several different activities to occur simultaneously. Examples of activities that are appropriate for inside are table tennis, reading, art (class and free expression), and board and card games. Sufficient outside space must be provided for more active games such as basketball, volleyball, badminton, and soccer.

12.24 Providers must ensure that children do not spend all (or most) of their leisure time watching television or playing video and computer games.

12.25 New buildings will be accessible to people with disabilities and reasonable accommodations should be made in older buildings.

12.26 CCIs must have a family visiting room or designated areas for visits.

12.27 Providers must have an insured, operable vehicle adequate for the number and needs of children placed.

Note: Appropriate exceptions to the Standards will be made for "Specialty" camp programs. Campsites shall be designed to meet the needs of the children served and shall be maintained in accordance with the ORCC rules and regulations for these programs.

General Administrative Matters

Standard 13 Provider Operations

Provider's administrative structure, programs and policies will provide the framework for delivering quality services to children and families.

13.0 Providers must maintain all licenses, certifications, or accreditations in effect at the time of the approval of the R.B.W.O. provider or as required by federal or state law or regulation of the Department or professional associations or entities providing accreditation, certification or licensing for staff, facilities and programs and must maintain compliance with R.B.W.O. Requirements.

13.1 Providers must have computers with internet access to be used by provider staff in performing requirements. Additionally providers must have telecommunications which ensure that the Department is able to reach the provider twenty-four (24) hours per day, seven (7) days per week.

13.2 Providers must maintain sound practice informed by literature, research, legislation, policies and procedures as well as professional ethics and values.

13.3 Providers must notify OPM of any change of address, telephone contacts, administrator/executive director, admissions contact, GA + Score reporting contact and After-hours contact via the GA+Score system within 48 hours of the change.

13.4 Providers must notify OPM of change to policies and procedures that significantly impact the delivery of services or programmatic changes (i.e. gender or ages served).

13.5 Providers must use contracted service vendors who possess the appropriate license, certificate, or accreditation, which may be required by the OPM when providing services to children to whom services are provided pursuant to these requirements.

13.6 Providers must comply with all requests for information and records for use in and to participate, as requested, in the annual Time Study and Cost Report, including, but not limited to providing the OPM with a copy of the provider's Annual Independent Audit Report, and to comply with all requests made by the Department to assist it in its efforts to obtain payment or recovery of costs of R.B.W.O services from third parties.

13.7 Providers must provide to OPM such data and reports as it requests for use in developing baselines, baseline data and other reports or review processes to promote improvement in performance under these requirements and in any other area related to the services provided to children placed by DFCS in the following areas: Child health and safety, Family and community involvement, Permanency, Functioning levels, Placement stability, and Reentry to care.

13.8 Providers must fully and accurately submit all required data into the GA+Score Services Tracking and Reporting system. Information must be entered timely and kept up to date.

13.9 Providers must employ an adequate number of qualified staff to provide the necessary services (See Staffing Standards).

13.10 At a minimum, RBWO providers must staff the following positions:

CCI's: Director, Human Services Professional (HSP) and the Direct Child Care Worker to meet Staffing Standards.

CPA's: Director, Case Support Supervisor and Case Support Worker (CSW) to meet Staffing Standards.

13.11 Providers must ensure that no staff employed by the facility has an unsatisfactory determination related to his or her criminal record.

13.12 All provider staff must meet the minimum educational and experiential requirements based upon their position as outlined in the Staffing section of the RBWO Minimum Standards.

13.13 Staffing ratios must meet the minimum standards as outlined in the Staffing Section of the RBWO Minimum Standards.

13.14 Providers must designate a staff member to coordinate training.

13.15 An individual staff development plan must be developed for each service staff member and kept on file.

13.16 Case support workers and supervisors, direct care staff and human services professionals must be supported by regular, ongoing supervision.

13.17 Directors must be supported by regular ongoing supervision or consultation.

13.18 Providers must maintain appropriate, clear, relevant, concise, timely and up-to-date records, including electronic and/or hard copy case records. Documentation relevant to children and young people is dated, signed and makes reference to the time of occurrence and is legible. Providers must review the quality of documentation on a regular basis and continuously improve methods. Records must be fully maintained at all times.

13.19 Services must comply with relevant regulations for the protection of the confidentiality and must keep all documentation in a secure environment.

13.20 Providers must comply with all applicable rules and regulations of the Office of Residential Child care (ORCC).

13.21 Providers must ensure that DFCS has access to children in its custody 24 hours a day, 7 days a week, regardless of placement in CPA foster homes or CCIs.

13.22 Providers will submit Monthly Summary Reports on each child to DFCS Case Manager by the 10th day of the following month. Providers must maintain proof of submission in the child's case record.

13.23 CCI and CPA staff with direct child care or case support responsibilities including direct care staff, human services professionals and case support workers and supervisors must participate in a minimum of twenty-four (24) clock hours of annual training in issues related to the employee's job assignment and to the types of services provided by the agency . The training requirement applies to part-time or contract employees who work at least 20 hours per week.

13.24 OPM must be informed in writing if providers offer placements through other agencies (such as DJJ) or via private placements for children/youth who may have greater needs than the DFCS program designations for which the provider is approved for DFCS placements. Notification to OPM may result in a special site review or request for additional information. Providers should also make this information available to county staff seeking placements to assist in making informed placement decisions.

Independent Living and Transitional Living Programs

Transitional and Independent Living Programs provide youth in foster care with opportunities to prepare to live independently, self-sufficiently, and prepare for adulthood. The goal of transitional and independent living programs is to provide older youth in foster care with the support, instruction, and opportunities to practice the necessary independent living skills and acquire the knowledge to become productive adults.

Comprehensive and effective independent living transitional services are key to helping youth function as productive citizens and acquire skills needed for pursuing an education, finding a job, obtaining suitable housing, and protecting their health and well-being when they leave the foster care system.

Transitional and Independent Living Programs serve youth in DFCS custody and those who have agreed to Extended Youth Supportive Services (EYSS). Youth who participate in these programs must be at least age sixteen (16) years through age twenty-one (21) years. Placements may also be provided to youth who were formerly in foster care; and who were discharged from DHS custody on or after their 18th birthday and who have not yet attained their 21st birthday. Transitional and Independent Living Programs must be flexible in order to meet a wide variety of needs and skill levels while providing youth the opportunity to accept more responsibility with decreasing structure and adult supervision.

Transitional Living Programs (TLP) are specialized RBWO programs for youth at least age 16 years. Youth may be older than 18 years old if they have agreed to EYSS. TLP is designed for youth who are ready to enter a phase of care that will eventually transition them to independent living. Transitional living affords youth an opportunity to practice basic independent living skills in a variety of settings with decreasing degrees of supervision. This specialized RBWO placement provides youth the opportunity to experience increased personal responsibility so youth can become responsible for their own care when they exit foster care. The goal of a transitional living placement is to prepare youth to become socially, emotionally and personally independent of social services while connecting them to life-long permanency connections and laying the foundation for the pursuit of educational and career opportunities.

Independent Living Programs (ILP) are specialized RBWO programs for youth who are at least 18 years of age through 21 years of age. ILP is different from TLP in that youth may live in an alternative living arrangement (i.e., community based housing) rather than a group home, or other residential type facility. ILP placements shall begin no earlier than a youth's 18th birthday. Youth in ILP will experience "graduated independence" regarding program expectations, skill development and levels or types of supervision provided. The goal of an independent living placement is to prepare youth to become socially, emotionally and personally independent of social services while connecting them to life-long permanency connections and laying the foundation for the pursuit of educational and career opportunities.

Hybrid Program Models

RBWO providers who have applied for and been approved to provide Teen Development services may exclusively provide ILP, TLP or both programs under the same program/site/name. Programs who operate a combined program or hybrid model must assign youth to their ILP or TLP programs based upon age, ability and overall assessment. Youth under the age of 18 may only participate in TLP programs whereas youth over the age of 18 years may participate in either program. Provider performance will be assessed based upon each youth's program.

TLP and ILP Program Outcomes

Overall outcomes expected from transitional and independent living programs are as follows:

- youth have an affordable and permanent place to live upon their discharge from foster care;
- youth have a permanent connection with at least one safe, stable , nurturing adult outside of the social services system;
- youth have obtained a high school diploma or GED and are pursuing secondary or technical education;
- youth are employed or have gained significant employment experience or vocational training;
- youth can demonstrate self-sufficiency and independence from social services;
- youth can demonstrate personal responsibility;
- youth are free from illegal entanglements and risky behaviors;
- youth have secure, positive peer relationships; and
- youth understand their rights and responsibilities as a citizen.

II. RBWO Providers

OPM has developed Minimum Standards for TLP and ILP placements to help provide consistency in the development and delivery of services. All agencies desiring to provide transitional and/or independent living programs through an RBWO contract must be able to meet Standards.

Providers of Transitional Living Programs, which are for youth who are at least 16 years of age must be licensed through the ORCC. Providers of Independent Living Programs who only accept youth who have already turned 18 years and who are not and cannot be licensed through ORCC, must go through a pre-approval process with OPM before submitting a request to be a contracted provider.

Approval Requirements for Unlicensed Provider Applicants[3]

The general requirements are grouped into five categories: (1) Business Acumen; (2) Program Policies and Procedures; (3) Qualified Staff; (4) Program Curriculum Implementation; and (5) Environment. The complete list of requirements and the process is outlined in the appendix of this document. The entire process may take up to 90 days once a complete application with all attachments are submitted to the Office of Provider

[3] This process is under development and will not be available until FY 2013.

Management. When an unlicensed provider is approved, a separate application must be submitted to become a continued RBWO provider of Independent Living Programs.

Difference between Provision of Independent Living Skills and Specialized RBWO Programs for Independent and Transitional Living

All RBWO providers who serve youth ages 14 years and up must incorporate independent living skills into their services. These "soft skills" may be achieved through regular and natural opportunities in the foster home (helping with chores, cooking meals…), through classes or workshops and / or participation in a county or regional Independent Living program through an Independent Living Coordinator (ILC).

Regardless of the administering entity (child-placing agency, residential facility or DFCS foster home), youth must be provided opportunities to learn the skills they need to live independently. These skills, at a minimum, may include: preparing meals; doing laundry; cleaning the home; living cooperatively with other housemates or neighbors; maintaining employment; paying bills; handling finances in general; washing and ironing; using public transportation; handling basic maintenance, simple repairs; creating and maintaining order in a living space; and training in basic first aid, for example. Regardless of the skills being taught, the skills must be tailored to a youth's current level of functioning. Additional skills may be introduced as a youth progresses, achieves success in the minimum skills, and desires to learn more advanced skills.

RBWO providers who are designated as ILP or TLP providers have programs which specialize in preparing youth for independence or supporting emancipated youth who have chosen to remain in foster care. These programs have specific goals and requirements which differentiate them from other RBWO programs. Youth in RBWO TLP and ILP programs are being further prepared for adulthood by being provided a realistic living experience, through transitional or independent living placements where they can take full responsibility for themselves. Elements of living experiences include, but are not limited to, the following:

- Direct experience with the consequences of daily actions and decisions;
- Youth being involved in their skill development planning;
- Life skills practice while having access to staff for support and advice;
- Ability to determine needed areas of support before emancipation or transfer to a less supervised living arrangement;
- Daily social contacts;
- Emotional adjustment to the difference between present living situation and previous ones, and to the loneliness that may occur due to a change in living situations;
- Practice in living alone;
- Use of emergency medical procedures;
- Obtaining and using transportation to access needed resources;
- Safe use of household appliances;
- Practice in basic housekeeping;
- Negotiating a rental agreement;
- Use of leisure time;
- Practice in money management and budgeting; and
- Experience in shopping, food preparation, food storage, and

- Consumer skills.

These experiences must also be tailored to a youth's current level of functioning. Additional experiences and opportunities may be introduced as a youth's skill level increases and more complex opportunities are desired.

III. Transitional Living Minimum Standards

RBWO providers are responsible for assuring that their transitional living programs meet the following requirements as well as applicable *ORCC Standards.* TLP youth who are under the age of 18 years are still in DFCS custody and thus TLP providers of these youth must follow the RBWO Minimum Standards for all providers *and* the Standards for this specialized program. Providers with youth who are over the age of 18 years and in a TLP will be assessed using general RBWO Standards and TLP standards with exceptions made where general Standards are not applicable to youth over the age of 18 years.

Standard 14: TLP Admissions

Providers must only admit youth to a TLP for whom the admissions assessment indicates that the youth is appropriate for the program.

14.0 Admitted youth must be at least 16 years of age, with any permanency plan and have been assessed by the provider to be invested in and able to benefit from TLP.

14.1 Providers must have defined admittance criteria, which include a youth-completed application and interview.

14.2 Providers must document all referrals including the reasons for admittance or denial into the TL program.

14.3 Providers must determine whether youth will be accepted or denied admission within three business days of a completed application.

14.4 Youth admitted into a TLP must have an orientation to the program. Youth should be provided with a handbook or other literature describing the program.

14.5 Youth admitted into a TLP must sign an acknowledgement of having participated in an orientation to the program and an understanding of their rights and responsibilities as a participant in the program.

Standard 15: TLP Supervision and Independence

Youth should receive levels of supervision that fit their needs and be provided with appropriate independence to practice skills needed for successful independent living.

15.0 TLP youth must have a documented assessment which supports a Supervision and Independence plan regarding levels of supervision and independence.

15.1 The Supervision and Independence Plan must be signed by the youth and communicated to the DFCS case manager.

15.2 The Supervision and Independence Plan should be re-assessed at least every three months or as often as circumstances or changes dictate.

15.3 Youth in TLPs must be supervised under the same standards as general RBWO programs. However, TLP youth may be appropriate for "Graduated Independence" which outlines decreasing levels of supervision based upon the program objectives, the youth's maturity and other factors. [4]

Standard 16: Independent Living Skill Building

TLP programs must assist youth in making progress toward achieving the goals of the TLP ISP.

16.0 Providers must utilize the DFCS Written Transitional Living Plan (WTLP) in the development of the youth's TLP Individual Skills Plan (TLP ISP). The TLP ISP must support the WTLP and be based upon the youth's needs, desires, Ansell Casey Life Skills Assessment (ACLSA) and permanency plan. (The TLP ISP is the ISP for TLP programs. All other standards for the ISP apply.)

16.1 The TLP ISP must have defined goals and objectives with timeframes established. Case documentation should reflect progress and/or efforts toward meeting goals.

16.2 Providers must submit a monthly summary of each youth's progress to the regional Independent Living Coordinator (ILC) and the DFCS case manager by the 10th of the following month. The list of ILCs and the monthly summary form is located in the Appendix.[5]

16.3 TLP youth must be engaged in learning and developing "soft" and "hard" independent living skills, daily living and self-care skills. Hard skills include the teaching of areas including, but limited to banking, apartment hunting, job search, budgeting and educational planning. Soft skills include the teaching of areas including, but not limited to anger management, goal-oriented behaviors, parenting skills, problem solving skills and interpersonal communication. Daily living skills should include instruction in nutrition, menu planning, grocery shopping, meal preparation, dining decorum, kitchen cleanup, food storage, home management, and home safety. Opportunities for youth to apply these skills would include developing menus, shopping for ingredients, preparing meals, cleaning the kitchen and dishes at the conclusion of the meals, and appropriately storing leftover food. Self-care skills should include instruction about topics such as hygiene, health, alcohol, drugs, tobacco, parenting skills, responsible sexuality and sexual practices. Opportunities for youth to apply these skills would include discussions as well as role playing and rehearsal of parenting and hygiene skills.

16.4 At a minimum, providers should document at least two efforts weekly that record the youth's engagement in independent living skills development.

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[4] This policy is under-development and should be released Summer 2011.
[5] This form is being updated and will be available Summer 2011.

16.5 Youth should attend county/regional IL meetings unless there is a documented reason why it is not possible or practical.

16.6 Providers must coordinate educational services, facilitate career plan development, provide tutors, and help youth attain educational goals.

16.7 Providers must assist youth in developing a career plan. The plan should include the youth's interests, strengths in school, visions for career and personal life, and opportunities for career and work experience.

16.8 Providers must connect youth with local industries and employment programs so that youth have the opportunity to explore career opportunities and develop a plan to achieve their career aspirations.

16.9 Providers must offer job search training in areas such as resume writing and interviewing.

16.10 Providers must assist youth with obtaining part-time employment.

Standard 17: Permanency Planning

Providers must provide support of the youth's permanency plan.

17.0 Providers must document supportive activities which assist youth with achieving DFCS permanency goal.

17.1 For youth with Another Planned Living Arrangement (APPLA) goals which includes emancipation, providers must include in the TLP ISP incremental steps or goals which include the following:

- Development of Permanency Pacts or other agreements with caring adult connections;
- Living arrangements upon discharge from foster care;
- Consideration of extending foster care services;
- Educational and/or vocational planning; and
- Any other goals or objectives which will assist the youth in being successful post discharge from foster care.

17.2 Youth between the ages of 17 to 17 ½ must be provided with an orientation to benefits provided by the state Independent Living program, community resources as well as any other public assistance benefits such as food stamps, housing, or TAN-F.

17.3 Within three months prior to a youths exit plan from foster care, in collaboration with DFCS, providers and youth should jointly develop and sign a formal transition plan describing how the youth will successfully move from state custody to independence. At a minimum, the plan should indicate what steps the youth will take to meet his or her education and vocational goals, identify community services the youth can turn to if he or she needs assistance, and outline individualized tasks the youth will undertake to meet specific challenges identified on his or her TLP ISP or WTLP.

Standard 18: Life Coaching

Youth are supported in achieving personal goals through a Life Coach.

18.0 Youth in TLP programs must have a life coach. Life coaches must meet the same educational and experiential requirements of a Human Services Professional (HSP). Life coaching is a practice that helps people identify and achieve personal goals. Life coaches help clients set and reach goals using a variety of tools and techniques. Life Coaches model life skills (e.g., assertiveness, communication, conflict management, problem solving and decision making) and provide activities for youth to practice life skills and provide appropriate feedback to the youth.

Note: Life Coaches serve as the HSP for TLP programs.

18.1 TLP Life Coaches must participate in a basic certification training provided by the state IL Program Manager. Training covers independent living policies, ACLSA and other requirements of the program. [6]

18.2 TLP Life Coaches must attend at least one county/regional/ state IL training, meeting or workshop quarterly. This requirement may also be met by meeting individually with the regional ILC to staff the youth in the TLP .

18.3 Life coaches must have a plan for each youth and have at least bi-monthly sessions with youth. The Life Coach plan may be a separate document or incorporated into the TLP ISP.

Standard 19: TLP Outcome Measures

Providers must track outcomes of youth and overall program performance.

19.0 TLP providers must track outcomes for youth. Minimally, programs should compile, on an annual basis, results on the following:

- Demographics on youth served;
- Life skills programming;
- Educational outcomes;
- Vocational outcomes;
- Youth involvement with DJJ or DOC; and
- Housing, adult connection, employment, educational status of youth emancipating from the program.

19.1 Providers must distribute reports for the contract year by July 30th annually (reports cover July 1- June 30). Reports should be provided to the OPM, regional ILC and the state IL Program Manager.

Standard 20: TLP Housing Options

20.0 Transitional living placements may be offered through a variety of residential on-campus living arrangements where youth have the opportunity to practice independent living skills with decreasing degrees of care and supervision. Apartment living may also

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[6] This training is under-development and will be available in Summer 2011.

be considered when the apartments are grouped together in what is known as a "pod," and only individuals participating in the program are allowed to live within the pod. A pod must be in a specific location with a supervisor living on-site twenty four (24) hours a day, seven days a week (i.e., 24/7). Other supervisory regulations will be determined on a program by program basis.

20.1 Providers are prohibited from using mobile homes as the housing unit for transitional living placements.

20.2 Transitional living facilities must be in locations that are designated for the unique purpose of transitional living (e.g., a separate wing in a building; a freestanding building) and must allow the residents free access to the exterior (e.g. no lock-down units).

IV. Independent Living Program Minimum Standards

RBWO providers are responsible for assuring that their independent living programs meet the following requirements as well as any applicable *ORCC Standards.* The Office of Provider Management is responsible for monitoring RBWO providers to assure that Standards are met. Independent Living Programs (ILP) are different from TLP in that youth may live in an alternative living arrangement (i.e., community based housing) rather than a group home, or other residential type facility. All ILP youth must eventually transition into independent housing. This placement provides the opportunity for youth to experience decreased care and supervision as they become responsible for their own care. The goal of an independent living placement is to prepare youth to become socially and financially independent from the foster care system. Independent living placements shall begin no earlier than a youth's 18th birthday.

Standard 21: ILP Admissions

Providers must only admit youth to ILPs for whom the admissions assessment indicates that the youth is appropriate for the program.

21.0 Admitted youth must be at least 18 years of age and elected to Extended Youth Support Services. Youth must be assessed by the provider to be invested in and able to benefit from ILP. Admissions criteria must include that youth must be employed at least part time (15-20 hrs. /week) prior to entering the ILP. Part time employment will only be acceptable if the youth is enrolled in an educational / vocational training program. All other ILP participants must maintain full time employment.

21.1 Providers must have defined admittance criteria, which includes a youth-completed application and interview and review of the CCFA Youth Assessment.

21.2 Providers must document all referrals including the reasons for admittance or denial into the ILP.

21.3 Providers must determine whether youth will be accepted or denied admission within three business days of a completed application.

21.4 Youth admitted into an ILP must have an orientation to the program. Youth should be provided with a handbook or other literature describing the program.

21.5 Youth admitted into an ILP must sign an acknowledgement of having participated in an orientation to the program and an understanding of their rights and responsibilities as a participant in the program.

21.6 ILP Youth must sign an acknowledgement that they may be discharged from the ILP if they willingly and knowingly participate in illegal or disruptive behavior or it is determined that they are unable or unwilling to benefit from the program.

21.7 Providers must meet with the ILC to discuss youth's eligibility for services and funding.

21.8 Providers must administer the DFCS ILP entrance and exit surveys on all youth enrolled in the program. Copies of the surveys will be forwarded to assigned ILC within 30 days of admission or discharge.

Standard 22: ILP Supervision and Independence

Youth should receive levels of supervision that fit their needs and be provided with appropriate independence to practice skills needed for successful independent living.

22.0 ILP youth must have a documented assessment which supports a Supervision and Independence plan regarding levels of supervision and independence.

22.1 ILP youth must have twenty-four (24) hour telephone access to the provider.

22.2 Providers must develop a schedule for providing supervision based on a specific youth's maturity, acquired skills, and abilities. The supervisory schedule will be developed in collaboration with the youth and the DFCS ILC as appropriate. Supervision must be designed so that the provider may observe that the youth is practicing healthy life skills and decision-making.

22.3 Supervision of ILP youth includes at a minimum the following:

- safety, health, and overall well-being;
- ability to manage school and work responsibilities without daily
- supervision;
- ability to follow program and landlord rules;
- ability to use good judgment in daily activities; and
- overall progress toward established goals and desired outcomes.

22.4 The frequency of in-person supervision may vary due to many factors (e.g., readiness for independence; living arrangements chosen; presence or availability of other adults; other factors unforeseen until after placement). The following in person supervisory schedule, at a minimum, shall be utilized during the first eight (8) weeks in placement.

- 1st Week Daily Face-to-Face Supervision
- 2nd through 4th Weeks Twice A Week Face-to-Face Supervision
- 5th through 8th Weeks Once A Week Face-to-Face Supervision

After the eighth (8th) week, face-to-face supervision must occur no less than once a month based upon an assessment by the provider, youth and the ILC as appropriate. The full supervision plan should include telephone contacts and/ or other forms of check-ins or contacts.

22.4 The Supervision and Independence Plan must be signed by the youth and communicated to the assigned ILC.

22.5 The Supervision and Independence Plan should be re-assessed at least every three months or as often as circumstances or changes dictate.

Standard 23: Independent Living Skill Building

ILPs must assist youth in making progress toward achieving the goals of the ILP ISP.

23.0 Providers must develop an ILP Individual Service Plan (ILP ISP). The ILP ISP must be based upon the youth's needs, desires, Ansell Casey Life Skills Assessment (ACLSA) and future goals and objectives. (The ILP ISP is the ISP for ILP programs. All other standards for the ISP apply.)

23.1 The ILP ISP must have defined goals and objectives with timeframes established. Case documentation should reflect progress and/or efforts toward meeting goals.

23.2 If the ILP is housed in a group home or other congregate care type facility, the ILP ISP must include a goal directed at the youth obtaining and maintaining single occupancy housing.

23.3 Providers must submit a monthly summary of each youth's progress to the assigned Independent Living Coordinator (ILC) by the 10th of the following month. The list of ILCs and the monthly summary form is located in the Appendix .

23.4 ILP youth must be engaged in learning and developing "soft" and "hard" independent living skills, daily living and self-care skills. Hard skills include the teaching of areas development including, but limited to banking, apartment hunting, job search, budgeting and educational planning. Soft skills include the teaching of areas including, but not limited to anger management, goal-oriented behaviors, parenting skills, problem solving skills and interpersonal communication. Daily living skills should include instruction in nutrition, menu planning, grocery shopping, meal preparation, dining decorum, kitchen cleanup, food storage, home management, and home safety. Opportunities for youth to apply these skills would include developing menus, shopping for ingredients, preparing meals, cleaning the kitchen and dishes at the conclusion of the meals, and appropriately storing leftover food. Self-care skills should include instruction about topics such as hygiene, health, alcohol, drugs, tobacco, parenting skills, and responsible sexuality. Opportunities for youth to apply these skills would include discussions as well as role playing and rehearsal of parenting and hygiene skills.

23.5 At a minimum providers should document at least two efforts weekly that record the youth's engagement in independent living skills development.

23.6 Providers must coordinate educational services, facilitate career plan development, provide tutors, and help youth attain educational goals.

23.7 Providers must assist youth in developing a career plan. The plan should include the youth's interests, strengths in school, visions for career and personal life, and opportunities for career and work experience.

23.8 Providers must connect youth with local industries and employment programs so that youth have the opportunity to explore career opportunities and develop a plan to achieve their career aspirations.

23.9 Providers must offer job search training in areas such as resume writing and interviewing.

Standard 24: Single Occupancy Housing

Providers must assist youth with securing and maintaining stable, affordable housing.

24.0 Providers must assist the youth in securing appropriate, single occupant housing by the 13th month of participation in the program.

24.1 Providers must provide youth with an adequate monthly food allowance.

24.2 Providers must assist youth with maintaining their employment in order to remain in the ILP. If youth is dismissed from employment or out of work for any reason, they will be given 60 days to find another job. If another job is not identified within the time frame, a staffing must be held with ILC to determine next steps.

24.3 Providers must document youth's earnings (copies of pay stubs & bank statements).

24.4 Providers must support youth's development and maintenance of a savings account (Individual Development Accounts (IDA) are preferred.). Youth must save a percentage of their income as follows:

A. 1st year participants or youth 18-19 years of age are required to save 50% of their income.

B. 2nd year participants or youth 19-20 years of age are required to save 25% of their income.

24.5 Providers must develop a financial plan such that the youth will begin to gradually assume financial responsibilities of their housing and other expenses.

A. 1st year participants or youth 18 – 19 years of age will have all housing related expenses (rent, utilities, food allowance) paid for whether or not youth has already obtained single occupancy housing.

B. By the 2nd year all youth must be in single, occupancy housing. Youth in the 2nd year of an ILP must contribute in the following manner:

1. 1st – 3rd month: 100% of housing expenses will be paid by the provider.

2. 4th – 6th months: 70% of rent and all other expenses will be paid by provider. Youth must pay 30% of rent to provider with appropriate late fees assessed as applicable.

3. 7th – 9th month: 50% of rent and 70% of utilities will be paid by provider. Youth must pay 50% of rent and 30% of the utilities to provider with appropriate late fees assessed as applicable.

4. Starting the 10th month and ongoing: 25% of rent and 50% of utilities will be paid by TLP provider. Youth must pay 75% of rent and 50% of the utilities to provider with appropriate late fees assessed as applicable.

24.6 Providers must hold the youth contributions to expenses in savings for youth and reimburse the full amount to the youth upon case closure. Providers must maintain documentation of the contributions and disbursements.

24.7 Providers must ensure that youth in single occupancy housing are responsible for signing the lease related to housing, paying monthly rent and utilities. Utilities should be billed in the youth's name.

24.8 Providers must ensure that the youth has provided them with 24-hour access (key) to his/her residence.

24.9 Providers must continue to support youth's independence by including in the ILP ISP incremental steps or goals which include the following:

- Development of Permanency Pacts or other agreements with caring adult connections;
- Living arrangements upon discharge from Extended Youth Supportive Services;
- Educational and/or vocational planning; and
- Any other goals or objectives which will assist the youth in being successful post discharge.
-

Standard 25: Life Coaching

Youth are supported in achieving personal goals through a Life Coach.

25.0 Youth in ILP programs must have a life coach. Life coaches must meet the same educational and experiential requirements of a Human Services Professional (HSP). Life coaching is a practice that helps people identify and achieve personal goals. Life coaches help clients set and reach goals using a variety of tools and techniques. Life Coaches model life skills (e.g., assertiveness, communication, conflict management, problem solving and decision making) and provide activities for youth to practice life skills and provide appropriate feedback to the youth.

Life Coaches are minimally be responsible for the following activities:

- Assisting the youth in obtaining educational, vocational and employment opportunities;
- Providing transportation when necessary to achieve the goals of the ILP ISP;

- Assisting the youth in establishing and maintaining involvement in community/recreational activities;
- Assisting the youth in securing mental and medical health assistance when necessary; and
- Monitoring youth savings and expenditures to ensure proper budgeting of income.

Note: Life Coaches serve as the HSP for TLP programs.

25.1 ILP Life Coaches must participate in a basic certification provided by the state IL Program Manager. ILP Life Coaches must participate in a basic certification training provided by the state IL Program Manager. Training covers independent living policies, ACLSA and other requirements of the program. [7]

25.2 ILP Life Coaches must attend at least one county/regional/ state IL training, meeting or workshop quarterly. This requirement may also be met by meeting individually with the regional ILC to staff the youth in the ILP.

25.3 Life coaches must have a plan for each youth and have at least bi-monthly sessions with youth. The Life Coach plan may be a separate document or incorporated into the TLP ISP. If for any reason the youth becomes unemployed, Life Coach will have at least weekly contacts and closely support the youth's job search.

25.4 Provider will assign a Life Coach to each youth in the program. The ratio of Life Coaches to youth is no more than 1:15.

25.5 Life Coach must meet with ILC and youth to discuss progress in achieving the goals of the ILP ISP at least quarterly.

Standard 26: Outcome Measures

Providers must track outcomes of youth and overall program performance.

26.0 ILP providers must track outcomes for youth. Minimally, programs should compile on an annual basis the following:

- Demographics on youth served;
- Life skills programming and service delivery;
- Educational outcomes;
- Vocational outcomes;
- Youth involvement with DJJ or DOC; and
- Housing, adult connection, employment, educational status of youth discharged and continuing in the program.
-

26.1 Providers must distribute reports for the contract year by July 30th annually (reports cover July 1- June 30). Reports should be provided to the OPM, regional ILC and the state IL Program Manager.

[7] This training is under-development and will be available in Summer 2011.

Standard 27: General Administrative

27.0 Independent living placements may be offered through a variety of residential on-campus living arrangements where youth have the opportunity to practice independent living skills with decreasing degrees of care and supervision. Youth must be in single occupancy housing by the 2nd year of participation.

27.1 Providers may not use mobile homes as the housing unit for independent living placements.

27.2 Providers must contact the assigned ILC immediately when significant issues or incidents occur and the issue/incident is severe enough to risk a youth's loss of the independent living placement (e.g., apartment) or the issue/incident creates a danger to the youth.

27.3 Providers must notify the Office of Provider Management whenever significant events occur relating to the safety or well-being of IL youth or relating to the IL program.

27.4 Providers must adhere to applicable general RBWO Standards four (4), five (5), six (6), eight (8), nine (9) and eleven (11).

27.5 Providers must adhere to the CCI staffing standards with the exception of having Child Care Workers. The HSP may serve as the ILP Life Coach.

Program Designations

There are twelve types of R.B.W.O. care for all children whether they are served in residential care with Child Caring Institutions or Child Placing Agencies. The types of care and the children served are described as follows:

CPA	CCI
Traditional Care	BASE Care-BWO
BASE Care-BWO	Additional Watchful Oversight- AWO
Maximum Watchful Oversight- MWO	Maximum Watchful Oversight- MWO
Specialty Base Watchful Oversight- SBWO	
Specialty Maximum Watchful Oversight- SMWO	
Specialty Medically Fragile Watchful Oversight- SMFWO	
	Maternity Home
	Second Chance Homes
	Teen Development
	Independent Living Program
	Specialty Camp

Traditional (CPA) or BASE-BWO (CCI) Care:

A child served in Traditional Care or Base Care will have **mild to occasionally moderate** emotional and/or behavioral management problems that interferes with the child's ability to function in the family, school and/or community without guidance and supervision. The behaviors identified for Traditional Care children placed in a CPA are identified as **mild**. The behaviors identified for BWO children placed in a CCI are identified as **mild to moderate**.

The following are the child characteristics and operational impact on children in Traditional Care or BWO according to the Difficulty of Care Factors:

- May be learning disabled requiring supports such as Student Support Team and tutoring services
- May have poor concentration at school and home
- May have occasional disruptive or disobedient behaviors resulting in In-School Suspension
- May have behaviors that are managed by medications
- Disregard for others property – minor property damage
- Non-compliance with curfew and/or limits set by adults
- Difficulty in adjusting to new environments
- May lack age-appropriate knowledge of self care or life skills
- May have behavioral outbursts inclusive of profane and/or provocative language
- May exhibit "annoying" behaviors to include excessive teasing, horseplay, and language taunting
- May exhibit shyness, fear, anxiety, and nervousness in group/community settings
- May exhibit irritability and/or hostility toward peers
- May exhibit impulsive behaviors that create mild risk – inappropriate verbal outbursts, wanders away from the group
- May be easily frustrated; temper tantrums
- May have difficulty making friends

A child served in Base or Traditional programs will have **minimal to mild** medical needs and can have a mild developmental delay that does not coexist with any medical condition.

BASE-BWO (CPA) or Additional Watchful Oversight- AWO (CCI):

A child served in the Base with Watchful Oversight or Additional Watchful Oversight will have **moderate** to **occasionally serious** emotional and/or behavioral management problems. In the CCI program, the behaviors exhibited by a child interfere with his or her ability to function in the family, school, and/or community outside of a supervised and structured setting. The behaviors identified for BWO children placed in a CPA are identified as **moderate**. The behaviors identified for AWO children placed in a CCI are identified as more frequent and **serious**.

The following are the child characteristics and operational impact on children in BWO or AWO according to the Difficulty of Care Factors:

- Performance is not in accordance with ability
- Learning disability requiring IEP services
- Disruptive and/or disobedient to school rules, could result in suspension
- Frequent attendance and truancy problems
- Oppositional and defiance in the home and school setting
- Use of vulgar and/or provocative language

- Annoying behaviors – picks on peers, repetitive actions or language, and taunting
- Demanding and threatening
- Lacks age-appropriate knowledge of self care or life skills
- Occasionally assaultive without causing major injuries
- Disregard for the property of others; intentional property damage
- Occasionally runs away and/or refuses to abide by curfews
- Self harming behaviors, eraser burns, repeatedly picking at sores, biting fingernails until they bleed, and head banging
- Does not engage in typical peer interactions or recreational activities because of tendency to be picked on or bullied by others
- Often fearful, anxious, or sad
- Difficulty identifying and/or expressing emotions, emotionally blunted
- Easily annoyed, frequent and intense irritability
- Possible delinquent behaviors and Department of Juvenile Justice (DJJ) involvement
- Child has engaged in substance use, but use does not interfere with daily activities
- Impulsive actions that create risk (inappropriate outbursts, plays with fire and/or wanders away)

A child served in Base or Additional programs will have **minimal to mild** medical needs and can have a mild developmental delay that does not coexist with any medical condition.

Maximum Watchful Oversight- MWO (CPA & CCI)

A child served in the Maximum Watchful Oversight Program will have **serious** to **severe** emotional and/or behavioral management problems. In the CCI program, the behaviors exhibited by a child interfere with his or her ability to function in the family, school, and/or community outside of a supervised and structured setting. The behaviors identified for MWO children placed in a CPA are identified as **serious**. The behaviors identified for MWO children placed in a CCI are identified as more frequent and **severe**.

The following are the child characteristics and operational impact on children in MWO according to the Difficulty of Care Factors:

- School attendance is poor, grades are poor, concentration is poor when in school; requires oversight from teachers, family and/or caregiver
- Multiple school suspensions and disciplinary actions
- History of explosive outburst in schools
- Failure and/or inability to learn
- IEP with placement in specialized classes for behavioral or learning disabilities
- May require adaptive learning tools
- Refuses help with school work or tutoring
- Several years behind in the development of age-appropriate knowledge of self-care or life skills
- Verbal aggression (Use of vulgar and/or provocative language)

- Oppositional and defiant in the home and school setting
- Demanding and/or threatening
- Smearing and/or throwing of feces
- Bedwetting – graduating to intentional urination in places other than the toilet
- Hiding soiled clothing/bed linens
- Limited ability to perform routine tasks of daily living such as chores and laundry
- Deliberately or impulsively destroying property while in a structured setting breaking windows, pictures, mirrors, damage to furniture, appliances, clothing, electronics, and vehicles
- Preoccupation with fire
- History of cruelty to animals
- Sexual acting out with or without aggression that may be opportunistic, situational or planned
- Highly sexualized behaviors, promiscuity, seeking inappropriate relationships with older persons, poor physical boundaries, often with history of sexual abuse and poor self esteem
- Recurrent and/or severe self-injurious behaviors and/or suicidal behaviors that are under control
- Homicidal and/or suicidal threats
- Physical aggression and/or assault (hitting, kicking, spitting, attacking may with or without a weapon, throwing objects) toward adults and/or other children with and/or without injuries
- Withdrawn behavior, attention seeking behaviors that are excessive, constant complaining about physical ailments, nightmares, difficulty going to bed and/or refusal to stay in bedroom
- Fears, worries, and anxieties that affect daily activities; frequent and severe headaches, stomach aches and/or refusal to get out of bed
- Serious problems with personal hygiene
- Impulsive behaviors that present barrier to maintaining physical safety
- Chaotic and poor control of anger toward self and others with frequency and intensity that needs attention
- Inflexibly adheres to routines or rituals and has difficulty with transitions, which may lead to serious harm to self or others or extremely aggressive behaviors
- Difficulties with social interactions and/or communication (failure to speak, make eye contact, shake hands, hiding, standing too close, revealing personal information inappropriately to strangers, etc.)
- Odd, bizarre or explosive actions, which pose a significant risk of harm to self or others
- Hearing voices and/or seeing things that are not there
- Frequent and/or uncontrollable behavioral outbursts and mood swings
- Seems unable to form any meaningful friendships, is socially isolated and unable to enjoy activities with peers
- Delinquent behaviors – stealing, burglary, assault and/or battery
- Recurring involvement with Department of Juvenile Justice (DJJ)
- Fire setting with intent to destroy property or injure others and/or preoccupation with fire
- Intentionally and/or maliciously cruel to animals

- Runs away with involvement in situations where high risk activities are likely to occur
- Drinking and/or drug use which may have resulted in disciplinary actions and/or affect daily function
- Involvement with gangs and/or gang-like activities
- Poorly prepared for and lacking skills necessary for independent living

A child served in this group may have **moderate** medical needs requiring specialized services. Child generally sees 2 or more physicians at least on a quarterly basis for medical needs, requires routine lab work to assess the effectiveness of medications. Medical needs in this group could include two-three of the following:

- Global developmental delay as the primary diagnosis
- Mild Cerebral Palsy
- Fetal Alcohol Syndrome
- Recovering from head injury
- Cancer in remission
- Diabetes – managed with insulin and follow up with Endocrinologist
- Ordered to have physical, occupational, and/or speech therapy 1-2 times weekly
- Infant with sucking difficulty and/or on a monitor
- Reflux that is controlled with 1-2 medications
- HIV exposure with medications
- Severe visual impairment to include a diagnosis of legal blindness
- Seizure disorder requiring medication
- Episodes of enuresis or encopresis or a history of one or both
- Autism (high functioning)
- Deafness or severe hearing impairment
- May have self-harming behaviors such as cutting or ingesting harmful substances.
- Children with mental retardation may not be able to follow simple one and/or two-step directions and frequently have difficulty with three step directives.

Children with the identified medical needs can either be served in a MWO CPA or CCI program. However, there are children in the MWO category through selected CCI or Children's Transition Care Center (CTCC) programs whose medical needs are **serious to severe**. These children are deemed clinically stable by a physician but are dependent on life-sustaining medications, treatment/procedures and equipment. Children ages 0-12 are not permitted to be place in group setting without approval of a DFCS Director. However, under special circumstances with an exclusive contract a provider may be approved to place medically fragile children ages 0 –18 in a group setting.

Some of the characteristics in which a child would qualify for a medically fragile approved MWO CCI/ CTCC provider are as followed but not limited to:

- A medical condition which requires management with medications

- Child has a tracheotomy
- Child is oxygen and feeding tube dependent
- Complete or partial paralysis (child weighing 20 pounds or more)
- Depends upon medication to keep a life threatening condition under control including, but not limited to asthma, chronic lung disease, diabetes, heart disease, HIV infection, or chronic kidney disease being maintained by dialysis
- Limited mobility

Specialty Base Watchful Oversight- SBWO (CPA)

A child served in this specialty program will have **serious** emotional and/or behavioral management problems that interfere with the child's ability to function normally with in the family, school, and community. Due to the severity and required attentiveness in caring for a child approved with a specialty program designation, other children are not permitted to be placed in the home without the written approval from a DHS/DFCS Designee. The child characteristics on children in SBWO are the same as MWO; however the severity and frequency are increased.

Specialty Maximum Watchful Oversight- SMWO (CPA)

A child served in the Specialty with Maximum Oversight Program will have **severe** emotional and/or behavioral management problems that interfere with the child's ability to function in the family, school, and/or community. Due to the severity and required attentiveness in caring for a child approved with a specialty program designation, other children are not permitted to be placed in the home without the written approval from a DHS/DFCS Designee. The child characteristics on children in SMWO are the same as SBWO; however the severity and frequency are increased.

Specialty Medically Fragile Watchful Oversight- SMFWO (CPA)

A child served in the Specialty Medically Fragile program has **serious to severe** medical conditions. Non-compliance with any prescriptive regimen of care will endanger the life or health of the child. These children require time-intensive treatments/procedures to be performed daily by a trained caregiver. Due to the severity and required attentiveness in caring for a child approval with a specialty program designation, other children are not permitted to be placed in the home without the written approved from a DHS/DFCS Designee.

These are some of the characteristics in which a child would qualify for SMFWO but not limited to:

- A medical condition which requires management with medications
- Child has a tracheotomy
- Child is oxygen dependent
- Persistent reflux causing frequent vomiting
- Requires oral feedings that take at least 30 minutes or requires tub feedings
- Requires nebulizer treatments on a daily basis

- Requires medications by feeding tube, injection or suppository
- Requires ostomy care
- Has any type body cast
- Blindness
- Deafness or severe hearing impairment
- Complete or partial paralysis (child weighing 20 pounds or more)
- Has self-harming behaviors such as cutting, ingesting poisonous substances, etc.
- Depends upon medication to keep a life threatening condition under control – including, but not limited to asthma, chronic lung disease, diabetes, heart disease, HIV infection, or chronic kidney disease being maintained by dialysis
- Limited mobility
- Bedwetting and urination in places other than the toilet
- Several years behind in the development of age-appropriate knowledge of self-care or life skills
- Medical interventions may be required while in school

Maternity Homes & Second Chance Homes (SCH):

A child served in the Maternity Homes and Second Chance Homes is preparing for motherhood or receiving hands on parenting training. The premise of these program designations are to support an adolescent who is either pregnant or have a child/children with the skills and knowledge to care for their child(ren). The ages of the adolescent approved for this program designation can be 14-18. Their emotional and/or behavioral management problems are **mild**.

The following are the child characteristics and operational impact on children according to the Difficulty of Care Factors:

- May be learning disabled requiring supports such as Student Support Team and tutoring services
- May have poor concentration at school and home
- May have occasional disruptive or disobedient behaviors resulting in In-School Suspension
- May have behaviors that are managed by medications
- Non-compliance with curfew and/or limits set by adults
- Difficulty in adjusting to new environments
- May have behavioral outbursts inclusive of profane and/or provocative language
- May exhibit "annoying" behaviors to include excessive teasing, horseplay, and language taunting
- May exhibit impulsive behaviors that create mild risk – inappropriate verbal outbursts and wanders away from the group
- May be easily frustrated; temper tantrums
- May have difficulty making friends

A child under Maternity and Second Chance Homes have minimal to mild medical needs and can have a mild developmental delay that does not coexist with any medical condition.

The Second Chance Homes not only serves the mother but also the mother's child(ren). The following are the program designations codes for Second Chance Homes in GA SCORE:

- 2CMB1- Second Chance Mother with one (1) child
- 2CB1- Second Chance one (1) child
- 2CMB2- Second Chance Mother with two (2) children
- 2CB2- Second Chance two (2) children

Camp:

A child served in the Camp will have **moderate to severe** emotional and/or behavioral management problems that interfere with the child's ability to function in the family, school, and/or community outside of a supervised and structured setting. The child characteristics on children approved for the Camp are the same as AWO and MWO.

A child under, Camp has minimal to mild medical needs and can have a mild developmental delay that does not coexist with any medical condition.

Teen Development:

A child served in the Transitional Living/ Independent Living Program greatly benefits from life skill training to be more self-sufficient and preparing them for adulthood. The premise of this program designation assignment is not behavioral based as the BWO, AWO and MWO are. Behaviors may be considered in the placement of a child, based on each approved provider admission criteria. This program designation can serve adolescent as young as 16 years.

DESCRIPTION OF PROGRAM TYPES

Child Caring Institution (CCI)

- Any child-welfare facility that provides full-time room, board and watchful oversight to six or more children through 18 years of age (the exception would be if an emancipated child signed himself/herself back into the care of the Division of Family and Children Services, then 21 years of age or under). The children in CCI's are residing outside of their own home environment. These facilities provide care, supervision, and oversight in a residential setting, including neighborhood - based group homes, campus - based arrangements, and self-contained facilities. The facility Director, Human Service Professional, and Direct Care Staff work as a team to provide a stabilizing and nurturing environment that promotes, safety, well-being and permanency, and it allows the children to be stepped down to the less restrictive environment.

Second Chance Home (SCH)

- SCH is a Child Caring Institution by definition, however, this type of CCI serves between four and eight adolescents and their child or children. They may also serve no more than one pregnant adolescent in a six month period. Second Chance Homes help adolescent mothers to become self-sufficient by providing them with a safe living environment, support for long-term economic independence, child development, parenting and life skills.

Maternity Home (MH)

- MH is a Child Caring Institution by definition, however this type of facility admits, treats, or cares for, within a period of six months, more than one pregnant adolescent, either before, during or within two weeks after childbirth. This facility offers a group living experience to pregnant adolescents or young mothers. Professional staff assists the young women before and after giving birth to address individual problems and help them plan for living arrangements, employment and/or school, and caring for their new infants. The Director, Human Service Professional, Resident Staff, and Medical Staff work together as a team to promote the safety, permanency and well-being of the children that they serve.

Children's Transition Care Center (CTCC)

- CTCC is a Child Caring Institution by definition, but this type of CCI provides a temporary, home-like environment for medically fragile children, technology dependent children, and children with special health care needs, who are deemed clinically stable by a physician but are dependent on life-sustaining medications, treatments, and equipment. These children require assistance with activities of daily living to facilitate transitions from a hospital or other facility. The Director, Human Service Professional, Registered Nurse Staff, and the Direct Care Staff work together as a team to promote the safety, permanency and well-being of the children that they serve.

Outdoor Therapeutic Program -"Specialty" Camp (OTP)

- OTP is a Child Caring Institution by definition, however this type of CCI provides room, board and watchful oversight in a wilderness or camp environment that is designed to improve the emotional and behavioral adjustment of the children in care. The use of physical, environmental, athletic and other challenging activities are designed to improve the functioning of the children and to teach them pro-social and adaptive skills.

Independent Living Program:

- Specialized RBWO program for youth who are at least 18 years of age through 21 years. ILP is different from transitional living in that youth may live in an alternative living arrangement (i.e., community based housing) rather than a group home, or other residential type facility. Independent living placements shall begin no earlier than a youth's 18th birthday. Youth in ILP will experience "graduated independence" regarding program expectations, skill development and levels or types of supervision provided. The goal of an independent living placement is to prepare youth to become socially, emotionally and personally independent of social services while connecting them to life-long permanency connections and laying the foundation for the pursuit of educational and career opportunities.

Transitional Living Program:

- Specialized RBWO program for youth at least age 16 years. Youth may be older than 18 years old if they have agreed to Extended Youth Support Services. Transitional living is designed for youth who are ready to enter a phase of care that will eventually transition them to independent living. Transitional living affords youth an opportunity to practice basic independent living skills in a variety of settings with decreasing degrees of supervision. This specialized RBWO placement provides youth the opportunity to experience increased personal responsibility so youth can become responsible for their own care when they exit foster care. The goal of an transitional living placement is to prepare youth to become socially, emotionally and personally independent of social services while connecting them to life-long permanency connections and laying the foundation for the pursuit of educational and career opportunities.

Child Placing Agency (CPA)

- Any child welfare agency which places children in foster homes for temporary individualized care, supervision and oversight, and are provided in a resource family setting. These agencies that arrange for children to receive care in foster homes must make arrangements to assess the placement regarding the appropriateness of the room, board and watchful oversight that the prospective foster family will provide. The agency's Director, Case Support Staff, and the foster parents work as a team to provide a stabilizing and nurturing environment that promotes, safety, well-being and permanency.

CPA Staffing Standards

These requirements build on CPA rules and regulations and reflect the increasing needs and service requirements.

The R.B.W.O. CPA provider shall have the administrative and professional staff necessary to oversee and provide R.B.W.O. services to children and families. No person having an unsatisfactory determination based on his/her criminal record shall be employed by the agency.

Director

- Director must have a master's degree from an accredited college or university in the area of behavioral or social sciences, social work, or childhood education, business or public administration or related field and two (2) years of paid work experience in the field of social services or human service delivery and at least one of which has been in an administrative or supervisory capacity; or a bachelor's degree from an accredited college or university in the same areas of study and four (4) years of paid work experience in a human services delivery capacity or a related field and at least two of which have been in an administrative or supervisory capacity.

- The Director may serve as the Case Support Worker (C.S.W.) if the Director meets the educational qualifications of the Case Support Worker no longer than 90 days to cover a vacancy. OPM must be notified in writing when the position is vacated and the plan to replace the C.S.W.

Note: Some directors were grandfathered in and may not meet the current qualifications for case support supervisor or case support worker.

Case Support Supervisor

The role of the Case Support Supervisor is to plan, provide, arrange, coordinate and document services to children and families. Case Support Supervisor must have a master's degree from an accredited college or university in the area of behavioral or social sciences, social work, psychology, childhood education, special education, guidance counseling, or related field with one (1) year experience in the field of childcare or a bachelor's degree from an accredited college or university in the same areas of study with two (2) years of paid work experience in a human services delivery capacity or a related field.

Role of Case Support Supervisor (CSS)

- Responsible for ensuring that the case support worker is meeting the needs of the child and foster parent

Case Support Worker

Case Support Workers shall have a maximum caseload of the following:

- Traditional Care- 20 children on a caseload
- Base Care- 15 children on a caseload
- MWO- 10 children on a caseload
- SBWO, SMWO, SWFWO- For combined cases of specialty (SBWO, SMWO and SMFWO with lower program designations): No more than 12 children on a caseload.

Case Support Worker must have a bachelor's degree from an accredited college or university in the area of behavioral or social sciences, social work, psychology, childhood education, special education, guidance counseling, or related field with two (2) years direct service experience with children and families or a master's degree from an accredited college or university in the same areas of study with one (1) year of paid work experience with children and families.

Role of Case Support Worker (CSW)

- Responsible for ensuring that the educational, medical, emotional and social needs of the child are met.
- Responsible for ensuring that the foster parent's needs are met to enable them to care for the child

CCI Staffing Standards

The following Requirements are for Child Caring Institutions, "Specialty" Camps, and Maternity Homes providing Room, Board, and Watchful Oversight (R.B.W.O.) services to children. The Staffing Requirements for R.B.W.O. described below build on the ORCC rules and regulations, and reflect the increasing needs and service requirements of the children.

ADMINISTRATION AND ORGANIZATON

Each provider of R.B.W.O. shall employ or contract with an adequate number of qualified staff to provide the necessary services. Staff shall not be assigned more than one position except in rare situations based on the work assignment and responsibilities at the discretion of the agency's director.

- A Director shall not serve in the capacity of director for more than one agency that is under contract with the Department of Human Services as an R.B.W.O. provider. In addition, the Director may serve as the Human Services Professional (H.S.P.), when it is vacated, if the Director meets the educational qualifications of the H. S. P. The Director may act in the capacity of the H.S.P. for no longer than 90 days, and must notify the Department in writing when the position is vacated and of its plan to replace the H.S.P.

No person having an unsatisfactory determination as to his or her criminal record shall be employed by the facility.

The director may not rely on out of state staff to meet any of the staffing needs.

<u>Director</u>

When providing services for the following R.B.W.O. programs and designations, Base Watchful Oversight (BWO), Additional Watchful Oversight (AWO), 2nd Chance, Maternity, Teen Development, Camp and Maximum Watchful Oversight (MWO), the provider must designate an individual responsible for its administrative services. Based on the qualifications outlined below, this individual assumes final responsibility for the provision and oversight of all essential tasks and services described in these standards.

- A Director must have a master's degree from an accredited college or university in the area of behavioral or social sciences, social work, childhood education, business or public administration or related field and two (2) years of paid work experience in the field of social services or human service delivery and at least one of which has been in an administrative or supervisory capacity; or a bachelor's degree from an accredited

college or university in the same areas of study and four (4) years of paid work experience in a human services delivery capacity or a related field and at least two of which have been in an administrative or supervisory capacity.

- Ideally, the Director should not serve in any other capacity unless it is in an emergency situation (loss of an HSP or child care worker). If this occurs, the director may act in the capacity of the HSP or child care worker, for no longer than 90 days and must notify the Department of the situation and its plan to replace the staff. The director must meet the qualifications of an HSP in order to temporarily serve in this capacity.

Note: Some directors were grandfathered in and may not meet the current qualifications for serving as an HSP.

Human Services Professional

When providing services for the following programs and designations: Basic Watchful Oversight (BWO), Additional Watchful Oversight (AWO) and Maximum Watchful Oversight (MWO), Specialty Camps and Maternity Homes the provider must designate staff to assume the responsibilities of a Human Services Professional (HSP) to plan, provide, arrange, coordinate and document services to children and their families.

- An HSP is responsible for providing and/or coordinating services for no more than 16 children.

- The HSP must have a master's degree from an accredited college or university in the area of behavioral or social sciences, social work, or psychology, childhood education and (1) year of paid work experience in the field of social services or human service delivery or a bachelor's degree from an accredited college or university in the same areas of study with (2) year of paid work experience in social service, child care or a related field.

Role of Human Services Professional (HSP)

Responsible for ensuring that the educational, medical, emotional and social needs of the child are met. Responsible for providing and/ or coordinating ancillary and social services for the child.

Child Care Workers

The provider shall have designated Child Care Workers responsible for the daily care and supervision of children in the living unit. The Child Care Worker must be at least 21 years of age and possess at least a high school diploma or GED and two (2) years of direct service experience with children and families or an Associate's degree or higher in a behavioral or social science field. New Child Care Workers must log at least 40 hours of work with the provider before working unsupervised with children.

Child-Staff Ratios

- When providing services for children with a program designation of Base Watchful Oversight (BWO), Child Care Workers shall be available to provide a staff to child ratio of 1:10 (staff to child ratio is subject to change when the safety is in question). Programs that offer Base Watchful Oversight services only, are not required to have awake staff, unless the agency has residents who require constant supervision, e.g. children with histories of sexual offending or chronic runaway behavior.
- If only one Child Care worker is required to be on duty, day or night, there must be a designated, proximate back-up person on-call at all times in case of an emergency. The back-up person must be listed on the daily schedule. When a Child Care Worker is required to be on duty, the Child Care Worker shall monitor sleeping children every 15 minutes and document in writing.
- When providing services for children with a program designation of Additional Watchful Oversight (AWO), Child Care Workers shall be available to provide a staff to child ratio of 1:8 (staff to child ratio is subject to change when the safety is in question) during the day and night. The Child Care Worker shall monitor sleeping children every 15 minutes and document in writing.
- When providing services for children with a program designation of Maximum Watchful Oversight (MWO), Child Care Workers shall be available to provide a staff to child ratio of 1:5 (staff to child ratio is subject to change when the safety is in question) during the day and night. The Child Care Worker shall monitor sleeping children every 15 minutes and document in writing.
- When providing services for children with mixed program designations (AWO and MWO) and the number of MWO children is higher than 25% of the population in the facility, the MWO staff ratio standards apply.

Note: Providers may request in writing a review of their_child-staff ratio needs . The request to OPM should include a detailed explanation with supporting facts as to why an exception to the expected staffing standards should be granted. OPM will review the request and make an appropriate determination in writing. Until the written determination is made, providers must maintain expected staffing standards.

House Parent Model

- This model may be utilized for programs that accept Base Watchful Oversight designations only. The programs must have a process in place to ensure that children are asleep before the house parent goes to sleep and can be reasonably assured that children will be safe and secure overnight. Agencies must utilize awake staff if serving children who require constant supervision, e.g. children with histories of sexual offending or chronic runaway behavior. CCI Programs serving Additional Watchful Oversight (AWO) and Maximum Watchful Oversight designations shall not use the House Parent Model.

- Relief staff must have the same qualifications and training as regular child care staff.

Appendix

Definitions

Individual Service Plan Checklist

Internet Resources

Waivers and Program Designation Request Information

Grievances and Appeals

OPM Staff Contact List

Independent Living Coordinators and ACLSA Codes

Permanency Expeditors

Forms

Appendix A-DEFINITIONS

Ansell-Casey Life Skills Assessment (ACLSA) - A free assessment that the Georgia's Independent Living Program has adopted as a standard part of case planning. Youth will have their Independent Living Strengths and Needs assessed through the appropriate Ansell-Casey Life Skills Assessment (ACLSA).

Bullying - Deliberately hurtful behavior, usually repeated over a period of time, where it is difficult for those bullied to defend themselves. It can take many forms, but the three main types are physical (e.g. hitting, kicking, theft), verbal (e.g. racist or homophobic remarks, threats, name calling) and emotional (e.g. isolating an individual from the activities and social acceptance of their peer group). The damage inflicted by bullying can frequently be underestimated. It can cause considerable distress to children, to the extent that it affects their health and development or, at the extreme, causes them significant harm (including self-harm). All settings in which children are provided with services or are living away from home should have in place rigorously enforced anti-bullying strategies.

Chemical Restraints - Drugs that that are administered to manage a youth's behavior in a way that reduces the safety risk to the youth or others; that have the temporary effect of restricting the youth's freedom of movement; and that are not being used as part of a standard regimen, as specified in the youth's treatment plan, to treat current symptoms of a medical or psychiatric condition.

Child Abuse - (O.C.G.A.19-7-5):

- Physical injury or death inflicted upon a child by a parent or caretaker by other than accidental means; provided however, physical forms of discipline may be used as long as there is no physical injury to the child;
- Neglect or exploitation of a child by a parent or caretaker;
- Sexual abuse of a child; or
- Sexual exploitation of a child.

Child/Youth - A person less than 18 years of age or considered to be a minor under State law.

Corporal Punishment - This is any physical punishment of a child to inflict pain as a deterrent to wrong doing. It may produce transitory pain and potential bruising. If pain and bruising are not excessive or unduly severe and result only in short-term discomfort, this is not considered maltreatment.

Criminal Records Check - Statement regarding results of criminal records check by way of GCIC and NCIC fingerprint screenings for all adult household members eighteen (18) years and older residing temporarily or permanently in the home and having access to the children. If an adult residing in the home has a criminal record history and the home is being recommended for approval, discussion of the offense and justification for approval are required (Refer to Section 104.7 and Policy 1014.27 in the Foster Care Manual). Live Scan results of GBI and NCIC reports must be kept in a locked file.

Emergency Safety Intervention (E.S.I.) - Those behavior management techniques that are authorized by an approved individualized emergency safety intervention plan; emergency safety interventions are only utilized by properly trained staff in an urgent situation to prevent a consumer from doing immediate harm to self or others.

Every Child Every Month (ECEM)- Purposeful contacts with the child monthly.

Every Parent Every Month (EPEM) – Purposeful contacts with child's parents or other permanency person monthly.

Family Team Meeting – Is a task oriented, facilitated, structured meeting which exist to craft, implement or change the individualized child and family plan; or to make critical case decisions regarding child safety, permanency and well-being.

Foster Care - A Federal-State program that provides financial support to a person, family, or institution that is raising a child or children that are not their own.

GaDOE – Georgia Department of Education www.doe.k12.ga.us

Individualized Service Plan – Provider's service plan for the child.

Individual Skills Plan – Provider's service plan for youth age 14 years and up focusing on independent living skills.

LEA – Language Assistance Program

Maltreatment - This refers to one or more forms of neglect, abuse or exploitation. It may be used as a general term or in reference to a specific category such as neglect, physical abuse, emotional neglect, medical neglect, emotional abuse, sexual abuse, exploitation or exposure to family violence.

Mandated Reporter - This is a person required to report known or suspected child abuse, neglect or exploitation under penalty of law for failure to report. Mandated reporters include physicians, osteopathic physicians, interns, residents and other hospital personnel, dentists, psychologists, podiatrists, nursing personnel, social work personnel (including all DFCS professional staff), school teachers and administrators, school guidance counselors, child care personnel, day care personnel, law enforcement personnel, child counseling and child service organization personnel.

Medical Neglect - This is a form of neglect involving the absence or omission of essential medical care or services, causing harm or seriously threatening harm to the physical or emotional health of a child younger than eighteen years. It includes the withholding of medically indicated treatment for disabled infants with life-threatening conditions.

Multi-Disciplinary Team (MDT) Meeting - Multiple disciplines meets to review all relevant aspects of the child's case information. It is the team's responsibility to make the best and most appropriate recommendations for services and placement (if appropriate) that meets the needs of the child and family. The team will select reasonable, achievable goals/objectives that are positively stated, measurable, clear, concise, and address the specific behaviors or conditions that must be corrected for the child to be safely returned to the parent and incorporated into the initial case plan.