



Region 12

Biennial Regional Services Strategic Plan Child Protection Plan and Service Array Plan

Section 5 – Service Array Appendix

SFY 2013-2014

February 2, 2012

**Biennial Regional Services Strategic Plan
Service Array Appendix**

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Service Array

Service Standard-August 26, 2011R	Revision/Clarification
Adoption	
Family Prep	“Reports” language added (Section II) and Reports billable unit to Billable Unit (Section VI).(June 7, 2011)
Family Centered Services	
Home-Based Family Centered Casework Services	Crisis Service Language added (Section IV) (May 5, 2011)
Home-Based Family Centered Casework Services	“Reports” language added (Section V) and Reports billable unit to Billable Unit (Section IX). (June 7, 2011)
Home-Based Family Centered Therapy Services	Crisis Service Language added (Section IV) (May 5, 2011)
Home-Based Family Centered Therapy Services	“Reports” language added (Section V) and Reports billable unit to Billable Unit (Section IX) (June 7, 2011)
Homemaker/Parent Aid	Crisis Service Language added (Section III) (May 5, 2011)
Homemaker/Parent Aid	“Reports” language added (Section IV) and Reports billable unit to Billable Unit (Section VIII) (June 8, 2011)
Homemaker/Parent Aid	Life Skills Training not Provision of Child Care added to Care of Children(Section I) (August 26, 2011)
Other Services	
Care Network	“Reports” language added (Section IV) and Reports billable unit to Billable Unit (Section VIII) (June 8, 2011)
Counseling	Initial Assessment added as a bullet point in second paragraph of what the Professional staff provides under Section I. Service Description (March 8, 2011)
Counseling	“Reports” language added (Section IV) and Reports billable unit to Billable Unit (Section VIII) (June 8, 2011)

Diagnostic and Evaluation Services	“Reports” language added (Section III) and Reports billable unit to Billable Unit (Section VII) (June 8, 2011)
Diagnostic and Evaluation Services	“Comprehensive Report” language added to Service Delivery (Section II) and Comprehensive Report Billable Component added to Billable Unit (Section VII) (July 21, 2011)
Diagnostic and Evaluation Services	Under Clinical Interview and Assessment in Service Delivery (Section II)-bullet point for Bio-psychological assessment /bullet point for Parenting Functioning assessment deleted.(July 7, 2011)
Domestic Violence-Batterer Intervention Services	“Reports” language added (Section III) and Reports billable unit to Billable Unit (Section VII) (June 8, 2011)
Domestic Violence-Batterer Intervention Services	“Therapeutic DV Batterer Intervention” added to Section II and to Per Person Per Group-Therapeutic DV Batterer Intervention billable unit to Billable Unit (Section VII) (July 12,2011)
Domestic Violence-Batterer Intervention Services	Per Person Per Group billable unit added to Billable Unit (Section VII)(July 12, 2011)
Domestic Violence-Batterer Intervention Services	II Service Delivery: Therapeutic DV Batterer Intervention facilitator qualifications revised. (August 26, 2011)
Domestic Violence-Survivor and Child Intervention Services	“Reports” language added (Section III) and Reports billable unit to Billable Unit (Section VII) (June 8, 2011)
Father Engagement Programs	“Reports” language added (Section III) and Reports billable unit to Billable Unit (Section VII) (June 8, 2011)
Father Engagement Programs	Billing language for additional collateral contacts added to Billable Unit (Section VII0 (July 7, 2011_
Parent Education	“Reports” language added (Section II) and Reports billable unit to Billable Unit (Section VI) (June 8, 2011)
Parent Education	“Group” definition revised in Billable Unit (Section VII), June 10,2011
Parenting/Family Functioning	“Reports” language added (Section III) and

Assessment	Reports billable unit to Billable Unit (Section VII) (June 8, 2011)
Sex Offender Treatment	“Reports” language added (Section IV) and Reports billable unit to Billable Unit (Section VIII) (June 8, 2011)
Transition From Restrictive Placement	Removed the following sentence: “Transition from Restrictive Placement (TRP) is a court-ordered program for youth adjudicated a CHINS or JD/JS” (Section I) (April 21, 2011)
Transition From Restrictive Placement	“Reports” language added (Section IV) and Reports billable unit to Billable Unit (Section VIII) (June 8, 2011)
Addictions	
Drug Testing & Supplies	Language added to I. Service Description: “The drug test list includes Drugs of Abuse (illegal drugs), Therapeutic Drugs (Prescription Drugs-Painkillers, Mental Health Meds, etc.) and Designer drugs (i.e. Ks, “Spice”). (March 21, 2011)
Random Drug Testing	Language added to I. Service Description: “The drug test list includes Drugs of Abuse (illegal drugs), Therapeutic Drugs (Prescription Drugs-Painkillers, Mental Health Meds, etc.) and Designer drugs (i.e. Ks, “Spice”). (March 21, 2011)
Detoxification Services	“Reports” language added (Section III) and Reports billable unit to Billable Unit (Section VII) (June 8, 2011)
Substance Use Disorder Assessment	“Reports” language added (Section IV) and Reports billable unit to Billable Unit (Section VIII) (June 8, 2011)
Substance Use Outpatient Treatment	“Reports” language added (Section IV) and Reports billable unit to Billable Unit (Section VIII) (June 8, 2011)

Service	Service Standard	Method of Payment	
		DCS funding	
		Medicaid Rehabilitation Option (MRO)	
		Medicaid Clinic Option (MCO)	Page Numbers
ADOPTION	Child Preparation	DCS	7
	Family Preparation (Revised 6/7/11-Effective 7/1/11)	DCS	12
FAMILY CENTERED SERVICES	Home-Based Family Centered Casework Services (Revised 5/5/11-Effective 7/1/11)	DCS/MRO	18
	Home-Based Family Centered Therapy Services(Revised 6/7/11-Effective 7/1/11)	DCS/MRO	28
	Homemaker/Parent Aid (Revised 8/26/11-Effective 7/1/11)	DCS	37
RESOURCE PARENT SERVICES	Resource Family Support Services	DCS	45
	Support Group Services for Resource Families	DCS	49
	Foster Home Studies / Updates / Relicensing Studies	DCS	52
OTHER SERVICES	Care Network (Revised 6/8/11-Effective 7/1/11)	DCS/MRO/	56
	CHINS Parent Support Services	DCS	64
	Counseling (Revised 6/8/11-Effective 7/1/11)	DCS/MRO/MCO	69

	Cross-System Care Coordination	DCS	77
	Diagnostic and Evaluation Services (Revised 7/7/11-Effective 7/7/11)	DCS/MCO	84
	Domestic Violence - Batterer Intervention Services (Revised 8/26/11-Effective 8/26/11)	DCS	92
	Domestic Violence - Survivor and Child Intervention Services (Revised 6/8/11-Effective 7/1/11)	DCS	100
	Father Engagement Programs (Revised 7/7/11-Effective 7/7/11)	DCS	110
	Functional Family Therapy	DCS	117
	Parent Education (Revised 6/10/11-Effective 7/1/11)	DCS	123
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	Quality Assurance for Children in Residential Placement	DCS	134
	Sex Offender Treatment (Revised 6/8/11-Effective 7/1/11)	DCS/MRO/MCO	138
	Transition from Restrictive Placement (Revised 6/8/11-Effective 7/1/11)	DCS/MRO/MCO	145

	Tutoring/Literacy Classes	DCS	153
	Visitation Facilitation-Parent/Child/Sibling	DCS	159
ADDICTIONS	Drug Testing and Supplies (Revised 3/21/11-Effective 7/1/11)	DCS	166
	Random Drug Testing (Revised 3/21/11-Effective 7/1/11)	DCS	172
	Detoxification Services (Revised 6/8/11-Effective 7/1/11)	DCS/MCO/MRO	178
	Residential Substance Use Treatment	DCS/MCO	182
	Substance Use Disorder Assessment (Revised 6/8/11-Effective 7/1/11)	DCS/MCO	187
	Substance Use Outpatient Treatment (Revised 6/8/11-Effective 7/1/11)	DCS/MCO/MRO	193
PROBATION SERVICES (primarily)	Day Reporting/Treatment	DCS	202
	Truancy Termination	DCS	207

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

I. Service Description

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

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

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

Supportive Services

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

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

II. Target Population

- 1) Children who are free for adoption.
- 2) Children who have a permanency plan of adoption.
- 3) Children who have termination of parental rights initiated with an expected plan of adoption.

III. Goals and Outcome Measures

Goal #1

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

Outcome Measures

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

Goal #2

Increase the child's understanding of adoption.

Outcome Measures

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

Goal #3

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

Outcome Measures

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

Goal #4
DCS and child satisfaction with services
Outcome Measure

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

IV. Minimum Qualifications

Direct Worker:

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

Supervisor:

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

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

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

In addition the worker must have:

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

V. Billable Units

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

Translation or sign language

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

Group

Services include group goal directed work with clients. To be billed per group hour.

Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

• 0 to 7 minutes	do not bill	0.00 hour
• 8 to 22 minutes	1 fifteen minute unit	0.25 hour
• 23 to 37 minutes	2 fifteen minute units	0.50 hour
• 38 to 52 minutes	3 fifteen minute units	0.75 hour
• 53 to 60 minutes	4 fifteen minute units	1.00 hour

- **Court:** The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

VI. Case Record Documentation

- 1) A completed, dated, signed DCS referral form authorizing service
- 2) Documentation of contacts with the child and activities related to the preparation with the child.
- 3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

VII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS. Providers must initiate a re-authorization for services to continue beyond the approved period.

VIII. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
FAMILY PREPARATION/HOME STUDY
(Revised 6/7/11-Effective 7/1/11)

I. Service Description

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

- 1) Home study should address specific children if the following applies: a child has been identified to be placed or has already been placed in the home, such as in the case for foster to adopt and kinship adoption
- 2) Child Behavior Challenges Checklist
- 3) Reference forms completed by four (4) of which one (1) may be a relative
- 4) Financial profile
- 5) Medical Report for Foster Care/Adoption
- 6) Application for Foster Family/Adoptive/Approved Relative Home
- 7) Background check for all persons in the household:
 - a. See State Child Welfare Policies for details and directions.
- 8) Consent to Release of Information for Foster Family Home License or Adoption
- 9) Outline for Adoption/Foster Family Preparation Summary

Family Assessment

The Family Assessment Process includes the initial contact with a family, the application, several home visits at convenient times for the parent(s) including evenings and weekends if necessary. The process may include but is not limited to the following:

- processing the family's references, medical information forms, financial forms and all other necessary state forms
- creating with the family, family genograms, eco-map, etc
- preparing other members of the household who will affect the success of an adoption because of their relationship to the family, such as a live-in grandparent or a relative who is always at the home during the day
- using the challenges checklist as a learning tool to review common challenges the children have with the family and to gauge the families degree of acceptance of the child's needs/challenges and to help the family self-evaluate to determine how such needs/challenges will impact the family now and in the future as well as if special needs adoption is for them
- assists the family with pre-placement family support services and
- serving as advocate for the family throughout the adoption process

The Family Preparation should include the family's feelings about adoption and experiences with parenting as well as pertinent issues specific to adoption. Preparation should also prepare adoptive parents in understanding the commitment they are making to provide a permanent home for the child or children they will be including in their family whether young children, adolescents, or sibling groups. The contractor will engage in a dialogue with family members, providing information on all aspects of child abuse and neglect, typical resulting behaviors, common characteristics of children in the system and assist the family in planning and foreseeing what is needed for their own specific successful parenting of these children. The contractor will explore with the family the types of children that they feel able to parent and the specific special needs with which they can work.

The contractor will also make a recommendation about the family's ability to meet the needs of children in Indiana's custody. The assessment criteria must include but not be limited to specific children to be placed in the home, if a child has already been identified for the home.

Foster and Kinship Care Families

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

Foster/Adopt Families and Pre-Adoptive Families

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

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

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

- Services will be arranged at the convenience of the family and to meet the specific needs of the family.

II. When DCS is not paying for services:

A billable unit of “Reports” has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

III. Target Population

- 1) Families who are willing to parent a child or a sibling group of children, in Indiana's custody.
- 2) Families for whom adoptive home study update has been requested by the DCS.
- 3) ICPC requests for studies of Indiana families as potential placement for relative children from other states.

IV. Goals and Outcome measures

Goal#1

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

Outcome Measures

- 1) 95% of families referred will have their home study completed within 60 days of the referral.
- 2) 95% of families, who are approved by the SNAP Council, will not need additional work done or will have the recommended additions or changes completed within 30 days as recommended by the Council.

Goal #2

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

Outcome Measures

- 1) 95% of families with completed home studies will be sent to SNAP Council Team for approval within 30 days of the completion of the home study.
- 2) 100% of prepared adoptive families, who are in need of recruitment, will be presented at SNAP Council Team for approval.

Goal #3

Increase the number of adoptions of children.

Outcome Measures

- 1) 95% of families prepared for adoption will have an understanding of the special needs of a child(ren) that is being blended into their family through adoptive placement.

Goal #4

DCS and family awareness of available services

Outcome Measure

- 1) 95% of families will report an understanding of the adoption process to the SNAP Specialist.
- 2) 100% of families will be made aware of post adoptive services available to them.
- 3) DCS satisfaction will be rated level 4 and above on the Service Satisfaction Report.

V. Minimum Qualifications

Direct Worker:

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

Supervisor:

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

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

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

In addition to:

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

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

VI. Billable Units

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

The hourly rate includes face to face contact with the identified client/family members and professional time involved preparing the assessment report. Includes collateral contacts, case conferencing, follow up with the family, SNAP Team presentation at Statewide Council; and travel.

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

Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

- | | | |
|--------------------|------------------------|-----------|
| • 0 to 7 minutes | do not bill | 0.00 hour |
| • 8 to 22 minutes | 1 fifteen minute unit | 0.25 hour |
| • 23 to 37 minutes | 2 fifteen minute units | 0.50 hour |
| • 38 to 52 minutes | 3 fifteen minute units | 0.75 hour |
| • 53 to 60 minutes | 4 fifteen minute units | 1.00 hour |

Translation or sign language

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

Court: The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

Reports: If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.

VII. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services.
- 2) Documentation of contacts regarding foster parent interest in adopting children in their care or other children available. OR Documentation of all contacts with potential adoptive family and a record of services provided with goals and objectives of the services and dates of service.
- 3) Documentation includes a copy of the written home studies for all prospective families following the outline in the Child Welfare Policies.

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS. In the event a service provider receives verbal or email authorization to provide services from DCS an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS. Providers must initiate a re-authorization for services to continue beyond the approved period.

IX. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
HOME-BASED FAMILY CENTERED CASEWORK SERVICES
(Revised 6/7/11-Effective 7/1/11)

I. Services Description

Provision of home-based casework services for families involved with DCS/Probation. Home-based casework is also available for pre-adoption and post-adoption services for adoptive families at risk or in crisis. These in-home services should be high quality, family centered, and culturally competent. They should be effective in reducing maltreatment, improving caretaking and coping skills, enhancing family resilience, supporting healthy and nurturing relationships, and children's physical, mental, emotional and educational well-being. Home-Based Casework Services should help to safely maintain children in their homes (or foster home); prevent children's initial placement or reentry into foster care; preserve, support, and stabilize families; and promote the well-being of children, youth, and families. Home-based Caseworker Services (HCS) provides any combination of the following kinds of services to the families as approved by DCS/Probation:

- Home visits
- Participation in DCS Case planning
- Supervised visitation **
- Coordination of services
- Conflict management
- Emergency/crisis services
- Child development education
- Domestic violence education
- Parenting education/training
- Family communication
- Facilitate transportation*
- Participation in Child and Family Team meetings
- Family reunification/preservation
- Reactive Attachment Disorder (RAD) support
- Foster family support
- Advocacy
- Family assessment
- Community referrals and follow-up
- Develop structure/time management
- Behavior modification
- Budgeting/money management
- Meal planning/preparation
- Parent training with children present
- Monitor progress of parenting skills
- Community services information
- Develop long and short-term goals

* HCS transport limited to client goal-directed, face-to-face as approved/specified as part of the case plan or goals/objectives identified at the Child and Family Team Meeting. (e.g. housing/apartment search, etc.)

**Supervised Visits will be billed separately from other services within this standard. The “Visitation Monthly Progress Report” form must be used to report the supervised visitation portion of the services provided. The “Monthly Progress Report” will be used for the remainder.

II. Service Delivery

- 1) Service provision must occur with face-to-face contact with the family within 48 hours of referral.
- 2) Services must include 24 hour crisis intake, intervention, and consultation seven days a week and must be provided primarily in the family's home. Limited services may also be provided at a community site.
- 3) Services must include ongoing risk assessment and monitoring family/parental progress.
- 4) The family will be the focus of service, and services will focus on the strengths of the family and build upon these strengths. Members of the client family, which may include foster parents, are to be defined in consultation with the family and approved by DCS/Probation. This may include persons not legally defined as part of the family. Approved family members will be documented as those listed on the authorizing DCS/Probation referral and subsequent written documents.
- 5) Services will be time-limited and focused on limited objectives derived directly from the established DCS/Probation case plan or Informal Adjustment.
- 6) Services must include development of short and long-term family goals with measurable outcomes that are consistent with the DCS case plan.
- 7) Services must be family centered and child focused.
- 8) Services may include intensive in-home skill building and must include after-care linkage.
- 9) Services include providing monthly progress reports; requested supportive documentation such as case notes, social summaries, etc.; and requested testimony and/or court appearances including hearings and/or appeals; case conferences/staffing. Monthly reports are due by the 10th of each month following the month of service.
- 10) Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
- 11) Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life style choices, and complex family interactions and be delivered in a neutral-valued culturally-competent manner.
- 12) The caseload of the HCS will include no more than 12 active families at any one time.
- 13) Services will be provided within the context of the DCS practice model or Probation plan with involvement in Child and Family Team (CFT) meetings if invited. A treatment plan will

be developed based on assessment by the provider and agreements reached in the Child and Family Team meetings and/or documented in the authorizing referral.

- 14) Each family receives comprehensive services through a single HCS acting within a team, with team back up and agency availability 24 hours a day, 7 days a week.
- 15) DCS may choose to select a standardized tool for evaluating family functioning. Services will include administration of this tool at the initiation of services as well as periodically during service provision.

III. Medicaid

For those families and children not eligible for Medicaid Rehabilitation Option, this service will be paid by DCS. For eligible families and children, some services may be provided through Medicaid Rehabilitation Option (MRO) with the remaining services paid by DCS. While the primary focus of these services is on the needs of the family, it is expected that some of these services will be deemed medically necessary to meet the behavioral health care needs of the MRO eligible client, and therefore may be billable to MRO. The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The Services not eligible for MRO may be billed to DCS.

IV. Crisis Service

“Safely Home Families First” is the Indiana Department of Child Services (DCS) Initiative for 2011. Our goal is to keep as many children “Safely Home” with their caretakers when possible. When removal of a child is necessary, then placement should be with “Families First.” Placing children with relatives is the next healthiest action to take, regarding meeting a child’s safety needs as well as their emotional needs. Crisis services may be necessary to prevent the removal of the child(ren). The family centered practice of the home based services is the best avenue to provide crisis services.

These crisis services are for families who have children at imminent risk of removal. Imminent risk is defined as: Immediate threat of injury or harm to a child when *no interventions* have occurred to protect the child. Goal is to resolve the immediate crisis, prevent removal of the child, and to transition and/or link the family to needed services.

Criteria for service:

- The crisis intervention provider must be available for contact 24/7.
- The provider must have a crisis intervention telephone number.
- The FCM will notify the Provider of a crisis situation and require a 1 hour response on the part of the provider.
- One (1) hour response time required. (No more than 1 hour from phone call to provider to a face to face contact with the family by the provider.)
- Referrals would be for families who are not currently receiving home based services (Home Based Casework, Home Based Therapy, Homemaker, or Homebuilders). Crisis Intervention services to existing clients in Home Based Services are already included as part of the service standards.
- Crisis Intervention includes, but is not limited to, crisis assessment, planning and counseling specific to the crisis. Most interventions are expected to be in the home.
- Crisis payment is for the “incident only”. The “incident” for payment purposes for the provider will start at the time of a face to face contact with the client and end when that face to face contact ends.
- A Crisis Report shall be electronically sent to the FCM within 24 hours. This report should document the start time and end time of the intervention. It shall report the assessment of the situation and recommendations for services, if any.
- The referral for this service will be after the incident and will include ongoing services if deemed necessary.

V. When DCS is not paying for services:

A billable unit of “Reports” has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

VI. Target Population

Services must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- 2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
- 4) All adopted children and adoptive families.

Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need.

VII. Goals and Outcomes

Goal #1

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

Objectives:

- 1) HCS or back-up is available for consultation to the family 24-7 by phone or in person.

Fidelity Measures:

- 1) 95% of all families that are referred will have face-to-face contact with the client within 48 hours of receipt of the referral or inform the current Family Case Manager/Probation Officer if the client does not respond to requests to meet.
- 2) 95% of families will have a written treatment plan prepared and sent to the current Family Case Manager/Probation Officer following receipt of the referral within 30 days of contact with the client.
- 3) 100% of all families will have monthly written summary reports prepared and sent to the current Family Case Manager/Probation Officer by the 10th of the month following the services.

Goal #2 Clients will achieve improved family functioning.

Objectives:

- 1) Goal setting, and service planning are mutually established with the client and Home Based Caseworker within 30 days of the initial face-to-face intake and a written report signed by the Home Based Caseworker and the client is submitted to the current FCM/ Probation Officer.

Client Outcome Measures:

- 1) 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period
- 2) 90% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of “substantiated” abuse or neglect throughout the service provision period. (To be measured/evaluated by DCS/Probation staff)
- 3) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.
- 4) If DCS elects to implement a standardized tool for evaluating family functioning, a related outcome measure will be added.

Goal #3 DCS/ Probation and clients will report satisfaction with services.

Outcome Measures:

- 1) DCS/ Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 90% of clients will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

VIII. Minimum Qualifications

Direct Worker:

Bachelor's degree in social work, psychology, sociology, or a directly-related human service field from an accredited college. Must possess a valid driver's license and the ability to use private car to transport self and others, and must comply with the state policy concerning minimum car insurance coverage.

In addition to the above:

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

Supervisor:

Master's or Doctorate degree in social work, psychology, or directly-related human services field from an accredited college.

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

Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with “best practices” and comply with the requirements of each provider’s accreditation body. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies. Under no circumstances is supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.

IX. Billable Unit

Medicaid: Services through the Medicaid Rehab Option (MRO) may be Case Management and/or Skills Training & Development. Medicaid shall be billed when appropriate.

- Medically necessary behavioral health care Skills Training and Development services for the MRO will be paid per 15 minute unit for Individual and Family per 15 minute unit for group.
- Medically necessary behavioral health care Case Management for the MRO child will be paid per 15 minute unit. Case Management services should not exceed those included in the MRO package.

Billing Code	Description
T1016 HW	Case Management, each 15 minutes
H2014 HW	Skills Training and Development , per 15 minutes
H2014 HW HR	Skills Training and Development, per 15 minutes (family/couple, consumer present)
H2014 HW HS	Skills Training and Development, per 15

	minutes (family/couple, without consumer present)
H2014 HW U1	Skills Training and Development , per 15 minutes (group setting)
H2014 HW HR U1	Skills Training and Development , per 15 minutes (group setting, family/couple, with consumer present)
H2014 HW HS U1	Skills Training and Development , per 15 minutes (group setting, family/couple, without consumer present)

DCS holds overall Case Management responsibility. In order to assist DCS with the coordination of medically necessary behavioral health care needs of the MRO client, CMHC's may provide case management services with this specific focus.

DCS Funding: Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below. These billable units will also be utilized for services to referred clients who are not Medicaid eligible and for those providers who are unable to bill Medicaid. .

Face to face time with the client:

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

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.
- Includes in-vehicle (or in-transport) time with client provided it is identified as goal-directed, face-to-face, and approved/specified as part of the client's intervention plan (e.g. housing/apartment search, etc.).
- Includes crisis intervention and other goal-directed interventions via telephone with the identified client family.
- Includes time spent completing any DCS approved standardized tool to assess family functioning.

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

Supervised Visit:

** Time spent supervising visits will be billed separately from other services within this standard. The rate will be the same as the face-to-face rate, but will include only time spent face-to-face supervising the visit. Any other billable time as defined in the face-to-face rate, should be billed under the face-to-face rate.

Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

- 0 to 7 minutes do not bill 0.00 hour
- 8 to 22 minutes 1 fifteen minute unit 0.25 hour
- 23 to 37 minutes 2 fifteen minute units 0.50 hour
- 38 to 52 minutes 3 fifteen minute units 0.75 hour
- 53 to 60 minutes 4 fifteen minute units 1.00 hour

Translation or sign language

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

Court

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS or subpoena to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

Reports

If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.

X. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

XI. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

XII. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD INDIANA DEPARTMENT OF CHILD SERVICES

Department of Child Services

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Regional Document for Child Welfare Services

Term 7/1/11-6/30/13

July 2011

HOME-BASED FAMILY CENTERED THERAPY SERVICES (Revised 6/7/11-Effective 7/1/11)

I. Service Description

This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation. These in-home services should be high quality, family centered, and culturally competent.

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

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

- Family of origin/intergenerational issues
- Family organization (internal boundaries, relationships, roles)
- Stress management
- Self-esteem
- Communication skills
- Conflict resolution
- Behavior modification
- Parenting skills/Training
- Substance abuse
- Crisis intervention
- Strengths based perspective
- Adoption issues
- Participation in Child and Family Team meetings
- Sex abuse
- Goal setting
- Family structure (external boundaries, relationships, socio-cultural history)
- Problem solving
- Support systems
- Interpersonal relationships
- Therapeutic supervised visitation**
- Family processes (adaptation, power authority, communications, META rules)
- Cognitive behavioral strategies
- Brief therapy
- Family reunification/preservation
- Grief and loss
- Domestic violence education
- Reactive Attachment Disorder (RAD) support

**Supervised Visits will be billed separately from other services within this standard. The “Visitation Monthly Progress Report” form must be used to report the supervised visitation portion of the services provided. The “Monthly Progress Report” will be used for the remainder.

II. Service Delivery

- 1) Services must include 24 hour crisis intake, intervention, and consultation seven days a week and must be provided primarily in the family's home. Limited services may also be provided at a community site.
- 2) Services must include ongoing risk assessment and monitoring family/parental progress.
- 3) The family will be the focus of service and services will focus on the strengths of the family and build upon these strengths. Members of the client family, which may include foster parents, are to be defined in consultation with the family and approved by DCS/Probation. This may include persons not legally defined as part of the family. Approved family members will be documented as those listed on the authorizing DCS/Probation referral and subsequent written documents.
- 5) Services will be time-limited and focused on limited objectives derived directly from the established DCS/Probation case plan or Informal Adjustment.
- 6) Services must include development of short and long-term family goals with measurable outcomes.
- 7) Services must be family focused and child centered.
- 8) Services may include intensive in-home skill building and must include after-care linkage.
- 9) Services include providing monthly progress reports; requested supportive documentation such as case notes, social summaries, etc.; and requested testimony and/or court appearances including hearings and/or appeals; case conferences/staffing.
- 10) Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
- 11) Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life style choices, and complex family interactions and be delivered in a neutral-valued culturally-competent manner.
- 12) The caseload of the Home-Based Family Centered Therapist (HBFCT) will include no more than 12 active families at any one time.
- 13) Services will be provided within the context of the DCS practice model or Probation plan with involvement in Child and Family Team (CFT) meetings if invited. A treatment plan will be developed based on agreements reached in the Child and Family Team meetings and/or documented in the authorizing referral.
- 14) Each family receives comprehensive services through a single HBFCT acting within a team, with team back up and agency availability 24 hours a day, 7 days a week.
- 15) DCS may choose to select a standardized tool for evaluating family functioning. Services will include administration of this tool at the initiation of services as well as periodically during service provision.

III. Medicaid

For those families and children not eligible for Medicaid Rehabilitation Option, this service will be paid by DCS. For eligible families and children, some services may be provided through Medicaid Rehabilitation Option (MRO) with the remaining services paid by DCS. While the primary focus of these services is on the needs of the family, it is expected that some of these services will be deemed medically necessary to meet the behavioral health care needs of the MRO eligible client, and therefore may be billable to MRO. The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The Services not eligible for MRO may be billed to DCS.

IV. Crisis Service

"Safely Home Families First" is the Indiana Department of Child Services (DCS) Initiative for 2011. Our goal is to keep as many children "Safely Home" with their caretakers when possible. When removal of a child is necessary, then placement should be with "Families First." Placing children with relatives is the next healthiest action to take, regarding meeting a child's safety needs as well as their emotional needs. Crisis services may be necessary to prevent the removal of the child(ren). The family centered practice of the home based services is the best avenue to provide crisis services.

These crisis services are for families who have children at imminent risk of removal. Imminent risk is defined as: Immediate threat of injury or harm to a child when *no interventions* have occurred to protect the child. Goal is to resolve the immediate crisis, prevent removal of the child, and to transition and/or link the family to needed services.

Criteria for service:

- The crisis intervention provider must be available for contact 24/7.
- The provider must have a crisis intervention telephone number.
- The FCM will notify the Provider of a crisis situation and require a 1 hour response on the part of the provider.
- One (1) hour response time required. (No more than 1 hour from phone call to provider to a face to face contact with the family by the provider.)
- Referrals would be for families who are not currently receiving home based services (Home Based Casework, Home Based Therapy, Homemaker, or Homebuilders). Crisis Intervention services to existing clients in Home Based Services are already included as part of the service standards.
- Crisis Intervention includes, but is not limited to, crisis assessment, planning and counseling specific to the crisis. Most interventions are expected to be in the home.

- Crisis payment is for the “incident only”. The “incident” for payment purposes for the provider will start at the time of a face to face contact with the client and end when that face to face contact ends.
- A Crisis Report shall be electronically sent to the FCM within 24 hours. This report should document the start time and end time of the intervention. It shall report the assessment of the situation and recommendations for services, if any.
- The referral for this service will be after the incident and will include ongoing services if deemed necessary.

V. When DCS is not paying for services:

A billable unit of “Reports” has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

VI. Target Population

Services must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or CHINS status.
- 2) Children and their families which have an IA or the children have the status of CHINS or JD/JS.
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
- 4) Any child who has been adopted and adoptive families.

Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need.

VII. Goals and Outcomes

Goal #1 Maintain timely intervention with the family and regular timely communication with referring worker.

Objectives:

- 1) HCS or back-up is available for consultation to the family 24-7 by phone or in person.

Fidelity Measures:

- 1) 95% of all families that are referred will have face-to-face contact with the client within 48 hours of receipt of the referral or inform the current Family Case Manager/Probation Officer if the client does not respond to requests to meet.
- 2) 95% of families will have a written treatment plan prepared and sent to the current Family Case Manager/Probation Officer following receipt of the referral within 30 days of contact with the client.
- 3) 95% of all families will have monthly written summary reports prepared and sent to the current Family Case Manager/Probation Officer by the 10th of the month following the services.

Goal #2 Clients will achieve improved family functioning.

Objectives:

- 1) Goal setting, and service planning are mutually established with the client and Home Based Therapist within 30 days of the initial face-to-face intake and a written report signed by the Home Based Therapist and the client is submitted to the current FCM/ Probation Officer.

Client Outcome Measures:

- 1) 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period
- 2) 90% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of “substantiated” abuse or neglect throughout the service provision period. (To be measured/evaluated by DCS/Probation staff)
- 3) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period
- 4) If DCS elects to implement a standardized tool for evaluating family functioning, a related outcome measure will be added.

Goal #3DCS/ Probation and clients will report satisfaction with services.

Outcome Measures:

- 1) DCS/ Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 90% of clients will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

VIII. Minimum Qualifications

MRO:

Department of Child Services
 Regional Document for Child Welfare Services
 Term 7/1/11-6/30/13
 July 2011

Providers must meet the either of the following qualifications:

- Licensed professional, except for a licensed clinical addiction counselor
- Qualified Behavioral Health Professional (QBHP)

DCS Direct Worker:

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

Must possess a valid driver's license and the ability to use a private car to transport self and others, and must comply with the state policy concerning minimum car insurance coverage.

In addition to the above:

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

Supervisor:

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

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

Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with "best practices" and comply with the requirements of each provider's accreditation body. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies. Under no circumstances is

supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.

IX. Billable Units

Medicaid: Services through the Medicaid Rehab Option (MRO) may be Behavioral Health Counseling and Therapy. Medicaid shall be billed when appropriate.

- Medically necessary behavioral health care services for MRO will be paid per 15 minute unit for Individual and Family per 15 minute unit for group.

Billing Code	Title
H0004 HW	Behavioral health counseling and therapy, per 15 minutes
H0004 HW HR	Behavioral health counseling and therapy, per 15 minutes (family/couple, with consumer present)
H0004 HW HS	Behavioral health counseling and therapy, per 15 minutes (family/couple, without consumer present)

DCS Funding: Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below. These billable units will also be utilized for services to referred clients who are not MRO eligible and for those providers who are unable to bill Medicaid. .

Face to face time with the client:

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

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

- Includes in-vehicle (or in-transport) time with client provided it is identified as goal-directed, face-to-face, and approved/specified as part of the client’s intervention plan (e.g. housing/apartment search, etc.).
- Includes time spent completing any DCS approved standardized tool to assess family functioning.

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

Therapeutic Supervised Visit:

** Time spent supervising visits will be billed separately from other services within this standard. The rate will be the same as the face-to-face rate, but will include only time spent face-to-face supervising the visit. Any other billable time as defined in the face-to-face rate, should be billed under the face-to-face rate.

Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

- | | | |
|--------------------|------------------------|-----------|
| • 0 to 7 minutes | do not bill | 0.00 hour |
| • 8 to 22 minutes | 1 fifteen minute unit | 0.25 hour |
| • 23 to 37 minutes | 2 fifteen minute units | 0.50 hour |
| • 38 to 52 minutes | 3 fifteen minute units | 0.75 hour |
| • 53 to 60 minutes | 4 fifteen minute units | 1.00 hour |

Translation or sign language

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

Court

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

Reports

If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.

X. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services
- 2) Documentation of regular contact with the referred families/children
- 3) Written progress reports no less than monthly or more frequently as prescribed by DCS/Probation and requested supportive documentation such as case notes, social summaries, etc. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

XI. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

XII. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
HOMEMAKER / PARENT AID
(Revised 8/26/11-Effective 7/1/11)

I. Service Description

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

- Time management
- Care of children (Life Skills Training not the provision of Child Care)
- Child development
- Health care
- Community resources (referrals)
- Transportation *
- Supervise visitation with child(ren)**
- Identify support systems
- Problem solving
- Family reunification/preservation

- Resource management/Budgeting
- Child safety
- Child nutrition
- Home management
- Parenting skills
- Housing
- Self esteem
- Crisis resolution
- Parent/child interaction
- Supervision

*Homemaker transportation limited to client goal-directed, face-to-face as approved/specified as part of the case plan or goals/objectives identified at the Child and Family Team Meeting. (e.g. housing/apartment search, etc)

****Supervised Visits will be billed separately from other services within this standard. The “Visitation Monthly Progress Report” form must be used to report the supervised visitation portion of the services provided. The “Monthly Progress Report” will be used for all other services outlined in this standard.**

II. Service Delivery

Services will be provided in the family’s home, a community site, or in the office (if approved by DCS/Probation), and in the course of assisting with transportation, accompanying the parent(s) during errands, job search, etc.

- 1) Services must be compatible with the established DCS/Probation case plan and authorized by the DCS/Probation referral.
- 2) Transportation can be provided in the course of assisting the client to fulfill the case plan or informal adjustment program, or as part of learning a particular task as specified in the service components, such as visitation, medical appointments, grocery shopping, house/apartment hunting, etc.
- 3) Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
- 4) Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued culturally-competent manner.
- 5) Services will include any requested testimony, for court appearances (to include hearings or appeals), or when requested participate in Child and Family Team (CFT) meetings. (To ensure provider participation, DCS/Probation will give the service provider at least two working days notice in advance of CFT meeting.)
- 6) Services to provide monthly reports outlining progress toward treatment goals. Reports should utilize the DCS approved monthly report form and provided to the Family Case Manager or Probation officer by the 10th day of the month following the month the service was provided.
- 7) Services to families will be available 24 hours per day, 7 days per week.
- 8) Services will focus on the strengths of families and build upon those strengths. Members of the client family, which may include foster parents, are to be defined in consultation with the family and approved by DCS/Probation. This may include persons not legally defined as part of the family and should be listed as part of the referral document or subsequent written documents from the referral source.
- 9) One (1) full-time homemaker/parent aid can have a caseload of no more than 12 active families at any one time.

10) DCS may choose to select a standardized tool for evaluating family functioning. Services will include administration of this tool at the initiation of services as well as periodically during service provision.

III. Crisis Service

"Safely Home Families First" is the Indiana Department of Child Services (DCS) Initiative for 2011. Our goal is to keep as many children "Safely Home" with their caretakers when possible. When removal of a child is necessary, then placement should be with "Families First." Placing children with relatives is the next healthiest action to take, regarding meeting a child's safety needs as well as their emotional needs. Crisis services may be necessary to prevent the removal of the child(ren). The family centered practice of the home based services is the best avenue to provide crisis services.

These crisis services are for families who have children at imminent risk of removal. Imminent risk is defined as: Immediate threat of injury or harm to a child when *no interventions* have occurred to protect the child. Goal is to resolve the immediate crisis, prevent removal of the child, and to transition and/or link the family to needed services.

Criteria for service:

- The crisis intervention provider must be available for contact 24/7.
- The provider must have a crisis intervention telephone number.
- The FCM will notify the Provider of a crisis situation and require a 1 hour response on the part of the provider.
- One (1) hour response time required. (No more than 1 hour from phone call to provider to a face to face contact with the family by the provider.)
- Referrals would be for families who are not currently receiving home based services (Home Based Casework, Home Based Therapy, Homemaker, or Homebuilders). Crisis Intervention services to existing clients in Home Based Services are already included as part of the service standards.
- Crisis Intervention includes, but is not limited to, crisis assessment, planning and counseling specific to the crisis. Most interventions are expected to be in the home.
- Crisis payment is for the "incident only". The "incident" for payment purposes for the provider will start at the time of a face to face contact with the client and end when that face to face contact ends.
- A Crisis Report shall be electronically sent to the FCM within 24 hours. This report should document the start time and end time of the intervention. It shall report the assessment of the situation and recommendations for services, if any.
- The referral for this service will be after the incident and will include ongoing services if deemed necessary.

IV. When DCS is not paying for services:

A billable unit of “Reports” has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

V. Target Population

Services must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- 2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
- 4) All adopted children and adoptive families.

VI. Goals and Outcome Measures

Goal #1 Maintain timely intervention with family regularly, and timely communication with DCS/Probation worker.

Objective:

- 1) Homemaker/Parent Aid or backup is available for consultation to the family 24/7 by phone or in person.

Outcome Measure/Fidelity Measure:

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

Goal #2 Improved family functioning including development of positive means of managing crisis.

Objective:

1) Service delivery is grounded in best practice strategies and building skills based on a strength perspective to increase family functioning.

Outcome Measure/Fidelity Outcome:

- 1) 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by the closure of the service provision period.
- 2) 90% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of “substantiated” abuse or neglect through the service provision period.
- 3) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.
- 4) Scores will be improved on the state approved, standardized needs and strengths assessment instruments used by the referring DCS or Probation.
5. If DCS elects to implement a standardized tool for evaluating family functioning, a related outcome measure will be added.

Goal #3 Maintain satisfactory services to the children and family

Objective

1) DCS/Probation and clients will report satisfaction with services.

Outcome Measure/Fidelity Measure:

1) DCS/Probation satisfaction with services will be rated 4 and above on the Service Satisfaction Report.

2) 90% of clients will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

VII. Minimum Qualifications

Homemaker/Parent Aid:

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

Qualities:

Ability to work as a team member

Ability to work independently

Patience

Nonjudgmental
Emotional maturity
Knowledge of child development
Knowledge of community resources
Belief that change is possible
Strong organizational skills
Exercise sound judgment
Belief in family preservation philosophy
Knowledge of child abuse and neglect
Thorough and empathetic communication skills

Supervisor:

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

Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with “best practices” and comply with the requirements of each provider’s accreditation body. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies. Under no circumstances is supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.

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

VIII. Billable Units

Face-to-face time with the client

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

- Includes client-specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal-directed interventions via telephone with the identified client family.
- Includes scheduled Child and Family Team meetings or case conferences (including crisis case conferences via telephone) initiated or approved by the DCS/Probation for the purposes of goal-directed communication regarding the services to be provided to the client/family. All cases conferences billed, including those via telephone, must be documented in the case notes.

- Includes in-vehicle (or in-transport) time with client provided it is identified as goal-directed, face-to-face, and approved/specified as part of the client’s intervention plan (e.g. housing/apartment search, etc.).
- Includes time spent completing any DCS approved standardized tool to assess family functioning.

Reminder: Not included are routine report writing and scheduling of appointments, collateral contacts unless ordered by DCS/Probation, travel time, and no shows. These activities are built into the cost of the face-to-face rate and shall not be billed separately.

Supervised Visit:

Time spent supervising visits will be billed separately from other services within this standard. The rate will be the same as the face-to-face rate, but will include only time spent face-to-face supervising the visit. Any other billable time as defined in the face-to-face rate, should be billed under the face-to-face rate.

Hourly services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

- 0 to 7 minutes do not bill 0.00 hour
- 8 to 22 minutes 1 fifteen minute unit 0.25 hour
- 23 to 37 minutes 2 fifteen minute units 0.50 hour
- 38 to 52 minutes 3 fifteen minute units 0.75 hour
- 53 to 60 minutes 4 fifteen minute units 1.00 hour

Translation or sign language

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

Court

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

Reports

If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.

IX. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation.
- 5) A copy of treatment plan to include short/long term goals with measurable outcomes consistent with case plan/agreements in the CFTM. Goals to be updated with each new referral.

X. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

XI. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

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

I. Service Description

Home Based Services

Face-to-face home-based caseworker services to preserve, support, and stabilize foster family home placements, and to promote the well-being of children, youth, and families.

Home-based caseworker will provide any combination of the following kinds of services to the families as approved by DCS/Probation:

- Home visits
- Coordination of services
- Conflict management
- Emergency/crisis services
- Child development education
- Developmental/behavioral effects of trauma education
- Parenting education/training
- Parent training with children present
- Monitor progress of parenting skills
- Family communication
- Foster family support
- Community services information
- Community referrals and follow-up
- Develop structure/time management
- Reactive Attachment Disorder (RAD) support

Target Population

Licensed resource families supervised by DCS.

DCS intends to develop specialized services targeting relative caregivers. Until such time, licensed and unlicensed relative caregivers may be referred to this service.

II. Goals and Outcome Measures

Goal #1 – Timely and on-going intervention with family

Outcome Measures

- 95% of all families that are referred will have face to face contact with the family within five (5) days of the referral
- 95% of all families will have monthly written summary reports prepared and sent to the referring worker

Goal #2 - Minimize the number of disrupted foster care placements (foster, pre-adoptive)

Outcome Measures

- 95% of foster parents will participate in supportive services that are recommended and available
- 95% of foster families and foster children requiring supportive services will maintain their placements

Goal #3 – DCS and foster family satisfaction with services

Outcome Measures

- DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 95% of families will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

III. Minimum Qualifications

Direct Worker:

Bachelor's degree in social work, psychology, sociology, or a directly-related human service field from an accredited college. Must possess a valid driver's license and the ability to use

private car to transport self and others, and must comply with the state policy concerning minimum car insurance coverage.

In addition to the above:

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

Supervisor:

Master's or Doctorate degree in social work, psychology, or directly-related human services field from an accredited college.

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

Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with "best practices" and comply with the requirements of each provider's accreditation body. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies. Under no circumstances is supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.

IV. Billable Units Face to Face Time With the Client

Face-to-Face time with the client

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

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

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

Translation or Sign Language

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

V. Case Record Documentation

Necessary case record documentation for service eligibility must include:

- A completed, dated, signed DCS referral form authorizing service
- Documentation of on-going contact with the referred foster families/children and referring agency
- Monthly written reports, or more frequently if requested, regarding the progress of the family/children provided to the referring agency

VI. Service Access

Services must be accessed through a Referral for Child Welfare Services Form. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS. Providers must initiate a reauthorization for services to continue beyond the approved time period.

Note: All services must be pre-approved through a Referral for Child Welfare Services Form from the referring DCS. In emergency situations, services may begin with a verbal approval but must be followed by a written referral within five (5) days. It is the responsibility of the service provider to obtain the written referral.

**SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
SUPPORT GROUP SERVICES FOR RESOURCE FAMILIES**

I. Service Description

The Support Group Coordinator will provide face-to-face support group services to local resource parents. Support group services should be provided no less than quarterly, but may be provided as frequently as monthly. Monthly phone or email contact should be made with resource parents for the purposes of coordinating services and identifying pertinent support group topics. The Coordinator will record the topic(s) of discussion and keep a sign-in sheet for each support group meeting. Child care should be provided if requested by families attending support group meetings. Anyone providing childcare must pass criminal history and CPS checks.

Support group services will be designed to assist resource families in strengthening their relationships with foster children placed in their homes, as well as to promote positive relationships between foster families and the local DCS Family Case Managers and Regional Foster Care Specialists. Support group services will also focus on enhancing placement stability, and promoting foster families' willingness and ability to foster special needs children and older youth that come into care. The Coordinator will collaborate with the Regional Foster Care Specialist(s) to invite prospective foster parents to the monthly support group meeting, in order for them to gain insight and information regarding the foster care program.

II. Target Population

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

III. Goals and Outcome Measures

Goal #1

Retention of the current number of foster parents that are licensed

Outcome Measures

- 1) 90% retention of currently licensed foster families that continue to reside in the county.
- 2) 70% of licensed foster families participate in support meetings at least one time per year.

Goal #2

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

Outcome Measures

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

Goal #3

DCS and foster family satisfaction with services

Outcome Measures

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

IV. Minimum Qualifications

Coordinator:

Bachelor's degree in social work, psychology, sociology, or a directly related human service field or hold an active foster home license.

The Coordinator must:

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

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

V. Billing Units

Support Group

Per hour of support group service. A minimum of 3 foster parents must be in attendance in order to bill for this service.

Translation or sign language

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

VI. Case Record Documentation

- 1) Support group sign in sheets including date and time of the group meeting
- 2) Meeting room documentation

VII. Service Access

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

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

I. Service Definition

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

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

II. Service Delivery

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

competent fashion.

III. Target Population

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

IV. Goals and Outcome Measures

Goal#1

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

Outcome Measures

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

Goal #2

DCS and foster family satisfaction with services

Outcome Measures

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

V. Minimum Qualifications

Direct Worker:

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

Supervisor:

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

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

In addition to:

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

Services will be conducted with behavior and language that demonstrates respect for

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

VI. Billable Units

Hourly rate (up to 8 hours for foster home studies and 4 hours for updates and relicensing studies; additional hours must be approved by the referring DCS):

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

Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

- | | | |
|--------------------|------------------------|-----------|
| • 0 to 7 minutes | do not bill | 0.00 hour |
| • 8 to 22 minutes | 1 fifteen minute unit | 0.25 hour |
| • 23 to 37 minutes | 2 fifteen minute units | 0.50 hour |
| • 38 to 52 minutes | 3 fifteen minute units | 0.75 hour |
| • 53 to 60 minutes | 4 fifteen minute units | 1.00 hour |

Translation or sign language

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

Court

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

VII. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.

- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation.
- 5) A copy of treatment plan to include short/long term goals with measurable outcomes consistent with case plan/agreements in the CFTM. Goals to be updated with each new referral.

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

IX. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
CARE NETWORK SERVICE STANDARD
(Revised 6/8/11-Effective 7/1/11)

I. Services Description

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

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

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

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

Services include working with the FCM to ensure necessary additional referrals are made. Those services within the referral network will include but are not limited to the following:

1) Behavioral Health Services

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

2) Mentor Services- hourly

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

3) Other Services

- Consultation with Other Professionals
- Team Meetings
- Transportation

4) Psychiatric Services- hourly

- Assessments Outpatient
- Medication Follow-up/ Psychiatric Review

5) Respite Services

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

6) Supervision Services

- Community Supervision
- Intensive Supervision

7) Services to meet the needs of children with complex medical needs or developmental delays.

II. Specific Responsibilities

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

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

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

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

3) The face- to- face intake must occur no later than the end of the day following the referral or as requested by the referring worker.

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

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

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

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

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

III. Medicaid

For those families and children not eligible for Medicaid Rehabilitation Option, this service will be paid by DCS. For eligible families and children, some services may be provided through

Medicaid Rehabilitation Option (MRO) with the remaining services paid by DCS. While the primary focus of these services is on the needs of the family, it is expected that some of these services will be deemed medically necessary to meet the behavioral health care needs of the MRO eligible client, and therefore may be billable to MRO. The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The Services not eligible for MRO may be billed to DCS.

IV. When DCS is not paying for services:

A billable unit of “Reports” has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

V. Target Population

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

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- 2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
- 4) All adopted children and adoptive families.

Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need.

VI. Goals and Outcomes

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

Objectives:

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- 1) Improved school functioning from case opening to closure
 - An increase in scores as found on grade reports in 85% of cases
 - Decrease in absenteeism/truancy as reflected by attendance reports in 85% of cases
 - A decrease amount in behavior reports in 85% of cases
 - A decrease in suspension/expulsion reports in 85% of cases

- 2) Progress in service coordination plan
 - Measured by monthly team report and Care Facilitator plan of care

- 3) Fewer days in out of home placement (the provider will track and report as a part of evaluation the number of continuous days in placement for each child).
 - Information submitted will be evaluated by DCS or Probation against DCS data.

- 4) 50% of the children and families will have statistically significant improvement in any life domain on the CANS (functioning, behavioral health systems, risks, caretaker needs and strengths, child strengths)

Goal #2 Improved family functioning including development of positive means of managing crisis.

Objectives:

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

Client Outcome Measures:

- 1) 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period.
- 2) 90% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of “substantiated” abuse or neglect throughout the service provision period. (To be measured/evaluated by DCS/Probation staff)
- 3) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.

Goal #3 DCS/Probation and clients will report satisfaction with services provided.

Outcome Measures:

- 1) DCS/Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 90% of the clients will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their

caseload (whichever results in a larger number) randomly selected from each county served.

VII. Minimum Qualifications

Supervisor

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

Care Network Facilitator

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

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

VIII. Billable Unit

Medicaid: Services through the Medicaid Rehab Option (MRO) may be Case Management. Medicaid shall be billed when appropriate.

- Medically necessary behavioral health care Case Management for the MRO child will be paid per 15 minute unit. Case Management services should not exceed those included in the MRO package.

Billing Code	Description
T1016 HW	Case Management, each 15 minutes

DCS holds overall Case Management responsibility. In order to assist DCS with the coordination of medically necessary behavioral health care needs of the MRO client, CMHC's may provide case management services with this specific focus.

DCS Funding: Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below. These billable units will also be utilized for services to referred clients who are not Medicaid eligible and for providers who are unable to bill Medicaid..

Face to face time with the client and collateral contacts:

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

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

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

Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

- | | | |
|--------------------|------------------------|-----------|
| • 0 to 7 minutes | do not bill | 0.00 hour |
| • 8 to 22 minutes | 1 fifteen minute unit | 0.25 hour |
| • 23 to 37 minutes | 2 fifteen minute units | 0.50 hour |
| • 38 to 52 minutes | 3 fifteen minute units | 0.75 hour |
| • 53 to 60 minutes | 4 fifteen minute units | 1.00 hour |

- **Translation or sign language**

Services include translation for families who are non-English language speakers or

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

- **Court**

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

- **Reports**

If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.

IX. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services
- 2) Documentation of regular contact with the referred families/children
- 3) Written progress reports no less than monthly or more frequently as prescribed by DCS/Probation and requested supportive documentation such as case notes, social summaries, etc. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation.

X. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation.

Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

XI. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
CHINS PARENT SUPPORT SERVICES

I. Services Description

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

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

Family support group meetings must provide:

- 1) information regarding the CHINS legal process including court procedures, parental participation requirements, court ordered services, visitation with the children, reimbursement of cost for services, and other aspects related to the legal process;
- 2) the expectations of the family related to participation in court ordered services and visitation with the children, attendance at court, appropriate dress for court, and other aspects related to the legal process;
- 3) information regarding the parent's rights and the CHINS proceedings, the length of time children may be in care prior to a permanency procedure, and termination of parental rights, family team meetings and their procedures
- 4) role of the Court Appointed Special Advocate or Guardian ad Litem,
- 5) interactive activities including pre and post tests related to the CHINS process, parental rights, parental participation, reimbursement for cost of services, permanency, termination of parental rights and other issues related to CHINS case to assist in the learning process and to ensure that learning is taking place,
- 6) an informal environment for parents to discuss issues that brought them to the attention of the DCS and develop suggestions that may assist in resolving these issues as a group, and;
- 7) educational programs using speakers recruited from the local professional community to assist and educate the families in areas such as:
 - abuse and neglect,

- increasing parenting skills,
- substance abuse,
- anger management,
- advocacy with public agencies including the children's schools, and;
- issues of interest to the parents related to their needs and the needs of their children.

II. Target Population

Services must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with CHINS status.
- 2) Children and their families which have the status of CHINS.

III. Goals and Outcomes

Goal #1 Educate parents regarding CHINS process and help them to understand the expectations of the involved parent.

Outcome Measures

- 1) 90% of parents participating can increasingly verbalize their rights and expectations related to the CHINS proceedings measured through pre/post surveys.

Goal #2 Improved family functioning including the development of positive means of managing crisis. Develop an environment where families feel they are being heard.

Objective:

Outcome Measures

- 1) 67% of the families that have a child in substitute care prior to the initiative of service will be reunited by closure of the service provision period.
- 2) 90% of the individuals/families will not be the subjects of "substantiated" abuse or neglect throughout the service provision period.
- 3) 90% of the individuals/families that were intact prior to the initiation of service will remain throughout the service provision period.
- 4) 90% of families participating will provide input and make recommendations at the meetings.

Goal #3 DCS/Probation clients will report satisfaction with services provided.

Outcome Measures

- 1) DCS/Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 90% of the families who have participated in Family Support Services will rate the services "satisfactory" or above on a satisfaction survey developed by the

service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

IV. Minimum Qualifications

Direct Worker:

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

Supervisor:

Master's degree in social work, psychology, or directly related human services field or a Bachelors degree in social work, psychology, or a directly related service field with 5 years child welfare experience.

The CPSW must:

- Possess clear oral and written communication skills
- Possess the ability to play the role of a mediator when necessary
- Possess the ability to address concerns/issues others in a positive manner and provide constructive feedback when necessary
- Demonstrate insight into human behavior
- Demonstrate emotional maturity and exercise sound judgment
- Be non-judgmental
- Be a self starter
- Have strong organizational skills
- Must respect confidentiality. (Failure to maintain confidentiality may result in immediate termination of the service agreement.)

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

V. Billable Unit

Face to face time with the client:

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

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

approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

- **Group**

Services include group goal directed work with clients. To be billed per group hour.

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

Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

• 0 to 7 minutes	do not bill	0.00 hour
• 8 to 22 minutes	1 fifteen minute unit	0.25 hour
• 23 to 37 minutes	2 fifteen minute units	0.50 hour
• 38 to 52 minutes	3 fifteen minute units	0.75 hour
• 53 to 60 minutes	4 fifteen minute units	1.00 hour

- **Translation or sign language**

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

- **Court**

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

VI. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services
- 2) Documentation of regular contact with the referred families/children
- 3) Written progress reports no less than monthly or more frequently as prescribed by DCS/Probation and requested supportive documentation such as case notes, social summaries, etc. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

VII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

VIII. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
COUNSELING
(Revised 6/8/11-Effective 7/1/11)

I. Service Description

This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation. These services include the provision of structured, goal-oriented therapy for families affected by physical abuse, sexual abuse, emotional abuse, or neglect. Other issues, including substance abuse, dysfunctional families of origin, etc., may be addressed in the course of treating the abuse or neglect. In addition, counseling may be provided to address family or youth issues that resulted in the involvement of juvenile probation.

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

- Initial Assessment
- Conflict resolution
- Behaviors modification
- Identify systems of support
- Interpersonal relationships
- Communication skills
- Substance abuse awareness/family dynamics *
- Parenting skills
- Anger management
- Supervised therapeutic visits**
- Problem solving
- Stress management
- Goal-setting
- Domestic violence issues
- School problems
- Family of origin/inter-generational issues
- Sexual abuse – victims and caretakers of sexual abusers

*Substance abuse Counseling/Treatment must be done under the Service Standard “Substance Abuse Treatment” due to the specific legal qualifications of the provider, not under this counseling service standard.

**Supervised Visits will be billed separately from other services within this standard. The “Visitation Monthly Progress Report” form must be used to report the supervised visitation portion of the services provided. The “Monthly Progress Report” will be used for the remainder.

II. Service Delivery

- 1) Services are provided at a specified (regularly scheduled) time for a limited period of time.
- 2) Service Settings:
 - a. For services billable to DCS, services are provided face-to-face in the counselor’s office or other setting.

- b. For services billable to Medicaid Clinic Option, the service setting is either outpatient or office setting.
 - c. For services billable to Medicaid Rehabilitation Option, the service must be provided at the client's home or other at other locations outside the clinic setting.
- 3) Services will be based on objectives derived from the family's established DCS/Probation case plan, Informal Adjustment, taking into consideration the recommendations of the Child and Family Team (CFT) and authorized by DCS/Probation referral, and subsequent written documents.
 - 4) The counselor will be involved in Child and Family Team Meetings (CFTM) if invited.
 - 5) Counselor must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
 - 6) Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued, culturally competent manner.
 - 7) Services include providing any requested testimony and/or court appearances, including hearings and/or appeals.
 - 8) Services must be provided at a time convenient for the family.
 - 9) Services will be time-limited.
 - 10) Written reports will be submitted monthly to provide updates on progress and recommendation for continuation or discontinuation of treatment. The DCS approved "Monthly Progress Report" form will be used.

III. Medicaid

For those families and children not eligible for Medicaid Rehabilitation Option, this service will be paid by DCS. For eligible families and children, some services may be provided through Medicaid Rehabilitation Option (MRO) or Medicaid Clinic Option (MCO) with the remaining services paid by DCS. While the primary focus of these services is on the needs of the family, it is expected that some of these services will be deemed medically necessary to meet the behavioral health care needs of the MRO eligible client, and therefore may be billable to MRO. Other services for Medicaid clients may be covered under MCO. The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The Services not eligible for MRO or MCO may be billed to DCS.

IV. When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay**

for reports when DCS is not paying for these services. If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

V. Target Population

Services must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or CHINS status.
- 2) Children and their families which have an IA or the children have the with a status of CHINS, and/or JD/JS;
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
- 4) All adopted children and adoptive families.

Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need. Services billable to MCO are for Medicaid eligible clients.

VI. Goals and Outcome Measures

Goal #1 Maintain timely intervention with family and regular and timely communication with current Family Case Manager or Probation Officer.

Objectives

- 1) Therapist or backup is available for consultation to the family 24-7 by phone or in person.

Fidelity Measures:

- 1) 95% of all families that are referred will have face-to-face contact with the client within 5 days of receipt of the referral or inform the current Family Case Manager or Probation Officer if the client does not respond to requests to meet.
- 2) 95% of families will have a written treatment plan prepared and sent to the current Family Case Manager/Probation Officer within 30 days of the receipt of the referral.
- 3) 100% of all families will have monthly written summary reports prepared and sent to the current Family Case Manager/Probation Officer. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.

Goal #2 Improved family functioning including development of positive means of managing crisis.

Objectives

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

Client Outcome Measures:

- 1) 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period.
- 2) 90% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of “substantiated” abuse or neglect throughout the service provision period. (To be measured/evaluated by DCS/Probation staff)
- 3) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.

Goal #3 DCS/Probation and clients will report satisfaction with services provided.

Outcome Measures:

- 1) DCS/Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 90% of the clients will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

VII. Minimum Qualifications

Counselor/Direct Worker:

MCO billable:

- Medical doctor, doctor of osteopath; licensed psychologist
- Physician or HSPP-directed services provided by the following: licensed clinical social worker, licensed marital and family therapist; licensed mental health counselor; a person holding a master’s degree in social work, marital and family therapy or mental health counseling; an advanced practice nurse.

MRO billable:

Providers must meet the either of the following qualifications:

- Licensed professional, except for a licensed clinical addiction counselor
- Qualified Behavioral Health Professional (QBHP).

DCS billable:

Counselor

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

Supervision:

Master's degree in social work, psychology, or marriage and family or related human service field, with a current license issued by the Indiana Social Worker, Marriage and Family Therapist

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or Mental Health Counselor Board, as one of the following: 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor.

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

Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with “best practices” and comply with the requirements of each provider’s accreditation body. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies. Under no circumstances is supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.

In addition to the above:

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

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

VIII. Billable Units

Medicaid:

It is expected that the majority of the individual, family and group counseling provided under this standard will be based in the clinic setting. Some group counseling may occur in the community. In these instances, the units may be billable through MRO. Medicaid shall be billed when appropriate.

Services through the **MCO** may be Outpatient Mental Health Services. Medicaid shall be billed first for eligible services under covered evaluation and management codes, including those in the 90000 range.

Services through the Medicaid Rehab Option (**MRO**) may be **group** Behavioral Health Counseling and Therapy.

Billing Code	Title
H0004 HW U1	Behavioral health counseling and therapy (group setting), per 15 minutes
H0004 HW HR U1	Behavioral health counseling and therapy, per 15 minutes (family/couple, group setting, with consumer present)
H0004 HW HS U1	Behavioral health counseling and therapy, per 15 minutes (family/couple, group setting, without consumer present)

DCS funding: Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below. These billable units will also be utilized for services to referred clients who are not Medicaid eligible and for those providers who are unable to bill Medicaid.

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

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

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

Supervised Visit:

** Time spent supervising visits will be billed separately from other services within this standard. The rate will be the same as the face-to-face rate, but will include only time spent face-to-face supervising the visit. Any other billable time as defined in the face-to-face rate, should be billed under the face-to-face rate.

Per person per group hour

Services include group goal directed work with clients. To be billed per client per hour attended.

Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

- 0 to 7 minutes do not bill 0.00 hour
- 8 to 22 minutes 1 fifteen minute unit 0.25 hour
- 23 to 37 minutes 2 fifteen minute units 0.50 hour
- 38 to 52 minutes 3 fifteen minute units 0.75 hour
- 53 to 60 minutes 4 fifteen minute units 1.00 hour

Translation or sign language

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

Court

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

Reports

If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.

IX. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services
- 2) Documentation of regular contact with the referred families/children
- 3) Written progress reports no less than monthly or more frequently as prescribed by DCS/Probation and requested supportive documentation such as case notes, social summaries, etc. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

X. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

XI. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

**SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
CROSS-SYSTEM CARE COORDINATION**

I. Services Description

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

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

The services provided are comprehensive and will include cross-system coordination, case management, safety and crisis planning, comprehensive strength-based discovery and assessment, activities of daily living training, assistance to the FCM in the facilitation of the child and family team process, and family and child centered care.

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

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

1) Behavioral Health Services

- Behavior Management Services
- Crisis Intervention
- Day Treatment
- Evaluation / Testing Services
- Family Assessment
- Family Therapy
- Group Therapy
- Individual Therapy
- Parenting/ Family Skills Training Groups
- Special Therapy

- Substance Abuse Therapy- Group
- Substance Abuse Therapy- Individual
- Family Preservation – home based services

2) Mentor Services

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

3) Other Services

- Consultation with Other Professionals
- Team Meetings
- Transportation

4) Psychiatric Services

- Assessments Outpatient
- Medication Follow-up/ Psychiatric Review

5) Respite Services

- Crisis Respite
- Planned Respite

6) Supervision Services

- Community Supervision
- Intensive Supervision

7) Residential Services

8) Services to meet the needs of children with complex medical needs or developmental delays.

II. Service Delivery

1) The Care Coordinator has the specific responsibilities for the following:

- Evaluates and interprets referral packet information and completes a strength based assessment with child and family and the Child and Adolescent Needs and Strengths Assessment (CANS).

- Collaborate with the Family Case Manager (FCM)/Probation Officer in convening the family members, service providers and other child and family team members to form a collaborative plan of care with clearly defined goals.
 - Addresses need for and develops, revises and monitors crisis plan with family and team members.
 - Ensures that parent and family involvement is maintained throughout the service period so that families have continual voice and choice in their care.
 - Maintains ongoing dialogue with the family and providers to assure that the philosophy of care is consistent and that there is progress toward service goals. Evaluates the progress and makes adjustments as necessary.
 - Maintains central file consisting of treatment summaries, payment and resource utilization records, case notes, legal documents and releases of information.
 - Facilitates the closing of the case and oversees transition to any ongoing care.
 - Uses resources and available flex funding to assure that services are based specifically on the needs of the child and family.
 - Able to deliver strength based, family centered, culturally competent services.
 - Able to interpret psychiatric, psychological and other evaluation data, and use that information in the formation of a collaborative plan of care.
 - Able to complete all documentation using a computerized clinical record.
 - Creativity, flexibility and optimism about the strengths of children and their families.
- 2) Providing agency receives referrals 24 hours a day, 7 days a week. There is a verbal determination between the referring worker and the agency that services are warranted, and there is agency availability for the service before the referral is sent.
 - 3) The initial face- to- face contact with the family must occur no later than two (2) business days following receipt of the completed referral or as requested by the referring worker.
 - 4) An abbreviated assessment to determine service tier is based on the needs of the youth and family and is mutually established between the referral source and care coordinator within 14 days of completed referral. Goal setting and service planning are mutually established between the youth, caregiver, care coordinator, providers and referral source based upon the comprehensive assessment within 21 days of the completed referral.
 - 5) Each family receives access to services through a single care coordinator acting within a team, with supports available 24 hours a day 7 days a week.
 - 6) Regular assessment of needs and strengths of the youth and family will be completed and discussed within the Child and Family team to guide decision making on services and supports for the youth and family. System-related concerns and directives are included in these team discussions as well.

- 7) Safety is of paramount importance. If there are concerns about safety within the home there is an obligation for the care coordinator and the current worker to communicate to address all safety concerns, and document safety steps taken to resolve the issues. If new incidences occur, the care coordinator is to notify the current worker immediately of the situation.
- 8) Confidentiality must be maintained. Failure to maintain confidentiality may result in termination of the service agreement.

III. Target Population

Services are restricted to cases where existence of complex needs has been documented within the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- 2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
- 4) All adopted children and adoptive families.

IV. Goals and Outcomes

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

Improved child and family functioning

A) Improved school functioning

- Maintain or improve CANS score for school achievement in 85% of cases.
- Maintain or improve CANS score for school attendance in 85% of cases.
- Maintain or improve CANS score for school behavior in 85% of cases
- In 85% of cases where a decrease in suspension/expulsion is identified as a goal, progress will be demonstrated
- The Care Coordinator Treatment Plan level rating decreases in severity in 85% of cases

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

- 85% of families with no further substantiated incidences of child abuse or neglect, which results in removal of the child from the home for a period of six and twelve months from dis-enrollment
- In 85% of cases where delinquency, runaway, truancy or violations of probation are identified as an issue, children will have no further substantiated incidences which results in placement failure during enrollment
- In 85% of cases where delinquency, runaway, truancy or violations of probation are identified as an issue, children will have no further substantiated incidences which results in placement failure for a period of six and twelve months from dis-enrollment

C) Improved CANS scores

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

D) Progress in Service Coordination Plan

- Child will show progress in goals established in the individual plan as measured by monthly team report and Care Coordinator Treatment Plan

Increased family autonomy

A) Assist the family to increase informal supports and reduce reliance on formal service providers.

- 95% of families will increase the number of informal supports.
- 95% of families will have a reduced the need for service providers.

B) Caregiver Strain Questionnaire

- Increase family autonomy or maintain satisfactory family autonomy as measured by the Caregiver Strengths and Needs Dimension of the CANS in 80% of cases.

V. Minimum Qualifications

Supervisor:

Master's Degree in Social Work, Psychology, Marriage and Family Therapy, or related Human Services field; and,

A current license issued by the Indiana Social Worker, Marriage and Family Therapist and Mental Health Counselor Board as one of the following:

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

Care Coordinator:

Bachelor's Degree in Social Work or related Human Service field; and,

Minimum of three years of clinical/management experience in human service field; and,

Demonstrated clinical intervention skills over 2 or more years; and,

Demonstrated skill in fiscal management activities, team building and development

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

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

VI. Billable Units

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

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

*Note that Medicaid MRO and MCO should be used to pay for care coordination and other services when possible.

- **Translation Services**

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

VII. Standard Rates

Per Youth per Day

Levels	150 Youth	225 Youth	300 Youth
1	\$51.45	\$49.08	\$46.72
2	\$91.40	\$89.03	\$86.66
3	\$141.04	\$138.67	\$136.31
4	\$213.70	\$211.33	\$208.96

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

VIII. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services

- 2) Documentation of regular contact with the referred families/children
- 3) Written progress reports no less than monthly or more frequently as prescribed by DCS/Probation and requested supportive documentation such as case notes, social summaries, etc. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation.

IX. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

X. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
DIAGNOSTIC AND EVALUATION SERVICES
(Revised 7/21/11-Effective 7/21/11)

I. Services Description

Diagnostic and assessment services will be provided as requested by the referring worker for parents, other family members, and children due to the intervention of the Department of Child Services because of alleged physical, sexual, or emotional abuse or neglect, the removal of children from the care and control of their parents, and/or children alleged to be a delinquent child or adjudicated a delinquent child. When either a psychological or emotional problem is suspected to be contributing to the behavior of an adult or child or interfering with a parent's ability to parent, they should be referred for an initial bio-psychosocial assessment by a direct worker. If a psychiatric consultation/medication evaluation or either psychological or neuropsychological testing is necessary to answer a specific question, testing may be included in the evaluation after a consultation with the Family Case Manager (FCM) about the purpose of testing. Specific tests may include instruments that assess ability and achievement, substance use/abuse, testing for personality and psychopathology, and assessments of adaptive living skills. The results of the evaluation including diagnostic impression and treatment recommendations will be forwarded to the Family Case Manager to assist the family in remedying the problems that brought the family to the attention of child protective services or probation.

II. Service Delivery

Clinical Interview and Assessment

The purpose of the Clinical Interview and Assessment is to have the following completed and summarized in a report:

- Bio-psychosocial assessment(including initial impressions of parent functioning)
 - Diagnosis (if applicable)
 - Summary of Recommended Services and Service Approach
1. The completed report will utilize the DCS standardized report format for Diagnostic Evaluation Services. The report should be completed with a summary to DCS within 15 calendar days of referral.
 2. The service provider may recommend psychological testing, neuropsychological testing and/or psychiatric consultation/medication evaluation as a result of the bio-psychosocial assessment. If psychological testing or neuropsychological testing is recommended, the service provider should include in the report the specific issues/questions the testing should address. A new referral under this service standard will be required for these services.

3. The service provider may recommend a Parenting/Family Functioning Assessment. Justification as to why this level of assessment is necessary should be included in the report. A new referral Parenting/Family Functioning Assessment will be required for this service.

Psychological Testing

1. The psychologist will conduct applicable psychological testing as recommended during the Clinical Interview and Assessment and approved by the Family Case Manager.
2. The psychologist will respond with a written report within 30 days from the date of the referral.

Neuropsychological Testing

1. The psychologist will conduct applicable neuropsychological testing as recommended by the service provider and approved by the Family Case Manager.
2. The psychologist will respond with a written report within 45 days from the date of the referral.

Medication Evaluation

If psychiatric consultation/medication evaluation is recommended, the psychiatrist will see the client within 14 days from the date of referral and complete a written report within 30 days from the date of evaluation.

Ongoing Medication Monitoring

Ongoing medication monitoring will be provided as needed based on the results of the Medicaid Evaluation.

Child Hearsay Evaluation

An evaluation completed by a psychiatrist, physician, or psychologist to determine if participation in court proceedings would create a substantial likelihood of emotional or mental harm to the child. A completed report will be provided to the referring worker within 14 days of referral.

Comprehensive Report

Comprehensive psychological evaluations include a detailed history of the client in order to obtain symptom development and configuration, and include objective/standardized psychological testing results. Collateral data is also collected, and includes but is not limited to interviews with service providers, treatment records of inpatient and outpatient care, and information with family members.

The comprehensive report will integrate all data into a summary of the issues creating barriers to reunification, explain the psychological diagnosis, and will provide recommendations for treatment. If requested reports can make recommendations regarding parental functioning or the prognosis of the permanency options.

III. When DCS is not paying for services:

A billable unit of “Reports” has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

IV. Target Population

Services must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- 2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
- 4) All adopted children and adoptive families

V. Goals and Outcomes

Goal #1

Timely receipt of evaluations.

Objective:

- 1) Service provider to submit written report to the referring Family Case Manager within the designated time frames of completion of evaluation.

Outcome Measure/Fidelity Measure

- 1) 95% of the evaluation reports will be submitted to the referring Family Case Manager within specified service delivery time frames.

Goal #2

Obtain appropriate recommendations based on information provided.

Outcome Measure

- 1) 100% of reports will meet information requested by the referring Family Case Manager/Probation Officer.
- 2) 100% of reports will include recommendations for treatment, needed services or indicate no further need for services.

Goal #3

Client satisfaction with service provided.

Outcome Measure

- 1) DCS and/or probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) A random Sample of Satisfaction Surveys will be completed at the conclusion of services.

VI. Minimum Qualifications

Clinical Interview and Assessment Reimbursed by DCS:

Diagnosis and assessment may only be done independently by a Health Services Provider in Psychology (HSPP). The following providers may provide bio-psychosocial assessments under the direct supervision of a Health Service Provider in Psychology (HSPP) psychologist or psychiatrist.

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

Clinical Interview and Assessment Reimbursed by Medicaid:

Subject to prior authorization by the office or its designee, Medicaid will reimburse physician or HSPP directed outpatient mental health services for group, family, and individual outpatient psychotherapy when such services are provided by one (1) of the following practitioners:

- (A) A licensed psychologist.
- (B) A licensed independent practice school psychologist.
- (C) A licensed clinical social worker.
- (D) A licensed marital and family therapist.

- (E) A licensed mental health counselor.
- (F) A person holding a master's degree in social work, marital and family therapy, or mental health counseling
- (G) An advanced practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing.

The physician, psychiatrist, or HSPP is responsible for certifying the diagnosis and for supervising the plan of treatment described as follows:

- (A) The physician, psychiatrist, or HSPP is responsible for seeing the recipient during the intake process or reviewing the medical information obtained by the practitioner listed above within seven (7) days of the intake process. This review by the physician, psychiatrist, or HSPP must be documented in writing.
- (B) The physician, psychiatrist, or HSPP must again see the patient or review the medical information and certify medical necessity on the basis of medical information provided by the practitioner listed above at intervals not to exceed ninety (90) days. This review must be documented in writing.

Psychological & Neuropsychological Testing Reimbursed by DCS:

Test Interpretation

Diagnosis and assessment may only be done independently by a Health Services Provider in Psychology (HSPP) or physician.

Test Administration

The following practitioners may **administer** psychological testing under the direct supervision of a HSPP or physician:

- (A) A licensed psychologist.
- (B) A licensed independent practice school psychologist.
- (C) A person holding a bachelor's degree and one (1) of the following:
 - (i) twenty (20) hours of documented specific instruction and direct supervision by a physician or HSPP psychologist at the performance site on the tests to be used including instruction on administration and scoring and practice assessments with non-patients and final approval to administer the specific instruments by a physician or HSPP psychologist at the performance site; or
 - (ii) status as a psychology intern enrolled in an American Psychological Association (APA)-approved internship program.
- (D) A psychology resident enrolled in an APA-approved training program or APPIC recognized internship or post-doctoral program.
- (E) An individual certified by a national organization in the administration and scoring of psychological tests.

The physician and HSPP are responsible for the interpretation and reporting of the testing performed. The physician and HSPP must provide direct supervision and maintain documentation to support the education, training, and hours of experience for any practitioner providing services under their supervision. A cosignature by the physician or HSPP is required for services rendered by one of the lower level practitioners.

Psychological & Neuropsychological Testing reimbursed by Medicaid:

Subject to prior authorization by the office or its designee, Medicaid will reimburse for neuropsychological and psychological testing when provided by a physician or an HSPP. The services are provided by one (1) of the following practitioners:

(A) A physician.

(B) An HSPP.

(C) The following practitioners may only **administer** neuropsychological and psychological testing under the direct supervision of a physician or HSPP:

1. A licensed psychologist.

2. A licensed independent practice school psychologist.

3. A person holding a master's degree in a mental health field and one (1) of the following:

(a) A certified specialist in psychometry (CSP).

(b) Two thousand (2,000) hours of experience, under direct supervision of a physician or HSPP, in administering the type of test being performed.

The physician and HSPP are responsible for the interpretation and reporting of the testing performed. The physician and HSPP must provide direct supervision and maintain documentation to support the education, training, and hours of experience for any practitioner providing services under their supervision. A cosignature by the physician or HSPP is required for services rendered by one of the practitioners listed in subdivision (C).

Medication Evaluation and Ongoing Medication Management:

(A) Physician

(B) Advanced Practice Nurses (Nurse Practitioners or Certified Nurse Specialists) with a 1) master or doctoral degree in nursing with a major in psychiatric or mental health nursing, 2) from an accredited school of nursing.

If working as an Authorized Health Professional staff must 1) be an Advance Practice Nurse as described above, 2)and prescriptive authority, 3)must work within the scope of his/her license and 4) have a supervisory agreement with a licensed physician.

VII. Billable Unit

Medicaid:

It is expected that the diagnostic and assessment services provided under this standard will be based in the clinic setting. Medicaid shall be billed when appropriate. Services will be billable by utilizing the 90000 codes.

DCS Funding:

Those services not billable under Medicaid, may be billed to DCS as follows:

- **Clinical Interview and Assessment:** Hourly Rate-Face to Face time with a client. Plus a maximum of 1 hour may be billed for report writing.
- **Psychological Testing:** Per Hour. Includes time face to face with the client and time spent administering, scoring, and interpreting testing. Plus a maximum of 1 hour may be billed for report writing.
- **Neuropsychological Testing:** Per Hour. Includes time face to face with the client and time spent administering, scoring, and interpreting testing. Plus a maximum of 1 hour may be billed for report writing.
- **Medication Evaluation:** per hour face to face with the client. Plus a maximum of ½ hour may be billed for report writing.
- **Ongoing Medication Monitoring:** per hour face to face with the client.
- **Child Hearsay Evaluation:** per hour face to face with the client. Plus a maximum of ½ hour may be billed for report writing.
- **Comprehensive Report**-per hour. Additional hours can be billed when prior DCS approval is given. The Comprehensive Report includes extra collateral contacts and a more extensive written report.

Hourly Services may be billed in 15 minute increments, partial units are rounded to the nearest quarter using the following guidelines:

○ 0 to 7 minutes	do not bill	0.00 hour
○ 8 to 22 minutes	1 fifteen minute unit	0.25 hour
○ 23 to 37 minutes	2 fifteen minute units	0.50 hour
○ 38 to 52 minutes	3 fifteen minute units	0.75 hour
○ 53 to 60 minutes	4 fifteen minute units	1.00 hour

- **Medication:** Actual Cost
The provider must access all sample medication resources and other medication sources (e.g., MAP) and pharmaceutical companies that provide free or reduced cost medications prior to billing DCS. Documentation of these efforts must be maintained in the case file.

- **Court:** The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.
- **Reports**
If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.
- **Translation or sign language:**
Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

VIII. Case Record Documentation

Necessary case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS/Probation referral form authorizing service;
- 2) Written reports as defined in this service standard.
- 3) Documentation regarding efforts to secure low cost or free medications prior to billing DCS.

IX. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved DCS referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

X. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
DOMESTIC VIOLENCE BATTERERS INTERVENTION SERVICES
(Revised 8/26/11-Effective 8/26/11)

A Batterers Intervention Program (BIP), Certified by the Indiana Coalition Against Domestic Violence (ICADV), shall be utilized by DCS as a preferred contract provider of services for domestic violence offenders/batterers in keeping with I.C. 35-50-9. If a contract service provider is needed in an area in which an ICADV Certified BIP is not available, the service provider must adhere to the DCS standards listed below.

I. Service Description

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

The batterer or offending parent may be selected for service delivery of Domestic Violence Batterers Intervention Services. Batterers' intervention services shall not exist in isolation, as it represents only one component of a coordinated community response to domestic violence. Services shall maintain cooperative working relationships with local programs (domestic violence programs and shelters, survivor programs, law enforcement, courts, advocates, legal services, etc.). Services shall focus on victim safety, batterer accountability and community collaboration, in that order. Services should be non-abusive, support change, and hold program clients accountable for their behavior.

II. Service Delivery

Group is the only method of services for the batterer. Group sessions will be for same-gendered participants only. All service must follow the ICADV approved policies and procedures for BIP service delivery as listed below:

- 1) The provider and the agency operating the program will not provide couples counseling involving the batterer until after the batterer/participant has successfully completed the program, and not thereafter if facilitators and advocates have reason to be concerned about the victim or child safety.
- 2) As a condition of program completion, each participant must attend a minimum of 26 weekly sessions, consisting of at least 1.5 hours each. Two of these sessions can be used for the orientation/intake and for the exit/program termination interviews.
- 3) A minimum of 24 of the 26 sessions will be group sessions.
- 4) Class size should not exceed 18.

- 5) The provider will establish objective criteria for program completion that will be enforced uniformly.
- 6) All on-going batterers' groups shall be conducted by qualified personnel.
- 7) The provider will have an established procedure for notification of victim/survivor/partner about expulsion and/or completions.
- 8) Any communication regarding program completion must include the following statement: *Program completion does not guarantee the absence of future violence or abusive behavior.*
- 9) The batterer may pursue other service methods after satisfactory completion of group services as determined and documented by BIP provider staff. The batterer should only be included in marital/couples or family services if the batterer has done extensive work to change violent behavior and there is proof of progress. The batterer should not be included in marital/couples or family services if there is reason to be concerned about the survivor/child's safety or wellbeing.
- 10) Services must be available to participants who have limited daytime availability.
- 11) Provider must respect confidentiality unless otherwise specified by the client-provider contract. Failure to maintain confidentiality may result in immediate termination of the service agreement between DCS and the provider.

Provider shall conduct intake with batterer within 72 hours after referral by DCS. Intake shall include but is not limited to:

- Acknowledgment of Batterer's past and current use of physical and sexual violence, including other abusive behaviors, within and outside of intimate relationships
- Substance abuse assessment and history
- History of mental illness, including threats or ideations of homicide

Substance abuse, addictions, and/or mental illness counseling/treatment is not an appropriate intervention for domestic violence and may not be substituted for the program. If intake indicates the need for substance abuse or mental health treatment, it shall be done separately and not in conjunction with batterer's intervention.

Providers shall require batterers to sign a contract as outlined in the ICADV Policies and Procedures for Services to Batterers. The provider shall require batterers to sign an explicit, written waiver of confidentiality at the time of intake, which will give the provider permission to make reports, to testify, to otherwise communicate as needed, and to reveal file and other information regarding the batterer to each of the following:

- 1) Indiana Department of Child Services;
- 2) The referral source, if legally mandated;
- 3) The court, prosecutor, police, probation and child protective agency of the referring county;
- 4) The victim/partner/survivor or her/his designated advocate;

- 5) Administrative and professional personnel who need information for record-keeping, monitoring, or professional development.
- 6) Any entity or person to whom the provider is legally bound to report suspected abuse or neglect of a child or protected adult;
- 7) Any person to whom the provider must report in order to fulfill its duty to warn or protect.

The waiver may include a specified end date, but an exception must be included in the text of the waiver that extends the waiver beyond the end date where necessary in order to prevent the participant from avoiding legal consequences for criminal or violent acts or in order for the provider to respond to a court subpoena for information or testimony.

Curriculum Content

- 1) The central focus of any provider curriculum will remain on participant responsibility and accountability for their beliefs and actions. It will actively challenge all abusive behaviors or victim blaming.
- 2) Any provider curriculum used or developed by provider programs will be based on ICADV-approved curriculum.
- 3) Provider curriculum should reflect an awareness of cultural diversity.

Therapeutic DV Batterer Intervention

Alternative approaches (e.g., therapeutic) with special approval from DCS. Group must be facilitated by someone with a Master's degree in social work, psychology, marriage and family therapy, or related human service field with a clinical license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board, as one of the following: 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor.

Program Monitoring

Provider will establish a written working agreement with a local independent domestic violence program or advocate. The local domestic violence program or advocate will be referred to as the "monitor". This written agreement will include all necessary elements as per ICADV Policies and Procedures.

The provider will develop guidelines for BIP participant expulsion reflecting ICADV policies so that decisions are uniform and predictable and so that discrimination does not occur against any participant based on race, class, age, physical handicap, religion, educational level, ethnicity, national origin, sexual orientation, or gender. Batterers may be re-enrolled in group on an individual basis at the provider's discretion in consultation with the referring FCM.

Partner Contact

Definition: “Partner contact” refers to any mail, phone, e-mail, or face-to-face contact, direct or indirect, with any partner, victim, survivor, ex-partner/victim/survivor, or child of a program participant, before, during, or after his/her enrollment in the program. Providers shall follow guidelines established by ICADV.

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

Batterer services must work in collaboration with local programs that serve survivors of domestic violence, law enforcement, the Indiana Coalition Against Domestic Violence and the Resource Center (ICADV) and others. Collaboration shall include: Measuring effectiveness of the services by outcome measures and being an active participant in local coordinated community response efforts.

III. When DCS is not paying for services:

A billable unit of “Reports” has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

IV. Target Population

Services must be restricted to cases where domestic violence has been documented within the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- 2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

V. Goals and Outcomes

Goal #1 BIP participants will not continue to engage in assaultive or coercive behavior, including physical, sexual, or psychological attacks as well as economic coercion against an intimate partner.

Outcome Measures

- 1) 90% of participants will acknowledge use of power and control in their relationship.
- 2) 70% of program participants have no further involvement with the DCS or criminal justice system related to domestic violence for a 12 month period beginning with program enrollment.
- 3) 80% of referrals will complete the full 26 week group curriculum.

Fidelity Measures:

Program fidelity/abiding by “best practices” is perhaps the best predictor of successful outcomes and provides an effective indirect measure. An audit undertaken by a DCS employee or designee may be conducted to assure program accountability. Programs must clearly link daily practices to the following program fidelity issues:

- 1) 90% of the supportive services (shelters, law enforcement, courts, advocates, legal agencies etc.) have a cooperative working relationship with the provider.
- 2) 100% of the BIP provider staff focus on victim safety as evidenced by adherence to appropriate policies and procedures of the provider agency.
- 3) 100% of program participants have an opportunity to participate in same-gender group sessions within 30 days of the referral.
- 4) 75% of programs are available to participants who have limited daytime availability.
- 5) 100% of groups are conducted by qualified personnel (see qualification section).
- 6) 100% of the BIP referrals are offered a 26-week group curriculum for batterers.
- 7) 80% of referrals have a provider contact attempted within 72 hours of referral and outcome of contact is documented.
- 8) 100% of program participants sign an agreement/contract as outlined by ICADV Policies and Procedures for BIP providers.
- 9) 100% of BIP providers will require staff to warn and protect victims, partners, children and others when and if the batterer has made a threat of violence as evidenced by adherence to appropriate policies and procedures of the provider agency.

VI. Minimum Qualifications

A. Initial Qualifications

Individuals must meet one of the following ICADV criteria in order to be deemed a qualified service provider by DCS:

1. Co-Facilitator: To qualify to co-facilitate a class or group session with a qualified Supervisor/Trainer or Facilitator, an individual must show:
 - a. Evidence of 60 hours of formal training approved by ICADV. A minimum of 40 hours of this training must be specific to domestic violence. The remaining 20 hours

- shall include evidence of training in each of the following areas of group facilitation skills, cultural diversity, substance abuse, and mental health.
- b. Evidence of observing a minimum of 26 different ICADV-approved sessions.
2. Facilitator: To qualify to facilitate an individual must show:
 - a. Evidence of meeting all the requirements of a Co-facilitator.
 - b. 100 hours of formal training approved by ICADV. A minimum of 60 hours of this training must be specific to domestic violence. The remaining 40 hours shall include evidence of training in each of the following areas of group facilitation skills, cultural diversity, substance abuse, and mental health.
 - c. Evidence of co-facilitating a minimum of 26 additional sessions with a Supervisor/Trainer.
 3. Supervisor: To qualify to supervise an individual must show:
 - a. Evidence of meeting all the requirements of a Facilitator.
 - b. 120 hours of formal training approved by ICADV. A minimum of 80 hours of this training must be specific to domestic violence. The remaining 40 hours shall include evidence of training in each of the following areas of group facilitation skills, cultural diversity, substance abuse, and mental health.
 - c. Evidence of facilitating a minimum of 26 additional sessions as a Facilitator under a Supervisor/Trainer.
 4. Trainer: To qualify to train staff or others related to work, an individual must show:
 - a. Evidence of fulfilling the requirements of a Supervisor.
 - b. Evidence of a minimum of 3 years experience as a supervisor (or the equivalent thereof).
 - c. Evidence of successfully completing the “train the trainer” offered by ICADV

VII. Billable Units

Group

Services include group goal directed work with clients. To be billed per group hour.

Per Person Per Group

Services include group goal directed work with clients. To be billed per client per hour attended.

Therapeutic Per Person Per Group

Services include group goal directed work with clients. To be billed per client per hour attended.

Group must be facilitated by a licensed Master-level Social Worker.

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

Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

- 0 to 7 minutes do not bill 0.00 hour
- 8 to 22 minutes 1 fifteen minute unit 0.25 hour
- 23 to 37 minutes 2 fifteen minute units 0.50 hour
- 38 to 52 minutes 3 fifteen minute units 0.75 hour
- 53 to 60 minutes 4 fifteen minute units 1.00 hour

Child and Family Team Meetings

Includes only Child and Family Team Meetings or case conferences initiated or approved by the DCS or Probation for the purposes of goal directed communication regarding the services to be provided to the client/family.

Translation or sign language

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

Court

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS or subpoena to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

Reports

If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.

Therapeutic DV Batterer Intervention

Alternative approaches (e.g., therapeutic) with special approval from DCS.

VIII. Case Record Documentation

Necessary case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.

- 4) Copy of DCS/Probation case plan, informal adjustment documentation

IX. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

X. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
DOMESTIC VIOLENCE SURVIVOR AND CHILD INTERVENTION SERVICES
(Revised 6/8/11-Effective 7/1/11)

I. Service Description

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

The targeted population for Domestic Violence services includes both survivors and children. Services may be provided comprehensively with service delivery including the survivor and child. The provider is responsible for the reporting and coordinating of services to all populations. Domestic Violence intervention services provided by DCS/Probation are not intended to exist in isolation, but as only one component of a coordinated community response to domestic violence. Services shall maintain cooperative working relationships with local programs (domestic violence, batterers' programs, survivor programs, shelters, law enforcement, advocates, legal services, etc.). Services shall be structured, goal-oriented, time-limited individual/group services and casework/victim advocacy services.

Services provided may include the following:

- Educational and skills-based support group for survivor and/or child
- Assistance with transportation
- Coordination of services
- Advocacy (which includes goal setting, case management, supportive services)
- Safety planning
- Crisis intervention
- Community referrals and follow up
- Family/Child assessment
- Child development education
- Domestic violence education
- Parenting education with or without children present
- Budgeting and money management
- Participation in Child and Family Team meetings
- Family reunification
- Individual and family services
- Cognitive behavioral strategies
- Family of origin/Intergenerational issues
- Family structure and organization (internal boundaries, relationships, roles,

- socio-cultural history)
- Conflict resolution
- Behavior modification
- Substance abuse assessment

II. Service Delivery

- 1) Child safety and ending violence takes precedence over saving relationships. The service focus shall be on child safety, survivor safety, and increasing the survivor and child's functioning, both emotionally and physically.
- 2) The provider must be available to respond for crisis intervention as needed.
- 3) Service will be provided within the context of the Department of Child Services' practice model with involvement in Child and Family Team meetings. The provider will develop a service plan based on the provider's assessment, and the agreements reached in the Child and Family Team meeting as convened by DCS/Probation. Service plans for survivors and children will be developed separately from service plans developed for batterers.
- 4) Services must be available to participants who have limited daytime availability. The provider must identify a plan to engage the participant in the process, and a plan to work with non-cooperative participants, including those who believe they have no problems to address.
- 5) Provider must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the agreement.
- 6) The provider shall establish a written policy requiring that all staff have a duty to warn and protect survivors, partners, children and others against whom the batterer has made a threat of violence.
- 7) Services include providing any subpoenaed/court ordered testimony and/or court appearances (to include hearings or appeals).
- 8) Supervision/consultation is to include not less than one (1) hour of face-to-face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.
- 9) Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued culturally-competent manner.

A. Child Services

- 1) Provider assessment shall occur within 24 hours after initiation of services, upon receipt of DCS/Probation referral. Children will receive an initial assessment of needs when DCS/Probation indicates imminent risk/immediate safety concerns. A full assessment shall be available to DCS/Probation no later than four (4) working days after receipt of DCS referral.
- 2) Assessments shall include, but are not limited to: safety and risk factors for the child; child abuse/neglect; food/shelter/clothing; the parent/child relationships; screening for other co-occurring issues (substance abuse, mental health issues, behavioral issues, social impairment,

educational impairment, etc.).

- 3) A child safety plan shall be developed. (Note: the child must be willing and able to use the plan, and have the ability to opt out of any step in the plan if needed.) Comprehensive safety plans that are age and developmentally appropriate will be developed. Plans at a minimum will include: input from the non-abusive parent and be age appropriate; input from the child when appropriate; identification of safe places to go inside/outside of the home during violence; identification of where to meet if exiting the home is necessary; identification of how and when to use the phone for help; and identification of how to stay safe during an argument/violence.
- 4) The provider shall develop a comprehensive domestic violence service plan based on the assessment. Plans, at a minimum, will identify the needs of the child, set goals for the child, and establish a timeline for the accomplishment of goals in plan.
- 5) Advocacy and support services shall be provided as needed and as consistent with the assessment. These services shall include, but are not limited to, crisis intervention, links to community resources, Court Appointed Special Advocate (CASA)/ Guardian Ad Litem (GAL), information, and referral.
- 6) Services should be provided in the method consistent with the assessment and comprehensive domestic violence service plan and may include: individual or group services, play services, group play services, family services, support groups, and casework/victim advocacy services.
- 7) Group services for children, if provided, are to occur in weekly sessions at least one (1) hour in length. The number of weekly sessions will be determined by the provider and DCS/Probation based on the child's individual needs. Class size shall contain a minimum of three (3) participants and is not to exceed twelve (12) participants.
- 8) Group curriculum will be age appropriate and shall include, but is not limited to: promoting safe discussion of experiences with violence; helping the child understand that violence is not their fault and/or the fault of the survivor; helping the child understand and cope with their emotional responses to domestic violence; helping children identify, label, and express their feelings; exploring the child's attitudes and beliefs about families and family violence; and teaching children how to effectively manage their own anger.

B. Survivor Services

A comprehensive domestic violence safety plan will be developed based on the assessment. Survivor safety plans at a minimum will include: strategies to increase the safety of themselves and their children; a list of emergency contacts; access to critical legal, financial, and medical documents; medications; and relocation or shelter services.

Provider assessment shall occur within 24 hours after initiation of services, upon receipt of DCS/Probation referral. Survivors will receive an initial assessment of needs when DCS/Probation indicates imminent risk/immediate safety concerns. A full assessment shall be available to DCS/Probation no later than four (4) working days after receipt of DCS/Probation referral.

Assessments shall include, but are not limited to, safety and risk factors for the survivor and his/her child(ren), emergency medical/dental care, legal assistance, food/shelter/clothing, parenting needs and the parent/child relationship, and screening for other co-occurring issues (substance abuse, mental health issues, etc.).

The provider shall develop a comprehensive domestic violence service plan based on the assessment. Plans, at a minimum, will identify the needs of the survivor, set goals for the survivor, establish a timeline for the accomplishment of goals in plan, and identify and promote the use of informal and community supports and community resources.

Advocacy and support services shall be provided as needed and as consistent with the assessment and comprehensive domestic violence service plan. These services shall include, but are not limited to, housing assistance, emergency medical/dental, legal advocacy, job training/employment, safety plan, transportation, links to educational resources and community resources, information, and referral.

Services should be provided in the method consistent with the assessment and comprehensive domestic violence service plan and may include individual, group and/or family services, case management, and advocacy services.

Group services, if provided, are for survivors of the same gender and occur in weekly sessions at least one (1) hour in length. Number of weekly sessions will be determined by the provider and DCS based on the survivor's individual needs. Class size shall be a minimum of three (3) and is not to exceed 20 participants.

Group curriculum shall include, but is not limited to, helping the survivors understand their attitudes and beliefs about families and family violence; helping the survivors understand that violence is not their fault and they have no control over the violence; helping the survivors understand the dynamics of domestic violence and aspects of power and control; helping the survivors understand the impact of family violence on their children's development; enhancing survivors' parenting skills and appropriate discipline methods; and enhancing the survivors' skills in interacting with the batterer on issues dealing with the best interest of the child, in circumstances where face-to-face contact is necessary (visitations, school/athletic events etc.).

If clinical services are identified as a need, and the agency does not provide that service, the agency shall notify the FCM, who may refer for additional services. If the agency has a clinician on staff, the clinician must adhere to qualifications below.

III. When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay**

for reports when DCS is not paying for these services. If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

IV. Target Population

Services must be restricted to cases where domestic violence has been documented within the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- 2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

V. Goals and Outcomes

Goal #1: To Improve Safety of Survivors

Outcome Measures:

- 1) 100 % of survivors know how to plan for their continued safety.
- 2) 90 % of survivors report having an increased understanding of their legal rights.
- 3) 90 % of survivors report they know how to access resources that meet their needs.

Goal #2: To Enhance Skills of Children Who are Exposed to Domestic Violence

Outcome Measures:

- 1) 100% of children report they know that the violence is not their fault.
- 2) 90% of children will have identified effective coping mechanisms to deal with emotional responses to domestic violence.
- 3) 90% of children will have identified strategies to effectively manage their own anger.

Goal #3: Improved functioning including development of positive means of managing crisis

Objectives:

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

Client Outcome Measures:

- 1) 100 % of survivors report an increased knowledge and understanding of the effects of domestic violence on their children.

- 2) 90% of survivors report an increased understanding of parenting skills and appropriate discipline.
- 3) 90% of survivors report an increased knowledge on how to interact with the batterer on issues dealing with the best interest of the child.
- 4) 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period
- 5) 90% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of “substantiated” abuse or neglect throughout the service provision period. (To be measured/evaluated by DCS/Probation staff)
- 6) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.
- 7) If DCS elects to implement a standardized tool for evaluating family functioning, a related outcome measure will be added.

Goal #4: DCS/Probation and clients will report satisfaction with services

Outcome Measures:

- 1) 90 % of the families who have participated in Domestic Violence Services will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.
- 2) DCS/Probation satisfaction will be rated 4 or above on the Service Satisfaction Report.

Program Fidelity Measures

Program fidelity/abiding by best practices is the best predictor of successful outcomes and provides an effective indirect measure. An audit undertaken by a DCS employee or DCS designee may be conducted to assure program accountability. Programs must clearly link daily practices to the following program fidelity issues:

- 1) 90% of families receive their first contact (telephone, mail or face-to-face) no later than the end of the first day following receipt of a referral from DCS/Probation.
- 2) 100% of referrals that are not seen within 24 hours of referral will be reported to the referral source.
- 3) 90% of required written domestic violence service plans/assessments will be completed and sent to the referring worker within 10 days of face-to-face intake with the client/family.
- 4) 90% of the community supportive services (BIP providers, law enforcement, courts, advocates, legal agencies, etc.) have a cooperative working relationship with the provider.
- 5) 100% of provider staff focus on child/victim safety as evidenced by adherence to appropriate provider policies and procedures.

- 6) 100% of program activities are carried out by qualified staff (see Qualifications).
- 7) 90% of programs are available to participants who have limited daytime availability.
- 8) 100% of provider staff are required to warn and protect children and victims and others when and if the batterer has made a threat of violence.
- 9) 100% of clients (children and victims) will have a comprehensive domestic violence service plan developed.
- 10) 100% of children referred and engaged in the program will have a developmentally-appropriate safety plan developed by provider staff.
- 11) 100% of clients will be able to access a provider staff in the event of an emergency, 7 days a week, 24 hours a day.

VI. Minimum Qualifications

Direct Worker:

Services may be provided as needed by personnel with a Associates degree in social work, psychology, sociology, or a directly related human services field and/or 2 years working with families in a social service setting. Worker should have knowledge of current Indiana state law and best practices regarding domestic violence.

Supervisor of Direct Worker:

Bachelor's degree in social work, psychology, marriage and family, or a related human services field. Minimum 4 years professional field experience in a social service setting. Or Master's degree in social work, psychology, marriage and family, or a related human services field. Minimum 2 years professional field experience in family violence services. Supervisor should have knowledge of current Indiana state law and best practices regarding domestic violence.

Counselor

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

Supervisor of Counselor:

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

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

Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with “best practices” and comply with the requirements of each provider’s accreditation body. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies. Under no circumstances is supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.

In addition to the above:

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

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

VII. Billable Units

If agency administers clinical services, there may be two face to face units: Direct Worker and Counseling.

Face to face time with the client:

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

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

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

Group

Services include group goal directed work with clients. To be billed per group hour.

Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

- 0 to 7 minutes do not bill 0.00 hour
- 8 to 22 minutes 1 fifteen minute unit 0.25 hour
- 23 to 37 minutes 2 fifteen minute units 0.50 hour
- 38 to 52 minutes 3 fifteen minute units 0.75 hour
- 53 to 60 minutes 4 fifteen minute units 1.00 hour

Translation or sign language

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

Court

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS or subpoena to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

Reports

If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.

VIII. Case Record Documentation

Necessary case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.

- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

IX. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

X. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
FATHER ENGAGEMENT PROGRAMS
(Revised 7/7/11-Effective 7/7/11)

I. Service Description

The Indiana Department of Child Services (DCS) intends to contract with providers throughout the state to implement fatherhood programming to provide assistance and support to fathers whose children are involved with the Department of Child Services. Providers will work actively with DCS employees to successfully engage fathers in services that will improve safety, stability, well-being and permanency for their children. Providers will assist fathers in strengthening the relationship with their children and promoting positive relationships between the families and the local DCS family case managers and others involved in their children's case.

II. Service Delivery

- The direct worker's home office will be located in a DCS office where most of the services outlined in this standard can be performed. The provider will secure and maintain a working relationship with the Family Case Managers and other relevant DCS staff to provide a liaison between the fathers and DCS. When Family Case Managers have exhausted all known diligent search efforts and inquiries, providers will assist in locating and engaging fathers (including those who may be incarcerated or who live out of state).
- The provider will actively engage referred fathers with the goal of increasing their involvement in the DCS case.
- The provider will conduct intake interviews, and collect demographic and other outcome data for reporting purposes. Services must include ongoing monitoring of father/parental progress.
- The provider will work collaboratively with DCS, other contracted service providers, community organizations, and individuals to develop, maintain, and provide appropriate programming for fathers whose children are involved in the child welfare system.
- The provider will possess a clear understanding of male learning styles and male help seeking behaviors and will practice effective techniques for father engagement through a non-judgmental, holistic viewpoint regarding father/child relationship, focusing on the child in the context of the family.
- Refers participants, when indicated, to community resources and other organizations.

- Promotes community awareness regarding the value of engaging fathers of children involved in the child welfare process, through presentation and written materials.
- Develop a working relationship with local child support enforcement offices and staff members in order to be of mutual assistance in helping obtain appropriate financial support of children.
- Services will be provided at times convenient for or necessary to meet the family's need, not according to a specified work week schedule.
- Services will be provided in home, in the community environment, in the DCS office, and/or the providers' office.
- Services will be based on the family's established DCS Case Plan/Disposition or Informal Adjustment, while taking into consideration the recommendation of the Child and Family Team as applicable.
- Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life style choices, and complex family interactions and be delivered in a neutral, valued, culturally competent manner.
- The provider will coordinate and provide Fatherhood Programming utilizing a DCS approved educational curricula such as *Bringing Back The Dads*, *National Partnership for Community Leadership*, *Bridges Out of Poverty* (any other curricula must have prior approval). The Programming can be provided through the use of group or one-on-one sessions. All curricula must include child support enforcement education and financial responsibility education. In addition, the Fatherhood Programming and other individual work with the father, may provide any combination of the following kinds of services:
 - information regarding the CHINS legal process including court procedures, parental participation requirements, court ordered services, visitation with the children, reimbursement of cost for services, and other aspects related to the legal process;
 - the expectations of the family related to participation in court ordered services and visitation with the children, attendance at court, appropriate dress for court, and other aspects related to the legal process;
 - information regarding the parent's rights and the CHINS proceedings, the length of time children may be in care prior to a permanency procedure, and termination of parental rights, family team meetings and their procedures
 - role of the Court Appointed Special Advocate or Guardian ad Litem,
 - an informal environment for fathers to discuss issues that brought them to the attention of the DCS and develop suggestions that may assist in resolving these issues as a group, and;

- educational programs using speakers recruited from the local professional community to assist and educate the fathers in areas such as:
- abuse and neglect,
- increasing parenting skills,
- substance abuse,
- anger management,
- advocacy with public agencies including the children's schools, and;
- issues of interest to the parents related to their needs and the needs of their children.
- coaching and information to develop attitudes and social skills needed for improved family relations and personal responsibility.
- After consultation with the Family Case Manager, providers will make concerted, organized and systematic efforts to connect children with their incarcerated father (if applicable), through video conferencing, face to face contact, correspondence and by telephone, unless the court has determined that visiting would put the child in danger.
- Supports fathers and paternal relatives in court and Child and Family Team Meetings by providing transportation and/or transportation voucher when appropriate.

III. When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

IV. Target Population

Services must be restricted to the following eligibility categories:

- Fathers of children who have substantiated cases of abuse and/or neglect and will likely develop into an open case an IA or CHINS status.
- Fathers of children which have an Informal Adjustment (IA) or the children have the status of CHINS.

V. Goals and Outcome Measures

Goal #1

Department of Child Services
 Regional Document for Child Welfare Services
 Term 7/1/11-6/30/13
 August 2011

Timely initiation of services with the fathers.

Outcome Measures

- 1) 90% of all fathers referred with a valid contact and/or address will receive a telephone call or a drop by contact within 5 working days of referral.
- 2) 75% of all fathers referred will have face to face contact within 10 working days of the referral.

Goal#2

Timely receipt of electronic outcome reports.

Outcome Measures

100% of reports will be received timely.

The report will include a summary of services to each father as well as the father's involvement with the child (ren) and father's parental progression as evidence by visitation supervised and unsupervised with child (ren), participation in Child and Family Team Meetings, fathers involvement in the DCS case plan, established paternity and if the father is paying child support. The summary will also include engagement in fatherhood curriculum and/or successfully/unsuccessful completion of referral sources will be provided to the referring FCM monthly. An approved excel spread sheet, documenting services, will be electronically forwarded to Central Office designated email address, no later then the 10th of each month. An approved monthly report, documenting services to each referred father, will be forwarded to the FCM, no later then the 10th of each month.

Goal #3

Engage fathers in services that will reduce barriers to safety, stability, well-being and permanency for their children.

Outcomes Measures

- 1) 60% of all fathers referred will become actively engaged in the DCS open case as evidenced by visitation with their children, participation in CFTM, and the Case Plan.
- 2) 60% of referred cases will have paternal relatives actively engaged.

Goal #4

Coordinate efforts between the department of corrections and/or local detention facilities, child welfare agencies, and the courts to ensure the incarcerated father is notified of court proceedings regarding the care and custody of their child (ren) when appropriate.

Outcome Measures

- 1) 60% of incarcerated fathers will become actively engaged in the DCS open case as evidenced by contact with their children

Goal# 5

All engaged fathers will complete a service satisfaction survey. DCS will randomly evaluate services provided to ensure services provided are in accordance with contract requirements and reflective of the practice model.

Outcome Measures

- 1) 95% of all engaged fathers will rate services “satisfactory” or above.
- 2) 100% DCS satisfaction with provider services will be rated “fair” or above on the provider evaluation tool.

Goal #6

Maintain satisfactory services to the children and family

Objective

- 1) DCS/Probation and clients will report satisfaction with services.

Outcome Measure/Fidelity Measure:

- 1) DCS/Probation satisfaction with services will be rated 4 and above on the Service Satisfaction Report.
- 2) 90% of clients will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

VI. Minimum Qualifications

Direct Worker:

Bachelor's degree in social work, psychology, sociology, or a directly-related human service field from an accredited college. Must possess a valid driver's license and the ability to use private car to transport self and others, and must comply with the state policy concerning minimum car insurance coverage.

In addition to the above:

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

Supervisor:

Master's or Doctorate degree in social work, psychology, or directly-related human services field from an accredited college.

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

Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with “best practices” and comply with the requirements of each provider’s accreditation body. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies. Under no circumstances is supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.

VII. Billing Units

Face to face time with the client:

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

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.
- Billing for additional collateral contacts can be approved by DCS when attempting to locate and/or engage an incarcerated client or client living out of state.
- **Group**
Services include group goal directed work with clients. To be billed per group hour

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

Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

- | | | |
|--------------------|------------------------|-----------|
| • 0 to 7 minutes | do not bill | 0.00 hour |
| • 8 to 22 minutes | 1 fifteen minute unit | 0.25 hour |
| • 23 to 37 minutes | 2 fifteen minute units | 0.50 hour |
| • 38 to 52 minutes | 3 fifteen minute units | 0.75 hour |

- 53 to 60 minutes 4 fifteen minute units 1.00 hour

- **Translation or sign language**

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

- **Court**

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

- **Reports**

If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.

VIII. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A approved and dated DCS referral form authorizing services
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports no less than monthly or more frequently as prescribed by DCS. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.

IX. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

X. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS staff. In the event a service provider receives verbal or email authorization to provide services from DCS an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS. Providers must initiate a re-authorization for services to continue beyond the approved period.

**SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
FUNCTIONAL FAMILY THERAPY**

I. Services Description

Functional Family Therapy (FFT) is an empirically-grounded, family-based intervention program for acting-out youth between 11-18, whose problems range from conduct disorder to alcohol/ substance abuse, and their families. A major goal of Functional Family Therapy is to improve family communication and supportiveness while decreasing the intense negativity. Other goals include helping family members adopt positive solutions to family problems, and developing positive behavior change and parenting strategies. Further information on FFT can be found at <http://www.fftinc.com> or <http://www.ncjrs.org/pdffiles1/ojdp/184743.pdf>.

FFT is designed to increase efficiency, decrease costs, and enhance the ability to provide service to more youth by:

- 1) Targeting risk and protective factors that can change and then programmatically changing them;
- 2) Engaging and motivating families and youth so they participate more in the change process;
- 3) Entering each session and phase of intervention with a clear plan and by using proven techniques for implementation; and
- 4) Constantly monitoring process and outcome.

II. Service Delivery

The program is conducted by FFT trained family therapists through the flexible delivery of services by one and two person teams to clients in the home and clinic settings, and at time of re-entry from residential placement. Service providers must adhere to the principles of the FFT model. FFT requires as few as 8-12 hours of direct service time for commonly referred youth and their families, and generally no more than 26 hours of direct service time for the most severe problem situations. Sessions are spread over a 3-month period or longer if needed by the family. Therapists must engage the family (as many members as reasonably feasible) through a face to face contact within 14 days of the referral and obtain their willingness to participate. FFT emphasizes the importance of respecting all family members on their own terms as they experience the intervention process. Therapists must be relationally sensitive and focused, as well as capable of clear structuring, in order to produce significantly fewer drop-outs and lower recidivism.

Empirically grounded and well-documented, FFT has three specific intervention phases. Each phase has distinct goals and assessment objectives, addresses different risk and protective factors, and calls for particular skills from the therapist providing treatment. The phases consist of:

- **Phase 1: Engagement and Motivation**

During these initial phases, FFT applies reframing and related techniques to impact maladaptive perceptions, beliefs, and emotions and to emphasize within the youth and family, factors that protect youth and families from early program dropout. This produces increasing hope and expectation of change, decreasing resistance, increasing alliance and trust, reduced oppressive negativity within the family and between the family and community, increased respect for individual differences and values, and motivation for lasting change.

- **Phase 2: Behavior Change**

This phase applies individualized and developmentally appropriate techniques such as communication training, specific tasks and technical aids, basic parenting skills, and contracting and response-cost techniques.

- **Phase 3: Generalization**

In this phase, Family Case Management is guided by individualized family functional needs, their interaction with environmental constraints and resources, and the alliance with the therapist to ensure long-term support of changes. FFT links families with available community resources and FFT therapists intervene directly with the systems in which a family is embedded until the family is able to do so itself.

Each of these phases involves both assessment and intervention components. Family assessment focuses on characteristics of the individual family members, family relational dynamics, and the multi-systemic context in which the family operates. The family relational system is described in regard to interpersonal functions and their impact on promoting and maintaining problem behavior. Intervention is directed at accomplishing the goals of the relevant treatment phase. For example, in the engagement and motivation phase, assessment is focused on determining the degree to which the family or its members are negative and blaming. The corresponding intervention would target the reduction of negativity and blaming. In behavior change, assessment would focus on targeting the skills necessary for more adaptive family functioning. Intervention would be aimed at helping the family develop those skills in a way that matched their relational patterns. In generalization, the assessment focuses on the degree to which the family can apply the new behavior in broader contexts. Interventions would focus on helping generalize the family behavior change into such contexts.

Program certification must be obtained and maintained through utilizing Functional Family Therapy certified trainers to train a site supervisor and therapists. Program fidelity must be maintained through adherence to using a sophisticated client assessment, tracking and monitoring system and clinical supervision requirements.

III. Target Population

Services must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- 2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
- 4) All adopted children and adoptive families.

IV. Goals and Outcome Measures

Goals #1 Services are provided timely as indicated in the service description above.

Outcome Measures:

- 1) 100% of referred children and families are engaged in services within 14 days of referral.
- 2) 100% of children and families being served have an assessment completed at the beginning of each phase.
- 3) 100% of children and families being served have a clear plan developed immediately following the assessment.
- 4) Progress reports are provided to the current worker. Monthly.

Goal #2 Improved family functioning as indicated by no further incidence of the presenting problem

Objective:

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

Outcome Measures:

- 1) 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period.
- 2) 90 % of the children and families will not be the subjects of a new investigation resulting in the assignment of a status of “substantiated” abuse or neglect throughout the service provision period.
- 3) 90% of children and families that were intact prior to the initiation of service will remain intact throughout the service provision period.
- 4) Scores will be improved on the Risk Assessment instruments in ICWIS used by the referring DCS or Youth Level of Service Inventory (YSLI) used by referring Juvenile Probation Officer.

Goal #3 DCS/Probation and clients will report satisfaction with services provided.

Outcome Measures:

- 1) Probation/DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 90% of clients will rate services “satisfactory” or above on satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

V. Minimum Qualifications

Direct Worker:

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

Supervisor:

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

Both Direct Worker and Supervisor must complete FFT certified training (See the links listed in the FFT Service Description.)

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

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

VI. Billable Unit

Face to face time with the client:

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

- Includes client specific face-to-face contact with the identified client/family

during which services as defined in the applicable Service Standard are performed.

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

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

Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

• 0 to 7 minutes	do not bill	0.00 hour
• 8 to 22 minutes	1 fifteen minute unit	0.25 hour
• 23 to 37 minutes	2 fifteen minute units	0.50 hour
• 38 to 52 minutes	3 fifteen minute units	0.75 hour
• 53 to 60 minutes	4 fifteen minute units	1.00 hour

Translation or sign language

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

Court

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

VII. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services
- 2) Documentation of regular contact with the referred families/children
- 3) Written progress reports no less than monthly or more frequently as prescribed by DCS/Probation and requested supportive documentation such as case notes, social

summaries, etc. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.

- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

IX. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
PARENT EDUCATION
(Revised 6/8/11-Effective 7/1/11)

I. Service Description

Parenting education is the provision of structured, parenting skill development experiences. Education regarding parenting, discipline and child development is a means to provide parents whose children are “at risk” or have been abused or neglected with tools to assist them in the lifelong task of disciplining, understanding, and loving their children. Family-centered parent training programs include family skills training and family activities to help children and parents take advantage of concrete social supports. A combination of individual and group parent training is the most effective approach when building skills that emphasize social connections and parents’ ability to access social supports. However, the individual approach is most effective when serving families in need of specific or tailored services.

The following evidence-based programs are approved for use:

- Parent-Child Interaction Therapy (PCIT)
- STAR Parenting Program
- Systematic Training for Effective Parenting (STEP)
- Strengthening Families Program (SFP)
- Incredible Years; Parent-Child Interaction Therapy (PCIT)
- Parent Management Training-Oregon Model (PMTO)
- Positive Parenting Practices (Triple P)
- Parents as Teachers-Born to Learn
- Safe-Care
- Nurturing Program
- Active Parenting
- Effective Black Parenting by the Center for the Improvement of Child Caring
- 1-2-3 Magic
- Parenting with Love and Limits

Other Parent Education programs may be used but they require **written approval from the DCS Central Office**. Additional evidence-based programs are outlined at: The California Evidence-Based Clearinghouse at www.cebc4cw.org or the National Registry for Evidence Based Programs-SAMHSA (Substance Abuse and Mental Health Services Administration) at www.nrepp.samhsa.gov or the Office of Juvenile Justice and Delinquency Prevention at <http://ojjdp.ncjrs.gov>

The Child Welfare Information Gateway (www.childwelfare.gov/pubs/issue_briefs/parented) outlines key program characteristics and parent training strategies. Providers should review this issue brief incorporate these characteristics and strategies where possible. The key program characteristics include:

- strength-based focus
- family centered practice
- individual and group approaches
- qualified staff
- targeted service groups
- clear program goals and continuous evaluation

Parent Training Strategies include:

- Encourage Peer Support
- Involve Fathers
- Promote Positive Family Interaction
- Use Interactive Training Techniques
- Provide Opportunities to Practice New Skills

In-home assessments

When the model does not have prescribed in-home assessment procedures, the following shall be considered as a minimum standard:

An in-home assessment should be completed with the parent(s) and children before participation in the program, during program participation, as well as at program completion. These assessments should identify but are not limited to the following areas that impact the relationship of the parent/child:

- Appropriate developmental expectations-parent/child
- Empathy towards children's needs
- Use of corporal punishment
- Use of role reversal-child/parent
- Lack of family cohesion
- Lack of family expressiveness
- Lack of family independence

Postprogram assessments should indicate that parents significantly changed their parenting behavior and child-rearing attitudes following program completion. These changes should include having more appropriate developmental expectations, increased empathy toward children's needs, decreased use of corporal punishment, and decreased use of role reversal.

An examination of family interaction patterns should identify several significant improvements at postprogram assessment, including family cohesion, family expressiveness, and family independence, whereas family conflict significantly decreased.

II. When DCS is not paying for services:

A billable unit of “Reports” has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

III. Target Population

Services must be restricted to the following eligibility categories:

- Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed
- All adopted children and adoptive families.

IV. Goals and Outcome Measures

Goal #1 Maintain timely intervention with the family and regular timely communication with DCS/Probation

Objectives:

1) Direct worker or backup is available for consultation to the family 24/7 by phone or in person.

Goal #2 Strengthen and increase the parent’s ability to provide for the emotional, physical, and safety needs of their children.

Outcome Measures

- 1) 75% of the parents referred to program will complete the services.
- 2) 90% of the parents completing the program will show a demonstrated increase in skills during the in home postprogram assessment.
- 3) 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period.

- 4) 90% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of “substantiated” abuse of neglect throughout the service provision period.
- 5) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.

Goal #3

DCS/Probation and clients will report satisfaction with services provided.

Outcome Measures:

- 1) DCS or Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 90% of the families who have completed Parent Education services will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

V. Minimum Qualifications

Providers must meet the minimum qualifications guidelines of the chosen model. When qualifications are not prescribed in the model, the following shall be considered minimum qualifications:

Direct worker:

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

Supervisor:

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

Direct worker and Supervisor must have direct training in the Parent Education curriculum they are teaching.

In addition to:

- Knowledge of child abuse and neglect
- Knowledge of child and adult development and family dynamics
- Ability to work as a team member
- Strong belief that people can change their behavior given the proper environment and opportunity

- Belief in helping families to change their circumstances, not just adapt to them.

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

VI. Billable Units

Face to face time with the client:

(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS or Probation. This may include persons not legally defined as part of the family). Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.

- Includes client-specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal-directed interventions via telephone with the identified client family.
- Includes scheduled Child and Family Team meetings or case conferences (including crisis case conferences via telephone) initiated or approved by the DCS/Probation for the purposes of goal-directed communication regarding the services to be provided to the client/family. All case conferences billed, including those via telephone, must be documented in the case notes.

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

Group

Services include group goal directed work with clients utilizing an approved curriculum. To be billed per group hour..

Hourly services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

- 0 to 7 minutes do not bill 0.00 hour
- 8 to 22 minutes 1 fifteen minute unit 0.25 hour
- 23 to 37 minutes 2 fifteen minute units 0.50 hour
- 38 to 52 minutes 3 fifteen minute units 0.75 hour
- 53 to 60 minutes 4 fifteen minute units 1.00 hour

Translation or sign language

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

Court

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

Reports

If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.

VII. Case Record documentation

Necessary case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services
- 2) Documentation of regular contact with the referred families/children. Signed attendance sheets for each group session.
- 3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation.
- 5) A copy of a treatment plan to include short/long term goals with measureable outcomes that is consistent with the case plan/agreements reached in the CFTM.

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorization required by the Medicaid program.

IX. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
PARENTING / FAMILY FUNCTIONING ASSESSMENT
(Revised 6/8/11-Effective 7/1/11)

I. Service Description

Parenting/family functioning assessment is an in home evaluation which includes standardized test instrument(s) to identify the strengths and needs of the family. The service is most appropriately used when the needs of the family are so complex that a traditional assessment completed by a Family Case Manager is not able to determine the services necessary to improve the family's functioning. These families tend to have multiple caregiver ratings on the CANS of 2 or higher which indicates complex needs.

II. Service Delivery

Testing and Interviews Required

- Parenting/family functioning assessment must include an interview with the adults and children being assessed in their current home environment;
- Completion by adults of standardized test(s) to include a parenting inventory (such as Parent-Child Relationship Inventory; Adult Adolescent Parenting Inventory-2; Family Assessment Device, Version 3; Family Assessment Measure Version III (FAM-III); and/or the Child Abuse Potential Inventory and /or another Standard Risk Assessment Instrument;
- Observation of the parent(s) relationship with the child(ren); tour of the proposed home environment noting any needs or challenges.
- Review of other information sources to verify family's reported history (e.g., previous DCS history, collateral contacts).

Parenting and family functioning assessments shall include at least two separate appointments held on different days, when possible, to be scheduled at the convenience of the client (to include evenings and weekends).

Written Report

All written reports must include the recommendations regarding services/treatment at the beginning of the report followed by information relating to specific categories. The written assessment must be prepared to include the following:

- 1) identifying information,

- 2) history of significant events, medical history, history of the children (including educational history),
- 3) family socio-economic situation, including income information of the parents and child(ren)
- 4) family composition, structure, and relationships
- 5) family strengths and skills
- 6) family motivation for change
- 7) description of home environment,
- 8) summary of any testing completed,
- 9) summary of collateral contacts,
- 10) assessment of relationship between parent(s), and child(ren), and
- 11) assessor's assessment of the client's ability to safely parent the children,
- 12) client's understanding of the current situation.

If assessing parents in separate households, a separate written report must be provided on each parent. The report must also include current issues that jeopardize reunification with either parent if separate as well as a description of ongoing issues that need to be addressed even if the children remain in the home or are returned to the home.

If the provider suspects substance use, the provider should notify the Family Case Manager immediately if children are present and within 24 hours if children are not present in the home.

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

Failure to maintain confidentiality may result in immediate termination of the service agreement.

III. When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

IV. Target Population

Services must be restricted to the following eligibility categories;

- 1) Children and families who have substantiated cases of abuse and/or neglect, and will likely develop into an open case with Informal Adjustment (IA) or CHINS status;
- 2) Children and their families which have an IA or the children with a status of CHINS, and/or JD/JS;
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed;
- 4) Any child who has been adopted, and adoptive families

V. Goals and Outcomes

Goal #1 Timely receipt of report (service must commence within 3 working days of receipt of the referral).

Outcome Measures:

- 1) 90% of the evaluation reports will be submitted to the referring DCS Family Case Manager or Probation Officer within 30 days of referral.

Goal #2 Obtain appropriate recommendations based on information provided.

Outcome Measures:

- 1) 100% of reports will meet information requested by DCS.
- 2) 100% of reports will include recommendations for treatment and needed services.

Goal #3 DCS and client satisfaction with service provided.

Outcome Measures:

- 1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 90% of the families who have completed Parent Education services will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

VI. Minimum Qualifications

Direct Worker:

Master's degree in social work, psychology, marriage and family therapy, or related human service field with 3 years related clinical experience or a masters degree with a clinical license issued by the Indiana Social Worker, Marriage and Family Therapist and Mental

Health Counselor Board, as one of the following: 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor.

In addition to the above:

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

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

VII. Billable Units

Parenting/Family Functioning Assessment: per hour. Includes time face to face with the client/family, time spent administering, scoring, and interpreting testing. Plus a maximum of 1 hour may be billed for writing the report.

Reminder: Not included is scheduling of appointments, collateral contacts, travel time and no shows. These activities are built into the hourly rate and shall not be billed separately.

Hourly services may be billed in 15 minute increments, partial units are rounded to the nearest quarter using the following guidelines:

○ 0 to 7 minutes	do not bill	0.00 hour
○ 8 to 22 minutes	1 fifteen minute unit	0.25 hour
○ 23 to 37 minutes	2 fifteen minute units	0.50 hour
○ 38 to 52 minutes	3 fifteen minute units	0.75 hour
○ 53 to 60 minutes	4 fifteen minute units	1.00 hour

Court: The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

Reports

If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.

Translation or sign language

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

VIII. Case Record Documentation

Necessary case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS/Probation referral form authorizing service;
- 2) Written reports as defined in this service standard.

IX. Service Access

Services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved DCS referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

X. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

**SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
QUALITY ASSURANCE FOR CHILDREN IN RESIDENTIAL PLACEMENT**

I. Service Description

Quality Assurance services will be provided for DCS and Probation children currently in residential placement to assist the local DCS and Probation offices in determining if the needs of the children are being met by the current placement, and to investigate and recommend alternative placement options that more suitably meet the child's individual needs at a lower cost if available. Children at-risk of residential placement will be evaluated to locate a placement that can meet the child's needs at an acceptable cost.

These quality assurance services will consist of, but are not limited to:

- Specific evaluations completed with regard to the child's educational, psychiatric, medical, and other needs to ensure each child is receiving the quality of services specified.
- Assure that each child is "matched" with a provider that can best meet the individual needs of the child.

II. Target Population

Services must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- 2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

III. Goals and Outcomes

Goal #1: Decrease the number of children in residential care.

Outcome Measure:

- 1) The number of children in residential placement will be monitored and compared to placement levels in previous years with a goal of decreasing the number of children in residential placement 25% by the end of the contract period.

Goal # 2: Children will be maintained at lower levels of care.

The level of services needed by individual children and provided at their placements will be monitored through visits to the facility and communication with the FCM to assess effectiveness of treatment and evaluate treatment progress.

Outcome Measure:

Department of Child Services
Regional Document for Child Welfare Services
Term 7/1/11-6/30/13
August 2011

- 1) 100% of the youth in the program will establish at least one community-based support that will continue to provide assistance and/or direction following completion of the program
- 2) 85% of youth will maintain their placement in a less restrictive setting at 6 month follow up.

Goal #3: Maintain satisfactory services to the children and family

Objective

DCS/Probation and clients will report satisfaction with services.

Outcome Measure/Fidelity Measure:

- 1) DCS/Probation satisfaction with services will be rated 4 and above on the Service Satisfaction Report.
- 2) 90% of clients will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

IV. Minimum Qualifications

A Master’s degree in social work, psychology or marriage and family therapy and 3 (three) years of related clinical experience is required.

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

V. Billable Unit

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

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

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

Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

- 0 to 7 minutes do not bill 0.00 hour
- 8 to 22 minutes 1 fifteen minute unit 0.25 hour
- 23 to 37 minutes 2 fifteen minute units 0.50 hour
- 38 to 52 minutes 3 fifteen minute units 0.75 hour
- 53 to 60 minutes 4 fifteen minute units 1.00 hour

Translation or sign language

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

Court

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

VI. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services
- 2) Documentation of regular contact with the referred families/children
- 3) Written progress reports no less than monthly or more frequently as prescribed by DCS/Probation and requested supportive documentation such as case notes, social summaries, etc. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation
- 5) Copy of treatment plan to include short/long term goals consistent with DCS case plan/agreements reached upon CFT meeting.

VII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

VIII. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
SEX OFFENDER TREATMENT
(Revised 6/8/11-Effective 7/1/11)

I. Service Description

This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation.

Sex offender specific treatment is designed to improve public safety by reducing the risk of reoccurring sexually based offenses. It is an intervention carried out in a specialized program containing a variety of cognitive behavioral and psycho-educational techniques that are designed to change offense supportive beliefs and attributions, improve handling of negative emotions, teach behavioral risk management, and promote pro-social behavior. Because programming will rely on a containment approach, providers shall work closely with local service and treatment agencies to enhance the community's response to sexual offending. Along with sexual offender specific treatment, containment teams shall be established for each referral in order to ensure consistency in service delivery and decision-making and foster collaboration. Programming will provide services to children and their families who are referred by the Department of Child Services and/or the local Juvenile Probation Department.

All referred cases shall follow a continuum that provides the following:

- 1) Risk and needs assessment for sexual offenders: **(emergency and non-emergency)**
Assessments must include the following components: Youth, family and community strengths; cognitive functioning; social/developmental history; current individual functioning; current family functioning; delinquency and conduct/behavioral issues; substance use and abuse; psychosexual assessment; mental health assessment; sexual evaluation; community risk and protective factors; awareness of victim impact; external relapse prevention systems including informed supervision amenable to treatment and treatment recommendations. It must also include an assessment of risk using the ERASOR (Estimated Risk of Adolescent Sexual Offender Recidivism).
- 2) Containment Teams for offenders Traditional supervision practices do not adequately address the unique challenges and risks that sexually maladaptive youth pose to the community. Therefore it is expected that the provider will establish a "network" of family members, friends, teachers, coaches and any other community members or professionals who are committed to the success of the youth, to provide intensive monitoring of the youth in the home, school and community. This monitoring will occur 24 hours a day while the youth receives treatment.
- 3) Treatment must include individual, group and family components for sex offenders including the following:

- a. Case-specific treatment components through individual therapy including addressing personal history of sexual victimization and behavioral techniques designed to modify deviant sexual arousal if appropriate
- b. Core treatment modules through group therapy including: psychoeducation about the consequences of abusive behavior; increasing victim empathy, identifying personal risk factors, promoting healthy sexual attitudes and beliefs; social skills training; sex education; anger management and relapse prevention as appropriate
- c. Parent components including: engendering support for treatment and behavior change; encouraging supervision and monitoring; teaching recognition of risk signs and promoting guidance and support to their teenager.
- d. Relapse prevention if appropriate
- e. Polygraph testing if appropriate
- f. Family support services
- g. Compliance monitoring and reporting

II. Service Delivery

- 1) For DCS, services are provided face-to-face in the counselor's office or other setting. For MCO, the service setting is either outpatient or office setting. For MRO, the service must be provided at the client's home or other at other locations outside the clinic setting.
- 2) Services must include 24 hour crisis intake, intervention and consultation seven days a week.
- 3) Services must include ongoing risk assessment and monitoring of progress.
- 4) Services must provide short/long term goals with measurable outcomes based on recommendation based on risk and needs assessment for sexual offenders. Services include monthly reports, to include treatment goals; requested supportive documentation such as case notes, social summaries, etc.; and requested testimony and/or court appearances including hearings and /or appeals; case conferences/staffing; CFTM, if invited.
- 5) Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.

III. Medicaid

For those families and children not eligible for Medicaid Rehabilitation Option, this service will be paid by DCS. For eligible families and children, some services may be provided through Medicaid Rehabilitation Option (MRO) or Medicaid Clinic Option (MCO) with the remaining services paid by DCS. While the primary focus of these services is on the needs of the family, it is expected that some of these services will be deemed medically necessary to meet the behavioral health care needs of the MRO eligible client, and therefore may be billable to MRO. Other services for Medicaid clients may be covered under MCO. The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements

and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid.

IV. When DCS is not paying for services:

A billable unit of “Reports” has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

V. Target Population

Services must be restricted to the following eligibility categories:

Youth, under the age of eighteen (18), experiencing sexually maladaptive behaviors, who are within the target populations described below:

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- 2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
- 4) All adopted children and adoptive families.

Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need. Services billable to MCO are for Medicaid eligible clients.

VI. Goals and Outcomes

Goal #1 Maintain timely intervention with family and regular and timely communication with current Family Case Manager or Probation Officer.

Objectives:

- 1) Therapist or backup is available for consultation to the family 24/7 by phone or in person.

Outcome Measures:

- 1) 95% of all families that are referred will have face-to-face contact with the client within 5 days of receipt of the referral or inform the current Family Case Manager or probation Officer if the client does not respond to requests to meet.
- 2) Emergency Assessments: 95% cases will include Initial recommendations being provided to the referring worker within 48 hours of the emergency assessment with a full assessment report to the worker within 72 hours of the emergency assessment (by email).
- 3) 95% of full assessment reports for nonemergency assessments must be available within fourteen calendar days of the referral (by email).
- 4) 95% of the initial treatment plans will including measurable goals, specific steps to be taken to meet those goals and estimated timeframes for completing each goal and must be sent to the referring worker within fifteen calendar days of the first face-to-face contact with the client (by email).
- 5) 100% of monthly progress must be completed and sent to the referring worker by email by the 10th of each month for the previous month. Reports must contain documentation of progress made since the previous report in each goal.

Goal #2 A Containment Team shall be implemented for each family referred to services. The Team approach will allow for families to participate in the decision making process regarding their family.

Outcome Measures:

- 1) 100% of all children/families referred for treatment will have a fully functional network in place within 60 days of the initial face-to-face contact and will thereafter meet monthly to review the adolescent's progress, strengths and needs. The meetings will have minutes prepared with action steps identified together with person(s) responsible for completing those steps. These minutes will be included with the monthly progress reports sent to the referring workers.

Goal #3 Youth participating in the program will have no behavioral issues and/or probation violations.

Outcome Measures:

- 1) 90% of youth participating in the program will not have any delinquency charges and/or probation violations during the treatment phase.
- 2) 75% of youth who successfully complete the program will not have any delinquency charges and/or probation violations within 12 months of completing the program.
- 3) 95% of youth who participate in the program will not be a perpetrator of child sexual abuse during the 12 months following program completion.

Goal #4 DCS/Probation and client will report satisfaction with services provided.

Outcome Measures:

- 1) DCS/Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 90% of the clients will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

VII. Minimum Qualifications

Service providers will only utilize professionals who are specifically trained and are licensed practitioners. Training can occur through the University of Louisville, KY, Ohio University, OH, the Indiana Association for Juvenile Sex Offender Practitioners, or an equivalent recognized credentialed authority. Further, staff members shall be knowledgeable of the dynamics surrounding child abuse/neglect, be knowledgeable of child and adult development and family dynamics, and also knowledgeable of community resources.

MCO:

- Medical doctor, doctor of osteopath, licensed psychologist
- Physician or HSPP-directed services provided by the following: licensed clinical social worker, licensed marital and family therapist; licensed mental health counselor; a person holding a master’s degree in social work, marital and family therapy or mental health counseling; an advanced practice nurse

MRO:

- Licensed professional, except for a licensed addiction counselor
- Qualified behavioral health professional (QBHP)

DCS:

- Minimum qualifications: Master’s degree in a behavioral health science.

VIII. Billing Units

Services through the **MCO** may be Outpatient Mental Health Services. Medicaid shall be billed first for eligible services under covered evaluation and management codes, including those in the 90000 range.

Services through the **MRO** may be Behavioral Health Counseling and Therapy.

Billing Code	Title
H0004 HW	Individual

H0004 HW HQ	Group
H0004 HW HR	Individual Setting with the Consumer Present
H0004 HW HS	Behavioral Health Counseling and Therapy
H0004 HW HR HQ	Behavioral Health Counseling and Therapy
H0004 HW HS HQ	Family/Couple Counseling and Therapy (Group Setting) without the Consumer Present

DCS funding: Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below. These billable units will also be utilized for services to referred clients who are not Medicaid eligible and for those providers who are unable to bill Medicaid.

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

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

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

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

Hourly Services may be billed in 15 minute increments, partial units are rounded to the nearest quarter using the following guidelines:

- | | | |
|--------------------|------------------------|-----------|
| ○ 0 to 7 minutes | do not bill | 0.00 hour |
| ○ 8 to 22 minutes | 1 fifteen minute unit | 0.25 hour |
| ○ 23 to 37 minutes | 2 fifteen minute units | 0.50 hour |
| ○ 38 to 52 minutes | 3 fifteen minute units | 0.75 hour |
| ○ 53 to 60 minutes | 4 fifteen minute units | 1.00 hour |

Court: The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the

court appearance, therefore additional costs associated with the appearance cannot be billed separately.

Reports

If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.

Translation or sign language:

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

Polygraphs

Polygraphs must be purchased from a licensed provider. Polygraphs are a unit rate and the provider must tell what their rates are as part of their proposal. The intent of the polygraph is for the sex offender only.

Per person per group hour

Services include group goal directed work with clients. To be billed per person per group hour .

IX. Case Record Documentation

Necessary case record documentation for service eligibility must include:

- 1) A DCS/Probation referral form, **Juvenile** Court Order, or written referral from the Juvenile Probation Department;
- 2) Documentation of regular contacts with the referred families/children and referring agency;
- 3) Written reports regarding each assessment;
- 4) Written minutes regarding each containment team meeting.
- 5) Written reports no less than monthly

X. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved DCS referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

XI. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
TRANSITION FROM RESTRICTIVE PLACEMENTS (TRP)
(Revised 4/21/11-Effective 7/1/11)

I. Services Description

TRP is a provision of services to assist children in a more restrictive placement to a less/least restrictive placement. The purpose of the program is to prevent a return of the youth to a more restrictive setting/placement. TRP must include the following kinds of services to the youth and family:

Therapeutic/clinical interventions to address the service needs of the youth and family. Therapeutic interventions must be based on an evidence-based model such as Functional Family Therapy (FFT), Multi-systemic Therapy (MST), Parenting with Love and Limits (PLL), or similar program.

Home-based services including but not limited to the following:

- Home assessment
- Child development education
- Educational transition services
- Vocational services
- Drug/alcohol screening & monitoring
- Conflict management
- Addiction Education
- Group Therapy
- Coordination of services, with special emphasis on education and employment services
- Emergency/crisis services
- Parenting education/training
- Family communication
- Assistance with transportation
- Family reunification
- Family assessment
- Community referrals and follow-up
- Behavior modification
- Budgeting/money management
- Other services as deemed appropriate based on the needs of the youth and family

II. Service Delivery

- 1) Services must include 24-hour access to crisis intervention seven days a week and may be provided in the family's home, at a community site, or in the office.
- 2) Services must include ongoing risk assessment and monitoring family/parental progress.
- 3) Services must include development of goals with measurable outcomes.
- 4) Provider must complete an intake interview with the family within five calendar days after receipt of the referral or notify referral source if client does not respond to meeting requests.

- 5) Provider must maintain monthly contact with the youth's referring agency during the time

the youth is in the more restrictive placement to ensure that the transition plan remains consistent between agencies.

- 6) Provider must participate in an initial meeting with the youth's FCM or probation officer, youth, and family within 48 hours of release.
- 7) For JD/JS youth, the provider must complete the Child and Adolescent Needs and Strengths (CANS) assessment within 30 days of transition from the more restrictive placement, if not completed at the time of discharge from the more restrictive placement, and every six months thereafter. If no CANS assessment was completed prior to the youth being admitted to the more restrictive placement, the service provider is responsible for completing the assessment within 2 weeks of the placement in a less restrictive placement. (DCS will be responsible for CANS assessments for CHINS youth.)
- 8) Provider must conduct a minimum of two (2) face to face visits per week with the youth during the first thirty (30) days of release from the more restrictive placement. The level of supervision after that period of time will be determined by the team but will never be less than 1 face to face visit per week.
- 9) When appropriate and requested by the Probation Officer or Family Case Manager, the provider may require the youth to submit to at least one random drug screen within fourteen (14) days of changing from a more restrictive placement. This may be done through the local probation department or another approved vendor.
- 10) Provider must maintain frequent contact with the FCM/probation officer and notify the FCM/probation officer in writing of non-compliance issues. The provider must also develop a recommendation for the FCM/probation officer as to a suitable therapeutic intervention.
- 11) The family will be the focus of service and services will focus on the strengths of the family and build upon these strengths.
- 12) Services must be family focused and child centered.
- 13) Services must include intensive in-home skill building and after-care linkage.
- 14) Services include providing monthly progress reports in a format approved by the Court, participation in team meetings, and providing requested testimony and/or presence at court hearings.
- 15) Additionally, the provider will recommend to the referring agency any other services, such as therapy, which might be needed. Recommendations for additional services not covered in the service standard should be made, in writing, to the current FCM or probation officer. Additional services require a separate referral and should not be started until one has been received.

16) Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.

17) The caseload of the therapist/case manager will include no more than ten (10) workload units. All youth in service are weighted at 1 workload unit.

III. Target Population

Services must be restricted to the following eligibility category:

- Children with a status of CHINS and/or JD/JS who have been placed in a restrictive setting.

Note that Transition From Restrictive Placements (TRP) can be provided to CHINS or probation youth who are transitioning out of residential or group home placements. TRP services may begin while a youth is still in a residential or group home placement if that youth will be transitioning within 30 days.

For JD/JS youth who are committed to the Department of Corrections, this service may begin within 60 days of the scheduled or anticipated discharge.

IV. Goals and Outcomes

Goal #1 To improve the transition for youth back to their home by providing therapeutic services to the youth and family

Outcome Measures

- 1) Based on the CANS Assessment, 100% of participants will have an individualized service plan developed.
- 2) 90% of families will actively participate in services during the youth's period of placement.
- 3) 90% of the youth will have a minimum of 2 face to face visits each week from their direct worker/therapist during the first 30 days following their placement from a more restrictive to a less restrictive placement.

Goal #2 To reduce routine barriers by providing direct assistance with transition issues

Outcome Measures

- 1) 90% of all participants will have a state-issued ID or driver's license by the completion of the program.
- 2) 90% of all participants will actively participate in an education program.
- 3) 100% of participants not involved in an educational program will be employed and/or participating in a formal employment assistance program.

Goal #3 To develop a system of community supports for each youth that will continue after completion of the program.

Outcome Measures

- 1) 100% of the youth in the program will establish at least one community-based support that will continue to provide assistance and/or direction following completion of the program
- 2) 85% of youth will maintain their placement in a less restrictive setting at 6 month follow up.

Goal #4 Maintain satisfactory services to the children and family
Objective

- 1) DCS/Probation and clients will report satisfaction with services.

Outcome Measures

- 1) DCS/Probation satisfaction with services will be rated 4 and above on the Service Satisfaction Report.
- 2) 90% of clients will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

V. Minimum Qualifications

Counselor/Direct Worker:

MCO billable:

- Medical doctor, doctor of osteopath; licensed psychologist
- Physician or HSPP-directed services provided by the following: licensed clinical social worker, licensed marital and family therapist; licensed mental health counselor; a person holding a master’s degree in social work, marital and family therapy or mental health counseling; an advanced practice nurse.

MRO billable:

Providers must meet the either of the following qualifications:

- Licensed professional, except for a licensed clinical addiction counselor
- Qualified Behavioral Health Professional (QBHP).

DCS billable:

Direct Worker:

A bachelor’s degree in social work, psychology, sociology, or a directly related human service field is required.

Therapist:

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

Supervisor:

A master's degree in social work, psychology, or marriage and family or related human service field with a current license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board, as one of the following: 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor 4) Addictions Counselor is required.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, and occur every two (2) weeks or more frequently.

The staff person must possess:

- Knowledge of community resources and ability to work as a team member.
- An understanding of issues specific to youth transitioning back into the community following a stay in restrictive placement.
- Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life style choices, and complex family interactions and be delivered in a neutral valued culturally competent manner.

VI. Billable Unit

Medicaid:

It is expected that the majority of the individual, family and group counseling provided under this standard will be based in the clinic setting. In these instances, the units may be billable through MCO. Medicaid shall be billed when appropriate.

Services through the **MCO** may be Outpatient Mental Health Services. Medicaid shall be billed first for eligible services under covered evaluation and management codes, including those in the 90000 range.

Services through the Medicaid Rehab Option (**MRO**) may be **group** Behavioral Health Counseling and Therapy, Case Management, and Skills Training and Development .

Billing Code	Title
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Department of Child Services
 Regional Document for Child Welfare Services
 Term 7/1/11-6/30/13
 August 2011

H0004 HW U1	Behavioral health counseling and therapy (group setting), per 15 minutes
H0004 HW HR U1	Behavioral health counseling and therapy, per 15 minutes (family/couple, group setting, with consumer present)
H0004 HW HS U1	Behavioral health counseling and therapy, per 15 minutes (family/couple, group setting, without consumer present)
T1016 HW	Case Management, each 15 minutes
H2014 HW	Skills Training and Development , per 15 minutes
H2014 HW HR	Skills Training and Development, per 15 minutes (family/couple, consumer present)
H2014 HW HS	Skills Training and Development, per 15 minutes (family/couple, without consumer present)
H2014 HW U1	Skills Training and Development , per 15 minutes (group setting)
H2014 HW HR U1	Skills Training and Development , per 15 minutes (group setting, family/couple, with consumer present)
H2014 HW HS U1	Skills Training and Development , per 15 minutes (group setting, family/couple, without consumer present)

DCS funding:

Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below. These billable units will also be utilized for services to referred clients who are not Medicaid eligible and for those providers who are unable to bill Medicaid.

If agency administers clinical services, there may be two face to face units: Direct Worker and Counseling.

Face to face time with the client:

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

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

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

Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

- 0 to 7 minutes do not bill 0.00 hour
- 8 to 22 minutes 1 fifteen minute unit 0.25 hour
- 23 to 37 minutes 2 fifteen minute units 0.50 hour
- 38 to 52 minutes 3 fifteen minute units 0.75 hour
- 53 to 60 minutes 4 fifteen minute units 1.00 hour

Translation or sign language

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

Court

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS or subpoena to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

VII. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services
- 2) Documentation of regular contact with the referred families/children

- 3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

IX. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

**SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
TUTORING/LITERACY CLASSES**

I. Services Description

Tutoring/literacy and math services will be provided to raise the academic performance of school aged youth to a level consistent with state education standards.

Services shall be provided in a manner that is age and developmentally appropriate, and consistent with the child's academic ability and learning style, interpersonal characteristics and special needs. Children will be connected as appropriate with both formal and informal community supports, services and activities that promote their literacy skills. The child's characteristics such as race, culture, ethnicity, language and personal history including child abuse and neglect will be considered when choosing or designing program interventions, materials and curriculum. The provider will develop an education plan to address the child's literacy and math needs.

A variety of activities and lessons shall be available to afford choice. Activities and lessons shall promote literacy skills and academic development and should demonstrate well-planned, flexible and responsive services. Services should include regular use of external resources such as libraries, museums and community educational sites. Services may also incorporate the use of video games and computers. The use of television and videos shall be strictly limited to a minimal portion of the child's participation. Video games, computers, television and videos should be age and developmentally appropriate, supportive of the child's educational goals, and the child should be monitored at all times when using these resources.

The provider will develop a plan to engage the child, caregiver, and educator in the process. The plan will accommodate persons who are difficult to engage if necessary. The provider will clearly communicate and coordinate the child's education plan goals with the caregiver and educator and will periodically and frequently give updates and review progress with them.

II. Service Delivery

Treatment Modality

Tutoring/literacy and math services shall be provided through direct one-on-one sessions or in small groups of 2 to 4 children who are matched by ability. Services should occur in locations that promote learning, are large enough to accommodate the group and teaching materials, allow the child to concentrate without being disturbed by others, and allow for meaningful and direct assistance. Services may take place after school, on weekends and/or other times when school is not in session. Services should not conclude later than normal bedtime hours.

Tutoring/literacy and math services shall incorporate evidence-based strategies that improve student achievement. Sessions shall be divided into segments, including: 1) an opening activity to set the stage, 2) activities based on individual learning goals, 3) opportunities to develop and

practice skills, and 4) a closing activity. All sessions shall include opportunities for the child to experience success and to progress. The provider should suggest home activities as appropriate.

Assessment

The provider will ensure the child receives an initial assessment in order to determine child specific learning needs no later than 10 days after being referred. The provider will make reasonable attempts to discover previous assessments and to utilize the findings of those assessments in conjunction with the provider's own assessment. Assessments shall include the use of standardized tools to obtain a baseline measurement and will at a minimum identify the following:

- Learning disabilities and/or impairments in cognitive functioning due to child abuse, neglect, or involvement with child welfare services
- Academic strengths, weaknesses and needs
- Level of ability compared to actual grade/age level

Services will be provided within the context of the Department of Child Services' practice model with participation in Child and Family team meetings if invited. An education plan will be developed and based on the agreements reached by means of the assessment and Child and Family Team Meeting (CFTM). Services will be provided in coordination with the child's Individualized Education Plan (IEP) if present, and the provider shall participate in IEP conferences with educators.

Education Plan

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

Include input from the child, caregiver and the educator.

Reflect underlying needs and goals.

Be tailored to the child's strengths, weaknesses, needs, available resources and unique circumstances.

Build on realistic possibilities and options

Identify strategies for lessening the effects of any disabilities and/or impairments in cognitive functioning.

Promote reading and math achievement at a level consistent with state education standards.

Be consistent with the child's Individualized Education Plan (IEP), if one is present

Support and/or build upon what the child is learning through their primary education program

Respond flexibly to the child's changing needs

The provider will evaluate the child's progress toward achieving identified goals and will regularly incorporate the use of standardized performance measurement tools to track progress

and adjust tutoring/ literacy and math activities. The provider will assist the child and caregiver in realizing ways of generating and maintaining gains. The provider will document progress and participation.

Services must be available to participants who have limited daytime availability.

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

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

III. Target Population

Services must be restricted to the following eligibility categories:

- 1) Children who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- 2) Children who have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- 3) All adopted children.

IV. Goals and Outcomes

Goal #1 Timely provision of services for the youth and regular and timely communication with referring worker.

Outcome Measures:

- 1) 95% of all youth referred will have face-to-face contact with the provider within 10 days of the referral.
- 2) 95% of all youth will have a written education plan within 30 days of the referral.
- 3) 100% of all youth will have monthly written summary reports prepared and sent to the referring worker.

Goal #2

Child has improved academic and/or literacy performance

Outcome Measures:

- 1) 90% of children improve academic and/or literacy performance as evidenced by pre and post-testing
- 2) 90% of children improve overall school performance as measured by grade point average or other standard indicators
- 3) 100% of children participate actively in the goals of their education plan as evidenced by provider documentation

Goal #3 DCS and youth satisfaction with services

Outcome Measures:

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

V. Minimum Qualifications

Direct Worker:

Tutoring services may be provided by workers with a Bachelor's degree or at least 60 hours of post secondary credit hours in education, social work, psychology, or a related field.

Supervisor:

A bachelor’s degree in education, social work, psychology, or a related field and 5 years experience tutoring children is required. Knowledge of state education standards is required.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client service hours provided. These sessions should occur no less frequently than every two (2) weeks.

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

Worker Qualities:

Providers working directly with children have the competencies and support needed to:

- Engage, empower and communicate effectively, respectfully and empathetically with children and families from a wide range of backgrounds, cultures and perspectives.
- Develop plans to meet the child’s literacy and tutoring needs.
- Recognize and identify the presence of cognitive impairments
- Collaborate with workers in other disciplines and access community resources
- Advocate for the child during Child and Family Team Meetings Individualized Case Plan (IEP) conferences

Providers working directly with children should be knowledgeable about:

- Child development
- Behavior management
- Learning disabilities
- Possible effects of child abuse and neglect on cognitive functioning
- The Individualized Education Plan (IEP) and its use in education
- Educational resources within the community
- Tutoring techniques

VI. Billable Unit

Face to face time with the client:

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

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

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

Group

Services include group goal directed work with clients. To be billed per group hour.

Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

- | | | |
|--------------------|------------------------|-----------|
| • 0 to 7 minutes | do not bill | 0.00 hour |
| • 8 to 22 minutes | 1 fifteen minute unit | 0.25 hour |
| • 23 to 37 minutes | 2 fifteen minute units | 0.50 hour |
| • 38 to 52 minutes | 3 fifteen minute units | 0.75 hour |
| • 53 to 60 minutes | 4 fifteen minute units | 1.00 hour |

Translation or sign language

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

Court

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS or subpoena to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

VII. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

IX. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

**SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
VISITATION FACILITATION**

I. Service Description

It is the fundamental right for children to visit with their parents and siblings. The relationship developed by the child with the parent is one of bonding, dependency, and being nurtured, all of which must be protected for the emotional well being of the child. It is of extreme importance for a child not to feel abandoned in placement by either the child's parents or by other siblings, and for a child to be reassured that no harm has befallen either parent or siblings when separation occurs.

Visit facilitation as identified by DCS/Probation will be provided between parents/children/siblings and/or others who have been separated due to a substantiated allegation of abuse or neglect or involvement with juvenile probation. Visitation allows the child an opportunity to reconnect and reestablish the parent/child/family relationship in a safe environment. It is an excellent time for parents to learn and practice new concepts of parenting and to assess their own ability to parent through interaction with the child. Supervised visitation allows the DCS/Probation to assess the relationship between the child and parent and to assist the parent in strengthening their parenting skills and developing new skills

The role of the visitation provider is to protect the integrity of the visit and provide a positive atmosphere where parents and children may interact in a safe, structured environment. Visitation may be held in a visitation facility; neutral sites such as parks, fast food restaurant with playground, or shopping malls; child's own home or relative's home; foster home; or other location as deemed appropriate by the referring agency and other parties involved in the child's case taking into consideration the child's physical safety and emotional well being.

II. Service Delivery

Referral process

In order for positive and productive visitation to occur, specific outlined below will be provided to the visitation provider by the child's family case manager or probation officer as part of the referral. Information may include:

- 1) desired/allowable location of visits (such as facility, neutral space, foster home, own, home, etc.), length of visits, number of visits requested per week,
- 2) placement of the child and contact information,
- 3) who may participate in visits with contact information and relationship to child,
- 4) who is restricted from visits,
- 5) level of supervision requested (such as in-room, drop-in during visit, audio monitored, video monitored, semi-supervised, unsupervised, etc),

- 6) what is expected of the parents or other approved person(s) regarding prior preparation related to bottle feeding, meals and snacks, change of clothes if needed, diapers and wipes, etc.,
- 7) restricted activities, if any, and
- 8) consequences when parents do not attend visits as planned and agreed upon (this may include no showing or being consistently late or consistently leaving early);
- 9) circumstances under which visits may be limited or terminated (such as parent or child has head lice, parent under influence of mood altering substance, parent's intimidating or threatening behavior, inability of parent to manage children's behavior in structured setting, etc.); and
- 10) any criminal, mental health, and safety information on all children and visiting parties
- 11) other information pertinent to the visits.
- 12) ratio of direct workers and clients.

In the event that the preceding information is incomplete, it is the responsibility of the visitation provider to obtain that information from the referring worker.

Upon receiving the referral from the DCS/Probation, the agency will contact all parties to set up the visits taking into consideration the ability of the parent to attend based on work schedules and the foster parent or relative caregiver ability to ensure attendance of the child. Every attempt must be made for visitation with the child's parent, guardian or custodian to occur within 48 hours of the child's removal from the home. For all other visitation referrals, visitation must be scheduled within 5 days. All cancelled visits by the parent or visit facilitator must be reported within 48 hours to the referring agency indicating who cancelled and the reason for cancellation.

Visit Observation and Reporting

Professional and/or paraprofessional staff will assist the family by strengthening, teaching, demonstrating, role modeling appropriate skills and monitoring in, but not limited to the following areas:

- Establishing and/or strengthening the parent-child relationship
- Instructing parents in child care skills such as feeding, diapering, administering medication if necessary, proper hygiene
- Teaching positive affirmations, praising when appropriate
- Providing instruction about child development stages, current and future
- Teaching age-appropriate discipline
- Teaching positive parent-child interaction through conversation and play
- Providing opportunities for snack and meal
- Responding to child's questions and requests
- Teaching safety regarding age-appropriate toys, climbing, running, jumping, or other safety issues depending on the environment
- Managing needs of children of differing ages at the same time
- Helping parents gain confidence in meeting their child's needs
- Visit Planning
- Teaching age appropriate activities that encourage child development and resiliency.
- Identifying and assessing potentially stressful situations between parent and their children
- Giving parents an opportunity to demonstrate

prep with children present

their willingness to complete their case plan.

At each visit, the visitation facilitator will accurately document for the referring agency the following information:

- 1) date, location, and level of supervision of visit;
- 2) those in attendance at the visit;
- 3) time of arrival and departure of all parties for the visit;
- 4) greeting and departure interaction between parent and child/ren;
- 5) positive interactions between parent and child;
- 6) planned activities by the parent for visit;
- 7) interventions required, if any and parent's response to direction provided with regard to interventions;
- 8) ability and willingness of parent to meet child's needs as requested by child or facilitator;
- 9) tasks given to the parent to be completed prior to or at the next visit, etc.
- 10) pertinent information/issues/concerns regarding the child's placement

Additionally, the following items apply:

- 1) Visitation staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
- 2) The current worker will be notified by phone immediately when inappropriate behavior occurs with either parent in a visit that affects the ability of the visit to continue or the safety of the child.
- 3) Services must demonstrate respect for sociocultural values, personal goals, life style choices, and complex family interactions and be delivered in a culturally competent fashion.
- 4) Attendance at case conferences may be required as well as testimony and/or court appearances at review or permanency hearings for the child.
- 5) Documentation of incidents in visitations which are or could be considered subjective must be followed by examples of the situation for clarification. The documentation of the visit must be provided to the current FCM/PO within 3 days of the visit. Phone calls shall be immediate for safety or recommendations for terminated visits.
- 6) Provider understands that documentation may be shared by DCS/Probation with the child's parents, foster parents or other placement of the child, the child's therapist, and other parties in the case to assist in decision making regarding decreased or increased levels of supervision and reunification.

III. Target Population

Services must be restricted to the following eligibility categories:

- Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.

- Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

IV. Goals and Outcome Measures

Goal #1

Ensure that all children removed from their parents have the opportunity to visit their parents/siblings on a regular basis.

Outcome Measures

- 1) 100% of the families will have the first face-to-face visit with their child(ren) within 48 hours of the child's removal from the home.
- 2) 100% of the families will have visitation set up and occurring with the frequency and duration requested by DCS/Probation within 5 working days of receipt of the referral.

Goal # 2

Strengthen and increase the parent's ability to provide for the emotional and physical needs as well as the safety of their children.

Outcome Measures

- 1) 85% of parents served will demonstrate an increased ability to recognize and respond appropriately to their children's cues by case closure.
- 2) 85% of the parents will actively reinforce positive behavior and address negative behavior.
- 3) 90% of parents will arrive with previously requested items by the visit facilitator for the children such as diapers, food, etc. and be prepared to provide a meal or snack if expected.

Goal # 3

Provide accurate and timely information in the child's case so that informed decisions may be made regarding reunification and permanency for the child.

Outcome Measures

- 1) 98% of visitation reports will be received by the DCS/Probation within 3 days of the visitation or immediately (by phone) when inappropriate behavior occurs with either parent, followed up with a monthly report form. Written reports will be completed on the DCS approved visitation report forms.

Goal #4

DCS/Probation and clients will report satisfaction with services provided

Outcome Measures

- 1) DCS or Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 94% of the families who have completed visitation facilitation services will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

V. Minimum Qualifications

Direct Worker

A high school diploma and 5 years of experience in providing visitation supervision OR Bachelor's degree in social work, psychology, sociology, or a directly related human service field.

Supervisor:

Master's degree in social work, psychology, or directly related human services field or a Bachelors degree in social work, psychology, or a directly related service field with 5 years child welfare experience.

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

VI. Billable Units

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

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS/Probation (which can include telephone case conferences) either with or without the client, for the purposes of goal directed communication regarding the services to be provided to the client/family.

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

Hourly services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

- | | | |
|--------------------|------------------------|-----------|
| • 0 to 7 minutes | do not bill | 0.00 hour |
| • 8 to 22 minutes | fifteen minute unit | 0.25 hour |
| • 23 to 37 minutes | 2 fifteen minute units | 0.50 hour |
| • 38 to 52 minutes | 3 fifteen minute units | 0.75 hour |
| • 53 to 60 minutes | 4 fifteen minute units | 1.00 hour |

Court

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

Translation or sign language

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

VII. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services
- 2) Documentation of regular contact with the referred families/children
- 3) Written progress reports no less than monthly or more frequently as prescribed by DCS/Probation and requested supportive documentation such as case notes, social summaries, etc. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent. The “Visitation Monthly Progress Report” form must be used to report the supervised visit.
- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to

provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

IX. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
DRUG TESTING AND SUPPLIES
(Revised 3/21/11-Effective 7/1/11)

I. Service Description

These services are designed for individuals who are suspected by DCS workers and Probation Officers of drug and/or alcohol use and require immediate testing. The drug test list includes Drugs of Abuse (illegal drugs), Therapeutic drugs (Prescription Drug-Painkillers, Mental Health Meds, etc.), and Designer drugs (i.e. K2, "Spice). The vendor must provide all required supplies and courier services to transport all specimens, test results, and testing materials to and from any location within the referring county.

The FCMs may administer saliva/oral fluid (swabs) only. Probation Officers are not prohibited by DCS from the administration of drug tests.

The types of drug screens included, but are not limited to, saliva/oral fluid, hair follicle, and urine.

Services include providing any requested testimony and/or court appearances (to include hearing or appeals), including chain-of-custody and/or testing procedures/results on an as needed basis and providing certified copies of drug tests, if requested, up to 2 years after screening.

The vendor shall provide Initial Testing and Gas Chromatography/Mass Spectrometry Confirmation (GC/MS) Testing or other federally approved testing methods which may include LC/MS/MS or GC/MS/MS (when the Initial Tests indicate a positive result) for any location within the referring county.

The Vendor shall ensure proper legal chain-of-custody procedures are maintained and comply with departmental procedure, state and federal law. The vendor shall also ensure complete integrity of each specimen tested and the respective test results. Receiving, transfer and handling of all specimens by laboratory personnel shall be fully documented using the proper chain-of-custody.

Testing shall not be conducted on any specimen without a legal chain-of-custody. All specimens found to be "Adulterated" or "Contaminated" shall be treated as an Invalid Specimen. Any specimen without a valid chain-of-custody is to be destroyed. The submitting location shall be notified in writing when a specimen has been rejected due to an invalid chain-of-custody or any other integrity problem. Monthly reports shall document how many random samples were taken minus how many "Adulterated" or "Contaminated" specimens there were for the month. (Note: This does not apply to oral fluid testing.)

Initial Testing

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All sample collections drug screens will be observed sample collections screens. Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Propoxyphene, and Methamphetamine and other drugs indicated by client's history. The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation.

For urine screens, testing for creatinine levels shall be conducted on all samples. The vendor shall also insure testing for total Cannabinoids per mg of creatinine using spectrophotometer technology. The Vendor shall insure testing for specific gravity on all samples with a creatinine level below 20 mg per deciliter. The Vendor shall also insure the administration of a nitrite test on any specimen that contains no creatinine and has a specific gravity test of 1.000.

Initial screening shall be conducted utilizing an enzyme immunoassay method. Testing should occur for the following substances utilizing the cut-off levels listed below:

DRUG	URINE	ORAL FLUID	HAIR LEVELS*
<i>Amphetamines</i>	<i>1000NG/ML</i>	<i>20NG/ML</i>	<i>500PG/MG</i>
<i>Cannabinoids</i>	<i>50NG/ML</i>	<i>1NG/ML</i>	<i>1PG/MG</i>
<i>Benzodiazepines</i>	<i>300NG/ML</i>	<i>10NG/ML</i>	<i>200PG/MG</i>
<i>Methamphetamine (including ECSTACY(MDMA), ADAM(MDA))</i>	<i>1000NG/ML</i>	<i>20NG/ML</i>	<i>500PG/MG</i>
<i>Opiates</i>	<i>2000NG/ML</i>	<i>10NG/ML</i>	<i>200PG/MG</i>
<i>Cocaine</i>	<i>300NG/ML</i>	<i>5NG/ML</i>	<i>500PG/MG</i>

**Hair uses = PG/MG = weight*

** For all other substances tested use recommended laboratory cutoff levels*

All negative samples held by the laboratory will be retained for one week. A retention time extension may be requested based upon need.

Confirmation Testing

Confirmation Testing **shall** be conducted utilizing GC/MS or LC/MS/MS Technology on all samples initially testing POSITIVE. The following cut-off levels shall be utilized:

DRUG	URINE	ORAL FLUID	HAIR LEVELS*
<i>Amphetamines</i>	<i>500NG/ML</i>	<i>10NG/ML</i>	<i>300PG/MG</i>
<i>Cannabinoids</i>	<i>15NG/ML</i>	<i>.5NG/ML</i>	<i>.05PG/MG</i>
<i>Benzodiazepines</i>	<i>100NG/ML</i>	<i>1NG/ML</i>	<i>50PG/MG</i>
<i>Methamphetamine (including ECSTACY(MDMA), ADAM(MDA))</i>	<i>500MG/ML</i>	<i>10NG/ML</i>	<i>300PG/MG</i>
<i>Opiates</i>	<i>150NG/ML</i>	<i>5NG/ML</i>	<i>200PG/MG</i>
<i>Cocaine</i>	<i>150NG/ML</i>	<i>1NG/ML</i>	<i>50PG/MG</i>

**Hair uses = PG/MG = weight*

** For all other substances tested use recommended laboratory cutoff levels*

All positive samples shall be frozen and maintained for 365 days by the laboratory. A retention time extension may be requested based upon need.

In situations where the source of the methamphetamine present in any specimen may come into question, the vendor must perform a d-1-isomer differentiation. This service is to be offered at no additional cost to the Department of Child Services and performed when requested by DCS or Probation.

Results Notification

The vendor shall notify the Department of Child Services and/or Probation of testing results via email or fax on vendor letterhead. The results will also be sent by U.S. mail to the referring agency as well. The vendor shall gain approval from DCS for any changes in the results notification system.

The referring agency will be notified of negative test results within 24 hours of the test. The specified time frame is from delivery to the testing laboratory to the time of notification. Positive test results will be provided within 72 hours of the lab receipt of the sample specimen.

For urine tests, diluted results must be reported on the result form.

Courier System

The vendor will coordinate all courier services to transport all specimens, test results, and testing materials to and from any location within the referring county. Deliveries shall be made during regular working days, normally between the hours of 8:00 am and 5:00pm unless otherwise indicated. The vendor shall be responsible for the cost of all courier services provided under the contract.

The vendor shall provide courier services that maintain the legal chain-of-custody, throughout the State of Indiana within 24 hours of request of pick up.

The vendor shall provide postage paid mailers or next day delivery services for utilization at any location that desires to use this method as an alternative to the courier services. This shall be at no additional charge to DCS.

The vendor's courier system shall provide documented, legal chain-of-custody throughout the State of Indiana which includes same day or next day delivery throughout Indiana.

Technical Support

A toll free 800 number will be available to all DCS local offices and Probation departments, in the State of Indiana to contact for technical support. Technical support staff and laboratory technicians shall be available during normal working hours via the 800 number, to provide technical assistance at no additional cost.

Supplies

The vendor shall provide the following supplies:

- 1) Sample containers
- 2) Specimen donor labels
- 3) Evidence security tape
- 4) Evidence bags
- 5) Evidence chain-of-custody forms with seals
- 6) Swabs
- 7) All supplies required for mailing or next day delivery
- 8) Any additional supplies necessary for referring specimens to the laboratory.

Note Regarding testing of Additional Substances:

A provider and/or the referral source may identify the need for screening of additional substances outside of what is specified above. This may be identified as a need in the entire region or for a specific client being referred.

If a contracted provider is proposing to test for additional substances to the already approved list of substances the provider shall submit an updated rate list to the Regional Child Welfare Services Coordinator to be approved by the Regional Services Counsel.

In the instance that the referral source has identified the need for testing of additional substances outside of what is specified above for a referred client, the provider will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation. All testing levels (initial and confirmation) for additional substances outside of what is specified above shall be in compliance with Substance Abuse and Mental Health Administration (SAHMSA) regulations. All rates shall be billed at actual cost.

II. Target Population

Services must be restricted to the following eligibility categories:

- 1) Parent(s) of children for whom a DCS assessment has been initiated
- 2) Children and parent(s) who have substantiated cases of abuse and/or neglect
- 3) Children with a status of CHINS, and/or JD/JS
- 4) Minor children suspected of drug use prior to adjudication

III. Goals and Outcome Measures

Goal #1 Services are provided timely as indicated in the service description above.

Outcome Measures

- 1) 100% of courier services will be provided within a 24 hours of a request for pick up.
- 2) 100% of referring agencies will be notified of negative test results within 24 hours of

laboratory receipt of sample specimen.

3) 100% of referring agencies will be notified of positive test results within 72 hours of laboratory receipt of sample specimen.

Goal #2 Services are provided as indicated in the service description above.

Outcome Measures

- 1) 100% of proper legal chain-of-custody procedures will be maintained and will comply with Departmental Policy, State and Federal law.
- 2) 100% of all specimens will be tested for illegal drugs or prescription medication if the client does not have a valid prescription. Amphetamines Cannabinoids Benzodiazepines Opiates, Cocaine, and Meth utilizing the cut-off levels listed above.
- 3) 100% of supplies will be provided to referring counties upon request.

IV. Qualifications

A laboratory participating in DCS/Probation drug testing must comply with all applicable Federal Department of Health and Human Service, and, under these federal requirements, are subsumed [Substance Abuse and Mental Health Services Administration](#) (SAMHSA), or College of American Pathology (CAP), or Clinical Laboratory Improvement Act (CLIA) requirements.

V. Billable Units

Providers shall submit a list of rates for all billable units listed in this section with the proposals. The rate list shall include the actual cost of all screens the provider is proposing to provide.

- **Drug Tests and Supplies:**

Actual cost of the screens.

- **Confirmation: Per test**

The billable units will include the following:

- 1) Retention of positive samples as required by other standard.
- 2) Technical Support
- 3) Cost of Courier System
- 4) Cost of Confirmation test

NOTE: The provider cannot claim for the handling of rejected specimens or those otherwise unfit for testing.

- **Court**

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written)

by DCS or subpoena to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

VI. Case Record Documentation

- 1) Receiving, transfer and handling of all specimens by laboratory personnel shall be fully documented using the proper chain-of-custody.
- 2) Documentation of notification of test results. Diluted results must be reported on the result form
- 3) The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation
- 4) All negative samples held by the laboratory will be retained for one week. A retention time extension may be requested based upon need.
- 5) All positive samples shall be frozen and maintained for 365 days by the laboratory. A retention time extension may be requested based upon need.

VII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

VIII. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
RANDOM DRUG TESTING
(Revised 3/21/11-Effective 7/1/11)

I. Service Description

Random screens are designed for individuals who may or may not meet the criteria for substance abuse and may or may not actively participate in drug treatment services. The drug test list includes Drugs of Abuse (illegal drugs), Therapeutic drugs (Prescription Drug-Painkillers, Mental Health Meds, etc.), and Designer drugs (i.e. K2, "Spice). Each random screen referral shall consist of no more than twenty-four (24) screens to be completed over a period not to exceed six (6) months, with a maximum of three (3) screens per week as indicated by the referral form. It is expected that the referring worker and provider agency will work together to develop a plan to determine the appropriate duration (up to 6 months) of each referral. A second referral will be required if an excess of twenty-four (24) screens per referral are necessary.

II. Service Delivery

The service provider must identify a plan to engage the client in the process, a plan to work with non-cooperative clients including those who believe they have no problems to address as well as working with special needs clients such as those who are mentally ill or developmentally delayed.

The types of drug screens include, but are not limited to, saliva drug screen/oral fluid based drug screen, hair follicle, and urine.

Initial Testing

All sample collections drug screens will be observed sample collections screens. Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Propoxyphene, and Methamphetamine. Other substances not listed that the client may report a history of using may also be tested. The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation.

For urine screens, testing for creatinine levels shall be conducted on all samples. The vendor shall also insure testing for total Cannabinoids per mg of creatinine using spectrophotometer technology. The Vendor shall insure testing for specific gravity on all samples with a creatinine level below 20 mg per deciliter. The Vendor shall also insure the administration of a nitrite test on any specimen that contains no creatinine and has a specific gravity test of 1.000.

Initial screening shall be conducted utilizing an enzyme immunoassay method. Testing should occur for the following substances utilizing the cut-off levels listed below:

DRUG	URINE	ORAL FLUID	HAIR LEVELS*
<i>Amphetamines</i>	<i>1000NG/ML</i>	<i>20NG/ML</i>	<i>500PG/MG</i>
<i>Cannabinoids</i>	<i>50NG/ML</i>	<i>1NG/ML</i>	<i>1PG/MG</i>
<i>Benzodiazepines</i>	<i>300NG/ML</i>	<i>10NG/ML</i>	<i>200PG/MG</i>
<i>Methamphetamine (including ECSTACY(MDMA), ADAM(MDA))</i>	<i>1000NG/ML</i>	<i>20NG/ML</i>	<i>500PG/MG</i>
<i>Opiates</i>	<i>2000NG/ML</i>	<i>10NG/ML</i>	<i>200PG/MG</i>
<i>Cocaine</i>	<i>300NG/ML</i>	<i>5NG/ML</i>	<i>500PG/MG</i>

**Hair uses = PG/MG = weight*

** For all other substances tested use recommended laboratory cutoff levels*

Confirmation Testing

Confirmation Testing **shall** be conducted utilizing GC/MS Technology on all samples initially testing POSITIVE. The following cut-off levels shall be utilized:

DRUG	URINE	ORAL FLUID	HAIR LEVELS*
<i>Amphetamines</i>	<i>500NG/ML</i>	<i>10NG/ML</i>	<i>300PG/MG</i>
<i>Cannabinoids</i>	<i>15NG/ML</i>	<i>.5NG/ML</i>	<i>.05PG/MG</i>
<i>Benzodiazepines</i>	<i>100NG/ML</i>	<i>1NG/ML</i>	<i>50PG/MG</i>
<i>Methamphetamine (including ECSTACY(MDMA), ADAM(MDA))</i>	<i>500MG/ML</i>	<i>10NG/ML</i>	<i>300PG/MG</i>
<i>Opiates</i>	<i>150NG/ML</i>	<i>5NG/ML</i>	<i>200PG/MG</i>
<i>Cocaine</i>	<i>150NG/ML</i>	<i>1NG/ML</i>	<i>50PG/MG</i>

**Hair uses = PG/MG = weight*

** For all other substances tested use recommended laboratory cutoff levels*

In situations where the source of the Amphetamine present in any specimen may come into question, the vendor must insure the performance of a d-1-isomer differentiation. This service is to be offered at no additional cost to the Department of Child Services and performed when requested by DCS or Probation.

The Vendor shall ensure proper legal chain-of-custody procedures are maintained and comply with departmental procedure, state and federal law. The vendor shall also ensure complete integrity of each specimen tested and the respective test results. Receiving, transfer and handling of all specimens by personnel shall be fully documented using the proper chain-of-custody.

The vendor shall insure that all laboratories used for drug testing purposes must comply with all applicable Federal Department of Health and Human Service, and, under these federal requirements, are subsumed [Substance Abuse and Mental Health Services Administration](#)

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(SAMSHA) or The College of American Pathology (CAP), or Clinical Laboratory Improvement Act (CLIA) requirements.

A letter to all referred clients will be required within three (3) calendar days of referral with instructions for contacting the agency immediately to begin screens. It is expected that the first screen will be collected within seven (7) calendar days of referral and each subsequent screen will be random. One or more toll free phone lines for clients to call daily to determine the day their screen is to be required. Agency must have a plan in place to modify the phone messages every day by 5 a.m., instructing clients whether to report that day for a screen or call again the next day.

Note: It is expected that the referring worker and provider agency will work together to develop a plan to administer random testing for clients who do not have access to public transportation or telephone. In addition, the referring worker may also indicate the required number of random drug screens.

The agency shall update the referring worker, by phone or email, within ten (10) calendar days of the date the referral was sent regarding the status of the referral. Agencies should inform the referring worker of the date the client completed their first screen or, if the client has not contacted the agency to complete their first screen, a consultation with the referring worker should be held to determine the next steps of services.

Results Notification:

The vendor shall notify the local Department of Child Services Office/ Probation Officer (PO) of testing results via email or fax on vendor letterhead. The results will also be sent by U.S. mail to the referring county as well. The vendor shall gain approval from DCS or Probation for any changes in the results notification system.

The current FCM/PO (if not the referral source) will be notified of positive test results within 72 hours of sample collection. Negative test results will be provided within 24 hours of sample collections.

No-show alert forms will be provided by the contracted agency to the referring worker within 24 hours of the client's failure to show. Failure to show may result in an administrative discharge. Any client who is administratively discharged must request a new referral from the referring worker to begin receiving services again.

The DCS/Probation shall be notified in writing if the specimen has been rejected due to an invalid chain-of-custody or any other integrity problem.

For those employing urine tests diluted results must be reported on the result form.

Testing shall not be conducted on any specimen that does not have a legal chain-of-custody. All

specimens found to be “Adulterated” shall be treated as an Invalid Specimen. Any specimen without a valid chain-of-custody is to be destroyed. The referring location shall be notified in writing when a specimen has been rejected due to an invalid chain-of-custody or any other integrity problem. Monthly reports shall document how many random samples were attempted and completed minus how many "Adulterated" specimens there were for the month.

Note Regarding testing of Additional Substances:

A provider and/or the referral source may identify the need for screening of additional substances outside of what is specified above. This may be identified as a need in the entire region or for a specific client being referred.

If a contracted provider is proposing to test for additional substances to the already approved list of substances the provider shall submit an updated rate list to the Regional Child Welfare Services Coordinator to be approved by the Regional Services Counsel.

In the instance that the referral source has identified the need for testing of additional substances outside of what is specified above for a referred client, the provider will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation. All testing levels (initial and confirmation) for additional substances outside of what is specified above shall be in compliance with Substance Abuse and Mental Health Administration (SAHMSA) regulations. All rates shall be billed at actual cost.

III. Target Population

Services must be restricted to the following eligibility categories:

- 1) Parent(s) for whom a DCS assessment has been initiated.
- 2) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- 3) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- 4) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
- 5) Minor children suspected of drug use prior to adjudication.

IV. Goals and Outcome Measures

Goal #1 Drug screen results will be provided to the referring worker in a timely fashion.

Outcome Measures

- 1) 95% of positive screens will be reported to the FCM/PO by fax or email within 72 hours of sample collection.
- 2) 95% of negative screens will be reported to the FCM/PO by fax or email within 24 hours of sample collection.

Goal #2 “No Show” alerts based on occurrence.

Outcome Measures

- 1) 100% of “No Shows” alerts will be provided to referring worker within 24 hours of the client’s failure to show.

V. Minimum Qualifications

Sample collection does not require the services of a certified drug abuse counselor. The person providing this service must be trained in sample collection and the chain of custody procedures to document the integrity and security of the specimen from time of collection until receipt by the laboratory.

VI. Billable Units

Providers shall submit a list of rates for all billable units listed in this section with the proposals. The rate list shall include the actual cost of all screens the provider is proposing to provide.

The provider cannot claim for the handling of rejected specimens or those otherwise unfit for testing. Grantees will bill monthly:

The provider is to present a list of the drug screens available with the total cost of each drug screen or set of drug screens as part of proposal. The DCS will specify which drug screen or screens they are authorizing for each client on the authorizing referral form.

Initial Drug Screens

Services include all costs from the drug screen supplies needed to do the screen to the results notification (Includes but not limited to screening supplies, collection of specimen, lab costs, etc.) The vendor shall ensure that the chain of custody procedure is followed to maintain the integrity and security of the specimen from time of collection until receipt by the laboratory.

Confirmation of Positive Test (lab processing)

The confirmation test is for those initial drug screens with a “Positive” result. The unit rate will include all cost associated with confirming the status of the Initial Drug Screen and will include results notification. The vendor shall ensure that the chain of custody procedure is followed to maintain the integrity and security of the specimen from time of collection until receipt by the laboratory.

Translation or sign language

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

Court

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

VII. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services
- 2) Documentation of regular contact with the referred families/children
- 3) Documentation of screen results notification sent to DCS.
- 4) “No Show” alerts will be provided to referring worker within 24 hours of the client’s failure to show.
- 5) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

IX. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
DETOXIFICATION SERVICES
(Revised 6/8/11-Effective 7/1/11)

I. Service Description

This service standard applies to families and children involved with the Department of Child Services and/or Probation. Services may be provided for clients of all ages in need of detoxification services. Detoxification is a process of treating individuals who are physically dependent on alcohol or drugs, and includes the period of time during which the body's physiology is adjusting to the cessation of substance use.

Three immediate goals of detoxification shall be included, to provide a safe withdrawal from the alcohol/drug(s) of dependence and enable the patient to become drug free, to provide withdrawal that is humane and protects the patient's dignity, and to prepare the patient for ongoing treatment of his or her alcohol and other drug dependence.

II. Service Delivery

The detoxification program must be state licensed and certified as well as supervised by a licensed physician. In addition, the program shall provide living accommodations in a structured environment for individuals who require twenty-four (24) hour per day supervision while withdrawing from toxic levels of consumption. Detoxification clients will be monitored by qualified, experienced staff 24 hours a day. Services will be available continuously twenty-four (24) hours a day, seven (7) days per week. Ambulatory detoxification may be provided on an outpatient basis as an alternative in limited situations. A caring staff, a supportive environment, sensitivity to cultural issues, confidentiality, and the selection of appropriate detoxification medication (if needed) are all important to providing humane withdrawal.

Clients will be accepted into the program within twenty-four (24) hours of the referral or sooner if an emergency exists. The type, length, and intensity of an individual's detoxification are determined by the severity of the addiction. Consultation with the Family Case Manager (FCM) and a new referral must be issued if length of stay is longer than two to six days.

All sample collections drug screens will be observed sample collections screens. Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Propoxyphene, and Methamphetamine and other drugs indicated by client's history. The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation.

A laboratory participating in DCS/Probation drug testing must comply with all applicable Federal Department of Health and Human Service, and, under these federal requirements, are subsumed [Substance Abuse and Mental Health Services Administration](#) (SAMHSA), or

College of American Pathology (CAP), or Clinical Laboratory Improvement Act (CLIA) requirements.

The provider shall inform the referring worker, of the drug screen results within ten (10) calendar days of the initial test.

The provider will develop a recovery plan. The recovery plan should include client's mental health status at transition and recommendations for the next level of recovery support services, and substance use recovery resources. The recovery plan could include any needed recommendations for psychological testing, psychiatrist consultation and/or medication evaluation. A consultation with the Family Case Manager to obtain a new referral must be completed to refer client to the next level of care.

Best practice will have client transition only when the next step of the recovery plan is available immediately or in a short time frame.

III. When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

IV. Target Population

Services must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of Use and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or CHINS status.
- 2) Children and their families which have an IA or the children have the status of CHINS or JD/JS.
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

V. Goals and Outcomes

Goal #1: Maintain timely intervention with the family and regular and timely communication with referring worker.

Outcome Measures:

- 1) 90% of services initiated within 24 hours of the referral.
- 2) 100% of recovery reports will be submitted to the Family Case Manager or Probation Officer.
- 3) 100% of cases will include a consultation with the Family Case Manager Probation Officer to discuss the recommended next level of care.

Goal #2: Effective treatment for individuals

Outcome Measures:

- 1) 90% of clients will participate in continuing care upon completion of detoxification.

Goal #3 DCS/Probation and clients will report satisfaction with services provided

Outcome Measures:

- 1) 90% of the families who have participated in medical detoxification will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.
- 2) DCS/Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.

VI. Qualifications

Licensed Physician:

A licensed physician by the professional licensing agency shall be identified as the program's medical director. The vendor shall be licensed and/or certified by the Indiana Division of Mental Health and Addiction according to state law.

VII. Billable Units

Medicaid:

Providers should bill Medicaid or private insurance when appropriate. For information on coverage of detoxification services and specific Medicaid Programs, please refer to the Indiana Health Coverage Programs (IHCP) Provider Manual located at www.indianamedicaid.gov.

DCS funding:

- **Detoxification Services (inpatient):** For those not eligible for Medicaid a Per Diem rate

will be paid for services as defined in this service standard. Detoxification Services will not be paid for services not deemed medically necessary.

- **Detoxification Services (outpatient):** For those not eligible for Medicaid, a Per Diem rate will be paid for services as defined in this service standard. Detoxification Services will not be paid for service not deemed medically necessary.
- **Court:** The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.
- **Reports**
If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.

VIII. Case Record Documentation

Case record documentation for service eligibility must include:

1. A completed, signed, and dated DCS/ Probation referral form authorizing services
2. Written reports no less than 7 days from transition to next level of care. Case documentation shall show when report is sent.
3. Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

IX. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

X. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

**SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
RESIDENTIAL SUBSTANCE USE TREATMENT**

I. Service Description

This service standard applies to families and children involved with the Department of Child Services (DCS) and/or Probation. Services may be provided for clients of all ages with a substance-related disorder and with minimal manageable medical conditions; minimal withdrawal risk; or emotional, behavioral cognitive conditions that will not prevent the client from benefiting from this level of care. Residential treatment programs are characterized by offering 24 hour supervised living with a highly structured treatment program that includes individual, group, and family counseling. Residential treatment is most appropriate for clients who are unsuccessful in outpatient. Residential treatment is comprehensive and intensive. The focus of residential treatment is to give the client the tools to begin a substance-free lifestyle. The program must be licensed and/or certified by The Division of Mental Health and Addictions. The program shall be staffed by appropriately credentialed personnel who are trained and competent to implement residential programming.

II. Service Delivery

The minimum length of stay in the program shall be 10 days and the maximum stay 21 days.

The service provider must identify a plan to engage the client in the process, a plan to work with non-cooperative clients including those who believe they have no problems to address as well as working with special needs clients such as those who are mentally ill or developmentally delayed.

Services are planned and organized with addiction professionals and clinicians providing multiple treatment service components for the rehabilitation of alcohol and drug abuse or dependence in a group setting.

An individualized recovery plan must be developed that considers the client's age, ethnic background, cognitive development and functioning, and clinical issues. Recovery plans should connect substance use and how it affects child safety. Attention to adverse experiences in the client in an attempt to break the cycle of child maltreatment. Recovery plans shall provide a framework for measuring success and progress. Recovery plans should also include goals and objectives. Goals shall be designed to address the issue(s) identified in the substance use assessment and include an achievable time frame. Objectives shall have an expected result. A recovery plan partially based on a functional assessment of each resident's daily living, socialization, and coping skills that is based on structured evaluation and observation of behavior.

Residential treatment services must be based on a written, cohesive, and clearly stated philosophy and treatment orientation and must include the following standards:

- (1) There must be evidence that the philosophy is based on literature, research, and proven practice models.
- (2) The services must be client centered.
- (3) The services must consider client preferences and choices.
- (4) There must be a stated commitment to quality services.
- (5) The residents must be provided a safe, alcohol free, and drug free environment.
- (6) The individual environment must be as homelike as possible.
- (7) The services must provide transportation or ensure access to public transportation in accordance with the recovery plan.
- (8) The services must provide flexible alternatives with a variety of levels of supervision, support, and treatment as follows:
- (9) Service flexibility must allow movement toward the least restrictive environment but allow increases in intensity during relapses or cycles of relapse.
- (10) The Residential services must provide continuous or reasonably incremental steps between levels.
- (11) An agency cannot terminate a consumer from all services because of a need for more supervision, care, or direction without the agency making a good faith effort to continue to provide adequate, safe, and continuing treatment unless the resident is transferred to another entity with continuing treatment provided to the resident by that entity.
- (12) The treatment services must be carried out in residences that meet all life safety requirements and are licensed or certified as appropriate.
- (13) Residential services shall include specific functions that shall be made available to consumers based upon the individual recovery plan. These functions include the following:
 - Crisis services, including access to more intensive services, within twenty-four (24) hours of problem identification.
 - Case management services, including access to medical services, for the duration of treatment, provided by a case manager or primary therapist.
 - A consumer of Residential treatment services must have access to psychiatric or addictions treatment as needed.

All sample collections drug screens will be observed sample collections screens. Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Propoxyphene, and Methamphetamine and other drugs indicated by client's history. The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation.

A laboratory participating in DCS/Probation drug testing must comply with all applicable Federal Department of Health and Human Service, and, under these federal requirements, are subsumed [Substance Abuse and Mental Health Services Administration](#) (SAMHSA), or College of American Pathology (CAP), or Clinical Laboratory Improvement Act (CLIA) requirements.

III. Target Population

In addition, services must be restricted to the following eligibility categories:

1. Children and families who have substantiated cases of child abuse and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or CHINS status
2. Children and their families which have an IA or the children have the status of CHINS, and/or JD/JS
3. Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed

IV. Goals and Outcome Measures

Goals #1 Recovery plan goals developed from the substance use assessment

Outcome Measure

- 1) 100% of referred clients will have a recovery plan developed following the assessment with the recovery plan provided to the referring worker within 10 days of completion. Treatment goals will be individualized based on assessment with easy to evaluate outcomes. All goals will be developed with the expectation that the client will remain drug free.

Goal #2 Regularly modify and update the recovery plan to reflect client changes and progress

Outcome Measure:

- 1) 100% of Recovery plan should identify short term goals attainable at 10 to 21 days and measurable by an expected performance or behavior.
- 2) 100% of cases where the client successfully completes treatment will have a discharge plan submitted to the referring worker within 7 days of discharge. The discharge plan will include client's response to treatment and the aftercare plan.
- 3) 100% of cases where the client does not successfully complete treatment will have a recommendation report submitted to the referring worker within 7 days of termination of services.

Goal #3 Drug screens will be provided to the referring worker in a timely fashion.

Outcome Measures:

- 1) 100% of positive reports will be reported verbally by phone, voice mail or email within 24 hours of receiving the results of the drug screen. Written reports of the drug screen will be mailed/faxed to the referring worker within 24 hours of receipt of laboratory results.

Goal #4 Clients will remain drug free.

Outcome Measures:

- 1) 95% of clients who participate in Residential treatment will remain drug free during the service provision period as indicated by routine drug screens.
- 2) 75% of clients who participate in Residential treatment will transition to a lower level of substance use treatment.
- 3) 60% of clients who participate in Residential treatment will remain drug free until DCS case closure as indicated by routine drug screens.

Goal #5 Provide No-show alert to FCM

Outcome Measures:

- 1) 100% of no-show alerts will be provided to referring worker immediately following each no-show.

Goal #6 DCS and client satisfaction with services

Outcome Measures:

- 1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 80% of the clients who have completed substance use treatment services will rate the services “satisfactory” or above.

V. Qualifications

The program shall be staffed by appropriately credentialed personnel who are trained and competent to implement substance use treatment as outlined by state law. IC 25-23.6-10.5-9

VI. Billable Units

Medicaid Funding: Medicaid shall be billed when appropriate.

Providers should bill Medicaid or private insurance when appropriate. For information on coverage of residential services and specific Medicaid Programs, please refer to the Indiana Health Coverage Programs (IHCP) Provider Manual located at www.indianamedicaid.gov.

DCS funding:

Residential Treatment

Those services not deemed appropriate to bill Medicaid eligible client, will be billed to DCS per a day to day per diem rate for services as defined in this service standard.

Court Appearance

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

VII. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS/Probation referral form authorizing service;
- 2) Documentation of regular contact with the referred families/children and referring agency;
- 3) Documentation of progress notes that provide details of clients increase in performance and/or behavior that demonstrate growth and/or regression regarding the recovery process and lifestyle changes needed for the individual to remain drug free.
- 4) Recovery plan documenting short term goals attainable at 14 to 21 days and measurable by an expected performance or behavior.
- 5) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- 6) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

VII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved DCS referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

IX. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, assessing, planning and intervening to partner with families and the community to better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
SUBSTANCE USE DISORDER ASSESSMENT
(Revised 6/8/11-Effective 7/1/11)

I. Service Description

This service standard applies to families and children involved with the Department of Child Services and/or Probation. Services may be provided for clients of all ages in need of an assessment for substance use. The goal of the initial substance use assessment is to evaluate the client's substance use, the client's level of functioning and the appropriate entrance into substance use treatment services.

II. Service Delivery

A face-to-face clinical interview must take place with each referred individual. The provider must be able to complete the initial assessment within 72 hours of the referral if an emergency exists or sooner if the Family Case Manager suspects the client is in need of detoxification services. For emergency assessments, it is expected that a verbal report will be provided to the referring Family Case Manager within 72 hours and a written report provided within 7 days after the completion of the assessment with the client. Recommendations regarding the client's needs must be provided on each assessment.

The following standardized assessment tools for drug/alcohol use may be administered to accurately determine if further substance use assessment is indicated: Substance Use Subtle Screening Inventory (SASSI), Addiction Severity Index (ASI) Teen Addiction Severity Index (T-ASI), ASI Lite, Addiction Society of Medicine Placement Patient Criteria Revised Version II (ASAM PPII), Drug Use Screening Test (DAST), Substance Use Relapse Assessment (SARA). Other standardized tools may be used to best assess the specific needs of the client.

A multi-axial system must be used to develop a comprehensive bio-psychosocial assessment to include a mental status examination at the time of the initial appointment.

Bio-Psychosocial Assessment must include:

A description of the presenting problem. Clinical Syndromes and/or other conditions that may be a focus of clinical attention. An in-depth drug and alcohol use history with information regarding onset, duration, frequency, and amount of use; substance(s) of use and primary drug of choice. Any associated medical, psychological and social history of the client, associated health, work, family, person, and interpersonal problems; driving record related to drinking or drug use; past participation in treatment programs. The assessment will also include client's attitude toward treatment.

Mental health examination must include: client's mood, affect, memory processes, hallucinations, judgment, insight, and impulse control.

Therapist Recommendations:

Following the assessment of each client, the service provider must make a recommendation which includes any necessary treatment as well as the treatment modality and length.

Services must be available to clients who have limited daytime availability. The service provider must identify a plan to work with non-cooperative clients including those who believe they have no problems to address as well as working with special needs clients such as those who are mentally ill or developmentally delayed.

No-show alert forms will be provided by the contracted agency to inform the referring worker of the client's failure to attend the initial assessment. After three no-shows, a new referral from the referring worker must be sent to initiate new services.

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

III. Medicaid

It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The Services not eligible for MEDICAID REHABILITATION OPTION (MRO) or MEDICAID CLINIC OPTION (MCO) may be billed to DCS.

IV. When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

V. Target Population

Services must be restricted to the following eligibility categories:

- Children and families who have substantiated cases of child abuse and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or CHINS status.
- Children and their families which have an IA or the children have the with a status of CHINS, and/or JD/JS;
- Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

VI. Goals and Outcome Measures

Goal #1 Maintain timely assessment with the family.

Outcome Measures:

- 1) 100% of emergency referred clients will be assessed within 72 hours or sooner if a medical crisis exists.
- 2) 90% of non-emergency referred clients will assessed within 10 days of the initial referral.

Goal #2 Timely receipt of report to prepare for services/court and regular and timely communication with the referring worker.

Outcome Measures:

- 1) For emergency assessment: 100% of the verbal reports will be received by the referring worker with 72 hours of the assessment; the written report received by the referring worker 7 calendar days after the assessment with the individual.
- 2) For non-emergency assessments: 100% of the written reports will be received by referring worker 10 days after the completion of the assessment with the individual.

Goal #3 Recommendations relevant and based on documentation in the body of the report.

Outcome Measures:

- 1) 100% of recommendations prepared as a result of the assessment are appropriate based on interviews, observations, review of other records, and completion of test instruments.
- 2) 100% of no-show alerts will be provided to referring worker immediately following the clients (3) third no-show.

VII. Minimum Qualifications

Medicaid

Medicaid will reimburse physician or HSPP directed outpatient mental health assessments: (1) of the following practitioners:

- (A) A licensed psychologist

- (B) A licensed independent practice school psychologist
- (C) A licensed clinical social worker
- (D) A license marital and family therapist
- (E) A license mental health counselor
- (F) A license clinical addiction counselor
- (G) An advanced practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in psychiatric or mental health nursing form an accredited school of nursing
- (H) Anyone authorized by the agency

DCS

Minimum Qualifications:

1) The program shall be staffed by appropriately credentialed personnel who are trained and competent to complete Substance Use Assessments as required by state law.

VIII. Billable Units

Medicaid:

Services through the **MEDICAID CLINIC OPTION** may be Outpatient Mental Health Services. Medicaid shall be billed first for eligible services under covered evaluation and management codes, including those in the 90000 range.

MRO

Billing Code	Title
H0015 HW U1	Alcohol and/or other drug services; intensive outpatient (treatment program that operates at least three(3) hours/day and at least three(3) days/week and is based on an individualized treatment plan, including <u>assessment</u> , counseling; crisis intervention, and activity therapies or education

DCS funding: Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below. These billable units will also be utilized for services to referred clients who are not Medicaid eligible and for those providers who are unable to bill Medicaid.

- **Substance Use Assessment**
per hour. Includes time face to face with the client administering, scoring, and interpreting testing and writing of reports. Maximum of 1 hour report writing may be billed per assessment.

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

Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

• 0 to 7 minutes	do not bill	0.00 hour
• 8 to 22 minutes	1 fifteen minute unit	0.25 hour
• 23 to 37 minutes	2 fifteen minute units	0.50 hour
• 38 to 52 minutes	3 fifteen minute units	0.75 hour
• 53 to 60 minutes	4 fifteen minute units	1.00 hour

- **Translation or sign language**
Services include translation for families who are non-English language speakers or hearing- impaired and must be provided by a non-family member of the client. Dollar-for-dollar amount.
- **Court**
The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.
- **Reports**
If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.

IX. Case Record Documentation

Necessary case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS/Probation referral form authorizing service;
- 2) Written reports as defined in this service standard.

X. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

XI. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
SUBSTANCE USE OUTPATIENT TREATMENT
(Revised 6/8/11-Effective 7/1/11)

I. Service Description

This service standard applies to families and children involved with the Department of Child Services and/or Probation. Services may be provided for clients of all ages with a substance-related disorder and with minimal manageable medical conditions; minimal withdrawal risk; or emotional, behavioral cognitive conditions that will not prevent the client from benefiting from this level of care. A variety of scientifically based approaches to Substance Use Recovery exists. Recovery prescribed for all clients must be evidenced based. Substance Use Recovery can include behavioral therapy (such as counseling, cognitive therapy, or psychotherapy), medications, or their combination.

Effective Recovery attends to multiple needs of the individual, not just his or her substance use. To be effective, Recovery must address the individual's substance use and any associated medical, social, psychological, vocational, and legal problems.

A face-to-face multi-axial clinical assessment must take place prior to admission to an outpatient program.

II. Service Delivery

Services must be available to clients who have limited daytime availability. The service provider must identify a plan to engage the client in the process, a plan to work with non-cooperative clients including those who believe they have no problems to address as well as working with special needs clients such as those who are mentally ill or developmentally delayed.

Services are planned and organized with addiction professionals and clinicians providing multiple Recovery service components for the rehabilitation of alcohol and drug use or dependence in a group setting.

An individualized Recovery plan must be developed that considers the client's age, ethnic background, cognitive development and functioning, and clinical issues. Recovery plans should connect substance use and how it affects child safety. Recovery plans shall provide a framework for measuring success and progress. Recovery plans should also include goals and objectives. Goals shall be designed to address the issue(s) identified in the substance use assessment and include an achievable time frame. Objectives shall have an expected result.

All sample collections drug screens will be observed sample collections screens. Minimum of

substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Propoxyphene, and Methamphetamine and other drugs indicated by clients history. The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation.

A laboratory participating in DCS/Probation drug testing must comply with all applicable Federal Department of Health and Human Service, and, under these federal requirements, are subsumed [Substance Abuse and Mental Health Services Administration](#) (SAMHSA), or College of American Pathology (CAP), or Clinical Laboratory Improvement Act (CLIA) requirements.

Addictions Counseling (Individual Setting) – is designed to be a less intensive alternative to IOT.

1. The client is the focus of the service.
2. Documentation must support how Addiction Counseling benefits the client, including when the client is not present.
3. Addiction Counseling requires face-to-face contact with the client and/or family members or non professional caregivers.
4. Addiction Counseling consists of regularly scheduled sessions as needed.
5. Addiction Counseling may include the following:
 - Education on addiction disorders.
 - Skills training in communication, anger management, stress management, relapse prevention.
6. Addiction Counseling goals are rehabilitative in nature.
7. Addiction Counseling must be provided in an age appropriate setting for a client less than eighteen (18) years of age receiving services.
8. Addiction Counseling must be individualized.
9. Drug Screens as recommended per level of care or requested by Family Case Manager.
10. Case managements/referrals to available community services.

Exclusions:

1. Clients with withdrawal risk or symptoms whose needs cannot be managed at this level of care, or who need detoxification services.
2. Clients at imminent risk of harm to self or others.
3. Addiction Counseling may not be provided for professional caregivers.
4. Addiction Counseling sessions that consists of education services only will not be reimbursed.

Addiction Counseling (Group Setting) - is designed to be less intensive alternative to IOT.

1. The consumer is the focus of Addiction Counseling.
2. Documentation must support how Addiction Counseling benefits the consumer, including when services are provided in a group setting and/or the consumer is not present.
3. Addiction Counseling requires face-to-face contact with the consumer and/or family members or non professional caregivers.
4. Addiction Counseling consists of regularly scheduled sessions.
5. Addiction Counseling is intended to be a less intensive alternative to IOT.
6. Addiction Counseling may include the following:
 - Education on addiction disorders.
 - Skills training in communication, anger management, stress management, relapse prevention.
7. Addiction Counseling must demonstrate progress toward and/or achievement of consumer Recovery goals identified in the IICP.
8. Addiction Counseling goals are rehabilitative in nature.
9. A licensed professional must supervise the program and approve the content and curriculum of the program.
10. Addiction Counseling must be provided in an age appropriate setting for a consumer less than eighteen (18) years of age receiving services.
11. Addiction Counseling must be individualized.
12. Drug Screens as recommended per level of care or requested by Family Case Manager.
13. Case managements/referrals to available community services.

Exclusions:

1. Clients with withdrawal risk or symptoms whose needs cannot be managed at this level of care, or who need detoxification services.
2. Clients at imminent risk of harm to self or others.
3. Addiction Counseling may not be provided for professional caregivers.
4. Addiction Counseling sessions that consists of education services only will not be reimbursed.

Intensive Outpatient Recovery (IOT)

1. Regularly scheduled sessions, within a structured program, that are at least three (3) consecutive hours per day and at least three (3) days per week.
 1. IOT includes the following components:
 - a. Referral to 12 step programs, peers and other community supports.
 - b. Education on Addictions disorders.

- c. Skills training in communication, anger management, stress management and relapse prevention.
 - d. Individual, group and family therapy (provided by a licensed professional or QBHP Only)
2. IOT must be offered as a distinct service.
 3. IOT must be provided in an age appropriate setting for a client age eighteen (18) and under.
 4. IOT must be individualized.
 5. Access to additional support services (e.g. peer supports, case management, 12-step programs, aftercare/relapse prevention services, integrated Recovery, referral to other community supports) as needed.
 6. The client is the focus of the service.
 7. Documentation must support how the service benefits the client, including when the service is in a group setting.
 8. Services must demonstrate progress toward or achievement of client Recovery goals identified in the IICP.
 9. Service goals must be rehabilitative in nature.
 10. Up to twenty (20) minutes of break time is allowed during each three consecutive hour session.
 11. Drug Screens as recommended per level of care or requested by the Family Case Manager.
 12. Referral to available community services is available.

Exclusions:

1. Clients with withdrawal risk/symptoms whose needs cannot be managed at this level of care or who need detoxification services
2. Clients at imminent risk of harm to self or others.
3. IOT will not be reimbursed for clients receiving Group Addictions Counseling on the same day.
4. IOT sessions that consist of education services only are not reimbursable.
5. Any service that is less than three hours may not be billed as IOT, but may be billed as Group Addictions Counseling (if provider qualifications and program standards are met)

Specialized Recovery:

Substance use Recovery can also be provided through the use of individual sessions as needed and 1 to 1.5 hours of group weekly or more than once weekly group counseling session based on assessment of individual's needs. Services will be conducted as outlined in the counseling and group counseling section of this service standard, and can include gender specific group counseling to deal specifically with gender issues that may cause barriers to the individual's ability to remain drug free i.e. domestic violence, traumatic events and/or childhood trauma.

Specialized Recovery can also include modalities of brief counseling therapy.

III. Medicaid

It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid

IV. When DCS is not paying for services:

A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. **DCS will only pay for reports when DCS is not paying for these services.** If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.

V. Target Population

In addition, services must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of use and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or CHINS status
- 2) Children and their families which have an IA or the children have the status of CHINS, and/or JD/JS
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed

VI. Goals and Outcome Measures

Goals #1

Recovery plan goals developed from the substance use assessment

Outcome Measure

- 1) 100% of referred clients will have a Recovery plan developed following the assessment with the Recovery plan provided to the referring worker within 10 days of completion.
Recovery goals will be individualized based on assessment with easy to evaluate outcomes.

Goal #2

Regularly modify and update the Recovery plan to reflect client changes and progress.

Outcome Measure:

- 1) Recovery Plan should identify long and short term goals attainable at 2-, 4-, and 6-month's intervals and measurable by an expected performance or behavior.
- 2) Vendor shall maintain progress notes that provide details of clients increase in performance and/or behavior that demonstrate growth and/or regression regarding the recovery process and lifestyle changes needed for the individual to remain drug free.
- 3) Upon successful completion of Recovery the provider shall submit a discharge plan to the referring worker to include client's response to Recovery and aftercare plan.
- 4) Written reports with no less than monthly or more frequently as prescribed by DCS

Goal #3

Drug screens will be provided to the referring worker in a timely fashion.

Outcome Measures:

- 1) 100% of positive reports will be reported verbally by phone, voice mail or email within 24 hours of receiving the results of the drug screen. Written reports of the drug screen will be mailed/faxed to the referring worker within 24 hours of receipt of laboratory results.

Goal #4

Provide No-show alert to FCM.

Outcome Measures:

- 1) 100% of no-show alerts will be provided to referring worker immediately following each no-show.

Goal #5

DCS and client satisfaction with services

Outcome Measures:

- 1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
- 2) 80% of the clients who have completed substance use Recovery services will rate the services "satisfactory" or above.

VII. Minimum Qualifications

Medicaid Reimbursed

It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid provider qualifications.

DCS Reimbursed

The program shall be staffed by appropriately credentialed personnel who are trained and competent to complete Substance Use Outpatient Treatment as required by state law.

VIII. Billable Units

Medicaid:

Services through the MCO may be Outpatient Mental Health Services. Medicaid shall be billed first for eligible services under covered evaluation and management codes, including those in the 90000 range.

MRO

Billing Code	Title
H2035 HW	Alcohol and/or other drug Recovery program, per hours
H2035 HW HR	Alcohol and/or drug Recovery program, per hour (family/couple, consumer present)
H2035 HW HS	Alcohol and/or drug Recovery program, per hour (family/couple, without consumer present)
H0005 HW	Alcohol and/or other drug services; group counseling by a clinician.
H0005 HW HR	Alcohol and/or drug services; group counseling by a clinician. (family/couple, consumer present)
H0005 HW HS	Alcohol and/or drug services; group counseling by a clinician. (family/couple, without consumer present)
H0015 HW U1	Alcohol and/or other drug services; intensive outpatient (Recovery program that operates at least three(3) hours/day and at least three(3) days/week and is based on an individualized Recovery plan, including assessment, counseling; crisis intervention, and activity therapies or education

DCS funding: Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below. These billable units will also be utilized for services to referred clients who are not Medicaid eligible and for those providers who are unable to bill Medicaid.

Addictions Counseling (Individual & Family): To be billed per hour

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

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

Addictions Counseling Group

Services include group goal directed work with clients. To be billed per person per hour.

Intensive Outpatient Treatment

Services include goal directed services as defined in this Service Standard. Per three hour session per person

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

Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

- | | | |
|--------------------|------------------------|-----------|
| • 0 to 7 minutes | do not bill | 0.00 hour |
| • 8 to 22 minutes | 1 fifteen minute unit | 0.25 hour |
| • 23 to 37 minutes | 2 fifteen minute units | 0.50 hour |
| • 38 to 52 minutes | 3 fifteen minute units | 0.75 hour |
| • 53 to 60 minutes | 4 fifteen minute units | 1.00 hour |

Court Appearance

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court

two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

Reports

If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.

Drug Screens

Actual cost of the screens.

Translation or sign language

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

IX. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, dated, signed DCS/Probation referral form authorizing service;
- 2) Documentation of regular contact with the referred families/children and referring agency;
- 3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

X. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved DCS referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

XI. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, assessing, planning and intervening to partner with families and the community to better outcomes for children.

**SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
DAY REPORTING/TREATMENT PROGRAMS**

I. Service Description

Day Treatment/Day Reporting programs provide intensive supervision to children exhibiting a pattern of delinquent behavior. The primary functions of Day Treatment/Day Reporting can include intensive supervision, utilization of a cognitive behavior change approach, and be utilized to prevent the removal of the child from the home, to increase community safety, and to improve family functioning.

Day Treatment/Day Reporting programs can vary in the intensity and length of supervision and service hours the child and family receive.

The Day Treatment service is designed to provide an environment in which each child can develop the skills necessary for successful living, and to alter the previous environment of the child so that newly acquired skills are encouraged and old inappropriate behaviors are discouraged. Family involvement is highly encouraged. The service also addresses the educational needs of the individual child, based on an assessment of their academic progress.

The day reporting service provides daily supervision and structured activities for youth who require more intensive oversight, as an alternative to secure detention. This program serves pre- or post-adjudicated youth.

Day Treatment

Providing agency receives referrals from the Department of Child Services FCM or the Probation Officer.

Upon receipt of a referral, the provider will respond to the referral source within two business days. Provider will conduct an interview with the child and family within 5 business days of the referral and notify the referral source regarding acceptance into the program within 24 hours after the interview.

Service delivery can range from 1-180 days, at 4-10 hours per day. Per Diem may not be billed if there is not at least 20 hours of face to face contact per week. Service delivery may be extended beyond 180 days if approved by referral source.

Services shall include, but are not limited to: Individualized educational planning, life skills training (including work readiness if appropriate), and community service projects.

Services shall also include a minimum of 6 hours per week of cognitive based instruction in a curriculum that demonstrates best practices of model programs. The use of role playing and interaction to teach new skills may be utilized. Services can address thinking errors, anger management, substance abuse, and other mental health needs identified by the provider and

referral source.

Pre- and post-tests for evaluation and progress must be utilized.

Provider must also include a component that requires family involvement for a minimum of one hour per week. This may be in the form of a parenting support group or parenting instruction.

Provider will communicate progress to the referral source at least once per month in the form of a written progress report and monthly attendance in program, including number of contact hours. Provider will attend all Court review hearings and provide written progress reports to the Court at each review hearing.

Day Reporting

Providing agency receives referrals from the Department of Child Services FCM or Probation Officer.

Upon receipt of a referral, the provider will respond to the referral source within two business days. Provider will conduct an interview with the child and family within 5 business days of referral and will notify the referral source regarding admission status within 24 hours of the interview.

Service delivery can range from 1-180 days, at 4-10 hours per day. Per Diem rate may not be billed if there are not at least 20 hours of face to face contact per week. Service delivery may be extended beyond 180 days if approved by referral source.

Services shall include, but are not limited to: Intensive supervision, educational planning assistance, and community/recreational activities.

Provider will communicate progress to the referral source and monthly attendance in program, including number of contact hours performed. Provider will submit written progress reports to the referral source prior to each court hearing.

II. Target Population

Services must be restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- 2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
- 4) All adopted children and adoptive families.

III. Goals and Outcomes

Day Treatment

Department of Child Services
Regional Document for Child Welfare Services
Term 7/1/11-6/30/13
August 2011

Goal #1: Reduce the risk of repetitive delinquent behavior.

Outcome Measures

- 1) 100% of children in the Day Treatment program will receive a minimum of 6 hours per week of cognitive based instruction required to successfully complete the program.
- 2) 50% of children will successfully complete the program with a reduction of the risk to re-offend based on a validated risk assessment tool.

Goal #2: Prevent removal from home or community.

Outcome Measures

- 1) 70% of parents will participate in required family activities as identified by the individual program.
- 2) 70% of children who successfully complete the program will have exhibited improved family relationships.
- 3) 70% of families that were intact at the initiation of service will remain intact with no out-of-home, county paid placement for more than five days throughout the service provision period, and will have avoided out of home placement 6 months following service closure.

Goal #3: Enrollment in education programming

Outcome Measures

- 1) 100% of children will be enrolled in some type of educational programming during their involvement in the program.
- 2) 70% of children will be enrolled in an education program three months after program completion.

Goal # 4: Provide opportunities for the child to make meaningful contributions to their community.

Outcome Measures

- 1) 100% of children will be given opportunities to participate in employment, community, and recreational activities during their involvement in the program.
- 2) 70% of children will be employed or involved in community activities three months after program completion

Day Reporting

Goal #1: Provide supervision as an alternative to incarceration.

Outcome Measures

- 1) 75% of youth will not return to secure detention while in the program.
- 2) 100% of youth will receive intensive supervision and participate in other activities while in the program.

Goal # 2: Provide opportunities for the child to make meaningful contributions to their community.

Outcome Measures

Department of Child Services
Regional Document for Child Welfare Services
Term 7/1/11-6/30/13
August 2011

- 1) 100% of children will be given opportunities to participate in employment, community, and recreational activities during their involvement in the program.
- 2) 70% of children will be employed or involved in community activities three months after program completion.

Goal #3: Enrollment in educational programming.

Outcome Measures

- 1) 100% of children will be enrolled in some type of educational programming during their involvement in the program.
- 2) 70% of children will be enrolled in an educational program three months after program completion.

IV. Minimum Qualifications

Direct Worker:

Program Coordinator must hold a Bachelor's degree in criminal justice, sociology, psychology, social work or related field.

Supervision:

Program Supervisor must hold a Master's degree in criminal justice, social work, psychology, Social Work or related field.

Overall supervision of the Day Treatment program must be provided by a person with a Master's degree in Supervision/consultation. Supervision is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, and must occur every two (2) weeks or more frequently.

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

V. Billable Units

Per Diem cost for each client placed in the program. This per diem rate includes all costs of the program. Per Diem rate may not be billed if there are not at least 20 hours of face to face contact per week. (There are two per diem units Day Reporting and Day Treatment.)

Translation or sign language

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

VI. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services
- 2) Documentation of regular contact with the referred families/children

- 3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

VII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

VIII. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

**SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
TRUANCY TERMINATION**

I. Services Description

The purpose of Truancy Termination services is to provide school drop-out prevention education, job readiness skills services, parent education, and family support services to youth and their families in order to reduce recidivism of delinquent youth and truants.

Family Support Services

Family support workers are to work with family members to identify reasons for youth's truancy and barriers to regular and positive school attendance as well as work with school personnel and Probation Officers to identify solutions and interventions necessary to ensure school attendance, increase the youth's involvement in the school, and improve academic performance.

Accomplishing these objectives may require the support worker to attend parent/teacher conferences and attend classes with the student. The support worker shall provide services in the areas of parent education and crisis intervention, including direct services. The support worker will be present as the court directs, including, but not limited to the initial hearing, where the worker will meet with the youth and family and complete the preliminary intake. The purpose of the preliminary intake is to gather basic information and provide a brief overview of the program.

The support worker is responsible for providing weekly written reports attending court hearing to provide testimony on progress, submitting monthly written progress reports regarding each family's circumstances, and monitoring school attendance, performance, and behavior. These reports shall reflect ongoing collaboration and cooperation among the family support workers, school social workers, and Probation Officers.

The family support workers shall conduct and complete comprehensive intake and assessment for each referral to create a Family Development Plan (FDP). The FDP will be shared with school social workers and Probation Officers. The family support worker will assist families with transportation to the program.

Training Modules

Training modules consist of six (6) weekly skills-based classes which the youth and parents are required to complete. The family support worker will assess progress of all program graduates, and identify youth and families who may benefit from additional training. Subsequent to the training an assessment of progress, including areas where additional improvement is needed should be made and any additional services recommended shared with school social workers, probation officers, and the court.

Youth Modules

The following youth modules of Skills Based programming will be taught:

- Personal Hygiene
- Truancy
- College Awareness
- Conflict Resolution
- Relationships (peer to peer and peer to parent)
- Substance Abuse
- Decision Making, Time Management, and Goal Setting

Parent Modules

The following parent modules of Skills Based programming will be taught:

- Role as a parent and self-esteem
- Understanding child growth and development/Sibling Rivalries
- Communication and listening skills/Relationships
- How to use effective discipline/Problem solving
- Anger management/Conflict resolution/Stress maintenance
- Teaching morals, values, and respect
- Financial Management

Subsequent to the completion of the training modules the family support worker shall continue to work with the school social workers, probation officers, and the court to monitor families' well-being to monitor school attendance. The support worker will conduct monthly activities designed to connect youth and families with positive sources of ongoing encouragement (i.e. career fairs, family dinners, age appropriate sports and/or entertainment events, etc.).

II. Target Population

Services must be restricted to the following eligibility categories:

- Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
- All adopted children and adoptive families.

III. Goals and Outcomes

Goal #1 Ensure youth and parents participating in the program build skills in the module areas.

Outcome Measures

- 1) 85% of youth and parents referred by the Juvenile Court shall complete six (6) skills-based modules.
- 2) 85% of those families completing the modules shall demonstrate increased knowledge resulting from participation in the skills-based modules.

Goal #2 Increase regular school attendance of youth completing the program.

Outcome Measures

- 1) 75% of youth completing the six week modules will have 95% attendance during the service provision period.
- 2) 75% of youth will have 95% attendance during the period of time that begins at program completion and ends at 6 month follow up.

Goal #3 Juvenile Court and client satisfaction with services

Outcome Measures

- 1) Juvenile Probation/DCS staff satisfaction will be rated 4 and above on the Services Satisfaction Report.
- 2) 90% of clients will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

IV. Minimum Qualifications

Training Facilitator (Paraprofessional):

A high school diploma or GED and 21 years of age. Must possess a valid driver’s license, the ability to transport self and others, and must have state minimum car insurance coverage in force at all times.

Family Support Worker:

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

Supervisor (Professional):

Bachelor’s Degree in social work, psychology, sociology, or directly related human service field plus three (3) years related experience.

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

V. Billable Unit

Face to face time with the client:

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

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

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

Group

Services include group goal directed work with clients. To be billed per group hour

Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

- | | | |
|--------------------|------------------------|-----------|
| • 0 to 7 minutes | do not bill | 0.00 hour |
| • 8 to 22 minutes | 1 fifteen minute unit | 0.25 hour |
| • 23 to 37 minutes | 2 fifteen minute units | 0.50 hour |
| • 38 to 52 minutes | 3 fifteen minute units | 0.75 hour |
| • 53 to 60 minutes | 4 fifteen minute units | 1.00 hour |

Translation or sign language

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

Court

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS or subpoena to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

VI. Case Record Documentation

Case record documentation for service eligibility must include:

- 1) A completed, signed, and dated DCS/ Probation referral form authorizing services
- 2) Documentation of regular contact with the referred families/children
- 3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- 4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

VII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

VI. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

Intervention Services Providers by Service Standard

Region 12

Source: KidTraks Contract Service Guide Query

Date: 12/9/2011

Service Desc	Service Code	Vendor
CARE NETWORK	10529	CENTERSTONE OF INDIANA INC.
CARE NETWORK	10529	COMMUNITY MENTAL HEALTH CENTER INC
CHINS PARENT SUPPORT SERVICES	10531	CENTERSTONE OF INDIANA INC.
COUNSELING	10532	ANCHOR BEHAVIORAL COUNSELING LLC.
COUNSELING	10532	CASTLE COUNSELING CENTER LLC
COUNSELING	10532	CENTERSTONE OF INDIANA INC.
COUNSELING	10532	COMMUNITY MENTAL HEALTH CENTER INC
COUNSELING	10532	DAMAR SERVICES INC.
COUNSELING	10532	INDIANA JUVENILE JUSTICE TASK FORCE INC.
COUNSELING	10532	LIFEWORCS COUNSELING L.L.C.
COUNSELING	10532	MERIDIAN HEALTH SERVICES CORP.
COUNSELING	10532	WERNLE YOUTH & FAMILY TREATMENT CTR INC
COUNSELING	10532	YOUTH OPPORTUNITY CENTER INC.
COUNSELING	10532	YOUTH SERVICE BUREAU OF JAY COUNTY INC
DETOXIFICATION SERVICES	10806	COMMUNITY MENTAL HEALTH CENTER INC
DETOXIFICATION SERVICES	10806	THE SALVATION ARMY an ILLINOIS CORPORATION
DIAGNOSTIC AND EVALUATION SERVICES	10534	ANCHOR BEHAVIORAL COUNSELING LLC.
DIAGNOSTIC AND EVALUATION SERVICES	10534	BLOOMINGTON MEADOWS G.P.
DIAGNOSTIC AND EVALUATION SERVICES	10534	CENTERSTONE OF INDIANA INC.
DIAGNOSTIC AND EVALUATION SERVICES	10534	COMMUNITY MENTAL HEALTH CENTER INC
DIAGNOSTIC AND EVALUATION SERVICES	10534	CONNECTIONS INC
DIAGNOSTIC AND EVALUATION SERVICES	10534	LINDA MCINTIRE PSYD LLC
DIAGNOSTIC AND EVALUATION SERVICES	10534	MERIDIAN HEALTH SERVICES CORP.
DIAGNOSTIC AND EVALUATION SERVICES	10534	PSYCHOLOGICAL LABORATORIES OF
DIAGNOSTIC AND EVALUATION SERVICES	10534	RESOURCE COMMUNITY BASED SERVICES INC.
DIAGNOSTIC AND EVALUATION SERVICES	10534	WERNLE YOUTH & FAMILY TREATMENT CTR INC
DIAGNOSTIC AND EVALUATION SERVICES	10534	YOUTH OPPORTUNITY CENTER INC.

Service Desc	Service Code	Vendor
DIAGNOSTIC AND EVALUATION SERVICES	10534	YOUTH SERVICE BUREAU OF JAY COUNTY INC
DOMESTIC VIOLENCE BATTERERS	10811	COMMUNITY MENTAL HEALTH CENTER INC
DOMESTIC VIOLENCE VICTIM AND CHILD	10812	COMMUNITY MENTAL HEALTH CENTER INC
DOMESTIC VIOLENCE VICTIM AND CHILD	10812	VICTORIA HARRIS LCSW LCAC CTRTC
DOMESTIC VIOLENCE VICTIM AND CHILD	10812	YOUTH SERVICE BUREAU OF JAY COUNTY INC
DRUG TESTING AND SUPPLIES	10541	FORENSIC FLUIDS LABORATORIES INC.
FAMILY PREPARATION	10516	ANCHORS FOR YOUTH LLC
FAMILY PREPARATION	10516	GIBAULT INC.
FAMILY PREPARATION	10516	NATIONAL MENTOR HEALTHCARE LLC
FAMILY PREPARATION	10516	THE VILLAGES OF INDIANA INC.
FATHER ENGAGEMENT PROGRAMS	10813	CHILDREN'S BUREAU INC.
FUNCTIONAL FAMILY THERAPY	10536	CEDARBRIDGE TREATMENT CENTERS LLC
FUNCTIONAL FAMILY THERAPY	10536	GEORGE JUNIOR REPUBLIC IN INDIANA INC.
HOME-BASED FAMILY CENTERED CASEWORK SERVICES	10521	CENTERSTONE OF INDIANA INC.
HOME-BASED FAMILY CENTERED CASEWORK SERVICES	10521	CHILDREN'S BUREAU INC.
HOME-BASED FAMILY CENTERED CASEWORK SERVICES	10521	COMMUNITY MENTAL HEALTH CENTER INC
HOME-BASED FAMILY CENTERED CASEWORK SERVICES	10521	GEORGE JUNIOR REPUBLIC IN INDIANA INC.
HOME-BASED FAMILY CENTERED CASEWORK SERVICES	10521	LIFELINE YOUTH & FAMILY SERVICES INC.
HOME-BASED FAMILY CENTERED CASEWORK SERVICES	10521	MERIDIAN HEALTH SERVICES CORP.
HOME-BASED FAMILY CENTERED CASEWORK SERVICES	10521	RESOURCE COMMUNITY BASED SERVICES INC.
HOME-BASED FAMILY CENTERED CASEWORK SERVICES	10521	WERNLE YOUTH & FAMILY TREATMENT CTR INC
HOME-BASED FAMILY CENTERED CASEWORK SERVICES	10521	YOUTH SERVICE BUREAU OF JAY COUNTY INC
HOME-BASED FAMILY CENTERED THERAPY SERVICES	10522	CASTLE COUNSELING CENTER LLC
HOME-BASED FAMILY CENTERED THERAPY SERVICES	10522	CENTERSTONE OF INDIANA INC.
HOME-BASED FAMILY CENTERED THERAPY SERVICES	10522	COMMUNITY MENTAL HEALTH CENTER INC
HOME-BASED FAMILY CENTERED THERAPY SERVICES	10522	GEORGE JUNIOR REPUBLIC IN INDIANA INC.

Service Desc	Service Code	Vendor
HOME-BASED FAMILY CENTERED THERAPY SERVICES	10522	INDIANA JUVENILE JUSTICE TASK FORCE INC.
HOME-BASED FAMILY CENTERED THERAPY SERVICES	10522	LIFELINE YOUTH & FAMILY SERVICES INC.
HOME-BASED FAMILY CENTERED THERAPY SERVICES	10522	MERIDIAN HEALTH SERVICES CORP.
HOME-BASED FAMILY CENTERED THERAPY SERVICES	10522	RESOURCE COMMUNITY BASED SERVICES INC.
HOME-BASED FAMILY CENTERED THERAPY SERVICES	10522	WERNLE YOUTH & FAMILY TREATMENT CTR INC
HOME-BASED FAMILY CENTERED THERAPY SERVICES	10522	YOUTH SERVICE BUREAU OF JAY COUNTY INC
HOMEMAKER/PARENT AID	10525	CENTERSTONE OF INDIANA INC.
HOMEMAKER/PARENT AID	10525	COMMUNITY MENTAL HEALTH CENTER INC
MED-ASSESSMENT FOR MRO	10512	CENTERSTONE OF INDIANA INC.
MED-ASSESSMENT FOR MRO	10512	COMMUNITY MENTAL HEALTH CENTER INC
MED-ASSESSMENT FOR MRO	10512	MERIDIAN HEALTH SERVICES CORP.
MED-MEDICATION TRAINING AND SUPPORT	10561	CENTERSTONE OF INDIANA INC.
MED-MEDICATION TRAINING AND SUPPORT	10561	COMMUNITY MENTAL HEALTH CENTER INC
MED-PEER RECOVERY SERVICES	10564	CENTERSTONE OF INDIANA INC.
MED-PEER RECOVERY SERVICES	10564	COMMUNITY MENTAL HEALTH CENTER INC
PARENT EDUCATION	10537	CENTERSTONE OF INDIANA INC.
PARENT EDUCATION	10537	COMMUNITY MENTAL HEALTH CENTER INC
PARENT EDUCATION	10537	MERIDIAN HEALTH SERVICES CORP.
PARENTING / FAMILY FUNCTIONING ASSESSMENT	10538	CEDARBRIDGE TREATMENT CENTERS LLC
PARENTING / FAMILY FUNCTIONING ASSESSMENT	10538	CENTERSTONE OF INDIANA INC.
PARENTING / FAMILY FUNCTIONING ASSESSMENT	10538	COMMUNITY MENTAL HEALTH CENTER INC
PARENTING / FAMILY FUNCTIONING ASSESSMENT	10538	LIFEWORCS COUNSELING L.L.C.
PARENTING / FAMILY FUNCTIONING ASSESSMENT	10538	RESOURCE COMMUNITY BASED SERVICES INC.
PARENTING / FAMILY FUNCTIONING ASSESSMENT	10538	YOUTH SERVICE BUREAU OF JAY COUNTY INC
RANDOM DRUG TESTING	10543	INDIANA JUVENILE JUSTICE TASK FORCE INC.
RESIDENTIAL SUBSTANCE USE TREATMENT	10805	TARA TREATMENT CENTER INC

Service Desc	Service Code	Vendor
RESIDENTIAL SUBSTANCE USE TREATMENT	10805	THE SALVATION ARMY an ILLINOIS CORPORATION
SEX OFFENDER TREATMENT; VICTIMS OF SEX ABUSE TREATMENT	10539	DAMAR SERVICES INC.
SEX OFFENDER TREATMENT; VICTIMS OF SEX ABUSE TREATMENT	10539	LIFELINE YOUTH & FAMILY SERVICES INC.
SEX OFFENDER TREATMENT; VICTIMS OF SEX ABUSE TREATMENT	10539	MERIDIAN HEALTH SERVICES CORP.
SEX OFFENDER TREATMENT; VICTIMS OF SEX ABUSE TREATMENT	10539	PSYCHOLOGICAL LABORATORIES OF
SEX OFFENDER TREATMENT; VICTIMS OF SEX ABUSE TREATMENT	10539	RESOURCE COMMUNITY BASED SERVICES INC.
SEX OFFENDER TREATMENT; VICTIMS OF SEX ABUSE TREATMENT	10539	WERNLE YOUTH & FAMILY TREATMENT CTR INC
SEX OFFENDER TREATMENT; VICTIMS OF SEX ABUSE TREATMENT	10539	YOUTH SERVICE BUREAU OF JAY COUNTY INC
SUBSTANCE USE DISORDER ASSESSMENT	10807	ANCHOR BEHAVIORAL COUNSELING LLC.
SUBSTANCE USE DISORDER ASSESSMENT	10807	CASTLE COUNSELING CENTER LLC
SUBSTANCE USE DISORDER ASSESSMENT	10807	CENTERSTONE OF INDIANA INC.
SUBSTANCE USE DISORDER ASSESSMENT	10807	COMMUNITY MENTAL HEALTH CENTER INC
SUBSTANCE USE DISORDER ASSESSMENT	10807	LIFEWORCS COUNSELING L.L.C.
SUBSTANCE USE DISORDER ASSESSMENT	10807	MERIDIAN HEALTH SERVICES CORP.
SUBSTANCE USE DISORDER ASSESSMENT	10807	TARA TREATMENT CENTER INC
SUBSTANCE USE DISORDER ASSESSMENT	10807	THE SALVATION ARMY an ILLINOIS CORPORATION
SUBSTANCE USE DISORDER ASSESSMENT	10807	WERNLE YOUTH & FAMILY TREATMENT CTR INC
SUBSTANCE USE DISORDER ASSESSMENT	10807	YOUTH SERVICE BUREAU OF JAY COUNTY INC
SUBSTANCE USE OUTPATIENT TREATMENT	10808	CASTLE COUNSELING CENTER LLC
SUBSTANCE USE OUTPATIENT TREATMENT	10808	CENTERSTONE OF INDIANA INC.
SUBSTANCE USE OUTPATIENT TREATMENT	10808	COMMUNITY MENTAL HEALTH CENTER INC
SUBSTANCE USE OUTPATIENT TREATMENT	10808	MERIDIAN HEALTH SERVICES CORP.
SUBSTANCE USE OUTPATIENT TREATMENT	10808	TARA TREATMENT CENTER INC
SUBSTANCE USE OUTPATIENT TREATMENT	10808	THE SALVATION ARMY an ILLINOIS CORPORATION
SUBSTANCE USE OUTPATIENT TREATMENT	10808	VICTORIA HARRIS LCSW LCAC CTRTC
SUBSTANCE USE OUTPATIENT TREATMENT	10808	WERNLE YOUTH & FAMILY TREATMENT CTR INC
SUBSTANCE USE OUTPATIENT TREATMENT	10808	YOUTH SERVICE BUREAU OF JAY COUNTY INC

Service Desc	Service Code	Vendor
TRANSITION FROM RESTRICTIVE PLACEMENTS (TRP)	10551	CEDARBRIDGE TREATMENT CENTERS LLC
TRANSITION FROM RESTRICTIVE PLACEMENTS (TRP)	10551	CENTERSTONE OF INDIANA INC.
TRANSITION FROM RESTRICTIVE PLACEMENTS (TRP)	10551	CHILDREN AND FAMILY SERVICES CORPORATION
TRANSITION FROM RESTRICTIVE PLACEMENTS (TRP)	10551	COMMUNITY MENTAL HEALTH CENTER INC
TRANSITION FROM RESTRICTIVE PLACEMENTS (TRP)	10551	INDIANA JUVENILE JUSTICE TASK FORCE INC.
TRUANCY TERMINATION	10552	CEDARBRIDGE TREATMENT CENTERS LLC
TRUANCY TERMINATION	10552	WERNLE YOUTH & FAMILY TREATMENT CTR INC
TRUANCY TERMINATION	10552	YOUTH SERVICE BUREAU OF JAY COUNTY INC
VISITATION FACILITATION-PARENT/CHILD/SIBLING	10540	CENTERSTONE OF INDIANA INC.
VISITATION FACILITATION-PARENT/CHILD/SIBLING	10540	COMMUNITY MENTAL HEALTH CENTER INC
VISITATION FACILITATION-PARENT/CHILD/SIBLING	10540	KIDSPACE NATIONAL CENTERS OF NORTH AMERICA INC.
VISITATION FACILITATION-PARENT/CHILD/SIBLING	10540	LIFELINE YOUTH & FAMILY SERVICES INC.
VISITATION FACILITATION-PARENT/CHILD/SIBLING	10540	MERIDIAN HEALTH SERVICES CORP.
VISITATION FACILITATION-PARENT/CHILD/SIBLING	10540	WERNLE YOUTH & FAMILY TREATMENT CTR INC

Prevention Service Array

Region 12

Community Partners for Child Safety

Local Agency Name: Children's Bureau
Contact Person: Carl Scheib
Address: 2508 Western Ave., Connersville, IN 47331
Phone: (765)827-2045 E-mail: cscheib@childrensbureau.org

Healthy Families Indiana

Agency Name: Healthy Families of Fayette County
Contact Person:
Address: 1455 E. 5th Street, Connersville, IN 47331
Phone: (765) 827-4402 E-mail

Agency Name: RUSH COUNTY HEALTHY FAMILIES
Contact Person: BONNIE POLLACK
Address: 201 Harcourt Way, Rushville, IN 46173
Phone: (765) 938-1182 E-mail

Agency Name: Birth to Five
Contact Person: Vickie Grimm-Powell
Address: 315 NW 5th Street, Richmond, IN 47374
Phone: (765) 966-6080 E-mail: info@mybirthtofive.org

Agency Name: Healthy Families
Contact Person: Christine Heath
Address: 14 N. Market St; Liberty, IN 47353
Phone: (765) 458- 9151 E-mail: [Christine heath@newhopeservices.com](mailto:Christine_heath@newhopeservices.com)

Agency Name: Healthy Families of Henry Co
Contact Person: Christy Howard
Address: 1809 Bundy Ave; New Castle, IN 47362
Phone: (765) 529- 4505 E-mail:

Agency Name: Family Services and Prevention Programs
Contact Person: Peggy Faulk
Address: 2021 S Riley Highway; Shelbyville, IN 46176
Phone: (317) 398-0955 E-mail: peggy@fspp.org

Agency Name: Family Connections
Contact Person: Marsha Billman

Address: 202 N Gaslight Dr PO Box 766; Versailles, IN 47042
Phone: (812) 689-6363 E-mail: marsha_billman@hotmail.com

First Steps

Agency Name: First Steps

Contact Person:

Address: 715 W. 21st Street, Connersville, IN 47331

Phone: (765) 825-8312 E-mail

Agency Name: FIRST STEPS – SOUTHEAST REGION

Contact Person: Lynne Eckerle

Address: 1531 13TH Street, Suite G900, PO Box 2249, Columbus, IN 47202

Phone: (812) 314-2982 E-mail: firststepssoutheast@areaXI.org

Describe Services Provided: Early intervention services for children under 3 years of age & their families. Services include evaluation, assessment & referral to applicable services

Agency Name: First Steps

Contact Person: Amanda Hinkle or Kim James

Address: 7221 Engle Rd., Suite 100, Fort Wayne, IN 46804

Phone: (866) 316-9800 E-mail:

Describe Services Provided: Assistive technology, audiology, developmental therapy, health services, nutrition, physical therapy, occupational therapy, service coordination, and speech therapy and vision services.

Indiana Youth Service Bureaus

Agency Name: Boys & Girls Clubs of Wayne County

County: Wayne

Contact Person: Bruce Daggy

Address: 1717 South L St; Richmond, IN 47374

Phone: (765) 962-6922 E-mail: bdaggy@bgcrichmond.org

Agency Name: Youth Service Bureau of Jay County

County: Jay

Contact Person:

Address: 603 West Arch St., Portland, IN 47374

Phone: (260) 726-8535 E-mail: ysbjc@ysbjc.com

Describe Services Provided: Accept referrals from DCS and Probation. Immediate placement for boys and girls ages 6-19 years, 24 hours a day, Crisis Stabilization. Provides bed for emergency and residential place, and a continuum of community directed projects, including: Healthy Families, Title IV-B programs and integrated services, Community Partners, KARSS, Independent Living Services and Children in the middle classes.

Domestic Violence Intervention

Agency Name: RUSH CO. VICTIMS ASSISTANCE
County: RUSH
Contact Person: BARBARA KUHN
Address: 315 N. Main St., PO Box 303, Rushville, IN 46173
Phone: (765) 938-1555 **E-mail:** rcva924@mvfrontiermail.com

Agency Name: Gensis of the YWCA
County: Wayne
Contact Person: Director: Rebecca Studabaker
Address: P.O. Box 2430, Richmond, IN 47375
Phone: (765) 935-3920/Toll Free: 800-886-4508 **E-mail:** richywca@yahoo.com
Provides: Temporary housing, support groups, victim advocacy, community counseling, 24 hour a day crisis line.

Agency Name: Safe Passage, Inc
County: Franklin
Contact Person:
Address: PO Box 235; Batesville, IN 47006
Phone: (812) 933-1990 **Website:** www.safepassageinc.org
Provides: Temporary housing, support groups, victim advocacy, community counseling, 24 hour a day crisis line.

Agency Name: Safe at Home
County: Henry
Contact Person: Mary Anne Legge
Address: Henry County Court House
Phone: (765) 529- 0647 **E-mail:**

Other Prevention Services

Agency Name: Early Head Start/Community Action of East Central IN. (CAECI)
County: Wayne
Contact Person: Melissa Lingar
Address: 1845 W Main Street, Richmond, IN 47374
Phone: (765-966-7733 ext. 240) **E-mail:** milingar@caeci.org

Agency Name: Cradles
County: Henry
Contact Person: Becky Malone
Address:
Phone: (765) 593- 6629 **E-mail:**

Region 12 Barriers to Service Responses

0 = County did not contract / no providers exist
 1 = Lack of office or staff person located in county or limited hours
 2 = Lack of local telephone number or 800 number to contact direct service staff
 3 = Waiting list if provider is unable to contact family within required number of days per Service Standard
 4 = Lack of options of service providers
 5 = Language/Cultural barriers (insufficient bi-lingual staff, paid confidential interpreters of services provided to non-English speakers and interpreters who can sign)
 6 = Lack of transportation (public or otherwise) if the service is only available in office
 7 = Lack of handicap accessibility (if the service is only available in office)
 8 = Quality of service not available
 9 = Not identified as a priority

#	Service Description	Fayette	Franklin	Henry	Rush	Union	Wayne
1	Adoption – Family Preparation / Home Study			0	1,4		
2	Adoption Child Preparation		1,4	0	1,4	4	4
3	Care Network		0	0	0	0,9	4,9
4	CHINS Parent Support Services	0	4	0	0,9	9	1,6
5	Counseling	3	4		1,4,6,8	4,6,8	1,4,8
6	Cross-System Care Coordination	1		0	0	9	4,9
7	Day Reporting / Treatment Programs		1,4,6	0	0,9	4,6	4
8	Detoxification Services	1	1,6		0	4,6	0
9	Diagnostic and Evaluation Services	1,6	4		1,4,6,8		4
10	Domestic Violence Batterers Intervention	1,6	4		0	4	4
11	Domestic Violence Survivor and Child	1,6	1,6		0	4,8	0,4
12	Drug Testing and Supplies	4			9		
13	Father Engagement Programs			0	0		4
14	Foster Home Studies / Updates / Re-licensing	0,9		0	9		
15	Functional Family Therapy	3,4,5	4		1,4,8	4,8	4,8
16	Home-Based Family Centered Casework	3,4,5			1,8	4,8	8,9
17	Home-Based Family Centered Therapy Services	3,4,5	4		1,4,8	4,8	4,8
18	Homemaker / Parent Aid	0	0	0	0,9	0,9	0
19	Outpatient Substance Use Treatment	4	1,4,6		1,4,6,8	4,6,8	4,8

#	Service Description	Fayette	Franklin	Henry	Rush	Union	Wayne
20	Parent Education	0,4		0	4,6,8	9	0
21	Parenting / Family Functioning Assessment	1			1,4,6,8	0,9	0
22	Quality Assurance for Children in Residential	0		0	0,9		9
23	Random Drug Testing	0,4		0	0,9		
24	Residential Substance Use Treatment	1	0,1,4,6	0	0,1,4,8	4,6	4,6,8
25	Resource Family Support Services	0			0,9		0,9
26	Sex Offender Treatment	1,5,7	1		0,1,4	4,6	4,6,8
27	Substance Use Disorder Assessment	0	4,8		1,4,8	4,6,8	4,8
28	Support Group Services for Resource Families	0		0	0,9		0
29	Transitions from Restrictive Placements	1	9	0	0,1,4,8	9	0,9
30	Truancy Termination	0	9	0	0,9	9	0,9
31	Tutoring / Literacy Classes	0		0	0,9	9	0,9
32	Visitation Facilitation	4		0	0,9	4	4
33	Affordable child/day care	3,4	3,4	0	9	4	9
34	Sex education / teen pregnancy prevention	1		0	0,9	9	9
35	Adult-child mentoring programs	1	4	0	0,9	9	9
36	After-school, recreational, or youth development	1	1	0	6		9
37	Support services for lesbian, gay, bi-sexual,	0	4	0	0,9	9	9
38	Outreach services for at-risk children and adults	0	4	0	0,9	9	9
39	Programs for parents who are in the process of	1		0	0	9	9
40	Alcohol, tobacco, and other chemical	4,6		0	0,9	9	9
41	Inpatient mental health treatment services -	1	1	0	0	4,6	4,6,9
42	Early childhood education / preschool programs	0		0	9	9	9
43	Early childhood intervention /	0		0	9	9	9
44	Special Education	0		0	9	9	9
45	Support programs for teen parents / pregnant teens to	0		0	0	9	9

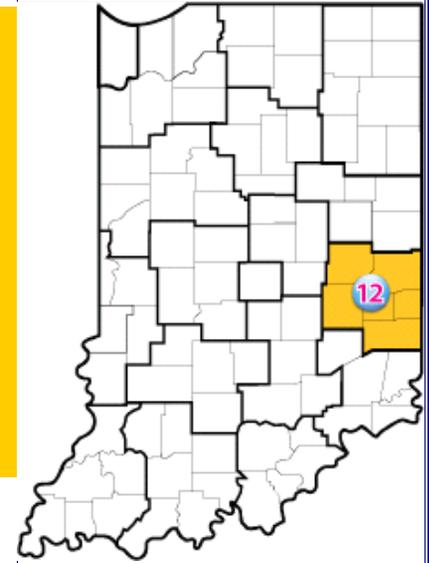
#	Service Description	Fayette	Franklin	Henry	Rush	Union	Wayne
46	Job retraining, employment preparation /	0			4,6	4,9	9
47	Low-income health services/clinics - children	1,4	4		0	9	9
48	Low-income health services/clinics - adults	1,4	4		0	9	9
49	Dental care for low- income adults / children /	1,4	4		0	9	9
50	Family shelters for the homeless	0	1	0	0	9	9
51	Safe, affordable low- income housing	4	2	3	4	4	4
52	Food and nutrition resources (e.g. food	0,8			9	9	4
53	Assistance with clothing and household goods	4,8			0	4	
54	Emergency financial assistance (e.g. utilities,	8			0	4	4
55	Transportation assistance (formal or informal) so	4			0	4,9	9
56	Gang prevention services	9	4,9	0	0,9	9	9
57	Translation services	0	1	0	0,1,4	4,9	9



INDIANA
DEPARTMENT OF
CHILD
SERVICES

*Protecting our children,
families and future*

Department of Child Services Practice Indicator Reports For January 2011



Region 12 January 2011

Data in the report (both historical and current) may be subject to change as it is continually being validated and updated. This may result in statistical data in previous reports to be inconsistent with statistics found in more recent reports even when the data pertain to the same time period.



**Published
February 2011**



DCS Practice Indicator Report Initial Assessment - Use of Substitute Care

For January 2011

Report Description

This report uses data collected over a rolling three month period ending with the current report month. The graphs and numbers for historical months also use a rolling three month period ending with the historical month listed.

Reports Taken – This section has data regarding the reports taken during the three month period ending with the report month.

Count – This is the total number of reports of abuse or neglect that are entered into ICWIS during the period ending with the report month.

Percent Resulting in Screen Outs – This is the percentage of reports that are screened out divided by the total reports taken during the period ending with the report month.

Assessments Substantiated – This section has data regarding the number of assessments with substantiated findings of abuse and/or neglect during the three month period ending with the report month.

Count – This is the total number of assessments with substantiated findings of abuse and/or neglect during the period ending with the report month.

Percent Resulting in Removal – This is the percentage of substantiated assessments during the period that resulted in removal of the child from the home by the end of the report month divided by the total number of substantiated assessments during the period ending with the report month.



DCS Practice Indicator Report

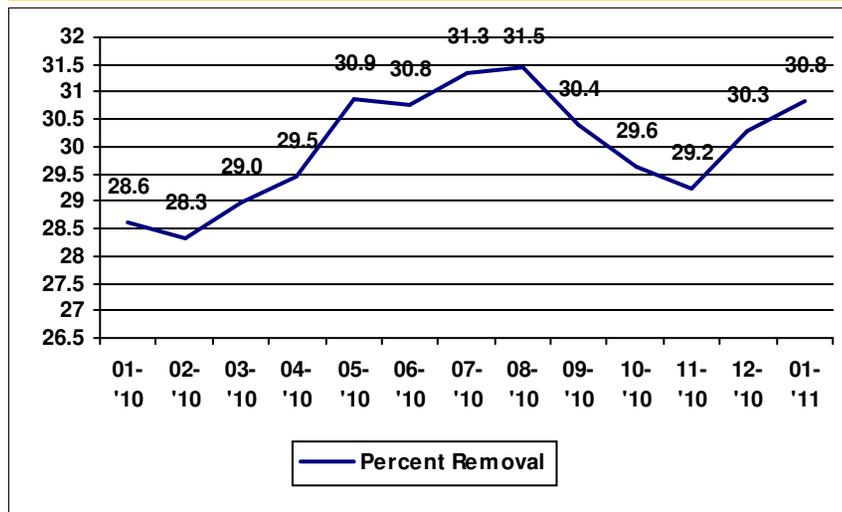
Initial Assessment - Use of Substitute Care

For January 2011

January 2011

Location	Reports Taken For Nov 2010 to Jan 2011		Assessments Substantiated For Nov 2010 to Jan 2011	
	Count	Percent Resulting in Screen Outs	Count	Percent Resulting in Removal
Statewide	36,064	34.1%	5,343	30.8%
Region 12	1,192	39.77%	122	18.03%
Fayette	175	42.9%	14	42.9%
Franklin	115	34.8%	5	20.0%
Henry	288	41.0%	29	10.3%
Rush	148	41.2%	17	11.8%
Union	41	46.3%	5	20.0%
Wayne	425	37.9%	52	17.3%

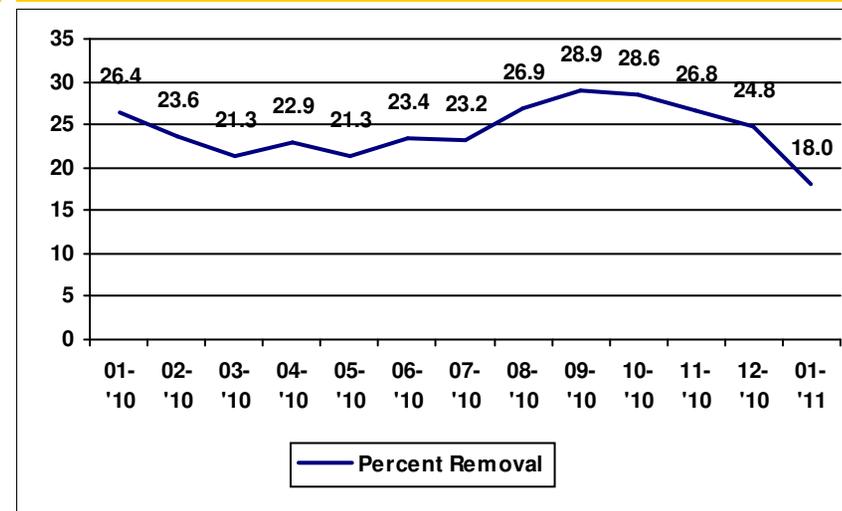
Statewide Percent Removal Trend



Region 12 For January 2010 to January 2011

Month	Reports Taken For Nov 2010 to Jan 2011		Assessments Substantiated For Nov 2010 to Jan 2011	
	Count	Percent Resulting in Screen Outs	Count	Percent Resulting in Removal
Jan 2011	1,192	39.8%	122	18.0%
Dec 2010	1,205	39.1%	157	24.8%
Nov 2010	1,305	41.1%	157	26.8%
Oct 2010	1,221	40.3%	189	28.6%
Sep 2010	1,208	39.2%	173	28.9%
Aug 2010	1,116	34.1%	182	26.9%
Jul 2010	1,157	32.4%	164	23.2%
Jun 2010	1,106	26.4%	154	23.4%
May 2010	1,116	22.1%	155	21.3%
Apr 2010	979	17.0%	153	22.9%
Mar 2010	964	14.1%	160	21.3%
Feb 2010	858	12.0%	157	23.6%
Jan 2010	887	9.7%	193	26.4%

Region 12 Percent Removal





DCS Practice Indicator Report CHINS Placements by County

For January 2011

Report Description

This report uses data collected at the end of the current report month. The graphs and numbers for historical months also use data from the end of the historical month listed. This report looks at CHINS children from CHINS cases that were open on the last day of the report month. It also collects where that child is located (in their own home or in substitute care). For the purpose of this report, a child with a non-custodial parent is considered "in home".

Total CHINS Count – This is the number of children that have an open CHINS case on the last day of the report month.

CHINS – This section has data regarding all children that have an open CHINS case on the last day of the month.

In Home – This section has data regarding children that have an open CHINS case on the last day of the month and are in their own home.

Count- This is the number of children that have an open CHINS case on the last day of the month and are in their own home.

Percent- This is the number of children that have an open CHINS case on the last day of the month and are in their own home divided by the total number of children that have an open CHINS case on the last day of the month.

Foster Care – This section has data regarding children that have an open CHINS case on the last day of the month and are in out of home placement.

Count- This is the number of children that have an open CHINS case on the last day of the month and are in out of home placement.

Percent- This is the number of children that have an open CHINS case on the last day of the month and are in out of home placement divided by the total number of children that have an open CHINS case on the last day of the month.

Out of Home Placements – This section has data for children that have an open CHINS case on the last day of the month and are in out of home placement.

Relative Homes – This section has data for children that have an open CHINS case on the last day of the month and are placed with relatives.

Count- This is the number of children that have an open CHINS case on the last day of the month and are placed with relatives.

Percent- This is the number of children that have an open CHINS case on the last day of the month and are placed with relatives divided by the total number of CHINS children in out of home placement at the end of the month.

Foster Homes – This section has data for children that have an open CHINS case on the last day of the month and are placed in foster homes.

Count- This is the number of children that have an open CHINS case on the last day of the month and are placed in foster homes.

Percent- This is the number of children that have an open CHINS case on the last day of the month and are placed in foster homes divided by the total number of CHINS children in out of home placement at the end of the month.

Residential – This section has data for children that have an open CHINS case on the last day of the month and are placed in residential setting.

Count- This is the number of children that have an open CHINS case on the last day of the month and are placed in residential setting.

Percent- This is the number of children that have an open CHINS case on the last day of the month and are placed in residential setting divided by the total number of CHINS children in out of home placement at the end of the month.

Other – This section has data for children that have an open CHINS case on the last day of the month and are in other placement settings. Example would be a court ordered unlicensed placement.

Count- This is the number of children that have an open CHINS case on the last day of the month and are in other placement settings.

Percent- This is the number of children that have an open CHINS case on the last day of the month and are in other placement settings divided by the total number of CHINS children in out of home placement at the end of the month.



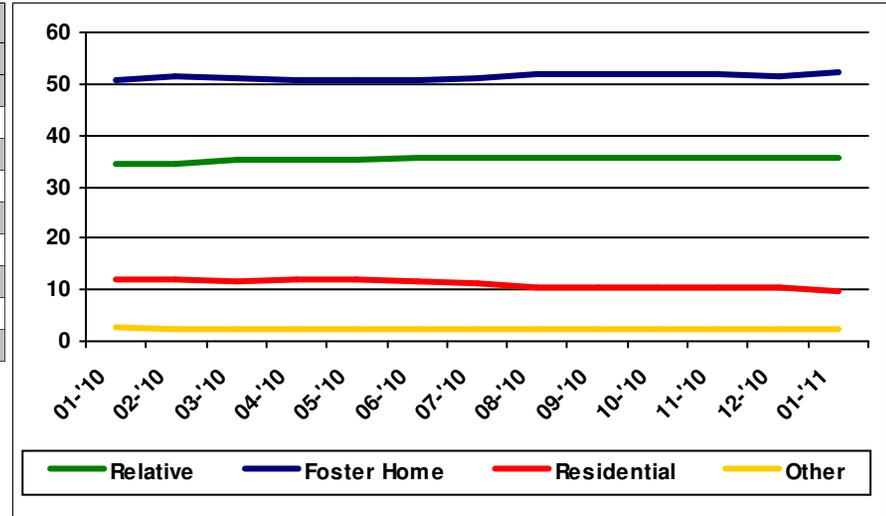
DCS Practice Indicator Report CHINS Placements by County

For January 2011

January 2011

Location	Total CHINS Count	CHINS				Out of Home Placements							
		In Home		Foster Care		Relative Home		Foster Homes		Residential		Other	
		Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
Statewide	14172	4207	29.7%	9,965	70.3%	3554	35.7%	5192	52.1%	981	9.8%	238	2.4%
Region 12	219	46	21.0%	173	79.0%	59	34.1%	93	53.8%	13	7.5%	8	4.6%
Fayette	52	4	7.7%	48	92.3%	18	37.5%	22	45.8%	4	8.3%	4	8.3%
Franklin	26	7	26.9%	19	73.1%	7	36.8%	11	57.9%	1	5.3%	0	0.0%
Henry	53	17	32.1%	36	67.9%	16	44.4%	17	47.2%	3	8.3%	0	0.0%
Rush	18	1	5.6%	17	94.4%	3	17.6%	11	64.7%	3	17.6%	0	0.0%
Union	24	3	12.5%	21	87.5%	6	28.6%	13	61.9%	2	9.5%	0	0.0%
Wayne	46	14	30.4%	32	69.6%	9	28.1%	19	59.4%	0	0.0%	4	12.5%

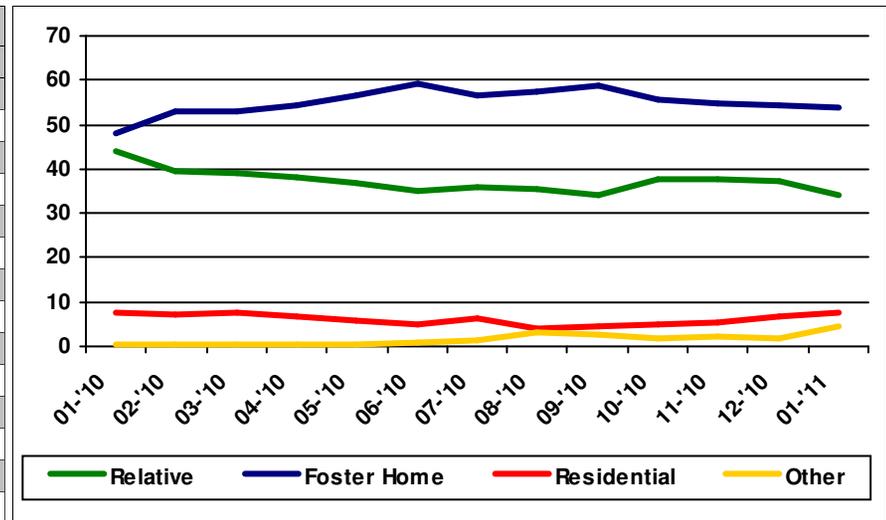
Statewide Foster Care Placement Breakdown



Region 12 For January 2010 to January 2011

Month	Total CHINS Count	CHINS				Out of Home Placements							
		In Home		Foster Care		Relative Home		Foster Homes		Residential		Other	
		Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
Jan 2011	219	46	21.0%	173	79.0%	59	34.1%	93	53.8%	13	7.5%	8	4.6%
Dec 2010	228	48	21.1%	180	78.9%	67	37.2%	98	54.4%	12	6.7%	3	1.7%
Nov 2010	243	58	23.9%	185	76.1%	70	37.8%	101	54.6%	10	5.4%	4	2.2%
Oct 2010	247	59	23.9%	188	76.1%	71	37.8%	105	55.9%	9	4.8%	3	1.6%
Sep 2010	261	74	28.4%	187	71.6%	64	34.2%	110	58.8%	8	4.3%	5	2.7%
Aug 2010	258	87	33.7%	171	66.3%	61	35.7%	98	57.3%	7	4.1%	5	2.9%
Jul 2010	261	88	33.7%	173	66.3%	62	35.8%	98	56.6%	11	6.4%	2	1.2%
Jun 2010	264	83	31.4%	181	68.6%	63	34.8%	107	59.1%	9	5.0%	2	1.1%
May 2010	272	87	32.0%	185	68.0%	68	36.8%	105	56.8%	11	5.9%	1	0.5%
Apr 2010	288	99	34.4%	189	65.6%	72	38.1%	103	54.5%	13	6.9%	1	0.5%
Mar 2010	305	103	33.8%	202	66.2%	79	39.1%	107	53.0%	15	7.4%	1	0.5%
Feb 2010	318	94	29.6%	224	70.4%	88	39.3%	119	53.1%	16	7.1%	1	0.4%
Jan 2010	331	102	30.8%	229	69.2%	101	44.1%	110	48.0%	17	7.4%	1	0.4%

Region 12 Foster Care Placement Breakdown





DCS Practice Indicator Report Use of Foster Care by County

January 2011

Report Description

This report uses data collected at the end of the current report month. The graphs and numbers for historical months also use data from the end of the historical month listed. This report looks at CHINS children from CHINS cases that were open on the last day of the report month. It also collects where that child is located (in their own home or in substitute care). For the purpose of this report, children with non-custodial parents are considered to be in their own home.

Total CHINS Count – This is the number of children that have an open CHINS case on the last day of the report month.

In Home or Relative Care – This section has data regarding children that have an open CHINS case on the last day of the month and are in their own home or in relative care.

Count- This is the number of children that have an open CHINS case on the last day of the month and are in their own home or in relative care.

Percent- This is the number of children that have an open CHINS case on the last day of the month and are in their own home or in relative care divided by the total number of children that have an open CHINS case on the last day of the month.

Target (At or Above) % – The target for the percent of the number of children that have an open CHINS case on the last day of the month and are in their own home or in relative care to the total number of children that have an open CHINS case on the last day of the month is 50% or higher.

Non Relative Foster Care – This section has data for children that have an open CHINS case on the last day of the month and are not in their own home or in relative care.

Count- This is the number of children that have an open CHINS case on the last day of the month and are not in their own home or in relative care.

Percent- This is the number of children that have an open CHINS case on the last day of the month and are not in their own home or in relative care divided by the total number of CHINS children in out of home placement at the end of the month.

Target (At or below) % – The target for the percent of the number of children that have an open CHINS case on the last day of the month and are not in their own home or in relative care to the total number of children that have an open CHINS case on the last day of the month is 50% or higher.



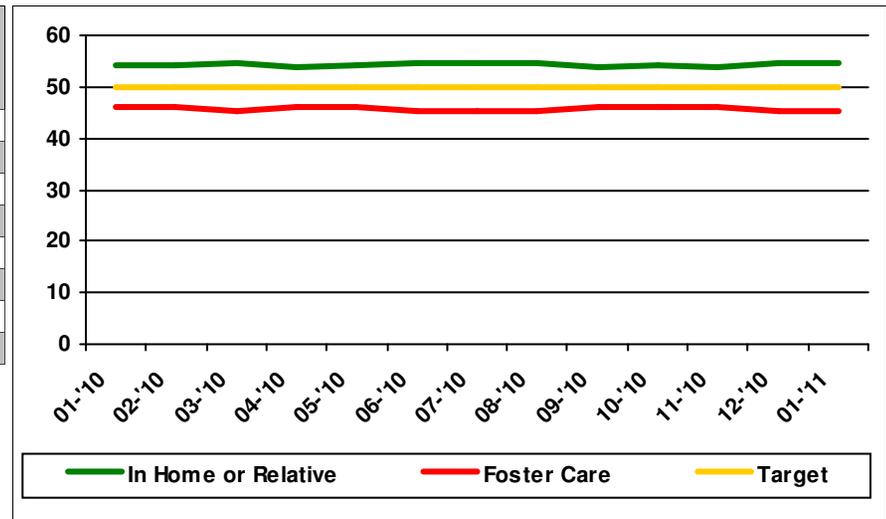
DCS Practice Indicator Report Use of Foster Care by County

For January 2011

January 2011

Location	Total CHINS	In Home or Relative Care		Target (At or Above) %	Non-Relative Foster Care		Target (At or Below) %
	Count	Count	%		Count	%	
Statewide	14172	7761	54.8%	50.0%	6,411	45.2%	50.0%
Region 12	219	105	47.9%	50.0%	114	52.1%	50.0%
Fayette	52	22	42.3%	50.0%	30	57.7%	50.0%
Franklin	26	14	53.8%	50.0%	12	46.2%	50.0%
Henry	53	33	62.3%	50.0%	20	37.7%	50.0%
Rush	18	4	22.2%	50.0%	14	77.8%	50.0%
Union	24	9	37.5%	50.0%	15	62.5%	50.0%
Wayne	46	23	50.0%	50.0%	23	50.0%	50.0%

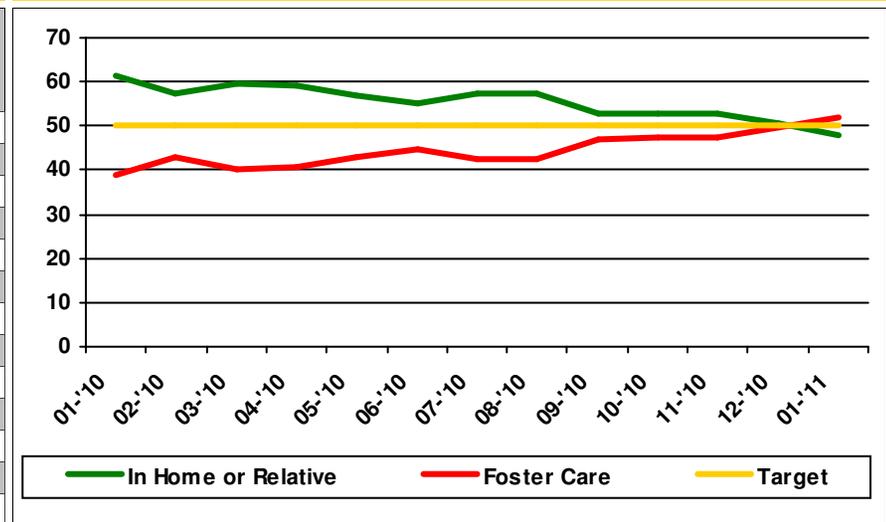
Statewide Foster Care Placement Breakdown



Region 12 For January 2010 to January 2011

Month	Total CHINS	In Home or Relative Care		Target (At or Above) %	Non-Relative Foster Care		Target (At or Below) %
	Count	Count	%		Count	%	
January 2011	219	105	47.9%	50.0%	114	52.1%	50.0%
December 2010	228	115	50.4%	50.0%	113	49.6%	50.0%
November 2010	243	128	52.7%	50.0%	115	47.3%	50.0%
October 2010	247	130	52.6%	50.0%	117	47.4%	50.0%
September 2010	261	138	52.9%	50.0%	123	47.1%	50.0%
August 2010	258	148	57.4%	50.0%	110	42.6%	50.0%
July 2010	261	150	57.5%	50.0%	111	42.5%	50.0%
June 2010	264	146	55.3%	50.0%	118	44.7%	50.0%
May 2010	272	155	57.0%	50.0%	117	43.0%	50.0%
April 2010	288	171	59.4%	50.0%	117	40.6%	50.0%
March 2010	305	182	59.7%	50.0%	123	40.3%	50.0%
February 2010	318	182	57.2%	50.0%	136	42.8%	50.0%
January 2010	331	203	61.3%	50.0%	128	38.7%	50.0%

Region 12 Foster Care Placement Breakdown





DCS Practice Indicator Report Locally Placed CHINS

For January 2011

Report Description

This report uses data collected over at the end of the current report month. The graphs and numbers for historical months also use data from the historical month listed. For the purpose of this report, children with their non-custodial parents are considered to be in their own home.

Total Out of Home Placements – This is the total number of CHINS children that are in out of home placement on the last day of the report month.

Placed in Same County – This is the total number of CHINS children that are placed in the same county as the county of their case.

Percent Locally Placed – This is the percentage of CHINS children that are placed in the same county as the county of their case divided by the total number of CHINS children which are in out of home placement on the last day of the report month.



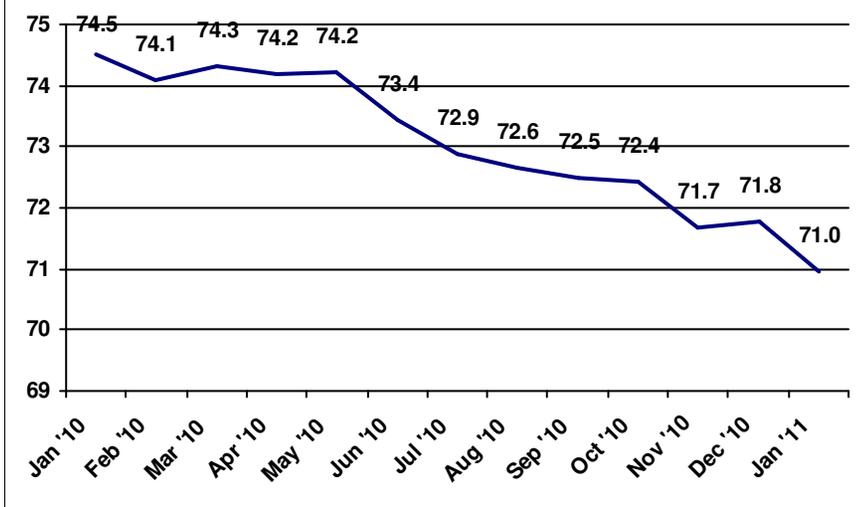
DCS Practice Indicator Report Locally Placed CHINS

For January 2011

January 2011

Location	Total Out of Home Placements	Placed in Same County	Percent Locally Placed
Statewide	9,965	7,071	71.0%
Region 12	173	107	61.8%
Fayette	48	22	45.8%
Franklin	19	18	94.7%
Henry	36	30	83.3%
Rush	17	8	47.1%
Union	21	7	33.3%
Wayne	32	22	68.8%

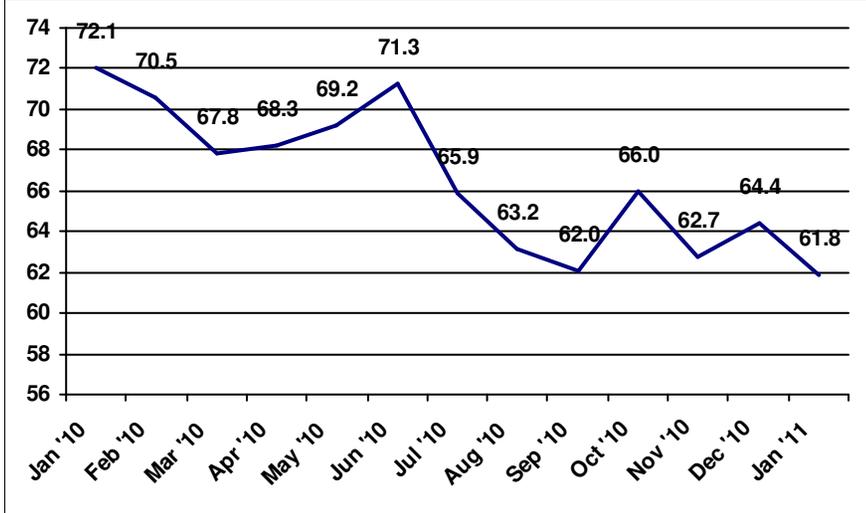
Statewide Percent Placed Locally



Region 12 For January 2010 to January 2011

Month	Total Out of Home Placements	Placed in Same County	Percent Locally Placed
Jan 2011	173	107	61.8%
Dec 2010	180	116	64.4%
Nov 2010	185	116	62.7%
Oct 2010	188	124	66.0%
Sep 2010	187	116	62.0%
Aug 2010	171	108	63.2%
Jul 2010	173	114	65.9%
Jun 2010	181	129	71.3%
May 2010	185	128	69.2%
Apr 2010	189	129	68.3%
Mar 2010	202	137	67.8%
Feb 2010	224	158	70.5%
Jan 2010	229	165	72.1%

Region 12 Percent Placed Locally





DCS Practice Indicator Report Average Number of Placements

For January 2011

Report Description

This report uses data collected at the end of the current report month. The graphs and numbers for historical months also use data from the historical month listed.

Average Number of Placements Per Child – This is the total number of out of home placements for each CHINS child in out of home placement on the last day of the report month. This includes all placements during the current removal episode. If a child had at least one placement end in the first 8 days from removal, then that child's number of placements was reduced by one.

This number is divided by the total number CHINS children who are in out of home placement on the last day of the report month.



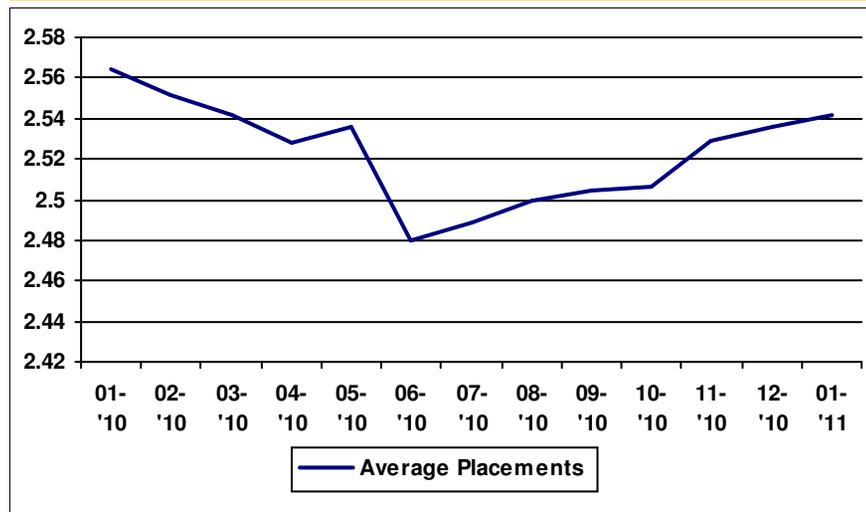
DCS Practice Indicator Report Average Number of Placements

For January 2010 to January 2011

January 2011

Location	Average Number of Placements Per Child
Statewide	2.5
Region 12	2.2
Fayette	2.3
Franklin	1.7
Henry	2.0
Rush	3.4
Union	1.3
Wayne	2.4

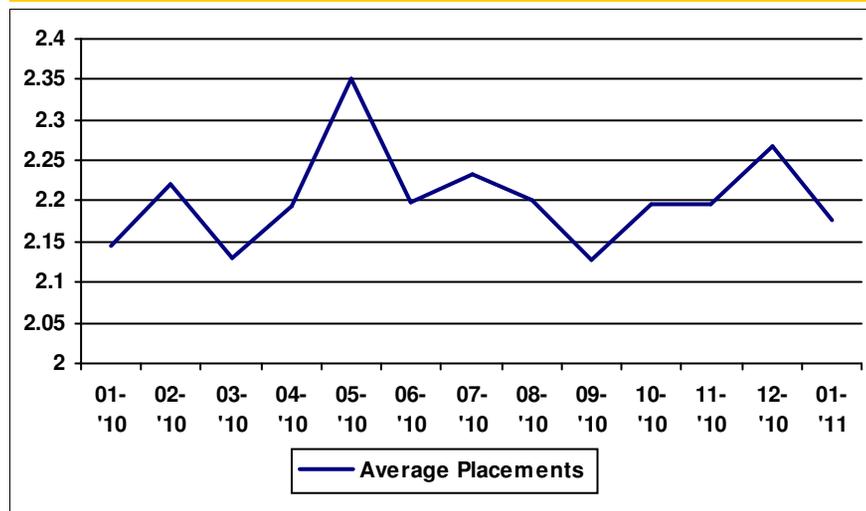
Statewide Average Number of Placements



Region 12 For January 2010 to January 2011

Month	Average Number of Placements Per Child
January 2011	2.2
December 2010	2.3
November 2010	2.2
October 2010	2.2
September 2010	2.1
August 2010	2.2
July 2010	2.2
June 2010	2.2
May 2010	2.4
April 2010	2.2
March 2010	2.1
February 2010	2.2
January 2010	2.1

Region 12 Average Number of Placements





DCS Practice Indicator Report Sibling Placement Report

For January 2011

Report Description

This report uses data collected at the end of the current report month. The graphs and numbers for historical months also use data from the end of the historical month listed. For the purpose of this report, children with a non-custodial parent are considered to be in their own home.

Count of Sibling Cases – This is the number of open cases as of the end of the report month which have more than one child in out of home placement at the end of the report month.

Cases With All Children Placed Together – This is the number of cases with more than one child in out of home placement where all of the children are placed in the same resource with the same resource ID.

Percent Placed Together of Sibling Cases– This is the percentage of the number of cases where all of the children in out of home placement are placed together divided by the number of open cases with more than one child in out of home placement as of the end of the report month.

Average Number of Children per Case – This number takes the number of children in out of home placement from cases with more than one child in out of home placement and divides it by the number of cases with more than one child in out of home placement as of the end of the report month.



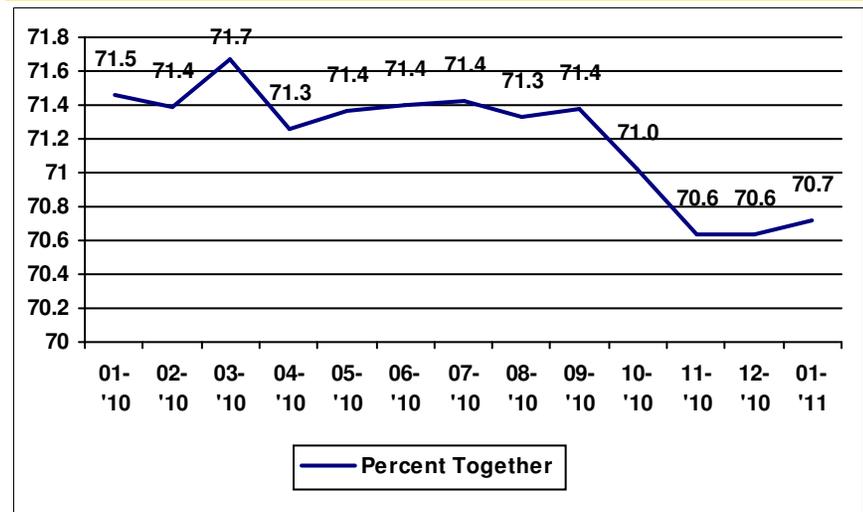
DCS Practice Indicator Report Sibling Placement Report

January 2011

January 2011

Location	Count of Sibling Cases	Cases With All Children Placed Together	Percent Placed Together of Sibling Cases	Average Number of Children per Case
Statewide	2452	1734	70.7%	2.68
Region 12	44	37	84.1%	2.34
Fayette	12	8	66.7%	2.42
Franklin	6	6	100.0%	2.33
Henry	9	8	88.9%	2.00
Rush	4	3	75.0%	2.00
Union	4	4	100.0%	3.75
Wayne	9	8	88.9%	2.11

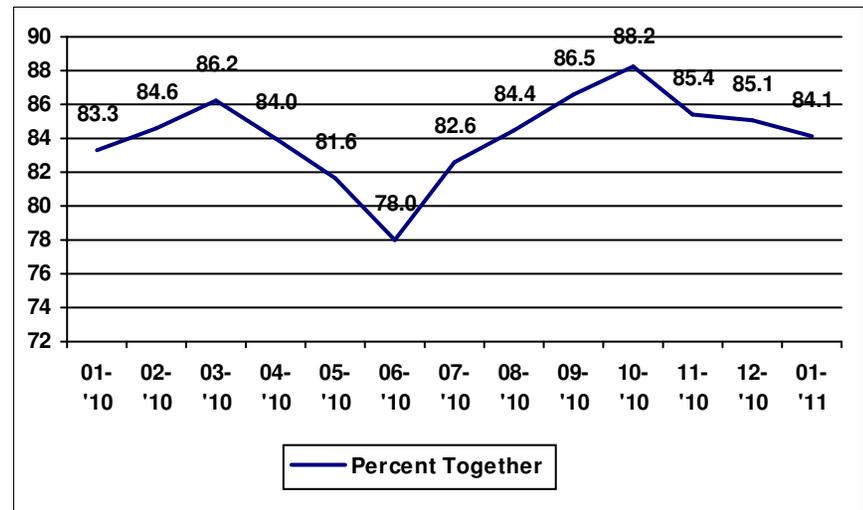
Statewide Percent Together



Region 12 For January 2010 to January 2011

Month	Count of Sibling Cases	Cases With All Children Placed Together	Percent Placed Together of Sibling Cases	Average Number of Children per Case
January 2011	44	37	84.1%	2.34
December 2010	47	40	85.1%	2.36
November 2010	48	41	85.4%	2.40
October 2010	51	45	88.2%	2.35
September 2010	52	45	86.5%	2.38
August 2010	45	38	84.4%	2.33
July 2010	46	38	82.6%	2.33
June 2010	50	39	78.0%	2.26
May 2010	49	40	81.6%	2.24
April 2010	50	42	84.0%	2.26
March 2010	58	50	86.2%	2.24
February 2010	65	55	84.6%	2.26
January 2010	66	55	83.3%	2.27

Region 12 Percent Together





DCS Practice Indicator Report

Length of Stay in Out of Home Placement

Children in Out of Home Placement by Length of Time Since Latest Removal

For January 2011

Report Description

This report uses data collected at the end of the current report month. The graphs and numbers for historical months also use data from the end of the historical month listed. This report looks at CHINS children that were in out of home placement at the end of the month. It measures the number of days since the child was last removed from its home.

One Year - 0 to 365 Days— This is column shows data for CHINS children that have been in out of home placement between 0 and 365 days since the child's removal.

Count- This is the number of CHINS children that have been in out of home placement between 0 and 365 days since the child's last removal.

Percent- This is the number of CHINS children that have been in out of home placement between 0 and 365 days since the child's last removal divided by the total number of CHINS children in out of home placement at the end of the month.

One Year - 366 to 730 Days— This is column shows data for CHINS children that have been in out of home placement between 366 and 730 days since the c last removal.

Count- This is the number of CHINS children that have been in out of home placement between 366 and 730 days since the child's last removal.

Percent- This is the number of CHINS children that have been in out of home placement between 366 and 730 days since the child's last removal divided by the total number of CHINS children in out of home placement at the end of the month.

One Year - 731 to 1095 Days— This is column shows data for CHINS children that have been in out of home placement between 731 to 1095 days since the child's last removal.

Count- This is the number of CHINS children that have been in out of home placement between 731 to 1095 days since the child's last removal.

Percent- This is the number of CHINS children that have been in out of home placement between 731 to 1095 days since the child's last removal divided by the total number of CHINS children in out of home placement at the end of the month.

One Year - 1096 Days+— This is column shows data for CHINS children that have been in out of home placement 1096 days or more since the child's last removal.

Count- This is the number of CHINS children that have been in out of home placement 1096 days or more since the child's last removal.

Percent- This is the number of CHINS children that have been in out of home placement 1096 days or more since the child's last removal divided by the total number of CHINS children in out of home placement at the end of the month.

Length Per Child – This column shows data for length of time of CHINS children who were in out of home placement at the end of the report month have been in out of home placement since the child's last removal from their home.

Average- This column calculates the average or "mean" length of time in out of home placement since the last removal per child in out of home placement at the end of the report month.

Median- This column calculates the median length of time in out of home placement since the last removal per child in out of home placement at the end of the report month.



DCS Practice Indicator Report

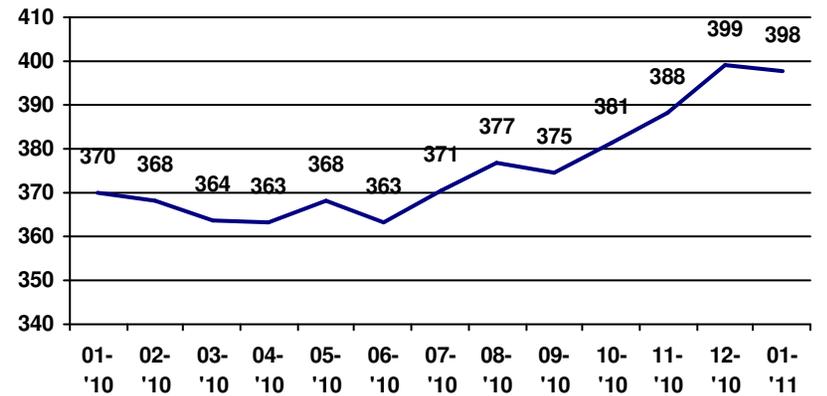
Length of Stay in Out of Home Placement

Children in Out of Home Placement by Length of Time Since Latest Removal For January 2011

January 2011

Location	One Year 0 to 365 Days		Two Years 366 to 730 Days		Three Years 731 to 1095 Days		Three + Years 1096 Days+		Length Per Child	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Average	Median
Statewide	4,746	47.6%	2,462	24.7%	1,192	12.0%	1,565	15.7%	627.4	397.6
Region 12	102	59.0%	46	26.6%	6	3.5%	19	11.0%	483.0	238.6
Fayette	33	68.8%	11	22.9%	1	2.1%	3	6.3%	406.9	209.5
Franklin	8	42.1%	3	15.8%	2	10.5%	6	31.6%	796.2	672.4
Henry	17	47.2%	15	41.7%	0	0.0%	4	11.1%	431.1	370.0
Rush	6	35.3%	7	41.2%	2	11.8%	2	11.8%	713.5	581.4
Union	19	90.5%	1	4.8%	1	4.8%	0	0.0%	207.7	206.5
Wayne	19	59.4%	9	28.1%	0	0.0%	4	12.5%	527.6	258.5

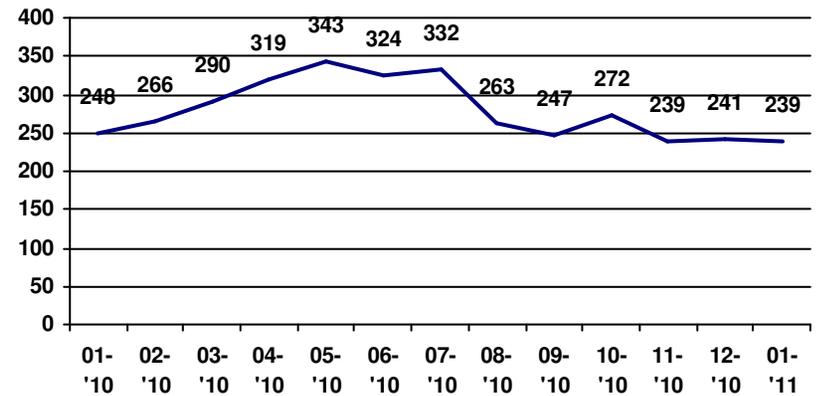
Statewide Median Length



Region 12 For January 2010 to January 2011

Month	One Year 0 to 365 Days		Two Years 366 to 730 Days		Three Years 731 to 1095 Days		Three + Years 1096 Days+		Length Per Child	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Average	Median
January 2011	102	59.0%	46	26.6%	6	3.5%	19	11.0%	483.0	238.6
December 2010	108	60.0%	42	23.3%	9	5.0%	21	11.7%	494.1	241.0
November 2010	113	61.1%	40	21.6%	14	7.6%	18	9.7%	467.2	238.6
October 2010	112	59.6%	44	23.4%	15	8.0%	17	9.0%	464.2	271.5
September 2010	110	58.8%	45	24.1%	14	7.5%	18	9.6%	459.7	247.4
August 2010	96	56.1%	48	28.1%	9	5.3%	18	10.5%	476.6	263.3
July 2010	100	57.8%	44	25.4%	10	5.8%	19	11.0%	497.2	331.7
June 2010	102	56.4%	51	28.2%	9	5.0%	19	10.5%	491.2	324.3
May 2010	100	54.1%	55	29.7%	10	5.4%	20	10.8%	505.1	343.4
April 2010	106	56.1%	51	27.0%	12	6.3%	20	10.6%	494.7	318.6
March 2010	119	58.9%	49	24.3%	12	5.9%	22	10.9%	491.2	290.0
February 2010	144	64.3%	43	19.2%	14	6.3%	23	10.3%	469.3	266.0
January 2010	152	66.4%	45	19.7%	9	3.9%	23	10.0%	446.7	248.2

Region 12 Median Length





DCS Practice Indicator Report CHINS and IA Permanency Report

For January 2011

Report Description

This report uses CHINS and IA case types that have case type status end date occurring during the month. It then groups these cases using the closure reasons codes into categories of closure reasons. Case with closure reason code “Case opened in error – disregard” are filtered out for the purpose of this report. This report uses the reason codes selected by the worker at the date of case closure. **Adoption closure reasons will not match the number of actual finalized adoptions reported from the hearing information fields in ICWIS/MaGik.**

Closure Reasons are group by:

Description	Category	Description	Category
Child Reunited with Parents	Reunification	Case closed; AG case created	Guardianship
Child never Removed from own home, wardship terminated	Reunification	Child placed with relatives	Relative
Extended wardship terminated (on court order for age 18 to 21)	Emancipation	Child Placed with Legal guardian	Guardianship
Child Returned to Primary Home	Reunification	Child Reached Age of Majority (age 18)	Emancipation
Period of IA ended code used for Informal Adjustment cases only	Reunification	Emancipated Court Ordered (age 18)	Emancipation
Child Adoption Finalized	Adoption	Child Already Reunited with parent (s) when wardship terminated	Reunification

The Permanency column “Total” refers to the total case with reason codes in the Reunification, Adoption, Relative, Guardianship, and Emancipation categories.

The Permanency column “Total within 24 months” refers to the total case that ended within 24 month of the case status type begin date in the Reunification, Adoption, Relative, Guardianship, and Emancipation categories.



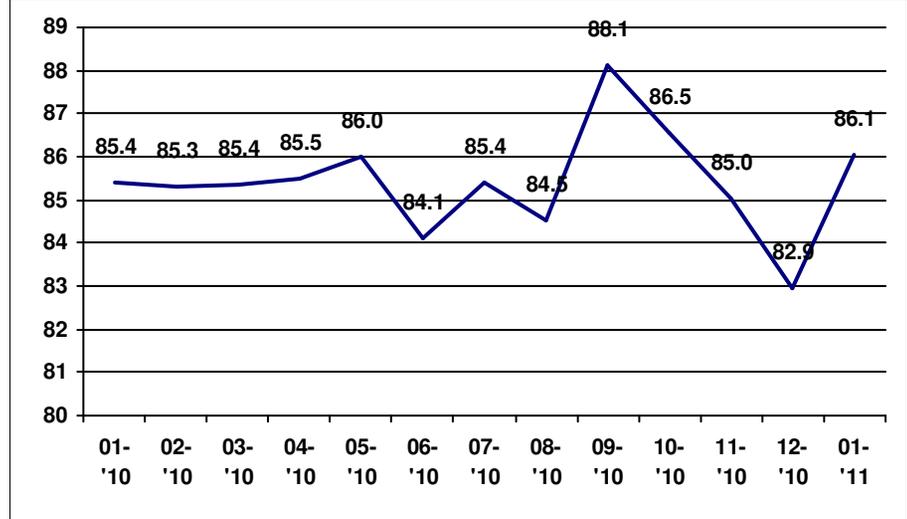
DCS Practice Indicator Report CHINS and IA Permanency Report

For January 2011

January 2011

Location	Closed Cases Types with Permanency Outcomes					Permanency		
	Reunification	Adoption	Relative	Guardianship	Emanicipation	Total	Within 24 Months	24 Month Rate
Statewide	726	97	12	64	26	925	796	86.1
Region 12	18	3	0	1	0	22	19	86.4
Fayette	4	0	0	0	0	4	4	100.0
Franklin	1	0	0	0	0	1	1	100.0
Henry	7	2	0	1	0	10	8	80.0
Rush	1	0	0	0	0	1	0	0.0
Union	3	0	0	0	0	3	3	100.0
Wayne	2	1	0	0	0	3	3	100.0

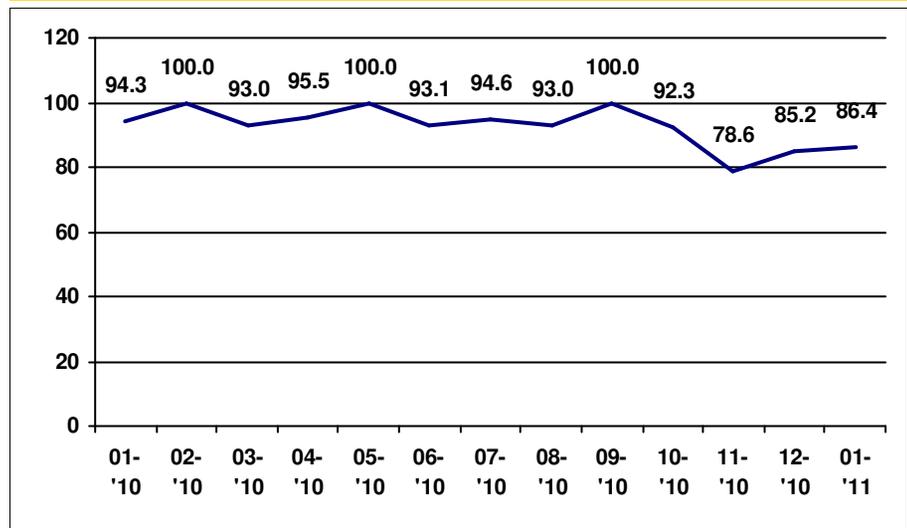
Statewide Permanency within 24 Months



Region 12 For January 2010 to January 2011

Location	Closed Cases Types with Permanency Outcomes					Permanency		
	Reunification	Adoption	Relative	Guardianship	Emanicipation	Total	Within 24 Months	24 Month Rate
Jan 2011	18	3	0	1	0	22	19	86.4
Dec 2010	21	4	0	2	0	27	23	85.2
Nov 2010	19	7	0	2	0	28	22	78.6
Oct 2010	13	0	0	0	0	13	12	92.3
Sep 2010	18	1	0	2	0	21	21	100.0
Aug 2010	34	1	0	7	1	43	40	93.0
Jul 2010	29	3	0	4	1	37	35	94.6
Jun 2010	24	2	0	2	1	29	27	93.1
May 2010	35	1	2	1	0	39	39	100.0
Apr 2010	36	5	0	3	0	44	42	95.5
Mar 2010	36	4	0	2	1	43	40	93.0
Feb 2010	29	1	1	2	0	33	33	100.0
Jan 2010	29	0	0	4	2	35	33	94.3

Region 12 Permanency within 24 Months





DCS Practice Indicator Report Family Case Manager Contacts Report

For January 2011

Report Description

This report uses data collected over at the end of the current report month. The graphs and numbers for historical months also use data from the historical month listed. For the purpose of this report, a person is considered family for the child if they have the following relationships:

- Father
- Mother
- Stepfather
- Stepmother
- Grandfather
- Grandmother
- Pre-adoptive father
- Pre-adoptive mother
- Adoptive grandparent
- Legal Guardian

Children Out of Home Entire Month – This column shows the number of children in out of home placement at the end of the report month who also have a removal date prior to the first of the report month.

Contact Information – This section of the reports shows information regarding FCM contacts (from the contact screens) during the report month.

FCM with Family – This section of the report shows FCM contacts with the child's family (as described above) during the report month.

Children – This is the total number of children that the FCM had at least one contact with a member of the child's family during the report month.

Rate – This is the total number of children that FCM had at least one contact with a member of the child's family divided by the total number of children in out of home placement for the entire month (as described above).

FCM with Child – This section of the report shows FCM contacts with the child during the report month.

Children – This is the total number of children that the FCM had at least one contact with a the child during the report month.

Rate – This is the total number of children that FCM had at least one contact with the child divided by the total number of children in out of home placement for the entire month (as described above).

FCM with Family and Child – This section of the report shows FCM contacts with the child's family (as described above) **AND** the child during the report month. Contact with both had to have occurred for the child to be included in this section. The family and child do not need to present at the same contact, contact with each could have been made in two separate contacts.

Children – This is the total number of children that the FCM had at least one contact with a member of the child's family **and** at least one contact with the child during the report month.

Rate – This is the total number of children that FCM had at least one contact with a member of the child's family **and** at least one contact with the child during the report month divided by the total number of children in out of home placement for the entire month (as described above).



DCS Practice Indicator Report

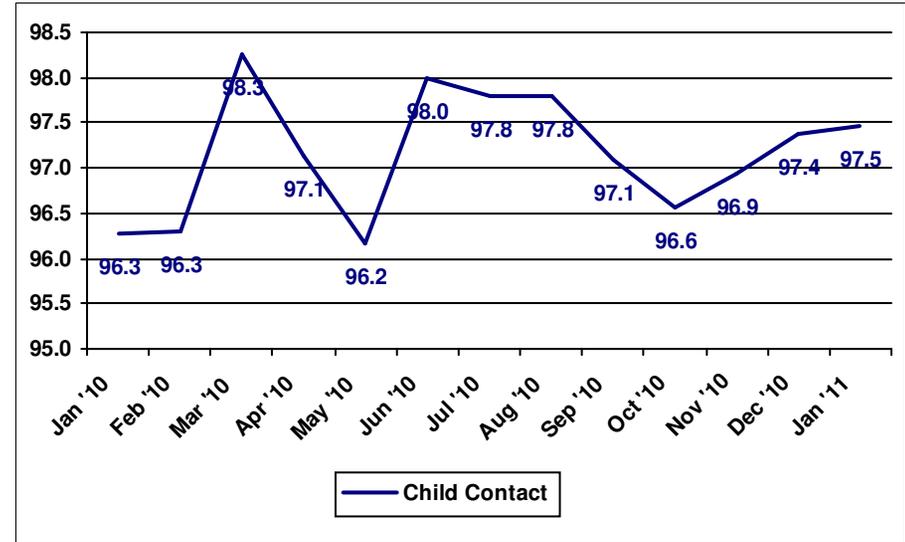
Family Case Manager Contacts Report

For January 2011

January 2011

Location	Children out of home entire month	Contact Information					
		FCM with Family		FCM with Child		FCM with Family and Child	
		Children	Rate	Children	Rate	Children	Rate
Statewide	9,558	2,669	27.9%	9,315	97.5%	2,634	27.6%
Region 12	163	74	45.4%	163	100.0%	74	45.4%
Fayette	47	17	36.2%	47	100.0%	17	36.2%
Franklin	19	11	57.9%	19	100.0%	11	57.9%
Henry	35	16	45.7%	35	100.0%	16	45.7%
Rush	17	5	29.4%	17	100.0%	5	29.4%
Union	16	10	62.5%	16	100.0%	10	62.5%
Wayne	29	15	51.7%	29	100.0%	15	51.7%

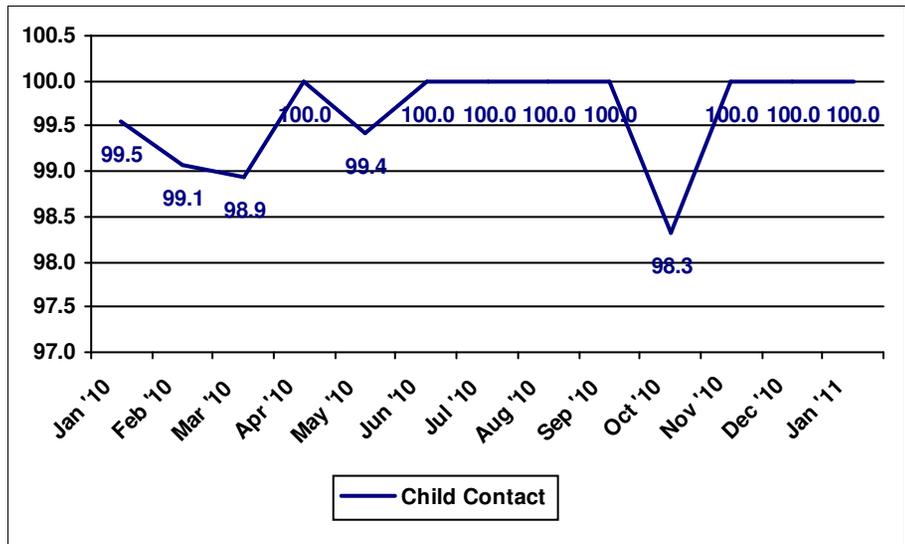
Statewide Child Contact Rate



Region 12 For January 2010 to January 2011

Month	Children out of home entire month	Contact Information					
		FCM with Family		FCM with Child		FCM with Family and Child	
		Children	Rate	Children	Rate	Children	Rate
Jan 2011	163	74	45.4%	163	100.0%	74	45.4%
Dec 2010	176	81	46.0%	176	100.0%	81	46.0%
Nov 2010	179	78	43.6%	179	100.0%	78	43.6%
Oct 2010	179	76	42.5%	176	98.3%	76	42.5%
Sep 2010	169	91	53.8%	169	100.0%	91	53.8%
Aug 2010	155	76	49.0%	155	100.0%	76	49.0%
Jul 2010	162	69	42.6%	162	100.0%	69	42.6%
Jun 2010	167	90	53.9%	167	100.0%	90	53.9%
May 2010	176	80	45.5%	175	99.4%	80	45.5%
Apr 2010	180	85	47.2%	180	100.0%	85	47.2%
Mar 2010	189	89	47.1%	187	98.9%	89	47.1%
Feb 2010	216	98	45.4%	214	99.1%	96	44.4%
Jan 2010	220	107	48.6%	219	99.5%	107	48.6%

Region 12 Child Contact Rate





DCS Practice Indicator Report Child Visitation Report

For January 2011

Report Description

This report uses data collected at the end of the current report month. The graphs and numbers for historical months also use data from the historical month listed. For the purpose of this report, a person is considered family for the child if they have the following relationships:

- Father
- Mother
- Stepfather
- Stepmother
- Grandfather
- Grandmother
- Pre-adoptive father
- Pre-adoptive mother
- Adoptive grandparent
- Legal Guardian

Children out of home with case plan goal of reunification – This column shows the number of children in out of home placement at the end of the report month who also have reunification as the most recently entered primary case plan goal.

Children with visits to their family during the month – This section of the report shows data regarding children who have had a visit with the child's family (as described above) begin during the report month.

Children – This is the total number of children that the child had at least one visit with a member of the child's family during the report month.
Rate – This is the total number of children that the child had at least one visit with a member of the child's family divided by the total number of children in out of home placement at the end of the report month with case plan goal of reunification(as described above).



DCS Practice Indicator Report

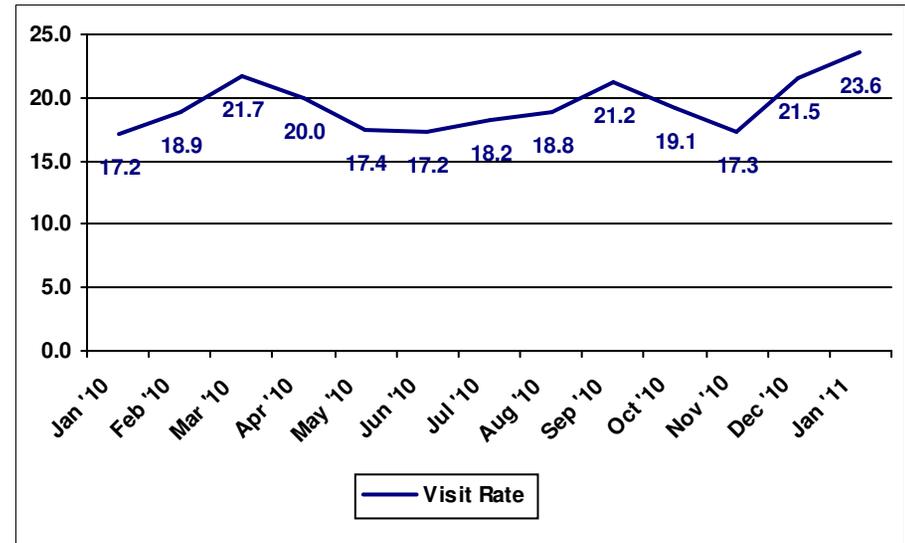
Child Visitation Report

For January 2011

January 2011

Location	Children out of home with case plan goal of reunification	Children with visits to their family during the month	
		Children	Rate
Statewide	5,268	1,245	23.6%
Region 12	102	36	35.3%
Fayette	32	17	53.1%
Franklin	7	2	28.6%
Henry	21	4	19.0%
Rush	6	2	33.3%
Union	15	8	53.3%
Wayne	21	3	14.3%

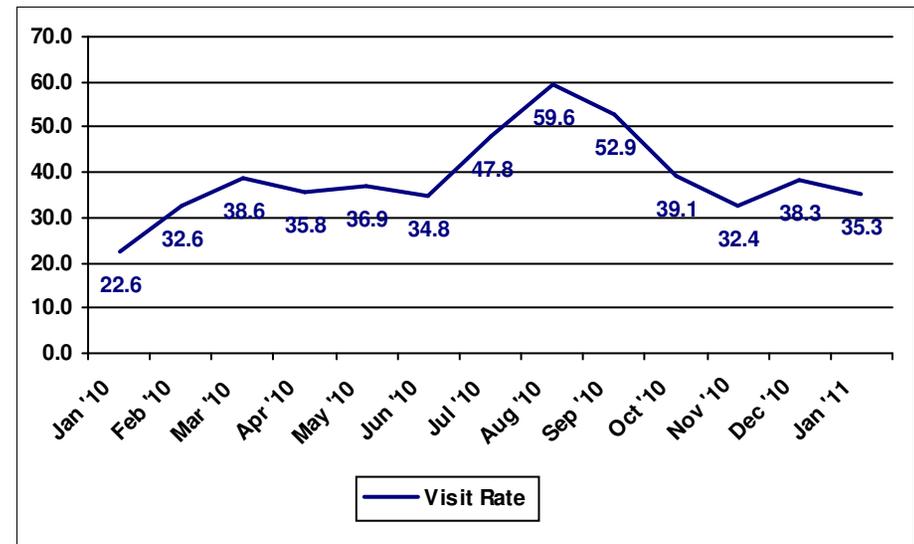
Statewide Visitation Rate



Region 12 For January 2010 to January 2011

Month	Children out of home with case plan goal of reunification	Children with visits to their family during the month	
		Children	Rate
Jan 2011	102	36	35.3%
Dec 2010	107	41	38.3%
Nov 2010	108	35	32.4%
Oct 2010	110	43	39.1%
Sep 2010	102	54	52.9%
Aug 2010	89	53	59.6%
Jul 2010	92	44	47.8%
Jun 2010	92	32	34.8%
May 2010	103	38	36.9%
Apr 2010	109	39	35.8%
Mar 2010	114	44	38.6%
Feb 2010	144	47	32.6%
Jan 2010	155	35	22.6%

Region 12 Visitation Rate





DCS Practice Indicator Report Absence of Repeat Maltreatment

For January 2011

Report Description

This is a description of the key elements used in this report.

Time Period – The time period used in this report is the 12 months prior to the month of the report.

Assessments during time period – The assessment used in this report are assessment with BOTH report date AND approval date during the time period (12 months prior to the month of the report).

Victim Selection – The children used in this report were identified as having at least one substantiated allegation of abuse or neglect on an assessment during the time period.

First Occurrence – This looks at the victims of substantiated abuse or neglect during the first 6 months of the time period (6 to 12 months prior to the month of the report). If a child was a victim in multiple assessments with substantiated abuse or neglect, the assessment with the earliest report date is considered the first occurrence.

Recurrence Time Period – The time period used to see if a child is a substantiated victim in a recurring assessment of abuse or neglect is based off the report date of the first occurrence. The recurrence period begins one day after the first occurrence report date and ends 183 after the first occurrence report date ($\geq 1^{\text{st}}$ Occurrence +1 and $\leq 1^{\text{st}}$ Occurrence +183). If a child has multiple recurrences, the earliest report date in the recurring time period is considered the recurring assessment.

Here is a visual representation of an example. This is a report for December of a given year. The time period to review assessments would run from Jan 1st to Dec 31st. The time period for a first occurrence would be Jan 1st to Jun 30th. If a child had a first occurrence on Feb 7th, the recurrence period would run from Feb 8th to Aug 9th. If the child had a recurrence in Aug 5th, that would be considered repeat maltreatment. If the child had a recurrence Oct 10th, that would not be considered repeat maltreatment because it fell outside the recurrence period.

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Time Period (Jan 1 st to Dec 31 st)											
1 st Occurrence Time Period (Jan 1 st to Jun 30 th)											
						Recurrence Period (Feb 8 th to Aug 9 th)					

Percent of absence of repeat maltreatment – This calculations uses the terms defined above. The numerator is the number of children with a first occurrence minus the number of children with a recurrence. The denominator is the number of children with first occurrence.

$$\frac{(1^{\text{st}} \text{ Occurrence} - \text{Recurrence})}{1^{\text{st}} \text{ Occurrence}}$$

For the purposes of this report, the county the child is assigned to is based off the county of first occurrence. If a child has a recurrence in a different county, the repeat will show for the county of the first occurrence.



DCS Practice Indicator Report

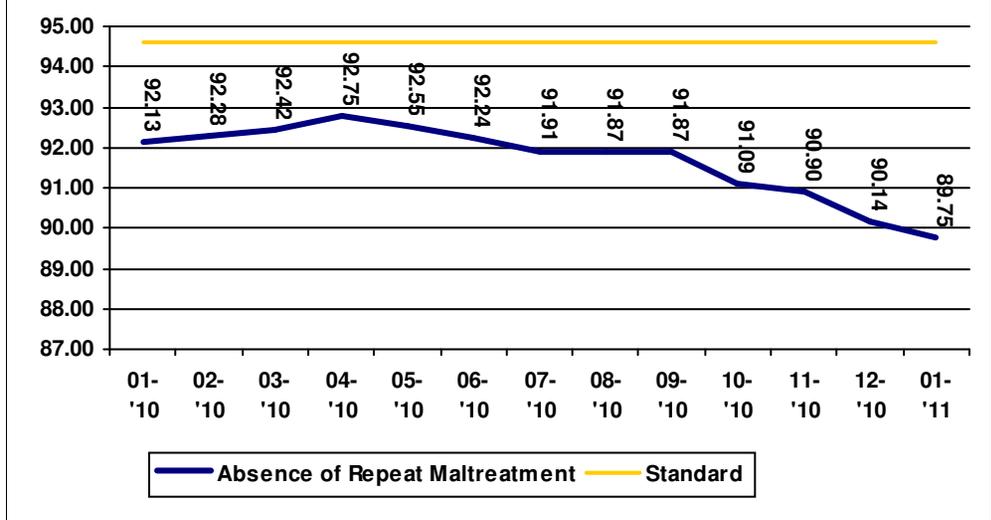
Absence of Repeat Maltreatment

For January 2011

January 2011

County	Victims from Feb 2010 to Aug 2010	Victims without a recurrence within 6 months	Absence of Repeat Maltreatment Percent	National Standard
Statewide	11,919	10,697	89.75%	94.60%
Region 12	286	263	91.96%	94.60%
Fayette	33	28	84.85%	94.60%
Franklin	37	32	86.49%	94.60%
Henry	69	69	100.00%	94.60%
Rush	28	24	85.71%	94.60%
Union	28	27	96.43%	94.60%
Wayne	91	83	91.21%	94.60%

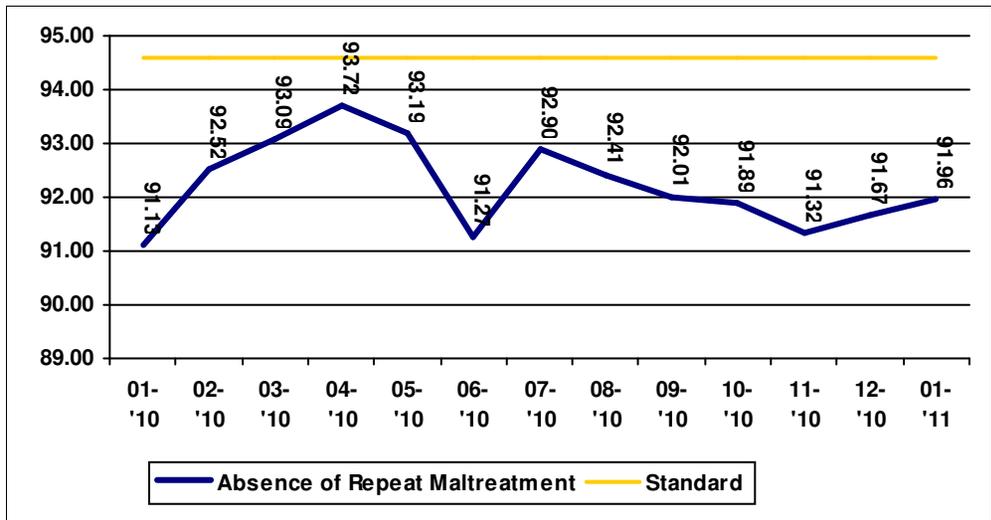
Statewide Absence of Repeat Maltreatment



Region 12 For January 2010 to January 2011

County	Victims from Feb 2010 to Aug 2010	Victims without a recurrence within 6 months	Absence of Repeat Maltreatment Percent	National Standard
January 2011	286	263	91.96%	94.60%
December 2010	276	253	91.67%	94.60%
November 2010	265	242	91.32%	94.60%
October 2010	259	238	91.89%	94.60%
September 2010	288	265	92.01%	94.60%
August 2010	316	292	92.41%	94.60%
July 2010	352	327	92.90%	94.60%
June 2010	355	324	91.27%	94.60%
May 2010	382	356	93.19%	94.60%
April 2010	430	403	93.72%	94.60%
March 2010	434	404	93.09%	94.60%
February 2010	428	396	92.52%	94.60%
January 2010	417	380	91.13%	94.60%

Region 12 Absence of Repeat Maltreatment





DCS Practice Indicator Report Absence of Maltreatment in Foster Care

For January 2011

Report Description

This is a description of the key elements used in this report.

Time Period – The time period used in this report is the 12 months prior to the month of the report.

Assessments during the time period – The assessment used in this report are assessment with BOTH report date AND approval date during the time period (12 months prior to the month of the report).

Victim of maltreatment in Foster Care – The children used in this report were identified as having at least one substantiated allegation of abuse or neglect on an assessment during the time period where the perpetrator is a foster parent or institutional staff.

Children in Foster Care during the time period – All CHINS children with an open removal episode at any time during the 12 months prior to the month of the report. Also included are Probation children (who are IV-E eligible) with an open removal episode at any time during the 12 months prior to the month of the report.

Percent of absence of maltreatment – This calculations uses the terms defined above. The numerator is the number of children in foster care minus the number of victims of maltreatment in foster care. The denominator is the number of children in foster care.

$$\frac{(\text{Children in Foster Care} - \text{Victims of maltreatment in Foster Care})}{\text{Children in Foster Care}}$$



DCS Practice Indicator Report

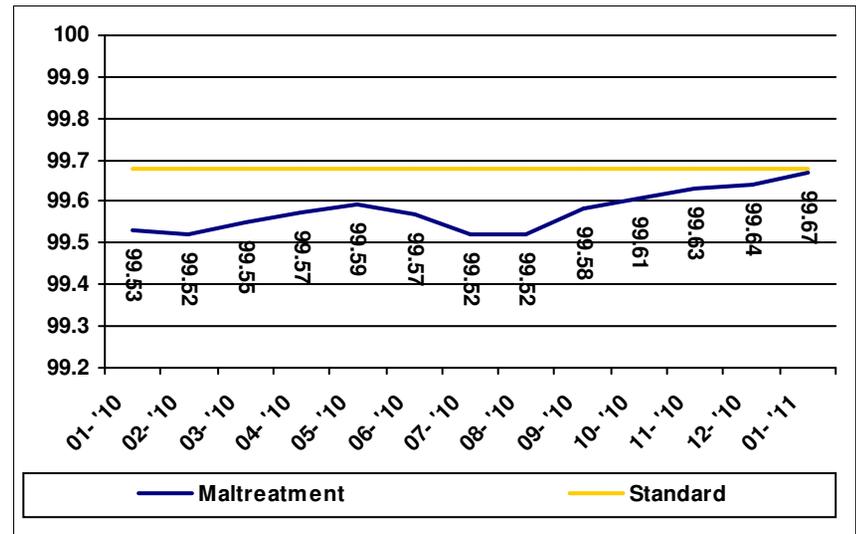
Absence of Maltreatment in Foster Care

For January 2011

For January 2011

Location	Children in Foster Care from Feb 2010 to Jan 2011	Substantiated Victims in Foster Care	Absence of Maltreatment Percent	National Standard
Statewide	21,543	71	99.67%	99.68%
Region 12	454	1	99.78%	99.68%
Fayette	96	0	100.00%	99.68%
Franklin	39	0	100.00%	99.68%
Henry	133	1	99.25%	99.68%
Rush	43	0	100.00%	99.68%
Union	37	0	100.00%	99.68%
Wayne	106	0	100.00%	99.68%

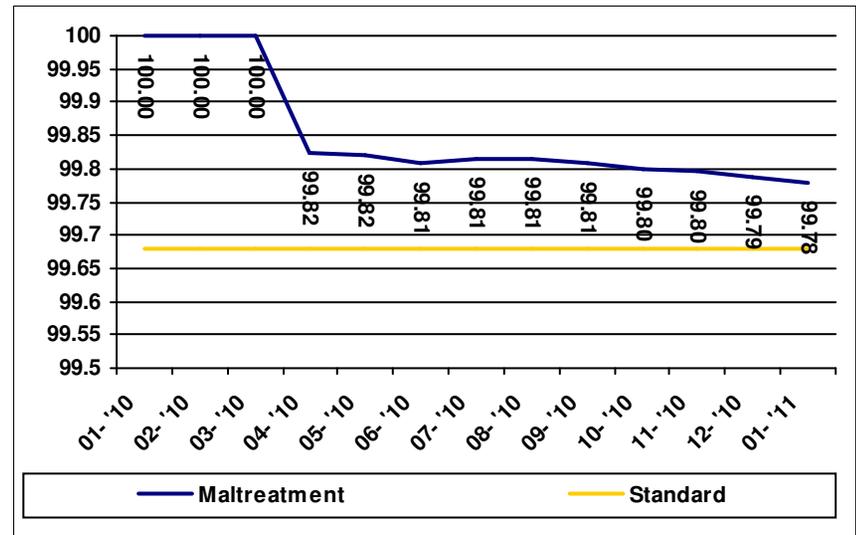
Statewide Trend of Absence of Maltreatment in Foster Care



Region 12 for January 2010 to January 2011

Month	Children in Foster Care from Feb 2010 to Jan 2011	Substantiated Victims in Foster Care	Absence of Maltreatment Percent	National Standard
January 2011	454	1	99.78%	99.68%
December 2010	472	1	99.79%	99.68%
November 2010	493	1	99.80%	99.68%
October 2010	496	1	99.80%	99.68%
September 2010	518	1	99.81%	99.68%
August 2010	540	1	99.81%	99.68%
July 2010	539	1	99.81%	99.68%
June 2010	523	1	99.81%	99.68%
May 2010	554	1	99.82%	99.68%
April 2010	562	1	99.82%	99.68%
March 2010	578	0	100.00%	99.68%
February 2010	578	0	100.00%	99.68%
January 2010	596	0	100.00%	99.68%

Region 12 Trend of Absence of Maltreatment in Foster Care

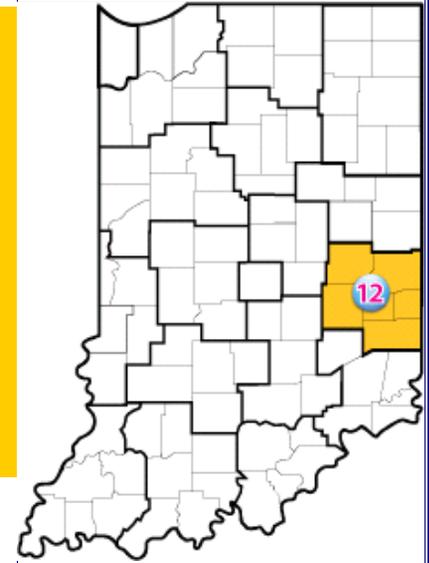




INDIANA
DEPARTMENT OF
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families and future*

Department of Child Services Practice Indicator Reports For February 2011



Region 12 February 2011

Data in the report (both historical and current) may be subject to change as it is continually being validated and updated. This may result in statistical data in previous reports to be inconsistent with statistics found in more recent reports even when the data pertain to the same time period.



**Published
March 2011**



DCS Practice Indicator Report Initial Assessment - Use of Substitute Care

For February 2011

Report Description

This report uses data collected over a rolling three month period ending with the current report month. The graphs and numbers for historical months also use a rolling three month period ending with the historical month listed.

Reports Taken – This section has data regarding the reports taken during the three month period ending with the report month.

Count – This is the total number of reports of abuse or neglect that are entered into ICWIS during the period ending with the report month.

Percent Resulting in Screen Outs – This is the percentage of reports that are screened out divided by the total reports taken during the period ending with the report month.

Assessments Substantiated – This section has data regarding the number of assessments with substantiated findings of abuse and/or neglect during the three month period ending with the report month.

Count – This is the total number of assessments with substantiated findings of abuse and/or neglect during the period ending with the report month.

Percent Resulting in Removal – This is the percentage of substantiated assessments during the period that resulted in removal of the child from the home by the end of the report month divided by the total number of substantiated assessments during the period ending with the report month.



DCS Practice Indicator Report

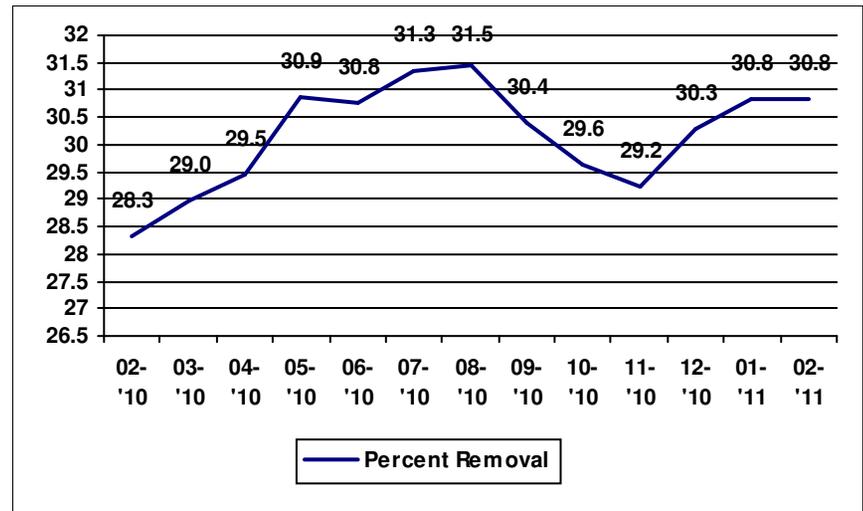
Initial Assessment - Use of Substitute Care

For February 2011

February 2011

Location	Reports Taken For Dec 2010 to Feb 2011		Assessments Substantiated For Dec 2010 to Feb 2011	
	Count	Percent Resulting in Screen Outs	Count	Percent Resulting in Removal
Statewide	34,738	34.9%	5,149	30.8%
Region 12	1,100	40.45%	114	24.56%
Fayette	180	42.8%	14	50.0%
Franklin	97	33.0%	5	0.0%
Henry	265	41.1%	23	8.7%
Rush	128	43.0%	13	15.4%
Union	31	41.9%	11	54.5%
Wayne	399	39.8%	48	22.9%

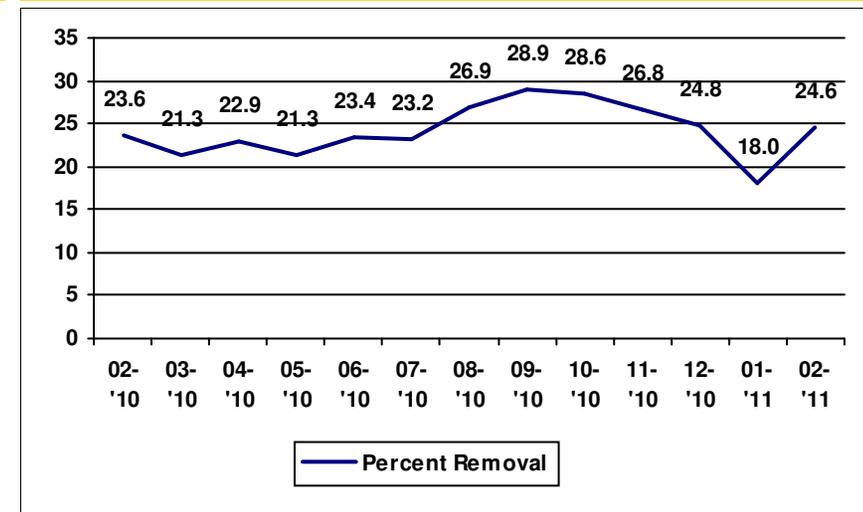
Statewide Percent Removal Trend



Region 12 For February 2010 to February 2011

Month	Reports Taken For Dec 2010 to Feb 2011		Assessments Substantiated For Dec 2010 to Feb 2011	
	Count	Percent Resulting in Screen Outs	Count	Percent Resulting in Removal
Feb 2011	1,100	40.5%	114	24.6%
Jan 2011	1,192	39.8%	122	18.0%
Dec 2010	1,205	39.1%	157	24.8%
Nov 2010	1,305	41.1%	157	26.8%
Oct 2010	1,221	40.3%	189	28.6%
Sep 2010	1,208	39.2%	173	28.9%
Aug 2010	1,116	34.1%	182	26.9%
Jul 2010	1,157	32.4%	164	23.2%
Jun 2010	1,106	26.4%	154	23.4%
May 2010	1,116	22.1%	155	21.3%
Apr 2010	979	17.0%	153	22.9%
Mar 2010	964	14.1%	160	21.3%
Feb 2010	858	12.0%	157	23.6%

Region 12 Percent Removal





DCS Practice Indicator Report CHINS Placements by County

For February 2011

Report Description

This report uses data collected at the end of the current report month. The graphs and numbers for historical months also use data from the end of the historical month listed. This report looks at CHINS children from CHINS cases that were open on the last day of the report month. It also collects where that child is located (in their own home or in substitute care). For the purpose of this report, a child with a non-custodial parent is considered "in home".

Total CHINS Count – This is the number of children that have an open CHINS case on the last day of the report month.

CHINS – This section has data regarding all children that have an open CHINS case on the last day of the month.

In Home – This section has data regarding children that have an open CHINS case on the last day of the month and are in their own home.

Count- This is the number of children that have an open CHINS case on the last day of the month and are in their own home.

Percent- This is the number of children that have an open CHINS case on the last day of the month and are in their own home divided by the total number of children that have an open CHINS case on the last day of the month.

Foster Care – This section has data regarding children that have an open CHINS case on the last day of the month and are in out of home placement.

Count- This is the number of children that have an open CHINS case on the last day of the month and are in out of home placement.

Percent- This is the number of children that have an open CHINS case on the last day of the month and are in out of home placement divided by the total number of children that have an open CHINS case on the last day of the month.

Out of Home Placements – This section has data for children that have an open CHINS case on the last day of the month and are in out of home placement.

Relative Homes – This section has data for children that have an open CHINS case on the last day of the month and are placed with relatives.

Count- This is the number of children that have an open CHINS case on the last day of the month and are placed with relatives.

Percent- This is the number of children that have an open CHINS case on the last day of the month and are placed with relatives divided by the total number of CHINS children in out of home placement at the end of the month.

Foster Homes – This section has data for children that have an open CHINS case on the last day of the month and are placed in foster homes.

Count- This is the number of children that have an open CHINS case on the last day of the month and are placed in foster homes.

Percent- This is the number of children that have an open CHINS case on the last day of the month and are placed in foster homes divided by the total number of CHINS children in out of home placement at the end of the month.

Residential – This section has data for children that have an open CHINS case on the last day of the month and are placed in residential setting.

Count- This is the number of children that have an open CHINS case on the last day of the month and are placed in residential setting.

Percent- This is the number of children that have an open CHINS case on the last day of the month and are placed in residential setting divided by the total number of CHINS children in out of home placement at the end of the month.

Other – This section has data for children that have an open CHINS case on the last day of the month and are in other placement settings. Example would be a court ordered unlicensed placement.

Count- This is the number of children that have an open CHINS case on the last day of the month and are in other placement settings.

Percent- This is the number of children that have an open CHINS case on the last day of the month and are in other placement settings divided by the total number of CHINS children in out of home placement at the end of the month.



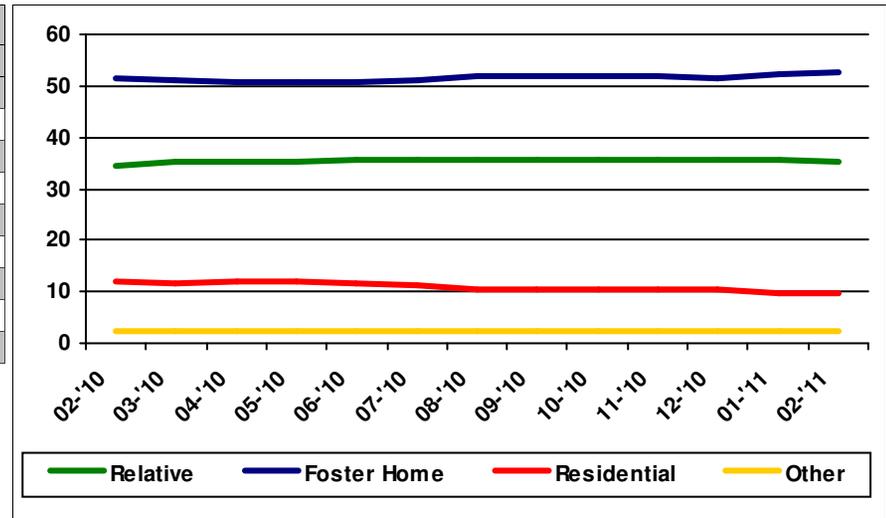
DCS Practice Indicator Report CHINS Placements by County

For February 2011

February 2011

Location	Total CHINS Count	CHINS				Out of Home Placements							
		In Home		Foster Care		Relative Home		Foster Homes		Residential		Other	
		Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
Statewide	14102	4181	29.6%	9,921	70.4%	3507	35.3%	5235	52.8%	956	9.6%	223	2.2%
Region 12	233	51	21.9%	182	78.1%	68	37.4%	94	51.6%	12	6.6%	8	4.4%
Fayette	52	4	7.7%	48	92.3%	17	35.4%	24	50.0%	3	6.3%	4	8.3%
Franklin	30	7	23.3%	23	76.7%	12	52.2%	10	43.5%	1	4.3%	0	0.0%
Henry	58	22	37.9%	36	62.1%	16	44.4%	17	47.2%	3	8.3%	0	0.0%
Rush	18	0	0.0%	18	#####	4	22.2%	11	61.1%	3	16.7%	0	0.0%
Union	24	3	12.5%	21	87.5%	6	28.6%	13	61.9%	2	9.5%	0	0.0%
Wayne	51	15	29.4%	36	70.6%	13	36.1%	19	52.8%	0	0.0%	4	11.1%

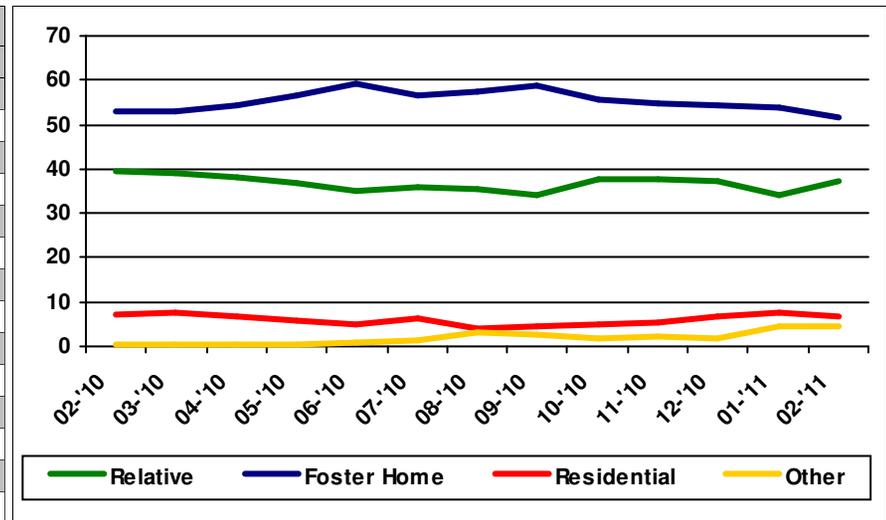
Statewide Foster Care Placement Breakdown



Region 12 For February 2010 to February 2011

Month	Total CHINS Count	CHINS				Out of Home Placements							
		In Home		Foster Care		Relative Home		Foster Homes		Residential		Other	
		Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
Feb 2011	233	51	21.9%	182	78.1%	68	37.4%	94	51.6%	12	6.6%	8	4.4%
Jan 2011	219	46	21.0%	173	79.0%	59	34.1%	93	53.8%	13	7.5%	8	4.6%
Dec 2010	228	48	21.1%	180	78.9%	67	37.2%	98	54.4%	12	6.7%	3	1.7%
Nov 2010	243	58	23.9%	185	76.1%	70	37.8%	101	54.6%	10	5.4%	4	2.2%
Oct 2010	247	59	23.9%	188	76.1%	71	37.8%	105	55.9%	9	4.8%	3	1.6%
Sep 2010	261	74	28.4%	187	71.6%	64	34.2%	110	58.8%	8	4.3%	5	2.7%
Aug 2010	258	87	33.7%	171	66.3%	61	35.7%	98	57.3%	7	4.1%	5	2.9%
Jul 2010	261	88	33.7%	173	66.3%	62	35.8%	98	56.6%	11	6.4%	2	1.2%
Jun 2010	264	83	31.4%	181	68.6%	63	34.8%	107	59.1%	9	5.0%	2	1.1%
May 2010	272	87	32.0%	185	68.0%	68	36.8%	105	56.8%	11	5.9%	1	0.5%
Apr 2010	288	99	34.4%	189	65.6%	72	38.1%	103	54.5%	13	6.9%	1	0.5%
Mar 2010	305	103	33.8%	202	66.2%	79	39.1%	107	53.0%	15	7.4%	1	0.5%
Feb 2010	318	94	29.6%	224	70.4%	88	39.3%	119	53.1%	16	7.1%	1	0.4%

Region 12 Foster Care Placement Breakdown





DCS Practice Indicator Report Use of Foster Care by County

February 2011

Report Description

This report uses data collected at the end of the current report month. The graphs and numbers for historical months also use data from the end of the historical month listed. This report looks at CHINS children from CHINS cases that were open on the last day of the report month. It also collects where that child is located (in their own home or in substitute care). For the purpose of this report, children with non-custodial parents are considered to be in their own home.

Total CHINS Count – This is the number of children that have an open CHINS case on the last day of the report month.

In Home or Relative Care – This section has data regarding children that have an open CHINS case on the last day of the month and are in their own home or in relative care.

Count- This is the number of children that have an open CHINS case on the last day of the month and are in their own home or in relative care.

Percent- This is the number of children that have an open CHINS case on the last day of the month and are in their own home or in relative care divided by the total number of children that have an open CHINS case on the last day of the month.

Target (At or Above) % – The target for the percent of the number of children that have an open CHINS case on the last day of the month and are in their own home or in relative care to the total number of children that have an open CHINS case on the last day of the month is 50% or higher.

Non Relative Foster Care – This section has data for children that have an open CHINS case on the last day of the month and are not in their own home or in relative care.

Count- This is the number of children that have an open CHINS case on the last day of the month and are not in their own home or in relative care.

Percent- This is the number of children that have an open CHINS case on the last day of the month and are not in their own home or in relative care divided by the total number of CHINS children in out of home placement at the end of the month.

Target (At or below) % – The target for the percent of the number of children that have an open CHINS case on the last day of the month and are not in their own home or in relative care to the total number of children that have an open CHINS case on the last day of the month is 50% or higher.



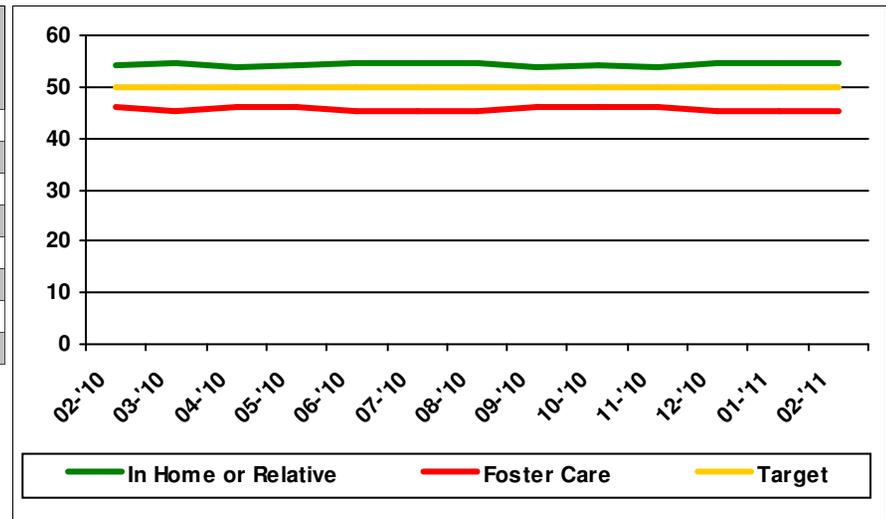
DCS Practice Indicator Report Use of Foster Care by County

For February 2011

February 2011

Location	Total CHINS	In Home or Relative Care		Target (At or Above) %	Non-Relative Foster Care		Target (At or Below) %
	Count	Count	%		Count	%	
Statewide	14102	7688	54.5%	50.0%	6,414	45.5%	50.0%
Region 12	233	119	51.1%	50.0%	114	48.9%	50.0%
Fayette	52	21	40.4%	50.0%	31	59.6%	50.0%
Franklin	30	19	63.3%	50.0%	11	36.7%	50.0%
Henry	58	38	65.5%	50.0%	20	34.5%	50.0%
Rush	18	4	22.2%	50.0%	14	77.8%	50.0%
Union	24	9	37.5%	50.0%	15	62.5%	50.0%
Wayne	51	28	54.9%	50.0%	23	45.1%	50.0%

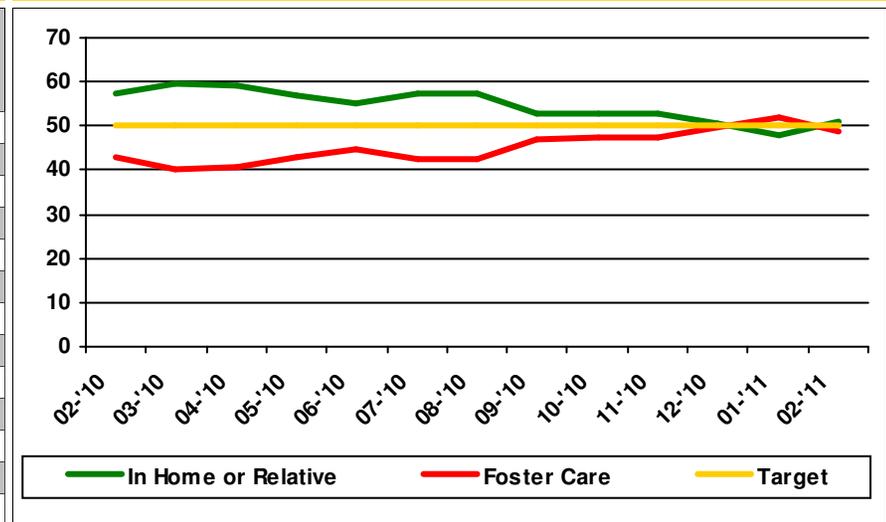
Statewide Foster Care Placement Breakdown



Region 12 For February 2010 to February 2011

Month	Total CHINS	In Home or Relative Care		Target (At or Above) %	Non-Relative Foster Care		Target (At or Below) %
	Count	Count	%		Count	%	
February 2011	233	119	51.1%	50.0%	114	48.9%	50.0%
January 2011	219	105	47.9%	50.0%	114	52.1%	50.0%
December 2010	228	115	50.4%	50.0%	113	49.6%	50.0%
November 2010	243	128	52.7%	50.0%	115	47.3%	50.0%
October 2010	247	130	52.6%	50.0%	117	47.4%	50.0%
September 2010	261	138	52.9%	50.0%	123	47.1%	50.0%
August 2010	258	148	57.4%	50.0%	110	42.6%	50.0%
July 2010	261	150	57.5%	50.0%	111	42.5%	50.0%
June 2010	264	146	55.3%	50.0%	118	44.7%	50.0%
May 2010	272	155	57.0%	50.0%	117	43.0%	50.0%
April 2010	288	171	59.4%	50.0%	117	40.6%	50.0%
March 2010	305	182	59.7%	50.0%	123	40.3%	50.0%
February 2010	318	182	57.2%	50.0%	136	42.8%	50.0%

Region 12 Foster Care Placement Breakdown





DCS Practice Indicator Report Locally Placed CHINS

For February 2011

Report Description

This report uses data collected over at the end of the current report month. The graphs and numbers for historical months also use data from the historical month listed. For the purpose of this report, children with their non-custodial parents are considered to be in their own home.

Total Out of Home Placements – This is the total number of CHINS children that are in out of home placement on the last day of the report month.

Placed in Same County – This is the total number of CHINS children that are placed in the same county as the county of their case.

Percent Locally Placed – This is the percentage of CHINS children that are placed in the same county as the county of their case divided by the total number of CHINS children which are in out of home placement on the last day of the report month.



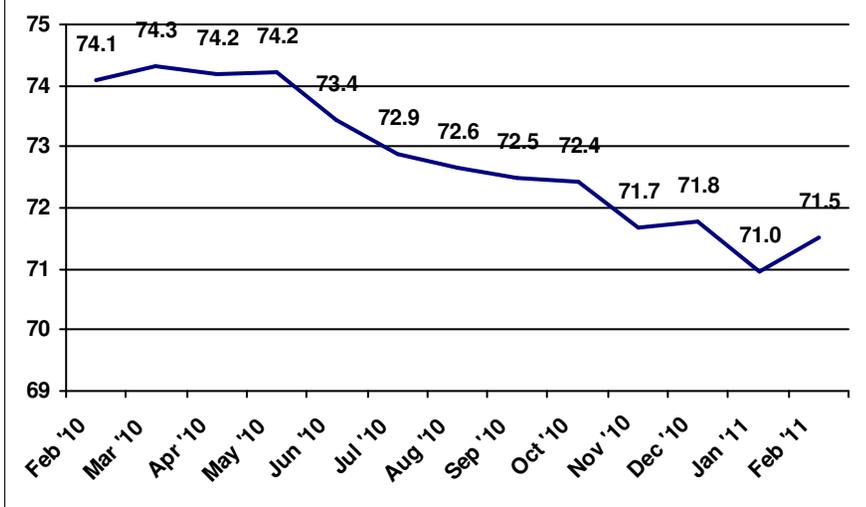
DCS Practice Indicator Report Locally Placed CHINS

For February 2011

February 2011

Location	Total Out of Home Placements	Placed in Same County	Percent Locally Placed
Statewide	9,921	7,093	71.5%
Region 12	182	115	63.2%
Fayette	48	23	47.9%
Franklin	23	21	91.3%
Henry	36	29	80.6%
Rush	18	9	50.0%
Union	21	7	33.3%
Wayne	36	26	72.2%

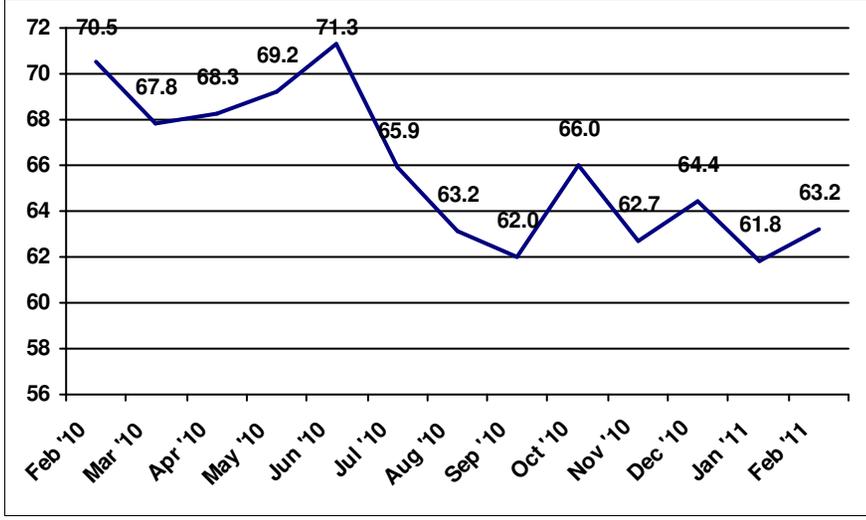
Statewide Percent Placed Locally



Region 12 For February 2010 to February 2011

Month	Total Out of Home Placements	Placed in Same County	Percent Locally Placed
Feb 2011	182	115	63.2%
Jan 2011	173	107	61.8%
Dec 2010	180	116	64.4%
Nov 2010	185	116	62.7%
Oct 2010	188	124	66.0%
Sep 2010	187	116	62.0%
Aug 2010	171	108	63.2%
Jul 2010	173	114	65.9%
Jun 2010	181	129	71.3%
May 2010	185	128	69.2%
Apr 2010	189	129	68.3%
Mar 2010	202	137	67.8%
Feb 2010	224	158	70.5%

Region 12 Percent Placed Locally





DCS Practice Indicator Report Average Number of Placements

For February 2011

Report Description

This report uses data collected at the end of the current report month. The graphs and numbers for historical months also use data from the historical month listed.

Average Number of Placements Per Child – This is the total number of out of home placements for each CHINS child in out of home placement on the last day of the report month. This includes all placements during the current removal episode. If a child had at least one placement end in the first 8 days from removal, then that child's number of placements was reduced by one.

This number is divided by the total number CHINS children who are in out of home placement on the last day of the report month.



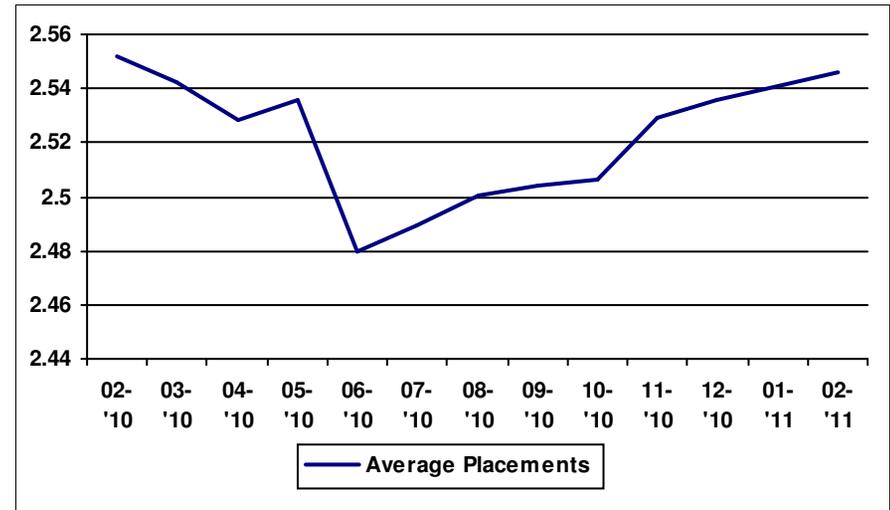
DCS Practice Indicator Report Average Number of Placements

For February 2010 to February 2011

February 2011

Location	Average Number of Placements Per Child
Statewide	2.5
Region 12	2.1
Fayette	2.3
Franklin	1.6
Henry	2.0
Rush	3.3
Union	1.3
Wayne	2.3

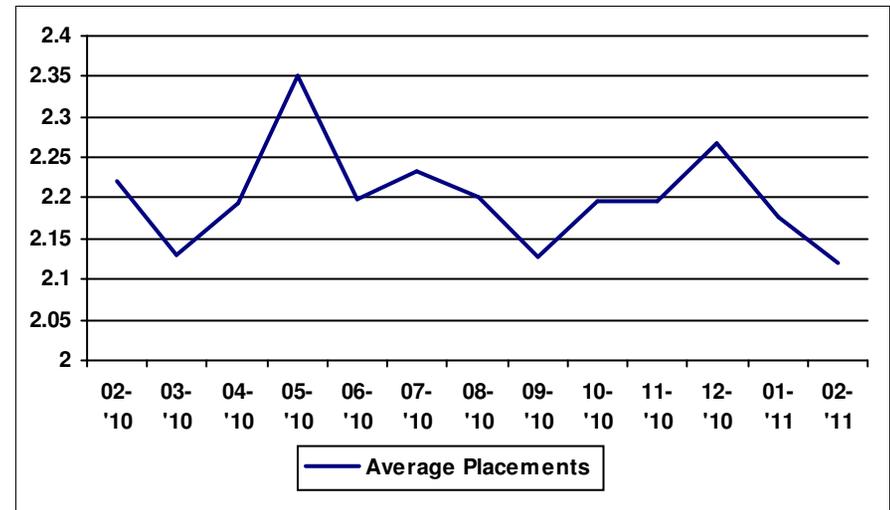
Statewide Average Number of Placements



Region 12 For February 2010 to February 2011

Month	Average Number of Placements Per Child
February 2011	2.1
January 2011	2.2
December 2010	2.3
November 2010	2.2
October 2010	2.2
September 2010	2.1
August 2010	2.2
July 2010	2.2
June 2010	2.2
May 2010	2.4
April 2010	2.2
March 2010	2.1
February 2010	2.2

Region 12 Average Number of Placements





DCS Practice Indicator Report Sibling Placement Report

For February 2011

Report Description

This report uses data collected at the end of the current report month. The graphs and numbers for historical months also use data from the end of the historical month listed. For the purpose of this report, children with a non-custodial parent are considered to be in their own home.

Count of Sibling Cases – This is the number of open cases as of the end of the report month which have more than one child in out of home placement at the end of the report month.

Cases With All Children Placed Together – This is the number of cases with more than one child in out of home placement where all of the children are placed in the same resource with the same resource ID.

Percent Placed Together of Sibling Cases– This is the percentage of the number of cases where all of the children in out of home placement are placed together divided by the number of open cases with more than one child in out of home placement as of the end of the report month.

Average Number of Children per Case – This number takes the number of children in out of home placement from cases with more than one child in out of home placement and divides it by the number of cases with more than one child in out of home placement as of the end of the report month.



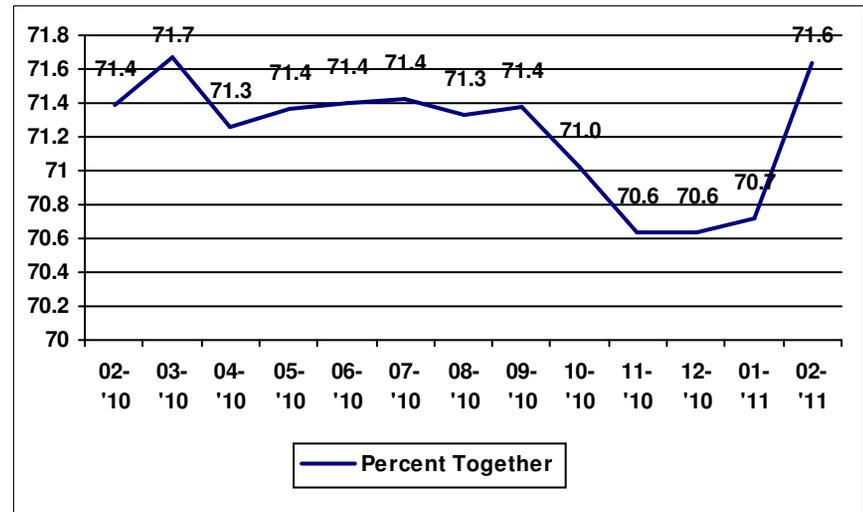
DCS Practice Indicator Report Sibling Placement Report

February 2011

February 2011

Location	Count of Sibling Cases	Cases With All Children Placed Together	Percent Placed Together of Sibling Cases	Average Number of Children per Case
Statewide	2433	1743	71.6%	2.70
Region 12	45	38	84.4%	2.40
Fayette	12	8	66.7%	2.42
Franklin	7	7	100.0%	2.57
Henry	9	8	88.9%	2.00
Rush	4	3	75.0%	2.00
Union	4	4	100.0%	3.75
Wayne	9	8	88.9%	2.22

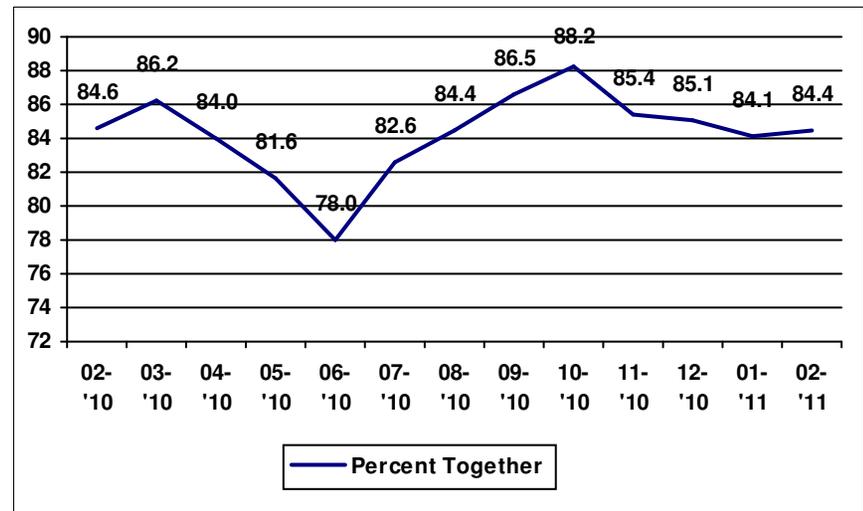
Statewide Percent Together



Region 12 For February 2010 to February 2011

Month	Count of Sibling Cases	Cases With All Children Placed Together	Percent Placed Together of Sibling Cases	Average Number of Children per Case
February 2011	45	38	84.4%	2.40
January 2011	44	37	84.1%	2.34
December 2010	47	40	85.1%	2.36
November 2010	48	41	85.4%	2.40
October 2010	51	45	88.2%	2.35
September 2010	52	45	86.5%	2.38
August 2010	45	38	84.4%	2.33
July 2010	46	38	82.6%	2.33
June 2010	50	39	78.0%	2.26
May 2010	49	40	81.6%	2.24
April 2010	50	42	84.0%	2.26
March 2010	58	50	86.2%	2.24
February 2010	65	55	84.6%	2.26

Region 12 Percent Together





DCS Practice Indicator Report

Length of Stay in Out of Home Placement

Children in Out of Home Placement by Length of Time Since Latest Removal

For February 2011

Report Description

This report uses data collected at the end of the current report month. The graphs and numbers for historical months also use data from the end of the historical month listed. This report looks at CHINS children that were in out of home placement at the end of the month. It measures the number of days since the child was last removed from its home.

One Year - 0 to 365 Days— This is column shows data for CHINS children that have been in out of home placement between 0 and 365 days since the child's removal.

Count- This is the number of CHINS children that have been in out of home placement between 0 and 365 days since the child's last removal.

Percent- This is the number of CHINS children that have been in out of home placement between 0 and 365 days since the child's last removal divided by the total number of CHINS children in out of home placement at the end of the month.

One Year - 366 to 730 Days— This is column shows data for CHINS children that have been in out of home placement between 366 and 730 days since the c last removal.

Count- This is the number of CHINS children that have been in out of home placement between 366 and 730 days since the child's last removal.

Percent- This is the number of CHINS children that have been in out of home placement between 366 and 730 days since the child's last removal divided by the total number of CHINS children in out of home placement at the end of the month.

One Year - 731 to 1095 Days— This is column shows data for CHINS children that have been in out of home placement between 731 to 1095 days since the child's last removal.

Count- This is the number of CHINS children that have been in out of home placement between 731 to 1095 days since the child's last removal.

Percent- This is the number of CHINS children that have been in out of home placement between 731 to 1095 days since the child's last removal divided by the total number of CHINS children in out of home placement at the end of the month.

One Year - 1096 Days+— This is column shows data for CHINS children that have been in out of home placement 1096 days or more since the child's last removal.

Count- This is the number of CHINS children that have been in out of home placement 1096 days or more since the child's last removal.

Percent- This is the number of CHINS children that have been in out of home placement 1096 days or more since the child's last removal divided by the total number of CHINS children in out of home placement at the end of the month.

Length Per Child – This column shows data for length of time of CHINS children who were in out of home placement at the end of the report month have been in out of home placement since the child's last removal from their home.

Average- This column calculates the average or "mean" length of time in out of home placement since the last removal per child in out of home placement at the end of the report month.

Median- This column calculates the median length of time in out of home placement since the last removal per child in out of home placement at the end of the report month.



DCS Practice Indicator Report

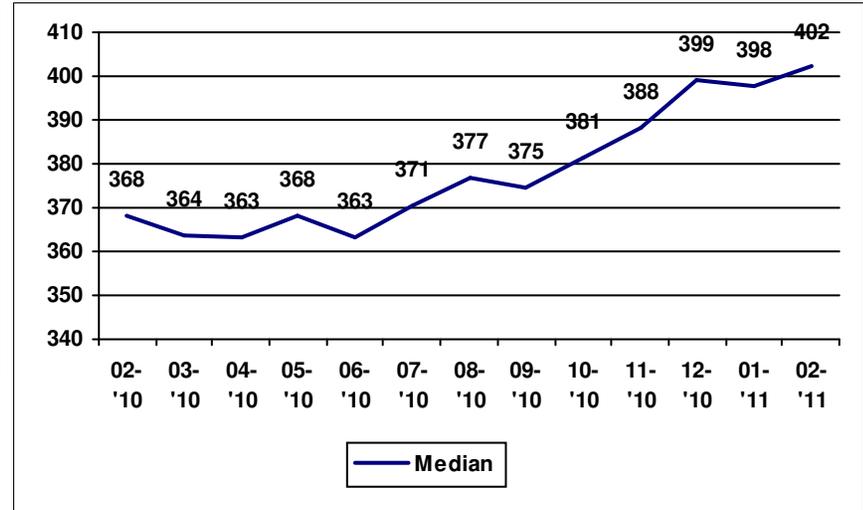
Length of Stay in Out of Home Placement

Children in Out of Home Placement by Length of Time Since Latest Removal For February 2011

February 2011

Location	One Year 0 to 365 Days		Two Years 366 to 730 Days		Three Years 731 to 1095 Days		Three + Years 1096 Days+		Length Per Child	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Average	Median
Statewide	4,635	46.7%	2,469	24.9%	1,234	12.4%	1,583	16.0%	635.4	402.3
Region 12	110	60.4%	46	25.3%	6	3.3%	20	11.0%	481.0	249.0
Fayette	32	66.7%	12	25.0%	1	2.1%	3	6.3%	427.8	215.5
Franklin	12	52.2%	2	8.7%	3	13.0%	6	26.1%	685.3	355.6
Henry	16	44.4%	16	44.4%	0	0.0%	4	11.1%	459.1	398.0
Rush	7	38.9%	7	38.9%	2	11.1%	2	11.1%	700.9	577.5
Union	19	90.5%	1	4.8%	0	0.0%	1	4.8%	235.7	234.5
Wayne	24	66.7%	8	22.2%	0	0.0%	4	11.1%	476.6	242.5

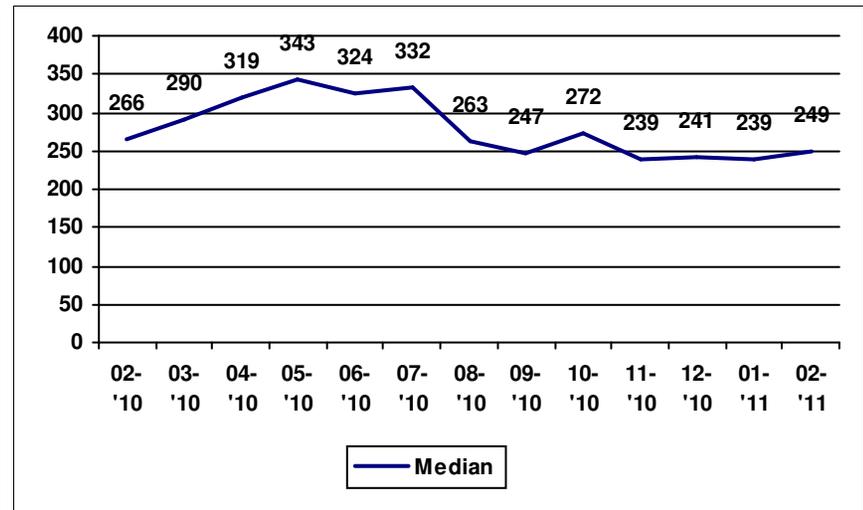
Statewide Median Length



Region 12 For February 2010 to February 2011

Month	One Year 0 to 365 Days		Two Years 366 to 730 Days		Three Years 731 to 1095 Days		Three + Years 1096 Days+		Length Per Child	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Average	Median
February 2011	110	60.4%	46	25.3%	6	3.3%	20	11.0%	481.0	249.0
January 2011	102	59.0%	46	26.6%	6	3.5%	19	11.0%	483.0	238.6
December 2010	108	60.0%	42	23.3%	9	5.0%	21	11.7%	494.1	241.0
November 2010	113	61.1%	40	21.6%	14	7.6%	18	9.7%	467.2	238.6
October 2010	112	59.6%	44	23.4%	15	8.0%	17	9.0%	464.2	271.5
September 2010	110	58.8%	45	24.1%	14	7.5%	18	9.6%	459.7	247.4
August 2010	96	56.1%	48	28.1%	9	5.3%	18	10.5%	476.6	263.3
July 2010	100	57.8%	44	25.4%	10	5.8%	19	11.0%	497.2	331.7
June 2010	102	56.4%	51	28.2%	9	5.0%	19	10.5%	491.2	324.3
May 2010	100	54.1%	55	29.7%	10	5.4%	20	10.8%	505.1	343.4
April 2010	106	56.1%	51	27.0%	12	6.3%	20	10.6%	494.7	318.6
March 2010	119	58.9%	49	24.3%	12	5.9%	22	10.9%	491.2	290.0
February 2010	144	64.3%	43	19.2%	14	6.3%	23	10.3%	469.3	266.0

Region 12 Median Length





DCS Practice Indicator Report CHINS and IA Permanency Report

For February 2011

Report Description

This report uses CHINS and IA case types that have case type status end date occurring during the month. It then groups these cases using the closure reasons codes into categories of closure reasons. Case with closure reason code "Case opened in error – disregard" are filtered out for the purpose of this report. This report uses the reason codes selected by the worker at the date of case closure. **Adoption closure reasons will not match the number of actual finalized adoptions reported from the hearing information fields in ICWIS/MaGik.**

Closure Reasons are group by:

Description	Category	Description	Category
Child Reunited with Parents	Reunification	Case closed; AG case created	Guardianship
Child never Removed from own home, wardship terminated	Reunification	Child placed with relatives	Relative
Extended wardship terminated (on court order for age 18 to 21)	Emancipation	Child Placed with Legal guardian	Guardianship
Child Returned to Primary Home	Reunification	Child Reached Age of Majority (age 18)	Emancipation
Period of IA ended code used for Informal Adjustment cases only	Reunification	Emancipated Court Ordered (age 18)	Emancipation
Child Adoption Finalized	Adoption	Child Already Reunited with parent (s) when wardship terminated	Reunification

The Permanency column "Total" refers to the total case with reason codes in the Reunification, Adoption, Relative, Guardianship, and Emancipation categories.

The Permanency column "Total within 24 months" refers to the total case that ended within 24 month of the case status type begin date in the Reunification, Adoption, Relative, Guardianship, and Emancipation categories.



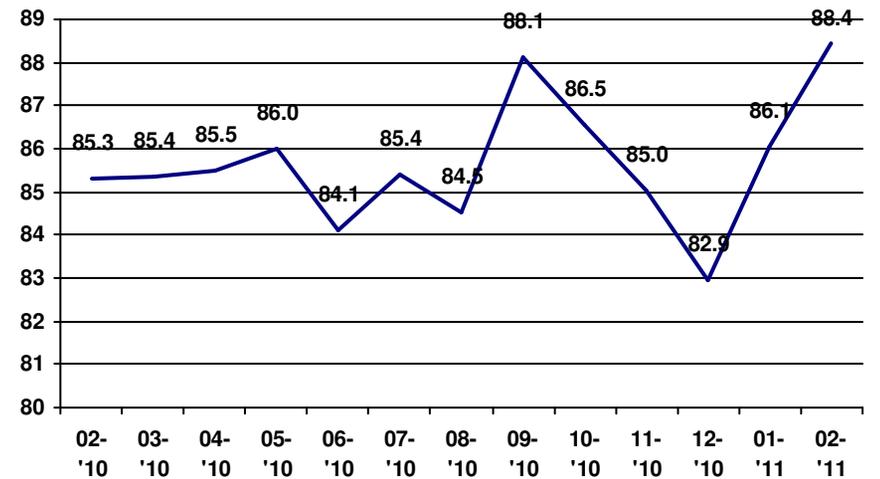
DCS Practice Indicator Report CHINS and IA Permanency Report

For February 2011

February 2011

Location	Closed Cases Types with Permanency Outcomes					Permanency		
	Reunification	Adoption	Relative	Guardianship	Emanicipation	Total	Within 24 Months	24 Month Rate
Statewide	583	73	21	51	24	752	665	88.4
Region 12	15	0	1	0	0	16	16	100.0
Fayette	1	0	0	0	0	1	1	100.0
Franklin	3	0	0	0	0	3	3	100.0
Henry	3	0	0	0	0	3	3	100.0
Rush	0	0	1	0	0	1	1	100.0
Union	0	0	0	0	0	0	0	NA
Wayne	8	0	0	0	0	8	8	100.0

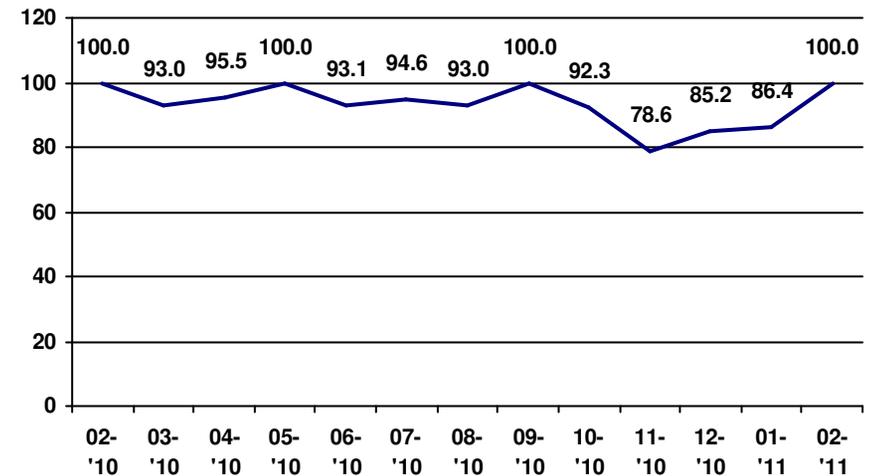
Statewide Permanency within 24 Months



Region 12 For February 2010 to February 2011

Location	Closed Cases Types with Permanency Outcomes					Permanency		
	Reunification	Adoption	Relative	Guardianship	Emanicipation	Total	Within 24 Months	24 Month Rate
Feb 2011	15	0	1	0	0	16	16	100.0
Jan 2011	18	3	0	1	0	22	19	86.4
Dec 2010	21	4	0	2	0	27	23	85.2
Nov 2010	19	7	0	2	0	28	22	78.6
Oct 2010	13	0	0	0	0	13	12	92.3
Sep 2010	18	1	0	2	0	21	21	100.0
Aug 2010	34	1	0	7	1	43	40	93.0
Jul 2010	29	3	0	4	1	37	35	94.6
Jun 2010	24	2	0	2	1	29	27	93.1
May 2010	35	1	2	1	0	39	39	100.0
Apr 2010	36	5	0	3	0	44	42	95.5
Mar 2010	36	4	0	2	1	43	40	93.0
Feb 2010	29	1	1	2	0	33	33	100.0

Region 12 Permanency within 24 Months





DCS Practice Indicator Report Family Case Manager Contacts Report

For February 2011

Report Description

This report uses data collected over at the end of the current report month. The graphs and numbers for historical months also use data from the historical month listed. For the purpose of this report, a person is considered family for the child if they have the following relationships:

- Father
- Mother
- Stepfather
- Stepmother
- Grandfather
- Grandmother
- Pre-adoptive father
- Pre-adoptive mother
- Adoptive grandparent
- Legal Guardian

Children Out of Home Entire Month – This column shows the number of children in out of home placement at the end of the report month who also have a removal date prior to the first of the report month.

Contact Information – This section of the reports shows information regarding FCM contacts (from the contact screens) during the report month.

FCM with Family – This section of the report shows FCM contacts with the child's family (as described above) during the report month.

Children – This is the total number of children that the FCM had at least one contact with a member of the child's family during the report month.

Rate – This is the total number of children that FCM had at least one contact with a member of the child's family divided by the total number of children in out of home placement for the entire month (as described above).

FCM with Child – This section of the report shows FCM contacts with the child during the report month.

Children – This is the total number of children that the FCM had at least one contact with a the child during the report month.

Rate – This is the total number of children that FCM had at least one contact with the child divided by the total number of children in out of home placement for the entire month (as described above).

FCM with Family and Child – This section of the report shows FCM contacts with the child's family (as described above) **AND** the child during the report month. Contact with both had to have occurred for the child to be included in this section. The family and child do not need to present at the same contact, contact with each could have been made in two separate contacts.

Children – This is the total number of children that the FCM had at least one contact with a member of the child's family **and** at least one contact with the child during the report month.

Rate – This is the total number of children that FCM had at least one contact with a member of the child's family **and** at least one contact with the child during the report month divided by the total number of children in out of home placement for the entire month (as described above).



DCS Practice Indicator Report

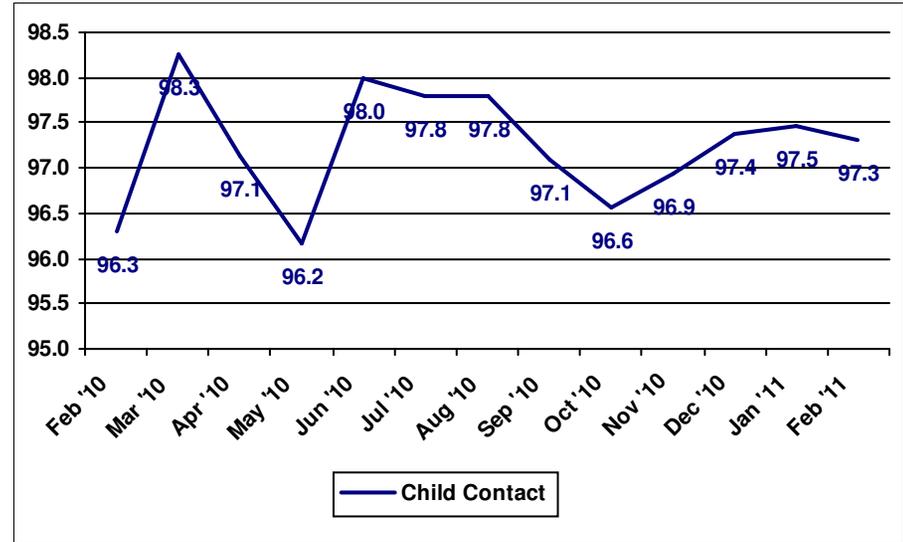
Family Case Manager Contacts Report

For February 2011

February 2011

Location	Children out of home entire month	Contact Information					
		FCM with Family		FCM with Child		FCM with Family and Child	
		Children	Rate	Children	Rate	Children	Rate
Statewide	9,638	2,728	28.3%	9,378	97.3%	2,684	27.8%
Region 12	171	75	43.9%	170	99.4%	75	43.9%
Fayette	47	17	36.2%	47	100.0%	17	36.2%
Franklin	19	8	42.1%	19	100.0%	8	42.1%
Henry	36	20	55.6%	36	100.0%	20	55.6%
Rush	17	5	29.4%	17	100.0%	5	29.4%
Union	21	12	57.1%	20	95.2%	12	57.1%
Wayne	31	13	41.9%	31	100.0%	13	41.9%

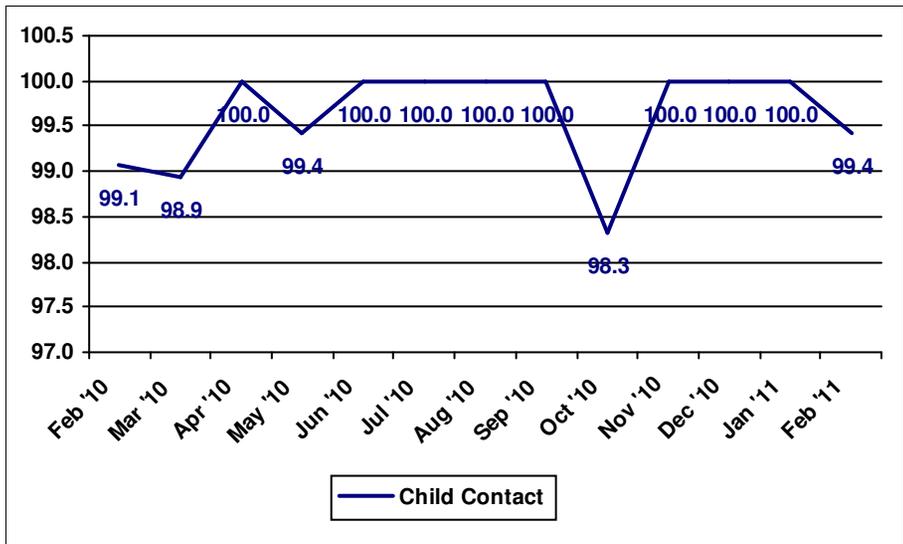
Statewide Child Contact Rate



Region 12 For February 2010 to February 2011

Month	Children out of home entire month	Contact Information					
		FCM with Family		FCM with Child		FCM with Family and Child	
		Children	Rate	Children	Rate	Children	Rate
Feb 2011	171	75	43.9%	170	99.4%	75	43.9%
Jan 2011	163	74	45.4%	163	100.0%	74	45.4%
Dec 2010	176	81	46.0%	176	100.0%	81	46.0%
Nov 2010	179	78	43.6%	179	100.0%	78	43.6%
Oct 2010	179	76	42.5%	176	98.3%	76	42.5%
Sep 2010	169	91	53.8%	169	100.0%	91	53.8%
Aug 2010	155	76	49.0%	155	100.0%	76	49.0%
Jul 2010	162	69	42.6%	162	100.0%	69	42.6%
Jun 2010	167	90	53.9%	167	100.0%	90	53.9%
May 2010	176	80	45.5%	175	99.4%	80	45.5%
Apr 2010	180	85	47.2%	180	100.0%	85	47.2%
Mar 2010	189	89	47.1%	187	98.9%	89	47.1%
Feb 2010	216	98	45.4%	214	99.1%	96	44.4%

Region 12 Child Contact Rate





DCS Practice Indicator Report Child Visitation Report

For February 2011

Report Description

This report uses data collected at the end of the current report month. The graphs and numbers for historical months also use data from the historical month listed. For the purpose of this report, a person is considered family for the child if they have the following relationships:

- Father
- Mother
- Stepfather
- Stepmother
- Grandfather
- Grandmother
- Pre-adoptive father
- Pre-adoptive mother
- Adoptive grandparent
- Legal Guardian

Children out of home with case plan goal of reunification – This column shows the number of children in out of home placement at the end of the report month who also have reunification as the most recently entered primary case plan goal.

Children with visits to their family during the month – This section of the report shows data regarding children who have had a visit with the child's family (as described above) begin during the report month.

Children – This is the total number of children that the child had at least one visit with a member of the child's family during the report month.
Rate – This is the total number of children that the child had at least one visit with a member of the child's family divided by the total number of children in out of home placement at the end of the report month with case plan goal of reunification(as described above).



DCS Practice Indicator Report

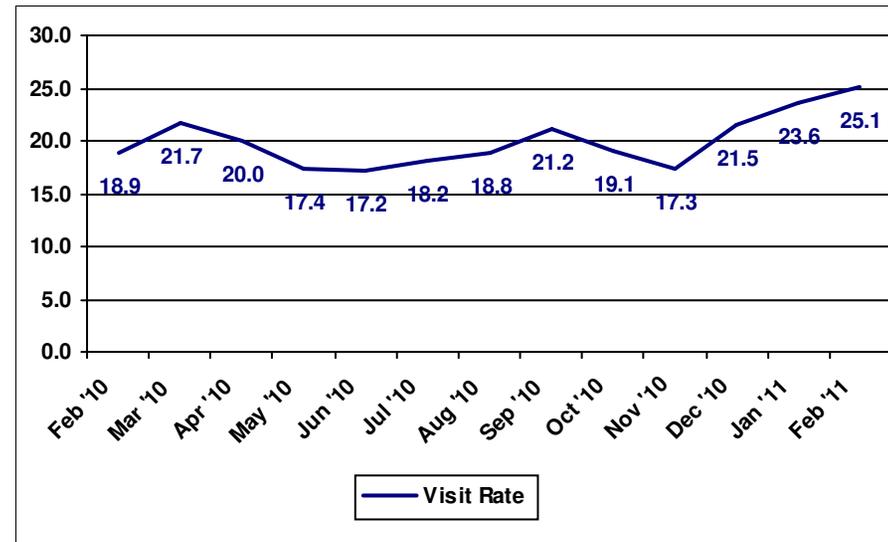
Child Visitation Report

For February 2011

February 2011

Location	Children out of home with case plan goal of reunification	Children with visits to their family during the month	
		Children	Rate
Statewide	5,238	1,313	25.1%
Region 12	105	47	44.8%
Fayette	31	17	54.8%
Franklin	9	0	0.0%
Henry	19	6	31.6%
Rush	6	4	66.7%
Union	15	8	53.3%
Wayne	25	12	48.0%

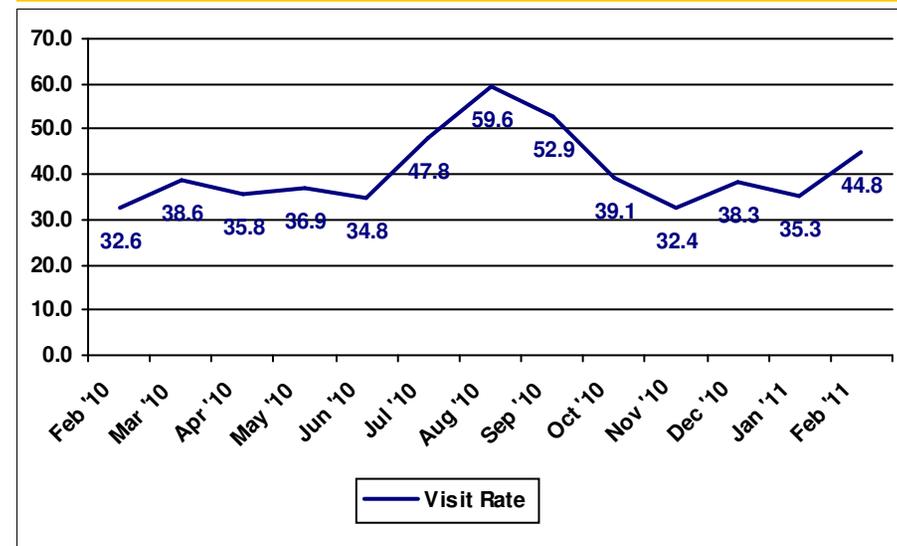
Statewide Visitation Rate



Region 12 For February 2010 to February 2011

Month	Children out of home with case plan goal of reunification	Children with visits to their family during the month	
		Children	Rate
Feb 2011	105	47	44.8%
Jan 2011	102	36	35.3%
Dec 2010	107	41	38.3%
Nov 2010	108	35	32.4%
Oct 2010	110	43	39.1%
Sep 2010	102	54	52.9%
Aug 2010	89	53	59.6%
Jul 2010	92	44	47.8%
Jun 2010	92	32	34.8%
May 2010	103	38	36.9%
Apr 2010	109	39	35.8%
Mar 2010	114	44	38.6%
Feb 2010	144	47	32.6%

Region 12 Visitation Rate





DCS Practice Indicator Report Absence of Repeat Maltreatment

For February 2011

Report Description

This is a description of the key elements used in this report.

Time Period – The time period used in this report is the 12 months prior to the month of the report.

Assessments during time period – The assessment used in this report are assessment with BOTH report date AND approval date during the time period (12 months prior to the month of the report).

Victim Selection – The children used in this report were identified as having at least one substantiated allegation of abuse or neglect on an assessment during the time period.

First Occurrence – This looks at the victims of substantiated abuse or neglect during the first 6 months of the time period (6 to 12 months prior to the month of the report). If a child was a victim in multiple assessments with substantiated abuse or neglect, the assessment with the earliest report date is considered the first occurrence.

Recurrence Time Period – The time period used to see if a child is a substantiated victim in a recurring assessment of abuse or neglect is based off the report date of the first occurrence. The recurrence period begins one day after the first occurrence report date and ends 183 after the first occurrence report date ($\geq 1^{\text{st}}$ Occurrence +1 and $\leq 1^{\text{st}}$ Occurrence +183). If a child has multiple recurrences, the earliest report date in the recurring time period is considered the recurring assessment.

Here is a visual representation of an example. This is a report for December of a given year. The time period to review assessments would run from Jan 1st to Dec 31st. The time period for a first occurrence would be Jan 1st to Jun 30th. If a child had a first occurrence on Feb 7th, the recurrence period would run from Feb 8th to Aug 9th. If the child had a recurrence in Aug 5th, that would be considered repeat maltreatment. If the child had a recurrence Oct 10th, that would not be considered repeat maltreatment because it fell outside the recurrence period.

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Time Period (Jan 1 st to Dec 31 st)											
1 st Occurrence Time Period (Jan 1 st to Jun 30 th)											
						Recurrence Period (Feb 8 th to Aug 9 th)					

Percent of absence of repeat maltreatment – This calculations uses the terms defined above. The numerator is the number of children with a first occurrence minus the number of children with a recurrence. The denominator is the number of children with first occurrence.

$$\frac{(1^{\text{st}} \text{ Occurrence} - \text{Recurrence})}{1^{\text{st}} \text{ Occurrence}}$$

For the purposes of this report, the county the child is assigned to is based off the county of first occurrence. If a child has a recurrence in a different county, the repeat will show for the county of the first occurrence.



DCS Practice Indicator Report

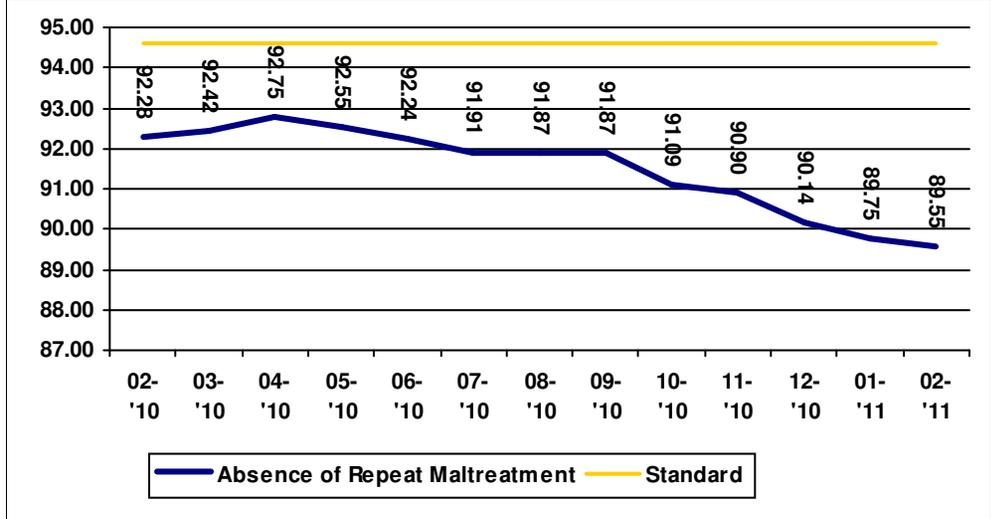
Absence of Repeat Maltreatment

For February 2011

February 2011

County	Victims from Mar 2010 to Sep 2010	Victims without a recurrence within 6 months	Absence of Repeat Maltreatment Percent	National Standard
Statewide	12,002	10,748	89.55%	94.60%
Region 12	301	281	93.36%	94.60%
Fayette	32	27	84.38%	94.60%
Franklin	33	32	96.97%	94.60%
Henry	71	70	98.59%	94.60%
Rush	36	30	83.33%	94.60%
Union	31	30	96.77%	94.60%
Wayne	98	92	93.88%	94.60%

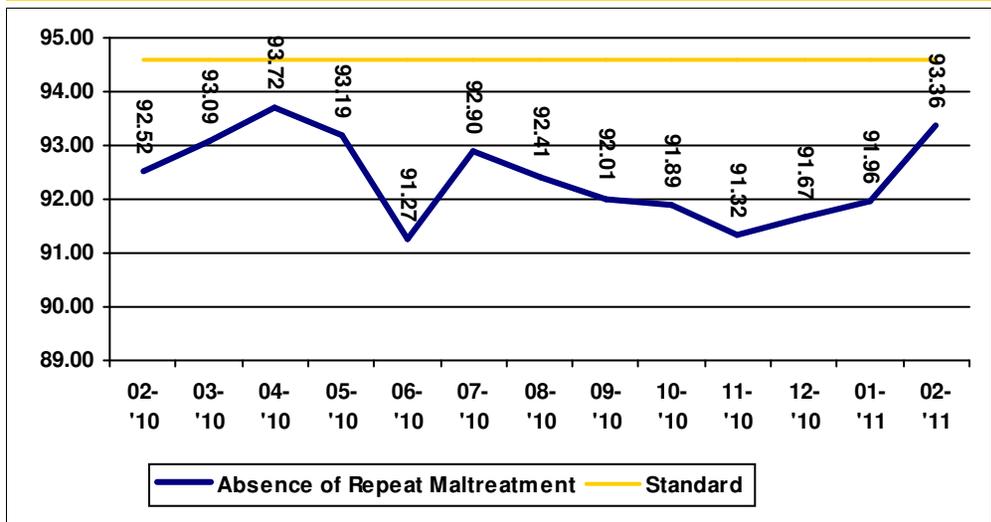
Statewide Absence of Repeat Maltreatment



Region 12 For February 2010 to February 2011

County	Victims from Mar 2010 to Sep 2010	Victims without a recurrence within 6 months	Absence of Repeat Maltreatment Percent	National Standard
February 2011	301	281	93.36%	94.60%
January 2011	286	263	91.96%	94.60%
December 2010	276	253	91.67%	94.60%
November 2010	265	242	91.32%	94.60%
October 2010	259	238	91.89%	94.60%
September 2010	288	265	92.01%	94.60%
August 2010	316	292	92.41%	94.60%
July 2010	352	327	92.90%	94.60%
June 2010	355	324	91.27%	94.60%
May 2010	382	356	93.19%	94.60%
April 2010	430	403	93.72%	94.60%
March 2010	434	404	93.09%	94.60%
February 2010	428	396	92.52%	94.60%

Region 12 Absence of Repeat Maltreatment





DCS Practice Indicator Report

Absence of Maltreatment in Foster Care

For February 2011

Report Description

This is a description of the key elements used in this report.

Time Period – The time period used in this report is the 12 months prior to the month of the report.

Assessments during the time period – The assessment used in this report are assessment with BOTH report date AND approval date during the time period (12 months prior to the month of the report).

Victim of maltreatment in Foster Care – The children used in this report were identified as having at least one substantiated allegation of abuse or neglect on an assessment during the time period where the perpetrator is a foster parent or institutional staff.

Children in Foster Care during the time period – All CHINS children with an open removal episode at any time during the 12 months prior to the month of the report. Also included are Probation children (who are IV-E eligible) with an open removal episode at any time during the 12 months prior to the month of the report.

Percent of absence of maltreatment – This calculations uses the terms defined above. The numerator is the number of children in foster care minus the number of victims of maltreatment in foster care. The denominator is the number of children in foster care.

$$\frac{(\text{Children in Foster Care} - \text{Victims of maltreatment in Foster Care})}{\text{Children in Foster Care}}$$



DCS Practice Indicator Report

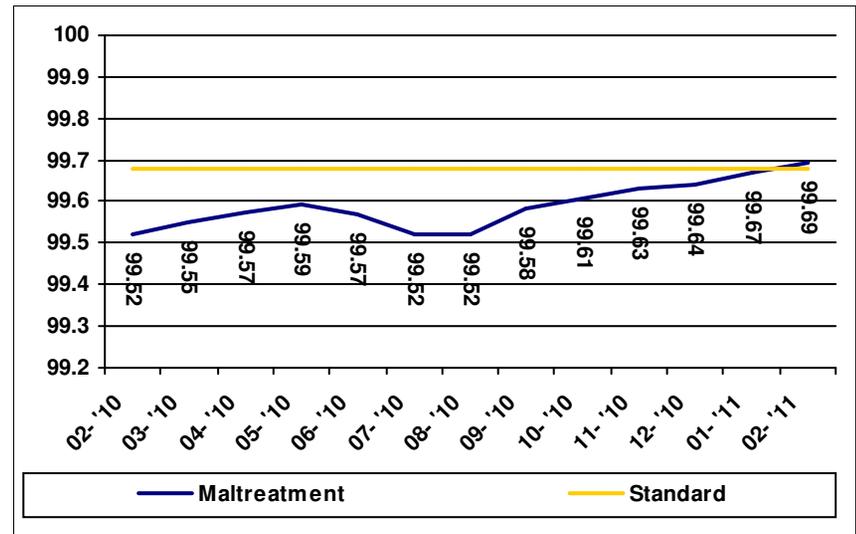
Absence of Maltreatment in Foster Care

For February 2011

For February 2011

Location	Children in Foster Care from Mar 2010 to Feb 2011	Substantiated Victims in Foster Care	Absence of Maltreatment Percent	National Standard
Statewide	21,280	65	99.69%	99.68%
Region 12	445	1	99.78%	99.68%
Fayette	95	0	100.00%	99.68%
Franklin	43	0	100.00%	99.68%
Henry	129	1	99.22%	99.68%
Rush	37	0	100.00%	99.68%
Union	37	0	100.00%	99.68%
Wayne	104	0	100.00%	99.68%

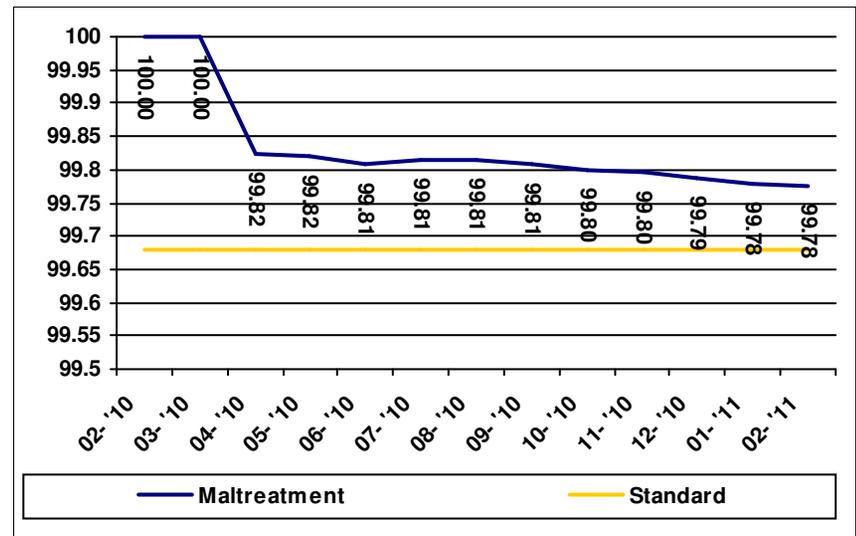
Statewide Trend of Absence of Maltreatment in Foster Care



Region 12 for February 2010 to February 2011

Month	Children in Foster Care from Mar 2010 to Feb 2011	Substantiated Victims in Foster Care	Absence of Maltreatment Percent	National Standard
February 2011	445	1	99.78%	99.68%
January 2011	454	1	99.78%	99.68%
December 2010	472	1	99.79%	99.68%
November 2010	493	1	99.80%	99.68%
October 2010	496	1	99.80%	99.68%
September 2010	518	1	99.81%	99.68%
August 2010	540	1	99.81%	99.68%
July 2010	539	1	99.81%	99.68%
June 2010	523	1	99.81%	99.68%
May 2010	554	1	99.82%	99.68%
April 2010	562	1	99.82%	99.68%
March 2010	578	0	100.00%	99.68%
February 2010	578	0	100.00%	99.68%

Region 12 Trend of Absence of Maltreatment in Foster Care



Quality Services Review (QSR) Results for Region 12

Source Used:

The Process and Quality Improvement (PQI) Team provided a dataset titled “Regional QSR Data,” which contained data for each region’s QSR.

Results:

- Region 12 has completed their second QSR, and it took place in March, 2011. The results shown below are from that specific QSR.
- The results are shown in percentages of cases that scored in the “Refine and Maintain” category for each indicator.

Indicators	Percentage of Cases Scoring in Refine and Maintain
Child Indicators	
Safety	100
Behavioral Risk	95
Stability	75
Permanency	63
Appropriate Living Arrangement	100
Physical Health	100
Emotional Status	90
Learning and Development	92
Pathway to Independence	40
Overall Child Status	100
Parent Indicators	
Bio-Parent Parenting Capacity	61
Current Caregiver Parenting Capacity	88
Congregate Caregiver Parenting Capacity	50
Bio-Parent Informal Support	67
Current Caregiver Informal Support	94
Overall Bio-Parent	56
Overall Current Caregiver	88
System Indicators	
Role/Voice of Mother	56
Role/Voice of Father	15
Role/Voice of Child	50
Role/Voice of Other	63

Team Formation	54
Team Function	35
Cultural Responsiveness	88
Assessing and Understanding of Child	67
Assessing and Understanding of Family	40
Long-Term View	58
Child and Family Planning Process	46
Planning Transitions and Life Adjustments	67
Intervention Adequacy	67
Resource Availability	100
Maintaining Relationships – Mother	91
Maintaining Relationships – Father	63
Maintaining Relationships – Siblings	100
Maintaining Relationships – Extended Family	100
Tracking and Adjusting	58
Overall System Performance	63

Agenda
Region 12
Meeting #1
May 12, 2011

- I. Welcome
- II. Purpose of Workgroup
- III. Timeline and Future Meetings
- IV. Overview of Practice Model
- V. Discussion of Service Array
- VI. Adjourn

Agenda
Region 12
Meeting #2
June 9, 2011

- I. Welcome

- II. Review of Service Array

- III. Finalize Service Array

- IV. Discuss other ways of getting information
 - a. Survey
 - b. Focus Groups
 - c. Public Testimony

- V. Adjourn

Biennial Regional Services Strategic Plan Workgroup Meeting Minutes Region #12

Meeting Date: June 9, 2011
Meeting Location: Fayette County DCS Conference Room
Meeting Chair: Vickie Jones
Meeting Secretary: Myrna Baldwin

Meeting Called to Order at: 1:30 p.m.

Roll Call:

In Attendance: Indiana Department of Child Services, Local Office Directors, (LOD), Mike Fleming, Henry County; Kelly Persinger, Franklin County; Courtney Mathews, Wayne and Union County; Bill Ammerman, Rush County; Mark Munchel, Fayette County, Karen Bowen, Wayne County CASA; Beth Ann Butsch, Judge, Fayette County Circuit Court; and Vickie Jones, DCS Regional Manager, Region 12.

Meeting Minutes

I. Welcome, Introductions and New Members

- a) Meeting agenda distributed by Kristin Obermeyer.
- b) Obermeyer thanked those attending for their coming and introductions were made.
- c) Obermeyer commended those who had completed and turned in to her the *Barriers to Service Availability Checklist* and noted that these will be discussed at the next meeting, after the public testimony.

II. Review of Service Array:

a) Obermeyer referred to the list of contracted services and explained that as of July 1, 2011, those providers will be re-contracted. The list does not include Child Advocacy and Independent Living Services. Those two items are approved and are currently in the contracting process.

b) Persinger noted there are no in-patient services for substance abuse. The closest provider is Harbor Lights (Salvation Army) in Indianapolis. Obermeyer stated that Terra is in Region 14, but are contracted state wide.

Mathews questioned how many see in-patient assessments. Bowen noted that with some providers, if a client enters Intensive Out-Patient (IOP) and fails the program, comes back to the program but fails again, that client is putting forth an effort; therefore they can stay in the community. Conversely, if a client does not put forth an effort at all, then some providers believe there is no reason to recommend in-patient services. Persinger stated providers shouldn't provide services based on what they can offer, but on what the client needs.

c) Jones concluded that anything related to substance abuse; good diagnostic, good treatment; is an issue, not just in Region 12, but everywhere. She added that was the big unmet need last time and it still is the biggest unmet need. It was pointed out that Wernle has out-patient services for substance abuse. Ammerman mentioned that Wernle is not

easily accessible to his county (Rush), transportation being a barrier. Bowen suggested the LOD's should contact Wernle directly and ask them to help figure out how transportation will work. Obermeyer agreed but said the provider can't bill for transportation, but if they go pick a client up, once that client is in the vehicle, they can bill.

d) Obermeyer informed those present that Tom Pennington, formerly with Aurora, is now employed at Wernle and they are looking at some expansion of their services. Mathews added that her understanding is that Pennington has been given permission to do groups and services for adults in the Franklin, Fayette and Union area.

e) Overmeyer asked what it was that Region 12 does not have. Persinger stated contracts for Wernle to do adults. Obermeyer affirmed that Wernle as of July 1, 2011, proposed for adults. Judge Bursch asked for clarification that Wernle would provide services for the parents of these children. Mathews asked if there wasn't a child at Wernle, would they still provide substance abuse services for adults. Obermeyer confirmed Wernle's proposal included services for the parents of children. In answer to Mathews' question, Obermeyer replied that DCS' service standard doesn't break down children verses adults; it's the same. If the provider has a contract for substance abuse and they have been willing to do that, then they could.

Persinger stated that Pennington has always wanted to come to the counties instead of everybody having to go to Wayne County. Mathews explained her understanding is that if we can figure out a way to bring clients all together for groups, Pennington is willing to do that. Jones added that Pennington is very well qualified and does excellent assessments. The suggestion was put forth for Mathews to schedule a meeting with Pennington, Probation, Judge Butsch, and DCS to see what can be set up for adults. Mathews will work toward getting this accomplished.

III. Finalize Service Array:

a) Homebased Therapy: Jones expressed this is not an unmet need with Region 12.

b) Sexually Maladaptive Programs: Fleming informed we usually go outside the area for this service. Persinger questioned if Wernle has that program. Ammerman stated that again, transportation is an issue for some counties.

c) Domestic Violence: All present agreed there are adequate services for Domestic Violence services.

d) Diagnostic Substance Abuse and Therapy: Mathews re-iterated this is a great need in the region- diagnostic meaning mental health.

e) Transportation: Ammerman asserted he would like a service standard for transportation. He stated this is one of the major barriers consistently on his list. If there were transportation and a way to pay for it- do a referral to the Yellow Cab Company- for 40 hours a week- it would eliminate a lot of barriers and get a lot of excuses taken care of. Jones was of the same opinion that a service standard for transportation would be great.

f) Child care: After discussion, it was determined the barrier with child care is not the availability, but getting it paid for by fiscal.

g) Prevention Services: Jones explained there are no prevention services regarding substance abuse. A proposal was set forth with \$55,000 allocated, but nothing was submitted. Ammerman inquired as to how we identify the client base, adding by the time we become aware of them, prevention is already past. Jones concurred, and then went on to say we had looked at Middle School age before, but still didn't get a proposal.

h) Past Unmet Needs: Obermeyer made mention of the unmet needs from the past plan that were not addressed in the action plan, including: Lesbian, Gay, Bisexual, Transgender and Questioning Services and Gang Prevention Services. Jones stated these were services not considered in the action plan because it was felt they weren't really needs.

i) Obermeyer outlined her plan for the action plan is for it to be a working plan that we come back to and check on, much like a Child and Family Team Meeting. Once a clean list is compiled for all the services for prevention and intervention, Obermeyer will forward it to all for review.

IV. Getting Information:

a) Survey: The survey will be in regards to the services DCS offers. LODs are to complete a list of recipients they would like the survey to go to. This list needs to be submitted to Obermeyer by the end of June.

b) Focus Groups: Obermeyer will facilitate focus groups consisting of youth and clients. LODs will each present three (3) DCS names and three (3) probation names, counting both former and opened cases, along with contact information, from each county. Parents should also be included in the Probation names submitted. LODs will also provide Obermeyer with suggestions for an off-site, neutral location in each county for the group to meet. Focus groups will need to be completed by September 1, 2011. Obermeyer needs the names submitted by July 1, 2011. She will use the questions on the survey as a starting point. The focus groups' meeting will not be recorded.

c) Public Testimony: The Public Testimony will take place on August 8, 2011, beginning at 4:00 P.M. at the Fayette County DCS office. The event will be published in the following newspapers: Liberty Herald; Richmond Palladium Item; Rushville Republican; Brookville Democrat; Connersville News-Examiner; and the New Castle Courier Times. Obermeyer will also offer for press release to Channel 3. Notices will be sent to each LOD for posting.

V. Adjourn:

Obermeyer noted she had anticipated having a draft or copy of the Child Protection Plan but it has not been completed. When that document is made available to her, she will forward it on.

Work Group #3 will be held Thursday, August 11, 2011 at 1:30 P.M.

Meeting adjourned at 2:55 P.M.

Respectfully submitted,

Myrna Baldwin, Secretary 3
Indiana Department of Child Services, Rush County Local Office

Agenda
Region 12
Meeting #3
August 11, 2011

- I. Welcome
- II. Review Public Testimony Summary
- III. Review focus group summary (none held)
- IV. Next Meeting- Action Plan
- V. Adjourn

Biennial Regional Services Strategic Plan Workgroup Meeting Minutes Region #12

Meeting Date: August 11, 2011
Meeting Location: Fayette County DCS Conference Room
Meeting Chair: Vickie Jones
Meeting Secretary: Myrna Baldwin

Meeting Called to Order at: 1:30 p.m.

Roll Call:

In Attendance: Indiana Department of Child Services, Local Office Directors, (LOD), Mike Fleming, Henry County; Kelly Persinger, Franklin County; Courtney Mathews, Wayne and Union County; Bill Ammerman, Rush County; Mark Munchel, Fayette County, Karen Bowen, Wayne County CASA; Wade Boils, foster parent/CASA, Henry County; and Vickie Jones, DCS Regional Manager, Region 12.

Meeting Minutes

I. Welcome, Introductions, New Members, and Announcements:

- a) Meeting agenda distributed by Kristin Obermeyer.
- b) Obermeyer thanked those in attendance for coming and introductions were made. Wade Boils was welcomed to the group.
- c) Obermeyer spoke briefly of the purpose for the present meeting and what was accomplished at the past two (2) meetings.
 - Work Group #1- What services are needed in Region 12 and how to bridge the gap to meet those needs. Child Protection Plan already developed, but not signed.
 - Work Group #2- Reviewed and finalized the Service Array for the area and background history on DCS.
- d) The web based survey, to assist in identifying needs, is scheduled to go out to over 4,000 email addresses on August 15, 2011. Obermeyer noted SPAM blockers need to be off to access the survey which should take about ½ hour to complete. Jones was concerned with clients and older youth getting the survey completed, some of whom Central Office, CO, only has a telephone number for contact. She requested that if CO is unable to contact these groups of people that Obermeyer let the local office know and they will assist in getting the survey completed.

II. Review Public Testimony Summary:

The Public Testimony took place in the conference room of the Fayette County DCS office on August 8, 2011. There was no Public Testimony presented.

Ammerman questioned what else can be done to inform the public. Bowen wondered if on-line publications were utilized. Obermeyer stated it depends on the paper whether they post notices on line. Jones added she has been involved with Public Testimonies for thirty years and only one (1) time has anybody come.

III. Review Focus Group Summary:

Obermeyer reported that she is not permitted to facilitate focus groups as discussed at the last meeting.

IV. Next Meeting/Action Plan:

- Between now and Work Group meeting #4 in October, the survey data will be compiled. Obermeyer stressed the importance of attending the October meeting as it will address what needs are the most important for our region.
- November- Jones, Obermeyer and Bob Daugherty, DCS Regional Finance Manager, will meet to discuss the fiscal aspect of the plan.
- December- A draft summarizing the plan will be presented. Obermeyer will email the plan prior to the meeting.
- February- Review the finalized plan to present to the Regional Service Council.

V. Adjourn:

Work Group #4 will be held in the Fayette County DCS conference room on Thursday, October 13, 2011 at 1:30 P.M. An email reminder will be sent.
Meeting adjourned at 2:07 P.M.

Respectfully submitted,

Myrna Baldwin, Secretary 3
Indiana Department of Child Services, Rush County Local Office

Agenda
Region 12
Meeting #4
November 10, 2011

- I. Welcome
- II. Review Data
- III. Review Survey Information
- IV. Develop Action Plan
- V. Adjourn

Biennial Plan Development Meeting Minutes Region #12

Meeting Date: November 10, 2011
Meeting Location: Fayette County DCS Conference Room
Meeting Chair: Kristin Obermeyer
Meeting Secretary: Lori Bane

Meeting Called to Order at: 1:30 p.m.

Roll Call:

In Attendance: Indiana Department of Child Services, Local Office Directors, (LOD), Mike Fleming, Henry County; Kelly Persinger, Franklin County; Courtney Mathews, Wayne and Union County; Bill Ammerman, Rush County; Mark Munchel, Fayette County; Jenna Turner, Fayette County Probation Department (sitting in for Judge Beth Butsch); Brenda Griffey, foster parent, Union County; and Vickie Jones, DCS Regional Manager, Region 12.

Meeting Minutes

I. Welcome, Introductions, New Members, and Announcements:

- a) Meeting agenda distributed by Kristin Obermeyer.
- b) Obermeyer thanked those in attendance for coming and introductions were made.
- c) Obermeyer spoke briefly of the purpose for the present meeting and what was accomplished at the past three (3) meetings.
 - Work Group #1- What services are needed in Region 12 and how to bridge the gap to meet those needs. Child Protection Plan already developed, but not signed.
 - Work Group #2- Reviewed and finalized the Service Array for the area and background history on DCS.
 - Work Group #3- Reviewed Public Testimony

II. Review Data:

Obermeyer reported over 7,000 emails with the survey were sent out statewide, 2,442 responses were received; 88 of those for Region 12. Feedback showed the survey was long and drawn out. Obermeyer reported the next survey will be reformatted and more user friendly.

III. Review Survey Information:

After reviewing the 2011 Needs Assessment Survey Results, substance abuse outpatient treatment was identified as one of the top needs for Region 12. Discussion was had regarding what could be done to lure new programs to the region. It was noted that of the current provider choices, quality of service is a big problem. The question was posed if there was a real need for outpatient services or if the clients were just not willing to go inpatient. The consensus was that the need is definitely there, it is just the quality of service that is the problem. Jenna Turner stated that in particular probation has a lot of problems with Centerstone especially when it comes to billing. Centerstone

will bill Medicaid and then won't follow the contract. Turner added they seem to be building new programs instead of fixing the old ones. It was noted the Region as a whole believes they are not getting anywhere with Community Mental Health Agencies.

It was reported that Region 12 has identified the need and information was distributed at the provider fair. Tata Treatment Facility and Fairbanks both get good reviews, but Fairbanks says our rates are too low. Persinger suggested Tom Pennington if Wernle could expand. Obermeyer noted our paperwork is not enticing to private companies.

Discussion was held on what the underlying needs to substance abuse issues are with the treatment part being identified as the first need. It was noted that there is a window of opportunity when the client agrees to the help. We have to be able to take advantage of that window of time.

As there is not a facility for outpatient substance abuse in Region 12, it was suggested that another obtainable goal be identified such as: the Summer Rocks Program; good outpatient services; and transportation.

IV. Develop Action Plan:

Step 1: Workgroup formation to try and establish why providers won't come to Region 12. The workgroup needs to consist of the following: One (1) representative from Drug Free Coalition; DCS, one (1) probation representative from each county; foster parents; previous clients; school personnel or social worker; and law enforcement. This workgroup should be formed by June 1, 2012, with invites sent out May 1, 2012.

Sub-committees need to be formed by September to address: why providers won't come to Region 12; how we address quality issues; who can help support funding; and any new or under used programs? Where do we go from here? Sub-committees will also address identified needs such as: Competition in our region so our current providers will raise the bar; prevention programs; and getting Summers Rock program in the whole region.

Sub-committees are to report to the workgroup, then to the members present at this meeting, and then to the Regional Service Council. All information should be back by June 1, 2013, with an update by December 1, 2012.

V. Adjourn:

Probation was not aware that DCS has Foster Care Specialists to help with placement.

There should be a Lunch-n-Learn with Probation and DCS in January or February. In attendance should be either the Local Office Directory (LOD) or Supervisor from DCS, Chief Probation Officer and at least one (1) Juvenile Probation Officer. Thursdays are better for this meeting.

Work Group #5 will be held only with Vickie Jones.

Work Group #6 will be held by e-mail.

The Biennial Plan should be approved by the Regional Service Council in January 2012, and published by April 2012.

Respectfully submitted,

Lori Bane, Clerical 3

Indiana Department of Child Services, Fayette County Local Office

Appendix B
Public Testimony

406 N Central Ave
PO Box 287
Connersville, IN 47331

NewsExaminer

PAXTON MEDIA GROUP

Ph: (765) 825-0581
Fax: (765) 825-4599
www.newsexaminer.com

State of Indiana,
Fayette County:

Before the undersigned personally
came

Rena Bailey

Who being duly sworn, says she is
Customer Service Rep of The News-
Examiner, that is a newspaper of
general circulation, printed and
published in Connersville, in said
county, and is qualified to accept and
publish legal notices according to the
law, and that the notice of which the
annexed is a true copy was published
in said paper on the 18 day of

July, 2011

and for 1 successive weeks
immediately following.

Rena Bailey

Subscribed and sworn to me before
this 13 day of July,
2011.

[Signature]
Christopher L. Foreman Notary Public

My commission expires 10/23/2016

Printer's Fee, \$ 53.07

Public Testimony

Child Protection Service
Plan/Biennial Regional
Services Strategic Plan

Notice of Public Hearing
to take Public Testimony

The Child Protection
Plan/Biennial Regional
Services Plan is prepared
biannually pursuant to IC
31-33-4-1 AND IC
31-26-6-5. Region 12, con-
sisting of
Fayette, Franklin, Henry, Ru-
sh, Union, Wayne, counties
is seeking Public Testi-
mony on the provision of
Child protection
services, local services need
and system change. The
services will be targeted to
the individual needs of
Children identified by the
Department of Child Ser-
vices or children alleged or
adjudicated as children in
need of services or delin-
quent.

To accommodate a large
number of potential speak-
ers, testimony will be lim-
ited to 3 minutes per
speaker and will be given
in the order of signature
on sign-in Sheet available
the day of the
Hearing. Submission of
written comments/testi-
mony is encouraged at the
time of the Hearing.

Public Testimony on;
Region 12 Child Protection
Services Plan/Biennial Re-
gional Services Strategic
Plan

Date; 08/08/2011

Time; 4:00 pm

Place; Fayette County
Local DCS Office
at 1501 Eastern Avenue
Connersville, IN 47331

July 18, 2011

Child Protection Service Plan/
 Biennial Regional Services
 Strategic Plan
 Notice of Public Hearing to take
 Public Testimony
 The Child Protection Service
 Plan/Biennial Regional Services
 Strategic Plan is prepared bi-annual-
 ly pursuant to IC 31-33-4-1 and IC
 31-26-6-5. Region 12, consisting of
 Fayette, Franklin, Henry, Rush,
 Union, Wayne Counties is seeking
 Public Testimony on the provision of
 child protection services, local ser-
 vice need and system change. The
 services will be targeted to the indi-
 vidual needs of children identified by
 the Department of Child Services or
 children alleged or adjudicated as
 children in need of services or delin-
 quent.
 To accommodate a large number
 of potential speakers, testimony will
 be limited to 3 minutes per speaker
 and will be given in the order of sig-
 nature on Sign-in Sheet available the
 day of the Hearing. Submission of
 written comments/testimony is en-
 couraged at the time of the Hearing.
 Public Testimony on: Region 12
 Child Protection Service Plan/Bienni-
 al Regional Services Strategic Plan
 Date: 08/08/2011
 Time: 4:00pm
 Place: Fayette County Local DCS
 Office at 1501 Eastern Avenue,
 Connersville, IN 47331
 RR-209 July 19 #493896

General Form No. 99P (Revised 1987)
 Tax I.D. 63-1253950
 To: The Rushville Republican/P O Box 189
 126 S. Main St., Rushville, IN 46173

Department Of Child Services
 (Governmental Unit)
 Rush County, Indiana

LINE COUNT

Display matter (Must not exceed two actual lines, neither
 than four solid lines of type in which the body of advertisi

-number of equivalent lines
 Head - number of lines
 Body - number of lines
 Tail - number of lines
 Total number of lines in notice

COMPUTATION OF CHARGES

39 lines, 1
39 equivalent lines at

Additional charge for notices containing rule or tabular work
 (50 percent of above amount)
 Charge for extra proofs of publication
 (\$1.00 for each proof in excess of two)
 Total Amount of Claim

Correction \$15.91
\$0.00
\$15.91

DATA FOR COMPUTING COST

Width of single column: 7 ems
 Number of Insertions: 1
 Size of type: 6 pt

Pursuant to the provisions and penalties of Chapter 155, Acts 1953, I hereby certify that the foregoing account is just
 and correct, that the amount claimed is legally due, after allowing all just credits, and that no part of the same has been paid.

Date: _____

Legal Advertising Clerk

PUBLISHERS AFFIDAVIT

ATTACH COPY
 OF ADVERTISEMENT HERE

State of Indiana)
) SS:
 Rush County)

Personally appeared before me, a notary public in and for said county
 and state, the undersigned, Kevin Green
 who being duly sworn, says that he/she is the Managing Editor of
 The Rushville Republican a newspaper of general circulation
 printed and published in the English language in the city of Rushville in
 state and county aforesaid, and the printed matter attached hereto is a
 true copy, which was duly published in said paper for
 the dates of publication being as follows:

1 time(s),

July 19, 2011

Kevin J. Green

Subscribed and sworn to before me
 this 25th day of

Jul-11

Shirley S. Hampton
 Notary Public

My commission expires: 3-Aug-11

PALLADIUM-ITEM

Indiana DCS

A Division of Federated Publications, Inc.
1175 North A Street
Richmond, Indiana 47374
Wayne County, Indiana

Federal ID #16-0980985

Account number **623344-53**
Order/Invoice number **490712**
Total Amount of Claim **\$18.20**

Please mail payments to: PALLADIUM-ITEM ~ PO BOX 677562 ~ DALLAS TX 75267-7562

PUBLISHER'S CLAIM

LINE COUNT

Display Master (Must not exceed two actual lines, neither of which shall total more than four solid lines of the type in which the body of the advertisement is set) --number of equivalent lines

Head - number of lines	1
Body - number of lines	50
Tail - number of lines	1
Total number of lines in notice	52

COMPUTATION OF CHARGES

52 lines, 1 columns wide equals 52 equivalent lines at 0.350 cents per line. \$ 18.20

Additional charge for notices containing rule or tabular work (50 percent of above amount) _____ -

Charge for extra proofs of publication (\$1.00 for each proof in excess of two) _____ -

TOTAL AMOUNT OF CLAIM \$ 18.20

DATA FOR COMPUTING COST

Width of single column 8 ems Size of type 6 point
Number of insertions 1

Pursuant to the provisions and penalties of IC 5-11-10-1, I hereby certify that the foregoing account claimed is just and correct, that the amount claimed is legally due, after allowing all just credits, and that no part of the same has been paid.

I also certify that the printed matter attached hereto is a true copy, of the same column width and type size, which was duly published in said paper 1 times. The dates of publication being as follows:

07/18/11

Additionally, the statement checked below is true and correct:

Newspaper does not have a website.



Newspaper has a website and this public notice was posted in the same day as it was published in the newspaper.

Newspaper has a website, but due to technical problem or error, public notice was posted on _____.

Newspaper has a website but refused to post the publish notice.

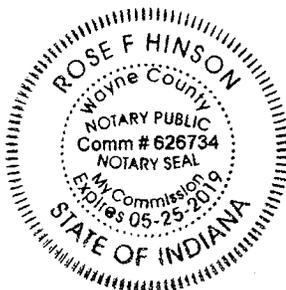
Tracie M Chapman
Title: Accounting Clerk

Rose F Hinson

Rose F Hinson Notary Public residing in Wayne County, Indiana

Subscribed and sworn to before me this day Tuesday, July 19, 2011

My Commission expires May 25, 2019.



Public Testimony
Child Protection Service
Plan/Biennial Regional
Services Strategic Plan
Notice of Public Hearing
to take Public Testimony
The Child Protection
Service Plan/Biennial Regional
Services Strategic
Plan is prepared
bi-annually pursuant to IC
31-33-4-1 and IC 31-26-6-5.
Region 12, consisting of
Fayette, Franklin, Henry,
Rush, Union, Wayne,
counties is seeking Public
Testimony on the provi-
sion of child protection
services, local service
need and system change.
The services will be tar-
geted to the individual
needs of children identi-
fied by the Department of
Child Services or children
alleged or adjudicated as
children in need of ser-
vices or delinquent.
To accommodate a large
number of potential speak-
ers, testimony will be lim-
ited to 3 minutes per
speaker and will be given
in the order of signature
on Sign-in Sheet available
the day of the Hearing.
Submission of written
comments/testimony is
encouraged at the time of
the Hearing.
Public Testimony on:
Region 12 Child
Protection Service Plan/
Biennial Regional
Services Strategic Plan
Date:
08/08/2011
Time:
4:00pm
Place: Fayette
County
Local DCS Office
at 1501 Eastern Avenue
Connersville, IN 47331
#1149712 7/18/2011

PROOF OF PUBLICATION

AFFIDAVIT

Franklin County)
) ss:
State Of Indiana)

Personally appeared before me, a notary public in and for said county and state, the undersigned Bonnie Chaney, who being duly sworn says that

(he or she) is of competent age and is Bookkeeper of The Brookville Democrat, a weekly newspaper which for at least five (5) consecutive years has been published in the town of Brookville, county of Franklin, state of Indiana, and which, during that time, has been a newspaper of general circulation, having a bona fide paid circulation, printed in the English language and entered, authorized and accepted by the post-office department of the United States of America as mailable matter of the second-class as defined by the Act of Congress of the United States of March 3, 1879, and that the printed matter attached

hereto is a true copy, which was duly published in said newspaper 1 times, the dates of publication being as follows:

7-20-11

Bonnie Chaney
Affiant

Subscribed and sworn to before me this 20th day of July, 2011.

My commission expires 2-4-15
Donna Schuler

Proof of Publication

Public Testimony
Child Protection Service
Plan/Biennial Regional Services
Strategic Plan
Notice of Public Hearing to take
Public Testimony

The Child Protection Service Plan/Biennial Regional Services Strategic Plan is prepared bi-annually pursuant to IC 31-33-4-1 and IC 31-26-6-5. Region 12, consisting of Fayette, Franklin, Henry, Rush, Union, Wayne counties is seeking Public Testimony on the provision of child protection services, local service need and system change. The services will be targeted to the individual needs of children identified by the Department of Child Services or children alleged or adjudicated as children in need of services or delinquent.

To accommodate a large number of potential speakers, testimony will be limited to 3 minutes per speaker and will be given in the order of signature on Sign-in Sheet available the day of the Hearing. Submission of written comments/testimony is

encouraged at the time of the Public Testimony Hearing.
Public Testimony on: Region 12
Child Protection Service
Plan/Biennial Regional Services
Strategic Plan
Date: 8/8/2011
Time: 4:00 p.m.
Place: Fayette County Local DCS services
Office at 1501 Eastern Avenue,
Connersville, IN 47331.

29-1tcD _____
Printer's Fees . \$ 20.16
Posters \$ _____
Total \$ 20.16

Filed:

STATE OF INDIANA, }
UNION COUNTY. } SS:

Personally appeared before the undersigned,

John Estridge, Editor

OF THE LIBERTY HERALD

A newspaper of general circulation published in Liberty, in the county aforesaid, who being duly sworn upon his oath, saith that the notice, of which the attached is a true copy, was

duly published in said paper ONE weeks successively, the first of which publications was on the 30th

day of June 2011,

and the last on the 30th day

of June 2011

at John Estridge Editor.

Subscribed and sworn to before me this

June day of 30 2011

Dannas Schuler

Notary Public

My Commission expires February 4, 2015

Printing and Publishing \$ 21.20

Cost Filed June 30 2011

Received Payment: _____

PUBLIC TESTIMONY
Child Protection Service Plan/
Biennial Regional Services
Strategic Plan
Notice of Public Hearing to
Take Public Testimony
The Child Protection Service Plan/Biennial Regional Services Strategic Plan is prepared bi-annually pursuant to IC 31-33-4-1 and IC 31-26-6-5. Region 12, consisting of Fayette, Franklin, Henry, Rush, Union, Wayne, counties is seeking Public Testimony on the provision of child protection services, local service need and system change. The services will be targeted to the individual needs of children identified by the Department of Child Services or children alleged or adjudicated as children in need of services or delinquent.
To accommodate a large number of potential speakers, testimony will be limited to 3 minutes per speaker and will be given in the order of signature on Sign-in Sheet available the day of the Hearing. Submission of written comments/testimony is encouraged at the time of the Hearing.
Public Testimony on: Region 12 Child Protection Service Plan/Biennial Regional Services Strategic Plan
Date: 08/08/2011
Time: 4:00 p.m.
Place: Fayette County Local DCS Office at 1501 Eastern Avenue, Connersville, IN 47331 26-1tc



Mitchell E. Daniels, Jr., Governor
James W. Payne, Director

Indiana Department of Child Services
Rush County Office
1340 N. Cherry Street
Rushville, Indiana 46173-1105

765-932-2392
FAX: 765-938-1623

www.in.gov/dcs

Child Support Hotline: 800-840-8757
Child Abuse and Neglect Hotline: 800-800-5556

Child Protection Service Plan/Biennial Regional Services Strategic Plan Public Testimony Region #12

Date: August 8, 2011
Location: Fayette County DCS Conference Room
Facilitator: Vickie Jones, DCS Regional Manager

On the roll to present public testimony:

Public Testimony Forum Called to Order at: 4:00 p.m.

Introduction: Vickie Jones, DCS Regional Manager, asked for Public Testimony to be brought forth on the record.

Public Testimony: No public testimony was received.

Adjournment: Facilitator Jones adjourned the public testimony forum at 4:05 p.m.



Protecting our children, families and future

Appendix C
Needs Assessment Survey

2011 Needs Assessment Methodology

Invitations to take the 2011 Needs Assessment Survey were sent by email to over 7000 email addresses on 8/23/2011. The survey was administered via SurveyMonkey. As part of the invitation, recipients were encouraged to forward the link to anyone they thought might want to answer. A link to the survey was also posted on the DCS website. The survey concluded on 9/15/2011.

Respondents answered the survey based on their experience and knowledge of the services offered in one particular county. They were encouraged to take the survey for each county for which they could provide answers. There were 2442 responses.

Respondents were asked to identify themselves by type of agency they represent. The agency types used:

Agency Type	Description
Court Staff	Judge, Attorney, CASA
Department of Child Services Staff	All DCS employees
Educational Staff	Administrator, Teacher, School Counselor, School Nurse
Foster Parent	Current and former foster parents
Law Enforcement	Prosecutor, Corrections
Other	Do not fit in one of the other categories
Probation	Juvenile or adult probation
Residential Staff	Employed by a Residential Service Provider
Service Provider	Employed by an organization that services the community

Respondents had the opportunity to provide input on some or all of the following service categories:

- Adoption Services
- Home-Based Services
- Substance Abuse Services
- Resource Family Services
- Mental Health Services
- Educational Services
- Placement/Housing/Shelter Services
- Health and Monetary Services
- General Services

Those who indicated they wanted to rate the service category were first asked to rate the availability of the individual services in that category. If they indicated that the service was not available, they were asked to rate the need for the services. If they indicated that there was at least a minimal availability, they were asked to rate the quality of the services.

For the purpose of this survey, the following definitions were used:

AVAILABILITY - Is this service readily accessible (i.e. no waiting list, convenient office hours and location, etc.)?

NEED – Would this service be of benefit to the families in your county (i.e. improve quality of life, address an identified concern or issue, etc.)?

QUALITY – Is this service delivered in an effective manner (i.e. families are satisfied with the service, service has a positive impact, etc.)?

Respondents were asked to rate the availability, need, and quality on the following scale. For evaluation purposes, the responses were assigned a numerical value.

Response	Value
Highly Available	5
Above Average Availability	4
Average Availability	3
Minimal Availability	2
Not Available	1
Highly Needed	5
Needed	4
Somewhat Needed	3
Minimally Needed	2
Not Needed	1
Excellent Quality	5
Above Average Quality	4
Average Quality	3
Poor Quality	2
Very Poor Quality	1

2011 Needs Assessment Survey Instrument

The Needs Assessment Survey was broken down into 9 service categories. Each service category contained questions regarding a specific service. The following is an outline of the survey instrument.

Survey Respondent Questions

- Please enter your email address so we can contact you if we have any questions.
- Please tell us about the type of agency that you represent.
 - Court Staff
 - DCS Staff
 - Educational Staff
 - Foster Parent
 - Law Enforcement
 - Probation
 - Residential Staff
 - Service Provider
 - Other (please specify)
- Please select the county for which you will be referring to in this survey:
 - Drop down list of all 92 Indiana counties
 - Only one county could be selected. If a respondent wanted to provide input on more than one county, they would have to complete the survey for each county.

Service Category Questions

Service Category: Adoption Services

- Child Prep
- Family Prep Home Study
- Adoptive Parent Recruitment
- Matching Adoptive Parents w/ children
- Post Adoption Home Based Therapy
- Respite for Adoptive Parent
- Support Groups for Adoptive Families

Question 1: Have you ever utilized, provided or referred for Adoption Services?

1. Yes, I utilize these services.
2. No, I do not utilize these services and do not wish to answer any questions regarding them. Please take me to the next service category.
3. No, I do not utilize these services, but I would still like to answer questions regarding them.

Question 1 for each service category requires a response. If the respondent selected the response 2 (No, I do not utilize these services and do not wish to answer any questions regarding them), then they skipped the services questions within that service category and were taken directly to the next service category. If the respondent selected response 1 or 3, then they were asked to answer questions regarding each of the services that fall into that service category.

A. Is this service available in your county?

Not Available	Minimally Available	Available	Above Average Availability	Highly Available
---------------	---------------------	-----------	----------------------------	------------------

If the respondent replied with "not available" to Question A for any of the services, then they were asked the following question:

B. Is there a need for this service in your county?

Not Needed	Minimally Needed	Somewhat Needed	Needed	Highly Needed
------------	------------------	-----------------	--------	---------------

If the respondent replied "minimally available", "available", "above average availability", or "highly available" to Question A for any of the services, then they were asked the following question:

C. Please rate the quality of the service in your county.

Very Poor Quality	Poor Quality	Average Quality	Above Average Quality	Excellent Quality
-------------------	--------------	-----------------	-----------------------	-------------------

Service Category: Home-based Services

- Child Prep
- Family Prep Home Study
- Adoptive Parent Recruitment
- Matching Adoptive Parents w/ children
- Post Adoption Home Based Therapy
- Respite for Adoptive Parent
- Support Groups for Adoptive Families

Question 1: Have you ever utilized, provided or referred for Home-based Services?

1. Yes, I utilize these services.
2. No, I do not utilize these services and do not wish to answer any questions regarding them. Please take me to the next service category.
3. No, I do not utilize these services, but I would still like to answer questions regarding them.

Question 1 for each service category requires a response. If the respondent selected the response 2 (No, I do not utilize these services and do not wish to answer any questions regarding them), then they skipped the services questions within that service category and were taken directly to the next service category. If the respondent selected response 1 or 3, then they were asked to answer questions regarding each of the services that fall into that service category.

A. Is this service available in your county?

Not Available	Minimally Available	Available	Above Average Availability	Highly Available
---------------	---------------------	-----------	----------------------------	------------------

If the respondent replied with "not available" to Question A for any of the services, then they were asked the following question:

B. Is there a need for this service in your county?

Not Needed	Minimally Needed	Somewhat Needed	Needed	Highly Needed
------------	------------------	-----------------	--------	---------------

If the respondent replied "minimally available", "available", "above average availability", or "highly available" to Question A for any of the services, then they were asked the following question:

C. Please rate the quality of the service in your county.

Very Poor Quality	Poor Quality	Average Quality	Above Average Quality	Excellent Quality
-------------------	--------------	-----------------	-----------------------	-------------------

Service Category: Substance Abuse Services

- Drug Testing and Supplies

- Random Drug Testing
- Detoxification Services
- Residential Substance Use Treatment
- Substance Use Disorder Assessment
- Outpatient Substance Use Treatment
- Substance Abuse Programs for Youth
- Substance Abuse Programs for Adults
- Inpatient Substance Abuse Services for Youth
- Inpatient Substance Abuse Services for Adults

Question 1: Have you ever utilized, provided or referred for Substance Abuse Services?

1. Yes, I utilize these services.
2. No, I do not utilize these services and do not wish to answer any questions regarding them. Please take me to the next service category.
3. No, I do not utilize these services, but I would still like to answer questions regarding them.

Question 1 for each service category requires a response. If the respondent selected the response 2 (No, I do not utilize these services and do not wish to answer any questions regarding them), then they skipped the services questions within that service category and were taken directly to the next service category. If the respondent selected response 1 or 3, then they were asked to answer questions regarding each of the services that fall into that service category.

A. Is this service available in your county?

Not Available	Minimally Available	Available	Above Average Availability	Highly Available
---------------	---------------------	-----------	----------------------------	------------------

If the respondent replied with "not available" to Question A for any of the services, then they were asked the following question:

B. Is there a need for this service in your county?

Not Needed	Minimally Needed	Somewhat Needed	Needed	Highly Needed
------------	------------------	-----------------	--------	---------------

If the respondent replied "minimally available", "available", "above average availability", or "highly available" to Question A for any of the services, then they were asked the following question:

C. Please rate the quality of the service in your county.

Very Poor Quality	Poor Quality	Average Quality	Above Average Quality	Excellent Quality
-------------------	--------------	-----------------	-----------------------	-------------------

Service Category: Resource Family Services

- Resource Family Support Services
- Support Group Services for Resource Families
- Foster Home Studies/Updates
- Foster Family Recruitment
- Short-term Emergency Foster Care
- Foster Homes - Accept Multiple Siblings
- Respite Services for Foster Parents
- Support Services for Kinship Caregivers

Question 1: Have you ever utilized, provided or referred for Resource Family Services?

1. Yes, I utilize these services.

2. No, I do not utilize these services and do not wish to answer any questions regarding them. Please take me to the next service category.
3. No, I do not utilize these services, but I would still like to answer questions regarding them.

Question 1 for each service category requires a response. If the respondent selected the response 2 (No, I do not utilize these services and do not wish to answer any questions regarding them), then they skipped the services questions within that service category and were taken directly to the next service category. If the respondent selected response 1 or 3, then they were asked to answer questions regarding each of the services that fall into that service category.

A. Is this service available in your county?

Not Available	Minimally Available	Available	Above Average Availability	Highly Available
---------------	---------------------	-----------	----------------------------	------------------

If the respondent replied with "not available" to Question A for any of the services, then they were asked the following question:

B. Is there a need for this service in your county?

Not Needed	Minimally Needed	Somewhat Needed	Needed	Highly Needed
------------	------------------	-----------------	--------	---------------

If the respondent replied "minimally available", "available", "above average availability", or "highly available" to Question A for any of the services, then they were asked the following question:

C. Please rate the quality of the service in your county.

Very Poor Quality	Poor Quality	Average Quality	Above Average Quality	Excellent Quality
-------------------	--------------	-----------------	-----------------------	-------------------

Service Category: Mental Health Services

- Counseling
- D/E Services
- Domestic Violence - Batterers Intervention
- Domestic Violence - Survivor & Child
- Functional Family Therapy
- Sex Offender Treatment
- Day Reporting / Treatment Programs
- Inpatient Mental Health Treatment for Youth

Question 1: Have you ever utilized, provided or referred for Mental Health Services?

1. Yes, I utilize these services.
2. No, I do not utilize these services and do not wish to answer any questions regarding them. Please take me to the next service category.
3. No, I do not utilize these services, but I would still like to answer questions regarding them.

Question 1 for each service category requires a response. If the respondent selected the response 2 (No, I do not utilize these services and do not wish to answer any questions regarding them), then they skipped the services questions within that service category and were taken directly to the next service category. If the respondent selected response 1 or 3, then they were asked to answer questions regarding each of the services that fall into that service category.

A. Is this service available in your county?

Not Available	Minimally Available	Available	Above Average Availability	Highly Available
---------------	---------------------	-----------	----------------------------	------------------

If the respondent replied with “not available” to Question A for any of the services, then they were asked the following question:

B. Is there a need for this service in your county?

Not Needed	Minimally Needed	Somewhat Needed	Needed	Highly Needed
------------	------------------	-----------------	--------	---------------

If the respondent replied “minimally available”, “available”, “above average availability”, or “highly available” to Question A for any of the services, then they were asked the following question:

C. Please rate the quality of the service in your county.

Very Poor Quality	Poor Quality	Average Quality	Above Average Quality	Excellent Quality
-------------------	--------------	-----------------	-----------------------	-------------------

Service Category: Education Services

- Parent Education
- Tutoring / Literacy Classes
- Truancy Termination
- Sex Education / Teen Pregnancy Prevention
- Independent Living Skills Development
- Special Education
- Early Childhood Education / Preschool
- Educational Support Programs - Pregnant/Parent Teen
- Alternative Services to Suspension/Expulsion
- Post Secondary Education Planning Foster Youth
- Job Retraining / Employment Prep

Question 1: Have you ever utilized, provided or referred for Education Services?

1. Yes, I utilize these services.
2. No, I do not utilize these services and do not wish to answer any questions regarding them. Please take me to the next service category.
3. No, I do not utilize these services, but I would still like to answer questions regarding them.

Question 1 for each service category requires a response. If the respondent selected the response 2 (No, I do not utilize these services and do not wish to answer any questions regarding them), then they skipped the services questions within that service category and were taken directly to the next service category. If the respondent selected response 1 or 3, then they were asked to answer questions regarding each of the services that fall into that service category.

A. Is this service available in your county?

Not Available	Minimally Available	Available	Above Average Availability	Highly Available
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If the respondent replied with “not available” to Question A for any of the services, then they were asked the following question:

B. Is there a need for this service in your county?

Not Needed	Minimally Needed	Somewhat Needed	Needed	Highly Needed
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If the respondent replied “minimally available”, “available”, “above average availability”, or “highly available” to Question A for any of the services, then they were asked the following question:

C. Please rate the quality of the service in your county.

Very Poor Quality	Poor Quality	Average Quality	Above Average Quality	Excellent Quality
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Service Category: Housing and Placement Services

- Care Network
- Quality Assurance - Residential Placement
- Transition from Restrictive Placement
- Transitional/Supervised Living - Older Youth
- Group Home & Residential Care
- Shelter Care for Battered Women & Children
- Family Shelters for Homeless
- Shelter Services for Homeless/Runaway Youth
- Safe Affordable Low Income Housing

Question 1: Have you ever utilized, provided or referred for Housing and Placement Services?

1. Yes, I utilize these services.
2. No, I do not utilize these services and do not wish to answer any questions regarding them. Please take me to the next service category.
3. No, I do not utilize these services, but I would still like to answer questions regarding them.

Question 1 for each service category requires a response. If the respondent selected the response 2 (No, I do not utilize these services and do not wish to answer any questions regarding them), then they skipped the services questions within that service category and were taken directly to the next service category. If the respondent selected response 1 or 3, then they were asked to answer questions regarding each of the services that fall into that service category.

A. Is this service available in your county?

Not Available	Minimally Available	Available	Above Average Availability	Highly Available
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If the respondent replied with "not available" to Question A for any of the services, then they were asked the following question:

B. Is there a need for this service in your county?

Not Needed	Minimally Needed	Somewhat Needed	Needed	Highly Needed
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If the respondent replied "minimally available", "available", "above average availability", or "highly available" to Question A for any of the services, then they were asked the following question:

C. Please rate the quality of the service in your county.

Very Poor Quality	Poor Quality	Average Quality	Above Average Quality	Excellent Quality
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Service Category: Health and Monetary Services

- Affordable Child Day Care
- Low Income Health Services for Family
- Dental Care for Low Income Families
- Family Planning / Preg Counseling
- Food & Nutrition Resources
- Assistance with Clothing & Household Goods
- Emergency Financial Assistance

Question 1: Have you ever utilized, provided or referred for Health and Monetary Services?

1. Yes, I utilize these services.

2. No, I do not utilize these services and do not wish to answer any questions regarding them. Please take me to the next service category.
3. No, I do not utilize these services, but I would still like to answer questions regarding them.

Question 1 for each service category requires a response. If the respondent selected the response 2 (No, I do not utilize these services and do not wish to answer any questions regarding them), then they skipped the services questions within that service category and were taken directly to the next service category. If the respondent selected response 1 or 3, then they were asked to answer questions regarding each of the services that fall into that service category.

A. Is this service available in your county?

Not Available	Minimally Available	Available	Above Average Availability	Highly Available
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If the respondent replied with "not available" to Question A for any of the services, then they were asked the following question:

B. Is there a need for this service in your county?

Not Needed	Minimally Needed	Somewhat Needed	Needed	Highly Needed
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If the respondent replied "minimally available", "available", "above average availability", or "highly available" to Question A for any of the services, then they were asked the following question:

C. Please rate the quality of the service in your county.

Very Poor Quality	Poor Quality	Average Quality	Above Average Quality	Excellent Quality
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Service Category: General Services

- CHINS Parent Support Services
- Father Engagement Programs
- Parenting/Family Functioning Assessment
- Child Advocacy Center Services
- Adult/Child Mentoring Programs
- After School Recreational Opportunities
- Support Services for LGBTQ Youth
- Outreach Services for Diverse Individuals
- Programs for Parents in Divorce
- Early Child. Intervention/Id of Dvlpmntl Delays
- Transportation Services
- Gang Prevention Services
- Translation Services

Question 1: Have you ever utilized, provided or referred for General Services?

1. Yes, I utilize these services.
2. No, I do not utilize these services and do not wish to answer any questions regarding them. Please take me to the next service category.
3. No, I do not utilize these services, but I would still like to answer questions regarding them.

Question 1 for each service category requires a response. If the respondent selected the response 2 (No, I do not utilize these services and do not wish to answer any questions regarding them), then they skipped the services questions within that service category and were taken directly to the next service

category. If the respondent selected response 1 or 3, then they were asked to answer questions regarding each of the services that fall into that service category.

A. Is this service available in your county?

Not Available	Minimally Available	Available	Above Average Availability	Highly Available
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If the respondent replied with "not available" to Question A for any of the services, then they were asked the following question:

B. Is there a need for this service in your county?

Not Needed	Minimally Needed	Somewhat Needed	Needed	Highly Needed
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If the respondent replied "minimally available", "available", "above average availability", or "highly available" to Question A for any of the services, then they were asked the following question:

C. Please rate the quality of the service in your county.

Very Poor Quality	Poor Quality	Average Quality	Above Average Quality	Excellent Quality
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2011 Needs Assessment Survey Results
Region 12 - Detailed Results
All Counties

Role	Region 12		Statewide	
	N	%	N	%
Court Staff	5	5.7%	187	7.7%
Department of Child Services Staff	46	52.3%	972	39.8%
Educational Staff	8	9.1%	323	13.2%
Foster Parent	11	12.5%	201	8.2%
Law Enforcement	1	1.1%	57	2.3%
Other	4	4.5%	124	5.1%
Probation	2	2.3%	133	5.4%
Residential Staff	1	1.1%	41	1.7%
Service Provider	10	11.4%	404	16.5%
Grand Total	88	100.0%	2442	100.0%

AVAILABILITY

Adoption Services	N	Avg Score	Highly Avail.		Above Avg		Average		Minimal		Not Avail.		(Skip)
Child Prep	39	2.6	1	2.6%	2	5.1%	21	53.8%	12	30.8%	3	7.7%	49
Family Prep Home Study	38	2.9	3	7.9%	6	15.8%	20	52.6%	4	10.5%	5	13.2%	50
Respite for Adoptive Parent	39	2.7	1	2.6%	1	2.6%	26	66.7%	6	15.4%	5	12.8%	49
Support Groups for Adoptive Families	39	2.1	0	0.0%	2	5.1%	10	25.6%	16	41.0%	11	28.2%	49
Adoptive Parent Recruitment	40	2.8	2	5.0%	4	10.0%	20	50.0%	10	25.0%	4	10.0%	48
Matching Adoptive Parents w/ children	39	2.7	1	2.6%	4	10.3%	21	53.8%	10	25.6%	3	7.7%	49
Post Adoption Home Based Therapy	37	2.5	0	0.0%	5	13.5%	12	32.4%	16	43.2%	4	10.8%	51

Home-based Services	N	Avg Score	Highly Avail.		Above Avg		Average		Minimal		Not Avail.		(Skip)
Home-based Family Centered Casework	73	3.3	8	11.0%	15	20.5%	39	53.4%	10	13.7%	1	1.4%	15
Home-based Family Centered Therapy	71	3.2	6	8.5%	11	15.5%	43	60.6%	11	15.5%	0	0.0%	17
Home-based Youth Services, 0-5, no DCS involvement	70	2.6	4	5.7%	2	2.9%	34	48.6%	23	32.9%	7	10.0%	18
Home-based Youth Services, 6-18, no DCS involvement	72	2.7	4	5.6%	7	9.7%	34	47.2%	19	26.4%	8	11.1%	16
Homemaker/Parent Aid	72	2.1	1	1.4%	1	1.4%	26	36.1%	23	31.9%	21	29.2%	16

Substance Abuse Services	N	Avg Score	Highly Avail.		Above Avg		Average		Minimal		Not Avail.		(Skip)
Drug Testing and Supplies	61	2.7	3	4.9%	6	9.8%	22	36.1%	27	44.3%	3	4.9%	27
Random Drug Testing	61	2.7	2	3.3%	7	11.5%	29	47.5%	19	31.1%	4	6.6%	27
Detoxification Services	60	1.4	0	0.0%	0	0.0%	5	8.3%	16	26.7%	39	65.0%	28
Residential Substance Use Treatment	61	1.4	1	1.6%	0	0.0%	3	4.9%	17	27.9%	40	65.6%	27
Substance Use Disorder Assessment	61	2.5	2	3.3%	3	4.9%	24	39.3%	28	45.9%	4	6.6%	27
Outpatient Substance Use Treatment	61	2.4	2	3.3%	2	3.3%	17	27.9%	37	60.7%	3	4.9%	27
Substance Abuse Programs for Youth	61	1.9	0	0.0%	1	1.6%	7	11.5%	35	57.4%	18	29.5%	27
Substance Abuse Programs for Adults	60	2.3	2	3.3%	2	3.3%	11	18.3%	40	66.7%	5	8.3%	28
Inpatient Substance Abuse Services for Youth	60	1.4	1	1.7%	0	0.0%	2	3.3%	14	23.3%	43	71.7%	28
Inpatient Substance Abuse Services for Adults	60	1.4	0	0.0%	1	1.7%	2	3.3%	15	25.0%	42	70.0%	28

Resource Family Services	N	Avg Score	Highly Avail.		Above Avg		Average		Minimal		Not Avail.		(Skip)
Resource Family Support Services	53	3.0	2	3.8%	12	22.6%	24	45.3%	14	26.4%	1	1.9%	35
Support Group Services for Resource Families	51	2.5	0	0.0%	6	11.8%	22	43.1%	16	31.4%	7	13.7%	37
Foster Home Studies/Updates	52	3.0	4	7.7%	8	15.4%	27	51.9%	11	21.2%	2	3.8%	36
Foster Family Recruitment	51	2.8	2	3.9%	5	9.8%	28	54.9%	13	25.5%	3	5.9%	37
Short-term Emergency Foster Care	53	2.8	2	3.8%	5	9.4%	32	60.4%	11	20.8%	3	5.7%	35
Foster Homes - Accept Multiple Siblings	52	2.8	0	0.0%	9	17.3%	24	46.2%	19	36.5%	0	0.0%	36
Respite Services for Foster Parents	53	2.7	2	3.8%	6	11.3%	23	43.4%	20	37.7%	2	3.8%	35
Support Services for Kinship Caregivers	51	2.4	2	3.9%	2	3.9%	18	35.3%	23	45.1%	6	11.8%	37

Mental Health Services	N	Avg Score	Highly Avail.		Above Avg		Average		Minimal		Not Avail.		(Skip)
Counseling	67	3.1	8	11.9%	5	7.5%	40	59.7%	12	17.9%	2	3.0%	21
Diagnostic and Evaluation Services	66	2.7	2	3.0%	5	7.6%	33	50.0%	25	37.9%	1	1.5%	22
Functional Family Therapy	66	2.7	2	3.0%	4	6.1%	34	51.5%	21	31.8%	5	7.6%	22
Sex Offender Treatment	65	1.8	1	1.5%	2	3.1%	8	12.3%	26	40.0%	28	43.1%	23
Day Reporting / Treatment Programs	63	2.0	0	0.0%	2	3.2%	17	27.0%	23	36.5%	21	33.3%	25
Inpatient Mental Health Treatment for Youth	65	1.8	0	0.0%	2	3.1%	12	18.5%	19	29.2%	32	49.2%	23
Domestic Violence - Batterers Intervention	65	2.1	1	1.5%	3	4.6%	14	21.5%	32	49.2%	15	23.1%	23
Domestic Violence - Survivor & Child	64	2.2	0	0.0%	4	6.3%	15	23.4%	36	56.3%	9	14.1%	24

Education Services	N	Avg Score	Highly Avail.		Above Avg		Average		Minimal		Not Avail.		(Skip)
Parent Education	47	2.5	0	0.0%	3	6.4%	21	44.7%	20	42.6%	3	6.4%	41
Tutoring / Literacy Classes	0		0		0		0		0		0		88
Sex Education / Teen Preg. Prevention	0		0		0		0		0		0		88
Independent Living Skills Development	47	2.9	3	6.4%	5	10.6%	22	46.8%	16	34.0%	1	2.1%	41
Truancy Termination	44	1.6	0	0.0%	0	0.0%	8	18.2%	11	25.0%	25	56.8%	44
Early Childhood Education / Preschool	47	3.0	3	6.4%	7	14.9%	26	55.3%	10	21.3%	1	2.1%	41
Special Education	46	3.2	4	8.7%	6	13.0%	32	69.6%	3	6.5%	1	2.2%	42
Educational Support Prgms - Preg/Parent Teen	45	2.3	0	0.0%	2	4.4%	16	35.6%	19	42.2%	8	17.8%	43
Alternative Services to Suspension/Expulsion	47	2.3	0	0.0%	3	6.4%	18	38.3%	18	38.3%	8	17.0%	41
Post Secondary Education Planning Foster Youth	45	2.6	1	2.2%	1	2.2%	25	55.6%	15	33.3%	3	6.7%	43
Job Retraining / Employment Prep	45	2.3	0	0.0%	0	0.0%	20	44.4%	19	42.2%	6	13.3%	43

Housing and Placement Services	N	Avg Score	Highly Avail.		Above Avg		Average		Minimal		Not Avail.		(Skip)
Care Network	43	1.8	1	2.3%	0	0.0%	9	20.9%	11	25.6%	22	51.2%	45
Cross-System Care Coordination	42	2.0	0	0.0%	1	2.4%	12	28.6%	14	33.3%	15	35.7%	46
Quality Assurance - Residential Placement	41	2.1	1	2.4%	2	4.9%	10	24.4%	14	34.1%	14	34.1%	47
Transition from Restrictive Placement	40	2.1	2	5.0%	1	2.5%	9	22.5%	16	40.0%	12	30.0%	48
Visitation Facilitation Services	42	2.9	6	14.3%	3	7.1%	16	38.1%	14	33.3%	3	7.1%	46
Transitional/Supervised Living - Older Youth	41	1.8	1	2.4%	1	2.4%	6	14.6%	12	29.3%	21	51.2%	47
Group Home & Residential Care	39	2.1	1	2.6%	3	7.7%	10	25.6%	11	28.2%	14	35.9%	49
Shelter Care for Battered Women & Children	41	2.0	2	4.9%	0	0.0%	9	22.0%	14	34.1%	16	39.0%	47
Family Shelters for Homeless	41	1.6	0	0.0%	1	2.4%	3	7.3%	15	36.6%	22	53.7%	47
Shelter Services for Homeless/Runaway Youth	41	1.4	0	0.0%	0	0.0%	3	7.3%	10	24.4%	28	68.3%	47
Safe Affordable Low Income Housing	42	2.5	0	0.0%	1	2.4%	19	45.2%	22	52.4%	0	0.0%	46

Health & Monetary Services	N	Avg Score	Highly Avail.		Above Avg		Average		Minimal		Not Avail.		(Skip)
Affordable Child Day Care	50	2.4	0	0.0%	1	2.0%	20	40.0%	26	52.0%	3	6.0%	38
Low Income Health Services for Family	50	2.3	0	0.0%	2	4.0%	14	28.0%	30	60.0%	4	8.0%	38
Dental Care for Low Income Families	50	1.7	0	0.0%	0	0.0%	7	14.0%	19	38.0%	24	48.0%	38
Family Planning / Preg Counseling	49	2.3	0	0.0%	2	4.1%	19	38.8%	21	42.9%	7	14.3%	39
Food & Nutrition Resources	50	2.8	1	2.0%	5	10.0%	28	56.0%	14	28.0%	2	4.0%	38
Assistance with Clothing & Household Goods	50	2.6	0	0.0%	6	12.0%	22	44.0%	20	40.0%	2	4.0%	38
Emergency Financial Assistance	49	2.2	0	0.0%	1	2.0%	10	20.4%	35	71.4%	3	6.1%	39

General Services	N	Avg Score	Highly Avail.		Above Avg		Average		Minimal		Not Avail.		(Skip)
CHINS Parent Support Services	51	2.1	0	0.0%	3	5.9%	19	37.3%	9	17.6%	20	39.2%	37
Father Engagement Programs	50	2.4	2	4.0%	2	4.0%	15	30.0%	24	48.0%	7	14.0%	38
Parenting/Family Functioning Assessment	49	2.4	0	0.0%	2	4.1%	22	44.9%	18	36.7%	7	14.3%	39
Child Advocacy Center Services	50	1.9	0	0.0%	4	8.0%	11	22.0%	12	24.0%	23	46.0%	38
Adult/Child Mentoring Programs	48	1.9	0	0.0%	0	0.0%	13	27.1%	18	37.5%	17	35.4%	40
After School Recreational Opportunities	50	2.1	1	2.0%	2	4.0%	15	30.0%	17	34.0%	15	30.0%	38
Support Services for LGBTQ Youth	48	1.3	0	0.0%	0	0.0%	3	6.3%	6	12.5%	39	81.3%	40
Outreach Services for Diverse Individuals	48	1.4	0	0.0%	0	0.0%	4	8.3%	12	25.0%	32	66.7%	40
Programs for Parents in Divorce	48	2.0	0	0.0%	1	2.1%	12	25.0%	20	41.7%	15	31.3%	40
Early Child. Intervention/ld of Dvlpmntl Delays	50	2.7	0	0.0%	6	12.0%	29	58.0%	10	20.0%	5	10.0%	38
Transportation Services	51	2.5	2	3.9%	2	3.9%	17	33.3%	26	51.0%	4	7.8%	37
Gang Prevention Services	50	1.2	0	0.0%	0	0.0%	1	2.0%	10	20.0%	39	78.0%	38
Translation Services	49	1.7	0	0.0%	0	0.0%	4	8.2%	26	53.1%	19	38.8%	39

NEED

Adoption Services	N	Avg Score	Highly Needed		Needed		Somewhat		Minimally		Not Needed		(Skip)
Child Prep	3	3.0	0	0.0%	2	66.7%	0	0.0%	0	0.0%	1	33.3%	85
Family Prep Home Study	5	3.4	1	20.0%	2	40.0%	1	20.0%	0	0.0%	1	20.0%	83
Respite for Adoptive Parent	5	2.4	0	0.0%	1	20.0%	2	40.0%	0	0.0%	2	40.0%	83
Support Groups for Adoptive Families	11	2.8	1	9.1%	2	18.2%	3	27.3%	4	36.4%	1	9.1%	77
Adoptive Parent Recruitment	4	4.0	1	25.0%	2	50.0%	1	25.0%	0	0.0%	0	0.0%	84
Matching Adoptive Parents w/ children	3	3.3	0	0.0%	2	66.7%	0	0.0%	1	33.3%	0	0.0%	85
Post Adoption Home Based Therapy	4	4.5	3	75.0%	0	0.0%	1	25.0%	0	0.0%	0	0.0%	84

Home-based Services	N	Avg Score	Highly Needed		Needed		Somewhat		Minimally		Not Needed		(Skip)
Home-based Family Centered Casework	1	3.0	0	0.0%	0	0.0%	1	100.0%	0	0.0%	0	0.0%	87
Home-based Family Centered Therapy	0		0		0		0		0		0		88
Home-based Youth Services, 0-5, no DCS involvement	9	3.3	1	11.1%	5	55.6%	0	0.0%	2	22.2%	1	11.1%	79
Home-based Youth Services, 6-18, no DCS involvement	8	3.5	2	25.0%	3	37.5%	1	12.5%	1	12.5%	1	12.5%	80
Homemaker/Parent Aid	21	2.4	1	4.8%	5	23.8%	4	19.0%	2	9.5%	9	42.9%	67

Substance Abuse Services	N	Avg Score	Highly Needed	Needed	Somewhat	Minimally	Not Needed	(Skip)
Drug Testing and Supplies	4	4.3	1 25.0%	3 75.0%	0 0.0%	0 0.0%	0 0.0%	84
Random Drug Testing	4	3.5	1 25.0%	2 50.0%	0 0.0%	0 0.0%	1 25.0%	84
Detoxification Services	40	4.5	25 62.5%	11 27.5%	4 10.0%	0 0.0%	0 0.0%	48
Residential Substance Use Treatment	40	4.5	26 65.0%	8 20.0%	6 15.0%	0 0.0%	0 0.0%	48
Substance Use Disorder Assessment	4	5.0	4 100.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	84
Outpatient Substance Use Treatment	3	5.0	3 100.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	85
Substance Abuse Programs for Youth	18	4.2	8 44.4%	6 33.3%	3 16.7%	1 5.6%	0 0.0%	70
Substance Abuse Programs for Adults	5	4.8	4 80.0%	1 20.0%	0 0.0%	0 0.0%	0 0.0%	83
Inpatient Substance Abuse Services for Youth	43	3.7	11 25.6%	12 27.9%	15 34.9%	5 11.6%	0 0.0%	45
Inpatient Substance Abuse Services for Adults	42	4.5	27 64.3%	8 19.0%	7 16.7%	0 0.0%	0 0.0%	46

Resource Family Services	N	Avg Score	Highly Needed	Needed	Somewhat	Minimally	Not Needed	(Skip)
Resource Family Support Services	1	4.0	0 0.0%	1 100.0%	0 0.0%	0 0.0%	0 0.0%	87
Support Group Services for Resource Families	8	3.5	0 0.0%	5 62.5%	2 25.0%	1 12.5%	0 0.0%	80
Foster Home Studies/Updates	3	2.7	0 0.0%	1 33.3%	1 33.3%	0 0.0%	1 33.3%	85
Foster Family Recruitment	4	4.0	1 25.0%	2 50.0%	1 25.0%	0 0.0%	0 0.0%	84
Short-term Emergency Foster Care	3	3.7	0 0.0%	2 66.7%	1 33.3%	0 0.0%	0 0.0%	85
Foster Homes - Accept Multiple Siblings	1	4.0	0 0.0%	1 100.0%	0 0.0%	0 0.0%	0 0.0%	87
Respite Services for Foster Parents	2	2.5	0 0.0%	1 50.0%	0 0.0%	0 0.0%	1 50.0%	86
Support Services for Kinship Caregivers	6	4.7	4 66.7%	2 33.3%	0 0.0%	0 0.0%	0 0.0%	82

Mental Health Services	N	Avg Score	Highly Needed	Needed	Somewhat	Minimally	Not Needed	(Skip)
Counseling	2	4.5	1 50.0%	1 50.0%	0 0.0%	0 0.0%	0 0.0%	86
Diagnostic and Evaluation Services	2	4.5	1 50.0%	1 50.0%	0 0.0%	0 0.0%	0 0.0%	86
Functional Family Therapy	6	4.3	2 33.3%	4 66.7%	0 0.0%	0 0.0%	0 0.0%	82
Sex Offender Treatment	29	3.4	3 10.3%	11 37.9%	10 34.5%	4 13.8%	1 3.4%	59
Day Reporting / Treatment Programs	22	3.4	2 9.1%	9 40.9%	7 31.8%	3 13.6%	1 4.5%	66
Inpatient Mental Health Treatment for Youth	33	3.4	4 12.1%	11 33.3%	12 36.4%	6 18.2%	0 0.0%	55
Domestic Violence - Batterers Intervention	15	4.1	5 33.3%	6 40.0%	4 26.7%	0 0.0%	0 0.0%	73
Domestic Violence - Survivor & Child	9	3.4	1 11.1%	3 33.3%	4 44.4%	1 11.1%	0 0.0%	79

Education Services	N	Avg Score	Highly Needed	Needed	Somewhat	Minimally	Not Needed	(Skip)
Parent Education	3	4.7	2 66.7%	1 33.3%	0 0.0%	0 0.0%	0 0.0%	85
Tutoring / Literacy Classes	0		0	0	0	0	0	88
Sex Education / Teen Preg. Prevention	0		0	0	0	0	0	88
Independent Living Skills Development	2	4.0	0 0.0%	2 100.0%	0 0.0%	0 0.0%	0 0.0%	86
Truancy Termination	27	3.4	6 22.2%	10 37.0%	2 7.4%	8 29.6%	1 3.7%	61
Early Childhood Education / Preschool	2	4.0	0 0.0%	2 100.0%	0 0.0%	0 0.0%	0 0.0%	86
Special Education	1	4.0	0 0.0%	1 100.0%	0 0.0%	0 0.0%	0 0.0%	87
Educational Support Prgms - Preg/Parent Teen	9	3.4	2 22.2%	1 11.1%	5 55.6%	1 11.1%	0 0.0%	79
Alternative Services to Suspension/Expulsion	8	4.1	3 37.5%	4 50.0%	0 0.0%	1 12.5%	0 0.0%	80
Post Secondary Education Planning Foster Youth	4	4.0	1 25.0%	2 50.0%	1 25.0%	0 0.0%	0 0.0%	84
Job Retraining / Employment Prep	7	4.3	3 42.9%	3 42.9%	1 14.3%	0 0.0%	0 0.0%	81

Housing and Placement Services	N	Avg Score	Highly Needed	Needed	Somewhat	Minimally	Not Needed	(Skip)
Care Network	22	3.3	2 9.1%	8 36.4%	7 31.8%	5 22.7%	0 0.0%	66
Cross-System Care Coordination	14	3.4	1 7.1%	8 57.1%	2 14.3%	2 14.3%	1 7.1%	74
Quality Assurance - Residential Placement	14	2.7	2 14.3%	1 7.1%	5 35.7%	3 21.4%	3 21.4%	74
Transition from Restrictive Placement	14	2.4	0 0.0%	1 7.1%	7 50.0%	2 14.3%	4 28.6%	74
Visitation Facilitation Services	3	2.7	0 0.0%	1 33.3%	1 33.3%	0 0.0%	1 33.3%	85
Transitional/Supervised Living - Older Youth	22	3.5	7 31.8%	5 22.7%	4 18.2%	5 22.7%	1 4.5%	66
Group Home & Residential Care	16	2.8	1 6.3%	3 18.8%	6 37.5%	4 25.0%	2 12.5%	72
Shelter Care for Battered Women & Children	17	3.9	4 23.5%	9 52.9%	3 17.6%	1 5.9%	0 0.0%	71
Family Shelters for Homeless	23	3.5	4 17.4%	9 39.1%	5 21.7%	5 21.7%	0 0.0%	65
Shelter Services for Homeless/Runaway Youth	29	3.2	6 20.7%	4 13.8%	9 31.0%	9 31.0%	1 3.4%	59
Safe Affordable Low Income Housing	0		0	0	0	0	0	88

Health & Monetary Services	N	Avg Score	Highly Needed	Needed	Somewhat	Minimally	Not Needed	(Skip)
Affordable Child Day Care	3	5.0	3 100.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	85
Low Income Health Services for Family	4	4.5	2 50.0%	2 50.0%	0 0.0%	0 0.0%	0 0.0%	84
Dental Care for Low Income Families	24	4.2	9 37.5%	11 45.8%	3 12.5%	1 4.2%	0 0.0%	64
Family Planning / Preg Counseling	8	4.0	3 37.5%	2 25.0%	3 37.5%	0 0.0%	0 0.0%	80
Food & Nutrition Resources	2	3.5	1 50.0%	0 0.0%	0 0.0%	1 50.0%	0 0.0%	86
Assistance with Clothing & Household Goods	2	5.0	2 100.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	86
Emergency Financial Assistance	4	4.0	2 50.0%	1 25.0%	0 0.0%	1 25.0%	0 0.0%	84

General Services	N	Avg Score	Highly Needed		Needed		Somewhat		Minimally		Not Needed		(Skip)
CHINS Parent Support Services	20	2.9	3	15.0%	2	10.0%	7	35.0%	6	30.0%	2	10.0%	68
Father Engagement Programs	8	3.3	0	0.0%	3	37.5%	4	50.0%	1	12.5%	0	0.0%	80
Parenting/Family Functioning Assessment	9	3.8	2	22.2%	3	33.3%	4	44.4%	0	0.0%	0	0.0%	79
Child Advocacy Center Services	25	3.4	4	16.0%	9	36.0%	7	28.0%	4	16.0%	1	4.0%	63
Adult/Child Mentoring Programs	19	4.2	9	47.4%	7	36.8%	1	5.3%	2	10.5%	0	0.0%	69
After School Recreational Opportunities	15	4.3	8	53.3%	4	26.7%	3	20.0%	0	0.0%	0	0.0%	73
Support Services for LGBTQ Youth	40	2.7	1	2.5%	5	12.5%	18	45.0%	11	27.5%	5	12.5%	48
Outreach Services for Diverse Individuals	33	2.6	2	6.1%	3	9.1%	11	33.3%	13	39.4%	4	12.1%	55
Programs for Parents in Divorce	16	3.6	3	18.8%	6	37.5%	4	25.0%	3	18.8%	0	0.0%	72
Early Child. Intervention/Id of Dvlpmntl Delays	6	3.5	1	16.7%	3	50.0%	0	0.0%	2	33.3%	0	0.0%	82
Transportation Services	3	4.3	2	66.7%	0	0.0%	1	33.3%	0	0.0%	0	0.0%	85
Gang Prevention Services	40	2.0	1	2.5%	1	2.5%	8	20.0%	17	42.5%	13	32.5%	48
Translation Services	19	2.2	0	0.0%	2	10.5%	3	15.8%	11	57.9%	3	15.8%	69

QUALITY

Adoption Services	N	Avg Score	Excellent		Above Avg		Average		Poor		Very Poor		(Skip)
Child Prep	35	3.0	0	0.0%	4	11.4%	27	77.1%	4	11.4%	0	0.0%	53
Family Prep Home Study	33	3.3	2	6.1%	8	24.2%	22	66.7%	1	3.0%	0	0.0%	55
Respite for Adoptive Parent	34	3.0	0	0.0%	3	8.8%	28	82.4%	3	8.8%	0	0.0%	54
Support Groups for Adoptive Families	28	2.9	0	0.0%	1	3.6%	22	78.6%	5	17.9%	0	0.0%	60
Adoptive Parent Recruitment	35	3.0	1	2.9%	3	8.6%	27	77.1%	4	11.4%	0	0.0%	53
Matching Adoptive Parents w/ children	36	3.2	2	5.6%	5	13.9%	26	72.2%	3	8.3%	0	0.0%	52
Post Adoption Home Based Therapy	33	2.8	0	0.0%	2	6.1%	22	66.7%	9	27.3%	0	0.0%	55

Home-based Services	N	Avg Score	Excellent		Above Avg		Average		Poor		Very Poor		(Skip)
Home-based Family Centered Casework	71	3.2	4	5.6%	16	22.5%	44	62.0%	6	8.5%	1	1.4%	17
Home-based Family Centered Therapy	71	3.2	3	4.2%	16	22.5%	48	67.6%	3	4.2%	1	1.4%	17
Home-based Youth Services, 0-5, no DCS involvement	63	3.0	2	3.2%	7	11.1%	46	73.0%	7	11.1%	1	1.6%	25
Home-based Youth Services, 6-18, no DCS involvement	64	3.0	1	1.6%	9	14.1%	45	70.3%	8	12.5%	1	1.6%	24
Homemaker/Parent Aid	50	3.0	1	2.0%	2	4.0%	42	84.0%	4	8.0%	1	2.0%	38

Substance Abuse Services	N	Avg Score	Excellent		Above Avg		Average		Poor		Very Poor		(Skip)
Drug Testing and Supplies	59	2.9	2	3.4%	8	13.6%	30	50.8%	18	30.5%	1	1.7%	29
Random Drug Testing	58	2.9	2	3.4%	5	8.6%	38	65.5%	12	20.7%	1	1.7%	30
Detoxification Services	25	2.6	1	4.0%	0	0.0%	15	60.0%	6	24.0%	3	12.0%	63
Residential Substance Use Treatment	21	2.8	1	4.8%	0	0.0%	13	61.9%	7	33.3%	0	0.0%	67
Substance Use Disorder Assessment	58	2.8	2	3.4%	1	1.7%	41	70.7%	14	24.1%	0	0.0%	30
Outpatient Substance Use Treatment	59	2.6	1	1.7%	4	6.8%	31	52.5%	19	32.2%	4	6.8%	29
Substance Abuse Programs for Youth	44	2.7	1	2.3%	1	2.3%	24	54.5%	18	40.9%	0	0.0%	44
Substance Abuse Programs for Adults	54	2.7	2	3.7%	2	3.7%	31	57.4%	17	31.5%	2	3.7%	34
Inpatient Substance Abuse Services for Youth	19	2.6	0	0.0%	1	5.3%	9	47.4%	9	47.4%	0	0.0%	69
Inpatient Substance Abuse Services for Adults	18	2.4	0	0.0%	0	0.0%	8	44.4%	9	50.0%	1	5.6%	70

Resource Family Services	N	Avg Score	Excellent		Above Avg		Average		Poor		Very Poor		(Skip)
Resource Family Support Services	52	3.1	2	3.8%	8	15.4%	37	71.2%	4	7.7%	1	1.9%	36
Support Group Services for Resource Families	44	3.1	0	0.0%	8	18.2%	33	75.0%	2	4.5%	1	2.3%	44
Foster Home Studies/Updates	50	3.3	3	6.0%	11	22.0%	35	70.0%	0	0.0%	1	2.0%	38
Foster Family Recruitment	51	2.8	2	3.9%	5	9.8%	28	54.9%	13	25.5%	3	5.9%	37
Short-term Emergency Foster Care	50	3.3	1	2.0%	11	22.0%	38	76.0%	0	0.0%	0	0.0%	38
Foster Homes - Accept Multiple Siblings	51	3.3	1	2.0%	12	23.5%	38	74.5%	0	0.0%	0	0.0%	37
Respite Services for Foster Parents	50	3.2	2	4.0%	9	18.0%	36	72.0%	3	6.0%	0	0.0%	38
Support Services for Kinship Caregivers	45	3.0	2	4.4%	2	4.4%	35	77.8%	5	11.1%	1	2.2%	43

Mental Health Services	N	Avg Score	Excellent		Above Avg		Average		Poor		Very Poor		(Skip)
Counseling	65	3.0	3	4.6%	10	15.4%	39	60.0%	10	15.4%	3	4.6%	23
Diagnostic and Evaluation Services	64	2.9	3	4.7%	4	6.3%	41	64.1%	14	21.9%	2	3.1%	24
Functional Family Therapy	61	3.0	1	1.6%	8	13.1%	41	67.2%	10	16.4%	1	1.6%	27
Sex Offender Treatment	37	3.0	1	2.7%	4	10.8%	27	73.0%	5	13.5%	0	0.0%	51
Day Reporting / Treatment Programs	42	2.9	1	2.4%	0	0.0%	35	83.3%	6	14.3%	0	0.0%	46
Inpatient Mental Health Treatment for Youth	33	2.7	0	0.0%	1	3.0%	22	66.7%	10	30.3%	0	0.0%	55
Domestic Violence - Batterers Intervention	49	2.9	1	2.0%	5	10.2%	31	63.3%	10	20.4%	2	4.1%	39
Domestic Violence - Survivor & Child	54	2.8	0	0.0%	5	9.3%	36	66.7%	11	20.4%	2	3.7%	34

Education Services	N	Avg Score	Excellent		Above Avg		Average		Poor		Very Poor		(Skip)
Parent Education	44	2.9	0	0.0%	3	6.8%	34	77.3%	6	13.6%	1	2.3%	44
Tutoring / Literacy Classes	0		0		0		0		0		0		88
Sex Education / Teen Preg. Prevention	0		0		0		0		0		0		88
Independent Living Skills Development	46	3.0	2	4.3%	6	13.0%	28	60.9%	8	17.4%	2	4.3%	42
Truancy Termination	19	2.8	0	0.0%	0	0.0%	16	84.2%	2	10.5%	1	5.3%	69
Early Childhood Education / Preschool	46	3.3	1	2.2%	13	28.3%	29	63.0%	3	6.5%	0	0.0%	42
Special Education	46	3.1	1	2.2%	9	19.6%	32	69.6%	3	6.5%	1	2.2%	42
Educational Support Prgms - Preg/Parent Teen	36	3.0	1	2.8%	4	11.1%	27	75.0%	3	8.3%	1	2.8%	52
Alternative Services to Suspension/Expulsion	39	2.8	1	2.6%	3	7.7%	24	61.5%	10	25.6%	1	2.6%	49
Post Secondary Education Planning Foster Youth	42	3.0	1	2.4%	3	7.1%	33	78.6%	5	11.9%	0	0.0%	46
Job Retraining / Employment Prep	39	2.7	0	0.0%	1	2.6%	29	74.4%	5	12.8%	4	10.3%	49

Housing and Placement Services	N	Avg Score	Excellent		Above Avg		Average		Poor		Very Poor		(Skip)
Care Network	22	2.9	1	4.5%	0	0.0%	16	72.7%	5	22.7%	0	0.0%	66
Cross-System Care Coordination	28	2.7	0	0.0%	1	3.6%	19	67.9%	7	25.0%	1	3.6%	60
Quality Assurance - Residential Placement	27	2.9	1	3.7%	2	7.4%	19	70.4%	4	14.8%	1	3.7%	61
Transition from Restrictive Placement	28	3.0	2	7.1%	1	3.6%	21	75.0%	3	10.7%	1	3.6%	60
Visitation Facilitation Services	39	3.2	3	7.7%	7	17.9%	23	59.0%	5	12.8%	1	2.6%	49
Transitional/Supervised Living - Older Youth	19	2.9	0	0.0%	0	0.0%	18	94.7%	1	5.3%	0	0.0%	69
Group Home & Residential Care	25	3.0	1	4.0%	3	12.0%	16	64.0%	4	16.0%	1	4.0%	63
Shelter Care for Battered Women & Children	25	3.0	2	8.0%	3	12.0%	13	52.0%	7	28.0%	0	0.0%	63
Family Shelters for Homeless	19	2.7	0	0.0%	3	15.8%	9	47.4%	6	31.6%	1	5.3%	69
Shelter Services for Homeless/Runaway Youth	12	3.0	1	8.3%	1	8.3%	7	58.3%	3	25.0%	0	0.0%	76
Safe Affordable Low Income Housing	42	2.7	0	0.0%	2	4.8%	27	64.3%	11	26.2%	2	4.8%	46

Health & Monetary Services	N	Avg Score	Excellent		Above Avg		Average		Poor		Very Poor		(Skip)
Affordable Child Day Care	47	2.9	1	2.1%	2	4.3%	38	80.9%	5	10.6%	1	2.1%	41
Low Income Health Services for Family	46	2.9	0	0.0%	5	10.9%	30	65.2%	11	23.9%	0	0.0%	42
Dental Care for Low Income Families	26	2.8	0	0.0%	0	0.0%	22	84.6%	4	15.4%	0	0.0%	62
Family Planning / Preg Counseling	42	3.0	1	2.4%	3	7.1%	33	78.6%	5	11.9%	0	0.0%	46
Food & Nutrition Resources	48	3.2	2	4.2%	7	14.6%	37	77.1%	2	4.2%	0	0.0%	40
Assistance with Clothing & Household Goods	48	3.0	1	2.1%	3	6.3%	39	81.3%	5	10.4%	0	0.0%	40
Emergency Financial Assistance	46	2.8	0	0.0%	4	8.7%	30	65.2%	11	23.9%	1	2.2%	42

General Services	N	Avg Score	Excellent		Above Avg		Average		Poor		Very Poor		(Skip)
CHINS Parent Support Services	31	3.0	0	0.0%	3	9.7%	25	80.6%	2	6.5%	1	3.2%	57
Father Engagement Programs	43	3.1	2	4.7%	7	16.3%	30	69.8%	2	4.7%	2	4.7%	45
Parenting/Family Functioning Assessment	43	2.9	0	0.0%	2	4.7%	35	81.4%	5	11.6%	1	2.3%	45
Child Advocacy Center Services	27	2.9	0	0.0%	1	3.7%	22	81.5%	3	11.1%	1	3.7%	61
Adult/Child Mentoring Programs	32	2.9	0	0.0%	1	3.1%	27	84.4%	4	12.5%	0	0.0%	56
After School Recreational Opportunities	34	3.1	0	0.0%	5	14.7%	28	82.4%	1	2.9%	0	0.0%	54
Support Services for LGBTQ Youth	8	3.0	0	0.0%	0	0.0%	8	100.0%	0	0.0%	0	0.0%	80
Outreach Services for Diverse Individuals	16	2.8	0	0.0%	0	0.0%	13	81.3%	3	18.8%	0	0.0%	72
Programs for Parents in Divorce	32	2.9	0	0.0%	1	3.1%	28	87.5%	2	6.3%	1	3.1%	56
Early Child. Intervention/Id of Dvlpmntl Delays	45	3.1	1	2.2%	7	15.6%	34	75.6%	3	6.7%	0	0.0%	43
Transportation Services	48	2.9	1	2.1%	4	8.3%	33	68.8%	9	18.8%	1	2.1%	40
Gang Prevention Services	10	2.5	0	0.0%	0	0.0%	6	60.0%	3	30.0%	1	10.0%	78
Translation Services	32	3.0	0	0.0%	5	15.6%	23	71.9%	4	12.5%	0	0.0%	56

Appendix D

Fiscal

Historical Spending Trends

Below is a listing of available funding sources utilized for service delivery.

Federal Funding Source	Objective of Funding Source
Title IV-B Part II: Promoting Safe and Stable Families Number: 93.556	To fund family preservation that serve families at risk or in crisis, including the following services: reunification and adoption services, pre-placement/preventive services, follow-up services after return of a child from foster care, respite care, services designed to improve parenting skills; and infant safe haven programs; to fund community-based family support services that promote the safety and well-being of children and families, to afford children a safe, stable and supportive family environment, to strengthen parental relationships and promote healthy marriages, and otherwise to enhance child development; to fund time-limited family reunification services to facilitate the reunification of the child safely and appropriately within a timely fashion; and to fund adoption promotion and support services designed to encourage more adoptions out of the foster care system, when adoption, promotes the best interests of the child. In addition, a portion of funds also is reserved in FY 2008 - FY 2011 for a separate formula grant for States and territories to support monthly caseworker visits with children who are in foster care. A small proportion of appropriated funds is reserved for research, evaluation and technical assistance, which may be awarded competitively through contracts or discretionary grants.

Federal Funding Source	Objective of Funding Source
Community-Based Child Abuse Prevention Grants Number: 93.590	To assist States to support community-based efforts to develop, operate, expand, and enhance, and where appropriate to network, initiatives aimed at the prevention of child abuse and neglect.
Child Welfare Services State Grants (Title IV-B Part I) Number: 93.645	The purpose of the Stephanie Tubbs Jones Child Welfare Services program is to promote State flexibility in the development and expansion of a coordinated child and family services program that utilizes community-based agencies and ensures all children are raised in safe, loving families.
Chafee Education and Training Vouchers Program (ETV) Chafee Education and Training Vouchers ETV Number: 93.599	To provide resources to States to make available vouchers for post-secondary training and education, to youths who have aged out of foster care or who have been adopted or left for Kinship guardianship from the public foster care system after age 16.
Chafee Foster Care Independence Program CFCIP Number: 93.674	To assist States and localities in establishing and carrying out programs designed to assist foster youth likely to remain in foster care until 18 years of age and youth who have left foster care because they attained 18 years of age, have not yet attained 21 years of age, to make the transition from foster care to self-sufficiency.

<p>Social Services Block Grant</p> <p>SSBG Program</p> <p>Number: 93.667</p>	<p>To enable each State to furnish social services best suited to the needs of the individuals residing in the State. Federal block grant funds may be used to provide services directed toward one of the following five goals specified in the law: (1) To prevent, reduce, or eliminate dependency; (2) to achieve or maintain self-sufficiency; (3) to prevent neglect, abuse, or exploitation of children and adults; (4) to prevent or reduce inappropriate institutional care; and (5) to secure admission or referral for institutional care when other forms of care are not appropriate. In addition, special funding was provided to some states in fiscal year 1995 and 1996 for supplemental SSBG grants in support comprehensive of community revitalization projects in 104 federally designated Empowerment Zones (EZs) and Enterprise Communities (ECs). The supplemental funding is called "EZ/EC SSBG." The States, through the designated localities, may use the EZ/EC SSBG funds for activities included in each locality's strategic plan for comprehensive revitalization and directed toward goals 1,2 or 3 listed above. These funds will remain available until December 21, 2004. Information about this component of the SSBG is included below as appropriate.</p>
<p>State Funding</p>	<p>Objective of Funding Source</p>
<p>Foster Care Title IV-E</p> <p>Number: 93.658</p>	<p>The Title IV-E Foster Care program helps States provide safe and stable out-of-home care for children under the jurisdiction of the State child welfare agency until the children are returned home safely; placed with adoptive families, or placed in other planned arrangements for permanency. The program provides funds to States to assist with the costs of foster care maintenance for eligible children; administrative costs to manage the program; and training for the State agency staff, foster parents and certain private agency staff. In addition, \$3 million is reserved for technical assistance and plan development/implementation grants to eligible Tribes beginning in FY 09.</p>

Youth Services Bureau (YSB)	<p>Youth Service Bureaus are funded with state funds for the purpose of providing administrative support to those bureaus that deliver services aimed at the prevention of juvenile delinquency. The primary statutory purpose is to provide information and referral to youth and their families, delinquency prevention, community education, and advocacy for youth. There is at least one YSB in every DCS region of the state. For more information, go to the website:</p>
State Funding	Objective of Funding Source
Project Safe Place	<p>Project Safe Place is funded with state funds for the purpose of providing a community outreach network that delivers emergency services, temporary shelter, and counseling for troubled youth in crisis situations. The triangular signs found in business establishments throughout the state that say "Safe Place" is provided through the efforts of this funding. These signs let youth in crisis know that this is a safe place to ask for help. Staff working in these businesses are trained to assist in offering appropriate referral to these youth.</p>
Child Welfare Funding	<p>Child Welfare Funding is state funds for the purpose of providing primary or secondary prevention services to reduce abuse and/or neglect.</p>
Kids First Trust Fund	<p>The Kids First Trust Fund is a fund whose capital is generated by public contribution through the purchase of a Kids First License plate, a portion of the divorce filing fees, and private contributions. The purpose of this fund is to support statewide child abuse prevention efforts. To make a contribution or to learn more about the fund, go to the website:</p>
Family and Children Fund	<p>Funding provided by the state for out-of-home care expenses as well as the cost of services to the child in need of services and/or delinquent child and their families.</p>