Department for Children and Families

Placement Service Standards Manual

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CHAPTER 1: INTRODUCTION

The Department for Children and Families (DCF) is designated as the State of Kansas child welfare agency. DCF focuses on child protection and strengthening families by working to reduce the number of children in care and providing needed services for the most vulnerable Kansans. DCF provides these services throughout its six regions and 38 offices across the state. DCF commits to providing quality services in the most efficient manner, while emphasizing the programs and projects that move DCF toward its objectives. Targeted work within communities has established a network of public and private partnerships, allowing DCF to support Kansans in need throughout the state, regardless of resource allocation. The agency commits to continually evaluating processes to ensure growth and improvement, enhance productivity and efficiency, and align all work to its mission: protect children, promote healthy families and encourage personal responsibility. DCF is dedicated to strengthening families, safely reducing the number of children in care, promoting employment, exercising responsible stewardship of public resources and building public and private partnerships.

Children with adverse childhood occurrences such as abuse, neglect, and removal from their family will have lasting complex trauma reactions and experiences. DCF is committed to providing child and family focused trauma-informed services. Placement services are expected to demonstrate this commitment by ensuring these services are delivered. Foster Care is a service for children and families. The goal of this work is to form cohesive partnerships with birth families, so they are supported and empowered in a manner that expands their own capacity to provide and care for their children.

The Secretary of DCF is responsible for ensuring children in state custody are safe, have their needs met and have permanent, legal connections to family. While children remain in out-of-home placement, DCF and its partners seek to provide safe family foster homes that encourage and support permanency. The priorities per state and federal law and best practice is placing children with relatives, keeping siblings together, ensuring placements minimize trauma and are conducive to support children's cultural, spiritual, academic and emotional development.

The Prevention and Protection Services (PPS) Placement Service Standards Manual was developed to provide general requirements and procedural information for all placement providers.

CHAPTER 2: FAMILY FOSTER HOME DESCRIPTIONS

All facilities and foster homes shall follow the guidelines outlined in K.S.A. 38-2202, "Reasonable and Prudent Parenting Standard", "means the standard characterized by careful and sensible parental decisions that maintain the health, safety and best interests of a child while at the same time encouraging the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in FC under the responsibility of the state to participate in extracurricular, enrichment, cultural and social activities."

A foster home is a family home in which 24-hour care is provided to children and youth in need of out-of-home placement to meet their safety and well-being needs. The foster home shall comply with all DCF Licensing regulations and be sponsored by a licensed child placing agency (CPA). The foster family is an integral part of the team working with the child or youth and their family to achieve timely permanency.

Practice Note: The descriptions below are modeled after the DCF Rate Structure guide and are to be used merely as a means to help match the most prepared FFH with the child/youth needing placement. These descriptions are to be used as general guidance, and all workers are encouraged to keep in mind the complex nature of humans forming relationships, particularly in terms of children and youth who come from hard places.

LEVELS OF SERVICE (LEVEL OF CARE/LOC):

Description of the Basic Family Foster Home (Basic 1)

A Basic-1 service level family foster home provides 24-hour care for youth to meet their safety and well-being needs. DCF Licensing regulations require at least eight hours of training annually per foster parent.

Basic 1 Service Level consists of a supportive family-setting, which is designed to maintain and/or improve the child's development and functioning, including:

- Routine guidance and supervision to ensure the child's safety and sense of security;
- Affection, reassurance, and involvement in activities appropriate to the child's age and development to promote the child's well-being (prudent parenting);
- Understanding of appropriate developmental and trauma-induced reactions to stressors and utilization of insightful, sensitive ways to address these reactions that creates a safe, nurturing, and trusting environment for the child;
- A shared parenting approach that promotes connections and contact, in a manner that is deemed in the best interest of the child, with family members and other persons significant to the child allowing the child to maintain a sense of identity and culture; and

- Ongoing access to trauma-sensitive therapeutic, habilitative, and/or medical intervention and guidance from professionals or paraprofessionals, on an as-needed basis, to help the child maintain or improve functioning appropriate to the child's chronological and developmental age.

Typically, children and youth qualifying for this level of care score low on the Client Assessment/Level of Care tool the CMP has identified to use in determining need of services. For example, a child who would qualify at this level of care has none or few school concerns, does not use any substances, demonstrates minimal if any verbal or physical aggression and has minimal or well-managed mental health needs.

Basic Level 2 and 3

A Basic Level 2 and/or 3 family foster home provides 24-hour care for children and youth to meet their safety and well-being needs. In addition, family foster parents may be required to complete additional training hours to meet the special needs of the children and youth placed in the home as deemed needed and warranted by the sponsoring CPA. Documentation of these additional training hours shall be kept in the family foster parent's file. The purpose of the additional training and continuing education is to provide opportunities for the family foster parent to increase their knowledge, skill and parenting abilities. The sponsoring agency for the FFH may determine a family's prior work experience, history of taking foster placements, and other relevant life experience into account when assessing for skills and abilities in meeting the needs of youth at these rate levels.

Description of the Basic 2 Service Level

The Basic 2 Level consists of a structured supportive setting, preferably in a family, in which most activities are designed to maintain and/or improve the child's development and functioning including:

- More than routine guidance and supervision to ensure the child's safety and sense of security;
- Affection, reassurance, and involvement in structured activities appropriate to the child's developmental age and trauma exposure to promote the child's well-being. Principles of prudent parenting should also be applied.
- Understanding of appropriate developmental and trauma-induced reactions to stressors and utilization of insightful, sensitive ways to address these reactions that creates a safe, nurturing, and trusting environment for the child;
- A shared parenting approach that promotes connections and contact, in a manner that is deemed in the best interest of the child, with family members and other persons significant to the child to maintain a sense of identity and culture; and
- Ongoing access to trauma-sensitive therapeutic, habilitative, and/or medical intervention and guidance from professionals or paraprofessionals to help the child attain or maintain functioning appropriate to the child's chronological and developmental age.

Caregivers shall demonstrate a commitment and capacity to continue to acquire and hone skills needed to consistently meet and attune to the needs of children who have ongoing complex needs.

Children and youth qualifying for Basic 2 LOC will typically fall in the low to moderate range on the Client Assessment/Level of Care tool the CMP has identified to use. For example, a child who would qualify at this level of care will have a few school concerns, may possibly use a substance, demonstrates more use of verbal or physical aggression and has increased mental health needs which are still manageable.

Description of the Basic 3 Service Level

The Basic 3 Service Level consists of a more intentional, trauma informed approach to caregiving, preferably in a family, in which caregivers have specialized training to provide behavioral health, connections, therapeutic, habilitative, and/or medical support and interventions including:

- 24-hour supervision to ensure the child's safety and sense of security, which may include close monitoring and increased measures to ensure complex developmental needs of the child are met in a consistent manner;
- Affection, reassurance, and involvement in trauma sensitive/informed therapeutic activities appropriate to the child's developmental age to promote the child's well-being. Principles of prudent parenting should also be applied;
- A shared parenting approach that promotes connections and contact, in a manner that is deemed in the best interest of the child, with family members and other persons significant to the child to maintain a sense of identity and culture; and
- Ongoing access to and regular involvement with trauma sensitive/informed therapeutic, habilitative, and/or medical intervention and guidance that are regularly scheduled and professionally designed and supervised to help the child attain/improve functioning appropriate to the child's chronological and developmental age.

In addition to the description in the section above, a child with primary medical and/or habilitative needs may require more regular interventions from their caregiver. Caregivers shall demonstrate a commitment and capacity to continue to acquire and hone skills needed to consistently meet and attune to the needs of children who have ongoing complex needs.

Children and youth qualifying for Basic 3 LOC will typically fall in the moderate to high range on the Client Assessment/Level of Care tool the CMP has identified to use. For example, a child who would qualify at this level of care will have more school concerns, may possibly use a substance, demonstrate more use of verbal or physical aggression and has increased mental health needs which are still able to be managed.

INTENSIVE FAMILY FOSTER HOME (INTENSIVE 1 & INTENSIVE 2)

Intensive-level family foster homes provide 24-hour care for children and youth to meet their safety and well-being needs. Intensive family foster parents are required to complete more annual training hours than basic and basic level 2 and 3 family foster parents due to the acute needs of the children and youth who may be placed in the home. FFH's providing care to this level of children shall have at a minimum five (5) additional training hours annually. The FFH's sponsoring agency may substitute comparable life/work experience, if applicable. (i.e., One of the parent's is employed at a PRTF facility and receives annual training through work.) Documentation of additional training hours shall be kept in the intensive family foster parent's file. If the agency is allowing the FFH to substitute work experience in place of annual training hours, the agency shall document how the FFH's experience/strengths pertain to their ability to serve children and youth at these levels. The purpose of training is to provide opportunities for the intensive family foster parent to greatly increase their knowledge, skill and parenting abilities. Placement in an intensive family foster home may serve as a support for the child or youth—allowing them to function in a setting outside of a hospital or residential setting or prevent the need for placement in a hospital or residential setting. The training requirements between Intensive Level 1 and 2 are not differentiated; rather, individualized to each FFH and the youth they are able to serve.

Description of the Intensive 1 Service Level

The Intensive 1 Service Level consists of a high degree of structure, preferably in a family, to limit the child's access to environments as necessary to protect the child. The caregivers have specialized training to provide intense therapeutic and/or habilitative supports and interventions. The child may have limited outside access, including:

- 24-hour supervision to ensure the child's safety and sense of security, which includes frequent one-to-one monitoring with the ability to provide immediate on-site response.
- Affection, reassurance, and involvement in therapeutic activities appropriate to the child's age and development to promote the child's well-being. Principles of prudent parenting apply.
- Shared parenting approach that promotes connections and contact, in a manner that is deemed in the best interest of the child, with family members and other persons significant to the child to maintain a sense of identity and culture; and
- Ongoing access to trauma sensitive/informed therapeutic, habilitative, and/or medical intervention and guidance that are regularly scheduled and professionally designed and supervised to help the child attain functioning appropriate to the child's age and development.
- Consistent and frequent attention, direction, and assistance to help the child attain stabilization and connect appropriately with the child's environment.

In addition to the supports and interventions listed in the section above:

- Children with intellectual or developmental disabilities needs require professionally directed, designed and monitored interventions to enhance mobility, communication, sensory, motor, and cognitive development, and self-help skills.
- Children with primary medical or habilitative needs require frequent and consistent interventions. The child may be dependent on people or technology for accommodation and require interventions designed, monitored, or approved by an appropriately constituted interdisciplinary team.

In summary, children and youth qualifying for Intensive Level 1 LOC will typically fall in the lower end of the intensive level range on the Client Assessment/Level of Care tool the CMP has identified to use. These children and youth for example may exhibit higher rates of learning struggles, moderate to severe verbal and physical aggression, demonstrate some sexualized behaviors, have more than one mental health diagnosis or may have legal issues due to trauma histories.

Description of the Intensive 2 Service Level

The Intensive 2 Service Level consists of a high degree of structure to support the child in his or her environment while intervening as necessary to protect the child. The caregivers have highly specialized training specific to each child's unique trauma-induced characteristics. Involved therapists have professional licensure or graduate level education to provide therapeutic services, intense therapeutic supports and interventions, including:

- 24-hour supervision to ensure the child's safety and sense of security, including constant one-to-one monitoring during waking hours by an employee trained on the child's therapeutic interventions and able to provide immediate on-site response.
- Participation in individual and group therapy sessions that are research-supported, evidence-based and reimbursable by Medicaid, and readily available in the community. These may include but are not limited to specialized therapies such as Eye Movement Desensitization and Reprocessing Therapy, Applied Behavior Analysis (certified), Treatment for Anorexia/Bulimia/Eating Disorders, and others as appropriate.
- Use of therapeutic programs that are documented as either well supported, promising practice or evidence based and are appropriate to the child's chronological and developmental age to promote the child's well-being. Therapy must address trauma and the behaviors resulting in the need for this level of care.
- Shared parenting approach that promotes connections and contact, in a manner that is deemed in the best interest of the child, with family members and other persons significant to the child to maintain a sense of identity and culture; and
- Services to help the child learn or improve skills and functioning for daily living.
- Medical intervention and/or therapy that is structured daily, and professionally designed and supervised to help the child attain functioning more appropriate to the child's chronological and developmental age and to address the behaviors resulting in the need for this level of care.
- Consistent and constant direction, intervention, and structured support to help the child attain stabilization and connect appropriately with the child's environment.

- Professionally directed, designed, and monitored interventions for a child with intellectual or developmental disabilities, to enhance mobility, communication, sensory, motor, cognitive development, behavioral and self-help skills.

In summary, children and youth qualifying for Intensive Level 2 LOC will typically fall in the highest range of the intensive level range on the Client Assessment/Level of Care tool the CMP has identified to use. These children and youth may exhibit high rates of learning struggles, moderate to severe verbal and physical aggression, demonstrate sexualized behaviors, have multiple mental health diagnosis and utilize several medications or may have legal issues due to trauma histories. Medically fragile children may also score at this level.

HCBS WAIVER FAMILY FOSTER HOME (HCBS – I/DD)

Home and Community Based Services (HCBS) family foster homes provide 24-hour care for children and youth to meet their safety and well-being needs. HCBS family foster homes may provide care for children and youth, with disabilities, eligible for HCBS waiver services. HCBS family foster parents are required to be trained and equipped to meet the extraordinary needs of the children and youth who may be placed in the home. Kansas Department for Aging and Disability Services (KDADS) provides oversight of the HCBS waiver programs. Services to the child or youth are provided according to the service and support plans.

RELATIVE & NON-RELATED KIN (NRKIN) PLACEMENTS

Relative Foster Home

A relative foster home provides 24-hour care in the home of a person related to the child or youth. Clearances and home assessments must be completed, per DCF policy. With approval, relatives may provide care to the related child or youth as a non-licensed relative home. Relatives also have the option to become a licensed foster home. Relatives pursuing licensure as a family foster home must meet and comply with all DCF Licensing requirements and be sponsored by a licensed CPA. A relative may request a waiver to non-safety regulations; PSMAPP/DT waiver allows the relative to complete this training as the annual training hours following the initial licensing period.

NON-RELATED KIN FOSTER HOME (NRKIN)

NRKIN foster homes provide 24-hour care in the home of an adult with whom the child/youth or the child/youth's parent already has close emotional ties. Clearances and home assessments must be completed, per DCF policy. NRKIN foster homes must meet and comply with all DCF Licensing requirements. However, to expedite placement of the child or youth with NRKIN, the requirement to complete pre-service training—prior to placement—is waived. Application for licensure shall be submitted within 14 days of placement. NRKIN homes must initiate the application process to become licensed as a family foster home.

CHAPTER 3: ALL FAMILY FOSTER HOMES

All facilities and foster homes shall follow the guidelines outlined in K.S.A. 38-2202, "Reasonable and Prudent Parenting Standard", "means the standard characterized by careful and sensible parental decisions that maintain the health, safety and best interests of a child while at the same time encouraging the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in FC under the responsibility of the state to participate in extracurricular, enrichment, cultural and social activities."

GENERAL PROGRAM REQUIREMENTS

Licensed family foster homes shall comply with all DCF Licensing regulations and be sponsored by a licensed child placing agency (CPA). The foster family is an integral part of the team working with the child or children and their family to achieve timely permanency.

FAMILY FOSTER PARENT TRAINING

Each family foster parent is required to comply with licensing regulations and the requirements of the sponsoring agency regarding pre-licensing and ongoing/annual training hours. Documentation of the training hours shall be kept in the family foster parent's file.

Ongoing/annual training is required to ensure family foster parents receive instruction to support their parenting roles and the level of care provided to children and youth in care. This training may include, but is not limited to, the following content areas:

- Impact of childhood trauma, brain development
- Managing child behaviors
- First aid, blood borne pathogens, CPR, medications
- Importance of maintaining meaningful connections between the child and parents
- Shared parenting
- Reasonable and Prudent Parenting
- Separation issues, grief and loss
- Attachment, attachment issues and disorders
- Constructive problem solving
- Communication skills
- Health, Home safety
- Human sexuality
- Cultural diversity
- Post-Traumatic Stress Disorder or other mental disorders

- Child development
- Specific topics related to youth with special needs
- Sensory Processing Disorders
- Fetal Alcohol Spectrum Disorders and other early substance exposures
- Trauma and the impact on adolescence
- LGBTQIA+ topics
- Self-Care

CRITERIA FOR ADMISSION

- Relatives and NRKIN shall be given placement preference and consideration
- Child Welfare Case Management Provider (CMP) will use the placement screening/assessment tool(s) approved by their agency to determine the most appropriate, least restrictive out-of-home placement setting
- Family foster parents must be properly trained, equipped and supported to provide the level of care necessary and meet the needs of each child or youth placed in the home
- A placement agreement shall be completed between the family foster parents and the sponsoring CPA

SCOPE OF SERVICES PROVIDED IN A FAMILY FOSTER HOME

DCF requires foster parents to apply the reasonable and prudent parenting standard. This standard is characterized by careful and sensible parental decisions that maintain a child's health, safety and best interests while at the same time encouraging the child's emotional and developmental growth that a caregiver must use when determining whether to allow a child in foster care to participate in extracurricular, enrichment, cultural, and social activities.

As part of this standard, it is recognized hair and skin care are an integral to self-worth of children, youth and young adults. Cultural identities of children and youth should be considered and honored, through a variety of activities related to hair and skin care. CPAs shall ensure licensed family foster homes have access to and knowledge of local and online resources for professional hair and skin care, as well as offer continuing education or training opportunities for caregivers on these topics. Furthermore, CPAs shall encourage and facilitate licensed family foster homes to consult with the child, youth, parents or other relatives/kin connections regarding preferences, tools and hygiene products recommended, processes, and supports for meeting the child's individual needs surrounding these matters.

All services to be provided shall be respectful of social and cultural differences and sensitive to the child's trauma history. Services provided in a family foster home include supervision, food, shelter, age-appropriate daily living skills instruction, transportation, recreation,

supporting parent/child visits (when appropriate), participation in development and review of case plan tasks and objectives.

- **Supervision–** Adequate supervision will be provided by the foster parent or another appropriate caregiver, during the foster parent's absence, based on the child's age, maturity and need.
- **Food and Shelter–** Nutritious meals and snacks will be provided. The foster home will meet the child's health and safety needs according to the DCF Licensing regulations.
- **Daily Living Skills Instruction–** Age-appropriate daily living skills instruction will be provided in such areas as: personal hygiene, laundry, meal preparation, shopping, cleaning, money management and health.
- **Transportation–** Transportation will be provided to school, medical appointments and day-to-day activities. The foster family will coordinate with the CMP to transport the child to visits with parents and siblings, case planning conferences, court hearings and reviews, etc.
- **Recreation–** Opportunities for recreation and for individual, school and community activities consistent with daily life of the family will be provided.
- **Supporting Parent/Child Interactions–** Foster parents will coordinate with the CMP for the scheduled parent/child visits directed in the youth's case plan. Foster parents may choose to make their home available for some of these visits or accompany the youth to the site for the visits.
- **Participation in Development and Review of Case Plan Tasks and Objectives–** Family foster parents are an integral part of the child's case planning team and are to actively participate in the development and review of the plan. Foster parents may provide a written report to the court using PPS Policy and Procedure Manual Appendix 3G: Foster Parent Report to Court.

http://www.dcf.ks.gov/services/PPS/Pages/Appendices.aspx

- **Supporting Permanency–** Foster parents will be a support to the youth's birth family, relative or adoptive family identified as the youth's planned permanency resource. Foster parents are expected to fully participate in Icebreaker conversations, as requested.

http://www.dcf.ks.gov/services/PPS/Documents/PPM_Forms/Appendices/Append ix_5A.pdf

EDUCATION OF CHILDREN AND YOUTH IN FOSTER CARE

Family foster parents are responsible to ensure school-aged children and youth attend school regularly, as required by Kansas statute. The school must be accredited by the Kansas State Department of Education. The Child Welfare Case Management Provider staff, the child's parents and the family foster parents will help the child in care achieve the highest level of education the child is capable of completing. If the child is not able to attend school due to illness or appointment, the family foster parent is responsible for proper notification of the absence to the child's school. The family foster parent shall also communicate with the

school regarding the student's academic progress and develop plans to address issues related to school performance.

RIGHTS OF CHILDREN AND YOUTH IN FOSTER CARE

Family foster parents shall help safeguard the rights of youth in care. Family foster parents shall also help ensure youth in care are aware of all their rights identified in DCF PPM Appendix 7D Kansas Foster Youth Rights Brochure. It is advised the brochure be accessed through the DCFs website for the most up to date policies, forms and appendices, such as through the link below.

HTTP://WWW.DCF.KS.GOV/SERVICES/PPS/DOCUMENTS/PPM_FORMS/APPENDICES/APPENDIX_7D.PDF

DISCIPLINE AND PROHIBITED PUNISHMENTS

Family foster parents are expected to fully comply with K.A.R. 28-4-815 and PPM 0290 Policy on Discipline. Discipline means positive methods of behavior management, including instruction, redirection and de-escalation techniques. Family foster parents shall ensure that positive methods used for behavior management are appropriate to the age and developmental level of the child or youth and encourage cooperation, self-direction and independence. If time-out is used to manage behavior, the child shall remain in time-out in accordance with the child's age and developmental level and only long enough to regain self-control. For each child or youth in care who is not able to develop self-control or self-management, behavior management techniques shall be approved, in writing, by the case planning team.

Prohibited punishments include, but are not limited to:

- Physical discipline, including hitting with the hand or any object, yanking arms or pulling hair, excessive exercise, exposure to extreme temperatures
- Punishment that is humiliating, frightening or physically harmful
- Restricting movement by tying or binding
- Confining in a closet, box, or locked area
- Withholding food, rest or toilet use
- Mental and emotional cruelty, including verbal abuse, derogatory statements about a child in care of the child's family or threats to expel the child from the home
- Placing soap, or any other substance that stings, burns or has a bitter taste, in the child's mouth or on the tongue or any other part of the child's body
- Refusing the child access to the family foster home
- Physical restraints

RECORD KEEPING

K.A.R. 28-4-808. Recordkeeping requirements; confidentiality. Each licensee shall ensure that all records pertaining to the licensure and operation of the family foster home, including the records specified within this regulation, are kept at the family foster home and are accessible to the secretary and the sponsoring child-placing agency.

YOUTH'S FILE

The family foster home shall maintain a file for each child and youth in placement. This file shall contain the following information:

- Child's name and date of birth
- Name and address of the referring agency case manager/PPS Practitioner
- Placement Agreement or Client Service Agreement (for child placed by DCF staff)
- Medical and surgical consents
- Medical and dental records
- Record of child's prescription and non-prescription medications and when administered
- Authorization for release of confidential information
- Records of critical/significant incident reports

CHILD MONTHLY REPORTS

The Child Monthly Report is completed by the sponsoring agency with information and input from the family foster home and the child or youth in care. The monthly progress reports shall document the child's adjustment in the home, school performance, medical, dental, vision and mental health appointments, critical/significant incidents reported, interactions with parents and any other significant events or issues related to the child and the family foster home. This will be documented on the "Monthly Progress Report Form" to be provided by the CMP. The Monthly Progress Report Form should reflect the child's activity during the calendar month.

The Monthly Progress Report Form shall be submitted to each child's provider no later than the 15th of each month following the reporting month, for all children who are in placement more than 15 nights of that calendar month.

Submission will be accepted by e-mail to:

- Cornerstones of Care: KSmonthlyprogressreports@Cornerstonesofcare.org
- KVC: KVCMonthlyReports@KVC.org
- St. Francis Ministries: MonthlyProgressReports@st-francis.org
- TFI: MonthlyReports@TFIFamily.org

PLACEMENT TRANSITION

All family foster homes are expected to work as a team with the CMP and the sponsoring agency to maintain placement stability for children and youth in care. When a disruption in placement is necessary, the family foster home is expected to provide adequate notice per policy and State Statue.

When a child exits a family foster home to return home or move to a new placement, the entirety of the child's belongings and records shall accompany the child. The family foster home shall assist with the transfer of the child's medications, medical supplies and medical equipment. The family foster home shall also communicate and share information about the ordinary and special needs/care of the child.

CHAPTER 4: INTENSIVE FAMILY FOSTER HOMES

All facilities and foster homes shall follow the guidelines outlined in K.S.A. 38-2202, "Reasonable and Prudent Parenting Standard", "means the standard characterized by careful and sensible parental decisions that maintain the health, safety and best interests of a child while at the same time encouraging the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in FC under the responsibility of the state to participate in extracurricular, enrichment, cultural and social activities."

Intensive 1 & 2 family foster homes provide 24-hour care for children and youth to meet their safety and well-being needs. Intensive family foster parents are required to complete more annual training hours than basic 1, 2, or 3 family foster parents due to the acute needs of the children and youth who may be placed in the home. Please see the previous section for more information on this matter. The purpose of training is to provide opportunities for the intensive family foster parent to greatly increase their knowledge, skill and parenting abilities. Placement in an intensive family foster home serves as a support for the child—allowing the child to function in a setting outside of a hospital or residential setting or prevent the need for placement in a hospital or residential setting.

Specific goals of intensive family foster home placements may include:

- Stabilizing and improving the psychological, interpersonal and social functioning of the child in care
- Reducing unplanned placement changes
- Increasing the child's ability to live safely in a family-based setting, attend school and be successful in an inclusive community environment
- Increasing the likelihood of legal permanency through reunification, adoption or permanent custodianship
- Increasing the child's capacity for independent living and transition to adulthood

GENERAL PROGRAM REQUIREMENTS

All family foster homes shall comply with DCF Licensing regulations and be sponsored by a licensed child placing agency (CPA). The foster family is an integral part of the team working with the child and the child's family to achieve timely permanency.

Placement in an intensive family foster home is much more than simply the provision of higher payment foster parents to care for children with more or higher needs. The purpose is to improve the safety, permanency and well-being of the child in care. The care provided by an intensive family foster home should help the child reach their optimal level of functioning and maintain stability in the least restrictive, family-based placement.

In addition to the standards applicable to all family foster homes in Chapter 5, additional standards—specific to intensive family foster homes—will be detailed in this chapter. If language or requirements appear to be in conflict, the standards and procedures in Chapter 5 are superseded by the more stringent standards and procedures in Chapter 6.

Because intensive family foster homes provide such a high level of care, the sponsoring CPA shall provide extensive support, technical assistance and supervision. It is recommended CPA staff supporting intensive family foster homes complete Trauma Informed Partnering for Safety and Permanence – Model Approach to Partnerships in Parenting (TIPS-MAPP) training. CPA services and supports to intensive family foster homes shall be available on an ongoing and on-demand basis. Respite care for the intensive family foster parents shall also be available and may be recommended.

As a service and support to the intensive family foster home, in-person consultation with the family foster parents and the child shall be provided by the sponsoring agency as-needed, but at a minimum of one time each week during the first month of placement of the child.

In accordance with K.A.R. 28-4-174 the supervising worker shall see the child a minimum of biweekly in the first three months of placement and monthly thereafter.

It is recognized at times long-standing foster parents may not need or desire such intensive in-person support during the initial month of placement. Thus, if the child or youth's Case Manager is in agreement, the CPA may instead provide support and contact through other means, such as phone calls, text messages or other methods each week during the initial first month of placement. Other means of support and contact shall be engaging, meaningful and supportive in nature (i.e. not a simple "how are you?" text message). The exception for this reduction of in-person contact shall be documented on the worker's logs, along with details of the other means of contact. Additionally, in person contact shall not be less than the minimum twice per month standard for this level of foster care service. Should at any time the worker feels the family is struggling and needs more support during the initial month of placement, contact should resume to weekly in-person contact to ensure support and placement stability.

INTENSIVE FAMILY FOSTER PARENT TRAINING

Providing this increased level of service requires an increased level of knowledge and skill. As noted previously, training hours must be relevant to serving children and youth requiring a high level of care. This includes any training specific to providing care for a child or youth currently placed in the home such as specialized medical, psychological or parenting training. Please see previous section(s) for more information regarding this matter.

Best Practice Note: Only experienced family foster parents who demonstrate considerable capacity and skill should be sponsored as intensive family foster parents.

CRITERIA FOR ADMISSION

As with all placement decisions, placement in an intensive family foster home should be in the best interests of the child. Children who are immediately dangerous to themselves or others shall not be placed in an intensive family foster home.

As noted in previous section(s), children placed in an intensive family foster home require a high level of care and are typically at risk of placement in a residential program or congregate care facility. Children in these circumstances generally require a high degree of supervision and service.

Some children may exhibit well established patterns of behavior or conduct which are antisocial, oppositional, defiant, aggressive or impulsive. Others may require additional care related to special medical needs or developmental delays. Children may exhibit significant interpersonal and relationship problems, substance use, sexually inappropriate behaviors, running away, destruction of property or poorly developed communication skills. Children placed in an intensive family foster home may have a history of placements in psychiatric facilities, residential treatment programs or congregate care.

Placement in an intensive family foster home should be made in consultation with the sponsoring agency, whenever possible. Special care should be taken when placing children in an intensive family foster home. The needs of the child, the capacity of the family foster home and the composition of any other children in the home, should be considered prior to placement.

SCOPE OF SERVICES PROVIDED IN AN INTENSIVE FAMILY FOSTER HOME

In general, children and youth in need of an intense level of care will require a higher degree of daily supervision, guidance and instruction. Intensive family foster homes are expected to provide additional services to support children and youth placed in the home. To do so, intensive family foster parents must have a comprehensive understanding of the child's needs and permanency plan.

Intensive family foster parents need experience navigating multiple service systems. Children and youth needing a high degree of supervision and care often require extensive professional and community-based services to manage behavior. Intensive family foster homes are expected to work with the CMP to help coordinate these services. Intensive family foster parents may be expected to help initiate services for the child, provide transportation to numerous appointments and monitor the child's progress through regular communication with service providers. Intensive family foster parents are expected to

participate in the development and review of any treatment, behavioral or educational plans. Some children require psychotropic medication to help facilitate control of impulses and emotions. Intensive family foster parents will be expected to ensure medication is taken as prescribed and to communicate compliance, observations and side effects as requested.

If the case plan goal is reunification, adoption or custodianship, intensive family foster parents are expected to invite/welcome the child's parents/caregivers or prospective parents/caregivers to participate in the child's services and care.

CHAPTER 5: RESIDENTIAL FACILITY AGREEMENT

All facilities and foster homes shall follow the guidelines outlined in K.S.A. 38-2202, "Reasonable and Prudent Parenting Standard", "means the standard characterized by careful and sensible parental decisions that maintain the health, safety and best interests of a child while at the same time encouraging the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in FC under the responsibility of the state to participate in extracurricular, enrichment, cultural and social activities."

In order to obtain an agreement with the Department for Children and Families (DCF), all Residential/Group Home facilities shall be licensed by DCF Licensing and meet the DCF/PPS Placement Service Standards. Implementing a new facility or modifying an agreement for an existing facility requires an onsite review conducted by DCF regional staff. Residential facilities may initiate the process by contacting their DCF regional office.

The list of the Regional Specialists is located at:

http://www.dcf.ks.gov/services/PPS/Documents/Contract%20Information/ProviderAgreement_Services.pdf

STEPS FOR IMPLEMENTING AN AGREEMENT:

1. Contact by the prospective provider, via phone or email, shall be made to the appropriate regional office.
2. DCF will determine need of the region and discuss history of the prospective provider (previous contact, previous denial, PPS history, etc.).
3. If given approval to move forward, DCF will send the Prospective Provider a Prospective Provider Letter and a copy of the Placement Service Standards.
4. The Prospective Provider shall submit a business plan. DCF will approve or deny the business plan.
5. Technical assistance throughout the process shall be given to the Prospective Provider via the appropriate regional staff.
6. Regional staff will conduct an initial site visit to ensure compliance with the Placement Service Standards. The provider shall address any and all program concerns prior to obtaining an agreement with DCF.
7. If the Prospective Provider successfully completes background checks and all required paperwork an agreement can be signed between the Prospective Provider and DCF.
8. Ninety (90) days following the first child/youth admission, DCF will conduct another site visit to ensure compliance with the Placement Service Standards.

ONGOING MONITORING:

The Department for Children and Families Regional staff will complete site-visits on at least an annual basis. DCF may conduct unannounced site visit at any time throughout the year. The purpose of the on-site visits is to ensure continued compliance with the Placement Service Standards.

CORRECTIVE ACTION PLAN (CAP):

DCF reserves the right to place a provider on a Corrective Action Plan (CAP) for the following but not limited to:

- Safety and security concerns
- Non-Compliance with Placement Service Standards

HOLDS AND SOFT HOLDS:

A provider may initiate or elect to be placed on hold or soft hold or be notified by DCF of the need for a hold or soft hold for the following but not limited to:

- Safety and security concerns
- Non-Compliance with Placement Service Standards
- Multiple reports to the Kansas Protection Report Center (KPRC) in a short period of time
- Substantiation of serious reports from the KPRC
- Reports of concerns from outside stakeholders

Prior to DCF notice of a hold or soft hold, communication will occur with the facility director regarding the circumstances to understand current actions in place and if the facility has already or desires to immediately elect a hold or soft hold status. If a facility experiences a circumstance that they wish to elect to initiate a hold or soft hold, the facility notifies the group home program manager.

Hold shall be defined as; all children/youth are removed from the provider and no new admissions will be allowed until DCF gives approval.

Soft hold has two Tiers:

1. No new admissions are allowed, and the current children/youth remain in placement with and under the care and supervision of the provider, unless DCF determines otherwise.
2. Current youth remain in placement with and under the care and supervision of the provider, unless DCF determines otherwise. If a child/youth discharges, the provider is permitted to admit a new child/youth but is not allowed to exceed the capacity as of the date of the notice letter regarding the soft hold.

CHAPTER 6: GENERAL REQUIREMENTS FOR ALL RESIDENTIAL FACILITIES

For DCF to establish an Agreement, all residential facilities must continually meet all general requirements established in the Placement Services Standards Manual.

1. **Staff Qualifications**: All residential facilities are required to comply with applicable staffing qualifications for their type of service. Facilities who cannot hire individuals with either academic qualifications or experience must submit a written request for exception to the Group Home Program Manager. The facility will receive written approval or denial of the request.
2. **Staff Clearances**: All facility staff shall be cleared through, Kansas Bureau of Investigation, Federal Fingerprints, Child Abuse Registry, Adult Abuse Registry and the National Sex Offender Registry **prior** to hire. The licensing division completes the background checks for licensed facilities. Annual checks are only completed for KBI and CANIS. Annual checks are not completed for fingerprints, adult registry or SOR. Affiliates are enrolled in the Kansas RAPBACK system. Unlicensed facilities are responsible for submitting request for CANIS and Adult registry on the PPS forms.
3. **Confidentiality**: All residential facilities are required to comply with applicable state and federal statutes/regulations regarding confidentiality of child information.
4. **Reports of Child Abuse and Neglect**: All residential facilities are required to report immediately to DCF any cases of suspected child abuse or neglect via the Kansas Protection Reporting Center:

http://www.dcf.ks.gov/pages/report-abuse-or-neglect.aspx

or call

1-800-922-5330

1. **Crimes committed Involving Children/youth**: All residential facilities are required to have their staff report immediately to the local police department or county sheriff's office any case of suspected crime or act committed by a child/youth which if committed by an adult would constitute a crime, against a DCF custody child who is placed in that facility.
2. **Discipline and Behavior Management**: All residential facilities and their personnel are required to adhere to DCF policies governing discipline, Emergency Safety Intervention and isolation. The DCF does not view any action administered in a fashion that may cause any child/youth to suffer physical or emotional damage as acceptable. This includes acts that cause pain, such as hitting, beating, shaking, cursing or derogatory comments about a child/youth or the child's/youth's family. The DCF will not hold agreements with any facility who uses discipline that is not acceptable. All residential facilities must have written policy and procedure regarding Emergency Safety Interventions. Consideration shall be given to any acts of horseplay or general disruptive behavior.

3. **Licensing**: All residential centers, group boarding homes, child placing agencies and foster homes must be licensed by DCF Foster Care Licensing Division. Please note, regardless of ages served, all residential facilities (excluding TLP and CIP level of service) will be required to obtain a DCF license.
4. **Suicide Precautions**: All children, aged five (5) years and older shall be assessed for suicidal ideations and/or self-injurious behaviors and the assessment shall be maintained in the child's file. Upon identification of these behaviors the facility shall immediately make referral(s) for appropriate services.
5. **Child/Youth Financial Accounts**: All the child's/youth's finances that are accrued during placement shall be released to the child/youth or the child's/youth's guardian, upon discharge. Policy and Procedure shall be maintained regarding tracking child/youth finances.
6. **Professional Conduct:** All residential facilities shall have written policy and procedure pertaining to staff professional conduct.
7. **Education/Enrollment**: All residential facilities shall contact the appropriate school, or equivalent educational program of origin, to begin the enrollment process immediately upon accepting placement of the child/youth. Documentation of all contacts and steps taken with educational facilities to enroll the child/youth shall be maintained in the child's/youth's file. Children/Youth shall be immediately enrolled in a new school if it is not in their best interest to stay in the school of origin. Immediate enrollment means that a child/youth shall be enrolled in a new school as soon as possible in order to prevent educational discontinuity. Residential facilities shall ensure routine communications between the staff and any educational program in which a child/youth is placed and shall participate in the development of an Individual Education Plan (IEP) for children/youth, when appropriate.

CHAPTER 7: YOUTH RESIDENTIAL CARE II (YRCII)

All facilities and foster homes shall follow the guidelines outlined in K.S.A. 38-2202, "Reasonable and Prudent Parenting Standard", "means the standard characterized by careful and sensible parental decisions that maintain the health, safety and best interests of a child while at the same time encouraging the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in FC under the responsibility of the state to participate in extracurricular, enrichment, cultural and social activities."

GENERAL PROGRAM DESCRIPTION

A Youth Residential Care (YRCII) facility is a 24-hour group home or residential facility that meets the requirements of K.A.R. 28-4-123-132 and K.A.R. 28-4-268-280. It is a non-secure residential service designed to provide an environment that will enhance the child's ability to achieve a higher level of functioning while avoiding future placement in a more highly structured treatment facility.

The range of services to be delivered by the YRCII facility to meet the variety of individual needs of the children shall be well defined. The General Program description approved by DCF Prevention and Protection Services for each facility shall include but not be limited to the:

- goals of the program
- behavior management system
- job descriptions (responsibilities, functions, and qualifications)
- policies and procedures
- daily living activities
- health services
- recreation activities
- visitation policies

The purpose of placement in an YRCII is to improve the child's decision making, coping skills, social skills, and to address any underlying problems which are affecting the child, while teaching the child how to handle their behaviors in order to transition successfully back into their family or community.

DCF requires foster parents and designated officials at childcare institutions to apply the reasonable and prudent parenting standard. The standard is characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while at the same time encouraging the child's emotional and developmental growth that a caregiver must use when determining whether to allow a child in foster care to participate in extracurricular, enrichment, cultural, and social activities.

As part of this standard, it is recognized hair and skin care are an integral to self-worth of children, youth, and young adults. Cultural identities of children, youth and young adults should be considered and honored, through a variety of activities related to hair and skin care. At no time should children, youth, or young adults be denied access to this basic right and need as a means of behavioral control, punishment, or rewards.

Facilities shall ensure staff have access to and knowledge of local and online resources for professional hair and skin care, as well as offer continuing education or training opportunities for staff on these topics. Furthermore, the facility shall encourage and facilitate staff to consult with the child, youth, young adults, parents or other relatives/kin connections regarding preferences, tools and hygiene products recommended, processes, and supports for meeting the individual's needs surrounding these matters.

DESCRIPTION OF CHILDREN/YOUTH TO BE SERVED

When determining population to be served, the YRCII facility should have specific safety measures and programming in place that enables the facility to effectively supervise the specific ages and ranges of youth the YRCII plans to serve.

Prior to placement of any child age twelve (12) or younger in a DCF congregate care setting, the CWCMP shall ensure all other placement options have been explored, through family meeting model approaches and discussions with the child's case team and partnering Child Placing Agencies (CPAs). Prior approval from a CWCMP program president or similar executive management role is required before placement of a child age 12 or younger in a DCF congregate care facility. The purpose of this prior approval is to prevent unnecessary use of group care placement and provide opportunity to understand trends in gaps, capacity and supports needed for children to be stable in a family-based placement setting.

- Population served is children and youth, ages 6 thru 21, who:
- Have a well established pattern of behavior or conduct which is antisocial, oppositional, defiant, aggressive, abusive, impulsive or high risk in nature.
- Children/Youth who DO NOT meet the standard for Psychiatric Residential Treatment Facility (PRTF) admission, who are not in need of intensive treatment, and for whom family based services are not appropriate to meet the child's/youth's needs.
- Children/Youth awaiting a PRTF screen may reside in a YRCII until the time of the screen.
- If a child/youth is in a YRCII awaiting a screen the screen shall be completed within 14 days but shall be completed as soon as possible. If the child/youth screens into a PRTF they can stay up to 14 days while awaiting a PRTF bed.
- No more than 50 percent of the children/youth in a YRCII facility may have screened into a PRTF and be in the 14-day waiting period for a PRTF placement.

- Children/Youth may step down to a YRCII from a PRTF after the screener and treatment team have determined the child/youth no longer needs the level of care provided by a PRTF.

GENERAL STAFFING REQUIREMENTS

- The administrator in a YRCII (meeting residential center standards K.A.R 28-4-268 (t) more than 10 residents) shall have a bachelors degree, prior administrative experience and a working knowledge of child development principles.
- The administrator in a YRCII (meeting group home standards K.A.R 28-4-268 (i)) not less than five nor more than ten persons) shall have at least a high school diploma or GED, prior administrative experience and a working knowledge of child development principles.
- Program plan development, review, and case supervision are carried out by the YRCII Provider.
- The Case Coordinator shall have at least a bachelor's degree in one of the human service fields (social work, psychology, human development and family life, criminal justice, counseling), nursing, or education. The child to case coordinator ratio in a YRCII is 1:16.
- Facility staff shall be trained to effectively meet the special needs of children who require this level of care. Facility staff shall be at least 21 years of age with a minimum of three years age difference between the facility staff and oldest youth who can be admitted to the facility. Facility staff shall possess a high school diploma or GED.
- Staff ratio is 1:7 during waking hours and 1:10 during sleeping hours. There shall be 24-hour awake staff to insure child safety. A higher ratio shall be maintained if a child and/or their behaviors become hard to manage at the listed ratios.
- Staff will randomly conduct a minimum of four (4) sight checks on youth every hour when the youth is at an increased risk of elopement or sexual misconduct.

CARE COORDINATION

The care coordinator has the responsibility for coordinating the child's program and progress with the CMP Case Manager, school, employer, family, important connections, Family Finding model or similar specific tools, and other appropriate community resources. This shall include, but not be limited to, talking with the youth about important connections and possible family connections, documenting connections, documenting phone calls, appointments and visits (on and off site). The care coordinator will add information about important connections and family connections, and Family Finding tools to the program plan, weekly and monthly progress reports sent to the CMP.

The Care Coordinator will maintain a resource base of services to address the needs identified in Individual Program Plans and document in the youth's file, when and what community resources have been contacted and utilized for services for the youth. The case coordinator shall be responsible for Weekly Progress Notes (see Section 14: Record Keeping).

STAFF IN-SERVICE TRAINING

Orientation: Each facility shall have an in-service orientation training program for new employees, which is especially directed toward the initial training needs of staff working directly with children. Documentation of completion of orientation training shall be kept, in the staff member's personnel file.

The documentation shall be placed in a specific area in the staff's file, indicating:

- staff training, reflecting orientation or annual training
- name of trainer
- name of training
- specify the number of training hours
- date of the training

Facility staff shall have completed a minimum of 18 hours of in-service orientation training. Staff shall demonstrate competency in the trainings from orientation before they can work independently with children.

All topics listed below shall be trained, even if it exceeds the minimum 18 hours of orientation:

Facility Trainings:

- Facility policy and procedures manual
- Facility emergency and evacuation procedures
- Facility discipline standards
- Child record documentation policies and procedures
- Resident rights (See Appendix 4, Resident Rights)
- Confidentiality laws
- Report Writing

Trainings from an outside source and/or trained trainers within the facility (source must be well recognized and qualified, trained trainers must have documentation on file):

- Emergency safety interventions (including management of aggressive or suicidal behavior) (if a facility chooses to use Emergency Safety Intervention staff shall be certified)
- De-escalation (staff shall be certified)
- The handling of blood borne pathogens
- Medication Administration (staff who pass medications shall be certified)
- Certified in CPR/First Aid
- Trauma based informed care/trauma specific intervention
- Mandated Reporting (Provided By DCF)
  http://www.dcf.ks.gov/services/MRT/Pages/default.aspx
- Health Insurance Portability and Accountability Act (HIPAA)
- Comprehensive LGBTQ+
- Human Trafficking and exploitation
- Cultural Diversity
- Suicide Prevention/Intervention/Safety
- Family-focused training (i.e., Family Finding, Team Decision Making, Family Group Decision Making, Signs of Safety, etc.)

Annual In-Service Training: Annual training is beyond or in addition to the initial 18-hour orientation training program from the date of employment. During the first year of employment staff shall receive a minimum of 36 hours of training (18 orientation hours, 18 annual In-Service).

All YRCII direct care staff shall have a minimum of 18 documented clock hours of in-service training per year. Documentation shall be provided in each staff member's personnel record to include content, amount of time, trainer, and qualifications.

The documentation shall be placed in a specific area in the staff's file, indicating:

- staff training, reflecting orientation or annual training
- name of trainer
- name of training
- specify the number of training hours
- date of the training

All topics listed below shall be trained, even if it exceeds the minimum 18 hours of annual in-service:

Facility Refreshers/Trainings:

- Facility policy and procedures manual
- Facility emergency and evacuation procedures
- Facility discipline standards
- Child record documentation policies and procedures
- Resident rights (See Appendix 4, Resident Rights)

- Confidentiality laws

Refreshers/Trainings from an outside source and/or trained trainers within the facility (source must be well recognized and qualified, trained trainers must have documentation on file):

- Emergency safety interventions (including management of aggressive or suicidal behavior) (staff shall maintain certification)
- De-escalation (staff shall maintain certification)
- The handling of blood borne pathogens
- Medication Administration (staff shall maintain certification, may or may not require annual training)
- CPR/First Aid (Staff shall maintain certification, may or may not require annual training)
- Trauma based informed care/trauma specific intervention
- Mandated Reporting (Provided By DCF)

  http://www.dcf.ks.gov/services/MRT/Pages/default.aspx

- Comprehensive LGBTQ+
- Childhood and adolescent sexuality issues, especially the effects of early sexual abuse
- Substance Use Disorders
- Blood Borne Pathogens
- Childhood and adolescent development (including developmental disorders)
- Childhood and adolescent psychopathology (including such topics as effects of abuse/neglect, reactive attachment disorders, separation anxiety disorders, ADHD)
- Suicide Prevention/Intervention/Safety
- Family-focused training (i.e., Family Finding, Team Decision Making, Family Group Decision Making, Signs of Safety, etc.)

CONFIRMATION OF PLACEMENT

A Foster Care Confirmation of Placement (PPS 5122) is available through the CareMatch system which confirms the placement arranged by the Child Welfare Case Management Provider (CMP).

INITIAL ASSESSMENT

When a child enters the facility, the YRCII shall begin immediately assessing their strengths and needs including documentation and shall have a completed assessment within 7 days from admission.

The assessment shall include but not be limited to the following:

- Reasons for referral to the facility
- Evaluation or assessment covering the following areas:
    1. Physical health
    2. Family relations
    3. Academic or vocational training
- Community life
- Interpersonal interactions
- Important connections and family connections
- Daily living skills as outlined in the scope of services listed above
- Immediate service needs:
    1. Mental Health
    2. Developmental
    3. Dental
    4. Medical
- Involvement or exposure to Substance Use/disorder
- Involvement or exposure to other trauma
- Assessment of the child/youth's self- injuring or suicidal attempts

Placement needs of the child shall be assessed with regards to most appropriate next placement. Physical and mental health needs shall be coordinated with assigned CMP Case Manager and the child's assigned Managed Care Organization (MCO).

ROOM ASSIGNMENT

To support the daily management and administration of children/youth, each residential provider shall develop an objective formal procedure to assess physical housing needs of children. Children in a residential facility shall be assigned to a room based upon a range of factors, as identified by risk/needs assessment(s) in addition to other indicators. Factors to consider in assigning rooms shall include (but are not limited to):

- Suicidal tendencies
- Level of specialized needs (i.e., mental health, medical, etc.)
- Displaying inappropriate sexual behaviors /victims of sexual abuse)
- Gender
- Age and/or maturity level
- Program needs (substance use disorder, cognitive behavioral, independent living, etc.)
- Vulnerability to being victimized by others (i.e., physical stature)
- Comprehensive LGBTQ+

While each child will have an individualized program plan, assigning rooms based upon risk/need/responsivity factors will allow for a safer, more secure environment, as well as

efficient and effective management of the living units. The child's room assignment and how the decision was made shall be documented in the child's file. The room assignment shall be completed immediately upon admission.

SERVICES

The provider shall write a policy and procedure manual for the operation of the YRCII facility that will be reviewed and approved by DCF Prevention and Protection Services. The daily schedule shall address the needs of the children and the use of time to enhance the child's physical, mental, emotional, and social development. The facility shall provide supervised indoor and outdoor recreation so that every child may participate. Age appropriate equipment and outdoor play space to promote physical development and physical fitness shall be available. Age appropriate socialization shall be provided utilizing community resources to assist the child in transitioning back into their community when appropriate.

The YRCII will provide a program for children in the facility that covers the following program components:

Daily Living Services: Daily living services shall be provided and include the following:

- Room and Board
- Child Care
- Personal spending money
- Personal care needs
- School fees
- Transportation to appointments within a 60-mile radius; including to and from school, medical care, recreation, etc.
- Academic activities such as; assistance with schoolwork, vocational training and/or GED training

Situational Training- to include but not limited to:

Personal Hygiene:

- teaching about body cleanliness
- use of deodorants and cosmetics
- appropriate clothing
- choosing clothing to fit individual and occasion
- keeping clothes neat and clean

Health:

- identifying and understanding children's health needs
- securing and utilizing necessary medical treatment including preventive and health maintenance services
- gaining information and education in health maintenance including:

    - preventive measures
    - nutrition
    - menstruation
    - rest
    - cleanliness
    - family planning
    - drugs
    - sexually transmitted diseases
    - exercise
    - motivation for meeting own health needs
- maintaining contact with providers of health services (physician, nurse, clinic)
- using outside resources for assistance (clinics, pharmacies, hospitals)

Consumer education for independent living:

- budgeting
- comparative buying
- installment buying
- avoiding risks
- identifying illegal or excessive interest rates
- use of credit
- avoiding or dealing with debts
- using checking and savings accounts
- paying taxes

Communication skills:

The child's articulating thoughts and feelings through appropriate use of such skills as:

- speech
- writing
- use of the landline/cell phones
- computer
- social networking
- internet

Home Management:

- making the bed and changing linens
- using the vacuum cleaner
- dusting
- organizing belongings
- disposing of trash
- cleaning all areas of the home
- operating appliances
- cooking complete meals

- making simple repairs
- who to call when a major repair is needed
- being aware of the need for upkeep
- handling emergencies
- knowing first aid

Situational Guidance:

- coping and self-regulation skills
- identifying and accepting strengths
- developing patterns of acceptance
- coping with authority figures
- getting along with others
- sharing responsibility
- being considerate of others
- developing friendships
- knowing when to go home when visiting
- recognizing or modifying attitudes toward self or others
- responsible work attitudes
- tolerance of constructive feedback
- reactions to praise
- punctuality
- attendance

Recreation:

- participating in leisure time activities
- learning how to spend leisure time
- developing outside activities
- managing time
- finding recreation with little or no expense involved
- finding community projects to take part in
- participating in social groups
- participating in sports and games
- arts and crafts
- appreciating fine arts
- self-care time (see Section 15)

BEHAVIOR MANAGEMENT

Each YRCII shall have a written program of consistent rules and regulations guiding and governing the daily behavior of the children under the care of the program. The behavior management system shall include a description of daily general routines of the program. The system of rules, rewards, and consequences for given behaviors shall be identified. Each child shall be oriented to the YRC's behavior management system by a staff member during

the admission or orientation process. Notation shall be made in the child's file and signed by the child that the rules, rewards and consequences have been discussed.

The YRCII facility shall post the behavior management system in a common area where children are able to easily access the system and the children shall be given a written copy of the system to use as a reference. Behavior management shall include rules governing:

- interpersonal interactions with staff and peers
- facility leave policies
- school attendance and behavior while at school
- verbal and physical aggression
- allowable possessions
- awakening and bedtime hours
- leisure hours,
- visitation policies
- runaway attempts
- involvement in recreation and other activities
- self-destructive behaviors
- sexuality
- communications with family and others outside the program
- religious worship
- involvement in therapies
- theft, property destruction
- behaviors resulting in mandatory removal from the program
- behaviors at the program which could result in legal prosecution.

When a child decides not to attend religious worship or activities, alternative supervised activities shall be made available.

The overarching goals shall be to not only help the child adjust to the residential facility but also to daily life within society. A resource list shall be maintained by the facility of the available resources to meet the child's need in the community.

Discipline at the facility shall be consistent and not be physically or emotionally damaging. Children shall not be subjected to cruel, severe, unusual, or unnecessary punishment. Children shall not be subjected to remarks that belittle or ridicule them or their families. Children shall not be denied food, mail, telephone calls or visits with their families as punishment. Seclusion shall not be utilized as a disciplinary measure. Only staff members shall discipline children.

RESETTING

A procedure used to assist the child to regain emotional control by removing them from his or her immediate environment and restricting the child to a quiet area or unlocked quiet room.

APPLICATION OF A RESET:

- A child in a reset shall never be physically prevented from leaving the reset area.
- Resets may take place away from the area of activity or from other children.
- Staff shall monitor the child while he or she is in resetting.

DE-ESCALATION CERTIFICATION

De-escalation is a technique used during a potential crisis situation in an attempt to prevent a child from causing harm to themselves, others and/or staff. De-escalation techniques shall be utilized for any activity required to diffuse a conflict or intense situation to ensure safety and calm the child. Staff shall be certified in authorized, evidenced based de-escalation techniques programs for managing aggressive behavior. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the child and parent (if applicable)/guardian and/or CMP Case Manager shall be oriented to the managing aggressive behaviors policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the child's case record.

EMERGENCY SAFETY INTERVENTIONS CERTIFICATION

An emergency safety intervention shall be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the child's chronological and developmental age, size, gender physical, medical, psychiatric condition, and personal history.

The use of emergency safety interventions shall be performed only through the use of nationally recognized restraint procedures applicable to this population designed to prevent a child from harming self or others by exerting external control over physical movement.

An emergency safety intervention is the application of physical force without any mechanical device, for the purpose of restricting the free movement of a child's body. **An emergency safety intervention shall be used only as last resort after all verbal de-escalation techniques have failed and when the child is at-risk of harming themselves or others.**

Mechanical restraint is the use of mechanical devices to restrict the free movement of the child's body, most often for purposes of preventing self-destructive behavior. **Mechanical restraints are not allowed in YRCII residential facilities.**

Each facility shall have a written policy and all staff shall be trained to provide safe emergency safety interventions. Staff shall be certified in authorized, evidenced based training programs for managing aggressive behavior and de-escalation techniques. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the child and parent (if applicable)/guardian (if applicable) and/or CMP Case Manager shall be oriented to the emergency safety intervention policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the child's case record.

PROGRAM PLAN

Each child residing in a residential facility shall have a program plan that is based on a thorough assessment. Assessment documents shall be included in the case record. The program plan shall be established by the end of 14 days from admission and shall address the identified needs in the emotional, physical, educational, social, familial, and where appropriate independent living skill domains. Children may not have identified needs in every domain. If so, document that no needs were identified. Program plans shall be updated when new needs are identified or when program goals are met. Program plans shall be thoroughly reviewed, and revisions made at the case review conferences within 30 days of completion of initial program plan and each 30 days thereafter, including updated information of the progress of the child's goals. Information obtained from the child, parent, guardian, and CMP Case Manager shall be considered in the report. The initial program plan and all updates shall be sent to the CMP Case Manager.

The program plan shall include individualized services to match the child's identified needs in the following areas:

- Long term goals in the areas of:
    1. physical health
    2. family relations
    3. daily living skills
    4. academic and/or vocational skills
    5. interpersonal relations
    6. substance use service needs
    7. emotional/psychological health
- Short term goals which will help a child eventually reach his/her long-term goals in each of the above areas.
- Services to meet independent living goals.
- Specific plans for reaching the short-term goals including services to be provided and frequency.
- Estimated time for reaching short term goals.

- The child shall sign and date the program plans indicating participation and input in the development of the plan.
- Updated information of the progress of the child's goals shall be included.

YRCII staff shall participate in case plan conducted by the CMP Case Manager.

PERMANENCY PLANNING:

Includes the evaluation and design of an approach for the children and family that focuses on opportunities for the child to have ongoing active and meaningful connections with family, kin, relatives, and the community. The goal for achieving permanency shall be coordinated with the child's CMP Case Manager and be included in the program plan to be reviewed every 30 days. The permanency plan shall include strategies and tasks to accomplish the child's goals. Behaviors which place the child at risk for disruption, activities to prepare the child's family or kinship network for reunification, identification of other less restrictive living environments and preparing the child for transition to these settings shall be addressed.

VISITATION

Subject to the provider's visitation guideline (days of the week, times, appropriate attire, etc.) a provider shall not prohibit contact with a child's immediate family except for the following reasons:

- A court orders no contact
- There is documented violence, threatening or disruptive behavior by family member that occurred during contact
- There is documented introduction of contraband into the facility

The facility shall provide private accommodations for visitation. Accommodations shall include but not be limited to a private office/room, no staff presence (unless required), free of any individuals that may overhear confidential information.

When home visits are a part of the treatment plan, there shall be coordinated connections with the child, their family, and the case coordinator/facility program staff regarding the youth's treatment and program goals and objectives. The goal of placement shall be to return the child to a family-like setting, so it is important that home visits be carefully planned and executed in the best interests of permanency planning for the child. All home visits shall be arranged through coordination with the child's CMP Case Manager. Documentation in child's file shall include who is transporting children to and from family visits and observation of the child's behavior during transportation.

The child shall have an approved contact list to include, the type of contact allowed (letter, phone, day passes, overnight passes, etc.) The contact list must be reviewed/updated every 60 days. Approved contacts shall be determined by the CMP Case Manager. The initial contact list and all reviews/updates shall include the CMP Case Manager signature.

DISRUPTIONS

Agencies must provide at least 14 business days' notice to the Case Management Provider in asking for a removal of the child placed less than 180 days (6 months) and 30 days' notice for children placed longer than 180 days (6 months) unless the child is in imminent danger to themselves or others as defined below. Timelines for placement move notices are defined as per KS Statute (i.e., K.S.A. 38-2258 of the Children in Need of Care code (K.S.A. 38-2201) and DCF's PPM (i.e., PPM 3362 Thirty Day Notice of Planned Move, PPM 3364 Exceptions to Thirty Day Notice of Planned Move) and should be followed accordingly.

If DCF or Law Enforcement is requiring immediate removal of a child due to the facility's inability to provide safety or stability for the child, CMP will be required to locate an alternate placement provider for the necessary disruption period. The Case Management Providers expects the placement provider to submit a Disruption Notice Form the next business day after the emergency removal occurs.

Emergency removal of a child from a residential facility that does not require the notice above will only be considered if one of the following has occurred:

- Child is admitted to an acute care facility
- Child is detained for a criminal offense
- Child is AWOL for more than 24 hours.
- Child has sexually assaulted a child within the facility or has attempted to sexually assault child within the facility.
- Physical harm to the staff or other children in the facility, which cannot be rectified by a safety plan or continues to escalate. Facilities are to first utilize other services available (i.e., law enforcement intervention, screening into acute services). These situations will be staffed on a case by case basis.

DISCHARGE/AFTERCARE PLAN

Discharge planning shall begin upon admission of the child to the facility. At a minimum, the child, the child's parents, if applicable or guardian, and the CMP Case Manager shall be involved in planning the discharge of a child from the residential facility.

A discharge summary shall be completed at the time of discharge and be forwarded to the CMP Case Manager within one business day. The discharge summary shall include written:

- Summary of progress, or lack thereof, of the child's goals and objectives while in placement

- Summary of the child's behavior while in placement
- Recommendations for aftercare services specifying the nature, frequency, duration of services and responsible parties
- Summary of the reasons the child was discharged

RECORD KEEPING

The record keeping requirements of K.A.R. 28-4-272 shall be met by the facility. In addition, the following shall be kept by the facility. If a facility chooses to use electronic filing full access shall be given to DCF employees who are conducting site visit.

CHILD'S FILE:

The provider shall maintain a file for each child. The file shall contain the following:

- Child's name and date of birth
- Name, address and emergency contact information of the child's CMP Case Manager
- Foster Care Confirmation of Placement
- Current CMP Referral form
- Current CMP Case Plan
- If reunification is the goal, evidence demonstrating that the parent from whom the child was removed provided input on the members of the family and permanency plan.
- Initial Assessment
- Suicide/self-injury questionnaire
- Room assignment assessment
- Medical and surgical consents
- Medical and dental records (history and current)
- Documentation of diagnosis (history and current)
- Records of the child's prescription(s) and non-prescription(s) and when administered
- Authorization for release of confidential information
- Daily observation logs by shift
- Weekly progress notes
- Program plans
- Treatment Plans, if applicable
- Discharge plans/Aftercare
- Approved contact list
- Resident's rights acknowledgement
- Emergency Safety Intervention/de-escalation acknowledgements
- Handbook/Rules acknowledgement
- Pre and Post visit documentation

- Significant incident reports
- Personal Property Inventory
- Educational documentation

RECORD RETENTION:

Case records, including medical records, shall be maintained for 6 years from the date of the child's discharge or until completion of an on-going audit and production of a final audit report, whichever is longer.

DAILY OBSERVATIONS:

A dated record of daily observations and significant occurrences involving each child shall be maintained by each shift and maintained in each child's individual file. The record shall include events which may affect the well-being of the child. Significant events should include but not be limited to; attendance at school or groups (specific group), interactions and/or interventions with staff and other children, medical appointments, mental health appointments, medication compliance, hygiene (if identified as a need), visits/passes, meals eaten and overall behavior. Each report shall include the staff member and/or child involved, the nature of the incident and the circumstances surrounding it. The record shall be available to review.

WEEKLY PROGRESS NOTES:

Notes shall be completed by the case coordinator. These notes shall be entered in the child's chart, reflecting the delivery of services according to the treatment plan. This documentation shall address the child's responses to interventions and the progress of the child on individualized goals and objectives. The note shall include any significant events that occurred during the week and shall also summarize contacts with family members and other involved agencies. If an unmet need is identified, the note shall reflect the actions to be taken to revise the plan to meet that need. The case coordinator shall document specific services and activities they are providing to each child. Each month the weekly progress notes shall be sent to the CMP Case Manager. The Monthly Progress Report Form shall be submitted to each child's provider no later than the 15th of each month following the reporting month, for all children who are in placement more than 15 days of that calendar month. Submission will be accepted by e-mail to:

- Cornerstones of Care: KSmonthlyprogressreports@Cornerstonesofcare.org
- KVC: KVCMonthlyReports@KVC.org
- St. Francis Ministries: MonthlyProgressReports@st-francis.org
- TFI: MonthlyReports@TFIFamily.org

HEALTH RECORDS:

Health Care and Records of children shall meet the requirements of K.A.R. 28-4-275. Records of over the counter and prescribed medications shall be kept in each child's case medical record and include the:

- name of the prescribing physician
- name of the medication
- dosage prescribed
- medication schedule
- purpose of the medication
- noted side effects
- date of the prescription
- date prescribed by a physician

A record of medication given, amount, date and time, and person dispensing shall be recorded. All doctor and dental visits, major illnesses, and accidents shall be recorded. Mental health appointments shall also be specifically documented in a child's medical record. This provides for a complete Health record for the child and their family, which documents the frequency of the youth's mental health treatment.

PERSONNEL RECORDS:

A separate file shall be maintained for each employee. Personnel files shall include the following:

- Written employment application, resume and reference checks
- Date of hire and Start Date
- Position description
- Educational transcripts, HS diploma, college degree, etc.
- Copy of driver's license/Kansas ID (current)
- Disciplinary action records
- Training records
- Out of state registry checks, when applicable (staff member has lived outside of Kansas within the last 5 years)

SELF-CARE TIME

KAR 28-4-271(d)(2): There shall be adequate staff to supervise the residents at all times.

Self-care time may be allowed on a case by case basis. Self-care time is not suitable for all youth. Examples of self-care time are:

- Walking/biking to work

- Time to go out and apply for jobs, if eligible
- Time to walk around the block to cool off

The following, but not limited to, shall be considered prior to self-care time being approved:

- Level within the behavior management system
- Daily/past behaviors
- Maturity (readiness to be out of sight of staff)

Self-care time shall be approved and agreed upon by the facility staff and the CMP. If approved, a safety plan shall be created and signed by the youth's facility Case Coordinator, CMP Case Manager and the youth. The safety plan shall be maintained in the youth's file. Conversations, assessments, etc. used to determine self-care for a youth shall also be maintained in the youth's file.

CHAPTER 8: EMERGENCY SHELTERS

All facilities and foster homes shall follow the guidelines outlined in K.S.A. 38-2202, "Reasonable and Prudent Parenting Standard", "means the standard characterized by careful and sensible parental decisions that maintain the health, safety and best interests of a child while at the same time encouraging the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in FC under the responsibility of the state to participate in extracurricular, enrichment, cultural and social activities."

GENERAL PROGRAM DESCRIPTION

An Emergency Shelter (ES) provides twenty-four hour care that meets the requirements of K.A.R. 28-4-123-132 and K.A.R. 28-4-268-280. It has been licensed by DCF Foster Care Licensing Division as a Group Boarding Home or Residential Center to cover the programming the facility will provide for the populations of children/youth whom the facility will serve. Twenty-four hour care which has been licensed by the DCF Foster Care Licensing Division. (K.A.R. 28-4-268-280) as a group boarding home or residential center to cover the programming the facility will provide to the population of children/youth whom the facility will serve.

An Emergency Shelter for Crossover youth (ESC) is an Emergency Shelter designated specifically to serve youth (12 and older) who have had negative law enforcement interaction within 90 days of admittance.

The purpose of placement in an Emergency Shelter/ESC is to ensure a child has a short-term safe place to stay until a long-term placement can be found.

The range of services to be delivered by the Emergency Shelter/ESC shall be documented in the facilities program description. The general program description approved by DCF Prevention and Protection Services for each residential facility shall include but not be limited to the:

- goals of the program
- behavior management system
- job descriptions (responsibilities, functions, and qualifications)
- policies and procedures
- daily living activities
- health services
- recreation activities
- visitation policies

Children shall not be placed in an emergency shelter/ESC for more than 30 days unless an extension is approved for a circumstance as indicated below:

- Extensions to the 30-day emergency shelter/ESC should be kept to minimum for the well-being of the youth.
- Extended stays should only be considered in the following circumstances:

    1. If a child is placed in an Emergency Shelter/ESC in the same school district from which they were previously attending, and no alternative placement is available in the district. If the child will be finishing the school term within 60 days of admission to the Emergency Shelter/ESC and movement of the child would result in the loss of school credit.
    2. The child is awaiting an identified placement, which will be available within 45 days of admission to the Emergency Shelter/ESC.
    3. A circumstance of substantially the same nature as above and it is in the best interest of the child to request an extension.

DCF requires facilities to apply the reasonable and prudent parenting standard. The standard is characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while at the same time encouraging the child's emotional and developmental growth that a caregiver must use when determining whether to allow a child in foster care to participate in extracurricular, enrichment, cultural, and social activities.

As part of this standard, it is recognized hair and skin care are an integral to self-worth of children, youth, and young adults. Cultural identities of children, youth and young adults should be considered and honored, through a variety of activities related to hair and skin care. At no time should children, youth, or young adults be denied access to this basic right and need as a means of behavioral control, punishment, or rewards.

Facilities shall ensure staff have access to and knowledge of local and online resources for professional hair and skin care, as well as offer continuing education or training opportunities for staff on these topics. Furthermore, the facility shall encourage and facilitate staff to consult with the child, youth, young adults, parents or other relatives/kin connections regarding preferences, tools and hygiene products recommended, processes, and supports for meeting the individual's needs surrounding these matters.

DESCRIPTION OF CHILDREN/YOUTH TO BE SERVED

Prior to placement of any child age twelve (12) or younger in a DCF congregate care setting, the CWCMP shall ensure all other placement options have been explored, through family meeting model approaches and discussions with the child's case team and partnering Child Placing Agencies (CPAs). Prior approval from a CWCMP program president or similar executive management role is required before placement of a child age 12 or younger in a

DCF congregate care facility. The purpose of this prior approval is to prevent unnecessary use of group care placement and provide opportunity to understand trends in gaps, capacity and supports needed for children to be stable in a family-based placement setting.

Emergency Shelters/ESCs are unique in their ability to accept children who present a wide range of behavioral and health needs. Emergency Shelters/ESCs shall be trained in trauma informed care. Emergency Shelters/ESCs are staffed and administered to serve all children from the state agencies with whom they have agreements. Placements of children shall only be denied in the most extreme circumstances, when the child's safety or the safety of other children in the Emergency Shelter/ESC cannot be assured.

Population served are children and youth, ages birth thru 21, who:

- Need safety and a short term placement until a more appropriate stable placement can be found for the child/youth
- Need Police Protective Custody

GENERAL STAFFING REQUIREMENTS

- The administrator of a residential center (meeting residential center standards K.A.R 28-4-268 (t) more than 10 residents) shall have a Bachelor's degree, prior administrative experience and a working knowledge of child development principles.
- The administrator of a group boarding home (meeting group home standards K.A.R 28-4-268 (i) not less than five nor more than ten persons) shall have at least a high school diploma, or its equivalent, prior administrative experience and a working knowledge of child development principles.
- Program plan development, review, and case supervision are carried out by the Emergency Shelter/ESC provider.
- Facility staff shall be at least 21 years of age with a minimum of three years age difference between facility staff and the oldest child/youth who can be admitted, have at least a high school diploma or equivalent and shall practice accepted methods of child care. Staff shall be trained to effectively meet the special needs of children who require this level of care.
- The facility shall be staffed appropriately to meet the needs of all the children in their care. The staff ratio is 1:7 during waking hours and 1:10 during sleeping hours. To insure youth safety, the Emergency Shelter/ESC facility will have awake staff 24 hours a day. A higher ratio shall be maintained if youth and/or their behaviors become hard to manage at the listed ratios.
- Staff will randomly conduct a minimum of four (4) sight checks on youth every hour when the youth is at an increased risk of elopement or sexual misconduct.

CASE COORDINATION

The care coordinator has the responsibility for coordinating the child's program and progress with the CMP Case Manager, school, employer, family, important connections, Family Finding model or similar specific tools, and other appropriate community resources. This shall include, but not be limited to, talking with the youth about important connections and possible family connections, documenting connections, documenting phone calls, appointments and visits (on and off site). The care coordinator will add information about important connections and family connections, and Family Finding tools to the program plan, weekly and monthly progress reports sent to the CMP.

The Care Coordinator will maintain a resource base of services to address the needs identified in Individual Program Plans and document in the youth's file, when and what community resources have been contacted and utilized for services for the youth. The case coordinator shall be responsible for Weekly Progress Notes (see Record Keeping).

STAFF IN-SERVICE TRAINING

Orientation

Each facility shall have an in-service orientation training program for new employees, which is especially directed toward the initial training needs of staff working directly with children. Documentation of completion of orientation training shall be kept, in the staff member's personnel file.

The documentation shall be placed in a specific area in the staff's file, indicating:

- staff training, reflecting orientation or annual training
- name of trainer
- name of training
- specify the number of training hours
- date of the training

Facility staff shall have completed a minimum of 18 hours of in-service orientation training. Staff shall demonstrate competency in the trainings from orientation before they can work independently with children.

All topics listed below shall be trained, even if it exceeds the minimum 18 hours of orientation:

FACILITY TRAININGS:

- Facility policy and procedures manual
- Facility emergency and evacuation procedures

- Facility discipline standards
- Child record documentation policies and procedures
- Resident rights (See Appendix 4, Resident Rights)
- Confidentiality laws
- Report Writing

Trainings from an outside source and/or trained trainers within the facility (source must be well recognized and qualified, trained trainers must have documentation on file):

- Emergency safety interventions (including management of aggressive or suicidal behavior) (if a facility chooses to use Emergency Safety Intervention staff shall be certified)
- De-escalation (staff shall be certified)
- The handling of blood borne pathogens
- Medication Administration (staff who pass medications shall be certified)
- Certified in CPR/First Aid
- Trauma based informed care/trauma specific intervention
- Mandated Reporting (Provided By DCF)

http://www.dcf.ks.gov/services/MRT/Pages/default.aspx

- Health Insurance Portability and Accountability Act (HIPAA)
- Comprehensive LGBTQ+
- Human Trafficking and exploitation
- Cultural Diversity
- Suicide Prevention/Intervention/Safety
- Family-focused training (i.e., Family Finding, Team Decision Making, Family Group Decision Making, Signs of Safety, etc.)

ANNUAL IN-SERVICE TRAINING

Annual training is beyond or in addition to the initial 18-hour orientation training program from the date of employment. During the first year of employment staff shall receive a minimum of 36 hours of training (18 orientation hours, 18 annual In-Service).

All QRTP direct care staff shall have a minimum of 18 documented clock hours of in-service training per year. Documentation shall be provided in each staff member's personnel record to include content, amount of time, trainer, and qualifications.

The documentation shall be placed in a specific area in the staff's file, indicating:

- staff training, reflecting orientation or annual training
- name of trainer

- name of training
- specify the number of training hours
- date of the training

All topics listed below shall be trained, even if it exceeds the minimum 18 hours of annual in-service:

FACILITY REFRESHERS/TRAININGS:

- Facility policy and procedures manual
- Facility emergency and evacuation procedures
- Facility discipline standards
- Child record documentation policies and procedures
- Resident rights (See Appendix 4, Resident Rights)
- Confidentiality laws

Refreshers/Trainings from an outside source and/or trained trainers within the facility (source must be well recognized and qualified, trained trainers must have documentation on file):

- Emergency safety interventions (including management of aggressive or suicidal behavior) (staff shall maintain certification)
- De-escalation (staff shall maintain certification)
- The handling of blood borne pathogens
- Medication Administration (staff shall maintain certification, may or may not require annual training)
- CPR/First Aid (Staff shall maintain certification, may or may not require annual training)
- Trauma based informed care/trauma specific intervention
- Mandated Reporting (Provided By DCF)

http://www.dcf.ks.gov/services/MRT/Pages/default.aspx

- Health Insurance Portability and Accountability Act (HIPAA)
- Comprehensive LGBTQ+
- Childhood and adolescent sexuality issues, especially the effects of early sexual abuse
- Substance Use Disorders
- Blood Borne Pathogens
- Childhood and adolescent development (including developmental disorders)
- Childhood and adolescent psychopathology (including such topics as effects of abuse/neglect, reactive attachment disorders, separation anxiety disorders, ADHD)

- Suicide Prevention/Intervention/Safety
- Family-focused training (i.e., Family Finding, Team Decision Making, Family Group Decision Making, Signs of Safety, etc.)

CONFIRMATION OF PLACEMENT

A Foster Care Confirmation of Placement (PPS 5122) **is available through the CareMatch system which confirms the placement arranged by the CMP.**

Youth shall not be placed in an emergency shelter/ESC for more than 30 days unless an extension is approved for a circumstance as indicated below:

- Extensions may only be requested by the referring agency. Extension requests and decisions for youth in DCF custody are managed by the child welfare case management provider case manager.
- Extensions to the 30-day emergency shelter/ESC stay will only be considered in the following circumstances:
    - If a youth is placed in an Emergency Shelter/ESC in the same school district from which they were previously attending, and no alternative placement is available in the district. If the youth will be finishing the school term within 60 days of admission to the Emergency Shelter/ESC and movement of the youth would result in the loss of school credit.
    - The youth is awaiting an identified placement, which will be available within 45 days of admission to the Emergency Shelter/ESC.
    - A circumstance of substantially the same nature as above and it is in the best interest of the child or youth to request an extension.

Documentation shall be placed in the youth's file at the facility, including but not limited to:

- The reason for the need of an extension for ES/ESC placement
- Participants (names and title of position) in the discussion for the need for an extension, including who agreed upon the extension
- The youth's updated plan of needed service(s) for the next 60 days, dated and signed by the appropriate parties.

INITIAL ASSESSMENT

When a youth enters the facility, the ES/ESC shall begin immediately assessing their strengths and needs and shall have a completed assessment within 3 days from admission. The assessment shall include but not be limited to the following:

- Reasons for referral to the facility
- Evaluation or assessment covering the following areas:
    1. physical health
    2. family relations
    3. academic or vocational training
- Community life
- Interpersonal interactions
- Important connections and family connections
- Daily living skills as outlined in the scope of services listed above
- Immediate service needs:
    1. mental health
    2. developmental
    3. dental
    4. medical
- Involvement or exposure to Substance Abuse/disorder
- Involvement or exposure to trauma
- Assessment of youth's self- injuring or suicidal attempts

Placement needs of the youth shall be assessed with regards to most appropriate next placement. Physical and mental health needs shall be coordinated with assigned CMP Case Manager and youth's assigned Managed Care Organization (MCO).

ROOM ASSIGNMENT

To support the daily management and administration of children/youth, each residential provider shall develop an objective formal procedure to assess physical housing needs of children. Children in a residential facility shall be assigned to a room based upon a range of factors, as identified by risk/needs assessment(s) in addition to other indicators. Factors to consider in assigning rooms shall include (but are not limited to):

- Suicidal tendencies
- Level of specialized needs (i.e., mental health, medical, etc.)
- Displaying inappropriate sexual behaviors /victims of sexual abuse)
- Gender
- Age and/or maturity level
- Program needs (substance use disorder, cognitive behavioral, independent living, etc.)
- Vulnerability to being victimized by others (i.e., physical stature)
- Comprehensive LGBTQ+

While each child will have an individualized program plan, assigning rooms based upon risk/need/responsivity factors will allow for a safer, more secure environment, as well as efficient and effective management of the living units. The child's room assignment and how

the decision was made shall be documented in the child's file. The room assignment shall be completed immediately upon admission.

SERVICES

The provider shall write a policy and procedure manual for the operation of the Emergency Shelter/ESC facility that will be reviewed and approved by DCF Prevention and Protection Services. The daily schedule shall address the needs of the children and the use of time to enhance the child's physical, mental, emotional, and social development. The facility shall provide supervised indoor and outdoor recreation so that every child may participate. Age appropriate equipment and outdoor play space to promote physical development and physical fitness shall be available. Age appropriate socialization shall be provided utilizing community resources to assist the youth in transitioning back into their community when appropriate.

The ES will provide a program for youth in the facility that covers the following program components:

Daily Living Services - Daily living services shall be provided and include the following:

- room
- board
- childcare
- personal spending money
- personal care needs
- school fees
- transportation to appointments within a 60-mile radius; including to and from school, medical care, recreation, etc.
- academic activities
    - assistance with schoolwork
    - vocational training
    - G.E.D. training

Situational Training- to include but not limited to:

Personal Hygiene:

- body cleanliness
- use of deodorants and cosmetics
- appropriate clothing
- choosing clothing to fit individual and occasion
- keeping clothes neat and clean

Health:

- identifying and understanding children's health needs
- securing and utilizing necessary medical treatment including preventive and health maintenance services

- gaining information and education in health maintenance including:
    1. preventive measures
    2. nutrition
    3. menstruation
    4. rest
    5. cleanliness
    6. family planning
    7. drugs
    8. sexually transmitted diseases
    9. exercise
    10. motivation for meeting own health needs
- maintaining contact with providers of health services (physician, nurse, clinic)
- using outside resources for assistance (clinics, pharmacies, hospitals)

Consumer education for independent living:

- budgeting
- comparative buying
- installment buying,
- avoiding risks
- identifying illegal or excessive interest rates
- use of credit
- avoiding or dealing with debts
- using checking and savings accounts
- paying taxes

Communication skills:

The youth's articulating thoughts and feelings through appropriate use of such skills as:

- speech
- writing
- use of the telephone landline/cell
- computer
- social networking
- internet

Home Management:

- making the bed and changing linens
- using the vacuum cleaner
- dusting
- organizing belongings
- disposing of trash,
- cleaning all areas of the home
- operating appliances

- cooking complete meals
- making simple repairs
- who to call when a major repair is needed
- being aware of the need for upkeep
- handling emergencies
- knowing first aid

Situational Guidance:

- coping and self-regulation skills
- identifying and accepting strengths
- developing patterns of acceptance
- coping with authority figures
- getting along with others
- sharing responsibility
- being considerate of others
- developing friendships
- knowing when to go home when visiting
- recognizing or modifying attitudes toward self or others
- responsible work attitudes
- tolerance of constructive feedback
- reactions to praise
- punctuality
- attendance

Recreation:

- participating in leisure time activities
- learning how to spend leisure time
- developing outside activities
- managing time
- finding recreation with little or no expense involved
- finding community projects to take part in
- participating in social groups,
- participating in sports and games
- arts and crafts
- appreciating fine arts

BEHAVIOR MANAGEMENT

Each Emergency Shelter/ESC shall have a written program of consistent rules guiding and governing the daily behavior of the youth under the care of the program. The behavior management system shall include a description of daily general routines of the program. The system of rules, rewards, and consequences for behaviors shall be identified. Notation shall

be made in the youth's file and signed by the youth that the rules, rewards and consequences have been discussed with the youth.

Each youth shall be oriented to the Emergency Shelter's/ESC's behavior management system by a staff member during the admission or orientation process. The youth shall be given a written copy of the system to use as a reference and the Emergency Shelter/ESC shall post the behavior management system in a common area where the youth are able to easily access the system. Behavior management shall include rules governing:

- interpersonal interactions with staff and peers
- facility leave policies
- school attendance and behavior while at school
- verbal and physical aggression
- allowable possessions
- awakening and bedtime hours
- leisure hours, visitation policies
- runaway attempts
- involvement in recreation and other activities
- self-destructive behaviors
- sexuality
- communications with family and others outside the program
- religious worship
- involvement in therapies
- theft
- property destruction
- behaviors resulting in mandatory removal from the program
- behaviors at the program which could result in legal prosecution

When a youth decides not to attend religious worship or activities, alternative supervised activities shall be made available.

The overarching goals shall be to help the youth adjust to the residential facility and to daily life within society. A resource list shall be maintained by the facility of the available resources to meet the youth's need in the community.

Discipline at the facility shall be consistent and not be physically or emotionally damaging. Youth shall not be subjected to cruel, severe, unusual, or unnecessary punishment. Youth shall not be subjected to remarks that belittle or ridicule them or their families. Children shall not be denied food, mail, telephone calls or visits with their families as punishment. Seclusion shall not be utilized as a disciplinary measure. Only staff members shall discipline children.

RESETTING

A procedure used to assist the child to regain emotional control by removing them from his or her immediate environment and restricting the child to a quiet area or unlocked quiet room.

APPLICATION OF A RESET:

- A child in a reset shall never be physically prevented from leaving the reset area.
- Resets may take place away from the area of activity or from other children.
- Staff shall monitor the child while he or she is in resetting.

DE-ESCALATION CERTIFICATION

De-escalation is a technique used during a potential crisis to prevent a child from causing harm to themselves, others and/or staff. De-escalation techniques shall be utilized for any activity required to diffuse a conflict or intense situation to ensure safety and calm the child. Staff shall be certified in authorized, evidenced based de-escalation techniques programs for managing aggressive behavior. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the child and parent (if applicable)/guardian and/or CMP Case Manager shall be oriented to the managing aggressive behaviors policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the child's case record.

EMERGENCY SAFETY INTERVENTIONS CERTIFICATION

An emergency safety intervention shall be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the child's chronological and developmental age, size, gender physical, medical, psychiatric condition, and personal history.

The use of emergency safety interventions shall be performed only through the use of nationally recognized restraint procedures applicable to this population designed to prevent a child from harming self or others by exerting external control over physical movement.

An emergency safety intervention is the application of physical force without any mechanical device, for the purpose of restricting the free movement of a child's body. **An emergency safety intervention shall be used only as last resort after all verbal de-escalation techniques have failed and when the child is at-risk of harming themselves or others.**

Mechanical restraint is the use of mechanical devices to restrict the free movement of the child's body, most often for purposes of preventing self-destructive behavior. **Mechanical restraints are not allowed in Emergency Shelter/ESC residential facilities.**

Each facility shall have a written policy and all staff shall be trained to provide safe emergency safety interventions. Staff shall be certified in authorized, evidenced based training programs for managing aggressive behavior and de-escalation techniques. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the child and parent (if applicable)/guardian (if applicable) and/or CMP Case Manager shall be oriented to the emergency safety intervention policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the child's case record.

PROGRAM PLAN

Each youth residing in a residential facility shall have a program plan that is based on a thorough assessment. Assessment documents shall be included in the case record. The program plan shall be established by the end of 7 days from admission and shall address the identified needs in the emotional, physical, educational, social, familial, and where appropriate independent living skill domains. Youth may not have identified needs in every domain. If so, document no needs were identified. Program plans shall be updated when new needs are identified or when program goals are met. Program plans shall be thoroughly reviewed, and revisions made within 30 days of completion of initial program plan and each 30 days thereafter. This includes updated information of the progress of the youth's goals. Information obtained from the youth, parent, guardian, and CMP Case Manager shall be considered in the report. The initial program plan and all updates shall be sent to the CMP Case Manager.

Program plan development, review, and case supervision are carried out by the Emergency Shelter/ESC provider.

The program plan shall include individualized services to match the youth's identified needs in the following areas:

- Long term goals in the areas of:
    1. physical health
    2. family relations
    3. daily living skills
    4. academic and/or vocational skills
    5. interpersonal relations
    6. substance use service needs
    7. emotional/psychological health
- Short term goals which will help a youth eventually reach his/her long-term goals in each of the above areas.
- Services to meet independent living goals.
- Specific plans for reaching the short-term goals including services to be provided and frequency.

- Estimated time for reaching short term goals.
- The youth shall sign and date the program plans indicating participation and input in the development of the plan.
- Updated information of the progress of the youth's goals shall be included.

Emergency Shelter/ESC staff shall participate in case planning conference conducted by CMP Case Manager.

PERMANENCY PLANNING

Includes the evaluation and design of an approach for the youth and family that focuses on opportunities for the youth to have ongoing active and meaningful connections with family, kin, relatives, and the community. The goal for achieving permanency shall be coordinated with the youth's CMP Case Manager and be included in the program plan to be reviewed every 30 days. The permanency plan shall include strategies and tasks to accomplish the youth's goals. Behaviors which place the youth at risk for disruption, activities to prepare the youth's family or kinship network for reunification, identification of other less restrictive living environments and preparing the youth for transition to these settings shall be addressed.

VISITATION

Subject to the provider's visitation guideline (days of the week, times, appropriate attire, etc.) a provider shall not prohibit contact with a child's immediate family except for the following reasons:

- A court orders no contact
- There is documented violence, threatening or disruptive behavior by family member that occurred during contact
- There is documented introduction of contraband into the facility

The facility shall provide private accommodations for visitation. Accommodations shall include but not be limited to a private office/room, no staff presence (unless required), free of any individuals that may overhear confidential information.

When home visits are a part of the treatment plan, there shall be coordinated connections with the child, their family, and the case coordinator/facility program staff regarding the youth's treatment and program goals and objectives. The goal of placement shall be to return the child to a family-like setting, so it is important that home visits be carefully planned and executed in the best interests of permanency planning for the child. All home visits shall be arranged through coordination with the child's CMP Case Manager. Documentation in child's file shall include who is transporting children to and from family visits and observation of the child's behavior during transportation.

The child shall have an approved contact list to include, the type of contact allowed (letter, phone, day passes, overnight passes, etc.) The contact list must be reviewed/updated every 60 days. Approved contacts shall be determined by the CMP Case Manager. The initial contact list and all reviews/updates shall include the CMP Case Manager signature.

DISRUPTIONS

Agencies must provide at least 14 business days' notice to the Case Management Provider in asking for a removal of the child placed less than 180 days (6 months) and 30 days' notice for children placed longer than 180 days (6 months) unless the child is in imminent danger to themselves or others as defined below. Timelines for placement move notices are defined as per KS Statute (i.e., K.S.A. 38-2258 of the Children in Need of Care code (K.S.A. 38-2201) and DCF's PPM (i.e., PPM 3362 Thirty Day Notice of Planned Move, PPM 3364 Exceptions to Thirty Day Notice of Planned Move) and should be followed accordingly.

If DCF or Law Enforcement is requiring immediate removal of a child due to the facility's inability to provide safety or stability for the child, CMP will be required to locate an alternate placement provider for the necessary disruption period. The Case Management Providers expects the placement provider to submit a Disruption Notice Form the next business day after the emergency removal occurs.

Emergency removal of a child from a residential facility that does not require the notice above will only be considered if one of the following has occurred:

- Child is admitted to an acute care facility
- Child is detained for a criminal offense
- Child is AWOL for more than 24 hours.
- Child has sexually assaulted another child within the facility or has attempted to sexually assault another child within the facility.
- Physical harm to the staff or other children in the facility, which cannot be rectified by a safety plan or continues to escalate. Facilities are to first utilize other services available (i.e., law enforcement intervention, screening into acute services). These situations will be staffed on a case by case basis.

DISCHARGE/AFTERCARE PLAN

Discharge planning shall begin upon admission of the youth to the facility. At a minimum, the child, the child's parents if applicable or guardian if applicable, and the placing agency shall be involved in planning the discharge from the facility.

A discharge summary shall be completed at the time of the youth's discharge and be forwarded to the CMP Case Manager within one business day. The discharge summary shall include be written:

- Summary of progress, or lack thereof, of the youth's goals and objectives while the youth was in placement

- Summary of the youth's behavior while in placement
- Recommendations for aftercare services specifying the nature, frequency, duration of services and responsible parties
- Summary of the reasons the youth was discharged

RECORD KEEPING

The record keeping requirements of K.A.R. 28-4-272 shall be met by the facility. In addition, the following shall be kept by the facility. If a facility chooses to use electronic filing full access shall be given to DCF employees who are conducting site visit.

CHILD'S FILE:

The provider shall maintain a file for each child. The file shall contain the following:

- Child's name and date of birth
- Name, address and emergency contact information of the child's CMP Case Manager
- Foster Care Confirmation of Placement
- Current CMP Referral form
- Current CMP Case Plan
- If reunification is the goal, evidence demonstrating that the parent from whom the child was removed provided input on the members of the family and permanency plan.
- Initial Assessment
- Suicide/self-injury questionnaire
- Room assignment assessment
- Medical and surgical consents
- Medical and dental records (history and current)
- Documentation of diagnosis (history and current)
- Records of the child's prescription(s) and non-prescription(s) and when administered
- Authorization for release of confidential information
- Daily observation logs by shift
- Weekly progress notes
- Program plans
- Treatment Plans, if applicable
- Discharge plans/Aftercare
- Approved contact list
- Resident's rights acknowledgement
- Emergency Safety Intervention/de-escalation acknowledgements
- Handbook/Rules acknowledgement
- Pre and Post visit documentation

- Significant incident reports
- Personal Property Inventory
- Educational documentation

RECORD RETENTION:

Case records, including medical records, shall be maintained for 6 years from the date of the child's discharge or until completion of an on-going audit and production of a final audit report, whichever is longer.

Daily Observations:

A dated record of daily observations and significant occurrences involving each child shall be maintained by each shift and maintained in each child's individual file. The record shall include events which may affect the well-being of the child. Significant events should include but not be limited to; attendance at school or groups (specific group), interactions and/or interventions with staff and other children, medical appointments, mental health appointments, medication compliance, hygiene (if identified as a need), visits/passes, meals eaten and overall behavior. Each report shall include the staff member and/or child involved, the nature of the incident and the circumstances surrounding it. The record shall be available to review.

WEEKLY PROGRESS NOTES:

Notes shall be completed by the case coordinator. These notes shall be entered the child's chart, reflecting the delivery of services according to the treatment plan. This documentation shall address the child's responses to interventions and the progress of the child on individualized goals and objectives. The note shall include any significant events that occurred during the week and shall also summarize contacts with family members and other involved agencies. If an unmet need is identified, the note shall reflect the actions to be taken to revise the plan to meet that need. The case coordinator shall document specific services and activities they are providing to each child. Each month the weekly progress notes shall be sent to the CMP Case Manager. The Monthly Progress Report Form shall be submitted to each child's provider no later than the 15th of each month following the reporting month, for all children who are in placement more than 15 days of that calendar month. Submission will be accepted by e-mail to:

- Cornerstones of Care: KSmonthlyprogressreports@Cornerstonesofcare.org
- KVC: KVCMonthlyReports@KVC.org
- St. Francis Ministries: MonthlyProgressReports@st-francis.org
- TFI: MonthlyReports@TFIFamily.org

HEALTH RECORDS:

Health Care and Records of children shall meet the requirements of K.A.R. 28-4-275. Records of over the counter and prescribed medications shall be kept in each child's case medical record and include the:

- name of the prescribing physician
- name of the medication
- dosage prescribed
- medication schedule
- purpose of the medication
- noted side effects
- date of the prescription
- date prescribed by a physician

A record of medication given, amount, date and time, and person dispensing shall be recorded. All doctor and dental visits, major illnesses, and accidents shall be recorded. Mental health appointments shall also be specifically documented in a child's medical record. This provides for a complete Health record for the child and their family, which documents the frequency of the youth's mental health treatment.

PERSONNEL RECORDS:

A separate file shall be maintained for each employee. Personnel files shall include the following:

- Written employment application, resume and reference checks
- Date of hire and start date
- Position description
- Educational transcripts, HS diploma, college degree, etc.
- Copy of driver's license/Kansas ID (current)
- Disciplinary action records
- Training records
- Out of state registry checks, when applicable (staff member has lived outside of Kansas within the last 5 years)

CHAPTER 9: RESIDENTIAL MATERNITY CARE (RMC)

All facilities and foster homes shall follow the guidelines outlined in K.S.A. 38-2202, "Reasonable and Prudent Parenting Standard", "means the standard characterized by careful and sensible parental decisions that maintain the health, safety and best interests of a child while at the same time encouraging the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in FC under the responsibility of the state to participate in extracurricular, enrichment, cultural and social activities."

GENERAL PROGRAM DESCRIPTION

A Residential Maternity Care (RMC) facility is a 24-hour group home or residential facility that meets the requirements of K.A.R. 28-4-123-132 and K.A.R. 28-4-268-280. It is non-secure residential services whose primary purpose is devoted to the maintenance and counseling of pregnant youth who need services related to their pregnancy and planning and care for the unborn child through labor, delivery and postnatal care. RMC's providing care for pregnant youth shall meet the requirements of K.A.R. 28-4-279. RMC's providing care for post-partum youth and infants shall meet the requirements of K.A.R. 28-4-280.

The range of services to be delivered by the RMC facility to meet the variety of individual needs of the youth shall be clearly defined. The General Program description approved by DCF Prevention and Protection Services shall include but not be limited to:

- goals of the program
- behavior management system
- job descriptions (responsibilities, functions, and qualifications)
- policies and procedures
- daily living activities
- health services
- recreation activities
- visitation policies

The purpose of placement in an RMC is to improve the youth's decision making, coping skills, social skills, and to address any underlying problems which are affecting the youth, while teaching the youth how to handle their behaviors in order to transition successfully back into their family or community.

DCF requires foster parents and designated officials at childcare institutions to apply the reasonable and prudent parenting standard. The standard is characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while at the same time encouraging the child's emotional and developmental growth that a caregiver

must use when determining whether to allow a child in foster care to participate in extracurricular, enrichment, cultural, and social activities.

As part of this standard, it is recognized hair and skin care are an integral to self-worth of children, youth, and young adults. Cultural identities of children, youth and young adults should be considered and honored, through a variety of activities related to hair and skin care. At no time should children, youth, or young adults be denied access to this basic right and need as a means of behavioral control, punishment, or rewards.

Facilities shall ensure staff have access to and knowledge of local and online resources for professional hair and skin care, as well as offer continuing education or training opportunities for staff on these topics. Furthermore, the facility shall encourage and facilitate staff to consult with the child, youth, young adults, parents or other relatives/kin connections regarding preferences, tools and hygiene products recommended, processes, and supports for meeting the individual's needs surrounding these matters.

DESCRIPTION OF YOUTH TO BE SERVED

- Population served is pregnant or post-partum mothers thru age 21, who:
    1. Display a need for more structure and supervision than provided in a family foster home due to behaviors which might include difficulty with authority figures, minor offenses, and difficulty in school.
    2. And child who is not a recipient of TANF
- Youth who DO NOT meet the standard for Psychiatric Residential Treatment Facility (PRTF) admission, who are not in need of intensive treatment, and for whom family based services are not appropriate to meet the youth's needs.
- Youth awaiting a PRTF screen may reside in an RMC until the time of the screen.
- If a youth is in an RMC awaiting a screen the screen shall be completed within 14 days but shall be completed as soon as possible. If the youth screens into a PRTF they can stay up to 14 days while awaiting a PRTF bed.
- No more than 50 percent of the youth in an RMC facility may have screened into a PRTF and be in the 14-day waiting period for a PRTF placement.
- Youth may step down to an RMC from a PRTF after the screener and treatment team have determined the youth no longer needs the level of care provided by a PRTF.

GENERAL STAFFING REQUIREMENTS

- The administrator in a RMC (meeting residential center standards K.A.R 28-4-268 (t) more than 10 residents) shall have a Bachelors degree, prior administrative experience and a working knowledge of child development principles
- The administrator in a RMC (meeting group home standards K.A.R 28-4-268 (i)) not less than five nor more than ten persons) shall have at least a high school diploma or

GED, prior administrative experience and a working knowledge of child dvelopment principles

- Program plan development, review, and case supervision are carried out by the RMC's Case Coordinator.
- The youth to case coordinator ratio in a RMC is 1:16
- The Case Coordinator shall have at least a bachelor's degree in one of the human service fields (social work, psychology, human development and family life, criminal justice, counseling), nursing, or education.
- Facility staff shall be trained to effectively meet the special needs of youth who require this level of care.
- Facility staff shall be at least 21 years of age with a minimum of three years age difference between the facility staff and oldest child/youth who can be admitted to the facility.
- The staff ratio is 1:7. during waking hours and 1:10 during sleeping hours. There shall be 24-hour awake staff to insure youth safety. A higher ratio shall be maintained if youth and/or their behaviors become hard to manage at the listed ratios.
- Staff will randomly conduct a minimum of four (4) sight checks on youth every hour when the youth is at an increased risk of elopement or sexual misconduct

CASE COORDINATION

The care coordinator has the responsibility for coordinating the child's program and progress with the CMP Case Manager, school, employer, family, important connections, Family Finding model or similar specific tools, and other appropriate community resources. This shall include, but not be limited to, talking with the youth about important connections and possible family connections, documenting connections, documenting phone calls, appointments and visits (on and off site). The care coordinator will add information about important connections and family connections, and Family Finding tools to the program plan, weekly and monthly progress reports sent to the CMP.

The Care Coordinator will maintain a resource base of services to address the needs identified in Individual Program Plans and document in the youth's file, when and what community resources have been contacted and utilized for services for the youth. The case coordinator shall be responsible for Weekly Progress Notes (see Section 14: Record Keeping).

STAFF IN-SERVICE TRAINING

ORIENTATION

Each facility shall have an in-service orientation training program for new employees, which is especially directed toward the initial training needs of staff working directly with children.

Documentation of completion of orientation training shall be kept, in the staff member's personnel file.

The documentation shall be placed in a specific area in the staff's file, indicating:

- staff training, reflecting orientation or annual training
- name of trainer
- name of training
- specify the number of training hours
- date of the training

Facility staff shall have completed a minimum of 18 hours of in-service orientation training. Staff shall demonstrate competency in the trainings from orientation before they can work independently with children.

All topics listed below shall be trained, even if it exceeds the minimum 18 hours of orientation:

Facility Trainings:

- Facility policy and procedures manual
- Facility emergency and evacuation procedures
- Facility discipline standards
- Child record documentation policies and procedures
- Resident rights (See Appendix 4, Resident Rights)
- Confidentiality laws
- Report Writing

Trainings from an outside source and/or trained trainers within the facility (source must be well recognized and qualified, trained trainers must have documentation on file):

- Emergency safety interventions (including management of aggressive or suicidal behavior) (if a facility chooses to use Emergency Safety Intervention staff shall be certified)
- De-escalation (staff shall be certified)
- The handling of blood borne pathogens
- Medication Administration (staff who pass medications shall be certified)
- Certified in CPR/First Aid
- Trauma based informed care/trauma specific intervention
- Mandated Reporting (Provided By DCF)
  http://www.dcf.ks.gov/services/MRT/Pages/default.aspx

- Health Insurance Portability and Accountability Act (HIPAA)
- Comprehensive LGBTQ+
- Human Trafficking and exploitation
- Cultural Diversity

- Suicide Prevention/Intervention/Safety
- Family-focused training (i.e., Family Finding, Team Decision Making, Family Group Decision Making, Signs of Safety, etc.)

ANNUAL IN-SERVICE TRAINING

Annual training is beyond or in addition to the initial 18-hour orientation training program from the date of employment. During the first year of employment staff shall receive a minimum of 36 hours of training (18 orientation hours, 18 annual In-Service).

All QRTP direct care staff shall have a minimum of 18 documented clock hours of in-service training per year. Documentation shall be provided in each staff member's personnel record to include content, amount of time, trainer, and qualifications.

The documentation shall be placed in a specific area in the staff's file, indicating:

- staff training, reflecting orientation or annual training
- name of trainer
- name of training
- specify the number of training hours
- date of the training

All topics listed below shall be trained, even if it exceeds the minimum 18 hours of annual in-service:

Facility Refreshers/Trainings:

- Facility policy and procedures manual
- Facility emergency and evacuation procedures
- Facility discipline standards
- Child record documentation policies and procedures
- Resident rights (See Appendix 4, Resident Rights)
- Confidentiality laws

Refreshers/Trainings from an outside source and/or trained trainers within the facility (source must be well recognized and qualified, trained trainers must have documentation on file):

- Emergency safety interventions (including management of aggressive or suicidal behavior) (staff shall maintain certification)
- De-escalation (staff shall maintain certification)
- The handling of blood borne pathogens
- Medication Administration (staff shall maintain certification, may or may not require annual training)
- CPR/First Aid (Staff shall maintain certification, may or may not require annual training)

- Trauma based informed care/trauma specific intervention
- Mandated Reporting (Provided By DCF)
  http://www.dcf.ks.gov/services/MRT/Pages/default.aspx

- Health Insurance Portability and Accountability Act (HIPAA)
- Comprehensive LGBTQ+
- Childhood and adolescent sexuality issues, especially the effects of early sexual abuse
- Substance Use Disorders
- Blood Borne Pathogens
- Childhood and adolescent development (including developmental disorders)
- Childhood and adolescent psychopathology (including such topics as effects of abuse/neglect, reactive attachment disorders, separation anxiety disorders, ADHD)
- Suicide Prevention/Intervention/Safety
- Family-focused training (i.e., Family Finding, Team Decision Making, Family Group Decision Making, Signs of Safety, etc.)

CONFIRMATION OF PLACEMENT

A Foster Care Confirmation of Placement (PPS 5122) **is available through the CareMatch system which confirms the placement arranged by the Child Welfare Case Management Provider (CMP).**

INITIAL ASSESSMENT

When a youth enters the facility, the RMC shall begin assessing their strengths and needs immediately and have a completed assessment within 7 days from admission.

The assessment shall include but not be limited to the following:

- Reasons for referral to the facility
- Evaluation or assessment covering the following areas:
  1. Physical health
  2. Family relations
  3. Academic or vocational training
- Community life
- Interpersonal interactions
- Important connections and family connections
- Daily living skills as outlined in the scope of services listed above
- Immediate service needs:
  1. Mental Health
  2. Developmental
  3. Dental

4. Medical

- Involvement or exposure to Substance Use/disorder
- Involvement or exposure to other trauma
- Assessment of youth's self- injuring or suicidal attempts

Placement needs of the youth shall be assess with regards to most appropriate next placement.

Physical and mental health needs shall be coordinated with assigned CMP and youth's assigned Managed Care Organization (MCO).

ROOM ASSIGNMENT

To support the daily management and administration of children/youth, each residential provider shall develop an objective formal procedure to assess physical housing needs of children. Children in a residential facility shall be assigned to a room based upon a range of factors, as identified by risk/needs assessment(s) in addition to other indicators. Factors to consider in assigning rooms shall include (but are not limited to):

- Suicidal tendencies
- Level of specialized needs (i.e., mental health, medical, etc.)
- Displaying inappropriate sexual behaviors /victims of sexual abuse)
- Gender
- Age and/or maturity level
- Program needs (substance use disorder, cognitive behavioral, independent living, etc.)
- Vulnerability to being victimized by others (i.e., physical stature)
- Comprehensive LGBTQ+

While each child will have an individualized program plan, assigning rooms based upon risk/need/responsivity factors will allow for a safer, more secure environment, as well as efficient and effective management of the living units. The child's room assignment and how the decision was made shall be documented in the child's file. The room assignment shall be completed immediately upon admission.

SERVICES

The provider shall write a policy and procedure manual for the operation of the RMC facility that will be reviewed and approved by DCF Prevention and Protection Services. The daily schedule shall address the needs of the children/youth and the use of time to enhance the child's/youth's physical, mental, emotional, and social development. The facility shall provide supervised indoor and outdoor recreation so that every child/youth may participate. Age appropriate equipment and outdoor play space to promote physical development and physical fitness shall be available. Age appropriate socialization shall be

provided utilizing community resources to assist the youth in transitioning back into their community when appropriate.

The RMC will provide a program for youth in the facility that covers the following program components:

Daily Living Services - Daily living services shall be provided and include the following:

- room
- board
- childcare
- personal spending money
- personal care needs
- school fees
- transportation to appointments within a 60-mile radius; including to and from school, medical care, recreation, etc.
- academic activities
  1. assistance with schoolwork
  2. vocational training, and/or
  3. G.E.D. training

Situational Training- to include but not limited to:

Personal Hygiene:

- teaching about body cleanliness
- use of deodorants and cosmetics
- appropriate clothing
- choosing clothing to fit individual and occasion
- keeping clothes neat and clean

Health:

- identifying and understanding children/youth health needs
- securing and utilizing necessary medical treatment including preventive and health maintenance services
- gaining information and education in health maintenance including:
  1. preventive measures
  2. nutrition
  3. menstruation
  4. rest
  5. cleanliness
  6. family planning
  7. drugs
  8. sexually transmitted diseases
  9. exercise
  10. motivation for meeting own health needs
- maintaining contact with providers of health services (physician, nurse, clinic)
- using outside resources for assistance (clinics, pharmacies, hospitals)

Consumer education for independent living:

- budgeting
- comparative buying
- installment buying
- avoiding risks
- identifying illegal or excessive interest rates
- use of credit
- avoiding or dealing with debts
- using checking and savings accounts
- paying taxes

Communication skills:

The youth's articulating thoughts and feelings through appropriate use of such skills as:

- speech
- writing
- use of the landline/cell telephones
- computer
- social networking
- internet

Home Management:

- making the bed and changing linens
- using the vacuum cleaner
- dusting
- organizing belongings
- disposing of trash
- cleaning all areas of the home
- operating appliances
- cooking complete meals
- making simple repairs
- who to call for major repairs
- being aware of the need for upkeep
- handling emergencies
- knowing first aid

Situational Guidance:

- coping and self-regulation skills
- identifying and accepting strengths
- developing patterns of acceptance
- coping with authority figures
- getting along with others
- sharing responsibility
- being considerate of others
- developing friendships

- knowing when to go home when visiting
- recognizing or modifying attitudes toward self or others
- responsible work attitudes
- tolerance of corrective feedback
- reactions to praise
- punctuality
- attendance
- birthing classes
- parenting classes
- recognizing post-partum depression

Recreation:

- participating in leisure time activities
- learning how to spend leisure time
- developing outside activities
- managing time
- finding recreation with little or no expense involved
- finding community projects to take part in, participating in social groups
- participating in sports and games
- arts and crafts
- appreciating fine arts

BEHAVIOR MANAGEMENT

Each RMC shall have a written program of consistent rules and regulations guiding and governing the daily behavior of the youth under the care of the program. The behavior management system shall include a description of daily general routines of the program. The system of rules, rewards, and consequences for given behaviors shall be identified. Each youth shall be oriented to the RMC's behavior management system by a staff member during the admission or orientation process. Notation shall be made in the youth's file and signed by the youth that the rules and regulations, rewards and consequences have been discussed with the youth.

The RMC facility shall post the behavior management system in a common area where youth are able to easily access the system and the youth shall be given a written copy of the system to use as a reference. Behavioral management shall include rules governing:

- interpersonal interactions with staff and peers
- facility leave policies
- school attendance and behavior while at school
- verbal and physical aggression
- allowable possessions
- awakening and bedtime hours

- leisure hours
- visitation policies
- runaway attempts
- involvement in recreation and other activities
- self-destructive behaviors
- sexuality
- communications with family and others outside the program
- religious worship
- involvement in therapies
- theft, property destruction
- behaviors resulting in mandatory removal from the program
- behaviors at the program which could result in legal prosecution

When a youth decides not to attend religious worship or activities, alternative supervised activities shall be made available.

The overarching goals shall be to not only help the youth adjust to the residential facility but also to daily life within society. A resources list shall be maintained by the facility of the available resources to meet the youth's needs in the community.

Discipline at the facility shall be consistent and not be physically or emotionally damaging. Youth shall not be subjected to cruel, severe, unusual, or unnecessary punishment. Youth shall not be subjected to remarks that belittle or ridicule them or their families. Children/youth shall not be denied food, mail, telephone calls or visits with their families as punishment. Seclusion shall not be utilized as a disciplinary measure. Only staff members shall discipline children/youth.

RESETTING

A procedure used to assist the child to regain emotional control by removing them from his or her immediate environment and restricting the child to a quiet area or unlocked quiet room.

APPLICATION OF A RESET:

- A child in a reset shall never be physically prevented from leaving the reset area.
- Resets may take place away from the area of activity or from other children.
- Staff shall monitor the child while he or she is in resetting.

DE-ESCALATION CERTIFICATION

De-escalation is a technique used during a potential crisis in an attempt to prevent a child from causing harm to themselves, others and/or staff. De-escalation techniques shall be

utilized for any activity required to diffuse a conflict or intense situation to ensure safety and calm the child. Staff shall be certified in authorized, evidenced based de-escalation techniques programs for managing aggressive behavior. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the child and parent (if applicable)/guardian and/or CMP Case Manager shall be oriented to the managing aggressive behaviors policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the child's case record.

EMERGENCY SAFETY INTERVENTIONS CERTIFICATION

An emergency safety intervention shall be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the child's chronological and developmental age, size, gender physical, medical, psychiatric condition, and personal history.

The use of emergency safety interventions shall be performed only through the use of nationally recognized restraint procedures applicable to this population designed to prevent a child from harming self or others by exerting external control over physical movement.

An emergency safety intervention is the application of physical force without any mechanical device, for the purpose of restricting the free movement of a child's body. **An emergency safety intervention shall be used only as last resort after all verbal de-escalation techniques have failed and when the child/youth is at-risk of harming themselves or others.**

Mechanical restraint is the use of mechanical devices to restrict the free movement of the child's body, most often for purposes of preventing self-destructive behavior. **Mechanical restraints are not allowed in RMC residential facilities.**

Each facility shall have a written policy and all staff shall be trained to provide safe emergency safety interventions. Staff shall be certified in authorized, evidenced based training programs for managing aggressive behavior and de-escalation techniques. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the child and parent (if applicable)/guardian (if applicable) and/or CMP Case Manager shall be oriented to the emergency safety intervention policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the child's case record.

PROGRAM PLAN

Each youth residing in a residential facility shall have a program plan that is based on a thorough assessment. Assessment documents shall be included in the case record. The program plan shall be established by the end of 14 days from admission and shall address the identified needs in the emotional, physical, educational, social, familial, and where appropriate independent living skill domains. Youth may not have identified needs in every domain. If so, document no needs were identified. Program plans shall be updated when new needs are identified or when program goals are met. Program plans shall be thoroughly reviewed, and revisions made at the case review conferences within 30 days of completion of initial program plan and each 30 days thereafter including updated information of the progress of the youth's goals. Information obtained from the youth, parent, guardian, and CMP Case Manager shall be considered in the report. The initial program plan and all updates shall be sent to the CMP Case Manager.

The program plan shall include individualized services to match the youth's identified needs in the following areas:

- Long term goals in the areas of:
    1. physical health
    2. family relations
    3. daily living skills
    4. academic and/or vocational skills
    5. interpersonal relations
    6. substance use service needs
    7. emotional/psychological health

- Short term goals which will help a youth eventually reach his/her long-term goals in each of the above areas.
- Services to meet independent living goals.
- Specific plans for reaching the short-term goals including services to be provided and frequency.
- Estimated time for reaching short term goals.
- The youth shall sign and date the program plans indicating participation and input in the development of the plan.
- Updated information of the progress of the youth's goals shall be included.

RMC staff shall participate in the case plan conducted by the CMP Case Manager.

PERMANENCY PLANNING

Includes the evaluation and design of an approach for the youth and family that focuses on opportunities for the youth to have ongoing active and meaningful connections with family,

kin, relatives, and the community. The goal for achieving permanency shall be coordinated with the youth's CMP Case Manager and be included in the program plan to be reviewed every 30 days. The permanency plan shall include strategies and tasks to accomplish the youth's goals. Behaviors which place the youth at risk for disruption, activities to prepare the youth's family or kinship network for reunification, identification of other less restrictive living environments and preparing the youth for transition to these settings shall be addressed.

VISITATION

Subject to the provider's visitation guideline (days of the week, times, appropriate attire, etc.) a provider shall not prohibit contact with a child's immediate family except for the following reasons:

- A court orders no contact
- There is documented violence, threatening or disruptive behavior by family member that occurred during contact
- There is documented introduction of contraband into the facility

The facility shall provide private accommodations for visitation. Accommodations shall include but not be limited to a private office/room, no staff presence (unless required), free of any individuals that may overhear confidential information.

When home visits are a part of the treatment plan, there shall be coordinated connections with the child, their family, and the case coordinator/facility program staff regarding the youth's treatment and program goals and objectives. The goal of placement shall be to return the child to a family-like setting, so it is important that home visits be carefully planned and executed in the best interests of permanency planning for the child. All home visits shall be arranged through coordination with the child's CMP Case Manager. Documentation in child's file shall include who is transporting children to and from family visits and observation of the child's behavior during transportation.

The child shall have an approved contact list to include, the type of contact allowed (letter, phone, day passes, overnight passes, etc.) The contact list must be reviewed/updated every 60 days. Approved contacts shall be determined by the CMP Case Manager. The initial contact list and all reviews/updates shall include the CMP Case Manager signature.

DISRUPTIONS

Agencies must provide at least 14 business days' notice to the Case Management Provider in asking for a removal of the child placed less than 180 days (6 months) and 30 days' notice for children placed longer than 180 days (6 months) unless the child is in imminent danger

to themselves or others as defined below. Timelines for placement move notices are defined as per KS Statute (i.e., K.S.A. 38-2258 of the Children in Need of Care code (K.S.A. 38-2201) and DCF's PPM (i.e., PPM 3362 Thirty Day Notice of Planned Move, PPM 3364 Exceptions to Thirty Day Notice of Planned Move) and should be followed accordingly.

If DCF or Law Enforcement is requiring immediate removal of a child due to the facility's inability to provide safety or stability for the child, CMP will be required to locate an alternate placement provider for the necessary disruption period. The Case Management Providers expects the placement provider to submit a Disruption Notice Form the next business day after the emergency removal occurs.

Emergency removal of a child from a residential facility that does not require the notice above will only be considered if one of the following has occurred:

- Child is admitted to an acute care facility
- Child is detained for a criminal offense
- Child is AWOL for more than 24 hours.
- Child has sexually assaulted another child within the facility or has attempted to sexually assault another child within the facility.
- Physical harm to the staff or other children in the facility, which cannot be rectified by a safety plan or continues to escalate. Facilities are to first utilize other services available (i.e., law enforcement intervention, screening into acute services). These situations will be staffed on a case by case basis.

DISCHARGE/AFTERCARE PLAN

Discharge planning shall begin upon admission of the youth to the facility. At a minimum, the child/youth, the child's/youth's parents, if applicable or guardian, and the CMP Case Manager shall be involved in planning the discharge from the facility.

A discharge summary shall be completed at the time of the youth's discharge and be forwarded to the CMP Case Manager within one business day. The discharge summary shall include written:

- Summary of progress, or lack thereof, of the youth's goals and objectives while the youth was in placement
- Summary of the youth's behavior while in placement
- Recommendations for aftercare services specifying the nature, frequency, duration of services and responsible parties
- Summary of the reasons the youth was discharged

RECORD KEEPING

The record keeping requirements of K.A.R. 28-4-272 shall be met by the facility. In addition, the following shall be kept by the facility. If a facility chooses to use electronic filing full access shall be given to DCF employees who are conducting site visit.

CHILD'S FILE:

The provider shall maintain a file for each child. The file shall contain the following:

- Child's name and date of birth
- Name, address and emergency contact information of the child's CMP Case Manager
- Current CMP Referral form
- Current CMP Case Plan
- Foster Care Confirmation of Placement
- If reunification is the goal, evidence demonstrating that the parent from whom the child was removed provided input on the members of the family and permanency plan.
- Initial Assessment
- Suicide/self-injury questionnaire
- Room assignment assessment
- Medical and surgical consents
- Medical and dental records (history and current)
- Documentation of diagnosis (history and current)
- Records of the child's prescription(s) and non-prescription(s) and when administered
- Authorization for release of confidential information
- Daily observation logs by shift
- Weekly progress notes
- Program plans
- Treatment Plans, if applicable
- Discharge plans/Aftercare
- Approved contact list
- Resident's rights acknowledgement
- Emergency Safety Intervention/de-escalation acknowledgements
- Handbook/Rules acknowledgement
- Pre and Post visit documentation
- Significant incident reports
- Personal Property Inventory
- Educational documentation

RECORD RETENTION

Case records, including medical records, shall be maintained for 6 years from the date of the child's discharge or until completion of an on-going audit and production of a final audit report, whichever is longer.

Daily Observations

A dated record of daily observations and significant occurrences involving each child shall be maintained by each shift and maintained in each child's individual file. The record shall include events which may affect the well-being of the child. Significant events should include but not be limited to; attendance at school or groups (specific group), interactions and/or interventions with staff and other children, medical appointments, mental health appointments, medication compliance, hygiene (if identified as a need), visits/passes, meals eaten and overall behavior. Each report shall include the staff member and/or child involved, the nature of the incident and the circumstances surrounding it. The record shall be available to review.

Weekly Progress Notes

Notes shall be completed by the case coordinator. These notes shall be entered the child's chart, reflecting the delivery of services according to the treatment plan. This documentation shall address the child's responses to interventions and the progress of the child on individualized goals and objectives. The note shall include any significant events that occurred during the week and shall also summarize contacts with family members and other involved agencies. If an unmet need is identified, the note shall reflect the actions to be taken to revise the plan to meet that need. The case coordinator shall document specific services and activities they are providing to each child. Each month the weekly progress notes shall be sent to the CMP Case Manager. The Monthly Progress Report Form shall be submitted to each child's provider no later than the 15th of each month following the reporting month, for all children who are in placement more than 15 days of that calendar month. Submission will be accepted by e-mail to:

- Cornerstones of Care: KSmonthlyprogressreports@Cornerstonesofcare.org
- KVC: KVCMonthlyReports@KVC.org
- St. Francis Ministries: MonthlyProgressReports@st-francis.org
- TFI: MonthlyReports@TFIFamily.org

HEALTH RECORDS

Health Care and Records of children shall meet the requirements of K.A.R. 28-4-275. Records of over the counter and prescribed medications shall be kept in each child's case medical record and include the:

- name of the prescribing physician
- name of the medication
- dosage prescribed
- medication schedule
- purpose of the medication
- noted side effects
- date of the prescription
- date prescribed by a physician

A record of medication given, amount, date and time, and person dispensing shall be recorded. All doctor and dental visits, major illnesses, and accidents shall be recorded. Mental health appointments shall also be specifically documented in a child's medical record. This provides for a complete Health record for the child and their family, which documents the frequency of the youth's mental health treatment.

Personnel Records

A separate file shall be maintained for each employee. Personnel files shall include the following:

- Written employment application, resume and reference checks
- Date of hire
- Position description
- Educational transcripts, HS diploma, college degree, etc.
- Copy of driver's license/Kansas ID (current)
- Disciplinary action records
- Training records
- Out of state registry checks, when applicable (staff member has lived outside of Kansas within the last 5 years)

CHAPTER 10: SECURE CARE

All facilities and foster homes shall follow the guidelines outlined in K.S.A. 38-2202, "Reasonable and Prudent Parenting Standard", "means the standard characterized by careful and sensible parental decisions that maintain the health, safety and best interests of a child while at the same time encouraging the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in FC under the responsibility of the state to participate in extracurricular, enrichment, cultural and social activities."

GENERAL PROGRAM DESCRIPTION

A Secure Care facility is a 24-hour residential facility that meets the requirements of K.S.A. 38-2202 (bb) and K.A.R. 28-4-350 (u): defining a secure care facility. It also meets the requirements of K. A. R. 28-4-350-28-4-360 to provide twenty-four hour care in a DCF Licensing licensed secure care facility.

Secure facility means a facility which is operated or structured so as to ensure that all entrances and exits from the facility are under the exclusive control of the staff of the facility, whether or not the person being detained has freedom of movement within the perimeters of the facility, or which relies on locked rooms and buildings, fences or physical restraint in order to control behavior of its children. No secure facility other than a juvenile detention center shall be attached to or on the grounds of an adult jail or lock-up.

DCF requires foster parents and designated officials at childcare institutions to apply the reasonable and prudent parenting standard. The standard is characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while at the same time encouraging the child's emotional and developmental growth that a caregiver must use when determining whether to allow a child in foster care to participate in extracurricular, enrichment, cultural, and social activities.

As part of this standard, it is recognized hair and skin care are an integral to self-worth of children, youth, and young adults. Cultural identities of children, youth and young adults should be considered and honored, through a variety of activities related to hair and skin care. At no time should children, youth, or young adults be denied access to this basic right and need as a means of behavioral control, punishment, or rewards.

Facilities shall ensure staff have access to and knowledge of local and online resources for professional hair and skin care, as well as offer continuing education or training opportunities for staff on these topics. Furthermore, the facility shall encourage and facilitate staff to consult with the child, youth, young adults, parents or other relatives/kin

connections regarding preferences, tools and hygiene products recommended, processes, and supports for meeting the individual's needs surrounding these matters.

DESCRIPTION OF YOUTH TO BE SERVED

Youth are admitted to the facility who have been placed in a secure care facility Per K.S.A 2260 (f) (2 -3). The court may authorize the custodian to place the youth in a secure facility or juvenile detention facility, if the court determines that all other placement options have been exhausted or are inappropriate, based upon a written report submitted by the Secretary, if the youth is in the Secretary's custody, or submitted by a public agency independent of the court and law enforcement, if the youth is in the custody of someone other than the Secretary. The report to the court shall detail the behavior of the youth and the circumstances under which the youth was brought before the court and made subject to the order entered pursuant to subsection (a) of the CINC code.

The authorization to place the youth in a secure facility or juvenile detention facility pursuant to this subsection shall expire 60 days, inclusive of weekend and legal holidays, after its issue. The court may grant extensions of such authorization for two additional periods, each not to exceed 60 days, upon rehearing pursuant to K.S.A. 38-2256, and amendments thereto.

GENERAL STAFFING REQUIREMENTS

- Each secure care center director shall have at least a master's degree in social work or a related field, or shall have a bachelor's degree in social work, human development and family life, psychology or education and a minimum of three years of supervisory experience within a childcare agency.
- Facility staff shall meet the requirements of K.A.R. 28-4-353a. Facility staff shall be at least 21 years of age with a minimum of three years age difference between the facility staff and oldest child who can be admitted to the facility. Facility staff shall have at least a high school diploma or its equivalent and shall also have a minimum of:
    1. three semester hours of college level study in adolescent development, psychology or a related subject
    2. Eight hours of orientation training before assuming supervisory responsibility of the children.
    3. Staff shall have 32 hours of training before assuming independent supervisory responsibilities.
    4. All staff shall have 40 hours of training per year
    5. One year of experience as a childcare worker or house parent in a facility serving youth of the same age.
    6. Staff will randomly conduct a minimum of four (4) sight checks on youth every hour when the youth is at an increased risk of elopement or sexual misconduct

- The facility shall be staffed appropriately to meet the neeeds of all the children in their care. The staff: child ratio is 1:7 during waking hours and 1:11 during sleeping hours in accordance with K.A.R. 28-4-353(e) There shall be 24-hour awake staff to insure youth safety. A higher ratio shall be maintained if youth and/or their behaviors become hard to manage at the listed ratios.

CASE COORDINATION

The care coordinator has the responsibility for coordinating the child's program and progress with the CMP Case Manager, school, employer, family, important connections, Family Finding model or similar specific tools, and other appropriate community resources. This shall include, but not be limited to, talking with the youth about important connections and possible family connections, documenting connections, documenting phone calls, appointments and visits (on and off site). The care coordinator will add information about important connections and family connections, and Family Finding tools to the program plan, weekly and monthly progress reports sent to the CMP.

The Care Coordinator will maintain a resource base of services to address the needs identified in Individual Program Plans and document in the youth's file, when and what community resources have been contacted and utilized for services for the youth. The case coordinator shall be responsible for Weekly Progress Notes (see Section 14: Record Keeping).

STAFF IN-SERVICE TRAINING

Orientation

Each facility shall have an in-service orientation training program for new employees, which is especially directed toward the initial training needs of staff working directly with children. Documentation of completion of orientation training shall be kept, in the staff member's personnel file.

The documentation shall be placed in a specific area in the staff's file, indicating:

- staff training, reflecting orientation or annual training
- name of trainer
- name of training
- specify the number of training hours
- date of the training

Regulation requires 8 hours before supervising residents and 32 hours before assuming independent supervision 40 hours of orientation KAR 28-4-353a(2). DCF requirements may exceed 40 hours.

Facility staff shall have completed a minimum of 18 hours of in-service orientation training. Staff shall demonstrate competency in the trainings from orientation before they can work independently with children.

All topics listed below shall be trained, even if it exceeds the minimum 18 hours of orientation:

Facility Trainings:

- Facility policy and procedures manual
- Facility emergency and evacuation procedures
- Facility discipline standards
- Child record documentation policies and procedures
- Resident rights (See Appendix 4, Resident Rights)
- Confidentiality laws
- Report Writing

Trainings from an outside source and/or trained trainers within the facility (source must be well recognized and qualified, trained trainers must have documentation on file):

- Emergency safety interventions (including management of aggressive or suicidal behavior) (if a facility chooses to use Emergency Safety Intervention staff shall be certified)
- De-escalation (staff shall be certified)
- The handling of blood borne pathogens
- Medication Administration (staff who pass medications shall be certified)
- Certified in CPR/First Aid
- Trauma based informed care/trauma specific intervention
- Mandated Reporting (Provided By DCF)
  http://www.dcf.ks.gov/services/MRT/Pages/default.aspx

- Health Insurance Portability and Accountability Act (HIPAA)
- Comprehensive LGBTQ+
- Human Trafficking and exploitation
- Cultural Diversity
- Suicide Prevention/Intervention/Safety
- Family-focused training (i.e., Family Finding, Team Decision Making, Family Group Decision Making, Signs of Safety, etc.)

ANNUAL IN-SERVICE TRAINING

Annual training is beyond or in addition to the initial 18-hour orientation training program from the date of employment. During the first year of employment staff shall receive a minimum of 36 hours of training (18 orientation hours, 18 annual In-Service).

All Secure Care direct care staff shall have a minimum of 18 documented clock hours of in-service training per year. Documentation shall be provided in each staff member's personnel record to include content, amount of time, trainer, and qualifications.

K.A.R. 28-4-353A(3) requires 40 hours of orientation and 40 hours of annual training. DCF requirements may exceed 80 hours.

The documentation shall be placed in a specific area in the staff's file, indicating:

- staff training, reflecting orientation or annual training
- name of trainer
- name of training
- specify the number of training hours
- date of the training

All topics listed below shall be trained, even if it exceeds the minimum 18 hours of annual in-service:

Facility Refreshers/Trainings:

- Facility policy and procedures manual
- Facility emergency and evacuation procedures
- Facility discipline standards
- Child record documentation policies and procedures
- Resident rights (See Appendix 4, Resident Rights)
- Confidentiality laws

Refreshers/Trainings from an outside source and/or trained trainers within the facility (source must be well recognized and qualified, trained trainers must have documentation on file):

- Emergency safety interventions (including management of aggressive or suicidal behavior) (staff shall maintain certification)
- De-escalation (staff shall maintain certification)
- The handling of blood borne pathogens
- Medication Administration (staff shall maintain certification, may or may not require annual training)
- CPR/First Aid (Staff shall maintain certification, may or may not require annual training)
- Trauma based informed care/trauma specific intervention
- Mandated Reporting (Provided By DCF)
  http://www.dcf.ks.gov/services/MRT/Pages/default.aspx

- Health Insurance Portability and Accountability Act (HIPAA)
- Comprehensive LGBTQ+
- Childhood and adolescent sexuality issues, especially the effects of early sexual abuse

- Substance Use Disorders
- Blood Borne Pathogens
- Childhood and adolescent development (including developmental disorders)
- Childhood and adolescent psychopathology (including such topics as effects of abuse/neglect, reactive attachment disorders, separation anxiety disorders, ADHD)
- Suicide Prevention/Intervention/Safety
- Family-focused training (i.e., Family Finding, Team Decision Making, Family Group Decision Making, Signs of Safety, etc.)

CONFIRMATION OF PLACEMENT

A Foster Care Confirmation of Placement (PPS 5122) is available through the CareMatch system which confirms the placement arranged by the Child Welfare Case Management Provider (CMP).

The initial service authorization period for a Secure Care Facility stay will be for 60 days. The court may grant extensions of such authorization for two additional periods, each not to exceed 60 days, upon rehearing pursuant to K.S.A. 38-2256, and amendments thereto.

INITIAL ASSESSMENT

When a youth enters a Secure Care Facility, the facility shall immediately begin assessing their strengths and needs including documentation and shall have a completed assessment within 1 day of admission. The assessment shall include but not be limited to the following:

- Reasons for referral to the facility
- Evaluation or assessment covering the following areas:
    1. Physical health
    2. Family relations
    3. Academic or vocational training
- Community life
- Interpersonal interactions
- Important connections and family connections
- Daily living skills as outlined in the scope of services listed above
- Immediate service needs:
    1. Mental Health
    2. Developmental
    3. Dental
    4. Medical
- Involvement or exposure to Substance Use/disorder
- Involvement or exposure to other trauma
- Assessment of youth's self- injuring or suicidal attempts

Placement needs of the youth shall be assessed regarding most appropriate next placement. Physical and mental health needs shall be coordinated with assigned CMP Case Manager and youth's assigned Managed Care Organization (MCO).

ROOM ASSIGNMENT

To support the daily management and administration of children/youth, each residential provider shall develop an objective formal procedure to assess physical housing needs of children. Children in a residential facility shall be assigned to a room based upon a range of factors, as identified by risk/needs assessment(s) in addition to other indicators. Factors to consider in assigning rooms shall include (but are not limited to):

- Suicidal tendencies
- Level of specialized needs (i.e., mental health, medical, etc.)
- Displaying inappropriate sexual behaviors /victims of sexual abuse)
- Gender
- Age and/or maturity level
- Program needs (substance use disorder, cognitive behavioral, independent living, etc.)
- Vulnerability to being victimized by others (i.e., physical stature)
- Comprehensive LGBTQ+

While each child will have an individualized program plan, assigning rooms based upon risk/need/responsivity factors will allow for a safer, more secure environment, as well as efficient and effective management of the living units. The child's room assignment and how the decision was made shall be documented in the child's file. The room assignment shall be completed immediately upon admission.

SERVICES

The provider shall write a policy and procedure manual for the operation of the Secure Care Facility that will be reviewed and approved by DCF Prevention and Protection Services. The daily schedule shall address the needs of the children and the use of time to enhance the child's physical, mental, emotional, and social development. The facility shall provide supervised indoor and outdoor recreation so that every child may participate. Age appropriate equipment to promote physical development and physical fitness shall be available. Age appropriate socialization shall be provided utilizing community resources to assist the youth in transitioning back into their community when appropriate.

The Secure Care will provide a program for youth in the facility that covers the following program components:

Daily Living Services - Daily living services shall be provided and include the following:

- room
- board
- childcare
- personal spending money
- personal care needs
- school fees
- transportation to appointments within a 60-mile radius; including to and from school, medical care, recreation, etc.
- academic activities
    1. assistance with schoolwork
    2. vocational training
    3. G.E.D. training

Situational Training to include but not limited to:

Personal Hygiene

- teaching about body cleanliness
- use of deodorants and cosmetics
- appropriate clothing
- choosing clothing to fit individual and occasion
- keeping clothes neat and clean

Health

- identifying and understanding children's health needs
- securing and utilizing necessary medical treatment including preventive and health maintenance services

- gaining information and education in health maintenance including:
    1. preventive measures
    2. nutrition
    3. menstruation
    4. rest
    5. cleanliness
    6. family planning
    7. drugs
    8. sexually transmitted diseases
    9. exercise
    10. motivation for meeting own health needs
- maintaining contact with providers of health services (physician, nurse, clinic)
- using outside resources for assistance (clinics, pharmacies, hospitals)
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Consumer education for independent living:

- budgeting
- comparative buying

- installment buying
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- avoiding or dealing with debts
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Communication skills: The youth's articulating thoughts and feelings through appropriate use of such skills as:

- speech
- writing
- use of the, landline/cell telephones
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Home Management:

- making the bed and changing linens
- using the vacuum cleaner
- dusting
- organizing belongings
- disposing of trash
- cleaning all areas of the home
- operating appliances
- cooking complete meals
- making simple repairs
- whom to call for major repairs
- being aware of the need for upkeep
- handling emergencies
- knowing first aid

Situational Guidance:

- coping and self-regulation skills
- identifying and accepting strengths
- developing patterns of acceptance
- coping with authority figures
- getting along with others
- sharing responsibility
- being considerate of others
- developing friendships
- knowing when to go home when visiting
- recognizing or modifying attitudes toward self or others
- responsible work attitudes

- tolerance of corrective feedback
- reactions to praise
- punctuality
- attendance

Recreation:

- participating in leisure time activities
- learning how to spend leisure time
- developing outside activities
- managing time
- finding recreation with little or no expense involved
- finding community projects to take part in
- participating in social groups
- participating in sports and games
- arts and crafts
- appreciating fine arts

Each Secure Care Facility shall have a written program of consistent rules and regulations guiding and governing the daily behavior of the youth under the care of the program. The behavior management system shall include a description of daily general routines of the program. The system of rules, rewards, and consequences for given behaviors shall be identified. Each youth shall be oriented to the Secure Care Facility's behavior management system by a staff member during the admission or orientation process. Notation shall be made in the youth's file and signed by the youth that the rules and regulations, rewards and consequences have been discussed with the youth.

The Secure Care Facility shall post the behavior management system in a common area where youth are able to easily access the system and the youth shall be given a written copy of the system to use as a reference.

The system shall include rules governing:

- interpersonal interactions with staff and peers
- facility leave policies
- school attendance and behavior while at school,
- verbal and physical aggression,
- allowable possessions,
- awakening and bedtime hours,
- leisure hours,
- visitation policies,
- runaway attempts,
- involvement in recreation and other activities,
- self-destructive behaviors,
- sexuality,
- communications with family and others outside the program,
- religious worship,

- involvement in therapies,
- theft, property destruction,
- behaviors resulting in mandatory removal from the program
- behaviors at the program which could result in legal prosecution

Emphasis in the design of the secure care facility program is to be on addressing the youth's chronic running behaviors to eliminate current and future running behavior so the youth can be successful in a community non-secure setting.

Discipline at the facility shall be consistent and not be physically or emotionally damaging. Youth shall not be subjected to cruel, severe, unusual, or unnecessary punishment. Youth shall not be subjected to remarks that belittle or ridicule them or their families. Children shall not be denied food, mail, telephone calls or visits with their families as punishment. Seclusion shall not be utilized as a disciplinary measure. Only staff members shall discipline children.

RESETTING

A procedure used to assist the child in regaining regain emotional control by providing a safe and quiet area.

APPLICATION OF A RESET:

- A child in a reset shall never be physically prevented from leaving the reset area.
- Resets may take place away from the area of activity or from other children.
- Staff shall monitor the child while he or she is in resetting.

DE-ESCALATION CERTIFICATION

De-escalation is a technique used during a potential crisis to prevent a child from causing harm to themselves, others and/or staff. De-escalation techniques shall be utilized for any activity required to diffuse a conflict or intense situation to ensure safety and calm the child. Staff shall be certified in authorized, evidenced based de-escalation techniques programs for managing aggressive behavior. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the child and parent (if applicable)/guardian and/or CMP Case Manager shall be oriented to the managing aggressive behaviors policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the child's case record.

EMERGENCY SAFETY INTERVENTIONS CERTIFICATION

An emergency safety intervention shall be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the child's chronological and

developmental age, size, gender physical, medical, psychiatric condition, and personal history.

The use of emergency safety interventions shall be performed only through the use of nationally recognized restraint procedures applicable to this population designed to prevent a child from harming self or others by exerting external control over physical movement.

An emergency safety intervention is the application of physical force without any mechanical device, for the purpose of restricting the free movement of a child's body. **An emergency safety intervention shall be used only as last resort after all verbal de-escalation techniques have failed and when the child at-risk of harming themselves or others.**

Mechanical restraint is the use of mechanical devices to restrict the free movement of the child's body, most often for purposes of preventing self-destructive behavior. **Mechanical restraints are not allowed in Secure Care residential facilities.**

Each facility shall have a written policy and all staff shall be trained to provide safe emergency safety interventions. Staff shall be certified in authorized, evidenced based training programs for managing aggressive behavior and de-escalation techniques. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the child and parent (if applicable)/guardian (if applicable) and/or CMP Case Manager shall be oriented to the emergency safety intervention policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the child's case record.

PROGRAM PLAN

Each youth residing in a secure residential facility shall have a program plan that is based on a thorough assessment. Assessment documents shall be included in the case record. The program plan shall be established by the end of 14 days from admission and shall address the identified needs in the emotional, physical, educational, social, familial, and where appropriate independent living skill domains. Youth may not have identified needs in every domain. If so, document "no needs were identified". Program plans shall be updated when new needs are identified or when program goals are met. Program plans shall be thoroughly reviewed, and revisions made at the case review conferences within 30 days of completion of initial program plan and each 30 days thereafter including updated information of the progress of the youth's goals. Information obtained from the youth, parent, guardian, and CMP Case Manager shall be considered in the report. The initial program plan and all updates shall be sent to the CMP Case Manager.

The program plan shall include individualized services to match the youth's identified needs in the following areas:

- Long term goals in the areas of:
    - physical health

    - family relations
    - daily living skills
    - academic and/or vocational skills
    - interpersonal relations
    - substance use service needs
    - emotional/psychological health

- Short term goals which will help a youth eventually reach his/her long-term goals in each of the above areas.
- Services to meet independent living goals.
- Specific plans for reaching the short-term goals including services to be provided and frequency.
- Estimated time for reaching short term goals.
- The youth shall sign and date the program plans indicating participation and input in the development of the plan.
- Updated information of the progress of the youth's goals shall be included.

Secure Care staff shall participate in case plan conducted by CMP Case Manager.

PERMANENCY PLANNING

Includes the evaluation and design of an approach for the youth and family that focuses on opportunities for the youth to have ongoing active and meaningful connections with family, kin, relatives, and the community. The goal for achieving permanency shall be coordinated with the youth's– CMP Case Manager and be included in the program plan to be reviewed every 30 days. The permanency plan shall include strategies and tasks to accomplish the youth's goals. Behaviors which place the youth at risk for disruption, activities to prepare the youth's family or kinship network for reunification, identification of other less restrictive living environments and preparing the youth for transition to these settings shall be addressed.

VISITATION

Subject to the provider's visitation guideline (days of the week, times, appropriate attire, etc.) a provider shall not prohibit contact with a child's immediate family except for the following reasons:

- A court orders no contact
- There is documented violence, threatening or disruptive behavior by family member that occurred during contact
- There is documented introduction of contraband into the facility
- The Secure Care milieu is determined to be unsafe for visitors

The facility shall provide private accommodations for visitation. Accommodations shall include but not be limited to a private office/room, no staff presence (unless required), free of any individuals that may overhear confidential information.

When home visits are a part of the treatment plan, there shall be coordinated connections with the child, their family, and the case coordinator/facility program staff regarding the youth's treatment and program goals and objectives. The goal of placement shall be to return the child to a family-like setting, so it is important that home visits be carefully planned and executed in the best interests of permanency planning for the child. All home visits shall be arranged through coordination with the child's CMP Case Manager. Documentation in child's file shall include who is transporting children to and from family visits and observation of the child's behavior during transportation.

The child shall have an approved contact list to include, the type of contact allowed (letter, phone, day passes, overnight passes, etc.) The contact list must be reviewed/updated every 60 days. Approved contacts shall be determined by the CMP Case Manager. The initial contact list and all reviews/updates shall include the CMP Case Manager signature.

DISRUPTIONS

Agencies must provide at least 14 business days' notice to the Case Management Provider in asking for a removal of the child placed less than 180 days (6 months) and 30 days' notice for children placed longer than 180 days (6 months) unless the child is in imminent danger to themselves or others as defined below. Timelines for placement move notices are defined as per KS Statute (i.e., K.S.A. 38-2258 of the Children in Need of Care code (K.S.A. 38-2201) and DCF's PPM (i.e., PPM 3362 Thirty Day Notice of Planned Move, PPM 3364 Exceptions to Thirty Day Notice of Planned Move) and should be followed accordingly.

If DCF or Law Enforcement is requiring immediate removal of a child due to the facility's inability to provide safety or stability for the child, CMP will be required to locate an alternate placement provider for the necessary disruption period. The Case Management Providers expects the placement provider to submit a Disruption Notice Form the next business day after the emergency removal occurs.

Emergency removal of a child from a residential facility that does not require the notice above will only be considered if one of the following has occurred:

- Child is admitted to an acute care facility
- Child is detained for a criminal offense
- Child is AWOL for more than 24 hours.
- Child has sexually assaulted another child within the facility or has attempted to sexually assault another child within the facility.
- Physical harm to the staff or other children in the facility, which cannot be rectified by a safety plan or continues to escalate. Facilities are to first utilize other services

available (i.e., law enforcement intervention, screening into acute services). These situations will be staffed on a case by case basis.

DISCHARGE/AFTERCARE PLAN

Discharge planning shall begin upon admission of the youth to the facility. At a minimum, the child, the child's parents (if applicable) or guardian, and the CMP Case Manager shall be involved in planning the discharge from the facility. The discharge plan and modifications to it shall be noted in the case file. All releases shall be approved by the court of jurisdiction, or the designated authority.

A discharge summary shall be completed at the time of the youth's discharge and be forwarded to the CMP Case Manager within one business day. The discharge summary shall include written:

- Summary of progress, or lack thereof, of the youth's goals and objectives while the youth was in placement
- Summary of the youth's behavior while in placement
- Recommendations for aftercare services specifying the nature, frequency, duration of services and responsible parties
- Summary of the reasons the youth was discharged

RECORD KEEPING

The record keeping requirements of K.A.R. 28-4-353b shall be met by the facility. In addition, the following shall be kept by the facility. If a facility chooses to use electronic filing full access shall be given to DCF employees who are conducting site visit.

CHILD'S FILE:

The provider shall maintain a file for each child. The file shall contain the following:

- Child's name and date of birth
- Name, address and emergency contact information of the child's CMP Case Manager
- Foster Care Confirmation of Placement
- Current CMP Referral form
- Current CMP Case Plan
- If reunification is the goal, evidence demonstrating that the parent from whom the child was removed provided input on the members of the family and permanency plan.
- Initial Assessment
- Suicide/self-injury questionnaire

- Apartment/Room assignment assessment
- Medical and surgical consents
- Medical and dental records (history and current)
- Documentation of diagnosis (history and current)
- Records of the child's prescription(s) and non-prescription(s) and when administered
- Authorization for release of confidential information
- Daily observation logs by shift
- Weekly progress notes
- Program plans
- Treatment Plans, if applicable
- Discharge plans/Aftercare
- Approved contact list
- Resident's rights acknowledgement
- Emergency Safety Intervention/de-escalation acknowledgements
- Handbook/Rules acknowledgement
- Pre and Post visit documentation
- Significant incident reports
- Personal Property Inventory
- Educational documentation

RECORD RETENTION:

Case records, including medical records, shall be maintained for 6 years from the date of the child's discharge or until completion of an on-going audit and production of a final audit report, whichever is longer.

DAILY OBSERVATIONS:

A dated record of daily observations and significant occurrences involving each child shall be maintained by each shift and maintained in each child's individual file. The record shall include events which may affect the well-being of the child. Significant events should include but not be limited to; attendance at school or groups (specific group), interactions and/or interventions with staff and other children, medical appointments, mental health appointments, medication compliance, hygiene (if identified as a need), visits/passes, meals eaten and overall behavior. Each report shall include the staff member and/or child involved, the nature of the incident and the circumstances surrounding it. The record shall be available to review.

WEEKLY PROGRESS NOTES:

Notes shall be completed by the case coordinator. These notes shall be entered into the child's chart, reflecting the delivery of services according to the treatment plan. This documentation shall address the child's responses to interventions and the progress of the child on individualized goals and objectives. The note shall include any significant events that occurred during the week and shall also summarize contacts with family members and other involved agencies. If an unmet need is identified, the note shall reflect the actions to be taken to revise the plan to meet that need. The case coordinator shall document specific services and activities they are providing to each child. Each month the weekly progress notes shall be sent to the CMP Case Manager. The Monthly Progress Report Form shall be submitted to each child's provider no later than the 15th of each month following the reporting month, for all children who are in placement more than 15 days of that calendar month. Submission will be accepted by e-mail to:

- Cornerstones of Care: KSmonthlyprogressreports@Cornerstonesofcare.org
- KVC: KVCMonthlyReports@KVC.org
- St. Francis Ministries: MonthlyProgressReports@st-francis.org
- TFI: MonthlyReports@TFIFamily.org

HEALTH RECORDS:

Health Care and Records of children shall meet the requirements of K.A.R. 28-4-356. Records of over the counter and prescribed medications shall be kept in each child's case medical record and include the:

- name of the prescribing physician
- name of the medication
- dosage prescribed
- medication schedule
- purpose of the medication
- noted side effects
- date of the prescription
- date prescribed by a physician

A record of medication given, amount, date and time, and person dispensing shall be recorded. All doctor and dental visits, major illnesses, and accidents shall be recorded. Mental health appointments shall also be specifically documented in a child's medical record. This provides for a complete Health record for the child and their family, which documents the frequency of the youth's mental health treatment.

PERSONNEL RECORDS:

A separate file shall be maintained for each employee. Personnel files shall include the following:

- Written employment application, resume and reference checks
- Date of hire
- Position description
- Educational transcripts, HS diploma, college degree, etc.
- Copy of driver's license/Kansas ID (current)
- Disciplinary action records
- Training records
- Out of state registry checks, when applicable (staff member has lived outside of Kansas within the last 5 years)

CHAPTER 11: STAFF SECURE FACILITY (SSF)

All facilities and foster homes shall follow the guidelines outlined in K.S.A. 38-2202, "Reasonable and Prudent Parenting Standard", "means the standard characterized by careful and sensible parental decisions that maintain the health, safety and best interests of a child while at the same time encouraging the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in FC under the responsibility of the state to participate in extracurricular, enrichment, cultural and social activities."

GENERAL PROGRAM DESCRIPTION

A Staff Secure Facility is a 24-hour residential facility that meets the requirements of K.A.R. 28-4-1250 and K.A.R. 28-4-1269: defining a secure care facility. It also meets the requirements of K.S.A. 65-535 to provide care in a residential setting.

A Staff Secure Facility (SSF) provides a safe and secure placement for juvenile victims of human trafficking. Law Enforcement who places a child/youth in police protective custody can directly place the child/youth in SSF. The Secretary of the Department for Children and Families (DCF) can place a child/youth in DCF custody in a SSF. CMPs may also place victims of human trafficking in a SSF when victim identification was discovered by the CMP during an open foster care referral. "Staff Secure Facility schedule shall maintain a staff: child ratio of 1:2 for direct care when there are one or two residents." At no time shall there be fewer than a minimum staffing ratio of two direct care staff members on active duty to three to seven residents during waking hours and two direct care staff members on active duty to three to seven residents during sleeping hours.

Additionally, it is recognized hair and skin care are an integral to self-worth of children, youth, and young adults. Cultural identities of children, youth and young adults should be considered and honored, through a variety of activities related to hair and skin care. At no time should children, youth, or young adults be denied access to this basic right and need as a means of behavioral control, punishment, or rewards.

Facilities shall ensure staff have access to and knowledge of local and online resources for professional hair and skin care, as well as offer continuing education or training opportunities for staff on these topics. Furthermore, the facility shall encourage and facilitate staff to consult with the child, youth, young adults, parents or other relatives/kin connections regarding preferences, tools and hygiene products recommended, processes, and supports for meeting the individual's needs surrounding these matters.

Staff member on active duty to four residents during waking hours and one direct care staff member on active duty to seven residents during sleeping hours. At no time shall there be

fewer than a minimum of two direct care staff members present on the living unit when three or more residents are in care.

A SSF shall provide the following services to children placed in such facility as appropriate, for the duration of the placement. The General Program description approved by DCF Prevention and Protection Services for each facility shall include but not be limited to the:

- Case management
- Scheduling curriculum for doing Life Skills, shall be made available on request and during DCF walkthroughs
- Health care
- Mental health counseling
- Substance abuse screening and treatment
- Any other appropriate services

A staff secure facility may be on the same premises as that of another licensed facility. If the staff secure facility is on the same premises as that of another licensed facility, the living unit of the staff secure facility shall be maintained in a separate, self-contained unit. No staff secure facility shall be in a city or county jail.

DESCRIPTION OF CHILDREN/YOUTH TO BE SERVED

Prior to placement of any child age twelve (12) or younger in a DCF congregate care setting, the CWCMP shall ensure all other placement options have been explored, through family meeting model approaches and discussions with the child's case team and partnering Child Placing Agencies (CPAs). Prior approval from a CWCMP program president or similar executive management role is required before placement of a child age 12 or younger in a DCF congregate care facility. The purpose of this prior approval is to prevent unnecessary use of group care placement and provide opportunity to understand trends in gaps, capacity and supports needed for children to be stable in a family-based placement setting.

Youth who have been identified as a Human Trafficking victim in the following, but not limited to:

- police protective custody
- custody of the Secretary of the Department for Children and Families in out of home placement

GENERAL STAFFING REQUIREMENTS

Administrators:

- Shall have at least a master's degree in social work, human development, psychology, education, nursing, counseling, family studies or a related field
- Shall demonstrate knowledge of the principles and practices of administration and management

- Shall have at least three years supervisory experience within a childcare facility providing treatment to children or youth

Supervisors:

- Shall have at least a bachelor's degree in a human services field

Case Coordinator:

- Shall be licensed by the Behavioral Sciences Regulatory Board (BSRB) pursuant to applicable statutes and licensing regulations.

Clinical Director:

- Is responsible for treatment programing for the youth, shall have a master's degree in Behavioral Science or a related field and be licensed through the Behavioral Sciences Regulatory Board (BSRB) to practice, diagnose and treat mental and behaviroal disorders.

Other Professional Staff:

- Shall maintain current licensure, certification or registration for that staff member's profession

Facility Staff:

- Shall be at least 21 years of age with a minimum of three years age difference between the care provider and the oldest child who can be admitted to the facility;
- Shall have at least a high school diploma or its equivalent;

Staff shall be trained to effectively meet the special needs of youth that require this level of care by having completed at least one of the following:

- A bachelor's degree from an accredited college or university and one year of experience supervising children or youth in a childcare facility;
- 60 semester hours from an accredited college or university and two years of experience supervising children or youth in a childcare facility;
- Four years of experience supervising children or youth in a childcare facility.

CASE COORDINATION:

The care coordinator has the responsibility for coordinating the child's program and progress with the CMP Case Manager, school, employer, family, important connections, Family Finding model or similar specific tools, and other appropriate community resources. This shall include, but not be limited to, talking with the youth about important connections and possible family connections, documenting connections, documenting phone calls, appointments and visits (on and off site). The care coordinator will add information about important connections and family connections, and Family Finding tools to the program plan, weekly and monthly progress reports sent to the CMP.

The Care Coordinator will maintain a resource base of services to address the needs identified in Individual Program Plans and document in the youth's file, when and what community resources have been contacted and utilized for services for the youth. The case coordinator shall be responsible for Weekly Progress Notes (see Section 14: Record Keeping).

STAFF IN-SERVICE TRAINING

ORIENTATION

Each facility shall have an in-service orientation training program for new employees, which is especially directed toward the initial training needs of staff working directly with children. Documentation of completion of orientation training shall be kept, in the staff member's personnel file.

The documentation shall be placed in a specific area in the staff's file, indicating:

- staff training, reflecting orientation or annual training
- name of trainer
- name of training
- specify the number of training hours
- date of the training

Facility staff shall have completed a minimum of 10 hours of in-service orientation training within 7 days of employment. And an additional 40 hours of in-service orientation and demonstrate competency in the trainings before they can work independently with children.

All topics listed below shall be trained, even if it exceeds the minimum 50 hours of orientation:

Facility Trainings:

- Facility policy and procedures manual
- Facility emergency and evacuation procedures
- Facility discipline standards
- Child record documentation policies and procedures
- Resident rights (See Appendix 4, Resident Rights)
- Confidentiality laws
- Report writing

Trainings from an outside source and/or trained trainers within the facility (source must be well recognized and qualified, trained trainers must have documentation on file):

- Emergency safety interventions (including management of aggressive or suicidal behavior) (if a facility chooses to use Emergency Safety Intervention staff shall be certified)
- De-escalation (staff shall be certified)
- The handling of blood borne pathogens
- Medication Administration (staff who pass medications shall be certified)

- Certified in CPR/First Aid
- Trauma based informed care/trauma specific intervention
- Mandated Reporting (Provided By DCF)
  http://www.dcf.ks.gov/services/MRT/Pages/default.aspx

- Health Insurance Portability and Accountability Act (HIPAA)
- Comprehensive LGBTQ+
- Human Trafficking and commercial sexual exploitation
- Indicators of gang involvement
- Cultural Diversity
- Suicide Prevention/Intervention/Safety
- Family-focused training (i.e., Family Finding, Team Decision Making, Family Group Decision Making, Signs of Safety, etc.)

ANNUAL IN-SERVICE TRAINING

All SSF staff shall have a minimum of 20 hours of in-service training per year, as pertinent to individual job duties and responsibilities. Documentation shall be provided in each staff member's personnel record to include content, amount of time, trainer, and qualifications.

The documentation shall be placed in a specific area in the staff's file, indicating:

- staff training, reflecting orientation or annual training
- name of trainer
- name of training
- specify the number of training hours
- date of the training

All topics listed below shall be trained, even if it exceeds the minimum 20 hours of annual in-service:

Facility Refreshers/Trainings:

- Facility policy and procedures manual
- Facility emergency and evacuation procedures
- Facility discipline standards
- Child record documentation policies and procedures
- Report writing
- Resident rights (See Appendix 4, Resident Rights)
- Confidentiality laws

Refreshers/Trainings from an outside source and/or trained trainers within the facility (source must be well recognized and qualified, trained trainers must have documentation on file):

- Emergency safety interventions (including management of aggressive or suicidal behavior) (staff shall maintain certification)

- De-escalation (staff shall maintain certification)
- The handling of blood borne pathogens
- Medication Administration (staff shall maintain certification, may or may not require annual training)
- CPR/First Aid (Staff shall maintain certification, may or may not require annual training)
- Trauma based informed care/trauma specific intervention
- Mandated Reporting (Provided By DCF)
  http://www.dcf.ks.gov/services/MRT/Pages/default.aspx

- Health Insurance Portability and Accountability Act (HIPAA)
- Comprehensive LGBTQ+
- Childhood and adolescent sexuality issues, especially the effects of early sexual abuse
- Substance Use Disorders
- Blood Borne Pathogens
- Childhood and adolescent development (including developmental disorders)
- Childhood and adolescent psychopathology (including such topics as effects of abuse/neglect, reactive attachment disorders, separation anxiety disorders, ADHD)
- Human Trafficking and exploitation
- Indicators of gang involvement
- Suicide Prevention/Intervention/Safety
- Family-focused training (i.e., Family Finding, Team Decision Making, Family Group Decision Making, Signs of Safety, etc.)

CONFIRMATION OF PLACEMENT

A Foster Care Confirmation of Placement (PPS 5122) **is available through the CareMatch system which confirms the placement arranged by the Child Welfare Case Management Provider (CMP).**

Staff Secure Facility placements have no limitations as to duration of stay. Short term stays where the victim is returned to a parent or guardian average 3-5 days in length. Longer term placements where the victim receives more services to help them deal with their situation may occur.

INITIAL ASSESSMENT

When a child enters the facility, the SSF shall begin immediately assessing their strengths and needs including documentation and shall have a completed assessment within 3 days.

The assessment shall include but not be limited to the following:

- Reasons for referral to the facility
- Evaluation or assessment covering the following areas:
    1. Physical health
    2. Family relations
    3. Academic or vocational training
- Community life
- Interpersonal interactions
- Important connections and family connections
- Daily living skills
- Immediate service needs:
    1. Mental Health
    2. Developmental
    3. Dental
    4. Medical
- Involvement or exposure to Substance Use/disorder
- Involvement or exposure to other trauma
- Assessment of the child/youth's self- injuring or suicidal attempts

ROOM ASSIGNMENT

To support the daily management and administration of children/youth, each residential provider shall develop an objective formal procedure to assess physical housing needs of children. Children in a residential facility shall be assigned to a room based upon a range of factors, as identified by risk/needs assessment(s) in addition to other indicators. Factors to consider in assigning rooms shall include (but are not limited to):

- Suicidal tendencies
- Level of specialized needs (i.e., mental health, medical, etc.)
- Displaying inappropriate sexual behaviors /victims of sexual abuse)
- Gender
- Age and/or maturity level
- Program needs (substance use disorder, cognitive behavioral, independent living, etc.)
- Vulnerability to being victimized by others (i.e., physical stature)
- Comprehensive LGBTQ+

While each child will have an individualized program plan, assigning rooms based upon risk/need/responsivity factors will allow for a safer, more secure environment, as well as efficient and effective management of the living units. The child's room assignment and how the decision was made shall be documented in the child's file. The room assignment shall be completed immediately upon admission.

SERVICES

The provider shall write a policy and procedure manual for the operation of the SSF facility that will be reviewed and approved by DCF Prevention and Protection Services. The daily schedule shall address the needs of the children and the use of time to enhance the child's physical, mental, emotional, and social development. The facility shall provide supervised indoor and outdoor recreation so that every child may participate. Age appropriate equipment and outdoor play space to promote physical development and physical fitness shall be available. Age appropriate socialization shall be provided utilizing community resources to assist the youth in transitioning back into their community when appropriate.

The SSF will provide a program, as appropriate, for the duration of the placement, for youth in the facility that cover the following program components:

Daily Living Services: Daily living services shall be provided and include the following:

- Room and Board
- Child Care
- Personal spending money
- Personal care needs
- School fees
- Transportation to appointments within a 60-mile radius; including to and from school, medical care, recreation, etc. as appropriate
- Academic activities such as; assistance with schoolwork, vocational training and/or GED training

Situational Training- to include but not limited to:

Personal Hygiene:

- teaching about body cleanliness
- use of deodorants and cosmetics
- appropriate clothing
- choosing clothing to fit individual and occasion
- keeping clothes neat and clean

Health:

- identifying and understanding children's health needs
- securing and utilizing necessary medical treatment including preventive and health maintenance services
- gaining information and education in health maintenance including:
    - preventive measures
    - nutrition
    - menstruation
    - rest
    - cleanliness
    - family planning
    - drugs

    - sexually transmitted diseases
    - exercise
    - motivation for meeting own health needs
- maintaining contact with providers of health services (physician, nurse, clinic)
- using outside resources for assistance (clinics, pharmacies, hospitals)

Consumer education for independent living:

- budgeting
- comparative buying
- installment buying
- avoiding risks
- identifying illegal or excessive interest rates
- use of credit
- avoiding or dealing with debts
- using checking and savings accounts
- paying taxes

Communication skills:

The youth's articulating thoughts and feelings through appropriate use of such skills as:

- speech
- writing
- use of the landline/cell telephones
- computer
- social networking
- internet

Home Management:

- making the bed and changing linens
- using the vacuum cleaner
- dusting
- organizing belongings
- disposing of trash
- cleaning all areas of the home
- operating appliances
- cooking complete meals
- making simple repairs
- who to call for major repairs
- being aware of the need for upkeep
- handling emergencies
- knowing first aid

Situational Guidance:

- coping and self-regulation skills
- identifying and accepting strengths

- developing patterns of acceptance
- coping with authority figures
- getting along with others
- sharing responsibility
- being considerate of others
- developing friendships
- knowing when to go home when visiting
- recognizing or modifying attitudes toward self or others
- responsible work attitudes
- tolerance of constructive feedback
- reactions to praise
- punctuality
- attendance

Recreation:

- participating in leisure time activities
- learning how to spend leisure time
- developing outside activities as appropriate
- managing time
- finding recreation with little or no expense involved
- finding community projects to take part in
- participating in social groups
- participating in sports and games
- arts and crafts
- appreciating fine arts

BEHAVIOR MANAGEMENT

Each SSF shall have a written program of consistent rules and regulations guiding and governing the daily behavior of the youth under the care of the program. The behavior management system shall include a description of daily general routines of the program. The system of rules, rewards, and consequences for given behaviors shall be identified. Each youth shall be oriented to the SSF's behavior management system by a staff member during the admission or orientation process. Notation shall be made in the youth's file and signed by the youth that the rules, rewards and consequences have been discussed with the youth.

The SSF facility shall post the behavior management system in a common area where youth are able to easily access the system and the youth shall be given a written copy of the system to use as a reference. Behavior management shall include rules governing:

- interpersonal interactions with staff and peers
- verbal and physical aggression
- allowable possessions
- awakening and bedtime hours

- leisure hours
- visitation policies
- runaway attempts
- involvement in recreation and other activities
- self-destructive behaviors
- sexuality
- communications with family and others outside the program
- religious worship
- involvement in therapies
- theft and/or property destruction
- behaviors resulting in mandatory removal from the program
- behaviors at the program which could result in legal prosecution.

The overarching goals shall be to help the youth learn to keep themselves safe from exploitation and adjust to daily life within the community. A resource list shall be maintained by the facility of the available resources to meet the youth's need in the community.

Discipline at the facility shall be consistent and not be physically or emotionally damaging. Youth shall not be subjected to cruel, severe, unusual, or unnecessary punishment. Youth shall not be subjected to remarks that belittle or ridicule them or their families. Children shall not be denied food, mail, telephone calls or visits with their families as punishment. Seclusion shall not be utilized as a disciplinary measure. Only staff members shall discipline children.

RESETTING

A procedure used to assist the child in regaining regain emotional control by providing a safe and quiet area.

APPLICATION OF A RESET:

- A child in a reset shall never be physically prevented from leaving the reset area.
- Resets may take place away from the area of activity or from other children.
- Staff shall monitor the child while he or she is in resetting.

DE-ESCALATION CERTIFICATION

De-escalation is a technique used during a potential crisis situation in an attempt to prevent a child from causing harm to themselves, others and/or staff. De-escalation techniques shall be utilized for any activity required to diffuse a conflict or intense situation to ensure safety and calm the child. Staff shall be certified in authorized, evidenced based de-escalation techniques programs for managing aggressive behavior. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the child and parent (if applicable)/guardian and/or CMP Case

Manager shall be oriented to the managing aggressive behaviors policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the child's case record.

EMERGENCY SAFETY INTERVENTIONS CERTIFICATION

An emergency safety intervention shall be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the child's chronological and developmental age, size, gender physical, medical, psychiatric condition, and personal history.

The use of emergency safety interventions shall be performed only through the use of nationally recognized restraint procedures applicable to this population designed to prevent a child from harming self or others by exerting external control over physical movement.

An emergency safety intervention is the application of physical force without any mechanical device, for the purpose of restricting the free movement of a child's body. **An emergency safety intervention shall be used only as last resort after all verbal de-escalation techniques have failed and when the child is at-risk of harming themselves or others.**

Mechanical restraint is the use of mechanical devices to restrict the free movement of the child's body, most often for purposes of preventing self-destructive behavior. **Mechanical restraints are not allowed in Staff Secure residential facilities.**

Each facility shall have a written policy and all staff shall be trained to provide safe emergency safety interventions. Staff shall be certified in authorized, evidenced based training programs for managing aggressive behavior and de-escalation techniques. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the child and parent (if applicable)/guardian (if applicable) and/or CMP Case Manager shall be oriented to the emergency safety intervention policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the child's case record.

PROGRAM PLAN

Each youth residing in a residential facility shall have a program plan that is based on a thorough assessment. Assessment documents shall be included in the case record. The program plan shall be established to address the identified needs of each child. Program plans shall be thoroughly reviewed, and revisions made within 30 days of completion of initial program plan and each 30 days thereafter. This includes updated information of the progress of the youth's goals. Information obtained from the youth, parent, guardian, and

CMP Case Manager shall be considered in the report. The initial program plan and all updates shall be sent to the CMP Case Manager.

Program plan development, review, and case supervision are carried out by the SSF Provider. The program plan shall include individualized services to match the youth's identified needs.

Staff Secure Facility staff shall participate in case planning conference conducted by CMP Case Manager.

PERMANENCY PLANNING

Includes the evaluation and design of an approach for the youth and family that focuses on opportunities for the youth to have ongoing active and meaningful connections with family, kin, relatives, and the community. The goal for achieving permanency shall be coordinated with the youth's CMP Case Manager and be included in the program plan to be reviewed every 30 days. The permanency plan shall include strategies and tasks to accomplish the youth's goals. Behaviors which place the youth at risk for disruption, activities to prepare the youth's family or kinship network for reunification, identification of other less restrictive living environments and preparing the youth for transition to these settings shall be addressed.

VISITATION

Visitation/family time will be determined on a case by case basis by the facility in partnership with the CMP.

DISRUPTIONS

Agencies must provide at least 14 business days' notice to the Case Management Provider in asking for a removal of the child placed less than 180 days (6 months) and 30 days' notice for children placed longer than 180 days (6 months) unless the child is in imminent danger to themselves or others as defined below. Timelines for placement move notices are defined as per KS Statute (i.e., K.S.A. 38-2258 of the Children in Need of Care code (K.S.A. 38-2201) and DCF's PPM (i.e., PPM 3362 Thirty Day Notice of Planned Move, PPM 3364 Exceptions to Thirty Day Notice of Planned Move) and should be followed accordingly.

If DCF or Law Enforcement is requiring immediate removal of a child due to the facility's inability to provide safety or stability for the child, CMP will be required to locate an alternate placement provider for the necessary disruption period. The Case Management Providers expects the placement provider to submit a Disruption Notice Form the next business day after the emergency removal occurs.

Emergency removal of a child from a residential facility that does not require the notice above will only be considered if one of the following has occurred:

- Child is admitted to an acute care facility
- Child is detained for a criminal offense
- Child is AWOL for more than 24 hours.
- Child has sexually assaulted another child within the facility or has attempted to sexually assault another child within the facility.
- Physical harm to the staff or other children in the facility, which cannot be rectified by a safety plan or continues to escalate. Facilities are to first utilize other services available (i.e., law enforcement intervention, screening into acute services). These situations will be staffed on a case by case basis.

DISCHARGE/AFTERCARE PLAN

Discharge planning shall begin upon admission of the youth to the facility. At a minimum, the child/youth, the child's/youth's parents, if applicable or guardian, and the CMP Case Manager shall be involved in planning the discharge from the facility.

A discharge summary shall be completed at the time of the youth's discharge and be forwarded to the CMP Case Manager within one business day. The discharge summary shall include written:

- Summary of progress, or lack thereof, of the youth's goals and objectives while the youth was in placement
- Summary of the youth's behavior while in placement
- Recommendations for aftercare services specifying the nature, frequency, duration of services and responsible parties
- Summary of the reasons the youth was discharged

RECORD KEEPING

The record keeping requirements of K.A.R. 28-4-1256 shall be met by the facility. In addition, the following shall be kept by the facility. If a facility chooses to use electronic filing full access shall be given to DCF employees who are conducting site visit.

Child's File:
The provider shall maintain a file for each child. The file shall contain the following:

- Child's name and date of birth
- Name, address and emergency contact information of the child's CMP Case Manager
- Foster Care Confirmation of Placement
- Current CMP Referral form
- Current CMP Case Plan

- If reunification is the goal, evidence demonstrating that the parent from whom the child was removed provided input on the members of the family and permanency plan.
- Initial Assessment
- Suicide/self-injury questionnaire
- Room assignment assessment
- Medical and surgical consents
- Medical and dental records (history and current)
- Documentation of diagnosis (history and current)
- Records of the child's prescription(s) and non-prescription(s) and when administered
- Authorization for release of confidential information
- Daily observation logs by shift
- Weekly progress notes
- Program plans
- Treatment Plans, if applicable
- Discharge plans/Aftercare
- Approved contact list
- Resident's rights acknowledgement
- Emergency Safety Intervention/de-escalation acknowledgements
- Handbook/Rules acknowledgement
- Pre and Post visit documentation
- Significant incident reports
- Personal Property Inventory
- Educational documentation

RECORD RETENTION:

Case records, including medical records, shall be maintained for 6 years from the date of the child's discharge or until completion of an on-going audit and production of a final audit report, whichever is longer.

DAILY OBSERVATIONS:

A dated record of daily observations and significant occurrences involving each child shall be maintained by each shift and maintained in each child's individual file. The record shall include events which may affect the well-being of the child. The record shall be available to review upon request.

WEEKLY PROGRESS NOTES:

Notes shall be completed by the case coordinator. These notes shall be entered into the child's chart, reflecting the delivery of services according to the treatment plan. This documentation shall address the child's responses to interventions and the progress of the child on individualized goals and objectives. The note shall include any significant events that occurred during the week and shall also summarize contacts with family members and other involved agencies. If an unmet need is identified, the note shall reflect the actions to be taken to revise the plan to meet that need. The case coordinator shall document specific services and activities they are providing to each child. Each month the weekly progress notes shall be sent to the CMP Case Manager. The Monthly Progress Report Form shall be submitted to each child's provider no later than the 15th of each month following the reporting month, for all children who are in placement more than 15 days of that calendar month. Submission will be accepted by e-mail to:

- Cornerstones of Care: KSmonthlyprogressreports@Cornerstonesofcare.org
- KVC: KVCMonthlyReports@KVC.org
- St. Francis Ministries: MonthlyProgressReports@st-francis.org
- TFI: MonthlyReports@TFIFamily.org

HEALTH RECORDS:

Health Care and Records of children shall meet the requirements of K.A.R. 28-4-1259. Records of over the counter and prescribed medications shall be kept in each child's case medical record and include the:

- name of the prescribing physician
- name of the medication
- dosage prescribed
- medication schedule
- purpose of the medication
- noted side effects
- date of the prescription
- date prescribed by a physician

A record of medication given, amount, date and time, and person dispensing shall be recorded. All doctor and dental visits, major illnesses, and accidents shall be recorded. Mental health appointments shall also be specifically documented in a child's medical record. This provides for a complete Health record for the child and their family, which documents the frequency of the youth's mental health treatment.

PERSONNEL RECORDS:

A separate file shall be maintained for each employee. Personnel files shall include the following:

- Written employment application, resume and reference checks
- Date of hire
- Position description
- Educational transcripts, HS diploma, college degree, etc.
- Copy of driver's license/Kansas ID (current)
- Disciplinary action records
- Training records
- Out of state registry checks, when applicable (staff member has lived outside of Kansas within the last 5 years)

The range of services provided are to be explicitly delineated for meeting the individual needs of the child. The General Program description approved by DCF Prevention and Protection Services for each facility shall include but not be limited to the:

- goals of the program
- behavior management system
- job descriptions (responsibilities, functions, and qualifications)
- policies and procedures
- daily living activities
- health services
- mental health services
- recreation activities
- visitation policies

CHAPTER 12: QUALIFIED RESIDENTIAL TREATMENT PROGRAM (QRTP)

All facilities and foster homes shall follow the guidelines outlined in K.S.A. 38-2202, "Reasonable and Prudent Parenting Standard", "means the standard characterized by careful and sensible parental decisions that maintain the health, safety and best interests of a child while at the same time encouraging the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in FC under the responsibility of the state to participate in extracurricular, enrichment, cultural and social activities."

GENERAL PROGRAM DESCRIPTION

A Qualified Residential Treatment Program (QRTP) is a 24-hour group home or residential facility that meets the requirements of K.A.R. 28-4-123-132 and K.A.R. 28-4-268-280. It is a non-secure residential, court ordered service designed to provide an environment with consistent structure, therapeutic intervention and stability with a high degree of supervision. This therapeutic environment will include a trauma-informed treatment model that is designed to address the needs, including clinical needs as appropriate, of children with serious emotional or behavioral disorders or disturbances. This environment will also enhance the child's ability to achieve a higher level of functioning without necessitating a Psychiatric Residential Treatment Facility (PRTF) placement or acute hospitalization.

QRTP staff shall be aware of a 30-day assessment to be completed by an independent accessor and a 60-day court review. Both the 30-day assessment and court review will determine appropriateness of placement in a QRTP. Requests for youth to stay in a QRTP beyond the specified time must be submitted per the following process:

- Director/President shall submit in writing the request to the Regional Foster Care Program Administrator for review. Information submitted shall include but is not limited to:
    - Youth's progress
    - Attempts made to step down the youth from the facility
    - Other treatment options explored
    - Family finding efforts
    - All other vital information about the youth's case
- Should the Regional staff (i.e., Foster Care Program Administrator) agree with the reasoning for the extension, the request shall then be sent to Administrative Staff including Deputy Director of Permanency, Foster Care Program Manager and Group Home Manager for review.
- Should DCF Administrative staff also agree with the extension, the request will then be submitted to the Deputy Secretary for review and approval.

Extension requests shall be submitted a minimum of 15 days before ending of the youth's allotted time, and requests shall only be accepted from the Program Director/President. The purpose for process is for DCF to ensure the Grant Program Director/President is aware a federal timeline has been exceeded and best practice standard has not been met for these youth.

QRTP programs shall also:

- be accredited by at least one of the three federally approved accreditors: The Commission on Accreditation of Rehabilitation Facilities (CARF), Concil on Accrediation (COA) or the Joint Comission (formerly JCAHO).
- utilize an Evidenced Based Program model
- have registered or licensed nursing staff and other licensed clinical staff, available 24/7, on-site according to the treatment model.
- demonstrate family engagement and outreach, including siblings, in the child's treatment.
- provide discharge planning and family-based aftercare supports for at least six months post-discharge.

The range of services provided are to be explicitly delineated for meeting the individual needs of the child. The General Program description approved by DCF Prevention and Protection Services for each facility shall include but not be limited to the:

- goals of the program
- behavior management system
- job descriptions (responsibilities, functions, and qualifications)
- policies and procedures
- daily living activities
- health services
- mental health services
- recreation activities
- visitation policies

The purpose of placement in an QRTP is to improve child's decision making, coping skills, social skills, and to address any underlying problems which are affecting the child, while teaching them how to handle their behaviors in order to transition successfully back into their family or community.

DESCRIPTION OF CHILDREN/YOUTH TO BE SERVED

Prior to placement of any child age twelve (12) or younger in a DCF congregate care setting, the CWCMP shall ensure all other placement options have been explored, through family meeting model approaches and discussions with the child's case team and partnering Child Placing Agencies (CPAs). Prior approval from a CWCMP program president or similar executive management role is required before placement of a child age 12 or younger in a DCF congregate care facility. The purpose of this prior approval is to prevent unnecessary

use of group care placement and provide opportunity to understand trends in gaps, capacity and supports needed for children to be stable in a family-based placement setting.

- Population served is children and youth in foster care who are under the age of 18
- Have a well established pattern of behavior or conduct which is antisocial, oppositional, defiant, aggressive, abusive, impulsive and rebelious in natrue.
- Assessed and qualified via an assessment for QRTP
- Court approved to be placed in a QRTP setting
- Children may step down to a QRTP from a PRTF after the screener and treatment team have determined the child no longer needs the level of care provided by a PRTF.

GENERAL STAFFING REQUIREMENTS

- The Program Administrator shall have a Bachelor's Degree, at least one year administrative
  experience and a working knowledge of child dvelopment principles.
- Program Director shall have a minimum of a Masters Degree in Social or Behavioral Sciences. This position is responsible for the operation of the entire program and may be the same person as the Administratior if desired.
- Clinical Director, on staff or contracted, is responsible for treatment programing for the youth, according to the treatment model, shall have a master's degree in Behavioral Science or a related field and be licensed through the Behavioral Sciences Regulatory Board (BSRB) to practice. Clinical Manager shall have at least three years' experience working with children who require out of home placement due to behavioral, emotional or developmental difficulties.
- Therapists shall have a Master's Degree in Behavioral Science or related field and be licensed through the Behavioral Sciences Regulatory Board (BSRB) to practice. Therapist to child/youth ratio shall be determined by the applicable accrediting body.
- RN's, LPN's and other licensed clinical staff, available 24/7, on-site, according to the treatment model. (on-site, on-call, Nurse PRN, etc.)
- The Case Coordinator in a QRTP shall have at least a Bachelor's Degree in one of the human service fields (social work, psychology, human development and family life, criminal justice, counseling, nursing, or education). The child to case coordinator ratio in a QRTP is 1:16.
- Facility staff shall be at least 21 years of age with a minimum of three years age difference between the facility staff and oldest child who can be admitted to the facility. Facility staff shall possess a high school diploma or GED.
- Staff ratio is 1:6 during waking hours and 1:8 during sleeping hours. There shall be 24-hour awake staff to insure child safety. According to the treatment model, capacity and acuity of children the ratio may differ. Due to the variety of persenting difficulites the child(ren) may possess, a staff ratio of 1:1 may be necessary.
- Staff will randomly conduct a minimum of four (4) sight checks on youth every hour when the youth is at an increased risk of elopement or sexual misconduct

CASE COORDINATION

The care coordinator has the responsibility for coordinating the child's program and progress with the CMP Case Manager, school, employer, family, important connections, Family Finding model or similar specific tools, and other appropriate community resources. This shall include, but not be limited to, talking with the youth about important connections and possible family connections, documenting connections, documenting phone calls, appointments and visits (on and off site). The care coordinator will add information about important connections and family connections, and Family Finding tools to the program plan, weekly and monthly progress reports sent to the CMP.

The Care Coordinator will maintain a resource base of services to address the needs identified in Individual Program Plans and document in the youth's file, when and what community resources have been contacted and utilized for services for the youth. The case coordinator shall be responsible for Weekly Progress Notes (see Section 14: Record Keeping).

STAFF IN-SERVICE TRAINING

Orientation

Each facility shall have an in-service orientation training program for new employees, which is especially directed toward the initial training needs of staff working directly with children. Documentation of completion of orientation training shall be kept, in the staff member's personnel file.

The documentation shall be placed in a specific area in the staff's file, indicating:

- staff training, reflecting orientation or annual training
- name of trainer
- name of training
- specify the number of training hours
- date of the training

Facility staff shall have completed a minimum of 18 hours of in-service orientation training. Facility staff shall demonstrate competency in the trainings from orientation before they can work independently with children.

All topics listed below shall be trained, even if it exceeds the minimum 18 hours of orientation:

Facility Trainings:

- Facility policy and procedures manual
- Facility emergency and evacuation procedures
- Facility discipline standards

- Child record documentation policies and procedures
- Resident rights (See Appendix 4, Resident Rights)
- Confidentiality laws
- Report Writing

Trainings from an outside source and/or trained trainers within the facility (source must be well recognized and qualified, trained trainers must have documentation on file):

- Emergency safety interventions (including management of aggressive or suicidal behavior) (if a facility chooses to use Emergency Safety Intervention staff shall be certified)
- De-escalation (staff shall be certified)
- The handling of blood borne pathogens
- Medication Administration (staff who pass medications shall be certified)
- Certified in CPR/First Aid
- Trauma based informed care/trauma specific intervention
- Mandated Reporting (Provided By DCF)
  http://www.dcf.ks.gov/services/MRT/Pages/default.aspx

- Health Insurance Portability and Accountability Act (HIPAA)
- Comprehensive LGBTQ+
- Human Trafficking and exploitation
- Cultural Diversity
- Suicide Prevention/Intervention/Safety
- Family-focused training (i.e., Family Finding, Team Decision Making, Family Group Decision Making, Signs of Safety, etc.)

ANNUAL IN-SERVICE TRAINING

Annual training is beyond or in addition to the initial 18-hour orientation training program from the date of employment. During the first year of employment staff shall receive a minimum of 36 hours of training (18 orientation hours, 18 annual In-Service).

All QRTP direct care staff shall have a minimum of 18 documented clock hours of in-service training per year. Documentation shall be provided in each staff member's personnel record to include content, amount of time, trainer, and qualifications.

The documentation shall be placed in a specific area in the staff's file, indicating:

- staff training, reflecting orientation or annual training
- name of trainer
- name of training
- specify the number of training hours
- date of the training

All topics listed below shall be trained, even if it exceeds the minimum 18 hours of annual in-service:

Facility Refreshers/Trainings:

- Facility policy and procedures manual
- Facility emergency and evacuation procedures
- Facility discipline standards
- Child record documentation policies and procedures
- Resident rights (See Appendix 4, Resident Rights)
- Confidentiality laws

Refreshers/Trainings from an outside source and/or trained trainers within the facility (source must be well recognized and qualified, trained trainers must have documentation on file):

- Emergency safety interventions (including management of aggressive or suicidal behavior) (staff shall maintain certification)
- De-escalation (staff shall maintain certification)
- The handling of blood borne pathogens
- Medication Administration (staff shall maintain certification, may or may not require annual training)
- CPR/First Aid (Staff shall maintain certification, may or may not require annual training)
- Trauma based informed care/trauma specific intervention
- Mandated Reporting (Provided By DCF)
  http://www.dcf.ks.gov/services/MRT/Pages/default.aspx

- Health Insurance Portability and Accountability Act (HIPAA)
- Comprehensive LGBTQ+
- Childhood and adolescent sexuality issues, especially the effects of early sexual abuse
- Substance Use Disorders
- Blood Borne Pathogens
- Childhood and adolescent development (including developmental disorders)
- Childhood and adolescent psychopathology (including such topics as effects of abuse/neglect, reactive attachment disorders, separation anxiety disorders, ADHD)
- Suicide Prevention/Intervention/Safety
- Family-focused training (i.e., Family Finding, Team Decision Making, Family Group Decision Making, Signs of Safety, etc.)

CONFIRMATION OF PLACEMENT

A Foster Care Confirmation of Placement (PPS 5122) **is available through the CareMatch system which confirms the placement arranged by the Child Welfare Case Management Provider (CMP).**

ASSESSMENTS

30-Day Assessment

All children in a QRTP shall have an assessment done within 30 days of placement to determine the appropriateness of placement in a QRTP for purposes of approving the case plan and the case system review procedure for the child. The residential facility shall accommodate, collaborate and coordinate with the independent accessor to ensure the assessment is completed within 30 days.

INITIAL ASSESSMENT

When a child enters the facility, the QRTP shall begin immediately assessing their strengths and needs including documentation and shall have a completed assessment within 7 days.

The assessment shall include but not be limited to the following:

- Reasons for referral to the facility
- Evaluation or assessment covering the following areas:
    1. Physical health
    2. Family relations
    3. Academic or vocational training
- Community life
- Interpersonal interactions
- Important connections and family connections
- Daily living skills as outlined in the scope of services listed above
- Immediate service needs:
    1. Mental Health
    2. Developmental
    3. Dental
    4. Medical
- Involvement or exposure to Substance Use/disorder
- Involvement or exposure to other trauma
- Assessment of the child/youth's self- injuring or suicidal attempts

ROOM ASSIGNMENT

To support the daily management and administration of children/youth, each residential provider shall develop an objective formal procedure to assess physical housing needs of children. Children in a residential facility shall be assigned to a room based upon a range of factors, as identified by risk/needs assessment(s) in addition to other indicators. Factors to consider in assigning rooms shall include (but are not limited to):

- Suicidal tendencies
- Level of specialized needs (i.e., mental health, medical, etc.)
- Displaying inappropriate sexual behaviors /victims of sexual abuse)
- Gender
- Age and/or maturity level
- Program needs (substance use disorder, cognitive behavioral, independent living, etc.)
- Vulnerability to being victimized by others (i.e., physical stature)
- Comprehensive LGBTQ +

While each child will have an individualized program plan, assigning rooms based upon risk/need/responsivity factors will allow for a safer, more secure environment, as well as efficient and effective management of the living units. The child's room assignment and how the decision was made shall be documented in the child's file. The room assignment shall be completed immediately upon admission.

SERVICES

The residential facility shall write a policy and procedure manual for the operation of the QRTP facility that will be reviewed and approved by DCF Prevention and Protection Services. The daily schedule shall address the needs of the children and the use of time to enhance the child's physical, mental, emotional, and social development. The facility shall provide supervised indoor and outdoor recreation so that every child may participate. Age appropriate equipment and outdoor play space to promote physical development and physical fitness shall be available. Age appropriate socialization shall be provided utilizing community resources to assist the child in transitioning back into their community when appropriate.

Additionally, it is recognized hair and skin care are an integral to self-worth of children, youth, and young adults. Cultural identities of children, youth and young adults should be considered and honored, through a variety of activities related to hair and skin care. At no time should children, youth, or young adults be denied access to this basic right and need as a means of behavioral control, punishment, or rewards.

Facilities shall ensure staff have access to and knowledge of local and online resources for professional hair and skin care, as well as offer continuing education or training opportunities for staff on these topics. Furthermore, the facility shall encourage and facilitate staff to consult with the child, youth, young adults, parents or other relatives/kin connections regarding preferences, tools and hygiene products recommended, processes, and supports for meeting the individual's needs surrounding these matters.

The QRTP will provide a program for children in the facility that covers the following program components, based on their approved treatment model:

Daily Living Services: Daily living services shall be provided and include the following:

- Room and Board
- Personal care needs
- School fees
- Transportation to appointments within a 60-mile radius; including to and from school, medical care, recreation, etc.
- Academic activities such as; assistance with schoolwork, vocational training and/or GED training

Behavioral Health:

- Crisis management up to the need for the next Level of Care
- Individual, group and family therapy
- Social rehabilitation and therapy
- Behavioral programming (including design, consultation and supervision) if indicated
- Therapy towards reunification with family, if indicated
- Supportive therapy during transitions
- Transition planning, to include identification of behavioral and substance abuse support services needed for successful transition into the community
- If developmentally appropriate, services which develop increased capacity for independent living

Situational Training- to include but not limited to:

Personal Hygiene:

- teaching about body cleanliness
- use of deodorants and cosmetics
- appropriate clothing
- choosing clothing to fit individual and occasion
- keeping clothes neat and clean

Health:

- identifying and understanding children's health needs
- securing and utilizing necessary medical treatment including preventive and health maintenance services

- gaining information and education in health maintenance including:
- preventive measures
- nutrition
- menstruation
- rest
- cleanliness
- family planning
- drugs
- sexually transmitted diseases
- exercise
- motivation for meeting own health needs
- maintaining contact with providers of health services (physician, nurse, clinic)
- using outside resources for assistance (clinics, pharmacies, hospitals)

Consumer education for independent living:

- budgeting
- comparative buying
- installment buying
- avoiding risks
- identifying illegal or excessive interest rates
- use of credit
- avoiding or dealing with debts
- using checking and savings accounts
- paying taxes

Communication skills:

The child's articulating thoughts and feelings through appropriate use of such skills as:

- speech
- writing
- use of the landline/cell telephones
- computer
- social networking
- internet

Home Management:

- making the bed and changing linens
- using the vacuum cleaner
- dusting
- organizing belongings
- disposing of trash
- cleaning all areas of the home
- operating appliances
- cooking complete meals

- making simple repairs
- who to call for major repairs
- being aware of the need for upkeep
- handling emergencies
- knowing first aid

Situational Guidance:

- coping and self-regulation skills
- identifying and accepting strengths
- developing patterns of acceptance
- coping with authority figures
- getting along with others
- sharing responsibility
- being considerate of others
- developing friendships
- knowing when to go home when visiting
- recognizing or modifying attitudes toward self or others
- responsible work attitudes
- tolerance of corrective feedback
- reactions to praise
- punctuality
- attendance

Recreation:

- participating in leisure time activities
- learning how to spend leisure time
- developing outside activities
- managing time
- finding recreation with little or no expense involved
- finding community projects to take part in
- participating in social groups
- participating in sports and games
- arts and crafts
- appreciating fine arts

BEHAVIOR MANAGEMENT

Each QRTP shall have a written program of consistent rules and regulations guiding and governing the daily behavior of the children under the care of the program. The behavior management system shall include a description of the daily routines of the program. The system of rules, rewards, and consequences for given behaviors shall be identified. Each child shall be oriented to the QRTP's behavior management system by a staff member during

the admission or orientation process. Notation shall be made in the child's file and signed by the child that the rules, rewards and consequences have been discussed.
The QRTP facility shall post the behavior management system in a common area where children are able to easily access the system and the children shall be given a written copy of the system to use as a reference. Behavior management shall include rules governing:

- interpersonal interactions with staff and peers
- facility leave policies
- school attendance and behavior while at school
- verbal and physical aggression
- allowable possessions
- awakening and bedtime hours
- leisure hours~~,~~
- visitation policies
- runaway attempts
- involvement in recreation and other activities
- self-destructive behaviors
- sexuality
- communications with family and others outside the program
- religious worship
- involvement in therapies
- theft, property destruction
- behaviors resulting in mandatory removal from the program ~~and~~
- behaviors at the program which could result in legal prosecution~~.~~

When a child decides not to attend religious worship or activities, alternative supervised activities shall be made available.

The overarching goals shall be to not only help the children adjust to the residential facility but also to daily life within society. A resource list shall be maintained by the facility of the available resources to meet the child's need in the community.

Discipline at the facility shall be consistent and not be physically or emotionally damaging. Children shall not be subjected to cruel, severe, unusual, or unnecessary punishment. Children shall not be subjected to remarks that belittle or ridicule them or their families. Children shall not be denied food, mail, telephone calls or visits with their families as punishment. Seclusion shall not be utilized as a disciplinary measure. Only staff members shall discipline children in placement.

RESETTING

A procedure used to assist the child in regaining regain emotional control by providing a safe and quiet area.

APPLICATION OF A RESET:

- A child in a reset shall never be physically prevented from leaving the reset area.
- Resets may take place away from the area of activity or from other children.
- Staff shall monitor the child while he or she is in resetting.

DE-ESCALATION CERTIFICATION

De-escalation is a technique used during a potential crisis situation in an attempt to prevent a child from causing harm to themselves, others and/or staff. De-escalation techniques shall be utilized for any activity required to diffuse a conflict or intense situation to ensure safety and calm the child. Staff shall be certified in authorized, evidenced based de-escalation techniques programs for managing aggressive behavior. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the child and parent (if applicable)/guardian and/or CMP Case Manager shall be oriented to the managing aggressive behaviors policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the child's case record.

EMERGENCY SAFETY INTERVENTIONS CERTIFICATION

An emergency safety intervention shall be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the child's chronological and developmental age, size, gender physical, medical, psychiatric condition, and personal history.

The use of emergency safety interventions shall be performed only through the use of nationally recognized restraint procedures applicable to this population designed to prevent a child from harming self or others by exerting external control over physical movement.

An emergency safety intervention is the application of physical force without any mechanical device, for the purpose of restricting the free movement of a child's body. **An emergency safety intervention shall be used only as last resort after all verbal de-escalation techniques have failed and when the child is at-risk of harming themselves or others.**

Mechanical restraint is the use of mechanical devices to restrict the free movement of the child's body, most often for purposes of preventing self-destructive behavior. **Mechanical restraints are not allowed in QRTP residential facilities.**

Each facility shall have a written policy and all staff shall be trained to provide safe emergency safety interventions. Staff shall be certified in authorized, evidenced based training programs for managing aggressive behavior and de-escalation techniques. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the child and parent (if

applicable)/guardian (if applicable) and/or CMP Case Manager shall be oriented to the emergency safety intervention policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the child's case record.

PROGRAM PLAN

Each child residing in a residential facility shall have a program plan that is based on a thorough assessment. Assessment documents shall be included in the case record. The program plan shall be established by the end of 14 days from admission and shall address the identified needs in the emotional, physical, educational, social, familial, and where appropriate independent living skill domains. Children may not have identified needs in every domain. If so, document that no needs were identified. Program plans shall be updated when new needs are identified or when program goals are met. Program plans shall be thoroughly reviewed, and revisions made at the case review conferences within 30 days of completion of initial program plan and each 30 days thereafter, including updated information of the progress of the child's goals. Information obtained from the child, parent, guardian, and CMP Case Manager shall be considered in the report. The initial program plan and all updates shall be sent to the CMP Case Manager.

The program plan shall include individualized services to match the child's identified needs in the following areas:

- Long term goals in the areas of:
    1. physical health
    2. family relations
    3. daily living skills
    4. academic and/or vocational skills
    5. interpersonal relations
    6. substance use service needs
    7. emotional/psychological health
- Short term goals which will help a child eventually reach his/her long-term goals in each of the above areas.
- Services to meet independent living goals.
- Specific plans for reaching the short-term goals including services to be provided and frequency.
- Estimated time for reaching short term goals.
- The child shall sign and date the program plans indicating participation and input in the development of the plan.
- Updated information of the progress of the child's goals shall be included.

QRTP staff shall participate in case plan conducted by CMP Case Manager.

PERMANENCY PLANNING:

The QRTP shall assemble a family and permanency team for the child in accordance with specified requirements.

- The team must consist of all appropriate biological family members, relatives, and fictive kin of the child, as well as professionals (as appropriate) who are a resource to the family of the child, such as teachers, medical or mental health providers who have treated the child, or clergy
- If the child is age 10 or older, the team must also include members of the permanency planning team for the child that are selected by the child

A child's Permanency Plan shall focus on opportunities for the child to have ongoing active and meaningful connections with family, kin, relatives, and the community. The goal for achieving permanency shall be coordinated with the child's CMP Case Manager and be included in the program plan to be reviewed every 30 days. The permanency plan shall include strategies and tasks to accomplish the child's goals. Behaviors which place the child at risk for disruption, activities to prepare the child's family or kinship network for reunification, identification of other less restrictive living environments and preparing the child for transition to these settings shall be addressed.

Physical and mental health needs shall be coordinated with assigned CMP Case Manager and child's assigned Managed Care Organization (MCO).

VISITATION

Subject to the provider's visitation guideline (days of the week, times, appropriate attire, etc.) a provider shall not prohibit contact with a child's immediate family except for the following reasons:

- A court orders no contact
- There is documented violence, threatening or disruptive behavior by family member that occurred during contact
- There is documented introduction of contraband into the facility
- The milieu is determined to be unsafe for visitors

The facility shall provide private accommodations for visitation. Accommodations shall include but not be limited to a private office/room, no staff presence (unless required), free of any individuals that may overhear confidential information.

When home visits are a part of the treatment plan, there shall be coordinated connections with the child, their family, and the case coordinator/facility program staff regarding the child's treatment and program goals and objectives. The goal of placement shall be to return

the child to a family-like setting, so it is important that home visits be carefully planned and executed in the best interests of permanency planning for the child. All home visits shall be arranged through coordination with the child's CMP Case Manager. Documentation in child's file shall include who is transporting children to and from family visits and observation of the child's behavior during transportation.

The child shall have an approved contact list to include, the type of contact allowed (letter, phone, day passes, overnight passes, etc.) The contact list must be reviewed/updated every 60 days. Approved contacts shall be determined by the CMP Case Manager. The initial contact list and all reviews/updates shall include the CMP Case Manager signature.

DISRUPTIONS

Agencies must provide at least 14 business days' notice to the Case Management Provider in asking for a removal of the child placed less than 180 days (6 months) and 30 days' notice for children placed longer than 180 days (6 months) unless the child is in imminent danger to themselves or others as defined below. Timelines for placement move notices are defined as per KS Statute (i.e., K.S.A. 38-2258 of the Children in Need of Care code (K.S.A. 38-2201) and DCF's PPM (i.e., PPM 3362 Thirty Day Notice of Planned Move, PPM 3364 Exceptions to Thirty Day Notice of Planned Move) and should be followed accordingly.

If DCF or Law Enforcement is requiring immediate removal of a child due to the facility's inability to provide safety or stability for the child, CMP will be required to locate an alternate placement provider for the necessary disruption period. The Case Management Providers expects the placement provider to submit a Disruption Notice Form the next business day after the emergency removal occurs.

Emergency removal of a child from a residential facility that does not require the notice above will only be considered if one of the following has occurred:

- Child is admitted to an acute care facility
- Child is detained for a criminal offense
- Child is AWOL for more than 24 hours.
- Child has sexually assaulted another child within the facility or has attempted to sexually assault another child within the facility.
- Physical harm to the staff or other children in the facility, which cannot be rectified by a safety plan or continues to escalate. Facilities are to first utilize other services available (i.e., law enforcement intervention, screening into acute services). These situations will be staffed on a case by case basis.

DISCHARGE/AFTERCARE

Discharge planning shall begin upon admission of the child to the facility. At a minimum, the child, the child's parents, if applicable or guardian, and the CMP Case Manager shall be involved in planning the discharge from the facility.

A discharge summary shall be completed at the time of the child's discharge and be forwarded to the CMP Case Manager within one business day. The discharge summary shall include written:

- Summary of progress, or lack thereof, of the child's goals and objectives while in placement
- Summary of the child's behavior while in placement
- Plan for monitoring services after discharge
- Summary of the reasons the child was discharged

QRTP aftercare is required as per Family First Prevention Services Act. Each facility is responsible for developing and carrying out the aftercare plan in conjunction with the youth's family, CMP workers, and other supports. The QRTP shall provide discharge planning and family-based aftercare support for at least 6 months post-discharge. The QRTP provider and the CMP shall work in conjunction to ensure there is no gap in services for a youth that is discharging from the QRTP.

Below are minimum recommendations each facility shall consider in planning and coordinating aftercare for youth upon discharge:

- Define what specific services they will be coordinated or provided for a period of 6 months post-discharge.
- Determine which direct services will be continued or provided within a 60-mile radius of the facility. (i.e., Services provided to a youth 45 miles from the facility.)
- Outline detailed strategies to provide services and support to youth who are discharged beyond the 60-mile radius from the facility. (i.e., Services provided to a youth placed 200 miles away from the facility.)
- Ensure monitoring and "check-ins" are done on a minimum of a monthly basis during the period of aftercare.

RECORD KEEPING

The record keeping requirements of K.A.R. 28-4-272 shall be met by the facility. In addition, the following shall be kept by the facility. If a facility chooses to use electronic filing full access shall be given to DCF employees who are conducting site visit.

Child's File:
The provider shall maintain a file for each child. The file shall contain the following:

- Child's name and date of birth
- Name, address and emergency contact information of the child's CMP Case Manager, and all members of the family and permanency team (to be included on the approved contact list)
- Name and contact information of other family members and fictive kin who are not part of the family and permanency plan (to be included on the approved contact list,

if applicable)
- Foster Care Confirmation of Placement
- Current CMP Referral form
- Current CMP Case Plan
- Evidence that meetings of the family and permanency team are held at a time and place convenient for family
- If reunification is the goal, evidence demonstrating that the parent from whom the child was removed provided input on the members of the family and permanency plan.
- Initial Assessment
- 30 Day Assessment
- Written recommendation by the independent accessor regarding the appropriateness of the QRTP placement
- Court Approval of the QRTP placement
- Suicide/self-injury questionnaire
- Room assignment assessment
- Medical and surgical consents
- Medical and dental records (history and current)
- Documentation of diagnosis (history and current)
- Records of the child's prescription(s) and non-prescription(s) and when administered
- Authorization for release of confidential information
- Daily observation logs by shift
- Weekly progress notes
- Program plans
- Treatment Plans, if applicable
- Discharge plans/Aftercare
- Approved contact list
- Resident's rights acknowledgement
- Emergency Safety Intervention/de-escalation acknowledgements
- Handbook/Rules acknowledgement
- Pre and Post visit documentation
- Significant incident reports
- Personal Property Inventory
- Educational documentation

RECORD RETENTION:

Case records, including medical records, shall be maintained for 6 years from the date of the child's discharge or until completion of an on-going audit and production of a final audit report, whichever is longer.

Daily Observations:

A dated record of daily observations and significant occurrences involving each child shall be maintained by each shift and maintained in each child's individual file. The record shall include events which may affect the well-being of the child. Significant events should include but not be limited to; attendance at school or groups (specific group), interactions and/or interventions with staff and other children, medical appointments, mental health appointments, medication compliance, hygiene (if identified as a need), visits/passes, meals eaten and overall behavior. Each report shall include the staff member and/or child involved, the nature of the incident and the circumstances surrounding it. The record shall be available to review.

WEEKLY PROGRESS NOTES:

Notes shall be completed by the case coordinator. These notes shall be entered in the child's chart, reflecting the delivery of services according to the treatment plan. This documentation shall address the child's responses to interventions and the progress of the child on individualized goals and objectives. The note shall include any significant events that occurred during the week and shall also summarize contacts with family members and other involved agencies. If an unmet need is identified, the note shall reflect the actions to be taken to revise the plan to meet that need. The case coordinator shall document specific services and activities they are providing to each child. Each month the weekly progress notes shall be sent to the CMP Case Manager. The Monthly Progress Report Form shall be submitted to each child's provider no later than the 15th of each month following the reporting month, for all children who are in placement more than 15 days of that calendar month. Submission will be accepted by e-mail to:

- Cornerstones of Care: KSmonthlyprogressreports@Cornerstonesofcare.org
- KVC: KVCMonthlyReports@KVC.org
- St. Francis Ministries: MonthlyProgressReports@st-francis.org
- TFI: MonthlyReports@TFIFamily.org

Health Records:
Health Care and Records of children shall meet the requirements of K.A.R. 28-4-275. Records of over the counter and prescribed medications shall be kept in each child's case medical record and include the:

- name of the prescribing physician
- name of the medication
- dosage prescribed
- medication schedule
- purpose of the medication
- noted side effects
- date of the prescription
- date prescribed by a physician

A record of medication given, amount, date and time, and person dispensing shall be recorded. All doctor and dental visits, major illnesses, and accidents shall be recorded. Mental health appointments shall also be specifically documented in a child's medical record. This provides for a complete Health record for the child and their family, which documents the frequency of the youth's mental health treatment.

Personnel Records:

A separate file shall be maintained for each employee. Personnel files shall include the following:

- Written employment application, resume and reference checks
- Date of hire
- Position description
- Educational transcripts, HS diploma, college degree, etc.
- Copy of driver's license/Kansas ID (current)
- Disciplinary action records
- Training records
- Out of state registry checks, when applicable (staff member has lived outside of Kansas within the last 5 years)

CHAPTER 13: TRANSITIONAL LIVING PROGRAM (TLP)

All facilities and foster homes shall follow the guidelines outlined in K.S.A. 38-2202, "Reasonable and Prudent Parenting Standard", "means the standard characterized by careful and sensible parental decisions that maintain the health, safety and best interests of a child while at the same time encouraging the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in FC under the responsibility of the state to participate in extracurricular, enrichment, cultural and social activities."

GENERAL PROGRAM DESCRIPTION

Transitional living is designed for youth who are ready to enter a phase of care that will eventually transition them to independent living. Transitional living affords youth an opportunity to practice basic independent living skills in a variety of settings with decreasing degrees of supervision. Transitional living placements are offered through residential living arrangements where youth are provided the opportunity to practice independent living skills with decreasing degrees of care and supervision. The youth's case planning team, which shall include the youth, is required to determine the youth's readiness to enter this program by a review of the youth's current life skills proficiency. The youth may remain in this level of care until it is determined the youth is ready to transition to a Community Integration Placement (CIP) or a fully independent living setting.

- Youth reside in apartments within one building or complex (contained apartments) or a single-family home. Each youth shall be afforded enough bedroom space to insure adequate privacy, safety and security.
- The provider shall insure the environmental safety of the apartment is in compliance with local oversight agencies such as HUD, Fire Marshall, Municipalities, Apartment Management, etc.
- Service Access plan development, review, and case supervision are carried out by the Transitional Living provider.
- Services will be designed to work in collaboration with other community-based providers to develop a strong foundation of service and support access.
- Staff shall have experience, skill and knowledge in adolescent development, behavior management, child abuse and neglect, family dynamics, provision of community-based services, development of youth's strengths and assets, and positive youth development.
- The provider shall provide assistance to ensure that youth obtain the basic necessities of daily life.
- The provider shall offer or arrange for strength-based interventions to address crisis and or daily living situations.

- The provider shall facilitate development of support systems to increase the youth's interdependency within the community in which they reside.
- All services accessed shall be appropriate to the age, gender, sexual orientation, cultural heritage, developmental and functional level, as well as the learning ability of each youth.
- Admission requirements shall include a list of support service needs as identified by the CMP Case Manager

DCF requires foster parents and designated officials at childcare institutions to apply the reasonable and prudent parenting standard. The standard is characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while at the same time encouraging the child's emotional and developmental growth that a caregiver must use when determining whether to allow a child in foster care to participate in extracurricular, enrichment, cultural, and social activities.

As part of this standard, it is recognized hair and skin care are an integral to self-worth of children, youth, and young adults. Cultural identities of children, youth and young adults should be considered and honored, through a variety of activities related to hair and skin care. At no time should children, youth, or young adults be denied access to this basic right and need as a means of behavioral control, punishment, or rewards.

Facilities shall ensure staff have access to and knowledge of local and online resources for professional hair and skin care, as well as offer continuing education or training opportunities for staff on these topics. Furthermore, the facility shall encourage and facilitate staff to consult with the child, youth, young adults, parents or other relatives/kin connections regarding preferences, tools and hygiene products recommended, processes, and supports for meeting the individual's needs surrounding these matters.

DESCRIPTION OF YOUTH TO BE SERVED

Prior to consideration for admission to any TLP service youth shall be able to demonstrate knowledge of basic life skills.

All youth in transitional living placements shall:

- Be at least 16 years of age
- Be working towards full or part-time employment
- Be working towards a diploma or equivalent (if not already obtained)
- Have demonstrated a basic knowledge of life skills
- Youth are required to maintain a savings account to at designated banks that allow accounts to be opened while resident is under the age of 18. (i.e., Credit Union of America).

- Youth shall deposit the full or partial amount (depending upon their employment status) of their share of the monthly apartment rent and utilities.
- The youth's planning team (facility staff in coordination with the CMP Case Manager) will determine the actual amount required to be deposited in trust. These monies are then available to the youth when they leave the TLP.
- Youth shall have access to their savings accounts and shall maintain their financial records.

GENERAL STAFFING REQUIREMENTS

Staff shall meet the qualifications and responsibilities as set forth in this document. Written job descriptions shall be developed for all staff and maintained on site where personnel functions are carried out. All youth in TLP placements shall have twenty-four (24) hour access to on-site program staff that is responsible for monitoring the activities of youth in their programs. Program staff shall develop a schedule for providing supervision with guidance based on a specific youth's maturity, acquired skills, and emotional status. The supervisory schedule shall be designed so that staff may observe that the youth is practicing healthy and responsible life skills and will be developed in collaboration with a youth's CMP Case Manager. This collaboration will determine the frequency and type of supervision/support provided to the youth. Based on the needs and behaviors of youth, staff may leave youth at the facility for short periods of time, for the purpose of transporting another youth to and from offsite activities (job, appointment, school, etc. Facility should have a video surveillance system if youth are to be left at home alone so that remote monitoring can be observed by staff (i.e., via Cellphone) to ensure remote supervision.

Administrator:

- Shall have a bachelor's degree and prior administrative experience.
- Shall not be a person restricted from working with youth as defined by K.S.A. 65-516.
- Shall have a working knowledge of adolescent development principles.
- Shall be responsible for working with, supervising and training other staff (e.g., case coordinator, life coach) who are working with youth in the transitional living program.

Case Coordinator:

- Shall have at least a bachelor's degree in one of the human service fields (social work, psychology, human development and family life, criminal justice, counseling, nursing or education) and a working knowledge of adolescent development principles. The youth to case coordinator ratio is 1:16.
- Shall be at least twenty-one (21) years of age and at least three years older than the oldest youth served.
- Shall not be a person restricted from working with youth as defined by K.S.A. 65-516.

Life Coach:

- Shall have at least a high school diploma or equivalent and have a working knowledge of adolescent development principles.
- Shall be at least twenty-one (21) years of age and at least three years older than the oldest youth served.
- Shall not be a person restricted from working with youth as defined by K.S.A. 65-516.
- Shall be responsible for any direct supervision of youth as required.
- Shall inspect youth's apartment as needed to ensure the safety and security of youth.
- Shall be responsible for the day-to-day modeling of life skills (e.g., assertiveness, communication, conflict management, problem solving and decision making).
- Shall monitor youth's daily life skills and provide appropriate feedback.
- Shall work in partnership with the case coordinator.

CASE COORDINATION

The care coordinator has the responsibility for coordinating the child's program and progress with the CMP Case Manager, school, employer, family, important connections, Family Finding model or similar specific tools, and other appropriate community resources. This shall include, but not be limited to, talking with the youth about important connections and possible family connections, documenting connections, documenting phone calls, appointments and visits (on and off site). The care coordinator will add information about important connections and family connections, and Family Finding tools to the program plan, weekly and monthly progress reports sent to the CMP.

The Care Coordinator will maintain a resource base of services to address the needs identified in Individual Program Plans and document in the youth's file, when and what community resources have been contacted and utilized for services for the youth. The case coordinator shall be responsible for Weekly Progress Notes (see Section 14: Record Keeping).

STAFF IN-SERVICE TRAINING

Orientation

Each facility shall have an in-service orientation training program for new employees, which is especially directed toward the initial training needs of staff working directly with children. Documentation of completion of orientation training shall be kept, in the staff member's personnel file.

The documentation shall be placed in a specific area in the staff's file, indicating:

- staff training, reflecting orientation or annual training
- name of trainer
- name of training

- specify the number of training hours
- date of the training

Facility staff shall have completed a minimum of 18 hours of in-service orientation training. Staff shall demonstrate competency in the trainings from orientation before they can work independently with children.

All topics listed below shall be trained, even if it exceeds the minimum 18 hours of orientation:

Facility Trainings:

- Facility policy and procedures manual
- Facility emergency and evacuation procedures
- Facility discipline standards
- Child record documentation policies and procedures
- Resident rights (See Appendix 4, Resident Rights)
- Confidentiality laws
- Report Writing

Trainings from an outside source and/or trained trainers within the facility (source must be well recognized and qualified, trained trainers must have documentation on file):

- Emergency safety interventions (including management of aggressive or suicidal behavior) (if a facility chooses to use Emergency Safety Intervention staff shall be certified)
- De-escalation (staff shall be certified)
- The handling of blood borne pathogens
- Medication Administration (staff who pass medications shall be certified)
- Certified in CPR/First Aid
- Trauma based informed care/trauma specific intervention
- Mandated Reporting (Provided By DCF)
  http://www.dcf.ks.gov/services/MRT/Pages/default.aspx

- Health Insurance Portability and Accountability Act (HIPAA)
- Comprehensive LGBTQ+
- Human Trafficking and exploitation
- Cultural Diversity
- Suicide Prevention/Intervention/Safety
- Family-focused training (i.e., Family Finding, Team Decision Making, Family Group Decision Making, Signs of Safety, etc.)

ANNUAL IN-SERVICE TRAINING

Annual training is beyond or in addition to the initial 18-hour orientation training program from the date of employment. During the first year of employment staff shall receive a minimum of 36 hours of training (18 orientation hours, 18 annual In-Service).

All QRTP direct care staff shall have a minimum of 18 documented clock hours of in-service training per year. Documentation shall be provided in each staff member's personnel record to include content, amount of time, trainer, and qualifications.

The documentation shall be placed in a specific area in the staff's file, indicating:

- staff training, reflecting orientation or annual training
- name of trainer
- name of training
- specify the number of training hours
- date of the training

All topics listed below shall be trained, even if it exceeds the minimum 18 hours of annual in-service:

Facility Refreshers/Trainings:

- Facility policy and procedures manual
- Facility emergency and evacuation procedures
- Facility discipline standards
- Child record documentation policies and procedures
- Resident rights (See Appendix 4, Resident Rights)
- Confidentiality laws

Refreshers/Trainings from an outside source and/or trained trainers within the facility (source must be well recognized and qualified, trained trainers must have documentation on file):

- Emergency safety interventions (including management of aggressive or suicidal behavior) (staff shall maintain certification)
- De-escalation (staff shall maintain certification)
- The handling of blood borne pathogens
- Medication Administration (staff shall maintain certification, may or may not require annual training)
- CPR/First Aid (Staff shall maintain certification, may or may not require annual training)
- Trauma based informed care/trauma specific intervention
- Mandated Reporting (Provided By DCF)
  http://www.dcf.ks.gov/services/MRT/Pages/default.aspx

- Health Insurance Portability and Accountability Act (HIPAA)
- Comprehensive LGBTQ+
- Cultural Diversity
- Childhood and adolescent sexuality issues, especially the effects of early sexual abuse
- Substance Use Disorders
- Blood Borne Pathogens

- Childhood and adolescent development (including developmental disorders)
- Childhood and adolescent psychopathology (including such topics as effects of abuse/neglect, reactive attachment disorders, separation anxiety disorders, ADHD)
- Suicide Prevention/Intervention/Safety
- Family-focused training (i.e., Family Finding, Team Decision Making, Family Group Decision Making, Signs of Safety, etc.)

CONFIRMATION OF PLACEMENT

A Foster Care Confirmation of Placement (PPS 5122) **is available through the CareMatch system which confirms the placement arranged by the Child Welfare Case Management Provider (CMP).**

INITIAL ASSESSMENT

When a youth enters the facility, the TLP shall begin immediately assessing their strengths and needs including documentation and shall have a completed assessment within 7 days from admission.
The assessment shall include but not be limited to the following:

- Reasons for referral to the facility
- Evaluation or assessment covering the following areas:
    1. Physical health
    2. Family relations
    3. Academic or vocational training
- Community life
- Interpersonal interactions
- Important connections and family connections
- Daily living skills as outlined in the scope of services listed above
- Immediate service needs:
    1. Mental Health
    2. Developmental
    3. Dental
    4. Medical
- Involvement or exposure to Substance Use/disorder
- Involvement or exposure to other trauma
- Assessment of the child/youth's self- injuring or suicidal attempts

Additional Assessments:
The case coordinator or life skills coach may administer life skills assessments as needed to further identify needs to be addressed in the service access plan.

APARTMENT/ROOM ASSIGNMENT

To support the daily management and administration of youth, each residential provider shall develop an objective formal procedure to assess physical housing needs of youth. Youth in a residential facility shall be assigned to an apartment/room based upon a range of factors, as identified by risk/needs assessment(s) in addition to other indicators. Factors to consider in assigning apartments/rooms shall include (but are not limited to):

- Suicidal tendencies
- Level of specialized needs (i.e., mental health, medical, etc.)
- Displaying inappropriate sexual behaviors /victims of sexual abuse)
- Gender
- Age and/or maturity level
- Program needs (substance use disorder, cognitive behavioral, independent living, etc.)
- Vulnerability to being victimized by others (i.e., physical stature)
- Comprehensive LGBTQ+

While each youth will have an individualized program plan, assigning apartments/rooms based upon risk/need/responsivity factors will allow for a safer, more secure environment, as well as efficient and effective management of the living units. The youth's apartment/room assignment and how the decision was made shall be documented in the youth's file. The apartment/room assignment shall be completed immediately upon admission.

SERVICES

Youth in transitional living placements may need access to supportive services including but not limited to the following categories:

- Mental health services
- Alcohol and substance use disorder treatment services
- Educational/vocational support services
- Individual counseling
- Sex Offender treatment services
- Pro-social recreational activities
- Preventative, routine and emergency health care
- Routine transportation
- Emergency transportation when routine transportation is not available
- Administration, oversight of youth's trust
- Financial guidance to youth (e.g., budgeting, consumer skills)

TLP services shall provide the opportunity to practice the skills necessary to live independently. These skills, at a minimum, shall include:

- Preparing meals
- Basic nutrition education
- Doing laundry
- Maintaining a clean, orderly, and safe living space
- Living cooperatively with other housemates or neighbors
- Handling landlord/tenant complaints
- Controlling guests' behavior
- Handling basic maintenance
- Handling simple repairs
- How to call the landlord about problems
- Developing and following a budget
- Access to routine transportation (e.g., public transportation, carpool)
- Shopping, food preparation, food storage, and consumer skills

POSITIVE AND REALISTIC LIVING EXPERIENCES

Youth are further prepared for adulthood by being provided a realistic living experience, through transitional living placements in which they can take increasing responsibility for themselves. Elements of those living experiences include, but are not limited to, the following:

- Direct experience with the consequences of daily actions and decisions
- Life skills practice while having access to staff for support and advice
- Daily social contacts
- Emotional adjustment to the difference between present living situation and previous ones
- Practice living alone via a transition to a CIP (i.e., activities of daily living skills such as cooking, cleaning, budgeting, etc.)
- Use of leisure time
- Obtaining and using transportation to access needed resources

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

HOME FURNISHINGS

The provider shall make available certain articles and supplies for furnishing the youths residence. The articles and supplies may be new or used but shall be in good condition. The articles and supplies shall include, but are not limited to:

- A bed and bed linens
- A dining table and chairs
- Living or sitting room furniture
- A stove and refrigerator
- Kitchen furnishings (e.g., pots, pans, cooking and eating utensils)
- Basic cleaning supplies
- Telephone
- Utilities (e.g., water, trash, electricity, gas)
- Access to laundry services
- Food in sufficient quantity to provide at least three (3) nutritionally balanced meals per day
- Kitchen and bath linens
- Entertainment equipment (e.g., television, stereo, video games) are optional, if not provided, youth shall be provided the opportunity to purchase these items when they are financially capable

BEHAVIOR MANAGEMENT

Each TLP shall have a written program of consistent rules guiding and governing the daily behavior of the youth under the care of the program. The behavior management system shall include a description of daily general routines of the program. The system of rules, rewards, and consequences for behaviors shall be identified. Notation shall be made in the youth's file and signed by the youth that the rules, rewards and consequences have been discussed.

Each youth shall be oriented to the TLP's behavior management system by a staff member during the admission or orientation process. The youth shall be given a written copy of the system to use as a reference and the TLP shall post the behavior management system in a common area where the youth are able to easily access the system. Behavior management shall include rules governing:

- interpersonal interactions with staff and peers
- facility leave policies
- school attendance and behavior while at school
- verbal and physical aggression
- allowable possessions
- awakening and bedtime hours
- leisure hours, visitation policies
- runaway attempts
- involvement in recreation and other activities

- self-destructive behaviors
- sexuality
- communications with family and others outside the program
- religious worship
- involvement in therapies
- theft
- property destruction
- behaviors resulting in mandatory removal from the program
- behaviors at the program which could result in legal prosecution

When a youth decides not to attend religious worship or activities, alternative supervised activities shall be made available.

The overarching goals shall be to help the youth adjust to the residential facility and to daily life within society. A resource list shall be maintained by the facility of the available resources to meet the youth's need in the community.

Discipline at the facility shall be consistent and not be physically or emotionally damaging. Youth shall not be subjected to cruel, severe, unusual, or unnecessary punishment. Youth shall not be subjected to remarks that belittle or ridicule them or their families. Youth shall not be denied food, mail, telephone calls or visits with their families as punishment. Seclusion shall not be utilized as a disciplinary measure. The use of separating youth for a "cool down" period may be used in abnormal situations (i.e., Physical altercation). This strategy should be kept to a minimum and only used for the benefit of the use to regroup and reset emotions, not as a disciplinary tactic used by staff. Only staff members shall discipline youth.

RESETTING

A procedure used to assist the child in regaining regain emotional control by providing a safe and quiet area.

APPLICATION OF A RESET:

- A youth in a reset shall never be physically prevented from leaving the reset area.
- Resets may take place away from the area of activity or from other youth.
- Staff shall monitor the youth while he or she is in resetting.

DE-ESCALATION CERTIFICATION

De-escalation is a technique used during a potential crisis situation in an attempt to prevent a youth from causing harm to themselves, others and/or staff. De-escalation techniques shall be utilized for any activity required to diffuse a conflict or intense situation to ensure safety and calm the youth. Staff shall be certified in authorized, evidenced based de-escalation

techniques programs for managing aggressive behavior. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the youth and parent (if applicable)/guardian and/or CMP Case Manager shall be oriented to the managing aggressive behaviors policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the youth's case record.

EMERGENCY SAFETY INTERVENTIONS CERTIFICATION

An emergency safety intervention shall be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the youth's chronological and developmental age, size, gender physical, medical, psychiatric condition, and personal history.

The use of emergency safety interventions shall be performed only using nationally recognized restraint procedures applicable to this population designed to prevent a youth from harming self or others by exerting external control over physical movement.

An emergency safety intervention is the application of physical force without any mechanical device, for the purpose of restricting the free movement of a youth's body. **An emergency safety intervention shall be used only as last resort after all verbal de-escalation techniques have failed and when the youth is at-risk of harming themselves or others.**

Mechanical restraint is the use of mechanical devices to restrict the free movement of the youth's body, most often for purposes of preventing self-destructive behavior. **Mechanical restraints are not allowed in TLP residential facilities.**

Each facility shall have a written policy and all staff shall be trained to provide safe emergency safety interventions. Staff shall be certified in authorized, evidenced based training programs for managing aggressive behavior and de-escalation techniques. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the youth and parent (if applicable)/guardian (if applicable) and/or CMP Case Manager shall be oriented to the emergency safety intervention policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the youth's case record.

PROGRAM PLAN

Each youth residing in a residential facility shall have a program plan that is based on a thorough assessment. Assessment documents shall be included in the case record. The program plan shall be established by the end of 14 days from admission and shall address

the identified needs in the emotional, physical, educational, social, familial, and independent living skill domains. Youth may not have identified needs in every domain. If so, document that no needs were identified. Program plans shall be updated when new needs are identified or when program goals are met. Program plans shall be thoroughly reviewed, and revisions made at the case review conferences within 30 days of completion of initial program plan and each 30 days thereafter, including updated information of the progress of the youth's goals. Information obtained from the youth, parent, guardian, and CMP Case Manager shall be considered in the report. The initial program plan and all updates shall be sent to the CMP Case Manager after review/updating and/or each month.

The program plan shall include individualized services to match the youth's identified needs in the following areas:

- Long term goals in the areas of:
    1. physical health
    2. family relations
    3. daily living skills
    4. academic and/or vocational skills
    5. interpersonal relations
    6. substance use service needs
    7. emotional/psychological health

- Short term goals which will help a youth eventually reach his/her long-term goals in each of the above areas.
- Services to meet independent living goals.
- Specific plans for reaching the short-term goals including services to be provided and frequency.
- Estimated time for reaching short term goals.
- The youth shall sign and date the program plans indicating participation and input in the development of the plan.
- Updated information of the progress of the youth's goals shall be included.

TLP staff shall participate in case plan conducted by CMP Case Manager.

PERMANENCY PLANNING:

Includes the evaluation and design of an approach for the youth and family that focuses on opportunities for the youth to have ongoing active and meaningful connections with family, kin, relatives, and the community. The goal for achieving permanency shall be coordinated with the youth's CMP Case Manager and be included in the program plan to be reviewed every 30 days. The permanency plan shall include strategies and tasks to accomplish the youth's goals. Behaviors which place the youth at risk for disruption, activities to prepare the youth's family or kinship network for reunification, identification of other less restrictive living environments and preparing the youth for transition to these settings shall be addressed.

VISITATION

Subject to the provider's visitation guideline (days of the week, times, appropriate attire, etc.) a provider shall not prohibit contact with a child's immediate family except for the following reasons:

- A court orders no contact
- There is documented violence, threatening or disruptive behavior by family member that occurred during contact
- There is documented introduction of contraband into the facility

The facility shall provide private accommodations for visitation. Accommodations shall include but not be limited to a private office/room, no staff presence (unless required), free of any individuals that may overhear confidential information.

When home visits are a part of the treatment plan, there shall be coordinated connections with the child, their family, and the case coordinator/facility program staff regarding the youth's treatment and program goals and objectives. The goal of placement shall be to return the child to a family-like setting, so it is important that home visits be carefully planned and executed in the best interests of permanency planning for the child. All home visits shall be arranged through coordination with the child's CMP Case Manager. Documentation in child's file shall include who is transporting children to and from family visits and observation of the child's behavior during transportation.

The child shall have an approved contact list to include, the type of contact allowed (letter, phone, day passes, overnight passes, etc.) The contact list must be reviewed/updated every 60 days. Approved contacts shall be determined by the CMP Case Manager. The initial contact list and all reviews/updates shall include the CMP Case Manager signature.

DISRUPTIONS

Agencies must provide at least 14 business days' notice to the Case Management Provider in asking for a removal of the child placed less than 180 days (6 months) and 30 days' notice for children placed longer than 180 days (6 months) unless the child is in imminent danger to themselves or others as defined below. Timelines for placement move notices are defined as per KS Statute (i.e., K.S.A. 38-2258 of the Children in Need of Care code (K.S.A. 38-2201) and DCF's PPM (i.e., PPM 3362 Thirty Day Notice of Planned Move, PPM 3364 Exceptions to Thirty Day Notice of Planned Move) and should be followed accordingly.

If DCF or Law Enforcement is requiring immediate removal of a child due to the facility's inability to provide safety or stability for the child, CMP will be required to locate an alternate placement provider for the necessary disruption period. The Case Management Providers expects the placement provider to submit a Disruption Notice Form the next business day after the emergency removal occurs.

Emergency removal of a child from a residential facility that does not require the notice above will only be considered if one of the following has occurred:

- Child is admitted to an acute care facility
- Child is detained for a criminal offense
- Child is AWOL for more than 24 hours.
- Child has sexually assaulted another child within the facility or has attempted to sexually assault another child within the facility.
- Physical harm to the staff or other children in the facility, which cannot be rectified by a safety plan or continues to escalate. Facilities are to first utilize other services available (i.e., law enforcement intervention, screening into acute services). These situations will be staffed on a case by case basis.

DISCHARGE/AFTERCARE PLAN

Discharge planning shall begin upon admission of the youth to the facility. At a minimum, the youth, the youth's parents (if applicable) or guardian, and the CMP Case Manager shall be involved in planning the discharge from the facility. The discharge plan and modifications to it shall be noted in the case file.

A discharge summary shall be completed at the time of the youth's discharge and be forwarded to the CMP Case Manager within one business day. The discharge summary shall include written:

- Summary of progress, or lack thereof, of the youth's goals and objectives while the youth was in placement
- Summary of the progress towards securing a residence, home furnishings and utilities for youth being released to live independently
- Summary of the youth's behavior while in placement
- Recommendations for aftercare services specifying the nature, frequency, duration of services and responsible parties
- Written list of community resources given to the youth upon discharge (food banks, 211.org, educational opportunities, job search methods/job fairs, health care resources, how to reach for help, banking/budgeting, etc.)
- Summary of the reasons the youth was discharged
- Attempts shall be made to provide as much notification as possible to the placement agency prior to any relocation or release of a resident. At a minimum 48 hours should be provided, unless emergency removal, move, orders or other circumstances occur.

RECORD KEEPING

The record keeping requirements of K.A.R. 28-4-272 shall be met by the facility. In addition, the following shall be kept by the facility. If a facility chooses to use electronic filing full access shall be given to DCF employees who are conducting site visit.

Youth's File:

The provider shall maintain a file for each youth. The file shall contain the following:

- Youth's name and date of birth
- Name, address and emergency contact information of the youth's CMP Case Manager
- Name and contact information of other family members and fictive kin who are not part of the family and permanency plan (to be included on the approved contact list, if applicable)
- Foster Care Confirmation of Placement
- Current CMP Referral form
- Current CMP Case Plan
- If reunification is the goal, evidence demonstrating that the parent from whom the youth was removed provided input on the members of the family and permanency plan.
- Initial Assessment
- Suicide/self-injury questionnaire
- Room assignment assessment
- Medical and surgical consents
- Medical and dental records (history and current)
- Documentation of diagnosis (history and current)
- Records of the youth's prescription(s) and non-prescription(s) and when administered
- Authorization for release of confidential information
- Daily observation logs by shift
- Weekly progress notes
- Program plans
- Treatment Plans, if applicable
- Discharge plans/Aftercare
- Approved contact list
- Resident's rights acknowledgement
- Emergency Safety Intervention/de-escalation acknowledgements
- Handbook/Rules acknowledgement
- Pre and Post visit documentation
- Significant incident reports
- Personal Property Inventory
- Educational documentation

RECORD RETENTION:

Case records, including medical records, shall be maintained for 6 years from the date of the youth's discharge or until completion of an on-going audit and production of a final audit report, whichever is longer.

DAILY OBSERVATIONS:

A dated record of daily observations and significant occurrences involving each youth shall be maintained by each shift and maintained in each youth's individual file. The record shall

include events which may affect the well-being of the youth. Significant events should include but not be limited to; attendance at school or groups (specific group), interactions and/or interventions with staff and other youth, medical appointments, mental health appointments, medication compliance, hygiene (if identified as a need), visits/passes, meals eaten and overall behavior. Each report shall include the staff member and/or youth involved, the nature of the incident and the circumstances surrounding it. The record shall be available to review.

WEEKLY PROGRESS NOTES:

Notes shall be completed by the case coordinator. These notes shall be entered into the youth's chart, reflecting the delivery of services according to the treatment plan. This documentation shall address the youth's responses to interventions and the progress of the youth on individualized goals and objectives. The note shall include any significant events that occurred during the week and shall also summarize contacts with family members and other involved agencies. If an unmet need is identified, the note shall reflect the actions to be taken to revise the plan to meet that need. The case coordinator shall document specific services and activities they are providing to each youth. Each month the weekly progress notes shall be sent to the CMP Case Manager. The Monthly Progress Report Form shall be submitted to each child's provider no later than the 15th of each month following the reporting month, for all children who are in placement more than 15 days of that calendar month. Submission will be accepted by e-mail to:

- Cornerstones of Care: KSmonthlyprogressreports@Cornerstonesofcare.org
- KVC: KVCMonthlyReports@KVC.org
- St. Francis Ministries: MonthlyProgressReports@st-francis.org
- TFI: MonthlyReports@TFIFamily.org

HEALTH RECORDS:

Health Care and Records of youth shall meet the requirements of K.A.R. 28-4-275. Records of over the counter and prescribed medications shall be kept in each youth's case medical record and include the:

- name of the prescribing physician
- name of the medication
- dosage prescribed
- medication schedule
- purpose of the medication
- noted side effects
- date of the prescription
- date prescribed by a physician

A record of medication given, amount, date and time, and person dispensing shall be recorded. All doctor and dental visits, major illnesses, and accidents shall be recorded. Mental health appointments shall also be specifically documented in a youth's medical record. This provides for a complete Health record for the youth and their family, which documents the frequency of the youth's mental health treatment.

Personnel Records:

A separate file shall be maintained for each employee. Personnel files shall include the following:

- Written employment application, resume and reference checks
- Date of hire
- Position description
- Educational transcripts, HS diploma, college degree, etc.
- OGC- 3004 Staff Information Sheet
- Copy of driver's license/Kansas ID (current)
- Disciplinary action records
- Training records
- Out of state registry checks, when applicable (staff member has lived outside of Kansas within the last 5 years)

CHAPTER 14: COMMUNITY INTEGRATION PROGRAM (CIP)

All facilities and foster homes shall follow the guidelines outlined in K.S.A. 38-2202, "Reasonable and Prudent Parenting Standard", "means the standard characterized by careful and sensible parental decisions that maintain the health, safety and best interests of a child while at the same time encouraging the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in FC under the responsibility of the state to participate in extracurricular, enrichment, cultural and social activities."

GENERAL PROGRAM DSECRIPTION

Community Integration is a service designed for youth who are ready to enter a phase of care, which will eventually transition them to independent living. Youth reside in apartments and are afforded the opportunity to practice independent living skills with decreasing degrees of supervision. Community Integration service is to prepare youth to become socially and financially independent from the program.

Community Integration placements may be offered through a variety of residential living arrangements where youth have the opportunity to evidence independent living skills with decreasing degrees of supervision. Residential living arrangements may include apartments within one building or scattered site housing. Scattered site housing are dwellings (e.g., apartments, town homes, duplexes) that are typically located in the same neighborhood. The youth may remain in this level of care until they age out of foster care or it is determined that youth is ready to transition to a fully independent living setting.

- Youth reside in apartments within one building or complex (contained apartments) or a single-family home or scatter site apartments. Each youth shall be afforded sufficient bedroom space to insure adequate privacy, safety and security.
- The provider shall insure the environmental safety of the apartment is in compliance with local oversight agencies such as HUD, Fire Marshall, Municipalities, Apartment Management, etc.
- Program Plan development, review, and case supervision are carried out by the Community Integration Specialist.
- Services will be designed to work in collaboration with other community-based providers to develop a strong foundation of service and support access.
- Staff shall have experience, skill and knowledge in adolescent development, behavior management, child abuse and neglect, family dynamics, provision of community-based services, development of youth's strengths and assets, and positive youth development.

- The provider shall provide assistance to ensure that youth obtain the basic necessities of daily life.
- The provider shall offer or arrange for strength-based interventions to address crisis and or daily living situations.
- The provider shall facilitate development of support systems to increase the youth's interdependency within the community in which they reside.
- All services accessed shall be appropriate to the age, gender, sexual orientation, cultural heritage, developmental and functional level, as well as the learning ability of each youth.
- Admission requirements shall include a list of support service needs as identified by the CMP Case Manager.
- Youth is required to maintain a savings account into which the youth deposits the full or partial amount (depending upon their employment status) of their share of the monthly apartment rent and utilities.
- For a youth to be considered for CIP Placement, youth should be employed or have a high likelihood of employment soon. Resident should have an active cell phone which allows for 24-hour contact/access with staff.

DCF requires foster parents and designated officials at childcare institutions to apply the reasonable and prudent parenting standard. The standard is characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while at the same time encouraging the child's emotional and developmental growth that a caregiver must use when determining whether to allow a child in foster care to participate in extracurricular, enrichment, cultural, and social activities.

As part of this standard, it is recognized hair and skin care are an integral to self-worth of children, youth, and young adults. Cultural identities of children, youth and young adults should be considered and honored, through a variety of activities related to hair and skin care. At no time should children, youth, or young adults be denied access to this basic right and need as a means of behavioral control, punishment, or rewards.

Facilities shall ensure staff have access to and knowledge of local and online resources for professional hair and skin care, as well as offer continuing education or training opportunities for staff on these topics. Furthermore, the facility shall encourage and facilitate staff to consult with the child, youth, young adults, parents or other relatives/kin connections regarding preferences, tools and hygiene products recommended, processes, and supports for meeting the individual's needs surrounding these matters.

DESCRIPTION OF YOUTH TO BE SERVED

All youth in community integration placements shall:

- Be at least 17 years of age
- Be working full or part-time
- Be working towards a diploma or equivalent (if not already obtained)

- Have demonstrated the ability to perform life skills (see below for definition)
- Youth shall deposit the full or partial amount (depending upon their employment status) of their share of the monthly apartment rent and utilities.
- The youth's planning team (facility staff in coordination with the CMP Case Manager) will determine the actual amount required to be deposited in trust. These monies are then available to the youth when they leave the CIP.
- CIP staff shall keep financial records for all money deposited or debited from the youth's account.
- Youth must have a functioning cell phone that will allow for incoming phone calls, and text messages.

Prior to consideration for admission to any Community Integration service youth shall be able to demonstrate the ability to perform basic life skills. These skills, at a minimum, shall include:

- Preparing meals
- Basic nutrition education
- Doing laundry
- Maintaining a clean, orderly and safe living space
- Living cooperatively with other housemates or neighbors
- Handling landlord/tenant complaints
- Controlling guests' behavior
- Handling basic maintenance
- Handling simple repairs
- How to call the landlord about problems
- Developing and following a budget
- Use of leisure time
- Obtaining and using transportation to access needed resources
- Identify safe and affordable housing
- Negotiate a lease
- Present oneself to a landlord
- Prevent actions that might lead to an eviction
- Understand landlord/tenant rights and responsibilities

GENERAL STAFFING REQUIREMENTS

Staff shall meet the qualifications and responsibilities as set forth in this document. Written job descriptions shall be developed for all staff and maintained on site where personnel functions are carried out.

Administrator:

- Shall have a bachelor's degree and prior administrative experience.
- Shall not be a person restricted from working with youth as defined by K.S.A. 65-516.
- Shall have a working knowledge of adolescent development principles

- Shall be responsible for working with, supervising and training other staff (e.g., Community Integration Specialist) who are working with youth in the community integration program.

Community Integration Specialist

- Shall have at least a High School Diploma, a bachelor's degree is preferred in one of the human service fields (social work, psychology, human development and family life, criminal justice, counseling, nursing or education) and have a working knowledge of adolescent development principles.
- Shall be at least twenty-one (21) years of age and at least three years older than the oldest youth served.
- Shall not be a person restricted from working with youth as defined by K.S.A. 65-516.
- Shall be responsible for Program Plan development, review, and development of collaborations with community-based service providers.
- Shall be responsible for any monitoring of youth activities as required.
- Shall inspect youth's apartment as needed to ensure the safety and security of youth.
- Shall coordinate or provide alternative transportation as deemed necessary.
- Shall complete paperwork or reports to CMP Case Manager as required.
- Shall work shifts and or be on-call 24 hours a day on a rotating basis (See section 4: Placement Supervision).
- Shall be responsible for the day-to-day modeling of life skills (e.g., assertiveness, communication, conflict management, problem solving, and decision making).
- Shall monitor youth's daily life skills and provide appropriate feedback.
- Shall review bank statements, check stubs, etc. to insure youth's adherence to savings requirements

PLACEMENT SUPERVISION

- All youth in shall have twenty-four (24) hour landline telephone access to community integration staff.
- Community Integration staff shall evaluate, at a minimum, the youth's:
- Safety, health, and overall well-being;
- Ability to manage school and work responsibilities without daily supervision;
    - Ability to follow program and landlord rules;
    - Ability to use good judgment in daily activities; and
    - Overall progress toward established goals and desired outcomes.
    - Placement may have video surveillance equipment in the main living areas to assist with youth monitoring within the placement. Equipment shall not replace the use of in person supervision

The frequency of contact may vary due to many factors (e.g., readiness for independence; living arrangements chosen; presence or availability of other adults; other factors unforeseen until after placement).

The following contact schedule, at a minimum, shall be utilized during the first eight (8) weeks in placement. In person contacts are to be in the youth's apartment.

- 1st Week: Daily Phone Contact and minimum of 1 in person contact
- 2nd through 4th Weeks: Twice a Week Phone Contact and minimum of 1 in person contact
- 5th through 8th Weeks: Once a Week Phone Contact and minimum of 1 in person contact
- After the 8th week: contact shall occur no less often than once a month and the Community Integration Specialist and CMP Case Manager shall reconvene to determine the necessity of the youth's continued placement. Contact will occur as per standard visitation schedules with other youth as outlined in CMP grants.

ORIENTATION

Each facility shall have an in-service orientation training program for new employees, which is especially directed toward the initial training needs of staff working directly with children. Documentation of completion of orientation training shall be kept, in the staff member's personnel file.

The documentation shall be placed in a specific area in the staff's file, indicating:

- staff training, reflecting orientation or annual training
- name of trainer
- name of training
- specify the number of training hours
- date of the training

Facility staff shall have completed a minimum of 18 hours of in-service orientation training. Staff shall demonstrate competency in the trainings from orientation before they can work independently with children.

All topics listed below shall be trained, even if it exceeds the minimum 18 hours of orientation:
Facility Trainings:

- Facility policy and procedures manual
- Facility emergency and evacuation procedures
- Facility discipline standards
- Child record documentation policies and procedures
- Resident rights (See Appendix 4, Resident Rights)
- Confidentiality laws
- Report Writing

Trainings from an outside source and/or trained trainers within the facility (source must be well recognized and qualified, trained trainers must have documentation on file):

- Emergency safety interventions (including management of aggressive or suicidal behavior) (if a facility chooses to use Emergency Safety Intervention staff shall be certified)
- De-escalation (staff shall be certified)
- The handling of blood borne pathogens
- Medication Administration (staff who pass medications shall be certified)
- Certified in CPR/First Aid
- Trauma based informed care/trauma specific intervention
- Mandated Reporting (Provided By DCF)
  http://www.dcf.ks.gov/services/MRT/Pages/default.aspx

- Health Insurance Portability and Accountability Act (HIPAA)
- Comprehensive LGBTQ+
- Human Trafficking and exploitation
- Cultural Diversity
- Suicide Prevention/Intervention/Safety
- Family-focused training (i.e., Family Finding, Team Decision Making, Family Group Decision Making, Signs of Safety, etc.)

ANNUAL IN-SERVICE TRAINING

Annual training is beyond or in addition to the initial 18-hour orientation training program from the date of employment. During the first year of employment staff shall receive a minimum of 36 hours of training (18 orientation hours, 18 annual In-Service).

All CIP direct care staff shall have a minimum of 18 documented clock hours of in-service training per year. Documentation shall be provided in each staff member's personnel record to include content, amount of time, trainer, and qualifications.

The documentation shall be placed in a specific area in the staff's file, indicating:

- staff training, reflecting orientation or annual training
- name of trainer
- name of training
- specify the number of training hours
- date of the training

All topics listed below shall be trained, even if it exceeds the minimum 18 hours of annual in-service:

Facility Refreshers/Trainings:

- Facility policy and procedures manual

- Facility emergency and evacuation procedures
- Facility discipline standards
- Child record documentation policies and procedures
- Resident rights (See Appendix 4, Resident Rights)
- Confidentiality laws

Refreshers/Trainings from an outside source and/or trained trainers within the facility (source must be well recognized and qualified, trained trainers must have documentation on file):

- Emergency safety interventions (including management of aggressive or suicidal behavior) (staff shall maintain certification)
- De-escalation (staff shall maintain certification)
- The handling of blood borne pathogens
- Medication Administration (staff shall maintain certification, may or may not require annual training)
- CPR/First Aid (Staff shall maintain certification, may or may not require annual training)
- Trauma based informed care/trauma specific intervention
- Mandated Reporting (Provided By DCF)
  http://www.dcf.ks.gov/services/MRT/Pages/default.aspx

- Health Insurance Portability and Accountability Act (HIPAA)
- Comprehensive LGBTQ+
- Cultural Diversity
- Childhood and adolescent sexuality issues, especially the effects of early sexual abuse
- Substance Use Disorders
- Blood Borne Pathogens
- Childhood and adolescent development (including developmental disorders)
- Childhood and adolescent psychopathology (including such topics as effects of abuse/neglect, reactive attachment disorders, separation anxiety disorders, ADHD)
- Suicide Prevention/Intervention/Safety
- Family-focused training (i.e., Family Finding, Team Decision Making, Family Group Decision Making, Signs of Safety, etc.)

CONFIRMATION OF PLACEMENT

A Foster Care Confirmation of Placement (PPS 5122) **is available through the CareMatch system which confirms the placement arranged by the Child Welfare Case Management Provider (CMP).**

INITIAL ASSESSMENT

When a youth enters the facility, the TLP shall begin immediately assessing their strengths and needs including documentation and shall have a completed assessment within 7 days from admission.

The assessment shall include but not be limited to the following:

- Reasons for referral to the facility
- Evaluation or assessment covering the following areas:
    1. Physical health
    2. Family relations
    3. Academic or vocational training
- Community life
- Interpersonal interactions
- Important connections and family connections
- Daily living skills as outlined in the scope of services listed above
- Immediate service needs:
    1. Mental Health
    2. Developmental
    3. Dental
    4. Medical
- Involvement or exposure to Substance Use/disorder
- Involvement or exposure to other trauma
- Assessment of the child/youth's self- injuring or suicidal attempts

Additional Assessments:
The case coordinator or life skills coach may administer life skills assessments as needed to further identify needs to be addressed in the service access plan.

APARTMENT/ROOM ASSIGNMENT

To support the daily management and administration of youth, each residential provider shall develop an objective formal procedure to assess physical housing needs of youth. Youth in a residential facility shall be assigned to an apartment/room based upon a range of factors, as identified by risk/needs assessment(s) in addition to other indicators. Factors to consider in assigning apartments/rooms shall include (but are not limited to):

- Suicidal tendencies
- Level of specialized needs (i.e., mental health, medical, etc.)
- Displaying inappropriate sexual behaviors /victims of sexual abuse)
- Gender
- Age and/or maturity level
- Program needs (substance use disorder, cognitive behavioral, independent living, etc.)

- Vulnerability to being victimized by others (i.e., physical stature)
- Comprehensive LGBTQ+

While each youth will have an individualized program plan, assigning apartments/rooms based upon risk/need/responsivity factors will allow for a safer, more secure environment, as well as efficient and effective management of the living units. The youth's apartment/room assignment and how the decision was made shall be documented in the youth's file. The apartment/room assignment shall be completed immediately upon admission.

SERVICES

Youth in community integration placements may need access to supportive services including but not limited to the following categories:

- Mental health services, including treatment to address sexual issues if needed
- Alcohol and substance use disorder treatment services
- Educational/vocational support services
- Individual counseling
- Pro-social recreational activities
- Preventative, routine and emergency health care
- Routine transportation
- Emergency transportation when routine transportation is not available
- Review of youth's financial records (e.g., bank statements, check stubs) to monitor youth's money management skills

POSITIVE AND REALISTIC LIVING EXPERIENCES

Youth are further prepared for adulthood by being provided a realistic living experience, through community integration placements in which they can take increasing responsibility for themselves. Elements of those living experiences include, but are not limited to, the following:

- Direct experience with the consequences of daily actions and decisions
- Life skills practice while having access to staff for support and advice
- Use emergency medical procedures
- Negotiating a rental agreement
- Practice in money management and budgeting
- Experience in shopping, food preparation, food storage, and consumer skills

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

Above and beyond the services listed above the CIP shall continue to monitor and assess the services that were provided while the youth was living in a TLP and address any needs that arise. If a youth was not living in a TLP prior to CIP placement the CIP shall assess these needs prior to accepting placement.

- Preparing meals
- Basic nutrition education
- Doing laundry
- Maintaining a clean, orderly, and safe living space
- Living cooperatively with other housemates or neighbors
- Handling landlord/tenant complaints
- Controlling guests' behavior
- Handling basic maintenance
- Handling simple repairs
- How to call the landlord about problems
- Developing and following a budget
- Access to routine transportation (e.g., public transportation, carpool)
- Shopping, food preparation, food storage, and consumer skills

HOME FURNISHINGS/SERVICES

The provider shall make available certain articles and supplies for furnishing the youths residence. The articles and supplies may be new or used, but ~~t~~ shall be in good condition. The articles and supplies shall include, but are not limited to:

- A bed and bed linens
- A dining table and chairs
- Living or sitting room furniture
- A stove and refrigerator
- Kitchen furnishings (e.g., pots, pans, cooking and eating utensils)
- Basic cleaning supplies
- Landline telephone
- Utilities (e.g., water, trash, electricity, gas)
- Access to laundry services
- Food in sufficient quantity to provide at least three (3) nutritionally balanced meals per day (Food costs included in room and board, youth to be responsible for shopping and food preparation);
- Kitchen and bath linens
- Entertainment equipment (e.g., television, stereo, video games) are optional, if not provided, youth shall be provided the opportunity to purchase these items when they are financially capable

BEHAVIOR MANAGEMENT

Each CIP shall have a written program of consistent rules guiding and governing the daily behavior and behavior within the community. The behavior management system shall include a description of daily general routines of the program. The system of rules, rewards, and consequences for behaviors shall be identified. Notation shall be made in the youth's file and signed by the youth that the rules, rewards and consequences have been discussed.

Each youth shall be oriented to the CIP's behavior management system by a staff member during the admission or orientation process. The youth shall be given a written copy of the system to use as a reference and the CIP shall post the behavior management system in a common area where the youth are able to easily access the system. Behavior management shall include rules governing:

- interpersonal interactions with staff and peers
- facility leave policies
- school attendance and behavior while at school
- verbal and physical aggression
- allowable possessions
- curfew
- leisure hours, visitation policies
- runaway attempts
- involvement in recreation and other activities
- self-destructive behaviors
- communications with family and others outside the program
- religious worship
- involvement in therapies
- theft
- property destruction
- behaviors resulting in mandatory removal from the program
- behaviors at the program which could result in legal prosecution

When a youth decides not to attend religious worship or activities, alternative supervised activities shall be made available.

The overarching goals shall be to help the youth adjust to living independently and to daily life within society. A resource list shall be maintained by the facility of the available resources to meet the youth's need in the community.

Discipline at the facility shall be consistent and not be physically or emotionally damaging. Youth shall not be subjected to cruel, severe, unusual, or unnecessary punishment. Youth shall not be subjected to remarks that belittle or ridicule them or their families. Youth shall not be denied food, mail, telephone calls or visits with their families as punishment.

Seclusion shall not be utilized as a disciplinary measure. Only staff members shall discipline youth.

RESETTING

A procedure used to assist the child in regaining regain emotional control by providing a safe and quiet area.

APPLICATION OF A RESET:

- A youth in a reset shall never be physically prevented from leaving the reset area.
- Resets may take place away from the area of activity or from other youth.
- Staff shall monitor the youth while he or she is in resetting.

DE-ESCALATION CERTIFICATION

De-escalation is a technique used during a potential crisis situation in an attempt to prevent a youth from causing harm to themselves, others and/or staff. De-escalation techniques shall be utilized for any activity required to diffuse a conflict or intense situation to ensure safety and calm the youth. Staff shall be certified in authorized, evidenced based de-escalation techniques programs for managing aggressive behavior. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the youth and parent (if applicable)/guardian and/or CMP Case Manager shall be oriented to the managing aggressive behaviors policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the youth's case record.

EMERGENCY SAFETY INTERVENTIONS CERTIFICATION

An emergency safety intervention shall be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the youth's chronological and developmental age, size, gender physical, medical, psychiatric condition, and personal history.

The use of emergency safety interventions shall be performed only through the use of nationally recognized restraint procedures applicable to this population designed to prevent a youth from harming self or others by exerting external control over physical movement.

An emergency safety intervention is the application of physical force without any mechanical device, for the purpose of restricting the free movement of a youth's body. **An emergency safety intervention shall be used only as last resort after all verbal de-escalation techniques have failed and when the youth is at-risk of harming themselves or others.**

Mechanical restraint is the use of mechanical devices to restrict the free movement of the youth's body, most often for purposes of preventing self-destructive behavior. **Mechanical restraints are not allowed in CIP residential facilities.**

Each facility shall have a written policy and all staff shall be trained to provide safe emergency safety interventions. Staff shall be certified in authorized, evidenced based training programs for managing aggressive behavior and de-escalation techniques. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the youth and parent (if applicable)/guardian (if applicable) and/or CMP Case Manager shall be oriented to the emergency safety intervention policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the youth's case record.

PROGRAM PLAN

Each youth residing in a residential facility shall have a program plan that is based on a thorough assessment. Assessment documents shall be included in the case record. The program plan shall be established by the end of 14 days from admission and shall address the identified needs in the emotional, physical, educational, social, familial, and independent living skill domains. Youth may not have identified needs in every domain. If so, document that no needs were identified. Program plans shall be updated when new needs are identified or when program goals are met. Program plans shall be thoroughly reviewed, and revisions made at the case review conferences within 30 days of completion of initial program plan and each 30 days thereafter, including updated information of the progress of the youth's goals. Information obtained from the youth, parent, guardian, and CMP Case Manager shall be considered in the report. The initial program plan and all updates shall be sent to the CMP Case Manager after review/updating and/or each month.

The program plan shall include individualized services to match the youth's identified needs in the following areas:

- Long term goals in the areas of:
    1. physical health
    2. family relations
    3. daily living skills
    4. academic and/or vocational skills
    5. interpersonal relations
    6. substance use service needs
    7. emotional/psychological health
- Short term goals which will help a youth eventually reach his/her long-term goals in each of the above areas.
- Services to meet independent living goals.
- Specific plans for reaching the short-term goals including services to be provided and frequency.
- Estimated time for reaching short term goals.

- The youth shall sign and date the program plans indicating participation and input in the development of the plan.
- Updated information of the progress of the youth's goals shall be included.

CIP staff shall participate in case plan conducted by CMP Case Manager.

PERMANENCY PLANNING

Includes the evaluation and design of an approach for the youth and family that focuses on opportunities for the youth to have ongoing active and meaningful connections with family, kin, relatives, and the community. The goal for achieving permanency shall be coordinated with the youth's CMP Case Manager and be included in the program plan to be reviewed every 30 days. The permanency plan shall include strategies and tasks to accomplish the youth's goals. Behaviors which place the youth at risk for disruption, activities to prepare the youth's family or kinship network for reunification, identification of other less restrictive living environments and preparing the youth for transition to these settings shall be addressed.

VISITATION

Subject to the provider's visitation guideline (days of the week, times, appropriate attire, etc.) a provider shall not prohibit contact with a child's immediate family except for the following reasons:

- A court orders no contact
- There is documented violence, threatening or disruptive behavior by family member that occurred during contact
- There is documented introduction of contraband into the facility

The facility shall provide private accommodations for visitation. Accommodations shall include but not be limited to a private office/room, no staff presence (unless required), free of any individuals that may overhear confidential information.

When home visits are a part of the treatment plan, there shall be coordinated connections with the child, their family, and the case coordinator/facility program staff regarding the youth's treatment and program goals and objectives. The goal of placement shall be to return the child to a family-like setting, so it is important that home visits be carefully planned and executed in the best interests of permanency planning for the child. All home visits shall be arranged through coordination with the child's CMP Case Manager. Documentation in child's file shall include who is transporting children to and from family visits and observation of the child's behavior during transportation.

The child shall have an approved contact list to include, the type of contact allowed (letter, phone, day passes, overnight passes, etc.) The contact list must be reviewed/updated every

60 days. Approved contacts shall be determined by the CMP Case Manager. The initial contact list and all reviews/updates shall include the CMP Case Manager signature.

DISRUPTIONS

Agencies must provide at least 14 business days' notice to the Case Management Provider in asking for a removal of the child placed less than 180 days (6 months) and 30 days' notice for children placed longer than 180 days (6 months) unless the child is in imminent danger to themselves or others as defined below. Timelines for placement move notices are defined as per KS Statute (i.e., K.S.A. 38-2258 of the Children in Need of Care code (K.S.A. 38-2201) and DCF's PPM (i.e., PPM 3362 Thirty Day Notice of Planned Move, PPM 3364 Exceptions to Thirty Day Notice of Planned Move) and should be followed accordingly.

If DCF or Law Enforcement is requiring immediate removal of a child due to the facility's inability to provide safety or stability for the child, CMP will be required to locate an alternate placement provider for the necessary disruption period. The Case Management Providers expects the placement provider to submit a Disruption Notice Form the next business day after the emergency removal occurs.

Emergency removal of a child from a residential facility that does not require the notice above will only be considered if one of the following has occurred:

- Child is admitted to an acute care facility
- Child is detained for a criminal offense
- Child is AWOL for more than 24 hours.
- Child has sexually assaulted another child within the facility or has attempted to sexually assault another child within the facility.
- Physical harm to the staff or other children in the facility, which cannot be rectified by a safety plan or continues to escalate. Facilities are to first utilize other services available (i.e., law enforcement intervention, screening into acute services). These situations will be staffed on a case by case basis.

DISCHARGE/AFTERCARE PLAN

Discharge planning shall begin upon admission of the youth to the facility. Thus, at the very beginning of a youth's case with the facility, staff should be coordinating and identifying supports and placement options for discharge. At a minimum, the youth, the youth's parents (if applicable) or guardian, and the CMP Case Manager shall be involved in planning the discharge from the facility. However, it is encouraged staff engage all the youth's identified supports in this process. This may include extended family, former or present foster placements, NRKIN, and others within the community that have a vested interest in supporting the youth but perhaps cannot be a placement option at the time of discharge. The discharge plan and modifications to it shall be noted in the case file.

A discharge summary shall be completed at the time of the youth's discharge and be forwarded to the CMP Case Manager within one business day. The discharge summary shall include written:

- Summary of progress, or lack thereof, of the youth's goals and objectives while the youth was in placement
- Summary of the progress towards securing a residence, home furnishings and utilities for youth being released to live independently
- Summary of the youth's behavior while in placement
- Recommendations for aftercare services specifying the nature, frequency, duration of services and responsible parties
- Written list of community resources given to the youth upon discharge (food banks, 211.org, educational opportunities, job search methods/job fairs, health care resources, how to reach for help, banking/budgeting, etc.)
- Summary of the reasons the youth was discharged

RECORD KEEPING

The record keeping requirements of K.A.R. 28-4-272 shall be met by the facility. In addition, the following shall be kept by the facility. If a facility chooses to use electronic filing full access shall be given to DCF employees who are conducting site visit.

Child's File:
The provider shall maintain a file for each child. The file shall contain the following:

- Child's name and date of birth
- Name, address and emergency contact information of the child's CMP Case Manager
- Foster Care Confirmation of Placement
- Current CMP Referral form
- Current CMP Case Plan
- Initial Assessment
- Suicide/self-injury questionnaire
- Apartment/Room assignment assessment
- Medical and surgical consents
- Medical and dental records (history and current)
- Documentation of diagnosis (history and current)
- Records of the child's prescription(s) and non-prescription(s) and when administered
- Authorization for release of confidential information
- Daily observation logs by shift
- Weekly progress notes
- Program plans
- Treatment Plans, if applicable
- Discharge plans/Aftercare

- Approved contact list
- Resident's rights acknowledgement
- Emergency Safety Intervention/de-escalation acknowledgements
- Handbook/Rules acknowledgement
- Significant incident reports
- Personal Property Inventory
- Educational documentation

RECORD RETENTION:

Case records, including medical records, shall be maintained for 6 years from the date of the child's discharge or until completion of an on-going audit and production of a final audit report, whichever is longer.

Daily Observations:

A dated record of "daily observations" (as based on Section 4: Placement Supervision, and in person contact with youth) and significant occurrences involving each child shall be maintained by each shift and maintained in each child's individual file. The record shall include events which may affect the well-being of the child. Significant events should include but not be limited to; attendance at school or groups (specific group), interactions and/or interventions with staff and other children, medical appointments, mental health appointments, medication compliance, hygiene (if identified as a need), visits/passes, meals eaten and overall behavior. Each report shall include the staff member and/or child involved, the nature of the incident and the circumstances surrounding it. The record shall be available to review.

Weekly Progress Notes:

Notes shall be completed by the case coordinator. These notes shall be entered into the child's chart, reflecting the delivery of services according to the treatment plan. This documentation shall address the child's responses to interventions and the progress of the child on individualized goals and objectives. The note shall include any significant events that occurred during the week and shall also summarize contacts with family members and other involved agencies. If an unmet need is identified, the note shall reflect the actions to be taken to revise the plan to meet that need. The case coordinator shall document specific services and activities they are providing to each child. Each month the weekly progress notes shall be sent to the CMP Case Manager. The Monthly Progress Report Form shall be submitted to each child's provider no later than the 15th of each month following the reporting month, for all children who are in placement more than 15 days of that calendar month. Submission will be accepted by e-mail to:

- Cornerstones of Care: KSmonthlyprogressreports@Cornerstonesofcare.org
- KVC: KVCMonthlyReports@KVC.org

- St. Francis Ministries: MonthlyProgressReports@st-francis.org
- TFI: MonthlyReports@TFIFamily.org

Health Records:

Health Care and Records of children shall meet the requirements of K.A.R. 28-4-275. Records of over the counter and prescribed medications shall be kept in each child's case medical record and include the:

- name of the prescribing physician
- name of the medication
- dosage prescribed
- medication schedule
- purpose of the medication
- noted side effects
- date of the prescription
- date prescribed by a physician

A record of medication given, amount, date and time, and person dispensing shall be recorded. All doctor and dental visits, major illnesses, and accidents shall be recorded. Mental health appointments shall also be specifically documented in a child's medical record. This provides for a complete Health record for the child and their family, which documents the frequency of the youth's mental health treatment.

Personnel Records:

A separate file shall be maintained for each employee. Personnel files shall include the following:

- Written employment application, resume and reference checks
- Date of hire
- Position description
- Educational transcripts, HS diploma, college degree, etc.
- OGC- 3004 Staff Information Sheet
- Copy of driver's license/Kansas ID (current)
- Disciplinary action records
- Training records
- Out of state registry checks, when applicable (staff member has lived outside of Kansas within the last 5 years)

CHAPTER 15: PROVIDER GUIDANCE

All facilities and foster homes shall follow the guidelines outlined in K.S.A. 38-2202, "Reasonable and Prudent Parenting Standard", "means the standard characterized by careful and sensible parental decisions that maintain the health, safety and best interests of a child while at the same time encouraging the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in FC under the responsibility of the state to participate in extracurricular, enrichment, cultural and social activities."

The Department for Children and Families (DCF) utilizes foster homes and/or residential facilities that comply with DCF licensure requirements for children in the custody of the Secretary when out of home placement is required. A foster home must be sponsored by a licensed child placing agency (CPA). A foster home or facility is expected to provide 24-hour care to children who are in out of home placement to meet their needs, namely in the areas of safety, permanency and well-being.

All Child Welfare Case Management Providers must be notified within 1 day of any significant changes of the provider, including changes in the following:

- Leadership
- Address
- Open DCF PPS or Licensing investigations
- Corrective Action plans through DCF

This information should be provided in email to each of the Case Management Providers as listed below:

- Cornerstones of Care: KSProviderRelations@cornerstonesofcare.org
- KVC: globaladmissions@kvc.org
- St. Francis Ministries: ProviderRelations@st-francis.org
- TFI: CMD@TFIFamily.org

Services to be provided in the home/facility will support the healing process as a part of the permanency goal and will include but not be limited to: supervision, food, shelter, age appropriate daily living skills instruction, transportation, recreation and supporting parent/child interactions (when not prohibited by court order). The placement provider will also be expected to participate and support the implementation of case plan tasks and objectives that may include but not be limited to the following:

1. **Accessing community services**
   Foster families and providers are expected to develop a supportive relationship with each child entrusted to their care. The supports needed to care for a child are directly related to the assessed needs of each child and often will need to be accessed through

naturally occurring community supports. To address the challenges present in the life of a child, placement providers are expected to partner with DCF and each Child Welfare Case Management Provider (CMP) in accessing recommended community services. These supports will directly promote permanency and will-being of the child. These services include but are not limited to:

2. **Supporting educational needs** and addressing challenges through partnerships developed with school districts (K.A.R. 28-4-813(d)).
3. Scheduling any and all appointments, keeping appointments and ensuring all follow up appointments are scheduled and kept regarding a child's **physical health** (K.A.R. 28-4- 819(d)).
    a. During the child's first Out of Home (OOH) placement, a health assessment will be completed within 30 days of placement.
    b. Along with the child's case management team, the placement provider will assess the child's health care needs, included but not limited to, dental, vision, immunizations and medical needs, to ensure any recommended care is acquired.
    c. The child's immunizations, dental records, vision records and any other medical records will be kept current and documented as requested.
4. Accessing **mental health** services initiated and authorized by the CMP. If an initial mental health appointment has been established by the CMP, it is expected that the foster family/residential provider will ensure the child maintains the first **available appointment** and keep all appointments, including follow-up appointments and services as recommend by the therapist. Expectations may include but not limited to:
    a. Cooperating and participating in **HCBS waiver services** (including Autism, IDD, SED, and TA) and concurrent case planning as assessed in addressing the needs of the child.
    b. Supporting the development of **independent living skills** to assist youth in achieving self- sufficiency as directed by their learning plan and/or transition plan.
5. **Supporting Birth Family Interaction**

    All placement providers are expected to support the reunification of the child with their birth family as directed by the case management team (K.A.R. 28-4-813(a)(1)). Providers support the reunification process by facilitating and encouraging authorized, consistent and frequent interactions (family time) between children and their birth parents/family. Biological parents are to be treated with respect for their strengths.
6. **Identifying and Supporting Adoptive Resources**

    Should a child's case plan change to adoption, CPAs, foster families, and residential providers are asked to contribute to and support the decisions

regarding the adoptive process. Permanency decisions are made in the best interest of the child.

Providers will work with the CMP to implement the appropriate transition plan. All communications pertaining to permanency with potential adoptive families will be directed with the authorization of the child's case management team.

7. **Sibling Interaction**
   CPAs and Placement providers are expected to work diligently in the placement of siblings since separation is considered a last resort. When placement in the same home is not possible, a visitation plan is developed by the CMP, through the case planning document, to keep siblings connected until arrangements can be made to place all the siblings together. Providers are expected to support sibling interaction through encouragement, and flexibility. Upon request, providers may be invited to participate in the 90-day sibling separation review.

TRAUMA INFORMED PRACTICE

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

CMPs, CPAs and Placement providers caring for children in the custody of the secretary shall demonstrate an understanding of trauma and develop trauma-sensitive and trauma-informed practices. An agency that is trauma- informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff and others involved with the system; and responds by fully integrating knowledge about trauma policies, procedures and practices and seeks to actively resist re-traumatization.

SOCIAL MEDIA USAGE

All facilities and foster homes shall follow the guidelines outlined in K.S.A. 38-2202, "Reasonable and Prudent Parenting Standard", "means the standard characterized by careful and sensible parental decisions that maintain the health, safety and best interests of a child while at the same time encouraging the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in FC under the

responsibility of the state to participate in extracurricular, enrichment, cultural and social activities."

Social media is defined as being various websites, applications or online tools which enable users to engage with each other as well as create and share content via a variety of methods including audio, video and images. Some commonly used social media tools include Facebook, Twitter, Snapchat, YouTube, Instagram, TikTok and other emerging platforms. DCF acknowledges how social media use is an ever-changing dynamic in much of everyone's lives. Additionally, DCF recognizes licensed family foster homes may use social media accounts in their daily lives as well as allowing usage by children, youth, and young adults in care to strive toward a sense of normalcy. It is further recognized Facilities may also utilize social media as a means of communication, notification, and other uses in providing services. Thus, it is recommended each CPA and Facility develop policies and tactics to discuss how social media accounts are used to ensure children, youth, and young adults in the custody of the Secretary maintain safety and confidentiality as much as feasibly possible.

Some suggested guidelines for policies for **CPAs** to develop may include but are not limited to:

- Ensuring there are no safety issues related to the youth's image being posted on social media platforms, when feasibly possible.
- Ensuring, whenever feasible, any pictures taken by the worker for the means of file maintenance, DCF policy requirements, recruitment or other purposes does not contain any embedded location information before being uploaded into a database or otherwise shared beyond the worker.
- Encouraging dialogue between licensed family foster homes with the child's parent, guardian and/or the identified child, youth or young adult around preferences and specifically opt out of any and all images being shared on social media.
- Training and encouraging staff or the foster family to speak directly to the child's parent, guardian and/or the identified child, youth or young adult around social media preferences or any concerns.
- Training and encouraging foster parents to set privacy settings to restrict the general public from viewing profiles.
- Training and encouraging foster parents, children, youth, and young adults to turn off location monitoring to help ensure location and other identifying information is not inadvertently disclosed.
- Training and guidance to foster families on helping youth of various ages identify both the benefits and dangers of utilizing social media platforms.

Some suggested guidelines for policies for **Facilities** to develop may include but are not limited to:

- Ensuring there are no safety issues related to the youth's image being posted on social media platforms, when feasibly possible.
- Encouraging dialogue between staff with the child's parent, guardian and/or the identified child, youth or young adult around preferences and specifically opt out of any and all images being shared on social media.
- Training and encouraging staff to speak directly to the child's parent, guardian and/or the identified child, youth or young adult around social media preferences or any concerns.
- Developing policies around social media use while staff are working/providing services to clients. This should include, but is not limited to, development of guidance around "tagging" the facility, youth in care, the staff member or making other such linkages.
- Training and guidance to youth and young adults on the benefits and dangers of utilizing social media platforms, as much as technically possible in an ever-changing virtual world.

To ensure regulations 28-4-808 (f) and 28-4-810 (c) are followed, all CPAs and Facilitates shall work to ensure:

- Any images of youth do not identify the youth as being in foster care (or any other similar terminology) and will be identified by first name only, when feasible.
- Any and all case specific information, including reason the youth is in care, visitation, parents' progress, and status of the case is not disclosed or discussed.

KAR 28-4-271(b)(4): Residents shall not be exploited in campaigns or publicity efforts to raise funds

PLACEMENT

DCF, CMPs, CPAs and Placement Providers shall strive to ensure placement stability for all children; particularly those children who are placed in new settings; those that cannot remain in the home of relatives or non-related kin. Strong relationships between all agencies and placement providers is encouraged. Open and consistent communication is essential in avoiding placement disruption and promoting permanency and well-being for children.

Case Management Providers prioritize placing children close to their families, friends, relatives, school, and home community. Placements are made in the least restrictive environment appropriate to meeting the needs of the child and will not be delayed or denied based on race, color or national origin. By developing strong relationships with placement providers and keeping the lines of communication open and consistent, children will not suffer from unnecessary disruptions in living environments.

In the best interest of the child, CMP's expect placement providers to respond to placement needs and requests with attempts and/or options within two hours of the request. Placement Providers will supply the CMP's with accurate contact information for placement services and be available for after-hour, weekend and holiday placement support. Failure to respond on the part of the placement provider within two hours may result in CMP directly contacting a home matched on the DCF Care Match website.

Case Management Providers support all foster families and Residential Facilities regardless of their sponsor. Pursuant to DCF requirements, Case Management Providers will provide all required documentation and known information about each child to the provider and/or facility. All providers and facilities receive electronically complete placement referrals from Case Management Providers with the child's current and historical behavior profile, a list of current medications, and information on preventative measures and interventions that have supported past challenging behaviors. Case Management Providers are committed to working with all CPAs placement departments and Residential Placement Providers for the successful coordination of services.

If a known Case Management Provider employee becomes licensed with a CPA, notify the appropriate agency below at time of licensure and prior to any placement or respite options being matched. Each agency has their own internal policies regarding the placement of children in employee homes.

- Cornerstones of Care: KSPlacementFinding@cornerstonesofcare.org
- KVC: Globaladmissions@KVC.org
- St. Francis Ministries: ProviderRelations@st-francis.org
- TFI: CMD@TFIFamily.org

EMPLOYED STAFF SERVING AS LICENSED FAMILY FOSTER HOMES AND/OR EMPLOYEES SEEKING TO ADOPT CHILDREN IN CARE

SECTION: EMPLOYED STAFF SERVING AS LICENSED FAMILY FOSTER HOMES AND/OR EMPLOYEES SEEKING TO ADOPT CHILDREN IN FOSTER CARE

Staff employed with DCF, CMPs, CPAs or other placement facilities may choose to support children and youth in the custody of the state through providing foster care, respite or placement during PPC. It is strongly advised such staff, if licensed as a family foster home, shall not be sponsored by their agency of employment. However, should the agency deem this to be an acceptable practice, measures shall be taken to ensure supervision of the agency/facility employed foster parent is provided by a different supervisory area other than the area in which staff receives employment supervision. If this is not feasible, the employee shall have a written plan on how job functions and foster care roles are separated. This documentation shall be kept in the employees file and made available for review if

requested by DCF. Employees and the agency CMP, CPA or other placement facilities they are employed by have an obligation to conduct business within guidelines that serve to avoid actual or potential conflict of interest. Avoiding such situations protects the employer, employee and the children, youth and families being served.

The employee and members of the household shall complete all necessary steps of the licensing process, including participation in pre-service training, background checks and compliance with DCF Licensing regulations. It is recommended the employee serving as a resource for a child or children receive their pre-service training (i.e. TIPS-MAPP/Deciding Together) from another agency separate from the employee's agency. For instance, it is recommended a ABC employee receive their pre-service training through agency XYZ to ensure the training is fully received and free of any bias.

To avoid ethical violations, it is strongly advised that an employee not be a placement option for a client on their current case load or a resident in the 24-hour treatment program for which that staff works. If staff knows a client due to a professional relationship, and the client is not on their caseload/client in the staff's residential program, an exception may be granted as long as there is no conflict of interest and placement is in the best interest of the child, youth, or young adult. If an employee serving as a foster parent is promoted to Supervisor or above, it is strongly advised they cease fostering. An exception may be granted to continue serving children currently placed in the home. No new placements will be made.

Each agency, CPA, CMP and placement facility shall have policy and an identified approval process for making these exceptions. Documentation and justification for an exception will be noted and placed in the employee's file and made available to DCF upon request.

Placement agencies are encouraged to develop comprehensive policies around employees who become licensed as family foster homes or desire to adopt children from foster care. Some suggested policies may include but are not limited to the following:

- Parameters, guidance and procedures to help avoid the occurrence of any potential or actual conflict of interest for employees.
- Processes to ensure employees are in compliance with the agency's values and provider agreements with regard to providing safe, stable placement and services to a child or youth in their care. Intervention processes should be in place should these not be followed.
- Procedures to ensure the employee's family foster home file and records are confidential, and access is limited to those authorized personnel responsible for supervision and review.

- Procedures are developed regarding utilization of placement management databases (i.e. CareMatch) by employees who are licensed family foster homes.
- Recognize that each circumstance is unique, and protocols may need to be applied or modified in specific cases to ensure the highest standards of practice.

In the event an employee who is a licensed family foster home intends to adopt or an employee seeks to be an adoptive resource for a child or youth (i.e. Adopt Only Family), it is recommended CPAs/CMPs have policies in place to guide both the agency and the family through the adoption process. Some recommendations include, but are not limited to:

- Avoid employee adopting children or youth who are current clients of their agency and on their current caseload.
- Ensure the employee's assigned worker/agency provides home study services as is considered best practices in Kansas.
- Ensure all BIS procedures are ~~be~~ facilitated by an uninterested third-party agency. If it is not feasible to have an uninterested third-party agency facilitate a BIS, it is recommended the reasoning be documented, and the child or youth's CMP agency shall work with the family's sponsoring agency to find a solution which is unbiased and avoids any actual or potential conflict of interest.

CHILD PLACEMENT INFORMATION BOOK

CHILD Placement Information book from each contracting agency are:

- COC Providers an Orange Binder
- KVC Provides a Red Binder.
- SFM Provides a Blue Binder
- TFI Provides a Green Binder

Each child or youth should enter the foster home or residential placement with a file or notebook that contains the following information:

- **Section A – Medical**
  To include the child's or youth's Medical History, Medical Card, Medical Consent to Treatment, Immunization Records, Kan Be Healthy screenings, medical and dental forms, prescription and non-prescription drug records, authorization to dispense medication at school and in foster home and medication profile.
- **Section B – Admissions**
  Includes child's or youth's placement agreement, intake/referral form, birth certificate, social security card, audio/video release, child's or youth's rights,

release of information, clothing inventory and court reports. Information about the child's relationship to the family that may affect the placement

- **Section C – Education**
  Individual Education Plan (IEP), Educational Advocate, educational notices and grade cards.
- **Section D – Daily Logs**
  Progress notes from a residential center placement or daily logs from a foster home placement (if appropriate).
- **Section E – Monthly Reports**
  Monthly reports from the foster family home placement and foster family home court reports.
- **Section F – Other**
- **Lifebook –** Instructions on creating or formatting the child's or youth's Lifebook

K.A.R.38-2212 (a)(9) describes the appropriate and necessary exchange and access of information between the secretary and foster parents, prospective foster parents, permanent custodian, prospective permanent custodian, adoptive parent or prospective adoptive parent for a child in care.

Other pertinent information is in the appropriate section. The file should be taken to medical and dental appointments as well as other appointments in which the information may be needed. All documentation needs to remain in the child's file. Placements are expected to add all pertinent information to the Child Information Placement Book. When the child(ren) or youth leaves the foster family home or residential facility, the file accompanies the child(ren) or youth. The file must be returned to the CMP when the child(ren) or youth has reached permanency. It is the responsibility of the placement to return the Child Placement Information Book to the CMP.

Each child's file should contain the following information, which is required by DCF:

ON OR BEFORE PLACEMENT:

- Medical and surgical consent
- Medical card
- Reason for custody and reason for circumstances leading to current placement
- Description of child's recent circumstances, including medical problems, mental health concerns, and safety concerns, including any assaultive behavior and victimization concerns
- Information about the child's medication and dietary needs, and the name of the child's current health care provider
- Any allergies from which the child suffers
- Name, address and telephone number of the contact individual for the last educational program the child attended

ITEMS REQUIRED NO LATER THAN 14 CALENDAR DAYS AFTER PLACEMENT:

- A copy of the court order confirming DCF custody of the child and authority of the CMP to place the child
- A designation of the race or cultural heritage of the child, including tribal affiliation, if any
- The name, address and telephone number of the child's parents or legal guardians
- The spiritual or religious affiliation of the child and the child's family
- The child's placement history summary, including name, address and telephone number of any advocates.
- A description of positive attributes and characteristics of the child and, if available, any related information from the child, the child's family including siblings, and concerned individuals of the child's life
- The name, address, telephone number and email address of the CMP who is responsible for supervising the child's placement
- A copy of the current case plan, if completed. If this plan has not been completed, the foster home shall receive a copy within 14 calendar days of the completed plan
- Authorization regarding disclosure of confidential information
- If applicable, documentation on case plan authorizing the use of physical restraint
- Current copy of Medical record/KBH conducted by a licensed physician and/or nurse with a current license to practice in Kansas
- Current copy of dental record
- Immunization record
- Educational Enrollment Information Form (EEIF), School records, IEP
- Social Security *
- Birth Certificate *
- GAL name, number and email
- Foster parent report to the court form and cover letter

*It is noted CMPs are not always able to obtain these items in a timely manner due to several different barriers. However, DCF, CMPs and when applicable, CPAs should all work together to ensure placement and/or youth have access to their social security care and birth certificate when needed.

LIFEBOOK

The CMP is responsible to provide a Lifebook to each child in out of home placement and to ensure the Lifebook is initiated and updated during the entire episode of out of home placement. Parents, foster families, residential providers, teachers, therapists, and others involved in the child's life may assist in keeping the information in the Lifebook current. The Lifebook format guidance is in the back of the Child Placement Information Book; however,

the Lifebook is a separate book and should not be combined with the Child Placement Information Book but created in addition to.

Various formats may be used for a Lifebook. For example, a foster home may enjoy scrapbooking and putting together a scrap book with a child. Regardless of format used, the Lifebook is considered property of the child or youth and shall remain with them if they leave the FFH.

A Lifebook is a record of the life of a child who is in out of home placement. It is essential the child participate in the development and maintenance of their own Lifebook. The book belongs to the child, and they determine with whom this book is shared.

- **Practice Note:** The Lifebook should be started when a child enters out of home care and should continue to be added to throughout the child's time in foster care. While the CMP is responsible to ensure the Lifebook is initiated and updated during the entire episode of out of home placement, the birth parents, foster families, child and practitioner should facilitate it together. Each person brings important information to add to the child's Lifebook. It is essential that the child participate in the development and maintenance of their own Lifebook. Each child's Lifebook is original and information from the original format can be added and taken away, as it is appropriate.

GATHERING LIFEBOOK INFORMATION

The ideal time to begin a Lifebook is when a youth enters out of home placement. Information for a Lifebook may be collected by:

- Reviewing case records;
- Interviewing biological parents, grandparents, relatives, teachers, CASA volunteers, etc.;
- Gathering and reviewing reports from mental health facilities, hospitals, doctor offices, schools, churches, police departments, and the court; and
- Reviewing newspapers for birth announcements, marriage announcements, court actions (divorces), and obituaries.

Once a Lifebook has been started, keeping it current and up to date will require cooperation among the youth, the foster care or residential care provider, and the practitioner. It is important that all these people be involved in the Lifebook process. Including the biological parents as much as possible is also important. The Lifebook should be reviewed and updated during Case Planning Conference, at a minimum.

● **Practice Note:** ***The Lifebook belongs to the youth and is his/her book to record past, present, and future life experiences. Adults should assist the youth in completing the***

Lifebook, however; caution must be taken to allow the youth to share his/her memories, dreams, hopes, feelings, and expectations.

PLASTIC MEDICAL CARDS

Each child or youth will receive a plastic medical card to be used for medical expenses/services. The medical card will be stored in the, Child's Placement Information Book (often referred to as Bluebook/Redbook/Orange Book, etc.). At the time of the child's placement, the placement will receive the plastic medical card as well as a letter with a PIN #.

The child's placement will call 1-800-766-9012 to set up the child's password for the plastic medical card, or to access medical information, including previous appointment dates.

The child's card will move with him or her when placement changes. A new card will not be issued for each placement; however, a replacement PIN# will be distributed every time a child changes placement.

In the event the card is lost, a replacement card can be requested by the placement provider or the Child Welfare Case Manager through Customer Service 1-800-766-9012. The number of replacement cards requested and issued will be tracked by DCF.

Below are the Managed Care Organization (MCO) contacts and providing member directories.

- **Sunflower**
  Member Services 1-877-644-4623
  https://www.sunflowerhealthplan.com/find-a-doctor.html

- **Aetna**
  Member Services 1-855-221-5656
  https://www.aetnabetterhealth.com/kansas/members/directory

- **United Health Care**
  Member Services 1-877-542-9238
  https://www.uhccommunityplan.com/ks/medicaid/community-plan

INCIDENT REPORTING

The CMP is responsible for reporting Critical incidents to DCF per DCF PPM 0510.

If any incident involves abuse, neglect or exploitation, the placement provider shall also follow mandated reporting requirements.

All facilities shall have procedures for reporting incidents and critical incidents administrative staff and recording all such incidents in the child's file.

An administrative file of incidents/critical incidents shall be kept by the facility. An administrative file shall be kept by the facility documenting incidents/critical incidents that is separate from the documentation in the child's file.

Each facility shall develop an internal process for obtaining on-call/emergency contact information for all CMP Case Managers in the event of an emergency, incident or critical incident.

Nothing in this section shall be deemed or construed to replace or eliminate any obligation to report child abuse or neglect, sexual abuse or exploitation, or abandonment required of Provider or a Provider employee or other person by K.S.A.38-2223, by a contract with Provider, or by terms of employment by Provider.

Understanding the behaviors of a child while in placement is essential to providing the best services to children and families. When an incident transpires, placement providers are expected to communicate efficiently and effectively with Case Management Provider staff. All concerns and responses will need to be documented on the Kansas Incident Report form, as well as the child's monthly report as required.

Providers are expected to have staff available, accessible and able to manage a crisis immediately in the manner needed to support the foster child. If there is an emergency that requires an emergency room visit or hospitalization of the child for any reason, it is the responsibility of the foster parent and child placing agency or residential facility to develop a plan to provide support to the child as required by the hospital staff.

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

1. Take immediate action as necessary (i.e., safety, emergency procedures, first aid, etc.)
2. Determine if emergent assistance from anyone is needed and take appropriate action to seek assistance (i.e., Police, Fire Department, EMS, etc.) **This shall include staff providing the DCF Family Crisis Response Helpline at 833-441-2240**.
3. Contact appropriate people within the time frames established for each incident type below (e.g. Parents, Case Management Provider, Case Manager, On Call, etc.)
    - During regular business hours, the case management team should be contacted.
    - Reports should be made to the appropriate Case Management Provider afterhours by contacting:
        - Cornerstones of Care:**1-855-778-5437**
        - KVC: **1-913-621-5753**
        - St. Francis Ministries: **1-888-732-4673 (SFA-HOPE)**
        - TFI: **1-877-921-4114**

4. Complete the Kansas Incident Report provided by the CMP within the times frames established for each incident type and email to appropriate Case Management Provider:
    - Cornerstones of Care: KSincidentreporting@Cornerstonesofcare.org
    - KVC: Globaladmissions@KVC.org
    - St. Francis Ministries: CCAdmissions@st-francis.org
    - TFI: CMD@TFIFamily.org
5. Mandated reporters must report allegations of abuse and neglect to the Protection Reporting Center (PRC) as pursuant to DCF requirements. Kansas Protection Report Center contacts are 1-800-922-5330 and www.prcform.dcf.ks.gov.
6. Place a copy of the report and verification of written notification to the Case Management Provider in both the child's file and the foster families file.

CRITICAL INCIDENTS

The below incidents must be reported verbally within one hour/ and a written report within 4 hours)

- Foster Child Death
- Foster Child Near Death
- Foster Child has severe injuries
- Foster Child who attempted suicide
- Death of resident of the family foster home
- Foster parent with criminal proceedings related to abuse or neglect
- Incident Which May Draw Public, Legislative or Media Attention

SIGNIFICANT INCIDENT

The below incidents must be reported verbally within 4 hours with a written report to follow within 12 hours

- Injury/Accident/Illness of a foster child requiring hospitalization or professional medical attention
- Foster child is missing or has runway
- Foster child has been arrested for a juvenile offense
- Foster child has screened for acute care
- Any sexual contact between youth
- Foster child safety was seriously compromised
- Safety of environment
- Motorized vehicle accident involving any child in foster care
- Fire damage or other damage to the dwelling or damage to the property that affects the structure of the dwelling or the safety of the child in foster care

UNUSUAL INCIDENT

The below incidents require written notification within 24 hours

- Alleged abuse or neglect
- Law Enforcement Contact
- Aggressive or assaulting behaviors
- Drug or alcohol involvement by the child
- Restraint of a foster child
- Injury/Accident/Illness of Resource parent requiring hospitalization or professional medical attention
- DCF PPS or Licensing Complaint Investigation
- Any resident of the foster home has an infectious or contagious disease
- Breach of Privacy or Confidentiality
- Medication/Pharmacy errors

SAFETY REVIEW PROCESS

A safety plan will be completed by the provider when a child poses imminent danger to themselves or others. In coordination with the case team, **the provider's licensed worker or DCF approved designee** will complete and submit the safety plan to the Case Management Providers with the monthly report.

If after hours, a plan must be submitted to and reviewed verbally with Case Management Providers on call. The written plan is then to be sent electronically and expected to be received by Case Management Providers with the monthly report.

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

- Alleged perpetrator of animal abuse
- Alleged victim of human trafficking (K.A.R. 28-4-807(d)(1)(J))
- Arrest of a child in foster care (K.A.R. 28-4-807 (d)(1)(G))
- Attempted suicide (K.A.R. 28-4-807(d)(1)(J))
- Child is an alleged perpetrator or victim of a criminal assault of any kind
- Criminal Behavior
- Drug/Alcohol Use/Abuse
- Fire Setting
- Frequent AWOL
- Physically aggressive
- Property Destruction
- Psychiatric emergency/screened for acute care

- Runaway or missing from placement (K.A.R. 28-4-807(d)(1)(C))
- Safety of environment
- Self-injury
- Sexual Acting Out/Offender
- Use of illegal drugs

FAMILY CRISIS RESPONSE HELPLINE

In an effort to avoid situations rising to the level of critical, significant or unusual incidents, staff are encouraged to review the Family Crisis Response Helpline services offered and ensure families have the phone number available and easily accessible in their homes. Staff and families should be aware that support is available 24-hours a day, all year around. Additionally, this service is offered at no cost to the agency or families.

Resources include:

- Phone support to help de-escalate a behavioral health crisis for a child or youth younger than 20 years of age
- Referrals to local community resources or recommendations of engagement of stabilization services
- In-person supports via mobile crisis response if phone support is unable to provide a resolution
- EMS, law enforcement and others may be asked to respond in emergency situations in which phone or in-person supports do not provide a resolution

833-441-2240

PLACEMENT MOVES

Case Management Providers believe stability of placement is paramount to a child's success. A disruption is an unplanned change in a child's placement when the child will not be returning to the foster home or residential facility. Once every effort is made to maintain stability of placement, Case Management Providers will need the documented steps that have been taken to prevent disruption on the Disruption Notice Form.

Agencies must provide at least 14 business days' notice to the Case Management Provider in asking for a removal of the child placed less than 180 days (6 months) and 30 days' notice for children placed longer than 180 days (6 months) unless the child is in imminent danger to themselves or others as defined below. Timelines for placement move notices are defined as per KS Statute (i.e., K.S.A. 38-2258 of the Children in Need of Care code (K.S.A. 38-2201) and DCF's PPM (i.e., PPM 3362 Thirty Day Notice of Planned Move, PPM 3364 Exceptions to Thirty Day Notice of Planned Move) and should be followed accordingly.

If a disruption notice is given and the foster home is unable or unwilling to provide care for the length of the notice, the sponsoring agency will be responsible to locate an appropriate alternate foster home to fulfill the remainder of the notice. It is not appropriate to utilize a residential facility for placement of a child to fulfill the notice of a child placed in a foster home. Case Management Providers encourage partnerships with other CPA's in an effort to locate an alternative placement provider.

If DCF or Law Enforcement is requiring immediate removal of a child due to the foster parents' inability to provide safety or stability for the child, the sponsoring agency will be required to locate an alternate placement provider for the necessary disruption period. The Case Management Providers expects the placement provider to submit a Disruption Notice Form the next business day after the emergency removal occurs.

Emergency removal of a child from a foster home or residential facility that does not require the notice above will only be considered if one of the following has occurred:

- Child is admitted to an acute care facility
- Child is detained for a criminal offense
- Child is AWOL for more than 24 hours.
- Child has sexually assaulted another child within the home or has attempted to sexually assault another child within the home.
- Physical harm to the foster parent or other children in the home, which cannot be rectified by a safety plan or continues to escalate. Families are to first utilize other services available (i.e., law enforcement intervention, screening into acute services). These situations will be staffed on a case by case basis.

Case Management Providers will only accept disruption notices if they are submitted on Disruption Notice Form provided by the CMP and submitted to the below email addresses for each provider. Disruption notices may only be submitted Monday through Friday, there will be no weekend or holiday disruption notices accepted. Case Management Providers will respond to a disruption notice ensuring the child has been added the placement list.

- Cornerstones of Care: KSPlacementFinding@cornerstonesofcare.org
- KVC: Globaladmissions@KVC.org
- St. Francis Ministries: CCAdmissions@st-francis.org
- TFI: CMD@TFIFamily.org

NOTICES OF MOVES FROM CASE MANAGEMENT PROVIDERS

EMERGENCY MOVE

The Case Management Providers may change the placement of a child without providing prior notice if:

- Assessment made by the Case Management Provider that an emergency exists requiring immediate action to ensure the safety and protection of the child
- Assessment made by the Case Management Provider that the environment in the current placement is detrimental to the child's well-being.

48-HOUR NOTICE OF PLANNED MOVE

When a child has been residing in a foster home or facility for less than six continuous months and is able to move to a less restrictive setting, the Case Management Provider at least provide 48-hour notice of the planned move to the provider, unless a court order deems the move immediately necessary. Less Restrictive environments include, but are not limited to:

- Reintegration
- Kinship placement
- Agency approved placement
- Informal care placement
- Foster homes where Pre-placement visits have occurred

Case Management Providers may change the placement of a child under the above conditions. If the below conditions are not met, a 14-day notice will be given to the placement provider.

Practice Note: While it is acknowledged there are times in which providing 48-hour notice to a placement of a move is appropriate. Best practice notes this is not ideal in most situations, and this type of notice and movement of children and youth should be discouraged. When at all possible, CMPs are encouraged to utilized at least a minimum of 14-days to provide notice of a move.

30-DAY NOTICE OF PLANNED MOVE

The Case Management provider must provide written notification 30 days in advance of the planned move for all children in court custody who have been in the same foster home or facility for six continuous months or longer or in the home of a relative for any period of time.

Within 14 calendar days, anyone receiving 30-day notice of planned move may request, either orally or by written motion, that the court conduct a hearing to determine whether or not the proposed change in placement is in the best interests of the child. When requested, K.S.A. 38-2258 requires the court to schedule a hearing and immediately notify DCF the time and date of such hearing and shall notify persons as identified by the court records. The child shall not be moved until action is approved by the court.

The move may take place prior to the expiration of the 30 days if all parties notified consent in writing by signing an Intent to Move 30 Days Waiver to be provided by CMPs.

Exceptions to the requirements of 30-day advance notice of a planned move:

- The move is to the home of the pre-adoptive family selected by the best interest staffing team.
- The child is being reintegrated.

TRANSPORTATION

Local Transportation:

Foster parents are responsible to provide local transportation for foster children as a condition of receiving the applicable standard Foster Care daily rate:

- To childcare
- To school if in the local school district
- To school extra-curricular activities if within the local school district
- To local school for the foster parent to attend school conferences
- Foster family trips / vacations
- To Sports, entertainment, or cultural events
- Other local transportation a parent may be expected to provide their children

Transportation not covered by the Foster Care Rates

CMPs are responsible to provide transportation not covered by the room and board payment or to compensate whoever does provide the transportation. Transportation not covered by the applicable standard foster care daily rate must be reasonable and necessary or, at a minimum, considered in the best interest of the foster child. CMPs have the option to approve or disapprove non-local transportation. Whenever reimbursement is available for transportation to through Medicaid reimbursable services, providers are expected to seek reimbursement through Medicaid (see backside of medical card) and will not be paid by CMP.

Transportation provided may include but is not limited to the following:

- Any transportation of the foster child outside the local area, which DCF defines as more than 40 miles round trip from the foster parent's home including meals and lodging when overnight travel is requested Transportation of a foster child to school and to extra-curricular school activities if the foster child is enrolled in a district other than the local district.
- Transportation of a foster parent to attend school conferences if the foster child is enrolled in a school district other than the local district.
- Transportation (of the foster parent or foster child) to administrative case/judicial reviews.

- Transportation of a foster child to visits home or with family members at an agreed upon location
- Transportation of a foster child for pre-placement visits

Procedure

When mileage reimbursement is needed, a Request for Mileage Reimbursement Form provided by CMP must be completed and submitted to the appropriate CMP email below:

- Cornerstones of Care: KSProviderRelations@cornerstonesofcare.org
- KVC: AccountsPayable@kvc.org
- St. Francis Ministries: ReDataManagement@st-francis.org
- TFI: Transportation@TFIFamily.org

Mileage will be paid to the foster home as per the DCF Rate Structure, and payments will be made directly to the Family Foster Home.

CLOTHING

Ensuring a child in foster care has adequate clothing is a shared responsibility between placement providers and the CMP.

CMP responsibilities:

- Initial clothing needs when the child first enters out-of-home placement are the responsibility of the CMP paid through their flex funds.
- the CMP when placed with an unlicensed relative using the CMPs flex funds.
- For special clothing needs such as a prom dress or tux, or uniforms for sports or work, please contact the CMP to discuss resource options.

PLACEMENT RESPONSIBILITY:

- Ongoing clothing needs, depending on the placement type, are the responsibility of:
    - the foster parent when placed in a licensed foster home; the daily rate paid to the licensed foster home contains funds to be used for replenishing old, damaged, or out-grown clothing.

RESPITE

DCF will pay licensed family foster homes and relative placements their usual daily rate for basic through intensive levels of care for up to two days of respite per calendar month while

the child in foster care resides with a respite provider. If the respite stay lasts longer than 2 days, the licensed family foster home or relative placement will only be paid for 2 days; the remaining days while the child resides in respite are unpaid to the placement.

PROCEDURE

Notification of the respite must be given in writing to the case management team and the Case Management Provider admissions department at least 24 hours prior to respite occurring.

The respite notification form provided by the CMP must have both agency designee signatures before it will be entered into CareMatch for payment through DCF. It is the responsibility of the placement provider to obtain all signatures prior to submitting the form to the Child Management Provider. It is the expectation that the form will be submitted the following business day after the respite services have been provided to the child's Case Management Provider at the below emails.

- Cornerstones of Care: KSPlacementFinding@CornerstonesofCare.org
- KVC: PlacementRequests@kvc.org
- St. Francis Ministries: Respite@st-francis.org
- TFI: CMD@TFIFamily.org

FOSTER CARE CHILD CARE (FC-CC) PROGRAM

Daycare is provided for foster caregivers (licensed foster parents and relatives) who work or attend school through the Economic and Employment Services division. The Foster Care-Child Care (FC-CC) program is specially designed to meet the needs of the caregiver of a child in foster care. See DCF's Fiscal Guide for more information as well as website listed below for details:

http://www.dcf.ks.gov/services/PPS/Pages/PPSservices.aspx

If a relative caregiver experiences out-of-pocket expense, the CMP shall cover any out-of-pocket day care expense and be reimbursed by DCF through the encounter process.

When the FC-CC program cannot be used (such as when no enrolled childcare provider is available), the CMP shall meet the needs of the foster caregiver by arranging for daytime respite. These expenses are reimbursable by DCF to the CMP through the encounter process.

LEVEL OF SERVICE CHANGE (LOS) AND DISPUTE RESOLUTION PROCESS

Level of Service (LOS)/Rate Range Review Timeline

Reviews will be conducted as follows:

Basic – every 365 days, unless disputed by the sponsoring agency

Basic Levels 2 and 3, Intensive Levels 1 and 2 –every 180 days

If a placement provider would like to dispute a child's LOS, a dispute resolution request must be submitted in writing to the CMP. The CMP will respond to the placement provider with a date the child's LOS will be reviewed. Shortly after the date of review, the CMP will notify the CPA of the decision.

If a child in the custody of DCF has maintained placement for ninety (90) days at a particular level of service; the case may qualify for a change in their level of service. The CMP will monitor length of stays and level of service monthly as part of the consultation review meeting process.

Reviewing a child's LOS shall include information gathered from the Foster Home and/or facility the child has been placed with for the last 180 days. All parties involved with directly caring for the child within the last 90 days, will need to give their input as well. This includes, but not limited to, Case Manager, Family Support Worker, Foster Care Worker and Therapist.

If the child has been approved to change levels, the CMP will notify **placement provider** (not placement directly) with a letter via email providing them with a thirty (30) day notice that the child's level of service will be changed.

The thirty (30) day notice letter will let the Foster Home, Foster Care Homes Worker, Foster Care Homes Supervisor and/or Admissions Department (if in another agency home) know that the child's level of service will be changed due to the improvement/decline of the child's behaviors and the caregiver's response to those.

Placement providers will have seven (7) calendar days to dispute the child's level of service. The child's CMP will make the decision to complete a variance or continue with the level of service change. The CMP will notify the placement provider of the final decision regarding the child's level of service change within seven (7) calendar days of receiving the dispute from the placement provider.

If a dispute is not received by the CMP within seven (7) calendar days, the level of care change cannot be disputed again for 90 days.

PROGRAM OUTCOMES

CPAs and residential providers shall assist in attainment of the child welfare system goals, consistent with Federal and State outcomes. In addition to chosen goal selections, CPAs will support CMP performance outcomes by providing direct/indirect services. CPAs will assist in compliance with the implementation of evidence-based strategies resulting in

improvements in targeted state-or community-level factors, while also contributing to the attainment of state and local outcomes as indicated below:

Safety Performance – The rate of victimizations per 100,000 days spent in care. Standard: 8.50 victimizations per 100,000 days in care.

Achieving Permanency 1 – The number of children discharged from foster care, who are legally free (parental rights termination dates or date of death for both mother and father) for adoption at the time of discharge, and who were discharged to a permanent home (discharge reasons of adoption, permanent custodianship, reunification, or living with relative) prior to their 18th birthday. Standard: 96.8%

Achieving Permanency 2 – The number of children who were either (1) discharged from foster care for emancipation, (2) reached their 18th birthday while in foster care and were in foster care for 3 years or longer. Standard: 47.8%

Permanency Performance 1 – Permanency Performance 1 – The number of children who entered foster care in the 12 month reporting period, who discharged to permanency (Reunification, Adoption, Guardianship, or Living with Other Relative) within 12 months of entering foster care and before turning age 18. Standard: 40.5%

Permanency Performance 2 – The number of children who were in foster care 12 to 23 months on the first day of the 12 month reporting period, who discharged to permanency (Reunification, Adoption, Guardianship, or Living with Other Relative) within 12 months of the first day of the reporting period and before turning age 18. Standard: 43.6%

Permanency Performance 3 – he number of children who were in foster care 24 months or longer on the first day of the 12 month reporting period, who discharged to permanency (Reunification, Adoption, Guardianship, or Living with Other Relative) within 12 months of the first day of the reporting period and before turning 18. Standard: 30.3%

Re-entry into Foster Care in 12 Months – The number of children in the denominator who re-enter foster care within 12 months of their discharge…. Standard: 8.3%

Placement Stability – The total number of placements moves during the 12-month period for children included in the denominator. Standard: 4.44 moves per 1,000 days in foster care.

Siblings – The number of children who are placed with at least one other sibling in OOH placement on last day of the month. Standard: 78%

Relatives – The number of children who are placed with a relative or non-related kin while in OOH placement on the last day of the month. Standard: 50%

Placement Settings – The number of children living in out of home placement who are placed with a relative, foster, pre-adoptive, independent living, or on runaway status on the last day of the reporting month. Standard: 90%

Adoption Performance 1 – Number of children who were discharged from foster care to a finalized adoption in less than 24 months from the removal from home date in the report period. Standard: 26.8%

Adoption Performance 2 – The number of children in foster care in the report period who became legally free for adoption in the 12 months prior to the year shown, who were discharged to a finalized adoption in less than 12 months of becoming legally free. Standard: 45.8%

Educational Progression – The # of children in out of home placement, on June 30th 2020 who are still in out of home placement on June 30 2021, and have progressed to the next grade level. Standard: 70%

Success Indicators – There are 4 success indicators involving the following:

1. Complete 12th grade. Standard: none indicated
2. Same School. Standard: 25%
3. Permanent Connection. Standard: none indicated
4. Adulthood Preparedness. Standard: non indicated

PROGRAM, SERVICES AND POLICY OUTCOMES

To assess performance of each CPA and/or placement provider, the state may review and monitor accountability for child welfare programs through direct oversight, case read processes and administrative site visits. Case read and oversight activities may be used to assess and improve the delivery of services to families and children. Results of case reads, and oversight activities may be published by DCF on the internet or in other public information material.

Performance based outcomes shall not be rewarded with monetary or other bonuses/awards for staff. All decisions are to be made in the best interest of the child and shall not be influenced by any other considerations. The grant performance year is the state fiscal year (SFY) July 1- June 30. Reports published may reflect both federal and state fiscal year periods.

Poor performance on case read questions, nonconformities identified during an audit, not meeting the requirements of an administrative site review, or other sources identifying a significant or repeated problem impairing performance or compliance may lead to the implementation of a corrective action plan (CAP).

The concepts of a CAP are:

Using clearly identified sources of data which identify problems that will be investigated.

- Completing a root cause analysis to identify the cause of a discrepancy or deviation and suggest corrective actions to potentially prevent recurrence of a similar problem,

or preventive action to ensure that discrepancies do not occur.

- Implementing corrections to rectify the problem which is identified.
- Identifying a timeframe and contact for CAP steps to be completed.

If a problem is identified by DCF, the CPA or placement provider, DCF shall develop a Corrective Action Plan (CAP), to address the root cause of the issue and action steps to be taken to make improvements and prevent recurrence of the problem. In the event parties are unable to agree on the CAP, parties will comply with the process determined by DCF.

Operational definitions for grant outcomes and success indicators are listed at the back of this manual.

APPENDIX 1: REPORTING ABUSE/NEGLECT

All foster parents and facility staff are mandated reporters. Mandated reporters shall report all witnessed or suspected abuse/neglect to the Kansas Protection Report Center (KPRC) at 1-800-922-5330 or the local Law Enforcement Agency. To request mandated reporting please visit: http://www.dcf.ks.gov/services/MRT/Pages/default.aspx.

Abuse is any act or failure to act which results in death, physical harm, emotional harm, or which presents a likelihood of harm to a person under age 18. The broad definition of abuse includes physical abuse, emotional abuse, and sexual abuse. Neglect is any act or omission resulting in harm to a child or which presents a likelihood of harm. Neglect includes failure to provide food, clothing, shelter, safety, adequate levels of appropriate supervision, medical treatment, or education.

Physical Abuse: Infliction of physical harm or the causation of a child's deterioration, and may include, but shall not be limited to, maltreatment or exploiting a child to the extent the child's health is endangered. K.S.A. 38-2202

Sexual Abuse: Any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child, or another person. Sexual abuse shall include, but is not limited to, allowing, permitting, or encouraging a child to:

A. Be photographed, filmed, or depicted in obscene or pornographic material; or

B. Be subjected to aggravated human trafficking, as defined in K.S.A. 2014 Supp. 21-5426(b), and amendments thereto, if committed in whole or in part for the purpose of the sexual gratification of the offender or another, or be subjected to an act which would constitute conduct proscribed by article 55 of chapter 21 of the Kansas Statutes Annotated or K.S.A. 2015 Supp. 21-6419 or 21-6422, and amendments thereto. K.S.A. 38-2202.

Contact solely between children shall meet the criteria only if the contact also involves force, intimidation, difference in maturity or coercion. K.A.R. 30-46-10 (i)

Mental or Emotional Abuse: Infliction of mental or emotional harm or the causing of a deterioration of a child, and may include, but shall not be limited to, maltreatment or exploiting a child to the extent the child's health or emotional well-being is endangered. This term may include any act, behavior, or omission that impairs or endangers a child's social or intellectual functioning. This term may include the following:

1. terrorizing a child, by creating a climate of fear or engaging in violent or threatening behavior toward the child or toward others in the child's presence that demonstrates a flagrant disregard for the child

2. emotionally abandoning a child, by being psychologically unavailable to the child, demonstrating no attachment to the child, or failing to provide adequate nurturance of the child
3. corrupting a child, by teaching or rewarding the child for unlawful, antisocial, or sexually mature behavior. K.S.A. 38-2202 and K.A.R. 30-46-10

Physical Neglect: Acts or omissions by a parent, guardian, or person responsible for the care of a child resulting in harm to a child, or presenting a likelihood of harm, and the acts or omissions are not due solely to the lack of financial means of the child's parents or other custodian. This term may include but shall not be limited to failure to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child. K.S.A. 38-2202

Medical Neglect: Acts or omissions by a parent, guardian, or person responsible for the care of a child resulting in harm to a child, or presenting a likelihood of harm, and the acts or omissions are not due solely to the lack of financial means of the child's parents or other custodian. This term may include the following but shall not be limited to: failure to use resources available to treat a diagnosed medical condition if such treatment will make a child substantially more comfortable, reduce pain and suffering, or correct or substantially diminish a crippling condition from worsening. A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent. K.S.A. 38-2202

Lack of Supervision: Acts or omissions by a parent, guardian, or person responsible for the care of a child resulting in harm to a child, or presenting a likelihood of harm, and the acts or omissions are not due solely to the lack of financial means of the child's parents or other custodian. This term may include the following but shall not be limited to: failure to provide adequate supervision of a child or to remove a child from a situation which requires judgment or actions beyond the child's level of maturity, physical condition or mental abilities and that results in bodily injury or a likelihood of harm to the child. K.S.A. 38-2202

Educational Neglect: Acts or omissions by a parent, guardian, or person responsible for the care of a child resulting in harm to a child, or presenting a likelihood of harm, and the acts or omissions are not due solely to the lack of financial means of the child's parents or other custodian. (K.S.A. 38-2202) This term may include the following, failure of the parent or caregiver to provide education as required by law.

Neglect of a Substance Affected Infant: Acts or omissions by a parent, guardian, or person responsible for the care of a child resulting in harm to a child, or presenting a likelihood of harm, and the acts or omissions are not due solely to the lack of financial means of the child's parents or other custodian. K.S.A. 38-2202. This term may include the following but shall not be limited to: failure of a parent, guardian, or person responsible for the care of a substance affected infant to use resources available to meet the needs of such infant (health and substance use disorder treatment, etc.). A substance affected infant is defined by K.A.R. 30-46-10 as the birth of an infant (birth to 1 year of age) who is identified as being affected by or having withdrawal symptoms resulting from prenatal exposure to a legal or illegal substance.

APPENDIX 2: ACCESSING OUTPATIENT MENTAL HEALTH/SUBSTANCE USE DISORDER SERVICES

Child Welfare Case Management Providers shall be responsible to complete a mental health and substance use disorder screen to determine each youth's need for further assessment in these areas.

If the mental health assessment indicates the need for outpatient mental health treatment services, the child shall receive the appropriate mental health services through an enrolled Medicaid provider through KanCare. The Managed Care Organization (MCO) assigned to the youth through KanCare will periodically assess the youth's progress and continued need for outpatient mental health treatment.

If the substance use disorder assessment indicates the need for outpatient substance use disorder treatment services, the child shall receive the appropriate substance use disorder services through an enrolled Medicaid provider through KanCare. The Managed Care Organization (MCO) assigned to the child through KanCare will periodically assess the youth's progress and continued need for outpatient substance use disorder treatment.

If the Mental Health assessment determines the youth may need inpatient mental health or substance use disorder treatment, the youth shall receive a Psychiatric Residential Treatment Facility screen or, if the youth's sole diagnosis is substance use disorder, a referral shall be made to the Managed Care Organization (MCO) assigned to the youth.

Providers may employ, contract or otherwise partner with an enrolled Medicaid provider through KanCare to provide Outpatient Mental Health/Substance Use Disorder services to youth residing at the program.

Providers shall not prohibit the youth's ability to request or receive services from any willing provider who are enrolled Medicaid providers through KanCare.

APPENDIX 3: RESIDENT'S RIGHTS

The staff of the facility shall allow privacy for each youth. The facility's space and furnishings shall be designed and planned with respect for the child/youth's right to privacy. The facility's design shall also provide supervision according to the ages and needs of the children/youth. Each child/youth shall have a quiet area where they can withdraw from the group when appropriate.

Contacts between the children/youth and their parents/guardian shall be allowed while they are in care unless the rights of the parents have been terminated by court order or family contact is not in the child/youth's best interest. The frequency of contact shall be

determined by the needs of the child/youth and his/her family or guardians per program plan requirements.

The facility shall have clearly written policies regarding visits, gifts, mail, E-mail and telephone (including cell phone) calls, pictures and social networking between the children/youth and their family, or guardian. These policies shall be made known to the children/youth and his/her family/guardian at or prior to admission.

Children/youth shall be allowed to send and receive mail and have telephone conversations with family members/guardians unless it is not in the best interest of the youth, the safety and security of facility, or if a court order necessitates restrictions.

If restrictions on communications or visits are necessary, these shall be documented in the youth's approved contact list and reviewed frequently. The youth's CMP Case Manager shall be notified of any new restrictions to communications or visitation implemented by the facility prior to its implementation.

A child/youth shall be allowed to bring personal possessions to the facility and may acquire other possessions in accordance with the policies of the facility. Prior to admission, information shall be made available to the youth and their parents/guardians concerning what possessions a youth may bring to the facility and the kinds of gifts they may receive. Possessions, which a youth cannot have or receive at the facility, shall be specified in writing and distributed to the youth and their parents/guardians.

OPERATIONAL DEFINITIONS FOR GRANT OUTCOMES AND SUCCESS INDICATORS ARE AS FOLLOWS:

Safety Performance	Population	Standard	Source
Maltreatment in Foster Care by rate of victimization	Children in foster care during a 12-month period	8.50 victimization per 100,000 days in care	**FACTS:** Removal date Discharge date Date of Birth Report Date Occurrence Date Decision Date

Operational Definition

Numerator: Total number of substantiated or affirmed reports of maltreatment by any perpetrator during a foster care episode within the 12-month period.

divided by

Denominator: Of children in foster care during 12-month period, the total number of days these children were in foster care as of the end of the 12-month period.

Exclusions to Outcome: 1) Foster care episodes lasting less than 8 days. 2) Reports that occur within 7 days of removal, 3) Victims age 18 or older, 4) Youth in foster care age 18 or older (youth who are 17 and turn 18 during 12-month period are counted in outcome until his/her 18th birthday)

Example:

Reporting Month July 2015 (12-month period = Aug. 1, 2014 – Jul. 31, 2015)

Number of substantiated reports of maltreatment while in foster care = 116.

Number of days children were in foster care in 12-month period = 2,191,500 days.

For July 2015, the rate of victimization per 100,000 days in foster care is 5.29
[(N=116/D=2,191,5000)*100,000]

Lower rates are better for this outcome

Achieving Permanency 1	Population	Standard	Source
Achieving Permanency: Permanency for all children with Termination of Parental Rights.	Children who were discharged from foster care in the report period and who were legally free** for adoption at the time of discharge.	96.8%	**FACTS:** Removal date Discharge date All discharge reasons Date of Birth Mothers PRT Date Fathers PRT Date

Operational Definition

In a Reporting Month:

Numerator: The number of children discharged from foster care, who were legally free (parental rights termination, dates or date of death for both mother and father) for adoption at the time of discharge, and who were discharged to permanent home* prior to their 18th birthday.

divided by

Denominator: The number of children discharged from foster care, who were legally free (parental rights termination, dates or date of death for both mother and father) for adoption at the time of discharge.

Exclusions to Outcome: 1) Foster care episodes lasting less than 8 days. 2) Reports that occur within 7 days of removal, 3) Victims age 18 or older, 4) Youth in foster care age 18 or older (youth who are 17 and turn 18 during 12-month period are counted in outcome until his/her 18th birthday)

Example:

Reporting Month July 2015

Number of children who were discharged from foster care in the report period, who were legally free for adoption at the time of discharge, and who were discharged to permanent home prior to their 18th birthday = 45

Number of children who were discharged from foster care in the report period, and who were legally free for adoption at the time of discharge = 45

Number of children who were discharged from foster care in the report period, and who were legally free for adoption at the time of discharge = 100

July 2015 Performance with Performance with Progress for Achieving Permanency is 45% [N=45/100]

*Permanent home is if the discharge reason is adoption, permanent custodianship/guardianship, reunification, or live with relative.
**Legally free is the date of the Last parents (mother or father) parental rights termination date or date of death. Both parents must have parental rights terminated or be deceased for legal freedom to occur.

Achieving Permanency 2	Population	Standard	Source
Growing Up in Foster Care: Children emancipated who were in care 3 years or longer.	Children in the report period who were either (1) discharged from foster care for reason of emancipation or (2) reached their 18th birthday while in foster care.	47.8%	**FACTS:** Removal date Discharge date Discharge reason of Emancipation Date of Birth

Operational Definition

In a Reporting Month:

Numerator: The number of children who were either (1) discharged from foster care for emancipation or (2) reached their 18th birthday while in foster care for 3 years or longer

divided by

Denominator: The number of children who were either (1) discharged from foster care for emancipation or (2) reached their 18th birthday while in foster care.

Example:

Reporting Month July 2015

Number of children in the report period who were either (1) discharged from foster care for reason of emancipation or (2) reached their 18th birthday while in foster care and were in foster care for 3 years or longer = 45

Number of children in the report period who were either (1) discharged from foster care for reason of emancipation or (2) reached their 18th birthday while in foster care = 100

July 2015 Performance with Performance for Growing in Foster Care is 45% [N=45/100]

(Note: Lower percentage is better on this measure)

Permanency Performance 1	Population	Standard	Source
Permanency in 12 months for children entering Foster Care	Children who enter foster care in a 12-month period	40.5%	**FACTS:** Removal date Discharge date Date of Birth Placement codes

Operational Definition

In a Reporting Month:

Numerator: The number of children who entered foster care in the 12 month reporting period, within 12 months of entering foster care and before turning age 18.

divided by

Denominator: Number of children who enter foster care in a 12-month reporting period

Exclusions to Outcome: 1) Outcome excludes children in care less than 8 days and any youth age 18 or older at entry or exit from foster care.

Example:

Reporting Month July 2015 (12-month period = Aug. 1, 2013 – Jul. 31, 2014)

Number of children in the denominator who discharged to permanency within 12 months = 1,1445

Number of children who entered foster care in a 12-month period = 3,556

For July 2015, Performance rate for Permanency in 12 months for children entering Foster Care is 40.6%. [N=1,1445/3,3556]

Trial Home adjustment is made in this outcome: If a child discharges to reunification after a placement setting of trial home visit, any time in that placement that exceeds 30 days is discounted from the length of stay in foster care.

Permanency Performance 2	Population	Standard	Source
Permanency in 12 months for children who enter Foster Care to 23 months	Children in foster care between 12 and 23 months on the first day of a 12-month period.	43.6%	**FACTS:** Removal date Discharge date Date of Birth Placement codes

Operational Definition

In a Reporting Month:

Numerator: The number of children who were in foster care 12 to 23 months on the first day of the 12 month reporting period, within 12 months of the first day of the reporting period and before turning 18.

divided by

Denominator: Number of children in foster care between 12 and 23 months on the first day of a 12-month reporting period.

Exclusions to Outcome: 1) Youth entering foster care age 18 or older

Example:

Reporting Month July 2015 (12-month period = Aug. 1, 2013 – Jul. 31, 2014)

Number of children in the denominator who discharged to permanency within 12 months = 651

Number of children who entered foster care in a 12-month period = 1,545

For July 2015, Performance rate for Permanency in 12 months for children entering Foster Care between 12 and 23 months is 42.1%. [N=651/1,545]

*Permanency is Reunification, Adoption, Guardianship, or Living with Other Relative

Permanency Performance 3	Population	Standard	Source
Permanency in 12 months for children in Foster Care 24 months or more	Children in foster care 24 months or more on the first day of a 12-month period	30.3%	**FACTS:** Removal date Discharge date Date of Birth Placement codes

Operational Definition

In a Reporting Month:

Numerator: The number of children in the denominator who discharged to permanency* within 12 months of the first day of the 12-month period and before turning age 18.

divided by

Denominator: Number of children who enter foster care 24 months or more on the first day of a 12-month period

Exclusions to Outcome: 1) Youth entering foster care age 18 or older

Example:

Reporting Month July 2015 (12-month period = Aug. 1, 2013 – Jul. 31, 2014)

Number of children in the denominator who discharged to permanency within 12 months = 401

Number of children who entered foster care in a 12-month period = 1,395

For July 2015, Performance rate for Permanency in 12 months for children entering Foster Care 24 months or more is 28.7%. [N=401/1,395]

* Permanency (Reunification, Adoption, Guardianship, or Living with Other Relative)

Permanency Performance 4	Population	Standard	Source
Re-entry into Foster Care in 12 Months	Children who entered Foster Care during a 12-month period and discharged within 12 months to reunification, living with a relative, or permanent custodianship/guardianship	8.3%	**FACTS:** Removal date Discharge date Date of Birth Placement codes

Operational Definition

Numerator: The number of children in the denominator who re-entered foster care within 12 months of their discharge. (If a child has multiple re-entries within 12 months of their discharge, only the first re-entry is selected)

divided by

Denominator: Number of children who entered foster care during a 12-month period and discharged within 12 months to reunification, living with a relative, or permanent custodianship/guardianship.

Exclusions to Outcome: 1) Foster care episodes lasting less than 8 days, 2) Youth entering or exiting foster care age 18 or older.

Example:

Reporting Month July 2015 (12-month period = Aug. 1, 2012 – Jul. 31, 2013)

Number of children in the denominator who discharged to permanency within 12 months = 75

Number of children who entered foster care in a 12-month period = 1,428

For July 2015, Performance rate for Re-entry into Foster Care in 12 Months is 5.3%. [N=75/1428]

Lower percentage are better for this outcome

Placement Stability	Population	Standard	Source
Placement Stability: Rate of moves by days in foster care	Children who enter foster care in a 12-month period.	4.44 moves per 1,000 days in foster care	**FACTS:** Removal date Discharge date Date of Birth Placement codes

Operational Definition

Numerator: Total number of placement moves for children included in the denominator.

divided by

Denominator: Of children who enter foster care in a 12-month period, the total number of days these children have been in foster care on the last day of the 12-month period.

Exclusions to Outcome: 1) Foster care episodes lasting less than 8 days, 2) Youth entering foster care age 18 or older (youth who are 17 and turn 18 during 12 month period are counted in outcome until his/her 18th birthday), 3) initial placement at time of removal is not counted as placement move, 4) Moves to following placements: placed at home, runaway, respite care, and changes in foster homes status

Example:

Reporting Month July 2015 (12-month period = Aug. 1, 2014 – Jul. 31, 2015)

Number of placements moves for children in the denominator = 3,511

Number of days children who entered foster care in a 12-month period had been in care on the last day of the 12-month period = 6,550,058 days

For July 2015, Performance rate for Re-entry into Foster Care in 12 Months is 5.36 [(N=3,511/D=6,550,058)*1,000].

Lower percentage are better for this outcome

Placement Stability	Population	Standard	Source
Children are entitled to live with other siblings in care when in the best interest of the child.	Children in OOH placement	78%	**FACTS:** Placement codes Sibling indicator Out of Home End Date
Operational Definition			
In a reporting Month: Using the last day of the month **Numerator:** The number of children who are placed with at least one other sibling in OOH placement on last day of the month. **divided by** **Denominator:** The number of children who have at least one other sibling in OOH placement on last day of the month.			

Relatives	Population	Standard	Source
Children are entitled to live with relatives or non-related kin while in care when in the best interest of the child	Children in OOH placement	50%	**FACTS:** Placement codes Out of Home End Date
Operational Definition			
In a reporting Month: Using the last day of the month **Numerator:** The number of children who are placed with a relative or non-related kin while in OOH placement on the last day of the month. **divided by** **Denominator:** The number of children who are in OOH placement on the last day of the month.			

Placement Setting	Population Cohort	Standard	Source
Placement in Family Like Setting	Children in OOH placement	90%	**FACTS:** Placement codes Out of Home End Date
Operational Definition			
In a reporting Month **Numerator:** The number of children in out of home placement (OOHP) who are placed with a relative, foster, pre-adoptive, independent living, or on runaway status on the last day of the reporting month. **divided by** **Denominator:** All children in out of home placement on the last day of the reporting month. *Children who are placed in a non-related kin setting are considered place in a foster home.			

Adoption Performance 1	Population	Standard	Source
Timely Adoption in less than 24 months	Children released from custody for reason of adoption in the report period	26.8%	**FACTS:** Removal date Discharge date Discharge reason of adoption

Operational Definition

In a reporting Month

Numerator: Number of children who were discharged from foster care to a finalized adoption in less than 24 months from the removal from home date in the report period.

divided by

Denominator: Children who were discharged from foster care to a finalized adoption in the report period.

Example:
Reporting Month July 2015

Number of children who were discharged from foster care to a finalized adoption in less than 24 months from their removal from home date in the report period =25

Number of children who were discharged from foster care to a finalized adoption in the report period = 100

July 2015 Performance for Timely Adoption 25% [N=25/100]

Adoption Performance 2	Population	Standard	Source
Progress Towards Adoption: Adoption in less than 12 months, once children is legally free	Children in foster care in the report period who became legally free** for adoption in that same report period.	48.8%	**FACTS:** Removal date Discharge date All discharge reason Mother PRT Father PRT

Operational Definition

In a reporting Month

Numerator: The number of children in foster care in the report period who became legally free for adoption in the 12 months prior to the year shown, who were discharged to a finalized adoption in less than 12 months of becoming legally free.

divided by

Denominator: The number children in foster care in the report period who became legally free for adoption in the 12 months prior to the reporting month.

Example:
Reporting Month July 2015

Number of children in foster care in the report period who became legally free for adoption in the 12 months prior to the year shown, then were discharged to a finalized adoption in less than 12 months of becoming legally free = 45

Number of children in foster care in the report period who became legally free for adoption in 12 months prior to the year shown = 100

July 2015 Performance with Progress Towards Adoption of Children Legally Free is 45% [N=45/100]

*Legally Free is the date of the last parents (mother or father) parental rights termination date or date of death. Both parents must have parental rights terminated or be deceased for legal freedom to occur.

Educational Progression	Population Cohort	Standard	Source
Educational Progression in 365 days	Children in OOH placement on the last day of the prior State fiscal year (June 30th) who are still in OOH placement on the last day of the current State fiscal year.	70%	**FACTS:** Highest grade level completed Out of Home End Date

Operational Definition

Data for this outcome will report progress toward the outcome; however, due to the nature of the cohort is not a valid measure until the completion of the state fiscal year.

In a Reporting Month:

Numerator: The number of children in out of home placement, on June 30th 2020 who are still in out of home placement on June 30 2021, and have progressed to the next grade level.

divided by

Denominator: The number children in out of home placement, June 30th, 2020, who are in out of home placement on June 30 2021.

Attributes	Description	Jul-Sep Q1	Oct-Dec Q2	Jan-Mar Q3	Apr-Jun Q4	SFY Total
1	Children in OOHP on June 30, 2015, who remain in OOHP on June 30, 2016					1,000
2	#Children from #1 who have progressed to the next grade level	100	175	180	200	655
Percent of children who were in foster care for 365 days and progressed to the next grade level (655/100)						65.5%

SUCCESS INDICATORS:

Completed 12th Grade	Population	Source
Adults ending custody with the Secretary for emancipation or runaway will have completed the 12th grade	Adults ending custody with the Secretary for reason of emancipation or runaway	**FACTS:** Date of Birth Highest Grade Level Completed Out of Home End Date Out of Home End Reason
Operational Definition		
In a Reporting Month: **Numerator:** The number of adults ending custody with the Secretary of DCF for reason of Emancipation or Runaway, who have completed the 12th grade **divided by** **Denominator:** The total number of adults ending custody with the Secretary for reason of emancipation or runaway.		

Same School	Population	Standard	Source
Children are entitled to remain in their same school when in the best interest of the child	Children in OOH placement	25%	**FACTS:** Placement codes for same school indicator Out of Home End Date
Operational Definition			
In a reporting Month: Using the last day of the month **Numerator:** The number of children who are age 6 or over and attending the same school as prior to removal on last day of the month. **divided by** **Denominator:** The number children who are age 6 and over in OOH placement on the last day of the month. A child is considered to be attending the same school if: 1. The school they are attending while in OOH placement is the same public or private school they were attending at the time of their entry into OOH; or 2. The school they are attending while in OOH placement is the same public or private school, they would have attended at the time of their entry into OOH respective to grated level or promotion for a child, (e.g. if entry onto care occurred during summer break and children had been promoted to a new middle or high school location); or,			

3. They are attending the same school as they would be attending if they were residing with the removal parent(s)/caregiver or the resource with whom reintegration, adoption or permanent custodianship is planned (for those situations where the parent/primary care giver had removed since the child entered OOH or they child reaching permanency in new community). For adoption this begins when the adoption agreement is signed by the prospective adoptive family, for permanent custodianship this begins when the permanent custodianship agreement is signed by the resource family
4. A child is considered to be attending the same school if they are in an independent living placement.

It is not an expectation that children continue with home school settings; however, there may be circumstances for a child or youth in which that home school setting is appropriated. If the child attended a home school setting school prior to removal into out of home placement and continues to attend that same setting after entering care, then that child is considered to be attending the same school purposes of outcome reporting.

Permanent Connection	Population	Source
Adults ending custody with the Secretary will have an identified overall/everyday living Connection for Success	Adults ending with the Secretary	**FACTS:** Date of Birth Out of Home End Date Out of Home End Reason Placement Codes for Overall/everyday living Connections for Success
Operational Definition		
In a reporting Month **Numerator:** The number of adults ending custody with the Secretary of DCF for reason of Emancipation or Runaway, who have an individual listed in Section 11 of their PPS 3059 Transition Plan for Successful Adulthood. **divided by** **Denominator:** The number of adults ending custody with the Secretary of DCF for reason of Emancipation or Runaway.		