SERVICE STANDARD

INDIANA DEPARTMENT OF CHILD SERVICES

INTENSIVE FOSTER CARE SERVICES (Per Diem Model)

ADDENDUM #1

I. Service Description

A. Intensive Foster Care Services are services designed to maintain children with intensive medical, mental, emotional, and/or behavioral needs in a single placement to encourage safety and stability, while supporting the Intensive Foster Family and assisting children in their transition to permanency through the introduction of appropriate services for the family. These children are often stepping down from congregate care settings and may have recently completed a treatment program. Specifically, DCS expects children from the following categories to be referred for these services:

1. Children leaving long term residential placements
2. Children with a history of foster care disruptions
3. Children with significant intellectual and/or developmental disabilities
4. Children with significant medical challenges
5. Children leaving a placement in an acute psychiatric facility
6. Children who have potentially experienced adverse childhoods and/or trauma

In addition, children targeted for participation in Intensive Foster Care Services often exhibit problematic behaviors, including, but not limited to the following:

- Elopement
- Aggression
- Property destruction
- Violence towards peers and adults
- Defiant behavior
- Maladaptive sexual behavior
- Self-harm
- Substance abuse

B. Providers shall propose a wide range of service offerings and work to assist Intensive Foster Families in their support of child(ren)'s transition to permanency. Intensive Foster Families shall directly care for the child(ren) and utilize the specific service offerings that best meet the unique needs of the child. These Intensive Foster Care Services are provided in tandem and in addition to traditional Foster Care Services. The State is interested in receiving proposals with innovative ideas and solutions for services to be provided via the Intensive Foster Care program.

1. "Intensive Foster Parent" and "Intensive Foster Family" are broadly defined to include:

a) Foster parent(s) providing care and housing to the child(ren) in the Intensive Foster Care program, as well as other family members residing in the same household that may be providing support to the referred child(ren).

2. Intensive Foster Parent Requirements:
    a) Foster parents participating in Intensive Foster Care Services may receive licensure from their identified Provider (if a LCPA-managed foster home) or DCS Local Office (if a DCS-managed foster home) before serving as foster parents in the Intensive Foster Care program.
        1. Foster parents participating in Intensive Foster Care Services do not need to receive the above licensure if they meet the following requirements:
            a. Are a kinship or other relative caregiver approved by DCS for the Intensive Foster Care program.
            b. Are an unlicensed placement that has been approved by DCS for the Intensive Foster Care Program.
    b) In order to perform services under this Service Standard, at least one foster parent:
        i. Must have the ability to care for the child(ren) 24 hours a day, 7 days per week. If the parent works outside the home, they must demonstrate how they will meet these requirements.
            i. This includes, but is not limited to:
                1. The ability to respond to crises like school suspensions or expulsions and mental health emergencies that may require immediate assessment for acute stabilization
                2. The ability to assist with the development and execution of intensive safety plans
                3. Must receive additional training from their assigned Provider.
    c) In addition, it is encouraged that at least one Intensive Foster Parent has some or all of the following skill sets:
        i. Experience (professional or personal) with children who have serious medical, psychological, emotional, and social needs
        ii. Professional experience as a social worker, counselor, therapist, healthcare provider, or similar
        iii. Experience with de-escalation techniques or mental health first aid
        iv. Experience with individuals who have struggled with drugs, alcohol, criminal behaviors, mental health issues, or child welfare
        v. Ability to provide a home environment with stability and predictability for the child

d) In conjunction with Intensive Foster Care Services, Foster Care Parents may also be trained in providing Intensive Respite Care. Provision of Intensive Respite Care shall be provided in accordance with the requirements in Section IV: Intensive Respite Care.

C. These services shall be provided to Intensive Foster Parents by the Provider, and the Intensive Foster Care program shall be provided with the entire family in mind (including both parents and children).
    1. The service shall include assessment of child/foster parent/family resulting in an appropriate service/treatment plan that is based on the assessed need.
    2. The clear goal for these services is to maintain the child's safety and stability and assist the child in their transition to permanency.

D. Services must be comprehensive and individualized to children and families' unique needs. Services for the Intensive Foster Care program should include enhanced service offerings and supports for foster parents. The goal of these services is to prepare the parent(s) to provide care and support for the child without the need for additional services from either DCS or the Provider. Providers must offer additional training to Intensive Foster Parents based on the individualized needs of the child(ren) and permanency goal(s) of the child(ren) being served. Training should focus on actionable steps the parent(s) can take to address problematic behaviors and assist with the overall development of the child(ren).

E. If using evidence-based practices or best practices, Providers will follow those to fidelity of the model. Note that Providers are not required to use the following examples of evidence-based therapeutic intervention models. The following are included as examples of potential models:
    1. Treatment Foster Care of Oregon (TFCO) Model
    2. Trauma Informed Partnering for Permanence and Safety: Model Approach to Partnerships in Parenting (TIPS-MAPP) Training
    3. Trust Based Relational Intervention (TBRI) Therapy
    4. Together Facing the Challenge
    5. Trauma-Focused Cognitive Behavioral Therapy
    6. Alternative for Families Cognitive Behavioral Therapy
    7. Cognitive Behavioral Therapy
    8. Motivational Interviewing
    9. Child Parent Psychotherapy
    10. Parent Child Interactive Therapy
    11. Please see the California Evidence-Based Clearinghouse for other evidence-based models.
        a) Please note that this list is provided as an example and Providers may utilize practices not included on the California Evidence-Based Clearinghouse, including practices that do not qualify as evidence-based, if approved by DCS. If a Provider chooses not to use an identified evidence-based practice, the Provider must submit a detailed written plan to explain how they will deliver Intensive Foster Care services to successfully accomplish the identified goals.

F. Providers may conduct recruitment and retention of foster parents for the Intensive Foster Care program through a variety of methods. Retention methods should focus on addressing issues that may arise for foster families that are specific to the Intensive Foster Care program, while recruitment methods may include, but are not limited to:
    1. Utilization of DCS foster homes
    2. Utilization of Provider's existing foster homes
    3. Identification and recruitment of families from the community that can provide Intensive Foster Care Services for children

G. Services must be family-centered and child-focused. Services may include intensive in-home skill building and may include aftercare linkage.

H. When applicable, Providers shall coordinate with aftercare service providers for children entering the Intensive Foster Care program from residential care.

I. The Provider must provide intensive safety planning and crisis response services 24 hours a day/7 days per week/365+ days a year. The Provider will be expected to speak directly with either a family case manager (FCM), a supervisor, local office director (LOD), or the DCS hotline at 800-800-5556 to report any identified safety concerns.

J. The Provider must have a clear, documented method for Intensive Foster Parents to reach them for assistance with any crisis, 24 hours a day/7 days per week/365+ days a year. An example of this is an emergency phone number that is staffed by qualified personnel who can coordinate a response to the home at any time when necessary.

K. Any identified safety concerns must be reported to DCS immediately.

L. The service shall be all inclusive (as defined below) and must maintain the child's safety and stability by addressing any present safety and supervision concerns.
    1. All family members (provided it is age-appropriate for children to do so) should be involved in treatment planning and establishment of goals.
        a) The overarching goal for these services is to maintain children with intensive medical, mental, emotional, or behavioral needs in one placement to encourage safety and stability, while supporting their Intensive Foster Parents and assisting children in their transition to permanency with the introduction of appropriate services for the family.
        b) The Intensive Foster Parent(s) shall support any required visitation with the child(ren)'s biological, kinship, and/or adoptive family. This may include, but is not limited to, coordinating transportation, attending visitation sessions, and working collaboratively with the biological, kinship, and/or adoptive family to reach the child(ren)'s treatment plan goals.
        c) When the child(ren)'s permanency plan is reunification, the Intensive Foster Parent(s) and the Provider are expected to fully support this plan. This support may include, based on the recommendations of the child and family team, allowing pictures of the foster home to be shared with the child(ren)'s family, engaging in therapeutic and other services that are in place for the biological parent/child(ren), potentially allowing the parent to visit the foster home, etc.

2. DCS must also be involved in the creation of treatment plans and safety plans.
    a) It is expected that Providers of this service will be actively engaged in the DCS Practice Model and attend scheduled Child and Family Team Meetings (CFTMs) whenever requested (see "Adherence to DCS Practice Model" section below).
        1. Providers are expected to provide support to ensure that all visitation needs are met, as required by the Court and/or the treatment plan, including but not limited to, providing/coordinating transportation, providing/coordinating visitation space, and providing qualified staff for supervision of visitation to ensure safety.
    b) Through the teaming process DCS should participate in the continuous development of family goals.

M. Providers, in order to ensure safety of the child(ren), must visit the child(ren) and foster parent(s) in the home at a minimum of twice weekly during the first three (3) months of a placement and one (1) time per week thereafter, or more frequently if requested by DCS.
    1. The entire home must be assessed for safety during these visits.
    2. Documentation of this must occur and be reflected in the required monthly reports.
    3. Virtual visits may be offered in addition to the required in-person home visits
    4. In-person and virtual (if offered) home visits must review and assess progress on the following items:
        a) Behavioral health plan
        b) Medication management as needed
        c) Child's sense of belonging in foster home and successful participation in school and community activities
    5. Any safety concerns found must be immediately reported to DCS in accordance with subsection I.J above.

N. Providers must submit their initial assessment that includes an initial treatment plan and an initial safety plan within seven (7) days of their first face-to-face visit to the FCM.
    1. Submissions should be made via upload to KidTraks

O. As described in Section II.K below, Intensive Foster Parents shall participate in treatment planning for the child(ren) prior to their placement in the home when applicable.

P. Whenever possible, Providers should arrange a pre-placement visit for the child and Intensive Foster Family.

Q. Whenever possible, Providers should offer Intensive Foster Care Services in close proximity to the child's community of origin, including identifying Intensive Foster Family placements near the child's community of origin, to support continuity of care for the child.

R. DCS prioritizes placing siblings together whenever possible and therefore encourages Providers to accept referrals for the Intensive Foster Care program that include sibling groups with different levels of need (i.e., a child with an Intensive Foster Care referral

and their sibling with a standard foster care referral may both be placed in the same Intensive Foster Care foster home).

S. Services include providing monthly progress reports; requested supportive documentation such as case notes, social summaries, etc.; and requested testimony and/or court appearances including hearings and/or appeals; case conferences/staffing.

T. Monthly reports are due by the 10th of each month following the month of service. Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.

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

II. Service Delivery

A. Providers will maintain compliance with federal and State laws. Providers will provide the services proposed in their RFP response. If changes need to be made, discussion will happen with DCS prior to making changes.

B. The service shall be all-inclusive to meet the needs of the child(ren) and family.

C. There should rarely be a need for DCS to refer the child(ren) or family for additional services.

1. Examples of services that may be outside of the services provided under this Service Standard include:
    a) Translation services
    b) Diagnostic and Evaluation services
    c) Residential Substance Use Treatment services
    d) Detoxification and other medical services
    e) Substance Use Outpatient Treatment
2. To avoid confusion regarding services payable in addition to the Intensive Foster Care Services placement per diem, the Provider must actively communicate with the assigned FCM to determine which services are appropriate for the child and are consistent with the model(s) or practice(s) in place.

D. The Provider shall assist and support the Intensive Foster Family in providing enhanced services for children, in addition to the Intensive Foster Family's provision of traditional foster family requirements. Intensive Foster Families are expected to:

1. Provide a safe, comfortable, and stable home
2. Provide for the child's basic physical and emotional needs
3. Provide resources for school attendance; monitor progress; note special needs and accomplishments; and provide tutoring and homework assistance, special education resources, and school discipline resources as needed
4. Provide enhanced mental, emotional, and behavioral health support to the child(ren) based on the child(ren)'s individualized needs
5. Attend to medical and dental needs
6. Cooperate with visitation plans
7. Maintain a record of the child's time in care: photos, report cards, etc.
8. Keep information confidential regarding the child and their biological family

E. Intensive Foster Care Services may include but are not limited to the services listed below. Please note that these services are provided as examples and Providers are not required to offer all of these services. In addition, Providers may propose services not included in this Service Standard, as the State is open to proposals including new and innovative service offerings for families. Providers' services shall be designed to help Intensive Foster Families meet the additional expectations and goals of this program.
    1. Weekly and/or monthly support group meetings with other Intensive Foster Parents
    2. Enhanced foster parent training including behavioral intervention training
    3. Access to professional caseworkers and therapists
    4. 24/7 crisis intervention support
    5. Wraparound services
    6. Financial stipends and other concrete supports
    7. Health insurance allowances
    8. Assessment of service need
    9. Home-based casework services
    10. Homemaker services
    11. Parent engagement services
    12. Parent Education
    13. Transportation assistance
    14. Therapy services
    15. Alternative schooling
    16. Independent living services
    17. Education for children on nutrition, financial independence, living skills, and housing options
    18. Coaching and/or modeling services to assist the parent in the home environment
F. Providers are expected to follow fidelity to the model(s), if any, that they are utilizing and must document fidelity adherence.
G. Wherever possible, the Provider shall build and maintain partnerships with community organizations, specifically CMHCs, intellectual and developmental disabilities (IDD) service providers, or other provider organizations, to support the provision of services.
H. If the child(ren) has to be formally and indefinitely removed from their referred Intensive Foster home, the referral for Intensive Foster Care Services may continue in another Intensive Foster Care placement, unless otherwise indicated by DCS.
    1. Providers must work with the DCS Local Office to assist with transitioning the child(ren) to an appropriate Intensive Foster Care placement and/or other appropriate services when this occurs. If a child is transitioned to a different placement type, then the referral for Intensive Foster Care Services ends effective the date of removal.
    2. If a child(ren) is removed from the home formally and indefinitely, but at least one child remains in the home, the child and family team (CFT) should discuss the appropriateness of continuing with Intensive Foster Care Services. In the

absence of a CFT, the Provider and DCS should discuss whether Intensive Foster Care Services should continue for the child(ren) remaining in the foster home. In the case of siblings, Providers and DCS shall prioritize keeping siblings together in the same placement whenever possible, while prioritizing safety.

I. Short-term removals may not meet the criteria to end the Intensive Foster Care Services referral, depending on circumstances.
    1. An example of a short-term removal that may not necessitate the cancellation of Intensive Foster Care Services is a removal that must occur for a foster parent to travel due to work, a family emergency, or other extenuating circumstances.

J. For Services Provided to Sexually Harmful or Reactive Youth
    1. If a child requires a Sexually Harmful or Reactive Youth Assessment, Providers shall provide the Assessment and/or coordinate with other entity(ies) to conduct the Assessment. The Provider and/or entity(ies) conducting the Assessment shall be familiar with the applicable Service Standard, which can be found here, and work with the child and family team to provide these services.
    2. In addition, Providers shall ensure adequate supervision and service provision for children who fall into this category, according to the applicable Service Standard linked above.

K. Discharge Planning
    1. The priority of the Intensive Foster Care program is the provision of stable affirming care in a single placement while working towards the achievement of permanency for children involved in the program. Intensive Foster Care parents shall work with the Family Case Manager, Probation Officer (when applicable), and the Child and Family Team to ensure that discharge from the Intensive Foster Care program to permanency is a seamless transition for the child. Intensive Foster Care Families shall be required to participate in discharge planning and meet with the applicable provider/caregiver/family at a frequency to be determined in the discharge plan.
        a) Permanency plan options include either reunification with the child's family/caregiver or adoption (if reunification with the child's family/caregiver is not possible).
        b) The Intensive Foster Parents shall engage with the biological, kinship, and/or adoptive family to ensure that the child has all necessary supports in place in their permanent home.
    2. For children that are stepping down to Intensive Foster Care from a more restrictive environment, such as residential or acute care, the Provider shall work with the residential or acute provider and family to create a discharge plan that, at minimum, includes the considerations listed below. Intensive Foster Care Families shall be required to participate in discharge planning and meet with the applicable provider at a frequency to be determined in the discharge plan.
        a) Medication management plan
        b) Safety and crisis plan(s)
        c) Referrals to necessary community services

d) Ongoing therapies and counseling
e) Education services
f) Behavioral intervention plans

3. Payment for discharge planning services will be covered by the Intensive Foster Care non-placement per diem rate (see Section VIII.B).

L. Education Continuity
1. The provider shall engage with the Intensive Foster Care Family, the child's Case Manager, and the child's family to ensure that the child is receiving continuing education and special education (if applicable) with minimal disruption.
2. It is preferred that the child, wherever possible, continues education in their community or current school. However, if the child does not currently attend a school program, or a better option is available, the Provider and Intensive Foster Care Family shall work with the Family Case Manager to enroll the child in an approved program.

M. The Provider shall provide planned respite care as a part of their Intensive Foster Care service delivery. The Provider shall also offer Intensive Respite Care Services in accordance with the program description in Section IV: Intensive Respite Care Provision below.

III. Target Population

A. All children served by Intensive Foster Care Services must be referred by DCS. These children will typically fit within the following eligibility categories:
a. Children with histories of severe trauma and emotional and/or behavioral health needs
b. Children with severe behavioral disorders, psychiatric diagnoses, delinquency, and symptoms of complex trauma
c. Children who are at risk of, or are current placed in, congregate care and/or psychiatric hospitals who have experienced emotional, behavioral, or mental health difficulties
d. Children who have been involved with the child welfare and/or delinquency court services, who want to reunite with their parent(s) and whose parent(s) are willing to be paired with an Intensive Foster Parent
e. Children not typically placed in foster care homes
f. Children that have experienced multiple placements and/or are at risk of experience multiple placements

B. Specifically, DCS expects children from the following categories to be referred for these services:
a. Children leaving long term residential placements
b. Children with a history of foster care disruptions
c. Children with significant developmental disabilities
d. Children with significant medical challenges
e. Children leaving a placement in an acute psychiatric facility
f. Children who have potentially experienced adverse childhoods and/or trauma

C. In addition, children targeted for participation in Intensive Foster Care Services often exhibit problematic behaviors, including, but not limited to the following:
    a. Elopement
    b. Aggression
    c. Property destruction
    d. Violence towards peers and adults
    e. Defiant behavior
    f. Maladaptive sexual behavior
    g. Self-harm
    h. Substance abuse

D. Foster parents providing Intensive Foster Care for the Intensive Foster Care Services program should be willing, able, and well-equipped to meet the goals outlined in this Service Standard. Foster parents participating in Intensive Foster Care Services may receive licensure from their identified Provider (if a LCPA-managed foster home) or DCS Local Office (if a DCS-managed foster home) before serving as foster parents in the Intensive Foster Care program. Intensive Foster parents must meet all requirements for this program listed in section I.B.2.
    1. Foster parents providing Intensive Foster Care for the Intensive Foster Care Services program do not need to receive the above licensure if they meet the following requirements:
        a) Are a kinship or other relative caregiver approved by DCS for the Intensive Foster Care program.
        b) Are an unlicensed placement that has been approved by DCS for the Intensive Foster Care Program.

IV. Intensive Respite Care Provision

A. As part of DCS's efforts to increase services and supports for children with high acuity and complex needs, Providers of Intensive Foster Care shall also offer Intensive Respite Care that can meet the needs of children and families. Intensive Respite Care Services shall support the following requirements.

B. Service Provision
    a. Intensive Foster Care Providers shall train Foster Care Families for short-term, Intensive Respite Care provision
    b. Intensive Respite Care shall be made available to any family whose child is accepted through the Intensive Respite Care referral process regardless of their affiliation with the DCS system
        i. Specifically, when applicable, Providers shall work with the Child Mental Health Wraparound and Child Mental Health Initiative programs to coordinate Intensive Respite Care for families and children enrolled in these programs.
    c. Services shall be provided in a highly structured, in-home environment that is approved by the Provider and DCS.
    d. Intensive Respite Care services shall, where appropriate, be planned/scheduled in advance to provide structure to the families and child

e. Outside of planned/scheduled respite care, referrals must be accepted or rejected within 24 hours with the respite care scheduled and confirmed within 48 hours.
f. Children accepted for respite care shall be placed with families that are located in their community whenever possible.
g. The Provider shall review and update treatment, safety, and crisis plans, if needed, to support the transition from Intensive Respite Care back to Intensive Foster Care or an otherwise approved home or program.

C. Target Population
   a. All children from Section III (above) that would benefit from Intensive Respite Care services
   b. Children and families that are in need of additional support and services to maintain the child in their home
   c. Children involved in DCS systems, including regular foster care
   d. Children involved in non-DCS systems, including probation and those enrolled in the CMHI and CMHW programs

D. Training
   a. The Contractor shall maintain a detailed training plan and provide appropriate training and support to all families that provide Intensive Respite Care in order to ensure that they are qualified and resourced to provide Intensive Respite Care to children with high acuity needs.

E. Capacity
   a. It is the State's intention to keep Intensive Respite Care capacity open and available for children and families at all times. The State will utilize Intensive Foster Care Families without an active Intensive Foster Care placement to provide Intensive Respite Care Services.
   b. The number of children, per Intensive Foster/Respite Family, in respite care shall not exceed one (1) at any given time, unless approved by DCS. Exceptions to this may be considered for sibling groups.
   c. If a child is already placed with an Intensive Respite Care family (for Intensive Foster Care, Intensive Respite Care, or other services), and the family receives a referral for Intensive Respite Care, DCS approval is required before the new Intensive Respite Care referral can be accepted.
   d. Children shall not exceed 72 continuous hours in Intensive Respite Care without written approval of DCS.

F. Staffing
   a. Intensive Respite Care Program Manager responsible for coordinating referrals, scheduling with families, and ensuring that all Intensive Respite Care families are trained appropriately. Note, this Intensive Respite Care Program Manager may also be staffed on other Intensive Foster Care responsibilities described herein.
   b. Intensive Foster Care Families that are trained and qualified to provide Intensive Respite Services throughout the State of Indiana
   c. It is preferred that families selected to provide Intensive Respite Care have "lived experience" with the behavioral health system

G. Payment

a. As an additional service incorporated into the Intensive Foster Care Program, Intensive Respite Care providers and families shall receive payment under the terms described in Section VIII.C.

V. Goals and Outcomes – Intensive Foster Care Services

A. Goal #1: Maintain placement stability and foster parent continuity while ensuring the safety of the child(ren).

1. Objective: Providers will have individualized, clearly-developed treatment plans that address the child's specific mental, emotional, and/or behavioral health needs, allowing them to remain in a single foster home throughout service provision.
    a) Families, as well as DCS, will participate in the development of these plans.
        1. Required Data Collection and Reporting
            a. Percent of families that participate in the development of treatment plans, measured monthly
    b) Plans will be reviewed and updated regularly (at least one time per month) with input from the Child and Family Team. Updated plans will be sent to the referring worker each month included with the monthly report.
    c) 90% of placements in Intensive Foster Care Services will not result in a disruption for any reason that is unrelated to the achievement of the child's permanency plan (i.e., for reasons unrelated to reunification, placement in a pre-adoptive home, or another move directly connected to the youth's permanency plan)
        1. Required Data Collection and Reporting
            a. Percent of children that experience disruption during their Intensive Foster Care placement and the reason(s) for the disruption, measured monthly
            b. Percent of children that are referred to residential or another more restrictive setting following a placement disruption, measured monthly
2. Objective: Families who engage in Intensive Foster Care Services will not be the subject of a report of abuse or neglect during service provision.
    a) 100% of youth in Intensive Foster Care will be safe while in the program and not be the victim of a new substantiated allegation of neglect or abuse.
        1. Required Data Collection and Reporting:
            a. Number of new substantiated allegations of abuse or neglect for children in the Intensive Foster Care program, measured daily
3. Objective: Quick access to treatment
    a) 90% of Intensive Foster Care families will have a face-to-face contact with the Provider within 3 days of receipt of referral

1. Required Data Collection and Reporting
    a. Percent of Intensive Foster Care families with a face-to-face contact with the Provider within 3 days of receipt of referral, measured monthly
    b. Number of days between the Intensive Foster Care family receiving the initial referral and the meeting with the Provider, measured monthly
    c. Number of days before a child is placed in Intensive Foster Care after the FCM and residential Provider confirm that they are ready to discharge (if applicable), measured monthly

b) 90% or more of Intensive Foster Care referrals received are accepted and services are offered in a timely and efficient manner
1. Required Data Collection and Reporting
    a. Percent of referrals for Intensive Foster Care accepted, measured monthly
    b. Time from receipt of referral to acceptance/denial of referral (minimum, maximum, and average), measured monthly
    c. Percent of referrals rejected and documented rationale for rejection, reported monthly

B. Goal #2: Intensive Foster Care Parents will be trained in Evidence-Based Practices, or provided other enhanced training, focused on caring for children with intensive mental, emotional, and/or behavioral needs.
1. 100% of Foster Parents will complete the minimum number of training hours required by the Evidence-Based Practice being utilized and/or outlined in the Provider's proposal.
    a) Required Data Collection and Reporting
        1. Percent of Foster Parents completing the minimum number of training hours required by the relevant Evidence-Based Practice, measured monthly
        2. Number of training hours completed by Foster Parents, measured monthly

C. Goal #3: Achieve permanency for children enrolled in Intensive Foster Care Services.
1. Objective: The child(ren) will achieve their permanency goal within twelve (12) months of enrolling in Intensive Foster Care Services.
    a) The Provider will identify the barriers preventing the child(ren) from achieving permanency.
    b) The Provider will assist the foster family in addressing the barriers to permanency and facilitate the child's transition to permanency.
    c) Required Data Collection and Reporting
        1. Percent of children who achieve their permanency goal, measured yearly
        2. Each child's total time to permanency, once permanency is

achieved

3. Percent of children who maintained permanency 12 months after transition to permanency plan, measured yearly (tracked by DCS)

D. Goal #4: Maintain timely intervention with the foster family and regular and timely communication with referring worker.
    1. 100% of cases will have a monthly report submitted to DCS/Probation by the 10th of the following month
        a) Required Data Collection and Reporting
            1. Percentage of cases that met the monthly reporting requirement, measured monthly
    2. 95% of families will receive initial contact from the Provider within 48 hours of receiving the referral
        a) Required Data Collection and Reporting
            1. Percent of families will receive initial contact from the Provider within 48 hours of receiving the referral, measured monthly
E. Goal #5: DCS and foster parents will report satisfaction with services
    1. DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
        a) Required Data Collection and Reporting
            1. Percent of Service Satisfaction Reports that rate satisfaction at a 4 or above, measured monthly
    2. 90% of foster parents will rate the services "satisfactory" or above on a satisfaction survey developed by the Provider, unless one is distributed by DCS to Providers for their use with foster parents, Providers are to survey a minimum of 12 foster parents or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.
        a) Required Data Collection and Reporting
            1. Percent of foster parents who rate the services as satisfactory or above on the Provider's survey, measured monthly
F. Goal #6: Parents, Families, Kinship Caregivers, and other Caregivers (collectively referred to as "Caregivers") will report satisfaction with services
    1. 90% of Caregivers whose children are in the program, will rate the services as satisfactory or above on the Provider's survey, measured monthly
        a) Required Data Collection and Reporting
            1. Percent of Caregivers who rate the services as satisfactory or above on the Provider's survey, measured monthly
    2. Three months after permanency is achieved via the IFC program, Caregivers will rate the services they received as satisfactory or above on the Provider's survey
        a) Required Data Collection and Reporting
            1. Percent of Caregivers who rate the services as satisfactory or above on the Provider's survey, measured monthly
G. Goal #7: Children who participate in Intensive Foster Care will share their feedback and experiences in the program
    1. Children will report positive experiences in Intensive Foster Care including feeling supported and cared for during their time in Intensive Foster Care

a) Required Data Collection and Reporting
1. Qualitative response data from children (ages 12 and older) in Intensive Foster Care collected every 3 months until discharge

2. Interviews with children shall be conducted in person and appropriate to the child's age and individual needs

VI. Goals and Outcomes – Intensive Respite Care Services

A. Goal #1: Intensive Foster Care Families receive Intensive Respite Care Services in a timely and efficient manner
1. Emergency requests (requests made less than 48 hours before the provision of Intensive Respite Care Services) for Intensive Respite Care services are scheduled within 24 hours and service provision begins within 48 hours
a) Required Data Collection and Reporting
1. Number of Intensive Foster Care Parents that request emergency Intensive Respite Care services, measured monthly
2. Percent of Emergency Intensive Respite Care requests that begin within 48 hours of the request

2. 90% or more of Intensive respite referrals received are accepted and services are offered in a timely and efficient manner
a) Required Data Collection and Reporting
1. Percent of referrals for Intensive Respite Care accepted, measured monthly
2. Time from receipt of referral to acceptance/denial of referral (minimum, maximum, and average), measured monthly
3. Percent of referrals rejected and documented rationale for rejection, reported monthly

3. Intensive Respite Care provision is scheduled regularly and on a repeating basis as recommended by the Provider and DCS.
a) Required Data Collection and Reporting
1. Percent of Intensive Foster Care Parents that participate in Intensive Respite Care services, measured monthly

B. Goal #2: Foster children and families that are not part of the Intensive Foster Care program receive timely and efficient Intensive Respite Care Services
1. Foster children and families who are in need of additional support and services can contact the Provider and have Intensive Respite Care scheduled within 24 hours, with service provision beginning within one to seven days after the request, depending on the level of need
a) Required Data Collection and Reporting
1. Number of Intensive Respite Care requests received from non-Intensive Foster Care Families, measured monthly
2. Percent of Intensive Respite Care requests received from non-Intensive Foster Care Families scheduled within 24 hours

3. Percent of Intensive Respite Care requests received from non-Intensive Foster Care Families that receive services within seven days of request

C. Goal #3: Children involved with other DCS programs and non-DCS systems (such as probation and CMHI/W programs) receive timely and efficient Intensive Respite Care Services
    1. Children involved in other DCS programs or non-DCS systems can contact the Provider and have Intensive Respite Care scheduled within 24 hours, with service provision beginning within one to seven days after the requested depending on the level of need
        a) Required Data Collection and Reporting
            1. Number of Intensive Respite Care requests received from other DCS programs or non-DCS systems involved children, measured monthly
            2. Percent of Intensive Respite Care requests received from other DCS programs or non-DCS systems involved children that are scheduled within 24 hours
            3. Percent of Intensive Respite Care requests received from other DCS programs or non-DCS systems involved children that receive services within seven days of request

VII. Data Collection and Reporting

A. The Provider shall collect, analyze, and share the required data outlined in Sections V and VI above.
B. The Provider shall collect and track the number of children who are currently receiving and/or have received Intensive Foster Care and Intensive Respite Care services and report this data to DCS on a monthly basis.
C. DCS reserves the right to request additional data collection throughout the life of the contract. The Provider shall provide data reports to DCS as requested or otherwise on a monthly basis.

VIII. Minimum Qualifications

A. The program shall be staffed by appropriately-credentialed personnel who are:
    1. Trained and competent to complete the service as required by federal and State of Indiana law.
    2. Credentialed according to the requirements of the evidence-based model(s) used (if applicable).
    3. Carrying appropriate caseloads. No member of the treatment team (excluding support staff) may carry a caseload greater than what is allowed by the model being delivered, provided that the caseload shall never be greater than 12.
B. Support Staff
    1. Support staff may be used to supplement the professional staff when approved as part of the model or to supplement the model.
    2. These staff must be trained in the basic principles of the chosen model and their

practice must be coordinated and directed by the direct professional staff.

C. Supervision
    1. Supervisors must possess a Master's or Doctorate degree in:
        a) Social work
        b) Psychology
        c) Marriage and family
        d) Related human service field
        e) Must possess a current license issued by the Indiana Behavioral Health and Human Services Licensing Board
            i. Or be consistent with model expectations for supervision.
    2. Supervision shall occur semi-monthly.
        a) With at least one instance of supervision being one-on-one supervision between the worker and the supervisor
            i. The other minimally-required supervision may be in a group format.
        b) Each supervision session must last for a minimum of one hour.
        c) If the model being utilized requires a different frequency or format of supervision, fidelity to the model must be followed.

D. Direct Worker
    1. The individual must possess a valid driver's license and the ability to use a private car to transport self and others, and must comply with the State policy concerning minimum car insurance coverage.
    2. In addition to the above:
        a) Knowledge of child abuse and neglect, and child and adult development
        b) Knowledge of community resources and ability to work as a team member
        c) Belief in helping clients change their circumstances, not just adapt to them
        d) Belief in foster care as a viable means to build families
        e) Understanding of issues that are specific and unique to foster care such as loss, mismatched expectations and flexibility, loss of familiar surroundings, customs and traditions of the child's culture, entitlement, gratification delaying, flexible parental roles, and humor.

E. Services provided will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions

F. Services will be delivered in a neutral-valued culturally-competent manner.

G. Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision.

H. The frequency and intensity of training and supervision are to be consistent with "best practices" and comply with the requirements of each Provider's accreditation body.

I. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies.

J. If applicable to the case, under no circumstances is supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.

K. Shadowing Criteria

1. All agencies must have policies that require regular shadowing (by supervisor) of all staff at established intervals based on staff experience and need.
2. Shadowing must be provided in accordance with the policy. The agency must provide clear documentation that shadowing has occurred.

IX. Billable Units

A. Intensive Foster Care Placement Per Diem Rate

1. Payment for Intensive Foster Care Services provided while a child is placed in a foster home shall be based on an Intensive Foster Care Placement Per Diem Rate for each child placed in an Intensive Foster home and the total number of days the child was in an Intensive Foster Care placement during a given month.
    a) The placement per diem rate shall include a pass-through rate, which shall be paid to the foster family. The details of this placement per diem rate, including the pass-through portion of this per diem rate, shall be established in the Intensive Foster Care Services proposal response submitted during the RFP and must be approved by the State.
    b) At a minimum, the pass-through per diem amount for Intensive Foster Parents shall be equal to or greater than the Therapeutic Plus Foster Rate for children ages 14 to 18. As of RFP posting, the 2023 rate would be a minimum of at least $73.51 per child, per day.
    c) If the Therapeutic Plus Foster Rate for children ages 14 to 18 increases to a level higher than the Provider's current Intensive Foster Parent pass-through per diem, the Intensive Foster Parent pass-through per diem rate shall increase by the same dollar amount that the Therapeutic Plus Foster Rate for children ages 14 to 18 increased, leading to a matching increase in the overall per diem rate. The remainder of the per diem (the amount retained by the Provider for services) shall remain flat throughout the life of the Contract, regardless of any increases to the Therapeutic Plus Foster Rate for children ages 14 to 18.
2. Referrals for a sibling group that include at least one (1) sibling with an Intensive Foster Care referral shall be placed in the same foster home whenever possible. For each sibling in the group not referred for Intensive Foster Care services, a separate per diem rate, determined by DCS based upon other foster care services rates, will be applied upon placement in the Intensive Foster Care home.
3. The Intensive Foster Care placement per diem rate will start the day the child(ren) is placed in the Intensive Foster Care home.
4. The Intensive Foster Care placement per diem rate will end the day the child(ren)

is removed from the placement.

B. Intensive Foster Care Non-Placement Per Diem Rate
    1. Payment to ensure homes remain open and available for children that have been matched with an appropriate Intensive Foster Care family and to fund pre- and post-placement planning services shall be based on an Intensive Foster Care Non-Placement Per Diem Rate applicable when a family has been confirmed as an Intensive Foster Care placement with the family case management team and formally begun discharge planning. Payment is made to the family providing services based on the total number of applicable days in a given month.
        a) The non-placement per diem rate shall include a pass-through rate, which shall be paid directly to the foster family. The details of this per diem rate, including the pass-through portion of this per diem rate, shall be established in the Intensive Foster Care Services proposal response submitted during the RFP and must be approved by the State.
        b) The proposed non-placement pass-through per diem rate shall be inclusive of costs for foster families to engage in discharge planning services for children and youth that will be stepping down from residential and/or acute care into the Intensive Foster Care placement and/or stepping down from the Intensive Foster Care placement into their home or other less restrictive setting (see Section II.J for details).
        c) The non-placement per diem rate proposed shall not be greater than the placement per diem rate for both the pass-through and total dollar amounts.
    2. Referrals for a sibling group that include at least one (1) sibling with an Intensive Foster Care referral shall be placed in the same home whenever possible. For each sibling in the group not referred for Intensive Foster or Respite Care services, a separate per diem rate, determined by DCS based upon other foster care services rates, will be applied as applicable.
    3. The Intensive Foster Care non-placement per diem rate:
        a) Will start the day an Intensive Foster Parent(s) are confirmed for an Intensive Foster Care placement with the family case management team and formally begun discharge planning.
        b) Will end the day the child(ren) are placed in the Intensive Foster Home or the day discharge planning ends with placement in an alternative setting.

C. Intensive Respite Care Per Diem Rate
    1. Payment for Intensive Respite Care services shall be based on an Intensive Respite Care Per Diem Rate applicable when a family is providing Intensive Respite services. Payment is made to the family providing services based on the total number of applicable days in a given month.
        a) The Intensive Respite Care per diem rate shall include a pass-through rate, which shall be paid directly to the foster family providing respite.

The details of this per diem rate, including the pass-through portion of this per diem rate, shall be established in the Intensive Foster Care Services proposal response submitted during the RFP and must be approved by the State.

b) The proposed Intensive Respite Care pass-through per diem rate shall be inclusive of costs for foster families to provide Intensive Respite Care (see Section IV for details)

2. Referrals for a sibling group that include at least one (1) sibling with an Intensive Respite Care referral shall be placed in the same home whenever possible. For each sibling in the group not referred for Intensive Foster or Respite Care services, a separate per diem rate, determined by DCS based upon other foster care / respite services rates, will be applied as applicable.
3. The Intensive Respite Care per diem rate:
    a) Will start the day the family begins providing respite services for the child(ren).
    b) Will end the day the family stops providing respite services for the child(ren).

D. Medicaid
1. For medically necessary services:
    a) Medicaid or other third party payers may be utilized to treat the presenting condition. If the child does not have insurance and all other payment alternatives have been exhausted, DCS will be the payer of last resort.
    b) Examples of medically necessary services include, but are not limited to:
        i. Substance Use Disorder Treatment
        ii. Detoxification
        iii. Acute hospitalization

E. Interpretation, Translation, and Sign Language Services
1. The location of and cost of interpretation, translation, and sign language services are the responsibility of the Provider.
2. If the translation, sign language, or interpretation service is needed in the delivery of Intensive Foster Care Services referred, DCS will reimburse the Provider for the cost of the interpretation, translation, or sign language service at the actual cost of the service to the Provider.
3. The referral from DCS must include the request for interpretation services and the agency's invoice for this service must be provided when billing DCS for the service.
4. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate, but this is not required.
5. The Provider is free to use an agency or persons of their choosing as long as the interpretation, translation, or sign language service is provided in an accurate and competent manner and billed at a fair market rate.

X. Reporting

A. Providers will be required to prepare, maintain, and provide any statistical reports, program reports, other reports, or other information as requested by DCS relating to the services provided.

B. These monthly reports are due by the 10th of the month, unless requested earlier by DCS, following service provision.

C. DCS will require an electronic reporting system which will include documenting time and services provided to families.

D. DCS may, but is not obligated to, adopt and require Provider to use a standardized tool for evaluating family functioning.

XI. Case Record Documentation

A. Case record documentation for service eligibility must include:

A. A completed, and dated DCS referral form authorizing services

B. Copy of DCS case plan, informal adjustment documentation, or documentation of request for these documents from referral source

C. Safety issues and Safety Plan documentation

D. Documentation of Termination/Transition/Discharge Plans

E. Treatment/Service Plan

1. Must incorporate DCS case plan goals and child safety goals.
2. Must use specific, measurable, attainable, relevant, and time sensitive goal language

F. Monthly reports are due by the 10th of each month following the month of service provision, unless requested earlier by DCS. Case documentation shall show when report is sent and include:

1. Provider recommendations to modify the service/treatment plan
2. Discuss overall progress related to treatment plan goals including specific examples to illustrate progress

G. Progress/Case Notes must document: date, start time, end time, participant(s), individual providing service, and location.

H. When applicable Progress/Case notes may also include:

1. Service/Treatment plan goal addressed (if applicable)
2. Description of intervention/activity used towards treatment plan goal
3. Progress related to treatment plan goal including demonstration of learned skills
4. Barriers: lack of progress related to goals
5. Clinical impressions regarding diagnosis and or symptoms (if applicable)
6. Collaboration with other professionals
7. Consultations/Supervision staffing
8. Crisis interventions/emergencies
9. Attempt to contact clients, FCMs, foster parents, other professionals, etc.
10. Communication with client, significant others, other professionals,

school, foster parents, etc.

11. Summary of CFT meetings, case conferences, staffing
12. Education/special education status

I. Supervision Notes must include:

1. Date and time of supervision and individuals present
2. Summary of supervision discussion including presenting issues and guidance given

XII. Service Access

A. All services must be accessed and pre-approved through a referral form from the referring DCS staff.

B. Once the Provider receives the referral from DCS, the Provider shall respond to the referral within 24 hours. Upon accepting the referral, the Provider shall begin services within the next 24 hours.

C. In the event a Provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required.

D. The referral will remain active indefinitely and end only if the child(ren) is removed from the Intensive Foster Care program or DCS contacts the Provider to cancel the referral.

XIII. Adherence to DCS Practice Model

A. Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness, and respect.

B. Providers will use the skills of engaging, teaming, assessing, planning, and intervening to partner with families and the community to achieve better outcomes for children.

XIV. Interpreter, Translation, and Sign Language Services

A. All Services provided on behalf of DCS must include interpretation, translation, or sign language for families who are non-English language speakers or who are hearing-impaired.

B. Interpretation is done by an interpreter who is fluent in English and the non-English language and is the spoken exchange from one language to another.

C. Certification of the interpreter is not required; however, the interpreter should have passed a proficiency test in both the spoken and the written language in which they are interpreting.

D. Interpreters can assist in translating a document for a non-English speaking client on an individual basis, (i.e. an interpreter may be able to explain what a document says to the non-English speaking client).

E. Sign language should be done in the language familiar to the family.

F. These services must be provided by a non-family member of the client, be conducted with respect for the socio-cultural values, life style choices, and complex family interactions of the clients, and be delivered in a neutral-valued culturally-competent manner.

G. The interpreter(s) is to be competent in both English and the non-English Language (and dialect) that is being requested and shall refrain from adding or deleting any of the information given or received during an interpretation session.

H. No side comments or conversations between the interpreters and the clients should occur.

XV. Trauma Informed Care

A. Prior to service initiation, Provider must develop a core competency in Trauma Informed Care as defined by the National Child Traumatic Stress Network (https://www.nctsn.org/trauma-informed-care/creating-trauma-informed-systems).

B. A service system with a trauma-informed perspective is one in which agencies, programs, and service providers:
   1. Routinely screen for trauma exposure and related symptoms.
   2. Use evidence-based, culturally responsive assessment and treatment for traumatic stress and associated mental health symptoms.
   3. Make resources available to children, families, and providers on trauma exposure, its impact, and treatment.
   4. Engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma.
   5. Address parent and family trauma and its impact on the family system.
   6. Emphasize continuity of care and collaboration across child-service systems.
   7. Maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff wellness.

C. These activities are rooted in an understanding that trauma-informed agencies, programs, and service providers:
   1. Build meaningful partnerships that create mutuality among children, families, Intensive Foster Parents, and professionals at an individual and organizational level.
   2. Address the intersections of trauma with culture, history, race, gender, location, and language.
   3. Acknowledge the compounding impact of structural inequity and are responsive to the unique needs of diverse communities.

XVI. Training

A. Provider employees are required to complete general training competencies at various levels.

B. Levels are labeled in Modules (I-IV), and requirements for each employee are based on the employee's level of work with DCS clients.

C. Training requirements, documents, and resources are outlined at the following link (or any designated successor link): http://www.in.gov/dcs/3493.htm
   1. Review the **Resource Guide for Training Requirements** to understand Training Modules, expectations, and Provider responsibility.
   2. Review **Training Competencies, Curricula, and Resources** to learn more about the training topics.
   3. Review the **Training Requirement Checklist** and **Shadowing Checklist** for expectations within each module.

XVII. Cultural and Religious Competence

A. Provider must respect the culture of the children and families with which it provides services.
B. All staff persons who come into contact with the family must be aware of and sensitive to the child's cultural, ethnic, and linguistic differences.
C. All staff also must be aware of and sensitive to the sexual and/or gender orientation of the child, including lesbian, gay, bisexual, transgender, or questioning (LGBTQ) children/youth.
    1. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook.
    2. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth.
    3. The guidebook can be found at the following link (or any designated successor link): http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf
D. Efforts must be made to employ or have access to staff and/or volunteers who are representative of the community served in order to minimize any barriers that may exist.
E. Provider must have a plan for developing and maintaining the cultural competence of their programs, including the recruitment, development, and training of staff, volunteers, and others as appropriate to the program or service type; treatment approaches and models; and the use of appropriate community resources and informal networks that support cultural connections.

XVIII. Child Safety

A. Services must be provided in accordance with the Principles of Child Welfare Services.
B. All services (even individual services) are provided through the lens of child safety.
    1. As part of service provision, it is the responsibility of the Provider to understand the child safety concerns and protective factors that exist within the family.
    2. Continual assessment of child safety and communication with the Local DCS Office is required. It is the responsibility of the Provider to report any safety concerns, per State statue, IC 31-33-5-1.
C. All service plans should include goals that address issues of child safety and the family's protective factors. The monthly reports must outline progress towards goals identified in the service plans.