

Questions	Answers
General RFP Questions –(Proposal Submission)	
Proposal Due Dates / Where and What to Submit / Two Proposals for Same Service	
<p>Are proposals due on march 3rd to DCS, as stated at the bidders conference, or postmarked by March 3rd, as stated in the RFP?</p> <p>When there is no County Director in place, is there someone else who should receive the proposal? If so, whom?</p> <p>Would it be acceptable to offer two proposals for the same service? For example, offer a basic package of visitation facilitation for one fee and enhanced visitation facilitation with more transportation (to aid in retention of foster parents) and perhaps other features for another fee?</p> <p>RFP, Section Two, Page 11, 2.1 General: Please clarify “the Certification Statement must be in the form of a letter.” Does this mean that I write a letter certifying that I have read the instructions, assurances, etc. – not that I retype the document into a letter?</p>	<p>Proposals are to be postmarked by March 3, 2008. All proposal originals, signed in blue ink, and one printed copy are to be mailed to the Child Welfare Services Coordinator(s) responsible for the Region(s) for which a provider is proposing to provide services. Proposals postmarked after the March 3, 2008 deadline will not be considered (see 1.7 of the RFP). A clearly labeled electronic copy of each proposal is to be included with the printed copies. An Executive Letter including the information in the 2.2 Certification Statement must also be included as part of the proposal.</p> <p>An electronic copy of each proposal is to be sent as an e-mail attachment to each Regional Manager and County DCS Director responsible for counties included in each proposal. If there is not currently a Director for a county the provider intends to serve, the Regional Manager will forward the documents sent to them to the appropriate person. It is expected that copies of the proposal will be sent to the Regional Managers and County DCS Directors at the time the documents are sent to the Child Welfare Services Coordinators.</p> <p>If a provider chooses to propose two substantially different approaches to providing the same service, this can be done by submitting two complete proposals to be considered. It is not the intent of DCS to select more than one proposal for a service for a Region from a single provider.</p> <p>The certification statement is on Attachment B1. The signature on the Proposal takes care of the "Certification Statement" requirement. A letter is not needed for the certification statement.</p>
Format for Submitting Proposals	
<p>Is the Excel template (which includes the drop-down choices for services that are being proposed) the only accepted format for submitting proposals?</p> <p>In the electronic submission requirements of our complete proposal, is a .pdf format acceptable for the entire proposal package?</p>	<p>The Excel template is the only acceptable format for submitting the information included in the template. This information must be submitted as an Excel file. The text portion of the proposal must follow the outline and guidelines in Section 2.5 and can be submitted as either a Microsoft Word or PDF format.</p>
Information Regarding Service Standards	
<p>Do you want all the specific information listed in I, II, & III of the service standard covered in D of the Program Narrative? For example, do you want the</p>	<p>It is expected that a provider will follow all the specifications included in each Service Standard for which the provider is applying. If circumstances</p>

<p>Goals and Outcome Measures to be listed?</p> <p>Given the State’s desire for providers to be concise in their narrative response and the instruction that “RFP language is not to be repeated within the response,” is it mutually assumed that the provider is agreeing to each element outlined in the service standards or must we address each required component referenced in the service standards somewhere in our narrative?</p>	<p>relevant to providing a specific service make it not possible to meet all the expectations associated with that service standard, these exceptions can be noted in the Technical Proposal. However, these exceptions will be noted by the reviewers and might be grounds for not accepting the proposal.</p>
<p>Allowable Units and Rates – Per Service and Per Region/County</p>	
<p>Are the units listed in the Service Standards (Attachment C, in each service’s respective “Billable Units” Section), the <i>only</i> approved units that can be included in an agency’s proposal application (the Excel template)?</p> <p>Can a different cost structure be submitted for <u>each county</u> based on actual costs per service? This would be for proposals applying to serve multiple counties.</p> <p>It may be prohibitive to provide services in rural areas with the newly established reimbursement maximums and service standards. Can an agency justify actual service costs and submit for reimbursement consideration?</p> <p>Can a provider propose different rates for different counties within a region? Costs may vary from county to county depending on the demographics.</p> <p>If a service standard has a standard rate but the agency believes that this standard rate does not meet its needs, should we assume that the agency should submit a budget for that service standard?</p>	<p>The only billing units or “payment points” allowed for each Service Standard are those listed within the Standard. Each Region will contract for services individually; therefore the cost of each unit proposed is to be the same within each Region. Unit rates for the same provider can be different from one Region to another. All costs to the DCS for the services proposed must be included in the specified unit rates. No other payments will be made by the DCS. Providers have the ability to request rates higher than the maximum rate listed in many of the Service Standards, but must submit budgets to justify these rates. Decisions regarding the validity of these requests will be made as part of the evaluation process and can, at the request of the DCS, involve negotiations with the provider.</p>
<p>Submitting Proposals for Multiple Services</p>	
<p>When proposing for multiple services, is it acceptable for one agency to submit separate proposal for each type of services?</p> <p>If an agency wishes to submit a proposal breaking down the proposal area to the large categories of service as outlined in the service standards (i.e. Adoption, Family Centered Service, Foster Parent Services, etc.) and then submit it to multiple regions, would this be acceptable? For example: An agency writes a proposal to provide all of the Adoption services – provides a narrative for each service as prescribed - and then submits this one Adoption proposal to multiple regions, would this be an acceptable way to submit the proposal?</p>	<p>The proposal process encourages the inclusion of “logically related” groups of services within the same set of proposal documents. Services that share the same target population, i.e. adoption, or focus of intervention, i.e. home based, could meet this criteria, depending on how the services were structured by the provider. If a shared process for intake/referral and/or practice model exists, this also might justify including multiple Service Standards within the same proposal. One purpose of the proposal process is to document how a provider will address the requirements of each Service Standard proposed. With this in mind, it is the responsibility of each provider to bundle services in a way that best communicates this information as efficiently as</p>

<p>If we are combining services in an application (e.g. home based intensive family preservation and home based intensive family reunification), can we combine ALL sections of the application?</p> <p>Can I put proposals for the same service standard in 2 different regions on the same application?</p> <p>If an agency would like to apply for several programs under the Family Centered Services Section of the RFP - Home-Based Family Centered Casework Services, Home-Based Family Centered Therapy Services, Homemaker/Parent Aid, can this all be combined under one proposal, or do the proposals need to be separate?</p> <p>If an agency would like to apply for several programs under Other Services such as Parenting/Family Functioning Assessment, Visitation Facilitation, Sexual Offender Treatment/Victims of Sexual Abuse Treatment, do all these need to be submitted as separate proposals or can they be submitted as one proposal. Can the above to questions be combined into one proposal?</p> <p>In completing Attachment B-1, if a provider would like to propose more than 10 services, should the provider just submit a Part 1 and a Part 2 of the Attachment B-1?</p> <p>Under the Program Narrative: A. General (Optional), “Maximum of 2 paragraphs and less than one-half page.”</p> <p>If we propose three different service standards, we should have 2 paragraphs for each of the 3 standards we are proposing under A, and 1 paragraph for each of the 3 service standards that we are proposing under C, D, and E. Therefore, we would have 2 paragraphs for each service standard that we are proposing under Intake & Proposal, 2 pages for each service standards under Practice Model, and 1 page for each service standard we are proposing under E. Is this correct?</p>	<p>possible. Section 2.4 lists those Service Standards that cannot be combined.</p>
<p>Submitting Multiple Region/County Proposals</p>	
<p>Do we submit proposals for entire regions or for specific counties?</p> <p>Can you apply for only one county out of a region?</p>	<p>The RFP process encourages the submission of the same set of proposal documents to multiple Regions. Separate proposals for individual Regions is necessary only if the unit rate is different in one or</p>

<p>Can proposals be submitted for individual counties and not for the entire DCS region?</p> <p>If we apply to provide the same service in more than one region is it reasonable to assume the majority of both applications will be identical?</p> <p>Does each region need its own Request for Funds and supporting documents, or may the information for all regions proposed be included on one Request for Funds?</p>	<p>more Regions or if the description of the service delivery process is significantly different. It is expected that the same unit rate and description of services will apply to all counties within a Region. It is preferred, but not required, that a provider apply to serve all counties in a Region.</p>
--	--

<p>Volume of Services Proposed</p>	
<p>In Attachments B-1 and B-3, the forms ask for totals (number of units, number of families to be served, and expenses). Is it correct that the provider needs to estimate the totals over the entire contract period (1/1/09 - 6/30/2011)?</p> <p>Can you provide anticipated info re volume by service by county?</p> <p>Is there any data available on the numbers and types of services needed in each DCS region/county and the number and types of services that were purchased by each DCS region/county during the current contracting period? Will this information be posted on the DCS website?</p> <p>What are the current usage statistics per county for all funded programs in the current grant</p>	<p>The totals numbers used in Attachments B-1 and B-3 are to be inclusive of the entire contract period. The volume of services proposed (number of units/number of families) is important in projecting the number of units proposed per family served for each service. All these contracts will be “zero based” and as such imply no guarantee as to the number of referrals any provider will receive nor the amount of billing likely to be generated. This is very dependent on the number of families becoming DCS clients in each County and the needs present in these families. It is important to note in the technical proposal if there are minimum service levels below which a specific service cannot be maintained by the provider or a maximum number of clients that the provider would be willing or able to serve.</p>

<p>Supporting Documents</p>	
<p>In Section 2.4 of the RFP, it states that supporting documentation can be used when appropriate. What is considered "supporting documentation?" What kind of supporting documentation might be needed under what circumstances? Give example of documentation and when do you want the documentation?</p> <p>What supporting documents can be provided as attachments to the proposals? Program procedures?</p> <p>Do the CD copies need to include the attachments or can it be just the narrative part?</p>	<p>Electronic copies of proposal documents need to include the transmittal certification letter, Attachment B.1. (Excel template), Attachment B.3. (budget) if applicable, and the Program Narrative (2.4) that includes the requested information for each service standard proposed. It was and continues to be the intent that no additional materials will be submitted as part of the proposal either electronically or in printed form. We regret that the statements in the first paragraph of section 2.4 referring to the inclusion of appendices were included in the document. These statements are not consistent with other instructions throughout the document and do not reflect the intent of the DCS.</p>

General RFP Questions (Billing/Fiscal)

Child Welfare Referral

Will there be additional training for probation officers and DCS Worker on completing the child welfare referral or should providers factor the extra time retrieving accurate referrals into the face to face rate?	No. Counties request referral training year-round, as needed for these staff.
General Fiscal	
Will the State consider a one-month advance payment at the beginning of the new contract?	No
The previous service standards capped the number of hours which could be billed for certain services. For those services with maximum hourly rates established, is there a cap on the number of hours which can be billed?	Not unless stated in the Service Standards.
The current child welfare services contracts were signed by the state in November, 2006, four months after the start of services. Providers are not provided with claim forms to bill for services without signed contracts. Only one month of services at a time can be billed. Will providers still be expected to deliver services without signed contracts? If so, will providers be allowed to bill in a timely manner for services delivered in good faith without a contract, or will providers be expected to carry the costs of delivering services that cannot be billed for several months?	Services being proposed are to be delivered during the defined contract period (January 1 st , 2009 – June 30 th , 2011). It is the intent of DCS to have contracts fully executed prior to the contract start date. Providers deliver services prior to having a fully executed contract at their on discretion..
What is the expected face to face time for an average homestudy (first time foster, relicense foster, step-parent/custody study)?	The State has not established an "expected" number.
Can face-to-face supervision time include telephone time?	No
Is this funding relative only to insurance cases or to all cases? * It is our understanding (and it's been made very clear to us) that if we accept insurance for a case sent to us from Dearborn County that we are not allowed to accept or balance bill as this is illegal. Most insurances only pay a small portion of what we charge for an evaluation and expect us to write off over half. We have never filed insurance for our Dearborn County cases as they are court and criminal related and most insurances do not accept claims for court related work We want to completely understand if you are now asking that we file insurance and then bill or request funding from you for our balance. We are very concerned about the above question as we don't want to put our practice in legal jeopardy.	This would vary between private pay insurance companies and providers and it is the providers' responsibility to understand these contracts/agreements with private pay insurers.
Will Substance Abuse Assessments be billed under Substance Abuse or under Diagnostic and Evaluation?	Substance Abuse
We were advised at the bidders conference that	There is no differentiation per the standards; rate

<p>Diagnostic and Evaluation costs have a Non-PhD level and a PhD level, how do we differentiate between the two.</p>	<p>structures are based on the cost providers incur to provide this service.</p>
<p>D&E The standards as they currently read only allows for face-to-face services with clients. A psychologist must spend time administering, interpreting, reporting and even testifying in addition to face-to-face services. A typical Medicaid reimbursement allows for face-to-face time with the clients plus units for the additional time spent for each test. Example: An MMPI would involve one-hour of face-to-face time with a client plus and additional two to three hours for administration, interpretation, and reporting. We request that we be allowed to bill for time for the process of testing and not just the face-to-face.</p>	<p>It is possible get reimbursed for those expenses. We just want them included in the in the face to face rate.</p>
<p>Billable Unit Rates and Definitions</p>	
<p>Is travel time and mileage the same?</p>	<p>No - see Attachment F Page 4 for definitions.</p>
<p>As the contract period covers a rather long period of time (2.5 years) and expenses will most certainly not remain constant (insurance, salaries, cost of gasoline, etc.) does DCS expect to make any adjustments to the rates that we are proposing during the contract period to reflect increases in expenses or should providers build in these expected increases in their proposed budgets when calculating proposed unit rates?</p> <p>What will be the method for providers to use to request a rate change after the contracts are signed?</p>	<p>Unit rates should be proposed taking into account the length of the contract period (2 ½ years).</p>
<p>Rates: What do you mean when you say we want the providers that receive contracts to continue to collect information on the previous payment points so that this information can be used in the future?</p> <p>What previous payment points are you referring to?</p> <p>For evaluation, do you want travel time tracked as “travel time” or “mileage”?</p>	<p>Information that needs to be tracked separately can be found in Attachment F (page 5) of the RFP (i.e. Court time, Child and Family Team Meetings, Travel Time, Collateral Contacts, and No Shows are to be tracked hourly on a monthly basis for evaluation purposes).</p>
<p>There appears to be a universal statement about report writing not being a billable service. That can perhaps be understood when the service is therapy or casework. When, however, the service <u>is</u> a report - like a psychological evaluation, family functioning assessment or a homestudy, could there be a way to make report writing a billable activity?</p> <p>Our current rate structure bills for face-to-face, travel time, collateral contacts, court time and no shows. The given rate in this RFP would cover expenses if we could continue to bill for these items. However, if</p>	<p>No. Only units listed in the “Billable Units” section of the applicable Service Standards will be approved. Please be sure your rates include time/costs spent on report writing. If your rate is above the one listed, yes you must submit a budget.</p>

<p>this is not permitted, the rate proposed would be significantly higher but with the same total cost for the service. We would like to propose billing “as is”. Would this be presented within the narrative of the proposal or would a budget sheet be required?</p>	
<p>To be absolutely clear, in the RFP when a “face to face maximum rate” is identified this refers to one hour of clock time?</p>	<p>Yes.</p>
<p>All of the service standards note that direct contact includes “crisis interventions and other goal directed interventions via telephone with the identified client family.” What are the specific criteria for determining when phone calls are billable?</p>	<p>FACE TO FACE PHONE CONTACT: Phone calls can be billable when they are providing a service that is consistent with the “Service Description” from the relevant Service Standard.</p>
<p>Other goal directed interventions via telephone with the identified client/family” is stated as a billable service. Since talking with the family about any aspect of service completion would be directed toward that goal, is all phone contact with the family billable?</p> <p>One billable activity is "crisis intervention and other goal-directed interventions via telephone with the identified family." Could you provide some definition of crisis intervention which often varies considerably dependent on work setting?</p>	<p>No, not <i>all</i> phone contact is billable. See FACE TO FACE PHONE CONTACT (above) for more information.</p>
<p>The Service Standards require that the providers “work closely with the DCS FCM” for each family, yet this time is not listed as billable. This would seem to be just as crucial as working directly with the family. Will this be billable?</p>	<p>Child and Family Team Meetings are considered face-to-face billable units if the family/client is present; other DCS meeting times should be built into the face-to-face rate.</p>
<p>How will DCS assign rates to each agency? Will each agency awarded a contract bill at the maximum rate listed on the service standards?</p>	<p>Rates are proposed by an agency, and if a proposed rate is above the maximum rate then the agency must provide a budget and written justification. Regional Service Councils will review all information included in the proposal.</p>
<p>Is attending appointments with clients considered face to face if approved by the DCS? Examples would be Dr.’s appointments, psychological evaluation appointments etc.</p>	<p>Yes.</p>
<p>If collateral contacts are approved by DCS for the purpose of...” goal directed communication re: the services”.... Is this a payment point if this is done <i>without</i> the client present? Examples would be school, probation, FCM’s, boys club, girls club, etc.</p>	<p>No. The cost/expense of the collateral contacts should be factored/built into the face to face rate.</p>
<p>What occasions of face-to-face time would be considered non-billable?</p>	<p>Not included is routine report writing and scheduling of appointments, collateral contacts, court time, travel time and no shows. These activities are to be included in the face to face rate and shall not be billed separately.</p>

Since "no shows" will no longer be billable, how many no shows are providers required to allow prior to closing cases?	Upon the 3 rd consecutive no-show, the provider must contact the referring FCM to determine if the continuation of services is appropriate.
Cost Structure	
Can a different cost structure be submitted for <u>each county</u> based on actual costs per service? This would be for proposals applying to serve multiple counties.	No. Unit rates should be proposed at the same cost for any County(-ies) within <i>the same</i> Region.
It may be prohibitive to provide services in rural areas with the newly established reimbursement maximums and service standards. Can an agency justify actual service costs and submit for reimbursement consideration? The inability to bill for travel time makes it cost prohibitive to deliver services in rural areas. As travel time across county lines was not billable under the current contract, the capped rate does not reflect the true cost. Will separate rates for rural DCS regions be approved to reflect the higher costs of delivering services to rural families?	No. Unit rates should be proposed taking geographic location of service delivery into account. If a proposed rate is above the maximum rate outlined in the Service Standards, a budget and written justification must be completed for those services.
Our agency uses 2- 15 passenger vehicles to transport clients to and from our visitation site, and other various appointments, etc. how will we now bill for this transportation? Each of our drivers have CDL's.	Costs should be built into the proposed face-to-face rate; if that proposed rate is above the maximum, a budget and written justification must be included in the proposal.
Budgets and Written Justification	
For clarification, budget justification worksheets are only required for services where a rate has not been established. Is this correct? If a service standard has a standard rate but the agency believes that this standard rate does not meet its needs, should we assume that the agency should submit a budget for that service standard?	Budget justifications and narratives are required for both: services where a <i>maximum rate has not been established</i> , and for <i>rates that are proposed that fall above the maximum rate outlined in the Service Standards</i> .
If we have non-DCS clients in our groups, can we just use the maximum rate per person per group under parenting education and substance abuse groups?	All services utilizing 'per person/per group hour' units must have a budget submitted; Non-DCS clients <i>cannot</i> be billed as part of these service units.
Maximum Rates/Determination	
We are concerned that the rates do not cover our direct costs in addition to not covering supervision and documentation to the standards of best practice. Our concern is that these rates will result in reduced quality in the provision of services to clients. Please explain the rationale in the determination of these rates? In addition to face to face visits with family	The maximum face-to-face rate is a statewide average based on the cost of <u>all</u> billable units from the previous contract year (which includes things such as: collateral contacts, court time, travel, no-shows, case conferencing, and face-to-face time). Providers can look at their actual costs to provide a service and roll all of the costs into one rate; if that rate falls above the maximum, a budget and written justification must be submitted with the proposal.

<p>members, a significant amount of time is required to comprehensively assess the information that has been gathered and to actually write adoptive and foster parent home studies. How many hours of collateral and report writing were included in the computation of the billable face to face rate?</p> <p>We are very concerned that the proposed rate structure will not cover even the direct costs of delivering most of these important community and family-based services and will minimize essential best practice standards of supervision and documentation integral to these services. It is very important that the number of collateral hours (non face to face contact) factored into the various maximum hourly rates be made available to prospective providers. Will this information be posted on the DCS website?</p> <p>How many collateral hours are built into the face-to-face rates?</p>	
<p>Bachelors level staff with Masters level supervision is required for most of the service standards, yet the maximum rates vary from \$35.00 per hour to \$71.00 per hour. Why is there so much variability in the maximum hourly rates for face to face direct contact if the staffing qualifications for delivering the services are the same? Do the number of collateral hours account for this variability? If so, will providers be told the number of collateral hours built into each rate?</p>	<p>RATES_ED: Maximum rates were established per program, using statewide averages. Maximum rate calculations were not necessarily based on educational qualifications.</p>
<p>General RFP (Programmatic)</p>	
<p>Linking or Bundling Services</p>	
<p>Several Questions on the linking or bundling of services. Here are just a few.</p> <p>At the bidder's conference, it was stated that several of the services are linked in that if a provider proposes to offer certain services, they must also propose to provide other identified services on the continuum. For example, it was stated that agencies proposing to provide pre and post adoption services must also provide adoption child and family preparation services. However, agencies could propose to provide adoption home studies / family preparation alone. Please clarify exactly which services are linked and how and which services can be proposed alone.</p> <p>Where in the service standards does it say if the service is linked to another service?</p>	<p>IFPS/IFRS is linked to Home-Based Family Centered Casework Service. Therefore if you apply for IFPS/IFRS you must also apply for HBFCCS. (vise versa not required.)</p> <p>Adoption:</p> <p>It is suggested that if you are an LCPA and wish to apply for Adoption Services that you apply for all three service standards, Child Preparation, Family Preparation and Pre/Post Placement and Post Adoption Services.</p> <p>If you are not an LCPA you can apply for Child Preparation and portions of the Pre/Post Placement and Post Adoption Services.</p>

<p>Please list all the services that DCS is mandating as linked to other services. Intensive services are already clearly mandated and do not need to be included in the answer to this question.</p> <p>The “linked” services were not all that clear. Is there an easy way to see what all services are linked? If we do not apply (due to over-sight) will there be some additional guidance on what <u>all</u> is included</p> <p>What specific services are linked? The conference mentioned required service linkages among service standards but the links are not stated in the RFP</p> <p>At the bidder’s conference it was mentioned that some of the Adoption services were “linked,” but it doesn’t say anything in the RFP’s about any Adoption services being linked. Which ones are linked?</p>	
<p>Linkage - If we apply for the HBC do we have to apply for the Pre/Post Adoption.</p>	<p>No</p>
<p>General Program Questions</p>	
<p>Kinship care has been shown to decrease the need for out of home placement for children. Are kinship caregiver families who are providing care to children who are not in the custody of the State of Indiana and who are not adopted, eligible to receive any services under this RFP?</p> <p>For what services might a family with an “indicated” abuse or neglect, or a family with substantiated abuse or neglect but assessed as “low-risk” qualify? (It appears no services are available)</p>	<p>The Community Partners for Child Safety (CPCS) secondary prevention service is available statewide. This service is for any family that is not a DCS case. If a case is substantiated by DCS, it must be served by DCS . If DCS does not substantiate a case, but indicates that a family could benefit from services DCS may refer a family to CPSCS. Participation in CPCS is voluntary.</p>
<p>Can a non-standardized service be proposed for funding under this RFP as in the past (e.g. in-school prevention/education programs)?</p>	<p>No. We anticipate that these services are family support services that are now seen as prevention. If the local DCS and Regional Services Council wishes to fund these Community Partners with these funds can, family support funds, can be transferred into CPCS contracts.</p>
<p>How do we know what services individual counties are interested in buying?</p>	<p>Assume they are interested in all services.</p>
<p>I’m developing a Children’s Advocacy Center for Region 15’s RSC. It’s expected to open January 2009. Would it be eligible for any of the funding?</p>	<p>Funding in this RFP follows the Service Standards. If the Advocacy Center wants to apply for one of the services under one of the Service Standards it can. If you are asking if there is funding for the administration of a Child Advocacy Center, not in this RFP.</p>
<p>In the RFP it states that every agency must carry as</p>	<p>Indiana Code IC 9-25-4-5 defines “Minimum</p>

much insurance coverage as the state. What are those insurance amounts?	Amounts"...\$25,00 for bodily injury to or the death of one individual, \$50,000 for bodily injury to or the death of two or more individuals in any one accident, \$10,000 for damage to or the destruction of property in one accident.
Is there any flexibility in modifying the outcome expectations as some of the outcomes listed are ones over which providers have no control?	The provider is welcome to write specific outcomes for their particular service and track information to include in the evaluation.
The Chins description focuses upon group service with a corresponding rate. What is the rate and service standard for individual service?	Sorry, but we have no idea what you are asking.
Will there be a Respite section in this grant?	If the question is whether there is a Service Standard for Respite Care, there is not. There are a some Services that have as a service component Respite Care.
If we decline to bid on this contract, does this mean we lose future business with completing evaluations for Dearborn County and does the decline have to be put in writing?	No
At the Bidder's conference, it was stated that IV-B could pay for a portion of a group-oriented service that was not fully covered by Medicaid; it was our understanding that State child welfare dollars could <i>not</i> be used to supplement Medicaid reimbursements. What is correct?	This was stated; it is incorrect. Medicaid payment must be accepted as full payment.
Will home based parenting education be available on this RFP?	There are several Home Based Family Centered service standards. You should look at these standards and the target population to see if your program could be written under these standards.
Under the pages titled "Federal Disallowed Expenses," stipends paid to employees are listed as unallowable. Is training costs to earn a specialized certification, as in Indiana Adolescent Sex Offender certification, an allowable expense? If you would please define "stipend" with an example or two, it might be clearer. For instance, can an agency pay for the tuition costs of an employee with Federal grant monies?	It is not considered a stipend if the tuition costs of an employee are not given directly to the employee. If the money is given to the agency where the certification is being sought, then it is allowable.
When referring to the number of days to respond to clients, file reports, etc., does this refer to business days or calendar days? Do holidays count in these numbers?	Business days only. Holidays do not count.
Face to face supervision requirements: Does this mean one-on-one supervision only, or does group supervision count in meeting this requirement?	One on one meets the requirement.
Are there any set limitations on the number of staff a supervisor may supervise?	The State has not established a maximum for these standards.
It has been our experience that referrals often require corrections and resubmission to our agency to meet the standards and requirements for billing. Once the accurate referral is received, it is our assumption that	The first date is what should be used for the outcome measures.

the date on the corrected, accurate referral is the date to be used for purposes of the outcome measures. Is this correct?	
Currently we provide home-based and parenting education programs in three counties through MOU's. These programs are designed to be county-need specific and although similar, are not the same as IV-B. Are there any limitations or restrictions to these MOU's?	The MOU's are a separate process than this RFP. Their limitations /restrictions are different from this RFP.
We have a residential drug/alcohol treatment facility for women and children (the majority of whom are CHINs). Our services are delivered in Allen County (Region 4). However, we have client families from other regions--most notably region 1 (Lake) and region 3 (St Joseph). So, the question is do we classify our program by the region in which the services are delivered (4) or do we identify the regions in which client families originate (1 and 3)?	Where the families originate.
SERVICE STANDARDS _ QUESTIONS	
“Other Services” (Billing/Fiscal)	
Rate Questions	
Substance Abuse Services - There is a statement regarding a per person per hour rate, yet there is only one rate given - \$118/hr - it seems implied that these are 2 types of payments, but is it not clear. What exactly is needed on the budget for Substance Abuse testing, etc	The Service Standards for Substance Abuse Services allow for the following 2 billable units: Face-to-face time with the client (billed hourly) with a maximum rate of \$118. There is also a per person, per group rate (billed hourly) that you must establish in your budget and written justification. It is also assumed that the provider will supply as part of the proposal a list of charges/fees for Drug Screens.
Under CHINS parent support services the “family finding techniques” are not billable. Can you estimate the number of hours this task will take? Is anything over that amount billable?	Estimates will vary depending on service needs, and only billable units listed in the Service Standards can be used.
If providing drug screens under the service standard "SUBSTANCE ABUSE ASSESSMENT, TREATMENT, & MONITORING", and doing the service for under the amount listed when is it necessary to provide a budget summary? Should the cost of the drug screen be included in the face to face rate or billed separately? If billed separately would that be a situation requiring a budget summary?	Budget justifications and narratives are required for both: services where a <i>maximum rate has not been established</i> ; and for rates that are <i>proposed that fall above the maximum rate outlined in the Service Standards</i> . Drug screens are to be billed at the actual cost of the screen, requiring no budget for this particular unit. Provider should include as part of the proposal a listing of charges/fees for Drug Screens.
At the meeting, it was explained that Therapeutic Supervised Visitation was no longer a billable service; is this correct?	Yes.
Face-to-Face Rate Building	
In reviewing your service standards under Diagnostic and Evaluation Services, your unit price is \$97.00 for face to face time with the client. How and Are	Unit rates should be proposed taking into account these costs.

we able to combine the time used when the patient is completing testing materials? We have to pay for those testing materials that we use and we have to pay to have them scored.	
CHINS PARENT SUPPORT SERVICES (P. 72-75) Billable Units (P. 74) – The definition of billable hours is limiting based upon the services provided under this standard. Can it be expanded to include collateral work?	See Service Standard. Collateral work is to be included in the face to face rate. .
Service Cap	
PARENTING / FAMILY FUNCTIONING ASSESSMENT Is there a cap on the length of time for each face-to-face meeting that can be billed for the completion of this assessment?	No.
“Other Services” (Programmatic)	
What is the definition of clinical experience?	Within the context used in this RFP it means practice within a social work setting.
Is Respite still a program to be funded?	There is no stand alone service standard for Respite. There are a couple of service standards that allow for respite for their target population. .
One (1) hour supervision per 20 service hours; 20 service hours to IV-B clients only or all clients served?	From the standpoint of the direct worker.
Is there any usage data per county for Functional Family Therapy?	No,
FFT – the service standards state the staff qualifications to be a Masters Degree, however, FFT does not require this. Therefore, we have members of an FFT certified team with a Bachelors degree and they are certified to perform the FFT program. Can this be reconsidered with respect to staff qualifications to match FFT requirements?	We will consider this with the stipulations that were in the last RFP.
Functional Family Therapy- I have made attempts to contact Thomas Sexton at IU Bloomington with no response. I am unable to locate anyone else in the state who indicates they provide education and training in this area. Who in the State of Indiana provides FFT training, certification and on going support? Contact information would be helpful.	State unable to provide this information.
How much FFT has been ordered? i.e. How much is it being used?	We show this service being purchased in 3 counties in the current contract.
Sex Offender Treatment:	As it relates to the youth.
Page 105, Item #1: Please clarify the meaning of	After the first face to face contact. Failure to comply

<p>“community strengths” and “community risk and protective factors.” Does this mean the “community” as it relates to the specific youth who has been referred (neighborhood, school, etc.) or to the community at large?</p> <p>Page 106, Section III, Goal #1, Item #3: Indicates the treatment plan must be completed and forwarded to worker within 15 calendar days of the first face-to-face contact with the client. Does this mean 15 days after the first interview for the assessment? This standard contains very tight time constraints, which are understandable. How does one account for the family’s failure to comply (no showing appointments) during the assessment phase?</p> <p>Page 107, Section III, Goal #5: Please clarify “no behavioral issues” – does this relate only to issues that are included in the safety/relapse prevention plans or to behaviors that are status offenses or delinquent acts?</p> <p>Page 107, Section IV: Is being a clinical member of the Association for the Treatment of Sexual Abusers (ATSA) qualify as an equivalent recognized credentialed authority?</p>	<p>will become part of the assessment. Contact with the referring DCS should take place if assessment is unable to be completed due to failure to comply. Discussions of next steps should take place with FCM.</p> <p>IF you look at the outcome measure it is talking about delinquency charges and/or probation violations.</p> <p>If you wish to send in information on ATSA we will evaluate.</p>
<p>How many parents were referred by DCS for parenting education services in last grant cycle (by region if available)?</p>	<p>Sorry, Not Available</p>
<p>Visitation</p>	
<p>Therapeutic Supervised Visitation not used in Service Standards but is then listed on the service unit definition (in attachment B1) as a service. Can we write to provide this service?</p>	<p>No.</p>
<p>Visit Facilitation – Parent/Child/Sibling could previously be provided by paraprofessionals (without degrees). The standard requirements now require services to be provided by employees with Bachelor’s degrees. We provide about 530 supervised visits across three regions. For the most part our staff doing supervised visits are over 40-years of age and a large portion of those staff are minorities. In rural areas it is difficult to recruit people with Bachelor’s degrees and the life experience to do supervised visits. With the standards as they current read in this RFP, we stand to lay off over half of our minority staff which are valuable in providing this and other services. Can the standard be modified to allow for</p>	<p>Yes the Service Standard will be modified to include a paraprofessional staff. The revised Service Standard will be posted at a later date.</p>

<p>paraprofessional staff (without degrees)?</p> <p>Our agency currently has a Supervised Visitation Site that is staffed by a Site Coordinator(who is working on her bachelors degree) and site monitors who are not degreed, do the visitation site coordinator and site monitors now have to have a bachelor's degree? and if so can we write a waiver for those that we have employed for the last 2 years?</p> <p>Supervised Visitation: The Observation and Reporting section refers to professional and para-professional staff. The staff qualifications section only lists a Bachelor level staff. Are para-professional staff allowed and if so, what are the qualifications?</p> <p>What are the staffing requirements to provide visit facilitation services? The service description on page 101 refers to both professional and para-professional staff conducting visit observation and reporting. However, the qualifications listed on page 103 for direct worker are for bachelor's level staff.</p>	
<p>Is the provider expected to provide transportation to and from visits as part of visit facilitation?</p>	<p>Depends on the situation, but travel time can be factored into the face to face rate.</p>
<p>Is Visitation Supervision going to be a service that will be funded through IVB? I believe it was stated at the Bidders conference that this will not be funded however, it is a service listed in the proposal.</p>	<p>Visitation Facilitation has a Service Standard and therefore can be funded through this RFP process.</p>
<p>“Prevention-Community Partners” (Programmatic)</p>	
<p>Regarding CPCS not being able to take families who qualify for Healthy Families: What if the family doesn't want to work with Healthy Families? What if Healthy Families has a waiting list and CPCS doesn't? What if the services the family needs doesn't fall under services provided by Healthy Families?</p>	<p>HFI is strictly voluntary. If the family has identified need for services CP can enroll the family and provide those services.</p> <p>HFI does not have waiting lists.</p> <p>If the services the family needs does not fall under services provided by Healthy Families, please contact the CPCS consultant for assistance.</p>
<p>Regarding CPCS referral date: When does the five day clock start if we are waiting to hear back from Healthy Families about whether the family qualifies and/or the family on whether they will work with Healthy Families?</p>	<p>Five day clock starts when family contacts CPCS wanting services. Eligibility information should be received from Healthy Families with 48 hrs or 3 working days. If the family is not eligible for HFI services can be provided.</p>
<p>The Community Partnerships Project manager is recruited and hired by what agency?</p>	<p>The agency is identified by the Regional Service Council as the Provider for the Region. The Provider then determines the Project Manager.</p>
<p>Can Community Partners include more than (one)</p>	<p>Yes, as a subcontractor.</p>

partner?	
What is the maximum rate for Prevention Services?	Actual costs
Does the subcontractor identification apply to the community partners? The RFP asks us to identify the subcontractors but it is unclear whether we have to ID the Community Partners subcontractors.	Yes. The CPCS contract states that subcontractors need to be approved by the State
Does the on-call staff offering crisis intervention counseling have to be a master's level therapist?	If your agency is following the IV-B standards, then you must comply with those standards as well
Can we be a neighborhood liaison through community partners for child safety without being the project manager?	There are two separate job descriptions, one for Community Partners Liaison and the other for Project Manager.
Can CPCS families be referred to parenting education classes? They do not meet the eligibility criteria because they do not have a substantiated case of abuse. (Page 87, Section II, Item #1)	There are opportunities available for parenting classes that do not meet that eligibility requirement.
How will a provider know whether a family avoided out of home placement for 12 months after the case closes?	The state is seeking legal advice in order to develop a state policy for providers and cases of this capacity.

ADOPTION QUESTIONS –(BILLING/FISCAL)

Educational Requirements

How is it that the Service Standards for Pre-Post Adoption Services require a minimum of a Bachelor's degree for a direct worker, and will pay \$82.00 per unit for face-to-face services, while Home-Based Family Centered Therapy services require a Master's degree for a direct worker and pay \$76.00 per unit?	Maximum rates were established per program, using statewide averages. Maximum rate calculations were not necessarily based on educational qualifications.
--	---

Face-to-face Rate Building

Regarding "Family Preparation": Will the "presenting" a case (home study) to a SNAP meeting be a "billable" unit(s)?	Unless a family member is present at the meeting, the cost for these meetings should be built into the proposed face-to-face rate; the meeting will not be a separate payment point.
Under adoption family preparation, the hourly billable rate is for face to face, direct contact. How are contractors to be paid for required attendance at regional SNAP meetings and at the SNAP Council meetings in Indianapolis? Will this be a separate payment point?	
Under Family Preparation, who pays for the separate costs of all Criminal history, CPS, Sex Offender and FBI checks? If a family has lived anywhere other than the immediate county, these can be very costly and very time consuming. If agencies are required to collect this information, will there be a Dollar for Dollar reimbursement for the costs?	Costs should be built into the proposed face-to-face rate; if that proposed rate is above the maximum, a budget and written justification must be included in the proposal.
Are the fees associated with the required Fingerprinting and background checks reimbursable through the IVB contract, the responsibility of the client, or are these expenses expected to be absorbed by the contractor?	The expense could be built into your billing rate.

Rate Questions	
<p>In the standards section for Family prep and step parent and custody studies, can you clarify what routine report writing is? Studies are usually 12-16 pages in length and take 4-6 hours to write. Since this written study is part of the service and final product, can we bill for those 4-6 hours of report writing?</p> <p>Question: Billable Units: “Reminder” (P. 11) – What is meant by “routine” reports? Is this a reference to statistical data or to the actual home study/assessment which, by nature of the service, is essential to assuring its delivery?</p>	<p>No. Report writing is not a separate billable service; only face-to-face contact with the client/family is billable. The report writing should be factored into the face to face rate.</p>
<p>Under pre/post adoption services, respite care/foster is listed as a service reimbursed at cost. What is included in “cost”?</p>	<p>“Cost” is defined as the <i>actual cost</i> of providing respite care in a licensed foster home, for a time period to be defined by an FCM (not exceed 30 days in one calendar year).</p>
<p>Is the adoption child preparedness rate correct?*</p>	<p>Yes.</p>
<p>Child Prep-Does the definition of face-to-face time with the client only include the 3 bullet points listed within the billable units section?</p>	<p>Yes</p>
<p>Child Prep - Please clarify what “all billed time must be associated with a client/family” means, and is this only face-to-face time?</p>	<p>Yes, the only billable units for this service are face-to-face time with the client, and interpreter services.</p>
<p>FAMILY PREPARATION (P. 8-12)</p> <p>Question: There is no mention of mileage reimbursement. Are the costs of mileage included in the \$50.50 rate for face-to-face contact?</p> <p>Question: For all home studies, is it possible to submit a per-study fee opposed to an hourly rate?</p> <p>Question: Please clarify if all time spent on a family’s case can be billed under face-to-face contact, or only under time actually spent with the client?</p> <p>Question: With regard to the exclusion of travel – Can the State propose another way of getting to/communicating with clients? Note: Telephone time has <u>not</u> been excluded from billable time.</p>	<p>RATE BUILDING: The maximum face-to-face rate is a statewide average based on the cost of <i>all</i> billable units from the previous contract year.</p> <p>ADDL. UNITS: No. Only units listed in the “Billable Units” Section of the Service Standards will be approved.</p> <p>DEFINING FACE-TO-FACE CONTACT: Billable time <i>must</i> be spent face-to-face with the client, or via telephone contact where phone calls can be billable when they are providing a service that is consistent with the “Service Description” from the relevant Service Standard.</p>
<p>Pre/Post Placement and Post Adoption Services</p> <p>Rates</p> <p>Are the “Actual Cost” rates based on DCS or LCPA per diem rates or another means of measuring actual cost?</p>	<p>“Actual Cost” rates are not per diem rates, but the total sum of costs that are incurred to provide either the respite service or translation service.</p>
<p>Maximum Rate Determination</p>	

In addition to face to face visits with family members, a significant amount of time is required to comprehensively assess the information that has been gathered and to actually write adoptive and foster parent home studies. How many hours of collateral and report writing were included in the computation of the billable face to face rate?	The maximum face-to-face rate is a statewide average based on the cost of <i>all</i> billable units from the previous contract year (which includes collateral contacts, court time, travel, no-shows, case conferencing, and face-to-face time).
Budget Justification	
It often takes a significant amount of time locating and scheduling families to conduct step-parent adoption studies. Providers are frequently given incomplete contact information. As this extra scheduling time was not billable in the current contract, the capped rate does not reflect the true cost. Will consideration be given to including this in the maximum rate?	Costs should be built into the proposed face-to-face rate; if that proposed rate is above the maximum, a budget and written justification must be included in the proposal.
Do you need a separate budget and written justification is required for pre/post placement and Post Adopt Services?	A budget and written justification is required for the 'per person/per group hour' unit, or if the 'face-to-face' rate proposed is above the maximum rate listed in the Service Standards.
Services/Documentation	
<u>Step-Parent Adoption/Custody Studies</u> - Is it our understanding that DCS, rather than families, will pay for these?	All services in the Service Standards can be accessed through State Child Welfare dollars.
To what degree is documentation to be submitted to validate and/or confirm the services being provided? <ul style="list-style-type: none"> • What form should this documentation be submitted in? • How does the documentation being submitted connect to the billing process for the contract? 	Written information required for the County of service is listed in the "Case Record Documentation" section of each Service Standard. For billing purposes, backup documentation submitted with claim forms should be the Coordinator's approved document for the Region of service. This documentation must include the date(s) and time(s) of all billable services being submitted for reimbursement.
Adoption – Child Preparation Billable Units Is the client family the biological family of the child who is in need of adoption or the family who desires to adopt an identified child?	The family (or family members) identified on the Service Referral.
Step-Parent Adoption Studies and Custody Studies Rates Is there a maximum unit expectation or service hour cap for the provision of this assessment?	No.
ADOPTION QUESTIONS – (Programmatic)	
The qualifications criteria for a direct worker in the pre-post placement and post adoption services require a bachelor's degree and "Three years experience in adoption? Would that include three	Working with Child Welfare adoptive families, performing HBS with children with plans of adoption, Training in adoption issues

years of experience with adoption related issues?	
We have provided Post adoption and Pre adoption services for the past 6 years now that adoption services has been linked can we continue to provide those services without being a licensed child placing agency.	Yes, See further information under - Link
The following statement was included in the 2006-2008 standards, pg 9 under billable units: <i>“The SNAP will sign a recommendation form that the contractor submits with their claim for payment. Contractors will be paid for their work without regard to approval or denial of the family preparation”</i> The previous statement defining when claims may be filed is not included in the new standards – p. 9. Will the recommendation form for claiming/billing continue to be approved and signed by the SNAP Specialists at the SNAP Regional Team meetings?	We are no longer doing approvals for “foster to adopt” placements. SNAP will not sign recommendation forms for home studies that are not presented at team.
The 2009 – 2011 service standards for Family Preparation state on pg. 9 that the contractor must receive a referral from the county to provide the family prep and upon completion submit the family preparation to the referring county. The contractor must also present the family preparation and receive approval by the SNAP Regional Team and submit the same to the SNAP council. The service standard does not speak to the contractor’s management and support to the adoptive family beyond this point. It appears that support for the family would be possible by an additional IV-B referral for pre/post adoption support services but that support according to the standards is limited to respite care, home based and support group services. Since the contractor’s relationship with the adoptive family appears to end with the completion and approval of the family preparation by DCS and SNAP, who will be responsible for providing on-going adoption services not covered under <i>Pre/Post Placement and Adoption Services</i> to the adoptive family and how will these services be paid? Such services would include but not be limited to matching and yearly updates of family preparations / home studies.	Our recommendation is if an LCPA is going to provide Family Preparation, that a bid be made for ALL services under adoption for continuity. In regard to updates or Family Preparation, that is cited on page 10 under Target Population.
Please define “within 60 days of the referral” on page 10. Is this the date the DCS worker has typed on the referral or the date the agency actually receives it?	Making the assumption that this provider is still asking questions on Adoption. Date on the referral.
In order to provide adoptive, step-parent, custody and foster parent home studies, must the agency be a Licensed Child Placing Agency (LCPA) or will DCS continue to be allowed to sign off on the studies for non-LCPAs?	The county DCS can approve home studies.
Under Adoption-Child Prep, using a Lifebook is	DCS have lifebooks ordered and usable for any

required. Is this a specific lifebook or can it take any format? If it is a specific Lifebook, will DCS be providing it to agencies?	agency that may require a supply.
Under Child Preparation, a goal is “95% of adoptions will be finalized within one year of placement.” Providers have no control over this timeline, as it is dependent upon the family and the court. Will providers be held to this outcome measure?	Obviously, there will be exceptions, but the providers will be held to this measure.
Goal number 3 (page 5) of Adoption Child Preparation calls for successful transition for the child and family. Is this the role of the provider or DCS?	Both. Best practice should be used here. Providers will obviously assist more in a role in the community and home.
Another goal under Child Preparation is that children over age 4 will verbalize their understanding and acceptance of the adoption process. Is this developmentally possible for four-year old children?	The previous standard had them drawing a picture.
It is requested that children age 10 and up complete a satisfaction survey under Child Preparation. The one currently required is not geared for children. Will DCS be preparing A User Friendly Form for children or will each agency use their own?	This too is not a change from the 2006-2008 standards. Providers may make up their own tool.
Please define what is meant by “several home visits” under Family Preparation.	Best practice would show that the more support a family has in transition of a child in the home, the more stable it may become. How many visits should be determined by the provider and the need of the family.
Please clarify: Foster and Kinship families do or do not sign/provide comments prior to submission of a homestudy to DCS? Also, please clarify: Only the homestudy goes to DCS (as stated in the RFP) or does supporting documentation go as well?	Families should sign and edit/comment on home studies. The home study should be submitted to DCS.
Goal 4 #2, page 10: Will the DCS offices provide all contractors with listing of post adoption services available, including names and numbers of the selected providers?	They are available upon request
Are the regional SNAP meetings and the Indianapolis SNAP council meetings considered to be the same as “Child and Family Team Meetings” for billing purposes	No
Under pre post placement and post adopt services, it states that FTF client contact within 10 days is required. Does that mean business days or calendar days? What if the scheduled date of the support group (the service being provided) or the respite date (the service being provided) is beyond that 10 days?	For those particular activities, respite and support groups, you will not be held accountable for that time line in the service standards.
Please clarify your service expectations for RAD (Reactive Attachment Disorder) support.	In the service standards RAD is used as a specific service example that can be addressed through Respite, HBCM, or Support Groups.
Pre and Post placement in adoption category – qualifications for staff state requires Bachelor’s and description states Master’s level person. Which is	We reviewed and cannot find this discrepancy you are stating. DCS is only asking for Bachelor’s Degree with 3 years of Child Welfare/Adoption

correct?*	experience.
At the bidder's conference there was something mentioned about LCPAs and Adoption services. There is no mention of it in the RFPs. What is the relationship? (e.g. Do you have to be an LCPA to apply for certain services?)	Only LCPA's and the DCS can approve home studies.
In the standards section for Family prep and step parent and custody studies, can you clarify what routine report writing is? Studies are usually 12-16 pages in length and take 4-6 hours to write. Since this written study is part of the service and final product, can we bill for those 4-6 hours of report writing?	There is a standard tool for foster/adopt home studies.
Are pre and post adoption service proposals mandatorily linked to other adoption services? Or, can an agency propose for pre and post adoption services as stand-alone services?	Not mandatory. Can stand alone.
Under service categories- all adopted children and adoptive parents: Question: Are these children who have been adopted and are now back in the CHINS system or does this refer to post adoption finalization counseling?	Both.
CHINS PREPARATION (P. 4) Question: Are foster to adopt and children being adopted by relatives included?	Yes
Question: How many sessions will be authorized or will there be a cap on sessions?	Best practice ideals should be used. "What is best for the child?"
Question: When will services start: prior to termination, or after termination?	Both
Question: If services start prior to termination, will it be expected that birth parents are able to contribute to the program?	This is a child based service but best practice measures should be used.
Question: Will the state supply one standard life book to be used throughout the state, or is it the responsibility of the contractor to provide the life books?	DCS has life books available
90% of the children prepared will move into an adoptive home: Question: What is the time frame on this move, immediately following prep services?	That is determined by the child's readiness.
If the placement disrupts will services be reinstated?	This service may be re-instated by DCS.
Under Goal 3: The person doing child preparation has no control over the recruitment of the families for a particular child.	That is not always true. A provider preparing a child may need/want to be involved in family interviews or recruitment due to the issues that are discussed with the child and their needs.
In order to meet the goal of "90% of the children prepared will move into an adoptive home," would it be appropriate to assume that all children referred for this service will already have an adoptive home	No, that should not be an assumption. The child may just have been exposed to the TPR and adoption and need some more intensive understanding and help with transition

selected by the county when referred for service.	
Under Goal 3: “95% of the adoptions will be finalized within one year of placement”: Will it be the responsibility of the county DCS worker to notify the agency that completes child preparation as to when an adoption is finalized so that this information can be tracked?	The agency should inquire to DCS as to the date.
FAMILY PREPARATION (P. 8-12) Service Description: Background check for persons age 14-17: It is our understanding that only the CPS checks can be requested for minors. This point asks for State/Sex Offenders and Local Law Enforcement Checks. Will the contractor be able to access/obtain State/Sex Offenders and Local Law Enforcement Checks for minors?	DCS has a policy for this age group, which is only a CPS check should be conducted for minor children between the ages of 14 and 17. This can be done through your local county office
1. Child Protection Services History (from other states of residence within past 5 years). Question: In order for the contractor to meet preparation deadlines, will the County DCS obtain these records and include them with the initial referral?	NO
Question: If not, will extensions be permitted to the contractor when CPS record requests have not been responded to by the CPS agency in a timely manner?	Yes
Who will add the families to the Sharepoint website of approved families?	DCS
Since the contractor completing family preparation is asked to present home studies at the adoption team meeting held in the region and to the SNAP council in Indianapolis, will the contractors be reimbursed for mileage to attend these meetings?	Mileage should be rolled into your rate
Question: Can contractors bill for face-to-face time under each represented client for attending these meetings and presenting these families?	No
Question: Since family assessment services must be completed within 60 days of receipt of a referral, would it be appropriate that that all families referred for home studies will have already successfully passed the criminal history checks, including fingerprinting and the completion of FAKT training prior to a referral?	It would be appropriate, but not always an occurrence.
Since the family assessment must be completed within 60 days of receipt of a referral, is it safe to assume that the counties and state will support an agency’s request to give families 2 weeks to complete their paperwork?	It would be appropriate, but not always an occurrence.
Under Goal # 4, DCS and family awareness of	Yes

available services, will the local DCS offices be maintaining and providing this list of services to families they refer?	
Please clarify what this means: “families will be supported through collaboration with the provider and DCS through the adoption finalization process within a year.”	The provider and DCS will work together to have a successful and healthy adoption finalization
Under Family Assessment, “Several home visits” is noted in the first sentence – Question: Will one longer visit suffice for outlying counties where travel time greatly exceeds travel time for local home visits?	Best practice should be used in the need of the child. A child may need more visits or one long visit may be enough
It appears that the contractor is held responsible for “pre-placement family support services as well as serving as advocate for the family throughout the adoption process” (P. 9). If the family has no identified match, can this be done at this point?	Yes, a provider can advocate for a family at SNAP meetings/council, if a specific child fits that families profile.
Foster/Adopt Families and Pre-Adopt Families: reads “An agency representative should also be presenting the family at the SNAP Council in Indianapolis.” (P. 9) This is over and above the regional SNAP Team: Can this presentation be made by the SNAP Coordinator?	The presentation should be made by a representative of the provider. To help with questions, it should be someone familiar with the family
Service Access: Referrals “are valid for 12 months,” but the service has to be completed within 60 days (30 for ICPC).” Question: When there is a delay beyond the contractor’s control (such as client not timely with paperwork, delays in receipt of criminal history checks, etc.), does this mean the contractor is to continue to request an updated referral or is there another way to deal with this?	An updated referral should be requested. This may be an indicator to DCS as to the dedication of the family. It can be the provider and DCS working together to gauge a family’s commitment.
STEP-PARENT ADOPTION/CUSTODY STUDIES (P. 17-19) Reminder” (P. 19) – What is meant by “routine” reports? Is this a reference to statistical data or to the actual home study/assessment which, by nature of the service, is essential to assuring its delivery?	Standard home study report
PRE/POST-PLACEMENT & POST-ADOPTIVE SERVICES (P. 13-16) The service description notes three different areas: respite care for adoptive families, home-based services, and support group services. Can an agency contract only for one of the three	Yes, the provider needs to be specific in the proposal as to which services they will provide

areas under this service description?	
General: What is the expected relationship between the IVB Adoption Services and the Adoption Recruitment Services RFP 8-40?	No official relationship
Adoption – Child Preparation Goal #1 Is the initial assessment and service plan a specific form/format or is this determined by the specific contracted agency?	Determined by the contracted agency
Goal #2 What is meant by “draw a version of an adopted family”? Is this a created picture that is to be submitted with the other documentation?	This is the child’s representation of their family. What does it look like to them?
Goal #3 Will the contracted agency be penalized due to delays in the legal proceedings causing adoptions to extend over one year of placement?	Not if all that can be handled or advocated by the provider is done for the service.
Goal #4 Will the contracted agency have access to the “Service Satisfaction Report” on an ongoing basis	On a requested basis
Billable Units Family Preparation Under family assessment, is the referenced “challenges checklist” a state form and if so where is this found? If not is this to be developed by the state or the contracted agency?	Most agencies develop their own tool or research tools that are the best for their purposes
Under Goals and Outcome measures, Goal #1, item 2) please clarify that home studies will be provided within 14 days after the family is approved by the Regional _____? This seems to be incomplete in there is no specific entity following Regional.	Regional SNAP team
In Goal #3 how is the families “understanding” to be quantified to be in compliance with this outcome goal?	Does the family understand the adoption process and how adoption is handled in Indiana
Pre/Post Placement and Post Adoption Services Home-based services: Is this expected to be “linked” with the IVB “Family Centered Services” program?	No
Please clarify reference to “counseling” as the direct worker requirements do not support direct therapy services as outlined by State credentialing requirements for direct or group therapy services.	The wording should be “case work services”.
Support Group Services	This could start this way, but may be started and

Is the “support group leader” expected to comply with the “direct worker” qualifications?	transitioned to someone of experience with group dynamics
Are the different speakers referenced expected to attend each scheduled group or is it appropriate for the direct care worker to facilitate this support group?	Direct care worker can facilitate.
Goals and Outcome Measures What format are the “written service plan” and “quarterly written summary” expected to be submitted in, if any?	No format is required at this time.
Goal #2 item 1 – Does the 95% standard apply to all pre/post adoptive parents in the state or only those who are directly referred to this program?	Those who are directly referred to the program
Goal #3 – Do the contractors efforts to engage a family to participate in support group services fulfill this requirement if a family chooses not to attend support group services to spite contractors best efforts?	Yes
Case Record Documentation To what degree, if any, is case record documentation for service eligibility to be submitted and to whom?	Monthly reports are submitted to the referring DCS office.
Step-Parent Adoption Studies and Custody Studies Case Record Documentation What is the DCS approved format for Step-parent adoption or custody study?	The same as foster/adopt home studies
How can an agency guarantee 100% participation in the support groups ?	This measure is only for “requesting” adoptive families. Provider should keep a log of attendance of requested families and volunteer.
How are contractors to be paid for the provision of adoption pre-placement and matching services throughout the adoption process as required in the service standards for family preparation when family assessment services must be completed within 60 days?	It should be built into their face to face rate.
Under Step Parent Adoptions and Custody Studies on pages 18 and 19, it states certain documents can be waived. What documents can be waived	Please contact your local SNAP specialist for this information.
IL QUESTIONS – (BILLING/FISCAL)	
Face-to-face rate building	
No shows for case management, direct services is an ongoing problem with the Chafee youth age 18-21 receiving room and board services. How were no show appointments calculated in the capped rate? It is a disincentive for providers to provide the room and board services when only face to face, direct contact can be billed for youth who want the financial stipend but not case management services.	Services are to be provided as stated in the Service Standards for Chafee Foster Care Independence Program. Costs should be built into the proposed face-to-face rate; if that proposed rate is above the maximum, a budget and written justification must be included in the proposal.

How are the expenses for CPS and Criminal Background checks covered in reference to Lifelong connections and Mentors?	Costs should be built into the proposed face-to-face rate; if that proposed rate is above the maximum, a budget and written justification must be included in the proposal.
Rate Questions	
The service standard for Chafee/IL Mentoring seeks supportive adults who will commit to a long-term relationship with the youth. Are there any provisions to allow for mentors to be given a financial stipend to assist in covering any out-of-pocket costs associated with mentoring such as travel, emergency cash assistance to the youth, etc.?	No.
Billing Questions	
Is room and board assistance paid initially by provider and then reimbursed through the contract or is this expensed billed/paid directly from the IVB grant?	Yes, Room and Board payments are paid directly to a vendor/landlord from the agency, and then claimed for State reimbursement with the appropriate paperwork/documentation submitted.
IL QUESTIONS – (Programmatic)	
Page 25 of the transition services standards requires that the worker meet the youth “at least one time a month in their current placement during months following referral and then weekly in the month prior to case dismissal.” If the provider is not notified by DCS of the case dismissal, will the provider be held accountable for meeting this expectation?	No, the provider will not be held accountable for information that they never received. However the provider should be maintaining contact with the DCS as well as the youth and be mindful of the timeline that is projected by the FCM.
Under Chafee FC Independence program can youth be referred for Transitional Services if the two transition conferences (at 17 and 17.5 years old) to be held by the DCS actually have not occurred? Will DCS provide copies of these plans and meeting minutes to the provider?	A provider may request a copy of the Transition Tool Kit
Most young people today use cell phones. Is a landline phone definitely required if using Room and Board funds?	No
Since No Shows are no longer billable under Chafee, and we know that this population has higher incidents of No Shows, can the provider set the limit on the number of No Shows it will accept before closing the case?	IL services are mandatory. It has been generally accepted practice in Indiana to stop services after 3 No Shows and contact the DCS worker for help in deciding the next steps.
Although the service standard lists the staff requirement as Bachelor Degree, can well experienced non-degreed personnel be considered for the Chafee IL services?	No
Service standard states for youth 18 - 20 that they "will be offered...counseling..." Does this mean if a provider has a qualified therapist that the IL program may offer counseling services to non wards?	If there is a need for counseling the provider will assist the youth in obtaining counseling.
Transitional services: Purpose of Services states "meet <i>at least</i> 1 time a month in their current placement". As this reads, IL providers are allowed to meet with transitional youth more than 1 time a	A provider may meet more than once a month if needed. That need will be determined by the level of service on the referral.

month if necessary...correct?	
Target population: In the sections discussing the eligibility requirements state for case management services, it does not state anywhere that the youth must have turned 18 in foster care, only that they must have spent at least 6 months in foster care between the ages of 16-18. Therefore, by these requirements a youth who turned 18 in detention, but spent at last 6 months in foster care should be eligible for case management services?	This is correct. A youth that is in detention on their 18 th birthday is still eligible for case management services.
Target population: Eligibility for case management services states that a youth must have been in foster care for 6 months between the ages of 16-18. It does not state if the months must be consecutive. Can the months spent in foster care be non-consecutive?	There is no requirement that states that the months have to be consecutive. The six month requirement is collective
Goals & Outcomes: It states that providers must have face-to-face contact with youth within 10 days of referral. What if IL provider has received the referral, but not the case plan...can we begin meeting with the youth without the case plan? Also, if we have a case plan, but it does not indicate IL services, do we have to wait to meet with the youth until we have a copy of the proper case plan?	There is no requirement that states that a provider must have a case plan in order to begin services. A case plan for a youth 16 and older that is in care will automatically state Independent Living.
Concrete Services: What form is used for DCS approval? What specific services can be purchased? Can “goods” be purchased also? If so, what goods in particular?	The following form gives this information. If you can not find this on the DCS website, talk with one of the IL Specialist. APPLICATION FOR EMANCIPATION GOODS AND SERVICES State Form 52690 (R / 11-06) / CW 2113 DEPARTMENT OF CHILD SERVICES
In providing experiential learning opportunities, under Life Skills and Social Skills Services, is it appropriate to facilitate this learning in a group setting or is this service expected to be provided one-on-one with client in the community setting?	Both situations may be appropriate. Services are tailored to the youth’s IL Plan. Although groups may occur a provider is still expected to work one-on-one with the youth.
Under the Target Population are children who are placed though the county office, in a therapeutic foster home (LCPA) not <i>eligible for case management services</i> through CHAFEE funds?	These youth are provided with IL services through their placements. This population of youth becomes eligible for Chafee services when they become 17 ½ years old.
Are the Voluntary Services reports referenced in Goals and Outcome Measures to be completed in a standard format or is this done by contractor discretion?	All Voluntary Services Report must be filled out on the standard form. No other format will be accepted
Currently significant staff time is used to review referrals for errors and obtaining corrected referrals. In addition, our staff is often assisting DCS staff with completing the correct paperwork for services to be obtained for IL youth. Will IL training be added to the FCM/Probation officer training to minimize referral errors?	Training is available
Should room and board assistance be decreased following the current guideline?	Yes

How do providers verify that a youth has a case plan in ICWIS identifying the need for IL services? To prevent servicing ineligible youth, should providers request the case plan prior to service initiation?	Eligibility is performed by the IL Specialist
How will service providers access records for case mining with voluntary youth?	There is no case mining for non-wards
Of you provide Chafee IL, must you do the Chafee mentoring program?	No
“Family Centered Services” (Billing/Fiscal)	
Face-to-Face Rate Building	
What is the process for continuing to bill collateral, travel time, and no shows for home-based services?	Those are no longer billable units; Only units listed in the “Billable Units” section of the applicable Service Standards will be approved.
Under Intensive Services, waiting lists are prohibited; however we are expected to respond to a new referral within 24 hours. Does this imply that our rate should include the cost of stand-by staff capacity?	No
Billing	
Can you have 1 HBFP family and also bill HBFCC for a different family on the same day the per diem is billed?	If you are asking if you have a staff person that delivers both IFPS/IFRS (The homebuilder's model.) and Home Based Family Centered Casework Services can be you bill for a daily rate for one family in the IFPS/IFRS program and another family on a face to face rate under HBFCCS. The answer is yes. What the provider has to be careful of is that they still must keep the staffing standards in check for both programs.
Is the per diem billed for every day even if there is no face-to-face contact for that day for HBFP/HBFR?	Yes
<p>For the Family Centered Services Standards it mentions \$500 concrete services and in the IFP Intensive stage it mentions \$500 of concrete services. Wanting to make sure the family who needs \$500 in intensive and then \$500 more in case management could truly use \$1000.</p> <p>For the reunification, could a family theoretically use \$500 in case management as part of the preparation for reunification, \$500 in the intensive part of reunification and another \$500 in the case management after intensive for a total of 1500?</p> <p>Is the \$500 cap for “Concrete Funds” that appears for services such as Home Based Family-Centered Casework a <i>lifetime</i> cap for a family receiving these services (regardless of their service provider); or is it a cap <i>just for that family</i> receiving services <i>from that particular provider</i>; or is it a cap that lasts just for</p>	The intent of the provision of concrete services is to afford the family the opportunity for use of funds that will support efforts to accomplish the outcomes specified in the service standard, for example, will eliminate a problem that could lead to removal of the child from the home. If there is a situation wherein use of concrete funds will help accomplish the goal as specified in the service standard, there must be written approval from DCS, and documentation of the need for the funds as well as the way the funds were spent and recorded in the agency files. It is feasible that a family will have a relevant need for concrete funds while receiving services under separate service standards, but care should be taken to make sure that expense is justified, documented and approved by the referring DCS.

<p>that family, at that provider, for the duration of the contract, or what?</p>	
<p><u>Homebased Family Centered Casework</u> – In #12 under service description it says that "attendance at family team meetings will not be a separate payment point" while the billable unit description includes child and family team meetings. Could you clarify this?</p>	<p>Child and Family Team meetings are billable <i>under the face-to-face billable unit</i> as long as long as the family/client is present.</p>
<p>“Family Centered Services” (Programmatic)</p>	
<p>Can the max caseload for Home -Based Therapist be higher if the service is not intensive? How as the max caseload for therapists (Home-Based) determined? Our therapists provide therapy in collaboration with case managers and one in the home less often as the case mgmt is more intensive.</p>	<p>As found in state code IC 31-26-5-6, it is stipulated that Family preservation service workers have a maximum caseload of twelve (12) families, which as you have indicated is different than the caseload size for intensive services.</p>
<p>Collateral ---will DCS be doing more case management in the practice reform making the HBFCC "collateral" work less a part of the job? This has impact on the rates.</p>	<p>As practice reform unfolds there will come the need for greater collaboration between DCS Family Case Managers and contracted service providers. Collateral work will continue to be part of the job for both the DCS case manager, and the contract service provider.</p>
<p>The services standards for Intensive Family Preservation and Intensive Family Reunification require providers to also have a contract for Home Based Family Centered Casework (HBFCC). Can a provider submit a proposal to provide HBFCC as a separate service and not provide the intensive services?</p>	<p>yes</p>
<p>Homemaker Services --In one place it states that written reports must be submitted monthly and in another place it states no less than quarterly. Which is it?</p>	<p>The word quarterly should be monthly.</p>
<p>Homemaker Services ---Services must be established by a DCS case plan. The target population is 1) children and families with substantiated abuse and/or abuse with a moderate to high level of risk 2) Children with a status of CHINS and or JD or JS. Under expectations-3 it states we can provide transportation in the course of assisting the client to fulfill the case plan or informal adjustment. Must the child be a CHINS? Can we serve families on IA's? Can we serve families on safety plans? Must DCS submit the plan with the referral?</p>	<p>The categorical qualifiers as listed in the target population are the CHINS, JD/JS, or it can be an IA case. DCS can submit the plan with the referral; it is up to the discretion of the local DCS office.</p>
<p>Visitation with child is a service component of Parent Aid/Homemaker. Does this mean that the worker can supervise visits for DCS?</p>	<p>The operable word in your question is “supervise”. Within the Home Based Homemaker/Parent Aid service standards, visitation is part of the agency service plan, performed by a paraprofessional and is an informal service structure, which is different than the supervised visitation as described in the</p>

	Visitation Facilitation-Parent/Child Sibling service standard which is performed in a formal session/report, by a degreed service provider.
Since the Intensive Reunification Services are limited to 28 days, will DCS automatically issue a written Casework referral prior to the end of the 28 days so that the provider can issue safety, step-down monitoring, and ongoing family support?	It is not automatic, it is dependent on need. It is very important that there be a lot of communication between the IFPS or IFRS worker and the FCM during the intensive phase of the services so that a referral can be made if necessary.
Under the Service Delivery requirements for Intensive Services, providers are given the option of refusing or terminating services within 72 hours if “the safety of the child cannot be reasonably assured”. Does that mean a provider is assuming liability for a child’s safety by accepting a referral?	Service providers have liability for the services they provide and for whom they provide services, a referral from DCS does not alter agency liability.
The RFP indicates that Home-Based Family-Centered Casework will be used for pre-Intensive Reunification Services and for post-Intensive Preservation Services. Will Home-Based Family-Centered Casework also be used for post-Intensive Reunification Services?	It could if needed.
Our current supervisor for Homebased Intensive reunification and Preservation services has a master's degree, but is not licensed? can she still function in that position to oversee the casemanagers since our overall Clinical Director is a LCSW, ACSW, LMHC?	The direct line supervisor for Home Based Intensive Family Preservation and Intensive Family Reunification must have a Master’s degree (as specified in the standards) with a current license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board as one of the following: 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor
Do licensed therapists providing HBFCTS require supervision from another licensed therapist? Do HBFCTS who are not licensed, but have the required 3 years related clinical experience require supervision from a licensed therapist?	Yes, the therapist for Home Based Family Centered Therapy must be supervised by a person meeting the qualifications as specified in the standards.
HBFCCC - Since the "scores will be improved on the Risk Assessment and needs and strengths assessment instruments in ICWIS is part of the outcome measure, will information about the areas being scored be available with the referral?	The information about the ICWIS Risk Assessment and the Needs and Strengths Assessment is available at the point of referral at the discretion of the local DCS office.
Page 40, Goal # 1, Item #4: Please clarify what “participation in Child and Family Team meetings will be accomplished as soon as possible” means.	Since it is up to the DCS office to facilitate and organize the Child and Family Team meetings, it is not possible for the service standards to establish timeframes for agency involvement in these meetings.
Page 46, Item 13: Please clarify “supervisors maintain constant direct contact with clients.”	Page 46 is discussing supervision for Intensive Family Preservation. In the Homebuilders Model duties for supervisors includes interaction between the supervisor, the direct worker (therapist) and the client family. The model explains that the supervisor would accompany each direct worker on a home visit

	at least quarterly for direct workers with less than 2 years of Homebuilders experience, or at least semi-annually for direct workers with more that 2 years of Homebuilders experience, in order to routinely observe the direct workers skills and to provide support and training. The required fundamental supervision for Homebuilders will go into more detail about these issues.
HBFCC-Are approved services for all family members listed on the referral or only those individuals who are specifically selected out of the family group?	Specifically with Home Based Family Centered Casework, the service standards focus would be on the child(ren) within the structure of the family. DCS and the family define who are members of the family. Persons listed on the referral as family members can receive services that can be billed as face-to-face. Other persons involved in the intervention process would be considered "collateral contacts" but are not considered part of the family. (neighbors, clergy, school personnel, etc.)
HBFCC - Will contractor have access to the DCS case plan to assist in focusing on limited objectives of treatment?	The DCS case plan is available for the contractor, at the discretion of the local DCS office.
HBFCC - Will the scores on the Risk Assessment and needs and strengths assessment in ICWIS be shared with contract providers?	The scores on the Risk Assessment and the needs and Strengths Assessment are available to the contractor at the discretion of the local DCS office.
IFPS-Is the therapist, referenced in the Service Delivery section, the same as the “direct worker” even if the individual only meets the Bachelor’s degree and work experience qualifications?	The title of therapist in the Home-Based Intensive Family Preservation and Intensive Family Reunification is different from the usage of the title of therapist in other service standards. You must combine the use of the title in the standard with the qualifications specified by each standard
Homemaker/Parent-Aid - What is the number of homemaker service referrals, by region, for the past grant cycle?	This information is not available.
Homemaker/Parent-Aid - Are wait lists appropriate for homemaker / parent aid referrals?	Waiting lists are not prohibited for Home-Based Homemaker/Parent Aid referrals, but discussion should be happening between the provider and DCS. Dependent on the needs of the family the local DCS may have to refer the family to other appropriate services.
“Foster Parent Services” (Billing/Fiscal)	
Face-to-Face Rate Billing	
The Foster Family Support Services standards state that bi-weekly phone contact is required, yet it is not billable. Why not?	Yes, phone calls can be billable when they are providing a service that is consistent with the “Service Description” from the relevant Service Standard.
Would monthly calls to foster families be considered goal directed intervention and be billable under face-to-face contact?	Yes
If the FFSC is responsible for completing the checks, how will the cost be billed and how will the service	Criminal background/CPS checks are required for anyone providing child care (which is to be done at

be billed since this would be time consuming collateral work?	the request of the foster family). Costs should be built into the proposed face-to-face rate; if that proposed rate is above the maximum, a budget and written justification must be included in the proposal.
Since the FFSC is required to have a support group, it requires 10 newsletters per year to inform of group topics, etc., how is this billed since it is for a group and not individual foster parents? Since providing refreshments for the support group meetings is required, how are they to be purchased and how is this service to be billed since it would be for the group and not an individual?	Costs should be built into the proposed face-to-face rate; if that proposed rate is above the maximum, a budget and written justification must be included in the proposal.
Since monthly reports are required to be provided to the licensing case manager, how are they to be billed since they are for a group and not specific foster families?	As part of coordination.
Since necessary activities such as report writing, travel, etc. are not to be billed separately, should the time spent on these activities be included with the face-to-face time billed?	Yes
One of the services provided by the FFSC is to provide childcare at bi-monthly support meetings. How is this to be billed?	It is to be built into the rate.
Is the mileage rate considered to be part of the face-to-face rate?	Yes
Does billing allow for sites large enough to facilitate a group this size including approximately as many children for childcare and if not, could this be a line item?	No. It can not be a line item but you can estimate the cost in your billable rate
Does interaction with prospective foster families require a referral from DCS to bill for services to that family?	All billable time spent with clients must be authorized by a DCS referral; see the "Service Access" Section of the Service Standards for further explanation.
Currently, the FFSC has initial contact with many prospective foster families to inform them of meetings, trainings, provide information, answer questions, etc. Does this require a DCS referral to provide this service and bill under that family's name?	Prospective foster families are not part of the "Target Population".
Bi-monthly FAKT Coordinator meetings are listed. These meetings are held monthly. May we attend and bill time for all state-conducted meetings?	Your "Coordination for training per hour" unit rate should include bi-monthly FAKT Coordinator meetings, along with other required training meetings (not to exceed 3 per contract year).
Will the claim forms for the FAKT Program have the same line items as they currently do (Coordination, Training, TOT, Newsletter, Interpreter, Site, etc.)?	No; See "Rates" (Section VI.) of the Service Standards for a description of the billable units.
Newsletter Costs – This states it includes the developing of the newsletter. This amount was	It is the intention that the cost of development and writing of the newsletter be built into the

previously billed under coordination time while the actual costs of the newsletter (printing and mailing) was billed under newsletter costs. Is the developing/writing of the newsletter to be figured into and billed under newsletter cost as opposed to coordination time?	Coordination unit, and the dollar-for-dollar reimbursement for the Newsletter unit is to include the printing and dissemination of the document.
Foster Home Studies and Step-Parent/Custody Studies: it is stated that routine report writing is not included in the face to face, does this also include writing the actual custody study?	Yes
Was it actually intended to leave the 10 hour limit for 2 cancelled training sessions clause in this RFP?	No
Billing for “crossed-county foster parents” is misleading and could be confusing. Should this section actually read “cross-county and other agency foster parents”?	yes
Budgets and Written Justifications	
Does FAKT training need a budget	Yes
“Foster Parent Services” (Programmatic)	
FAKT Questions	
LCPA’s are listed under the target population in the previous IV-B services standards for Foster/Adoptive/Kinship Caregiver TOT training. They are not listed under the target population for the same standard for the 2009-2011 contract period. Will LCPA’s be able to continue to participate in TOT trainings?	LCPA’s are welcome to attend FAKT TOT although they do not appear in the target population.
Will FAKT Coordinators be expected to provide FAKT TOT trainings in conjunction with Pre-Service and In-Service Trainings or can contractors propose to only provide FAKT TOT trainings. Will LCPA’s continue to be served in these trainings?	Providing FAKT TOT is a DCS Central Office function.
(FAKT TRAINING) “When appropriate and when available, introduction to foster parent supervised visitations should be included”. Is there a specific curriculum for this training since DCS approval is required? Would a specific DCS referral be required for this particular training other than the referral for FAKT training since foster parents who are already licensed would also likely be attending this?	There is no Central Office curriculum. Please get DCS approval for curriculum used. Referrals are not required for in-service training. Please handle introduction to foster parent supervised visitations as any other in-service trainings.
Please define “Pre-service training is to be offered monthly.” Does this mean at least one NEW session has to be started each month or if a session is continuing, the classes being offered to complete that session can be counted?	The requirement that pre-service training is offered monthly, is to ensure it is offered “on a regular, timely basis”. This does not require the initiation of a NEW session if continuing sessions are not yet completed and/or based on need.
Please clarify: Is the 6 hours of Permanency Training that is currently being offered separately to prospective foster families supposed to now be folded in to the current 20 hour pre-service curriculum?	The 6 hours of permanency training is separate is not being combined. Please handle this the same as what was previously done

<p>Please clarify: A referral from DCS is or is not required before an adult can participate in FAKT training. (Counties are currently making their own decisions on this.)</p>	<p>Referrals are not required.</p>
<p>One of the FAKT outcome measures states that “100% of foster parents licensed will complete the required number of in-service hours annually.” FAKT providers do not monitor the families for on-going training hour compliance nor do they have any control over the licensed families. How can providers be held to this standard?</p>	<p>An attendance record should be kept. Non compliance with annual in-service training requirements will be handled by licensing.</p>
<p>Please define the “mentoring process as developed by the FAKT Training Coordinator.” (pg 60)</p>	<p>This is determined by each coordinator to ensure each trainer has the following qualities: training style, curriculum knowledge, adult learning/content, etc.</p>
<p>FAKT - Please clarify the accuracy of the following: FAKT Service Standard page 58: “Provision of foster/adoptive/kinship caregiver training (FAKT), which include 20 hours of pre-service training covering the competencies listed below: A. This will include permanency training for prospective foster, kinship, and adoptive parents.” In the past, Permanency training has been 6 hours of training, separate from and in addition to, the 20-hour pre-service training. Is it going to continue to be delivered as 26 hours of training for Sessions 1 – 12 or has there been a change?</p>	<p>The 6 hours of permanency training is separate is not being combined. Please handle this the same as what was previously done.</p>
<p>FAKT - Under In-service Training: “Monthly in-service training will be provided for licensed DCS foster/kinship/adoptive families . . .” Is there a geographical area in which monthly in-service training must be offered, i.e. region, such as is specifically stated regarding pre-service?</p>	<p>No, yet it is best practice to make available in-service training when/where needed. The FAKT Coordinator should work with their counties/regions to determine possible locations and rotations of training.</p>
<p>Please clarify the accuracy of the following: FAKT Service Standard page 59: “II Target Population 1. Prospective foster parent who have passed a criminal history check or current foster parent of DCS. (County receives the application, runs the State background check and sends results along with the FAKT training request to the agency that will doing the training . . .” See information from a letter from Celia Leaird:</p>	<p>If your question is the FAKT Coordinator has no means of knowing if a potential foster parent has had a criminal history check if no referral is required from the local offices who have this information, the answer is yes, the FAKT Coordinator cannot be held accountable for the requirement in the service standard for the Target Population that requires a criminal history check prior to FAKT at this time. The standard will be changed to show that the criminal check does not need to be completed prior to FAKT.</p>
<p>Will contact information be provided to the contractor in reference to all individuals who should receive the news letter?</p>	<p>It is assumed that the contractor is compiling their own contact listing through collateral contacts with local offices and ongoing inquiries for foster parenting.</p>
<p>May an LCPA who receives this contract provide their own FAKT trainings to their potential foster home if said trainings are kept separate from the</p>	<p>Not sure of the question. The LCPA's are required to provide training to their Foster Parents. If the question is "can they use these funds to pay for the</p>

required county FAKT trainings?	training of their foster parents" the answer is no. Now is it allowed to use good judgment and help each other out the answer is yes. The agreements need to be written and the Regional Managers must approve.
Under In-service Training it states that foster parents are required to obtain 10 hours of in-service training annually. Special needs providers are required to obtain 20 hours annually. Since some county DCS' license special needs homes, can this difference be clarified for this section?	This requirement is in both the DCS manual and Indiana Code and the DCS offices should have that information. The 20 hours for special needs providers will be added to the standard.
Often families are referred to service providers (Training Coordinators) to be registered for training upon initial contact with the DCS or IFCAA, prior to the completion of the criminal history checks. Will this still be allowed or will a new referral system be put into place so that only those passing the criminal checks will be registered for training? This could delay the family in fulfilling their training requirements	This will still be allowed.
Foster Family Support Services	
Since the foster parent support group meetings are to be held at DCS, will DCS also be providing the space there for the child care?	The support group meetings are not "required" to be held at DCS. If space is available and appropriate then the local office would probably make it available. Alternate site can be utilized. It is up to the provider to find the space to have these group meetings.
Are there any guidelines for the child care services or those providing it under Foster Family Support Services?	Anyone providing childcare at support group meetings must pass a criminal history and CPS check.
How will providers receive updated information and biographical information on DCS staff that is required for the newsletter? Will each DCS have a contact person to provide this information?----- (ASSUME THIS IS FOR THE SERVICE STANDARD FOSTER FAMILY SUPPORT SERVICES. Provider did not say.)	The provider will need to contact the local office for this information.
The "Target Population" lists licensed foster/kinship parents yet the "Service Access" says prospective foster families are eligible. Please clarify who is eligible for Foster Family Support Services.	Thank you for noticing this inconsistency. VIII. Service Access will be changed immediately to read "Service can only be accessed by the target population as identified by DCS either verbally or in written form".
Outcome 2 #1 under Foster Family Support Services says "100% of foster families report that they believe DCS respects what they do." This is not under the providers control, so how can providers be responsible for this?	Please use best practice in developing an environment offering respect to foster families.
Does "other goal directed interventions via telephone" include the required monthly phone contact as listed in the service standard for Foster Family Support Services?	All contacts should be goal directed and regarding group topics.

Has the state determined a specific number or range of foster homes that are considered the maximum number one full time worker can serve, especially when much of the service time required is not currently billable?	No, not at this time.
Who will process the criminal history checks and CPS checks for childcare providers?	Provider will be responsible for making sure this is completed.
It states that the FFSC will work with all licensed foster families by the County being served. Does this include private agency foster parents as they do contact the FFSC at times concerning things like transferring their license, being on the respite list, etc.?	The intent is the DCS foster parents.
The first paragraph says there will be bi-weekly contact but number 6 in the same section states there will be at least monthly contact. Which is the expectation?	Service standard states the support group “may include at least one training hour per meeting and bi-weekly phone contact”. The stated minimum in #6 is monthly phone contact.
Foster Home Studies/Updates/Relicensing Studies	
Under foster home studies/update/relicensing studies, neither Criminal History checks nor DCS forms are required. Is this accurate? If so, does this mean that DCS will be doing the required checks and collecting the required homestudy information prior to sending the referral?	State policy must be followed in doing these criminal checks. The contractor is responsible for following state policy.
(P 70) – What do they mean by “routine” reports? Is this a reference to statistical data or to the actual home study/assessment which, by nature of the service, is essential to assuring its delivery?	It is both statistical data and the actual homes study/assessment. This is to built into the face to face rate.
Is it necessary to contract to do annual update/re-licensing studies along with the initial studies since some counties are already doing their own updates	This is dependent upon the needs of the local office/region.
Under Goals & Outcome Measures, Goal # 2 states that “94% of families who have participated in foster family support services will rate the services as satisfactory.” : Is this really meant to be a goal of Foster Home Studies/Updates & Relicensing Studies?	Yes it is, thanks for drawing this to our attention. This will be changed.
What is meant by "services should be completed within 60 days of receipt of referrals or by a time frame specified by DCS at the time of referrals"? Does this mean families should be licensed within 60 days? In light of the parts of the process over which we have little control (getting paperwork back from families, law enforcement agencies, etc) is that realistic? We agree that it is a good goal, but 98% seems quite high.	It is meant that the service is completed within the 60 days of receipt of referrals or by the time frame that is specified by DCS.
Do all services listed under Foster Parent Services require that these services be done by an agency who is a Foster Licensing Agency?	No
Are there any specific qualifications for an agency to be able to provide Foster Home	LCPA and DCS are the only organizations that can approve a home study for foster care/adoption.

Studies/Updates/Relicensing Studies?	
What is the average time expectation for a direct worker to complete a Foster Hope Study / Update/ Relicensing Study?	Current state policy is that there is 60 days to complete any one of these studies.
Other Questions Related to the RFP	
Staff Qualifications	
<p>1.The professional experience criteria for many of the service standards require a Masters degree and three years related to clinical experience. Does the three years include experience gained during the time the therapist is working on the degree, or is that three years post graduate?</p> <p>Does “three years clinical experience” have to be post-masters or can it be post-bachelor degree?</p> <p>What is the definition of “clinical experience?”</p> <p>What constitutes “experiences” for either a therapist or a case manager? Can you include time spent during internships, bachelor’s level experience (for a master level person)?</p> <p>New Masters-level graduates cannot be hired without three-years of experience or a license. It takes at least two years of supervised experience to get a license. Given the shortage of the state (especially in rural communities and given the increased recruitment by DCS), we are already asking our Masters level therapists to drive up to two counties away to ensure service delivery. This new qualification requirement has shrunken the pool of available candidates even further. What provision is the state making to allow providers to develop the number of future qualified professionals when we are not allowed to offer supervised therapy experience as a license is pursued or as a trained graduate begins their career?</p> <p>Does a Master’s-level graduate’s practicum experience count toward the required experience qualification?</p> <p>Clarification on qualifications for masters level clinician: for a person without a license, does all of the “related clinical experience” have to occur after the masters degree has been conferred?</p> <p>The counseling service standards require a Master’s degree with 3 years related clinical experience. Is the clinical experience post-Masters?</p>	<p>Total experience in Social Services, can be post Bachelor's degree. . Clinical experience in this context means time in the practice of social work.</p>

<p>Is a Master’s in Education a “directly related human services field?”</p> <p>Could you define “directly related human service field”?</p> <p>Would a person with a Bachelor’s in Education and 19 years of related experience in the human service field qualify for Home-Based Family Centered Casework?</p>	<p>There are several degrees that could be related. One must also look to see if there is a licensing requirement. For Example, a provider could hire someone as a direct worker because that worker has a degree that is related, but later not be able to promote that worker to a supervisor because the worker is unable to work toward a license that is required as a supervisor.</p> <p>We consider the following to be related Child Development, Family and Consumer Sciences, Criminal Justice, and/or Education.</p>
<p>In a situation where a therapist with three years of experience serving—for example—10 families leaves and no qualified replacement is immediately available, what does the state recommend we do to ensure that services are not abruptly ended? Is it possible to temporarily increase caseloads and/or use a Masters-level staff with less than three years experience until such a time as a new qualified candidate is able to be hired?</p> <p>We hire just about every Masters-level therapist we can find. Of the 24 that we have been able to hire, over half would not meet the new requirements due to the fact that they were hired right out of graduate school—often the only place new candidates can be found. Is there any consideration being given to allowing agencies to hire new graduates in an effort to develop experience and licensure opportunities to increase the overall number of qualified professionals serving families in need in our state?</p> <p>Your work to provide high quality therapists for your families is commendable and it is understandable that you want to end the use of waivers. At the same time, shortages of licensed personnel to do therapy with kids and adolescents is a reality in many parts of our state. There is a clear difference between the unlicensed private practitioner and the unlicensed practitioner mental health agency accredited by Joint Commission, surrounded by a multi-disciplinary team, given individual and group supervision, etc. Is it acceptable to write the proposal with what we can realistically provide and let the county director and regional services council decide if they need that option or not to provide services to their families?</p> <p>Is the continuation and/or extension of the waiver process being considered? For example, more than</p>	<p>We have some of the same concerns that you do as providers. We are open to setting guidelines for staff vacancies. We believe this is a state function not a Regions or a Regional Service Councils.</p> <p>We invite your input. Please e-mail Ginny Morris at Ginny.Morris@dcs.in.gov to express your interest in working with us on this issue.</p>

<p>50% of our current therapists (serving nearly 100 families at any given time) would not meet the new experience requirement. If these staff leave or are recruited by DCS, we would have a difficult time replacing them without a waiver process</p> <p>I have concern regarding gaps between one qualified (by services standard required credential) and the hiring of that person's replacement - that kids would be moved from treatment for a temporary gap in credential. Licensed staff is difficult to recruit.</p>	
<p>Can current staff who have an approved waiver to provide master level services also supervise staff where supervision qualifications in the new standards that do not require a Lic. Master level?</p>	<p>No - Waivers are specific to the service standard and the position, direct worker or supervision.</p>
<p>D&E with MMPI requires a licensed clinical psychologist, not an MSW. MMPIs can only be purchased administered and interpreted by an HSPP. Should the qualifications in the standards be changed?</p> <p>The service description notes psychological testing and drug/alcohol testing while the qualifications do not specify a psychologist or a drug/alcohol certification. Are general mental health evaluations to be included here?</p>	<p>Yes. Thanks! It will be changed.</p>
<p>If a current staff member has an eligible qualifications waiver, is this transferable to another organization? Given a situation where a current provider may cease to provide services under the new contract, this would allow effective professionals providing casework, therapy, etc. to continue meeting the needs of families through other service providers.</p>	<p>No - Waivers are specific to the service standard and the position, direct worker or supervision</p>
<p>Staff Qualification Waivers</p>	
<p>Staff Qualifications section says "There will not be a waiver process" then goes on to indicate that one can seek waivers & will be honored with these new contracts that begin 1-1-09. WILL WAIVER BE AVAILABLE?</p> <p>Does this mean there <i>is</i> a waiver process, even though it stated that there will not be a waiver process?</p>	<p>During this current contract which end on 12-31-08 waivers can be sought prior to 6-30-08. No waivers can be requested after 6-30-08. All waivers granted will be valid in the next contracting cycle which begins 1-1-09.</p>
<p>2. Given that there are no further staff qualification waivers-If you lose a qualified staff member and have no replacement staff that is considered</p>	<p>Please look at the new staff qualifications. We have listened to much input and have changes some of the requirements.</p>

qualified, does the agency simply cease providing that service?	
If a person has a waiver for supervision under “Master’s degree in social work, psychology, or directly related human services field” for one program, does that waiver carry to other programs that require the same qualifications? For example, if I have a supervisor waiver for Home-based Casework Services currently, can I also be waived for Supervision in the Step-Parent adoption studies program for the next grant cycle. This current grant period supervision for step-parent adoption studies requires a Master’s with a license and the 09-11 grant does not.	No, waivers are approved for a specific service standard and a particular position....direct worker or supervisor. The approval is also for a particular agency and is non-transferable.
This current contract the qualifications for supervision require a license the next grant year 09-11 does not. Can I start hiring toward the new standard without asking for a waiver?	Yes, You can use the new qualifications in the standards for 09-11 to hire staff. There have been some changes as a result of these questions and the results are listed in this Q & A. The Service Standard affected will be changed to reflect those changes. The changes are effect the date of the publication of this Q & A.
How do we go about getting a waiver done for some staff prior to June 30, 2008?	There is a form to complete. You can get this from by sending a request through e-mail to Ginny.Morris@dcs.IN.gov
Under Counseling Individual and Family can waivers be applied for if staff are currently serving in the Supervisory and Direct Worker roles but they do not fully meet the requirements now listed?	If current staff do not meet current qualifications for the service standards they are working under then waivers should be sought. People hired after this Q & A are published 2/12/08 can meet the requirements for the 2009-2011 contracts which are slightly different.
ASSURANCES	
Training On the issue of substance abuse, staff safety, and domestic violence, what are the expected qualifications of the trainer? Are the clinical staff considered to be qualified for the domestic violence and staff safety portion of the training?	At this point we are going to rely on the providers to use good judgment in making sure their staff have or get the appropriate training. If we find this not to be true, then of course more restrictions may be added in future contracts.
Is Assurance #21 accurate with Women or Minority Owned Business or should be “Buy Indiana?”	Yes, you are correct. Thanks! Please disregard the last sentence of Assurance 21.
Attachment G: Assurances 21. Subcontractors The company only employs one person, the owner and operator. All others are considered Independent Contractors (IC). The IC’s provide the direct service to the families, ie. Homemakers, Therapists, Visitation Supervisors, Home-Based Caseworkers. Some of the individuals also provide clinical supervision as well as supervision to paraprofessional staff. Some of these individuals have LLC’s, S-Corps, or are self-employed. Are the	Yes, all of these things are required, but not all are required to be sent as part of the proposal. By contract there has always been a requirement of state approval for subcontractors, this is no different. The Contractor has ultimate responsible for their subcontractors. Listing the subcontract and giving the obvious, who, what, when, where is sufficient to get approval for the proposal. The staff qualifications are the same for a contractor/sub-contractor. These are some of the things that the new Outcomes Unit will be checking as part of their Contract Reviews.

<p>following documents required for each IC?</p> <ul style="list-style-type: none"> -executed Independent Contract Agreement Or can one (1) copy of the agreement be submitted as the overall agreement? -identification of the function to be provided- can this be the job description? If not, what specifically would you like? - identification of the qualifications- can this be the resume? If not, what specifically would you like? - the amount of the subcontract- can this be done in the budget justification worksheet? Would this be per IC or per service? If not, how would you like that done? - qualifications of subcontractor- can this be the resume? If not, what specifically would you like? - names addresses and state in which formed- can this be the resume? If not, what specifically would you like? - for persons who have formed companies what pertinent information do you need regarding their companies? Documentation with the SOS? What specific documentation do you need regarding the corp. status? -willingness to carry out responsibilities- does the independent contract agreement suffice as to their willingness? If not, what specifically would you like? <p>Can we use contractors to perform direct services and if so do they have to be licensed to perform therapy and what are the requirements to use them?</p> <p>When submitting the proposal, such things as signed individual Independent Contract Agreements cannot be sent electronically. How would you like this information to be sent to the Regional Directors and County Directors?</p>	<p>The actual documentation will be required to be in the possession of the contractor available for review.</p> <p>.</p>
<p>Assurances - #20: What constitutes “proof of authority” for legal authorization to sign the contract?</p>	<p>It would depend on the providers' status. If you are a 501 c3 it may be in your by-laws.</p>