Region 4

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

Section 5 – Service Array Appendix

SFY 2015-2016

February 2, 2014
Biennial Regional Services Strategic Plan
Service Array Appendix

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<td>“The drug test list includes Drugs of Abuse (illegal drugs), Therapeutic Drugs</td>
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<td>(Prescription Drugs-Painkillers, Mental Health Meds, etc.) and Designer drugs (i.e. Ks, “Spice”).</td>
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I. Service Description

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

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

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

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

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

II. Target Population

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

III. Goals and Outcome Measures

Goal #1
Ensure that children in Indiana’s custody are adequately prepared for adoption.
Outcome Measures

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

Goal #2
Increase the child’s understanding of adoption.
Outcome Measures

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

Goal #3
Successful transition for the child and family to increase the probability of a successful adoption.
Outcome Measures
1. 90% of the children prepared will move into an adoptive home
2. 95% of adoptions will be finalized within one year of placement.

   Goal #4
   DCS and child satisfaction with services
   Outcome Measure

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

IV. Minimum Qualifications

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

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

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

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

In addition the worker must have:

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

V. Billable Units

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

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

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

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

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

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

VI. Case Record Documentation

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

VII. Service Access

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

VIII. Adherence to the DCS Practice Model

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

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

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

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

- processing the family's references, medical information forms, financial forms and all other necessary state forms
- creating with the family, family genograms, eco-map, etc
- preparing other members of the household who will affect the success of an adoption because of their relationship to the family, such as a live-in grandparent or a relative who is always at the home during the day
- using the challenges checklist as a learning tool to review common challenges the children have with the family and to gauge the families degree of acceptance of the child’s needs/challenges and to help the family self-evaluate to determine how such needs/challenges will impact the family now and in the future as well as if special needs adoption is for them
- assists the family with pre-placement family support services and
- serving as advocate for the family throughout the adoption process
The Family Preparation should include the family's feelings about adoption and experiences with parenting as well as pertinent issues specific to adoption. Preparation should also prepare adoptive parents in understanding the commitment they are making to provide a permanent home for the child or children they will be including in their family whether young children, adolescents, or sibling groups. The contractor will engage in a dialogue with family members, providing information on all aspects of child abuse and neglect, typical resulting behaviors, common characteristics of children in the system and assist the family in planning and foreseeing what is needed for their own specific successful parenting of these children. The contractor will explore with the family the types of children that they feel able to parent and the specific special needs with which they can work.

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

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

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

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

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

II. When DCS is not paying for services:

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

III. Target Population

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

IV. Goals and Outcome measures

Goal #1
Provide adoption home studies for families interested in adopting special needs children in a timely manner.

Outcome Measures

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

Goal #2
Ensure that the local SNAP Specialist are aware of each prepared and waiting family
Outcome Measures

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

Goal #3
Increase the number of adoptions of children.
Outcome Measures

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

Goal #4
DCS and family awareness of available services
Outcome Measure

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

V. Minimum Qualifications

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

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

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

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.
In addition to:
- Knowledge of family of origin/intergenerational issues
- Separation and loss issues
- Knowledge of adoption specific issues and the needed characteristics for families to parent these children differently
- Knowledge of child abuse/child neglect and how these impact behavior and development.
- Knowledge of community resources, especially adoption friendly services in the communities where families reside.

VI. Billable Units

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

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

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

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

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

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

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

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

**VII. Case Record Documentation**

Case record documentation for service eligibility must include:

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

2) Documentation of contacts regarding foster parent interest in adopting children in their care or other children available. OR Documentation of all contacts with potential adoptive family and a record of services provided with goals and objectives of the services and dates of service.

3) Documentation includes a copy of the written home studies for all prospective families following the outline in the Child Welfare Policies.

**VIII. Service Access**

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

**IX. Adherence to the DCS Practice Model**

Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.
I. Services Description
Provision of home-based casework services for families involved with DCS/Probation. Home-based casework is also available for pre-adoption and post-adoption services for adoptive families at risk or in crisis. These in-home services should be high quality, family centered, and culturally competent. They should be effective in reducing maltreatment, improving caretaking and coping skills, enhancing family resilience, supporting healthy and nurturing relationships, and children’s physical, mental, emotional and educational well-being. Home-Based Casework Services should help to safely maintain children in their homes (or foster home); prevent children's initial placement or reentry into foster care; preserve, support, and stabilize families; and promote the well-being of children, youth, and families. Home-based Caseworker Services (HCS) provides any combination of the following kinds of services to the families as approved by DCS/Probation:

- Home visits
- Participation in DCS Case planning
- Supervised visitation **
- Coordination of services
- Conflict management
- Emergency/crisis services
- Child development education
- Domestic violence education
- Parenting education/training
- Family communication
- Facilitate transportation*
- Participation in Child and Family Team meetings
- Family reunification/preservation
- Reactive Attachment Disorder (RAD) support
- Foster family support
- Advocacy
- Family assessment
- Community referrals and follow-up
- Develop structure/time management
- Behavior modification
- Budgeting/money management
- Meal planning/preparation
- Parent training with children present
- Monitor progress of parenting skills
- Community services information
- Develop long and short-term goals
* HCS transport limited to client goal-directed, face-to-face as approved/specified as part of the case plan or goals/objectives identified at the Child and Family Team Meeting. (e.g. housing/apartment search, etc.)

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

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

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

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

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

Criteria for service:

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

V. When DCS is not paying for services:

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

VI. Target Population

Services must be restricted to the following eligibility categories:

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

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

Goal #1
Maintain timely intervention with the family and regular and timely communication with referring worker.
Objectives:
1) HCS or back-up is available for consultation to the family 24-7 by phone or in person.

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

Goal #2 Clients will achieve improved family functioning.
Objectives:
1) Goal setting, and service planning are mutually established with the client and Home Based Caseworker within 30 days of the initial face-to-face intake and a written report signed by the Home Based Caseworker and the client is submitted to the current FCM/Probation Officer.

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

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

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

VIII. Minimum Qualifications

Direct Worker:
Bachelor's degree in social work, psychology, sociology, or a directly-related human service field from an accredited college. Other Bachelor’s degrees will be accepted in combination with a minimum of five years experience working directly with families in the child welfare system. Must possess a valid driver’s license and the ability to use private car to transport self and others, and must comply with the state policy concerning minimum car insurance coverage.

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

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

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

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

IX. Billable Unit

Medicaid: Services through the Medicaid Rehab Option (MRO) may be Case Management and/or Skills Training & Development. Medicaid shall be billed when appropriate.
• Medically necessary behavioral health care Skills Training and Development services for the MRO will be paid per 15 minute unit for Individual and Family per 15 minute unit for group.

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

<table>
<thead>
<tr>
<th>Billing Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>T1016 HW</td>
<td>Case Management, each 15 minutes</td>
</tr>
<tr>
<td>H2014 HW</td>
<td>Skills Training and Development, per 15 minutes</td>
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<tr>
<td>H2014 HW HR</td>
<td>Skills Training and Development, per 15 minutes (family/couple, consumer present)</td>
</tr>
<tr>
<td>H2014 HW HS</td>
<td>Skills Training and Development, per 15 minutes (family/couple, without consumer present)</td>
</tr>
<tr>
<td>H2014 HW U1</td>
<td>Skills Training and Development, per 15 minutes (group setting)</td>
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<tr>
<td>H2014 HW HR U1</td>
<td>Skills Training and Development, per 15 minutes (group setting, family/couple, with consumer present)</td>
</tr>
<tr>
<td>H2014 HW HS U1</td>
<td>Skills Training and Development, per 15 minutes (group setting, family/couple, without consumer present)</td>
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</tbody>
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DCS holds overall Case Management responsibility. In order to assist DCS with the coordination of medically necessary behavioral health care needs of the MRO client, CMHC’s may provide case management services with this specific focus.

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

Face to face time with the client:
(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)
• Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
• Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.
• Includes in-vehicle (or in-transport) time with client provided it is identified as goal-directed, face-to-face, and approved/specifed as part of the client’s intervention plan (e.g. housing/apartment search, etc.).
• Includes crisis intervention and other goal-directed interventions via telephone with the identified client family.
• Includes time spent completing any DCS approved standardized tool to assess family functioning.

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

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

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

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

(Note on Intermittent supervised visitation: when DCS requests the provider to check in intermittently - at least once per hour - , the provider can bill in increments of 30 minutes for each check-in, provided that the total amount of time billed should not exceed the total length of the visit.)

Translation or sign language
Services include translation for families who are non-English language speakers or hearing-impaired and must be provided by a non-family member of the client. (Actual Cost).
Court
The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a written request (email or subpoena) from DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

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

Crisis Intervention/Response
Crisis Intervention includes, but is not limited to, crisis assessment, planning and counseling specific to the crisis. Most interventions are expected to be in the home. Crisis payment is for the “incident only”. The “incident for payment purposes for the provider will start at the time of a face to face contact with the client and end when that face to face contact ends. An hourly rate will be paid.

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

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

XII. Adherence to the DCS Practice Model
Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.
SERVICE STANDARD  
INDIANA DEPARTMENT OF CHILD SERVICES  
HOME-BASED FAMILY CENTERED THERAPY SERVICES  
(Revised 1/30/13-Effective 2/1/13)

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

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

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

- Family of origin/intergenerational issues
- Family organization (internal boundaries, relationships, roles)
- Stress management
- Self-esteem
- Communication skills
- Conflict resolution
- Behavior modification
- Parenting skills/Training
- Substance abuse
- Crisis intervention
- Strengths based perspective
- Adoption issues
- Participation in Child and Family Team meetings
- Sex abuse
- Goal setting
• Family structure (external boundaries, relationships, socio-cultural history)
• Problem solving
• Support systems
• Interpersonal relationships
• Therapeutic supervised visitation**
• Family processes (adaptation, power authority, communications, META rules)
• Cognitive behavioral strategies
• Brief therapy
• Family reunification/preservation
• Grief and loss
• Domestic violence education
• Reactive Attachment Disorder (RAD) support** Supervised Visits will be billed separately from other services within this standard. The “Visitation Monthly Progress Report” form must be used to report the supervised visitation portion of the services provided. The “Monthly Progress Report” will be used for the remainder.

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

14) Each family receives comprehensive services through a single HBFCT acting within a team, with team back up and agency availability 24 hours a day, 7 days a week.

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

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

IV. Crisis Service

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

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

Criteria for service:

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

V. When DCS is not paying for services:

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

VI. Target Population
Services must be restricted to the following eligibility categories:

1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or CHINS status.
2) Children and their families which have an IA or the children have the status of CHINS or JD/JS.
3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
4) Any child who has been adopted and adoptive families.
Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need.

VII. Goals and Outcomes
Goal #1 Maintain timely intervention with the family and regular timely communication with referring worker.
Objectives:
1) HCS or back-up is available for consultation to the family 24-7 by phone or in person.

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

Goal #2 Clients will achieve improved family functioning.
Objectives:
1) Goal setting, and service planning are mutually established with the client and Home Based Therapist within 30 days of the initial face-to-face intake and a written report signed by the Home Based Therapist and the client is submitted to the current FCM/Probation Officer.

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

Goal #3 DCS/Probation and clients will report satisfaction with services.
Outcome Measures:
1) DCS/Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
2) 90% of clients will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

VIII. Minimum Qualifications

MRO:
Providers must meet the either of the following qualifications:
  o Licensed professional, except for a licensed clinical addiction counselor
  o Qualified Behavioral Health Professional (QBHP)

DCS Direct Worker:

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

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

In addition to the above:

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

Supervisor:

Master’s or Doctorate degree in social work, psychology, marriage and family, or related human service field, with a current license issued by the Indiana Social Worker, Marriage and Family Direct Worker, or Mental Health Counselor Board as one of the following: 1) Clinical Social Worker, 2) Marriage and Family Direct Worker, 3) Mental Health Counselor.
Services provided will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued culturally-competent manner.

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

IX. Billable Units

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

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

<table>
<thead>
<tr>
<th>Billing Code</th>
<th>Title</th>
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<tbody>
<tr>
<td>H0004 HW</td>
<td>Behavioral health counseling and therapy, per 15 minutes</td>
</tr>
<tr>
<td>H0004 HW HR</td>
<td>Behavioral health counseling and therapy, per 15 minutes (family/couple, with consumer present)</td>
</tr>
<tr>
<td>H0004 HW HS</td>
<td>Behavioral health counseling and therapy, per 15 minutes (family/couple, without consumer present)</td>
</tr>
</tbody>
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DCS Funding: Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below. These billable units will also be utilized for services to referred clients who are not MRO eligible and for those providers who are unable to bill Medicaid.

Face to face time with the client:
(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)
• Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
• Includes crisis intervention and other goal-directed interventions via telephone with the identified client family.
• Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.
• Includes in-vehicle (or in-transport) time with client provided it is identified as goal-directed, face-to-face, and approved/specified as part of the client’s intervention plan (e.g. housing/apartment search, etc.).
• Includes time spent completing any DCS approved standardized tool to assess family functioning.

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

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

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

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

(Note on Intermittent supervised visitation: when DCS requests the provider to check in intermittently - at least once per hour - , the provider can bill in increments of 30 minutes for each check-in, provided that the total amount of time billed should not exceed the total length of the visit.)

Translation or sign language
Services include translation for families who are non-English language speakers or hearing-impaired and must be provided by a non-family member of the client. (Actual Cost)
Court  
The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a written request (email or subpoena) from DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

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

Crisis Intervention/Response  
Crisis Intervention includes, but is not limited to, crisis assessment, planning and counseling specific to the crisis. Most interventions are expected to be in the home. Crisis payment is for the “incident only”. The “incident for payment purposes for the provider will start at the time of a face to face contact with the client and end when that face to face contact ends. An hourly rate will be paid.

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

XI. Service Access  
All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.
XII. Adherence to the DCS Practice Model
Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.
SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
HOMEMAKER / PARENT AID
(Revised 1/30/13-Effective 2/1/13)

I. Service Description

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

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

- Resource management/Budgeting
- Child safety
- Child nutrition
- Home management
- Parenting skills
- Housing
- Self esteem
- Crisis resolution
- Parent/child interaction
- Supervision
*Homemaker transportation limited to client goal-directed, face-to-face as approved/specified as part of the case plan or goals/objectives identified at the Child and Family Team Meeting. (e.g. housing/apartment search, etc)

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

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

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

III. Crisis Service

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

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

Criteria for service:

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

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

V. Target Population

Services must be restricted to the following eligibility categories:

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

VI. Goals and Outcome Measures

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

Objective:

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

**Outcome Measure/Fidelity Measure:**

1) 95% of all families that are referred will have face-to-face contact with the client within 5 days of the receipt of the referral. Provider will inform the current/referring Family Case Manager/Probation Officer if the client does not respond to requests to meet within that time period.
2) 95% of families will have a written plan prepared regarding expectations of the family and homemaker/parent aid and sent to the current Family Case Manager/Probation Officer following receipt of the referral within 30 days of contact with the client.
3) 100% of all families will have monthly written summary reports prepared and sent to the current Family Case Manager or Probation Officer.
Goal #2  Improved family functioning including development of positive means of managing crisis.
Objective:
1) Service delivery is grounded in best practice strategies and building skills based on a strength perspective to increase family functioning.

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

Goal #3  Maintain satisfactory services to the children and family
Objective
1) DCS/Probation and clients will report satisfaction with services.

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

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

VII. Minimum Qualifications

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

Qualities:
Ability to work as a team member
Ability to work independently
Patience
Nonjudgmental
Emotional maturity
Knowledge of child development
Knowledge of community resources
Belief that change is possible
Strong organizational skills
Exercise sound judgment
Belief in family preservation philosophy
Knowledge of child abuse and neglect
Thorough and empathetic communication skills

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

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

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

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

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

Includes time spent completing any DCS approved standardized tool to assess family functioning.

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

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

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

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

(Note on Intermittent supervised visitation: when DCS requests the provider to check in intermittently - at least once per hour - , the provider can bill in increments of 30 minutes for each check-in, provided that the total amount of time billed should not exceed the total length of the visit.)

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

Court
The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a written request (email or subpoena) from DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.
**Reports**
If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.

**Crisis Intervention/Response**
Crisis Intervention includes, but is not limited to, crisis assessment, planning and counseling specific to the crisis. Most interventions are expected to be in the home. Crisis payment is for the “incident only”. The “incident for payment purposes for the provider will start at the time of a face to face contact with the client and end when that face to face contact ends. An hourly rate will be paid.

**IX. Case Record Documentation**
Case record documentation for service eligibility must include:

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

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

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

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

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

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

Licensed resource families supervised by DCS.

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

II. Goals and Outcome Measures

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

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

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

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

Goal #3 – DCS and foster family satisfaction with services

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

III. Minimum Qualifications

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

In addition to the above:

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

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

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

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

**IV. Billable Units Face to Face Time With the Client**

*Face-to-Face time with the client*

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

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed
- Includes crisis intervention and other goal directed interventions via telephone with the identified client family
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family
Reminder: Not included is routine report writing and scheduling of appointment, collateral contacts, court time, travel time and no shows. These costs are built into the cost of the face to face rate and shall not be billed separately.

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

V. Case Record Documentation
Necessary case record documentation for service eligibility must include:
- A completed, dated, signed DCS referral form authorizing service
- Documentation of on-going contact with the referred foster families/children and referring agency
- Monthly written reports, or more frequently if requested, regarding the progress of the family/children provided to the referring agency

VI. Service Access

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

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

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

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

II. Target Population

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

III. Goals and Outcome Measures

Goal #1
Retention of the current number of foster parents that are licensed
Outcome Measures
1) 90% retention of currently licensed foster families that continue to reside in the county.
2) 70% of licensed foster families participate in support meetings at least one time per year.

Goal #2
Develop an environment where foster families believe they are being heard and respected for the work they do.
Outcome Measures
1) 100% of foster families can report their belief that the DCS respects the work they do.
2) 10% increase in the number of foster families willing to accept special needs children and older youth based on the support received.

Goal #3
DCS and foster family satisfaction with services

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

IV. Minimum Qualifications

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

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

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.
V. Billing Units  
**Support Group**  
Per support group. A minimum of 3 foster parents must be in attendance in order to bill for this service.

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

VI. Case Record Documentation  
1) Support group sign in sheets including date and time of the group meeting  
2) Meeting room documentation

VII. Service Access  
Service can only be accessed by licensed foster families, prospective foster families, or adoptive families as identified by DCS either verbally or in written form.
I. Service Definition
This is an information-gathering and evaluation of the family and home environment and making recommendations to DCS, provide foster home licensing studies, and or updates/re-licensing studies. Collects information and evaluates the family and home in some combination of the following areas:

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

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

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

IV. Goals and Outcome Measures
Goal#1
Provide that foster care home studies/updates/re-licensing studies are completed timely.

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

Goal #2
DCS and foster family satisfaction with services

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

V. Minimum Qualifications
Direct Worker:
Bachelor's degree in social work, psychology, sociology, or a directly related human service field.

Supervisor:
Master's degree in social work, psychology, or directly related human services field.
Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.
In addition to:
• Knowledge of family of origin/intergenerational issues.
• Knowledge of child abuse/neglect.
• Knowledge of child and adult development.
• Knowledge of community resources.
Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.

VI. Billable Units

Hourly rate (up to 8 hours for foster home studies and 4 hours for updates and relicensing studies; additional hours must be approved by the referring DCS):
Includes face to face contact with the identified clients during which services as defined in the service standard are performed. Collateral contacts, travel time, mileage not to exceed the State rate of $.40, scheduling of appointments, and report writing are included in this billable unit.

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

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

Translation or sign language

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

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

VII. Case Record Documentation
Case record documentation for service eligibility must include:

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

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

5) A copy of treatment plan to include short/long term goals with measurable outcomes consistent with case plan/agreements in the CFTM. Goals to be updated with each new referral.

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

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

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

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

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

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

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

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

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

3) Other Services
• Consultation with Other Professionals
• Team Meetings
• Transportation

4) Psychiatric Services- hourly
• Assessments Outpatient
• Medication Follow-up/ Psychiatric Review

5) Respite Services
• Crisis Respite
• Planned Respite
• Respite-Residential or Hospital 23 Hour

6) Supervision Services
• Community Supervision
• Intensive Supervision

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

II. Specific Responsibilities
1) The Care Network Facilitator conducts the following activities for the system of care:
   • Evaluates and interprets referral packet application;
   • Schedules and facilitates in coordination with the DCS Family Case Manager (FCM) family/child specific team meetings;
   • Address need for and develop, revise and monitor a crisis plan with family and team members;
   • Monitor progress by communicating with the family and child, as well other team members through no less than monthly team meetings;
   • Maintains comprehensive reports based on services and assessments while providing information to FCM and team members every 30 days;
• Makes recommendations to team members based on monthly assessments and service reports;
• Assist the family and child with gaining access to services and assuring that families are aware of available community-based services and other resources such as Medicaid State Plan services, Vocational Rehabilitation programs, educational, and public assistance programs; mental health and addiction services as indicated;
• Monitor use of service and engage in activities that enhance access to care, improve efficiency and continuity of services, and prevent inappropriate use of services;
• Monitor health and welfare of the child/youth;
• May provide crisis intervention.

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

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

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

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

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

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

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

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

IV. When DCS is not paying for services:

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

V. Target Population

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

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

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

VI. Goals and Outcomes

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

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

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

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

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

Goal #2 Improved family functioning including development of positive means of managing
   crisis.
   Objectives:
   1) Service delivery is grounded in best practice strategies, using such approaches as cognitive
      behavioral strategies, motivational interviewing, change processes, and building skills based
      on a strength perspective to increase family functioning.

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

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

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

VII. Minimum Qualifications

Supervisor

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

Care Network Facilitator

1. Bachelor’s Degree in Social Work or related Human Service field; and,
2. Minimum of three years of clinical/management experience in human service field; and,
3. Demonstrated 2 or more years of clinical intervention skills; and,
4. Demonstrated skill in fiscal management activities, team building and development.

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

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

VIII. Billable Unit

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

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

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<tr>
<th>Billing Code</th>
<th>Description</th>
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<td>T1016 HW</td>
<td>Case Management, each 15 minutes</td>
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DCS holds overall Case Management responsibility. In order to assist DCS with the coordination of medically necessary behavioral health care needs of the MRO client, CMHC’s may provide case management services with this specific focus.

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

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

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

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

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

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

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

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

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

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

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

**XI. Adherence to the DCS Practice Model**
Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.
SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
CHINS PARENT SUPPORT SERVICES
(Revised 2/1/2012-Effective 3/1/2012)

I. Services Description

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

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

Family support group meetings must provide:

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

II. Target Population
Services must be restricted to the following eligibility categories:
1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with CHINS status.
2) Children and their families which have the status of CHINS.

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

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

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

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

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

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

IV. Minimum Qualifications

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

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

The CPSW must:

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

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

V. Billable Unit

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

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

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

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

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

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

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

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

VI. **Case Record Documentation**
Case record documentation for service eligibility must include:
1) A completed, signed, and dated DCS/Probation referral form authorizing services
2) Documentation of regular contact with the referred families/children
3) Written progress reports no less than monthly or more frequently as prescribed by
   DCS/Probation and requested supportive documentation such as case notes, social
   summaries, etc. Monthly reports are due by the 10th of each month following the month of
   service, case documentation shall show when report is sent.
4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of
   requests for documents given to DCS/Probation
VII. Service Access
All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

VIII. Adherence to the DCS Practice Model
Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.
I. Service Description
This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation. These services include the provision of structured, goal-oriented therapy for families affected by physical abuse, sexual abuse, emotional abuse, or neglect. Other issues, including substance abuse, dysfunctional families of origin, etc., may be addressed in the course of treating the abuse or neglect. In addition, counseling may be provided to address family or youth issues that resulted in the involvement of juvenile probation.

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

- Initial Assessment
- Conflict resolution
- Behaviors modification
- Identify systems of support
- Interpersonal relationships
- Communication skills
- Substance abuse awareness/family dynamics *
- Parenting skills
- Anger management
- Supervised therapeutic visits**
- Problem solving
- Stress management
- Goal-setting
- Domestic violence issues
- School problems
- Family of origin/inter-generational issues
- Sexual abuse – victims and caretakers of sexual abusers
- Substance abuse Counseling/Treatment must be done under the Service Standard “Substance Abuse Treatment” due to the specific legal qualifications of the provider, not under this counseling service standard.

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

II. Service Delivery
1) Services are provided at a specified (regularly scheduled) time for a limited period of time.
2) Service Settings:
   a. For services billable to DCS, services are provided face-to-face in the counselor’s office or other setting.
b. For services billable to Medicaid Clinic Option, the service setting is either outpatient or office setting.
c. For services billable to Medicaid Rehabilitation Option, the service must be provided at the client’s home or other at other locations outside the clinic setting.

3) Services will be based on objectives derived from the family’s established DCS/Probation case plan, Informal Adjustment, taking into consideration the recommendations of the Child and Family Team (CFT) and authorized by DCS/Probation referral, and subsequent written documents.

4) The counselor will be involved in Child and Family Team Meetings (CFTM) if invited.

5) Counselor must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.

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

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

8) Services must be provided at a time convenient for the family.

9) Services will be time-limited.

10) Written reports will be submitted monthly to provide updates on progress and recommendation for continuation or discontinuation of treatment. The DCS approved “Monthly Progress Report” form will be used.

III. Medicaid

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

IV. When DCS is not paying for services:

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

V. Target Population
Services must be restricted to the following eligibility categories:

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

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

VI. Goals and Outcome Measures
Goal #1 Maintain timely intervention with family and regular and timely communication with current Family Case Manager or Probation Officer.
Objectives
1) Therapist or backup is available for consultation to the family 24-7 by phone or in person.

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

Goal #2 Improved family functioning including development of positive means of managing crisis.
Objectives
1) Service delivery is grounded in best practice strategies, using such approaches as cognitive behavioral strategies, motivational interviewing, change processes, and building skills based on a strength perspective to increase family functioning.
Client Outcome Measures:
1) 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period.
2) 90% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of “substantiated” abuse or neglect throughout the service provision period. (To be measured/evaluated by DCS/Probation staff)
3) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.

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

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

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

MRO billable:
Providers must meet the either of the following qualifications:
• Licensed professional, except for a licensed clinical addiction counselor
• Qualified Behavioral Health Professional (QBHP).

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

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

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

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

In addition to the above:

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

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

**VIII. Billable Units**

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

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

Services through the Medicaid Rehab Option (**MRO**) may be **group** Behavioral Health Counseling and Therapy.
### Billing Code | Title
--- | ---
H0004 HW U1 | Behavioral health counseling and therapy (group setting), per 15 minutes
H0004 HW HR U1 | Behavioral health counseling and therapy, per 15 minutes (family/couple, group setting, with consumer present)
H0004 HW HS U1 | Behavioral health counseling and therapy, per 15 minutes (family/couple, group setting, without consumer present)

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

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

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

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

**Supervised Visit:**
**Time spent supervising visits will be billed separately from other services within this standard. The rate will be the same as the face-to-face rate, but will include only time spent face-to-face supervising the visit. Any other billable time as defined in the face-to-face rate, should be billed under the face-to-face rate.
**Per person per group hour**
Services include group goal directed work with clients. To be billed per client per hour attended.

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

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

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

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

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

**IX. Case Record Documentation**
Case record documentation for service eligibility must include:

1) A completed, signed, and dated DCS/Probation referral form authorizing services
2) Documentation of regular contact with the referred families/children
3) Written progress reports no less than monthly or more frequently as prescribed by DCS/Probation and requested supportive documentation such as case notes, social summaries, etc. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation
X. Service Access
All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

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

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

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

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

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

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

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

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

3) Other Services
• Consultation with Other Professionals
• Team Meetings
• Transportation

4) Psychiatric Services
• Assessments Outpatient
• Medication Follow-up/ Psychiatric Review

5) Respite Services
• Crisis Respite
• Planned Respite

6) Supervision Services
• Community Supervision
• Intensive Supervision

7) All Out of Home Placements

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

II. Service Delivery
1) The Care Coordinator has the specific responsibilities for the following:
   • Evaluates and interprets referral packet information and completes a strength based assessment with child and family and the Child and Adolescent Needs and Strengths Assessment (CANS).
• Collaborate with the Family Case Manager (FCM)/Probation Officer in convening the family members, service providers and other child and family team members to form a collaborative plan of care with clearly defined goals.
• Addresses need for and develops, revises and monitors crisis plan with family and team members.
• Ensures that parent and family involvement is maintained throughout the service period so that families have continual voice and choice in their care.
• Maintains ongoing dialogue with the family and providers to assure that the philosophy of care is consistent and that there is progress toward service goals. Evaluates the progress and makes adjustments as necessary.
• Maintains central file consisting of treatment summaries, payment and resource utilization records, case notes, legal documents and releases of information.
• Facilitates the closing of the case and oversees transition to any ongoing care.
• Uses resources and available flex funding to assure that services are based specifically on the needs of the child and family.
• Able to deliver strength based, family centered, culturally competent services.
• Able to interpret psychiatric, psychological and other evaluation data, and use that information in the formation of a collaborative plan of care.
• Able to complete all documentation using a computerized clinical record.
• Creativity, flexibility and optimism about the strengths of children and their families.

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

3) The initial face-to-face contact with the family must occur no later than two (2) business days following receipt of the completed referral or as requested by the referring worker.

4) An abbreviated assessment to determine service tier is based on the needs of the youth and family and is mutually established between the referral source and care coordinator within 14 days of completed referral. Goal setting and service planning are mutually established between the youth, caregiver, care coordinator, providers and referral source based upon the comprehensive assessment within 21 days of the completed referral.

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

6) Regular assessment of needs and strengths of the youth and family will be completed and discussed within the Child and Family team to guide decision making on services and supports for the youth and family. System-related concerns and directives are included in these team discussions as well.
7) Safety is of paramount importance. If there are concerns about safety within the home there is an obligation for the care coordinator and the current worker to communicate to address all safety concerns, and document safety steps taken to resolve the issues. If new incidences occur, the care coordinator is to notify the current worker immediately of the situation.

8) Confidentiality must be maintained. Failure to maintain confidentiality may result in termination of the service agreement.

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

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

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

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

B) Improved records with the child welfare and juvenile justice system
   • 85% of families with no further substantiated incidences of child abuse or neglect, which results in removal of the child from the home for a period of six and twelve months from dis-enrollment.
   • In 85% of cases where delinquency, runaway, truancy or violations of probation are identified as an issue, children will have no further substantiated incidences which results in placement failure during enrollment.
   • In 85% of cases where delinquency, runaway, truancy or violations of probation are identified as an issue, children will have no further substantiated incidences which results in placement failure for a period of six and twelve months from dis-enrollment.
C) Improved CANS scores
• 50% of the children and families will have statistically significant improvement in any life domain on the CANS (functioning, behavioral health systems, risks, caretaker needs and strengths, child’s strengths)

D) Progress in Service Coordination Plan
• Child will show progress in goals established in the individual plan as measured by monthly team report and Care Coordinator Treatment Plan

Increased family autonomy
A) Assist the family to increase informal supports and reduce reliance on formal service providers.
• 95% of families will increase the number of informal supports.
• 95% of families will have a reduced need for service providers.

B) Caregiver Strain Questionnaire
• Increase family autonomy or maintain satisfactory family autonomy as measured by the Caregiver Strengths and Needs Dimension of the CANS in 80% of cases.

V. Minimum Qualifications

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

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

Care Coordinator:
Bachelor’s Degree in Social Work or related Human Service field; and, Minimum of three years of clinical/management experience in human service field; and, Demonstrated clinical intervention skills over 2 or more years; and, Demonstrated skill in fiscal management activities, team building and development

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral valued culturally competent manner.
The Care Coordinator assures care is delivered in a manner consistent with strength-based, family centered, and culturally competent values, offers consultation and education to all providers regarding the values of the model, monitors progress toward treatment goals and assures that all necessary data for evaluation is gathered and recorded.

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

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

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

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

VII. Standard Rates

<table>
<thead>
<tr>
<th>Levels</th>
<th>150 Youth</th>
<th>225 Youth</th>
<th>300 Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$51.45</td>
<td>$49.08</td>
<td>$46.72</td>
</tr>
<tr>
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<tr>
<td>4</td>
<td>$213.70</td>
<td>$211.33</td>
<td>$208.96</td>
</tr>
</tbody>
</table>

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

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

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

X. Adherence to the DCS Practice Model
Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.
SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
DIAGNOSTIC AND EVALUATION SERVICES
(Revised 2/1/12-Effective 3/1/12)

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

II. Service Delivery

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

- Bio-psychosocial assessment (including initial impressions of parent functioning)
- Diagnosis (if applicable)
- Summary of Recommended Services and Service Approach

1. The completed report will utilize the DCS standardized report format for Diagnostic Evaluation Services. The report should be completed with a summary to DCS within 15 calendar days of referral.
2. The service provider may recommend psychological testing, neuropsychological testing and/or psychiatric consultation/medication evaluation as a result of the bio-psychosocial assessment. If psychological testing or neuropsychological testing is recommended, the service provider should include in the report the specific issues/questions the testing should address. A new referral under this service standard will be required for these services.
3. The service provider may recommend a Parenting/Family Functioning Assessment. Justification as to why this level of assessment is necessary should be included in the report. A new referral Parenting/Family Functioning Assessment will be required for this service.

**Psychological Testing**

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

**Neuropsychological Testing**

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

**Medication Evaluation**

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

**Ongoing Medication Monitoring**

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

**Child Hearsay Evaluation**

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

**Comprehensive Report**

Comprehensive psychological evaluations include a detailed history of the client in order to obtain symptom development and configuration, and include objective/standardized psychological testing results. Collateral data is also collected, and includes but is not limited to interviews with service providers, treatment records of inpatient and outpatient care, and information with family members.
The comprehensive report will integrate all data into a summary of the issues creating barriers to reunification, explain the psychological diagnosis, and will provide recommendations for treatment. If requested reports can make recommendations regarding parental functioning or the prognosis of the permanency options.

III. When DCS is not paying for services:

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

IV. Target Population

Services must be restricted to the following eligibility categories:

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

V. Goals and Outcomes

Goal #1
Timely receipt of evaluations.
Objective:
1) Service provider to submit written report to the referring Family Case Manager within the designated time frames of completion of evaluation.

Outcome Measure/Fidelity Measure
1) 95% of the evaluation reports will be submitted to the referring Family Case Manager within specified service delivery time frames.
Goal #2
Obtain appropriate recommendations based on information provided.
Outcome Measure
1) 100% of reports will meet information requested by the referring Family Case Manager/Probation Officer.
2) 100% of reports will include recommendations for treatment, needed services or indicate no further need for services.

Goal #3
Client satisfaction with service provided.
Outcome Measure
1) DCS and/or probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
2) A random Sample of Satisfaction Surveys will be completed at the conclusion of services.

VI. Minimum Qualifications

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

- Master's degree in social work, psychology, marriage and family therapy, or related human services field.

- Masters degree with a clinical license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board, as one of the following: 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor.

Clinical Interview and Assessment Reimbursed by Medicaid:

Subject to prior authorization by the office or its designee, Medicaid will reimburse physician or HSPP directed outpatient mental health services for group, family, and individual outpatient psychotherapy when such services are provided by one (1) of the following practitioners:
(A) A licensed psychologist.
(B) A licensed independent practice school psychologist.
(C) A licensed clinical social worker.
(D) A licensed marital and family therapist.
(E) A licensed mental health counselor.
(F) A person holding a master's degree in social work, marital and family therapy, or mental health counseling
(G) An advanced practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing.

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

**Psychological & Neuropsychological Testing Reimbursed by DCS:**

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

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

(A) A licensed psychologist.
(B) A licensed independent practice school psychologist.
(C) A person holding a bachelor’s degree and one (1) of the following:
   (i) twenty (20) hours of documented specific instruction and direct supervision by a physician or HSPP psychologist at the performance site on the tests to be used including instruction on administration and scoring and practice assessments with non-patients and final approval to administer the specific instruments by a physician or HSPP psychologist at the performance site; or
   (ii) status as a psychology intern enrolled in an American Psychological Association (APA)-approved internship program.
(D) A psychology resident enrolled in an APA-approved training program or APPIC recognized internship or post-doctoral program.
(E) An individual certified by a national organization in the administration and scoring of psychological tests.
The physician and HSPP are responsible for the interpretation and reporting of the testing performed. The physician and HSPP must provide direct supervision and maintain documentation to support the education, training, and hours of experience for any practitioner providing services under their supervision. A cosignature by the physician or HSPP is required for services rendered by one of the lower level practitioners.

**Psychological & Neuropsychological Testing reimbursed by Medicaid:**

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

(A) A physician.
(B) An HSPP.
(C) The following practitioners may only **administer** neuropsychological and psychological testing under the direct supervision of a physician or HSPP:
   1. A licensed psychologist.
   2. A licensed independent practice school psychologist.
   3. A person holding a master's degree in a mental health field and one (1) of the following:
      (a) A certified specialist in psychometry (CSP).
      (b) Two thousand (2,000) hours of experience, under direct supervision of a physician or HSPP, in administering the type of test being performed.

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

**Medication Evaluation and Ongoing Medication Management:**

(A) Physician
(B) Advanced Practice Nurses (Nurse Practitioners or Certified Nurse Specialists) with a 1) master or doctoral degree in nursing with a major in psychiatric or mental health nursing, 2) from an accredited school of nursing.
If working as an Authorized Health Professional staff must 1) be an Advance Practice Nurse as described above, 2)and prescriptive authority, 3)must work within the scope of his/her license and 4) have a supervisory agreement with a licensed physician.

**VII. Billable Unit**

**Medicaid:**

Department of Child Services
Regional Document for Child Welfare Services
Term 7/1/11-6/30/13
February 5, 2013
It is expected that the diagnostic and assessment services provided under this standard will be based in the clinic setting. Medicaid shall be billed when appropriate. Services will be billable by utilizing the 90000 codes.

**DCS Funding:**

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

- **Clinical Interview and Assessment:** Hourly Rate-Face to Face time with a client. Plus a maximum of 1 hour may be billed for report writing.

- **Psychological Testing:** Per Hour. Includes time face to face with the client and time spent administering, scoring, and interpreting testing. Plus a maximum of 1 hour may be billed for report writing.

- **Neuropsychological Testing:** Per Hour. Includes time face to face with the client and time spent administering, scoring, and interpreting testing. Plus a maximum of 1 hour may be billed for report writing.

- **Medication Evaluation:** per hour face to face with the client. Plus a maximum of ½ hour may be billed for report writing.

- **Ongoing Medication Monitoring:** per hour face to face with the client.

- **Child Hearsay Evaluation:** per hour face to face with the client. Plus a maximum of ½ hour may be billed for report writing.

- **Comprehensive Report:** per hour. Additional hours can be billed when prior DCS approval is given. The Comprehensive Report includes extra collateral contacts and a more extensive written report.

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

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

- **Medication:** Actual Cost

  The provider must access all sample medication resources and other medication sources (e.g., MAP) and pharmaceutical companies that provide free or reduced cost medications prior to billing DCS. Documentation of these efforts must be maintained in the case file.
• **Court:** The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a written request (email or subpoena) from DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

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

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

**VIII. Case Record Documentation**
Necessary case record documentation for service eligibility must include:

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

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

**X. Adherence to the DCS Practice Model**
Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.
A Batterers Intervention Program (BIP), Certified by the Indiana Coalition Against Domestic Violence (ICADV), shall be utilized by DCS as a preferred contract provider of services for domestic violence offenders/batterers in keeping with I.C. 35-50-9. If a contract service provider is needed in an area in which an ICADV Certified BIP is not available, the service provider must adhere to the DCS standards listed below.

I. Service Description

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

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

II. Service Delivery

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

1) The provider and the agency operating the program will not provide couples counseling involving the batterer until after the batterer/participant has successfully completed the program, and not thereafter if facilitators and advocates have reason to be concerned about the victim or child safety.

2) As a condition of program completion, each participant must attend a minimum of 26 weekly sessions, consisting of at least 1.5 hours each. Two of these sessions can be used for the orientation/intake and for the exit/program termination interviews.

3) A minimum of 24 of the 26 sessions will be group sessions.

4) Class size should not exceed 18.
5) The provider will establish objective criteria for program completion that will be enforced uniformly.
6) All on-going batterers’ groups shall be conducted by qualified personnel.
7) The provider will have an established procedure for notification of victim/survivor/partner about expulsion and/or completions.
8) Any communication regarding program completion must include the following statement: *Program completion does not guarantee the absence of future violence or abusive behavior.*
9) The batterer may pursue other service methods after satisfactory completion of group services as determined and documented by BIP provider staff. The batterer should only be included in marital/couples or family services if the batterer has done extensive work to change violent behavior and there is proof of progress. The batterer should not be included in marital/couples or family services if there is reason to be concerned about the survivor/child’s safety or wellbeing.
10) Services must be available to participants who have limited daytime availability.
11) Provider must respect confidentiality unless otherwise specified by the client-provider contract. Failure to maintain confidentiality may result in immediate termination of the service agreement between DCS and the provider.

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

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

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

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

1) Indiana Department of Child Services;
2) The referral source, if legally mandated;
3) The court, prosecutor, police, probation and child protective agency of the referring county;
4) The victim/partner/survivor or her/his designated advocate;
5) Administrative and professional personnel who need information for record-keeping, monitoring, or professional development.
6) Any entity or person to whom the provider is legally bound to report suspected abuse or neglect of a child or protected adult;
7) Any person to whom the provider must report in order to fulfill its duty to warn or protect.

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

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

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

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

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

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

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

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

III. When DCS is not paying for services:

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

IV. Target Population

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

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

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

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

Fidelity Measures:

Program fidelity/abiding by “best practices” is perhaps the best predictor of successful outcomes and provides an effective indirect measure. An audit undertaken by a DCS employee or designee may be conducted to assure program accountability. Programs must clearly link daily practices to the following program fidelity issues:
1) 90% of the supportive services (shelters, law enforcement, courts, advocates, legal agencies etc.) have a cooperative working relationship with the provider.
2) 100% of the BIP provider staff focus on victim safety as evidenced by adherence to appropriate policies and procedures of the provider agency.
3) 100% of program participants have an opportunity to participate in same-gender group sessions within 30 days of the referral.
4) 75% of programs are available to participants who have limited daytime availability.
5) 100% of groups are conducted by qualified personnel (see qualification section).
6) 100% of the BIP referrals are offered a 26-week group curriculum for batterers.
7) 80% of referrals have a provider contact attempted within 72 hours of referral and outcome of contact is documented.
8) 100% of program participants sign an agreement/contract as outlined by ICADV Policies and Procedures for BIP providers.
9) 100% of BIP providers will require staff to warn and protect victims, partners, children and others when and if the batterer has made a threat of violence as evidenced by adherence to appropriate policies and procedures of the provider agency.

VI. Minimum Qualifications
A. Initial Qualifications
Individuals must meet one of the following ICADV criteria in order to be deemed a qualified service provider by DCS:
1. Co-Facilitator: To qualify to co-facilitate a class or group session with a qualified Supervisor/Trainer or Facilitator, an individual must show:
   a. Evidence of 60 hours of formal training approved by ICADV. A minimum of 40 hours of this training must be specific to domestic violence. The remaining 20 hours
shall include evidence of training in each of the following areas of group facilitation skills, cultural diversity, substance abuse, and mental health.

b. Evidence of observing a minimum of 26 different ICADV-approved sessions.

2. Facilitator: To qualify to facilitate an individual must show:
   a. Evidence of meeting all the requirements of a Co-facilitator.
   b. 100 hours of formal training approved by ICADV. A minimum of 60 hours of this training must be specific to domestic violence. The remaining 40 hours shall include evidence of training in each of the following areas of group facilitation skills, cultural diversity, substance abuse, and mental health.
   c. Evidence of co-facilitating a minimum of 26 additional sessions with a Supervisor/Trainer.

3. Supervisor: To qualify to supervise an individual must show:
   a. Evidence of meeting all the requirements of a Facilitator.
   b. 120 hours of formal training approved by ICADV. A minimum of 80 hours of this training must be specific to domestic violence. The remaining 40 hours shall include evidence of training in each of the following areas of group facilitation skills, cultural diversity, substance abuse, and mental health.
   c. Evidence of facilitating a minimum of 26 additional sessions as a Facilitator under a Supervisor/Trainer.

4. Trainer: To qualify to train staff or others related to work, an individual must show:
   a. Evidence of fulfilling the requirements of a Supervisor.
   b. Evidence of a minimum of 3 years experience as a supervisor (or the equivalent thereof).
   c. Evidence of successfully completing the “train the trainer” offered by ICADV

VII. Billable Units

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

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

Therapeutic Per Person Per Group
Services include group goal directed work with clients. To be billed per client per hour attended. Group must be facilitated by a licensed Master-level Social Worker.

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

Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:
• 0 to 7 minutes  do not bill  0.00 hour
• 8 to 22 minutes  1 fifteen minute unit  0.25 hour
• 23 to 37 minutes  2 fifteen minute units  0.50 hour
• 38 to 52 minutes  3 fifteen minute units  0.75 hour
• 53 to 60 minutes  4 fifteen minute units  1.00 hour

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

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

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

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

Therapeutic DV Batterer Intervention
Alternative approaches (e.g., therapeutic) with special approval from DCS.

VIII. Case Record Documentation
Necessary case record documentation for service eligibility must include:
1) A completed, signed, and dated DCS/Probation referral form authorizing services
2) Documentation of regular contact with the referred families/children
3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
4) Copy of DCS/Probation case plan, informal adjustment documentation
IX. Service Access
All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

X. Adherence to the DCS Practice Model
Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.
SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
DOMESTIC VIOLENCE SURVIVOR AND CHILD INTERVENTION SERVICES
(Revised 2/1/12-Effective 3/1/12)

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

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

Services provided may include the following:

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

- Conflict resolution
- Behavior modification
- Substance abuse assessment

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

A. Child Services
1) Provider assessment shall occur within 24 hours after initiation of services, upon receipt of DCS/Probation referral. Children will receive an initial assessment of needs when DCS/Probation indicates imminent risk/immediate safety concerns. A full assessment shall be available to DCS/Probation no later than four (4) working days after receipt of DCS referral.
2) Assessments shall include, but are not limited to: safety and risk factors for the child; child abuse/neglect; food/shelter/clothing; the parent/child relationships; screening for other co-occurring issues (substance abuse, mental health issues, behavioral issues, social impairment,
3) A child safety plan shall be developed. (Note: the child must be willing and able to use the plan, and have the ability to opt out of any step in the plan if needed.) Comprehensive safety plans that are age and developmentally appropriate will be developed. Plans at a minimum will include: input from the non-abusive parent and be age appropriate; input from the child when appropriate; identification of safe places to go inside/outside of the home during violence; identification of where to meet if exiting the home is necessary; identification of how and when to use the phone for help; and identification of how to stay safe during an argument/violence.

4) The provider shall develop a comprehensive domestic violence service plan based on the assessment. Plans, at a minimum, will identify the needs of the child, set goals for the child, and establish a timeline for the accomplishment of goals in plan.

5) Advocacy and support services shall be provided as needed and as consistent with the assessment. These services shall include, but are not limited to, crisis intervention, links to community resources, Court Appointed Special Advocate (CASA)/ Guardian Ad Litem (GAL), information, and referral.

6) Services should be provided in the method consistent with the assessment and comprehensive domestic violence service plan and may include: individual or group services, play services, group play services, family services, support groups, and casework/victim advocacy services.

7) Group services for children, if provided, are to occur in weekly sessions at least one (1) hour in length. The number of weekly sessions will be determined by the provider and DCS/Probation based on the child’s individual needs. Class size shall contain a minimum of three (3) participants and is not to exceed twelve (12) participants.

8) Group curriculum will be age appropriate and shall include, but is not limited to: promoting safe discussion of experiences with violence; helping the child understand that violence is not their fault and/or the fault of the survivor; helping the child understand and cope with their emotional responses to domestic violence; helping children identify, label, and express their feelings; exploring the child’s attitudes and beliefs about families and family violence; and teaching children how to effectively manage their own anger.

B. Survivor Services

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

Provider assessment shall occur within 24 hours after initiation of services, upon receipt of DCS/Probation referral. Survivors will receive an initial assessment of needs when DCS/Probation indicates imminent risk/immediate safety concerns. A full assessment shall be available to DCS/Probation no later than four (4) working days after receipt of DCS/Probation referral.
Assessments shall include, but are not limited to, safety and risk factors for the survivor and his/her child(ren), emergency medical/dental care, legal assistance, food/shelter/clothing, parenting needs and the parent/child relationship, and screening for other co-occurring issues (substance abuse, mental health issues, etc.).

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

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

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

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

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

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

III. When DCS is not paying for services:

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

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

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

V. Goals and Outcomes
Goal #1: To Improve Safety of Survivors

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

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

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

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

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

Client Outcome Measures:
1) 100 % of survivors report an increased knowledge and understanding of the effects of domestic violence on their children.
2) 90% of survivors report an increased understanding of parenting skills and appropriate discipline.
3) 90% of survivors report an increased knowledge on how to interact with the batterer on issues dealing with the best interest of the child.
4) 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period.
5) 90% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of “substantiated” abuse or neglect throughout the service provision period. (To be measured/evaluated by DCS/Probation staff)
6) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.
7) If DCS elects to implement a standardized tool for evaluating family functioning, a related outcome measure will be added.

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

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

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

1) 90% of families receive their first contact (telephone, mail or face-to-face) no later than the end of the first day following receipt of a referral from DCS/Probation.
2) 100% of referrals that are not seen within 24 hours of referral will be reported to the referral source.
3) 90% of required written domestic violence service plans/assessments will be completed and sent to the referring worker within 10 days of face-to-face intake with the client/family.
4) 90% of the community supportive services (BIP providers, law enforcement, courts, advocates, legal agencies, etc.) have a cooperative working relationship with the provider.
5) 100% of provider staff focus on child/victim safety as evidenced by adherence to appropriate provider policies and procedures.
6) 100% of program activities are carried out by qualified staff (see Qualifications).
7) 90% of programs are available to participants who have limited daytime availability.
8) 100% of provider staff are required to warn and protect children and victims and others when and if the batterer has made a threat of violence.
9) 100% of clients (children and victims) will have a comprehensive domestic violence service plan developed.
10) 100% of children referred and engaged in the program will have a developmentally-appropriate safety plan developed by provider staff.
11) 100% of clients will be able to access a provider staff in the event of an emergency, 7 days a week, 24 hours a day.

VI. Minimum Qualifications

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

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

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

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

Supervision/consultation is to include not less than one (1) hour of face-to-face supervision/consultation per 20 hours of direct client services provided, nor occur less than every two (2) weeks.
Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with “best practices” and comply with the requirements of each provider’s accreditation body. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies. Under no circumstances is supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.

In addition to the above:

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

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

VII. Billable Units

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

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

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.
- Includes crisis intervention and other goal-directed interventions via telephone with the identified client family.
Reminder: Not included are routine report writing and scheduling of appointments, collateral contacts, travel time and no shows. These activities are built into the cost of the face- to-face rate and shall not be billed separately.

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

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

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

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

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

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

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

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

X. Adherence to the DCS Practice Model
Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.
SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
FATHER ENGAGEMENT PROGRAMS
(Revised 8/1/12-Effective 8/1/12)

I. Service Description

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

II. Service Delivery

• The direct worker’s home office will be located in a DCS office where most of the services outlined in this standard can be performed. The provider will secure and maintain a working relationship with the Family Case Managers and other relevant DCS staff to provide a liaison between the fathers and DCS. When Family Case Managers have exhausted all known diligent search efforts and inquiries, providers will assist in locating and engaging fathers (including those who may be incarcerated or who live out of state).

• The provider will actively engage referred fathers with the goal of increasing their involvement in the DCS case.

• The provider will conduct intake interviews, and collect demographic and other outcome data for reporting purposes. Services must include ongoing monitoring of father/parental progress.

• The provider will work collaboratively with DCS, other contracted service providers, community organizations, and individuals to develop, maintain, and provide appropriate programming for fathers whose children are involved in the child welfare system.

• The provider will possess a clear understanding of male learning styles and male help seeking behaviors and will practice effective techniques for father engagement through a non-judgmental, holistic viewpoint regarding father/child relationship, focusing on the child in the context of the family.

• Refers participants, when indicated, to community resources and other organizations.
• Promotes community awareness regarding the value of engaging fathers of children involved in the child welfare process, through presentation and written materials.

• Develop a working relationship with local child support enforcement offices and staff members in order to be of mutual assistance in helping obtain appropriate financial support of children.

• Services will be provided at times convenient for or necessary to meet the family’s need, not according to a specified work week schedule.

• Services will be provided in home, in the community environment, in the DCS office, and/or the providers’ office.

• Services will be based on the family’s established DCS Case Plan-Disposition or Informal Adjustment, while taking into consideration the recommendation of the Child and Family Team as applicable.

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

• The provider will coordinate and provide Fatherhood Programming utilizing a DCS approved educational curricula such as Bringing Back The Dads, National Partnership for Community Leadership, Bridges Out of Poverty (any other curricula must have prior approval). The Programming can be provided through the use of group or one-on-one sessions. All curricula must include child support enforcement education and financial responsibility education. In addition, the Fatherhood Programming and other individual work with the father, may provide any combination of the following kinds of services:
  ➢ information regarding the CHINS legal process including court procedures, parental participation requirements, court ordered services, visitation with the children, reimbursement of cost for services, and other aspects related to the legal process;
  ➢ the expectations of the family related to participation in court ordered services and visitation with the children, attendance at court, appropriate dress for court, and other aspects related to the legal process;
  ➢ information regarding the parent’s rights and the CHINS proceedings, the length of time children may be in care prior to a permanency procedure, and termination of parental rights, family team meetings and their procedures
  ➢ role of the Court Appointed Special Advocate or Guardian ad Litem,
  ➢ an informal environment for fathers to discuss issues that brought them to the attention of the DCS and develop suggestions that may assist in resolving these issues as a group, and;
educational programs using speakers recruited from the local professional community to assist and educate the fathers in areas such as:
- abuse and neglect,
- increasing parenting skills,
- substance abuse,
- anger management,
- advocacy with public agencies including the children’s schools, and;
- issues of interest to the parents related to their needs and the needs of their children.
- coaching and information to develop attitudes and social skills needed for improved family relations and personal responsibility.
- After consultation with the Family Case Manager, providers will make concerted, organized and systematic efforts to connect children with their incarcerated father (if applicable), through video conferencing, face to face contact, correspondence and by telephone, unless the court has determined that visiting would put the child in danger.
- Supports fathers and paternal relatives in court and Child and Family Team Meetings by providing transportation and/or transportation voucher when appropriate.

III. When DCS is not paying for services:

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

IV. Target Population

Services must be restricted to the following eligibility categories:
- Fathers of children who have substantiated cases of abuse and/or neglect and will likely develop into an open case an IA or CHINS status.
- Fathers of children which have an Informal Adjustment (IA) or the children have the status of CHINS.

V. Goals and Outcome Measures

Goal #1
Department of Child Services
Regional Document for Child Welfare Services
Term 7/1/11-6/30/13
February 5, 2013
Timely initiation of services with the fathers.
Outcome Measures

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

Goal #2
Timely receipt of electronic outcome reports.
Outcome Measures

100% of reports will be received timely. The report will include a summary of services to each father as well as the father’s involvement with the child (ren) and father’s parental progression as evidence by visitation supervised and unsupervised with child (ren), participation in Child and Family Team Meetings, fathers involvement in the DCS case plan, established paternity and if the father is paying child support. The summary will also include engagement in fatherhood curriculum and/or successfully/unsuccesful completion of referral sources will be provided to the referring FCM monthly. An approved excel spread sheet, documenting services, will be electronically forwarded to Central Office designated email address, no later then the 10th of each month. An approved monthly report, documenting services to each referred father, will be forwarded to the FCM, no later then the 10th of each month.

Goal #3
Engage fathers in services that will reduce barriers to safety, stability, well-being and permanency for their children.
Outcomes Measures

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

Goal #4
Coordinate efforts between the department of corrections and/or local detention facilities, child welfare agencies, and the courts to ensure the incarcerated father is notified of court proceedings regarding the care and custody of their child (ren) when appropriate.
Outcome Measures

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

Goal # 5
All engaged fathers will complete a service satisfaction survey. DCS will randomly evaluate services provided to ensure services provided are in accordance with contract requirements and reflective of the practice model.

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

Goal #6
Maintain satisfactory services to the children and family

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

VI. Minimum Qualifications

Direct Worker:
Bachelor’s degree in social work, psychology, sociology, or a directly-related human service field from an accredited college. Other Bachelor’s degrees will be accepted in combination with a minimum of five years experience working directly with families in the child welfare system. Must possess a valid driver’s license and the ability to use private car to transport self and others, and must comply with the state policy concerning minimum car insurance coverage.
In addition to the above:
- Knowledge of child abuse and neglect, and child and adult development
- Knowledge of community resources and ability to work as a team member
- Belief in helping clients change their circumstances, not just adapt to them
- Belief in adoption as a viable means to build families
- Understanding regarding issues that are specific and unique to adoptions such as loss, mismatched expectations and flexibility, loss of familiar surroundings, customs and traditions of the child’s culture, entitlement, gratification delaying, flexible parental roles and humor

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

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

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

VII. Billing Units

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

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.
- Includes no more than 5 hours of time spent locating fathers including making telephone calls, attempted face-to-face contacts, collateral contacts, or completing online searches.
- Billing for additional collateral contacts can be approved by DCS when attempting to locate and/or engage an incarcerated client or client living out of state.

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

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

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

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

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

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

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

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

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

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

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

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

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

II. Service Delivery

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

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

- **Phase 1: Engagement and Motivation**
  During these initial phases, FFT applies reframing and related techniques to impact maladaptive perceptions, beliefs, and emotions and to emphasize within the youth and family, factors that protect youth and families from early program dropout. This produces increasing hope and expectation of change, decreasing resistance, increasing alliance and trust, reduced oppressive negativity within the family and between the family and community, increased respect for individual differences and values, and motivation for lasting change.

- **Phase 2: Behavior Change**
  This phase applies individualized and developmentally appropriate techniques such as communication training, specific tasks and technical aids, basic parenting skills, and contracting and response-cost techniques.

- **Phase 3: Generalization**
  In this phase, Family Case Management is guided by individualized family functional needs, their interaction with environmental constraints and resources, and the alliance with the therapist to ensure long-term support of changes. FFT links families with available community resources and FFT therapists intervene directly with the systems in which a family is embedded until the family is able to do so itself.

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

Program certification must be obtained and maintained through utilizing Functional Family Therapy certified trainers to train a site supervisor and therapists. Program fidelity must be maintained through adherence to using a sophisticated client assessment, tracking and monitoring system and clinical supervision requirements.
III. Target Population
Services must be restricted to the following eligibility categories:
1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
4) All adopted children and adoptive families.

IV. Goals and Outcome Measures
Goals #1 Services are provided timely as indicated in the service description above.

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

Goal #2 Improved family functioning as indicated by no further incidence of the presenting problem
Objective:
1) Service delivery is grounded in best practice strategies, using such approaches as cognitive behavioral strategies, motivational interviewing, change processes, and building skills based on a strength perspective to increase family functioning.

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

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

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

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

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

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

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

VI. Billable Unit
Face to face time with the client:
(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)
• Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
• Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.
• Includes crisis intervention and other goal-directed interventions via telephone with the identified client family.

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

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

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

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

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

VII. Case Record Documentation
Case record documentation for service eligibility must include:
1) A completed, signed, and dated DCS/ Probation referral form authorizing services
2) Documentation of regular contact with the referred families/children

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3) Written progress reports no less than monthly or more frequently as prescribed by DCS/Probation and requested supportive documentation such as case notes, social summaries, etc. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.

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

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

IX. Adherence to the DCS Practice Model
Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.
SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
PARENT EDUCATION
(Revised 2/1/12-Effective 3/1/12)

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

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

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

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

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

Parent Training Strategies include:
• Encourage Peer Support
• Involve Fathers
• Promote Positive Family Interaction
• Use Interactive Training Techniques
• Provide Opportunities to Practice New Skills

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

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

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

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

An examination of family interaction patterns should identify several significant improvements at postprogram assessment, including family cohesion, family expressiveness, and family independence, whereas family conflict significantly decreased.
II. When DCS is not paying for services:

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

III. Target Population

Services must be restricted to the following eligibility categories:

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

IV. Goals and Outcome Measures

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

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

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

**Outcome Measures**

1) 75% of the parents referred to program will complete the services.
2) 90% of the parents completing the program will show a demonstrated increase in skills during the in home postprogram assessment.
3) 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period.
4) 90% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of “substantiated” abuse of neglect throughout the service provision period.
5) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.

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

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

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

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

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

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

In addition to:

- Knowledge of child abuse and neglect
- Knowledge of child and adult development and family dynamics
- Ability to work as a team member
- Strong belief that people can change their behavior given the proper environment and opportunity
• Belief in helping families to change their circumstances, not just adapt to them.

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

VI. Billable Units

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

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

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

Group (Effective 3/1/2012)

Group will be defined as at least 3 clients (who are DCS or Probation referrals and are from no less than two different referred families. If there are less than 3 clients from at least two DCS/Probation referrals, the payment would be the face to face rate for each referral.

Issue:
Question: The provider has 3 DCS/Probation clients referred from 2 different families. When cost allocating it, do they charge 1/3 or ½ (by client or referral)?
Answer: By number of referrals. Therefore, ½ charged to each referral, or ½ of the cost would be allocated to each family.

Question: What if there are less than 3 clients referred?
Answer: The payment would be by the Face to Face rate for each referral. Example, if the Face to Face rate is $50, then the claim would be for $50 for each referral.
Hourly services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

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

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

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

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

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

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

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

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

II. Service Delivery

Testing and Interviews Required

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

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

Written Report

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

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

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

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

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

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

III. When DCS is not paying for services:

A billable unit of “Reports” has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences. DCS will only pay for reports when DCS is not paying for these services. If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS. Court testimony will be paid per appearance if requested on a referral form issued by DCS. In order to be paid for a court appearance a subpoena or written request from DCS should be on file.
IV. Target Population
Services must be restricted to the following eligibility categories;
1) Children and families who have substantiated cases of abuse and/or neglect, and will likely develop into an open case with Informal Adjustment (IA) or CHINS status;
2) Children and their families which have an IA or the children with a status of CHINS, and/or JD/JS;
3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed;
4) Any child who has been adopted, and adoptive families

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

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

Goal #2 Obtain appropriate recommendations based on information provided.

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

Goal #3 DCS and client satisfaction with service provided.

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

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

In addition to the above:

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

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

VII. Billable Units

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

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

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

<table>
<thead>
<tr>
<th>Time Range</th>
<th>Unit Description</th>
<th>Billable Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 7 minutes</td>
<td>do not bill</td>
<td>0.00 hour</td>
</tr>
<tr>
<td>8 to 22 minutes</td>
<td>1 fifteen minute unit</td>
<td>0.25 hour</td>
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<tr>
<td>23 to 37 minutes</td>
<td>2 fifteen minute units</td>
<td>0.50 hour</td>
</tr>
<tr>
<td>38 to 52 minutes</td>
<td>3 fifteen minute units</td>
<td>0.75 hour</td>
</tr>
<tr>
<td>53 to 60 minutes</td>
<td>4 fifteen minute units</td>
<td>1.00 hour</td>
</tr>
</tbody>
</table>

**Court:** The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a written request (email or subpoena) from DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.
**Reports**
If the services provided are not funded by DCS, the “Reports” hourly rate will be paid. A referral for “Reports” must be issued by DCS in order to bill.

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

**VIII. Case Record Documentation**
Necessary case record documentation for service eligibility must include:

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

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

**X. Adherence to the DCS Practice Model**
Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.
I. Service Description
Quality Assurance services will be provided for DCS and Probation children currently in residential placement to assist the local DCS and Probation offices in determining if the needs of the children are being met by the current placement, and to investigate and recommend alternative placement options that more suitably meet the child’s individual needs at a lower cost if available. Children at-risk of residential placement will be evaluated to locate a placement that can meet the child’s needs at an acceptable cost.

These quality assurance services will consist of, but are not limited to:
- Specific evaluations completed with regard to the child’s educational, psychiatric, medical, and other needs to ensure each child is receiving the quality of services specified.
- Assure that each child is "matched" with a provider that can best meet the individual needs of the child.

II. Target Population
Services must be restricted to the following eligibility categories:

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

III. Goals and Outcomes
Goal #1: Decrease the number of children in residential care.

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

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

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

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

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

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

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

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

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

V. Billable Unit

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

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

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

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

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

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

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

VI. Case Record Documentation
Case record documentation for service eligibility must include:
1) A completed, signed, and dated DCS/Probation referral form authorizing services
2) Documentation of regular contact with the referred families/children
3) Written progress reports no less than monthly or more frequently as prescribed by DCS/Probation and requested supportive documentation such as case notes, social summaries, etc. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation
5) Copy of treatment plan to include short/long term goals consistent with DCS case plan/agreements reached upon CFT meeting.
VII. Service Access
All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

VIII. Adherence to the DCS Practice Model
Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.
I. Service Description
This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation.

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

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

1) Risk and needs assessment for sexual offenders: (emergency and non-emergency) Assessments must include the following components: Youth, family and community strengths; cognitive functioning; social/developmental history; current individual functioning; current family functioning; delinquency and conduct/behavioral issues; substance use and abuse; psychosexual assessment; mental health assessment; sexual evaluation; community risk and protective factors; awareness of victim impact; external relapse prevention systems including informed supervision amenable to treatment and treatment recommendations. It must also include an assessment of risk using the ERASOR (Estimated Risk of Adolescent Sexual Offender Recidivism).

2) Containment Teams for offenders Traditional supervision practices do not adequately address the unique challenges and risks that sexually maladaptive youth pose to the community. Therefore it is expected that the provider will establish a “network” of family members, friends, teachers, coaches and any other community members or professionals who are committed to the success of the youth, to provide intensive monitoring of the youth in the home, school and community. This monitoring will occur 24 hours a day while the youth receives treatment.

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

II. Service Delivery

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

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

IV. When DCS is not paying for services:

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

V. Target Population

Services must be restricted to the following eligibility categories:

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

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

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

VI. Goals and Outcomes

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

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

Outcome Measures:
1) 95% of all families that are referred will have face-to-face contact with the client within 5 days of receipt of the referral or inform the current Family Case Manager or probation Officer if the client does not respond to requests to meet.

2) Emergency Assessments: 95% cases will include Initial recommendations being provided to the referring worker within 48 hours of the emergency assessment with a full assessment report to the worker within 72 hours of the emergency assessment (by email).

3) 95% of full assessment reports for nonemergency assessments must be available within fourteen calendar days of the referral (by email).

4) 95% of the initial treatment plans will including measurable goals, specific steps to be taken to meet those goals and estimated timeframes for completing each goal and must be sent to the referring worker within fifteen calendar days of the first face-to-face contact with the client (by email).

5) 100% of monthly progress must be completed and sent to the referring worker by email by the 10th of each month for the previous month. Reports must contain documentation of progress made since the previous report in each goal.

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

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

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

Outcome Measures:
1) 90% of youth participating in the program will not have any delinquency charges and/or probation violations during the treatment phase.

2) 75% of youth who successfully complete the program will not have any delinquency charges and/or probation violations within 12 months of completing the program.

3) 95% of youth who participate in the program will not be a perpetrator of child sexual abuse during the 12 months following program completion.
Goal #4 DCS/Probation and client will report satisfaction with services provided.

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

VII. Minimum Qualifications

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

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

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

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

VIII. Billing Units

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

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

<table>
<thead>
<tr>
<th>Billing Code</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0004 HW</td>
<td>Individual</td>
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</table>

Department of Child Services
Regional Document for Child Welfare Services
Term 7/1/11-6/30/13
February 5, 2013
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>H0004 HW HQ</td>
<td>Group</td>
</tr>
<tr>
<td>H0004 HW HR</td>
<td>Individual Setting with the Consumer Present</td>
</tr>
<tr>
<td>H0004 HW HS</td>
<td>Behavioral Health Counseling and Therapy</td>
</tr>
<tr>
<td>H0004 HW HR HQ</td>
<td>Behavioral Health Counseling and Therapy</td>
</tr>
<tr>
<td>H0004 HW HS HQ</td>
<td>Family/Couple Counseling and Therapy (Group Setting) without the Consumer Present</td>
</tr>
</tbody>
</table>

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

- **Face to face time with the client:**
  (Note: Members of the client family are to be defined in consultation with the family and approved by the DCS/Probation. This may include persons not legally defined as part of the family)
  - Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
  - Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
  - Includes Child and Family Team Meetings or case conferences including those initiated or approved by the DCS/Probation for the purposes of goal-directed communication regarding the services to be provided to the client/family.

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

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

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

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

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

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

**Polygraphs**
Polygraphs must be purchased from a licensed provider. Polygraphs are a unit rate and the provider must tell what their rates are as part of their proposal. The intent of the polygraph is for the sex offender only.

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

**IX. Case Record Documentation**
Necessary case record documentation for service eligibility must include:
1) A DCS/Probation referral form, **Juvenile Court Order**, or written referral from the Juvenile Probation Department;
2) Documentation of regular contacts with the referred families/children and referring agency;
3) Written reports regarding each assessment;
4) Written minutes regarding each containment team meeting.
5) Written reports no less than monthly

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

**XI. Adherence to the DCS Practice Model**
Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.
SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
TRANSITION FROM RESTRICTIVE PLACEMENTS (TRP)
(Revised 2/1/12-Effective 3/1/12)

I. Services Description
TRP is a provision of services to assist children in a more restrictive placement to a less/least restrictive placement. The purpose of the program is to prevent a return of the youth to a more restrictive setting/placement. TRP must include the following kinds of services to the youth and family:

Therapeutic/clinical interventions to address the service needs of the youth and family. Therapeutic interventions must be based on an evidence-based model such as Functional Family Therapy (FFT), Multi-systemic Therapy (MST), Parenting with Love and Limits (PLL), or similar program.

Home-based services including but not limited to the following:
- Home assessment
- Child development education
- Educational transition services
- Vocational services
- Drug/alcohol screening & monitoring
- Conflict management
- Addiction Education
- Group Therapy
- Coordination of services, with special emphasis on education and employment services
- Emergency/crisis services
- Parenting education/training
- Family communication
- Assistance with transportation
- Family reunification
- Family assessment
- Community referrals and follow-up
- Behavior modification
- Budgeting/money management
- Other services as deemed appropriate based on the needs of the youth and family

II. Service Delivery
1) Services must include 24-hour access to crisis intervention seven days a week and may be provided in the family’s home, at a community site, or in the office.

2) Services must include ongoing risk assessment and monitoring family/parental progress.

3) Services must include development of goals with measurable outcomes.

4) Provider must complete an intake interview with the family within five calendar days after receipt of the referral or notify referral source if client does not respond to meeting requests.

5) Provider must maintain monthly contact with the youth’s referring agency during the time...
the youth is in the more restrictive placement to ensure that the transition plan remains consistent between agencies.

6) Provider must participate in an initial meeting with the youth’s FCM or probation officer, youth, and family within 48 hours of release.

7) For JD/JIS youth, the provider must complete the Child and Adolescent Needs and Strengths (CANS) assessment within 30 days of transition from the more restrictive placement, if not completed at the time of discharge from the more restrictive placement, and every six months thereafter. If no CANS assessment was completed prior to the youth being admitted to the more restrictive placement, the service provider is responsible for completing the assessment within 2 weeks of the placement in a less restrictive placement. (DCS will be responsible for CANS assessments for CHINS youth.)

8) Provider must conduct a minimum of two (2) face to face visits per week with the youth during the first thirty (30) days of release from the more restrictive placement. The level of supervision after that period of time will be determined by the team but will never be less than 1 face to face visit per week.

9) When appropriate and requested by the Probation Officer or Family Case Manager, the provider may require the youth to submit to at least one random drug screen within fourteen (14) days of changing from a more restrictive placement. This may be done through the local probation department or another approved vendor.

10) Provider must maintain frequent contact with the FCM/probation officer and notify the FCM/probation officer in writing of non-compliance issues. The provider must also develop a recommendation for the FCM/probation officer as to a suitable therapeutic intervention.

11) The family will be the focus of service and services will focus on the strengths of the family and build upon these strengths.

12) Services must be family focused and child centered.

13) Services must include intensive in-home skill building and after-care linkage.

14) Services include providing monthly progress reports in a format approved by the Court, participation in team meetings, and providing requested testimony and/or presence at court hearings.

15) Additionally, the provider will recommend to the referring agency any other services, such as therapy, which might be needed. Recommendations for additional services not covered in the service standard should be made, in writing, to the current FCM or probation officer. Additional services require a separate referral and should not be started until one has been received.
16) Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.

17) The caseload of the therapist/case manager will include no more than ten (10) workload units. All youth in service are weighted at 1 workload unit.

III. Target Population
Services must be restricted to the following eligibility category:

- Children with a status of CHINS and/or JD/JS who have been placed in a restrictive setting.

Note that Transition From Restrictive Placements (TRP) can be provided to CHINS or probation youth who are transitioning out of residential or group home placements. TRP services may begin while a youth is still in a residential or group home placement if that youth will be transitioning within 30 days.

For JD/JS youth who are committed to the Department of Corrections, this service may begin within 60 days of the scheduled or anticipated discharge.

IV. Goals and Outcomes
Goal #1 To improve the transition for youth back to their home by providing therapeutic services to the youth and family

Outcome Measures

1) Based on the CANS Assessment, 100% of participants will have an individualized service plan developed.
2) 90% of families will actively participate in services during the youth’s period of placement.
3) 90% of the youth will have a minimum of 2 face to face visits each week from their direct worker/therapist during the first 30 days following their placement from a more restrictive to a less restrictive placement.

Goal #2 To reduce routine barriers by providing direct assistance with transition issues

Outcome Measures

1) 90% of all participants will have a state-issued ID or driver's license by the completion of the program.
2) 90% of all participants will actively participate in an education program.
3) 100% of participants not involved in an educational program will be employed and/or participating in a formal employment assistance program.
Goal #3 To develop a system of community supports for each youth that will continue after completion of the program.

Outcome Measures

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

Goal #4 Maintain satisfactory services to the children and family

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

Outcome Measures

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

V. Minimum Qualifications

Counselor/Direct Worker:

MCO billable:

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

MRO billable:

Providers must meet the either of the following qualifications:

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

DCS billable:

Direct Worker:

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

**Supervisor:**
A master's degree in social work, psychology, or marriage and family or related human service field with a current license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board, as one of the following: 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor 4) Addictions Counselor is required.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, and occur every two (2) weeks or more frequently.

The staff person must possess:

- Knowledge of community resources and ability to work as a team member.
- An understanding of issues specific to youth transitioning back into the community following a stay in restrictive placement.
- Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life style choices, and complex family interactions and be delivered in a neutral valued culturally competent manner.

**VI. Billable Unit**

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

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

Services through the Medicaid Rehab Option (**MRO**) may be **group** Behavioral Health Counseling and Therapy, Case Management, and Skills Training and Development.

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

### If agency administers clinical services, there may be two face to face units: Direct Worker and Counseling.
Face to face time with the client:
(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

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

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

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

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

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

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

**VII. Case Record Documentation**
Case record documentation for service eligibility must include:
1) A completed, signed, and dated DCS/Probation referral form authorizing services
2) Documentation of regular contact with the referred families/children

Department of Child Services
Regional Document for Child Welfare Services
Term 7/1/11-6/30/13
February 5, 2013
3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

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

IX. Adherence to the DCS Practice Model
Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.
SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
TUTORING/LITERACY CLASSES
(Revised 2/1/2012-Effective 3/1/2012)

I. Services Description
Tutoring/literacy and math services will be provided to raise the academic performance of school-aged youth to a level consistent with state education standards.

Services shall be provided in a manner that is age and developmentally appropriate, and consistent with the child’s academic ability and learning style, interpersonal characteristics and special needs. Children will be connected as appropriate with both formal and informal community supports, services and activities that promote their literacy skills. The child’s characteristics such as race, culture, ethnicity, language and personal history including child abuse and neglect will be considered when choosing or designing program interventions, materials and curriculum. The provider will develop an education plan to address the child’s literacy and math needs.

A variety of activities and lessons shall be available to afford choice. Activities and lessons shall promote literacy skills and academic development and should demonstrate well-planned, flexible and responsive services. Services should include regular use of external resources such as libraries, museums and community educational sites. Services may also incorporate the use of video games and computers. The use of television and videos shall be strictly limited to a minimal portion of the child’s participation. Video games, computers, television and videos should be age and developmentally appropriate, supportive of the child’s educational goals, and the child should be monitored at all times when using these resources.

The provider will develop a plan to engage the child, caregiver, and educator in the process. The plan will accommodate persons who are difficult to engage if necessary. The provider will clearly communicate and coordinate the child’s education plan goals with the caregiver and educator and will periodically and frequently give updates and review progress with them.

II. Service Delivery
Treatment Modality
Tutoring/literacy and math services shall be provided through direct one-on-one sessions or in small groups of 2 to 4 children who are matched by ability. Services should occur in locations that promote learning, are large enough to accommodate the group and teaching materials, allow the child to concentrate without being disturbed by others, and allow for meaningful and direct assistance. Services may take place after school, on weekends and/or other times when school is not in session. Services should not conclude later than normal bedtime hours.

Tutoring/literacy and math services shall incorporate evidence-based strategies that improve student achievement. Sessions shall be divided into segments, including: 1) an opening activity
to set the stage, 2) activities based on individual learning goals, 3) opportunities to develop and practice skills, and 4) a closing activity. All sessions shall include opportunities for the child to experience success and to progress. The provider should suggest home activities as appropriate.

Assessment
The provider will ensure the child receives an initial assessment in order to determine child specific learning needs no later than 10 days after being referred. The provider will make reasonable attempts to discover previous assessments and to utilize the findings of those assessments in conjunction with the provider’s own assessment. Assessments shall include the use of standardized tools to obtain a baseline measurement and will at a minimum identify the following:

- Learning disabilities and/or impairments in cognitive functioning due to child abuse, neglect, or involvement with child welfare services
- Academic strengths, weaknesses and needs
- Level of ability compared to actual grade/age level

Services will be provided within the context of the Department of Child Services’ practice model with participation in Child and Family team meetings if invited. An education plan will be developed and based on the agreements reached by means of the assessment and Child and Family Team Meeting (CFTM). Services will be provided in coordination with the child’s Individualized Education Plan (IEP) if present, and the provider shall participate in IEP conferences with educators.

Education Plan
Comprehensive education plans will be developed based on the assessment and will contain both long-term and short-term goals. Plans at a minimum will:

Include input from the child, caregiver and the educator.
Reflect underlying needs and goals.
Be tailored to the child’s strengths, weaknesses, needs, available resources and unique circumstances.
Build on realistic possibilities and options
Identify strategies for lessening the effects of any disabilities and/or impairments in cognitive functioning.
Promote reading and math achievement at a level consistent with state education standards.
Be consistent with the child’s Individualized Education Plan (IEP), if one is present
Support and/or build upon what the child is learning through their primary education program
Respond flexibly to the child’s changing needs
The provider will evaluate the child’s progress toward achieving identified goals and will
regularly incorporate the use of standardized performance measurement tools to track progress and adjust tutoring/ literacy and math activities. The provider will assist the child and caregiver in realizing ways of generating and maintaining gains. The provider will document progress and participation.

Services must be available to participants who have limited daytime availability.

Services shall include providing any requested testimony and/or court appearances (to include hearing or appeals).

Provider must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the contract.

III. Target Population
Services must be restricted to the following eligibility categories:
1) Children who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
2) Children who have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
3) All adopted children.

IV. Goals and Outcomes
Goal #1 Timely provision of services for the youth and regular and timely communication with referring worker.

Outcome Measures:
1) 95% of all youth referred will have face-to-face contact with the provider within 10 days of the referral.
2) 95% of all youth will have a written education plan within 30 days of the referral.
3) 100% of all youth will have monthly written summary reports prepared and sent to the referring worker.

Goal #2
Child has improved academic and/or literacy performance

Outcome Measures:
1) 90% of children improve academic and/or literacy performance as evidenced by pre and post-testing
2) 90% of children improve overall school performance as measured by grade point average or other standard indicators
3) 100% of children participate actively in the goals of their education plan as
evidenced by provider documentation

Goal #3 DCS and youth satisfaction with services

Outcome Measures:
1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
2) 90% of the youth who have participated will rate the services “satisfactory” or above.

V. Minimum Qualifications

Direct Worker:
Tutoring services may be provided by workers with a Bachelor's degree or at least 60 hours of post secondary credit hours in education, social work, psychology, or a related field.

Supervisor:
A bachelor’s degree in education, social work, psychology, or a related field and 5 years experience tutoring children is required. Knowledge of state education standards is required.

Supervision/consultation is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client service hours provided. These sessions should occur no less frequently than every two (2) weeks.

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

Worker Qualities:
Providers working directly with children have the competencies and support needed to:

- Engage, empower and communicate effectively, respectfully and empathetically with children and families from a wide range of backgrounds, cultures and perspectives.
- Develop plans to meet the child’s literacy and tutoring needs.
- Recognize and identify the presence of cognitive impairments
- Collaborate with workers in other disciplines and access community resources
- Advocate for the child during Child and Family Team Meetings Individualized Case Plan (IEP) conferences

Providers working directly with children should be knowledgeable about:

- Child development
- Behavior management
- Learning disabilities
- Possible effects of child abuse and neglect on cognitive functioning
- The Individualized Education Plan (IEP) and its use in education
- Educational resources within the community
VI. Billable Unit
Face to face time with the client:
(Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family)

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

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

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

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

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

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

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

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

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

IX. Adherence to the DCS Practice Model
Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.
SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
VISITATION FACILITATION
(Revised 2/5/13-Effective 2/1/13)

I. Service Description

It is the fundamental right for children to visit with their parents and siblings. The relationship developed by the child with the parent is one of bonding, dependency, and being nurtured, all of which must be protected for the emotional well being of the child. It is of extreme importance for a child not to feel abandoned in placement by either the child’s parents or by other siblings, and for a child to be reassured that no harm has befallen either parent or siblings when separation occurs.

Visit facilitation as identified by DCS/Probation will be provided between parents/children/siblings and/or others who have been separated due to a substantiated allegation of abuse or neglect or involvement with juvenile probation. Visitation allows the child an opportunity to reconnect and reestablish the parent/child/family relationship in a safe environment. It is an excellent time for parents to learn and practice new concepts of parenting and to assess their own ability to parent through interaction with the child. Supervised visitation allows the DCS/Probation to assess the relationship between the child and parent and to assist the parent in strengthening their parenting skills and developing new skills.

The role of the visitation provider is to protect the integrity of the visit and provide a positive atmosphere where parents and children may interact in a safe, structured environment. Visitation may be held in a visitation facility; neutral sites such as parks, fast food restaurant with playground, or shopping malls; child's own home or relative’s home; foster home; or other location as deemed appropriate by the referring agency and other parties involved in the child’s case taking into consideration the child’s physical safety and emotional well being.

II. Service Delivery

Referral process

In order for positive and productive visitation to occur, specific outlined below will be provided to the visitation provider by the child’s family case manager or probation officer as part of the referral. Information may include:

1) desired/allowable location of visits (such as facility, neutral space, foster home, own home, etc.), length of visits, number of visits requested per week,
2) placement of the child and contact information,
3) who may participate in visits with contact information and relationship to child,
4) who is restricted from visits,
5) level of supervision requested (such as in-room, drop-in during visit, audio monitored, video monitored, semi-supervised, unsupervised, etc).
6) what is expected of the parents or other approved person(s) regarding prior preparation related to bottle feeding, meals and snacks, change of clothes if needed, diapers and wipes, etc.,
7) restricted activities, if any, and
8) consequences when parents do not attend visits as planned and agreed upon (this may include no showing or being consistently late or consistently leaving early);
9) circumstances under which visits may be limited or terminated (such as parent or child has head lice, parent under influence of mood altering substance, parent’s intimidating or threatening behavior, inability of parent to manage children’s behavior in structured setting, etc.); and
10) any criminal, mental health, and safety information on all children and visiting parties
11) other information pertinent to the visits.
12) ratio of direct workers and clients.

In the event that the preceding information is incomplete, it is the responsibility of the visitation provider to obtain that information from the referring worker.

Upon receiving the referral from the DCS/Probation, the agency will contact all parties to set up the visits taking into consideration the ability of the parent to attend based on work schedules and the foster parent or relative caregiver ability to ensure attendance of the child. Every attempt must be made for visitation with the child’s parent, guardian or custodian to occur within 48 hours of the child’s removal from the home. For all other visitation referrals, visitation must be scheduled within 5 days. All cancelled visits by the parent or visit facilitator must be reported within 48 hours to the referring agency indicating who cancelled and the reason for cancellation.

**Visit Observation and Reporting**
Professional and/or paraprofessional staff will assist the family by strengthening, teaching, demonstrating, role modeling appropriate skills and monitoring in, but not limited to the following areas:

- Establishing and/or strengthening the parent-child relationship
- Instructing parents in child care skills such as feeding, diapering, administering medication if necessary, proper hygiene
- Teaching positive affirmations, praising when appropriate
- Providing instruction about child development stages, current and future
- Teaching age-appropriate discipline
- Teaching positive parent-child interaction through conversation and play
- Providing opportunities for snack and meal
- Responding to child's questions and requests
- Teaching safety regarding age-appropriate toys, climbing, running, jumping, or other safety issues depending on the environment
- Managing needs of children of differing ages at the same time
- Helping parents gain confidence in meeting their child's needs
- Visit Planning
- Teaching age appropriate activities that encourage child development and resiliency.
- Identifying and assessing potentially stressful situations between parent and their children
- Giving parents an opportunity to demonstrate
At each visit, the visitation facilitator will accurately document for the referring agency the following information:

1) date, location, and level of supervision of visit;
2) those in attendance at the visit;
3) time of arrival and departure of all parties for the visit;
4) greeting and departure interaction between parent and child/ren;
5) positive interactions between parent and child;
6) planned activities by the parent for visit;
7) interventions required, if any and parent's response to direction provided with regard to interventions;
8) ability and willingness of parent to meet child’s needs as requested by child or facilitator;
9) tasks given to the parent to be completed prior to or at the next visit, etc.
10) pertinent information/issues/concerns regarding the child’s placement

Additionally, the following items apply:

1) Visitation staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
2) The current worker will be notified by phone immediately when inappropriate behavior occurs with either parent in a visit that affects the ability of the visit to continue or the safety of the child.
3) Services must demonstrate respect for sociocultural values, personal goals, life style choices, and complex family interactions and be delivered in a culturally competent fashion.
4) Attendance at case conferences may be required as well as testimony and/or court appearances at review or permanency hearings for the child.
5) Documentation of incidents in visitations which are or could be considered subjective must be followed by examples of the situation for clarification. The documentation of the visit must be provided to the current FCM/PO within 3 days of the visit. Phone calls shall be immediate for safety or recommendations for terminated visits.
6) Provider understands that documentation may be shared by DCS/Probation with the child’s parents, foster parents or other placement of the child, the child’s therapist, and other parties in the case to assist in decision making regarding decreased or increased levels of supervision and reunification.

III. Target Population

Services must be restricted to the following eligibility categories:
• Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.

Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

IV. Goals and Outcome Measures

Goal #1
Ensure that all children removed from their parents have the opportunity to visit their parents/siblings on a regular basis.

Outcome Measures

1) 100% of the families will have the first face-to-face visit with their child(ren) within 48 hours of the child’s removal from the home.
2) 100% of the families will have visitation set up and occurring with the frequency and duration requested by DCS/Probation within 5 working days of receipt of the referral.

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

Outcome Measures

1) 85% of parents served will demonstrate an increased ability to recognize and respond appropriately to their children’s cues by case closure.
2) 85% of the parents will actively reinforce positive behavior and address negative behavior.
3) 90% of parents will arrive with previously requested items by the visit facilitator for the children such as diapers, food, etc. and be prepared to provide a meal or snack if expected.

Goal #3
Provide accurate and timely information in the child’s case so that informed decisions may be made regarding reunification and permanency for the child.

Outcome Measures

1) 98% of visitation reports will be received by the DCS/Probation within 3 days of the visitation or immediately (by phone) when inappropriate behavior occurs with either parent, followed up with a monthly report form. Written reports will be completed on the DCS approved visitation report forms.

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

Outcome Measures
1) DCS or Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
2) 94% of the families who have completed visitation facilitation services will rate the services “satisfactory” or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

V. Minimum Qualifications

Direct Worker
A high school diploma and 5 years of experience in providing visitation supervision OR Bachelor's degree in social work, psychology, sociology, or a directly related human service field.

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

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

VI. Billable Units

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

- Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
- Includes crisis intervention and other goal directed interventions via telephone with the identified client family.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS/Probation (which can include telephone case conferences) either with or without the client, for the purposes of goal directed communication regarding the services to be provided to the client/family.
Reminder: Not included is routine report writing and scheduling of appointments, collateral contacts, travel time and no shows. These activities are built into the cost of the face to face rate and shall not be billed separately.

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

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

(Note on Intermittent supervised visitation: when DCS requests the provider to check in intermittently - at least once per hour -, the provider can bill in increments of 30 minutes for each check-in, provided that the total amount of time billed should not exceed the total length of the visit.)

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

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

VII. Case Record Documentation
Case record documentation for service eligibility must include:
1) A completed, signed, and dated DCS/Probation referral form authorizing services
2) Documentation of regular contact with the referred families/children
3) Written progress reports no less than monthly or more frequently as prescribed by DCS/Probation and requested supportive documentation such as case notes, social summaries, etc. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent. The “Visitation Monthly Progress Report” form must be used to report the supervised visit.
4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation
VIII. Service Access
All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

IX. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging.
I. Service Description

These services are designed for individuals who are suspected by DCS workers and Probation Officers of drug and/or alcohol use and require immediate testing. The drug test list includes Drugs of Abuse (illegal drugs), Therapeutic drugs (Prescription Drug-Painkillers, Mental Health Meds, etc.), and Designer drugs (i.e. K2, “Spice). The vendor must provide all required supplies and courier services to transport all specimens, test results, and testing materials to and from any location within the referring county.

The FCMs may administer saliva/oral fluid (swabs) only. Probation Officers are not prohibited by DCS from the administration of drug tests.

The types of drug screens included, but are not limited to, saliva/oral fluid, hair follicle, and urine.

Services include providing any requested testimony and/or court appearances (to include hearing or appeals), including chain-of-custody and/or testing procedures/results on an as needed basis and providing certified copies of drug tests, if requested, up to 2 years after screening.

The vendor shall provide Initial Testing and Gas Chromatography/Mass Spectrometry Confirmation (GC/MS) Testing or other federally approved testing methods which may include LC/MS/MS or GC/MS/MS (when the Initial Tests indicate a positive result) for any location within the referring county.

The Vendor shall ensure proper legal chain-of-custody procedures are maintained and comply with departmental procedure, state and federal law. The vendor shall also ensure complete integrity of each specimen tested and the respective test results. Receiving, transfer and handling of all specimens by laboratory personnel shall be fully documented using the proper chain-of-custody.

Testing shall not be conducted on any specimen without a legal chain-of-custody. All specimens found to be “Adulterated” or “Contaminated” shall be treated as an Invalid Specimen. Any specimen without a valid chain-of-custody is to be destroyed. The submitting location shall be notified in writing when a specimen has been rejected due to an invalid chain-of-custody or any other integrity problem. Monthly reports shall document how many random samples were taken minus how many "Adulterated" or "Contaminated" specimens there were for the month. (Note: This does not apply to oral fluid testing.)

Initial Testing
All sample collections drug screens will be observed sample collections screens. Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Propoxyphene, and Methamphetamine and other drugs indicated by client’s history. The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation.

For urine screens, testing for creatinine levels shall be conducted on all samples. The vendor shall also insure testing for total Cannabinoids per mg of creatinine using spectrophotometer technology. The Vendor shall insure testing for specific gravity on all samples with a creatinine level below 20 mg per deciliter. The Vendor shall also insure the administration of a nitrite test on any specimen that contains no creatinine and has a specific gravity test of 1.000.

Initial screening shall be conducted utilizing an enzyme immunoassay method. Testing should occur for the following substances utilizing the cut-off levels listed below:

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<tr>
<th>DRUG</th>
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<td>500PG/MG</td>
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*Hair uses = PG/MG = weight
* For all other substances tested use recommended laboratory cutoff levels

All negative samples held by the laboratory will be retained for one week. A retention time extension may be requested based upon need.

**Confirmation Testing**

Confirmation Testing shall be conducted utilizing GC/MS or LC/MS/MS Technology on all samples initially testing POSITIVE. The following cut-off levels shall be utilized:

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*Hair uses = PG/MG = weight
*For all other substances tested use recommended laboratory cutoff levels*

All positive samples shall be frozen and maintained for 365 days by the laboratory. A retention time extension may be requested based upon need.

In situations where the source of the methamphetamine present in any specimen may come into question, the vendor must perform a d-1-isomer differentiation. This service is to be offered at no additional cost to the Department of Child Services and performed when requested by DCS or Probation.

**Results Notification**

The vendor shall notify the Department of Child Services and/or Probation of testing results via email or fax on vendor letterhead. The results will also be sent by U.S. mail to the referring agency as well. The vendor shall gain approval from DCS for any changes in the results notification system.

The referring agency will be notified of negative test results within 24 hours of the test. The specified time frame is from delivery to the testing laboratory to the time of notification. Positive test results will be provided within 72 hours of the lab receipt of the sample specimen.

For urine tests, diluted results must be reported on the result form.

**Courier System**

The vendor will coordinate all courier services to transport all specimens, test results, and testing materials to and from any location within the referring county. Deliveries shall be made during regular working days, normally between the hours of 8:00 am and 5:00pm unless otherwise indicated. The vendor shall be responsible for the cost of all courier services provided under the contract.

The vendor shall provide courier services that maintain the legal chain-of-custody, throughout the State of Indiana within 24 hours of request of pick up.

The vendor shall provide postage paid mailers or next day delivery services for utilization at any location that desires to use this method as an alternative to the courier services. This shall be at no additional charge to DCS.

The vendor’s courier system shall provide documented, legal chain-of-custody throughout the State of Indiana which includes same day or next day delivery throughout Indiana.

**Technical Support**

A toll free 800 number will be available to all DCS local offices and Probation departments, in the State of Indiana to contact for technical support. Technical support staff and laboratory technicians shall be available during normal working hours via the 800 number, to provide technical assistance at no additional cost.
**Supplies**
The vendor shall provide the following supplies:
1) Sample containers
2) Specimen donor labels
3) Evidence security tape
4) Evidence bags
5) Evidence chain-of-custody forms with seals
6) Swabs
7) All supplies required for mailing or next day delivery
8) Any additional supplies necessary for referring specimens to the laboratory.

**Note Regarding testing of Additional Substances:**
A provider and/or the referral source may identify the need for screening of additional substances outside of what is specified above. This may be identified as a need in the entire region or for a specific client being referred.

If a contracted provider is proposing to test for additional substances to the already approved list of substances the provider shall submit an updated rate list to the Regional Child Welfare Services Coordinator to be approved by the Regional Services Counsel.

In the instance that the referral source has identified the need for testing of additional substances outside of what is specified above for a referred client, the provider will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation. All testing levels (initial and confirmation) for additional substances outside of what is specified above shall be in compliance with Substance Abuse and Mental Health Administration (SAHMSA) regulations. All rates shall be billed at actual cost.

**II. Target Population**
Services must be restricted to the following eligibility categories:
1) Parent(s) of children for whom a DCS assessment has been initiated
2) Children and parent(s) who have substantiated cases of abuse and/or neglect
3) Children with a status of CHINS, and/or JD/JS
4) Minor children suspected of drug use prior to adjudication

**III. Goals and Outcome Measures**
Goal #1 Services are provided timely as indicated in the service description above.

Outcome Measures
1) 100% of courier services will be provided within a 24 hours of a request for pick up.
2) 100% of referring agencies will be notified of negative test results within 24 hours of

Department of Child Services
Regional Document for Child Welfare Services
Term 7/1/11-6/30/13
February 5, 2013
laboratory receipt of sample specimen.
3) 100% of referring agencies will be notified of positive test results within 72 hours of
laboratory receipt of sample specimen.

Goal #2 Services are provided as indicated in the service description above.

Outcome Measures
1) 100% of proper legal chain-of-custody procedures will be maintained and will
comply with Departmental Policy, State and Federal law.
2) 100% of all specimens will be tested for illegal drugs or prescription medication if
the client does not have a valid prescription. Amphetamines Cannabinoids
Benzodiazepines Opiates, Cocaine, and Meth utilizing the cut-off levels listed above.
3) 100% of supplies will be provided to referring counties upon request.

IV. Qualifications
A laboratory participating in DCS/Probation drug testing must comply with all applicable
Federal Department of Health and Human Service, and, under these federal requirements, are
subsumed Substance Abuse and Mental Health Services Administration (SAMHSA), or
College of American Pathology (CAP), or Clinical Laboratory Improvement Act (CLIA)
requirements.

V. Billable Units

Providers shall submit a list of rates for all billable units listed in this section with the
proposals. The rate list shall include the actual cost of all screens the provider is
proposing to provide.

- Drug Tests and Supplies:
  Actual cost of the screens.

- Confirmation: Per test
  The billable units will include the following:
    1) Retention of positive samples as required by other standard.
    2) Technical Support
    3) Cost of Courier System
    4) Cost of Confirmation test

  NOTE: The provider cannot claim for the handling of rejected specimens or those
  otherwise unfit for testing.

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

VI. Case Record Documentation
1) Receiving, transfer and handling of all specimens by laboratory personnel shall be fully documented using the proper chain-of-custody.
2) Documentation of notification of test results. Diluted results must be reported on the result form
3) The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation
4) All negative samples held by the laboratory will be retained for one week. A retention time extension may be requested based upon need.
5) All positive samples shall be frozen and maintained for 365 days by the laboratory. A retention time extension may be requested based upon need.

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

VIII. Adherence to the DCS Practice Model
Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.
SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
RANDOM DRUG TESTING
(Revised 2/1/12-Effective 3/1/12)

I. Service Description
Random screens are designed for individuals who may or may not meet the criteria for substance abuse and may or may not actively participate in drug treatment services. The drug test list includes Drugs of Abuse (illegal drugs), Therapeutic drugs (Prescription Drug-Painkillers, Mental Health Meds, etc.), and Designer drugs (i.e. K2, “Spice). Each random screen referral shall consist of no more than twenty-four (24) screens to be completed over a period not to exceed six (6) months, with a maximum of three (3) screens per week as indicated by the referral form. It is expected that the referring worker and provider agency will work together to develop a plan to determine the appropriate duration (up to 6 months) of each referral. A second referral will be required if an excess of twenty-four (24) screens per referral are necessary.

II. Service Delivery
The service provider must identify a plan to engage the client in the process, a plan to work with non-cooperative clients including those who believe they have no problems to address as well as working with special needs clients such as those who are mentally ill or developmentally delayed.

The types of drug screens include, but are not limited to, saliva drug screen/oral fluid based drug screen, hair follicle, and urine.

Initial Testing
All sample collections drug screens will be observed sample collections screens. Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Propoxyphene, and Methamphetamine. Other substances not listed that the client may report a history of using may also be tested. The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation.

For urine screens, testing for creatinine levels shall be conducted on all samples. The vendor shall also insure testing for total Cannabinoids per mg of creatinine using spectrophotometer technology. The Vendor shall insure testing for specific gravity on all samples with a creatinine level below 20 mg per deciliter. The Vendor shall also insure the administration of a nitrite test on any specimen that contains no creatinine and has a specific gravity test of 1.000.

Initial screening shall be conducted utilizing an enzyme immunoassay method. Testing should occur for the following substances utilizing the cut-off levels listed below:
**Confirmation Testing**

Confirmation Testing shall be conducted utilizing GC/MS Technology on all samples initially testing POSITIVE. The following cut-off levels shall be utilized:

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*Hair uses = PG/MG = weight

* For all other substances tested use recommended laboratory cutoff levels

In situations where the source of the Amphetamine present in any specimen may come into question, the vendor must insure the performance of a d-1-isomer differentiation. This service is to be offered at no additional cost to the Department of Child Services and performed when requested by DCS or Probation.

The Vendor shall ensure proper legal chain-of-custody procedures are maintained and comply with departmental procedure, state and federal law. The vendor shall also ensure complete integrity of each specimen tested and the respective test results. Receiving, transfer and handling of all specimens by personnel shall be fully documented using the proper chain-of-custody.

The vendor shall insure that all laboratories used for drug testing purposes must comply with all applicable Federal Department of Health and Human Service, and, under these federal requirements, are subsumed Substance Abuse and Mental Health Services Administration.
A letter to all referred clients will be required within three (3) calendar days of referral with instructions for contacting the agency immediately to begin screens. It is expected that the first screen will be collected within seven (7) calendar days of referral and each subsequent screen will be random. One or more toll free phone lines for clients to call daily to determine the day their screen is to be required. Agency must have a plan in place to modify the phone messages every day by 5 a.m., instructing clients whether to report that day for a screen or call again the next day.

Note: It is expected that the referring worker and provider agency will work together to develop a plan to administer random testing for clients who do not have access to public transportation or telephone. In addition, the referring worker may also indicate the required number of random drug screens.

The agency shall update the referring worker, by phone or email, within ten (10) calendar days of the date the referral was sent regarding the status of the referral. Agencies should inform the referring worker of the date the client completed their first screen or, if the client has not contacted the agency to complete their first screen, a consultation with the referring worker should be held to determine the next steps of services.

**Results Notification:**
The vendor shall notify the local Department of Child Services Office/ Probation Officer (PO) of testing results via email or fax on vendor letterhead. The results will also be sent by U.S. mail to the referring county as well. The vendor shall gain approval from DCS or Probation for any changes in the results notification system.

The current FCM/PO (if not the referral source) will be notified of positive test results within 72 hours of sample collection. Negative test results will be provided within 24 hours of sample collections.

No-show alert forms will be provided by the contracted agency to the referring worker within 24 hours of the client’s failure to show. Failure to show may result in an administrative discharge. Any client who is administratively discharged must request a new referral from the referring worker to begin receiving services again.

The DCS/Probation shall be notified in writing if the specimen has been rejected due to an invalid chain-of-custody or any other integrity problem.

For those employing urine tests diluted results must be reported on the result form.

Testing shall not be conducted on any specimen that does not have a legal chain-of-custody. All
specimens found to be “Adulterated” shall be treated as an Invalid Specimen. Any specimen without a valid chain-of-custody is to be destroyed. The referring location shall be notified in writing when a specimen has been rejected due to an invalid chain-of-custody or any other integrity problem. Monthly reports shall document how many random samples were attempted and completed minus how many "Adulterated" specimens there were for the month.

**Note Regarding testing of Additional Substances:**
A provider and/or the referral source may identify the need for screening of additional substances outside of what is specified above. This may be identified as a need in the entire region or for a specific client being referred.

If a contracted provider is proposing to test for additional substances to the already approved list of substances the provider shall submit an updated rate list to the Regional Child Welfare Services Coordinator to be approved by the Regional Services Counsel.

In the instance that the referral source has identified the need for testing of additional substances outside of what is specified above for a referred client, the provider will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation. All testing levels (initial and confirmation) for additional substances outside of what is specified above shall be in compliance with Substance Abuse and Mental Health Administration (SAHMSA) regulations. All rates shall be billed at actual cost.

**III. Target Population**
Services must be restricted to the following eligibility categories:

1) Parent(s) for whom a DCS assessment has been initiated.
2) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
3) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
4) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
5) Minor children suspected of drug use prior to adjudication.

**IV. Goals and Outcome Measures**
Goal #1 Drug screen results will be provided to the referring worker in a timely fashion.

- **Outcome Measures**
  1) 95% of positive screens will be reported to the FCM/PO by fax or email within 72 hours of sample collection.
  2) 95% of negative screens will be reported to the FCM/PO by fax or email within 24 hours of sample collection.
Goal #2 “No Show” alerts based on occurrence.

Outcome Measures
1) 100% of “No Shows” alerts will be provided to referring worker within 24 hours of the client’s failure to show.

V. Minimum Qualifications
Sample collection does not require the services of a certified drug abuse counselor. The person providing this service must be trained in sample collection and the chain of custody procedures to document the integrity and security of the specimen from time of collection until receipt by the laboratory.

VI. Billable Units

Providers shall submit a list of rates for all billable units listed in this section with the proposals. The rate list shall include the actual cost of all screens the provider is proposing to provide.

The provider cannot claim for the handling of rejected specimens or those otherwise unfit for testing. Grantees will bill monthly:
The provider is to present a list of the drug screens available with the total cost of each drug screen or set of drug screens as part of proposal. The DCS will specify which drug screen or screens they are authorizing for each client on the authorizing referral form.

Initial Drug Screens

Services include all costs from the drug screen supplies needed to do the screen to the results notification (Includes but not limited to screening supplies, collection of specimen, lab costs, etc.) The vendor shall ensure that the chain of custody procedure is followed to maintain the integrity and security of the specimen from time of collection until receipt by the laboratory.

Confirmation of Positive Test (lab processing)
The confirmation test is for those initial drug screens with a “Positive” result. The unit rate will include all cost associated with confirming the status of the Initial Drug Screen and will include results notification. The vendor shall ensure that the chain of custody procedure is followed to maintain the integrity and security of the specimen from time of collection until receipt by the laboratory.

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

VII. Case Record Documentation
Case record documentation for service eligibility must include:
1) A completed, signed, and dated DCS/Probation referral form authorizing services
2) Documentation of regular contact with the referred families/children
3) Documentation of screen results notification sent to DCS.
4) “No Show” alerts will be provided to referring worker within 24 hours of the client’s failure to show.
5) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

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

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

This service standard applies to families and children involved with the Department of Child Services and/or Probation. Services may be provided for clients of all ages in need of detoxification services. Detoxification is a process of treating individuals who are physically dependent on alcohol or drugs, and includes the period of time during which the body’s physiology is adjusting to the cessation of substance use.

Three immediate goals of detoxification shall be included, to provide a safe withdrawal from the alcohol/drug(s) of dependence and enable the patient to become drug free, to provide withdrawal that is humane and protects the patient’s dignity, and to prepare the patient for ongoing treatment of his or her alcohol and other drug dependence.

II. Service Delivery

The detoxification program must be state licensed and certified as well as supervised by a licensed physician. In addition, the program shall provide living accommodations in a structured environment for individuals who require twenty-four (24) hour per day supervision while withdrawing from toxic levels of consumption. Detoxification clients will be monitored by qualified, experienced staff 24 hours a day. Services will be available continuously twenty-four (24) hours a day, seven (7) days per week. Ambulatory detoxification may be provided on an outpatient basis as an alternative in limited situations. A caring staff, a supportive environment, sensitivity to cultural issues, confidentiality, and the selection of appropriate detoxification medication (if needed) are all important to providing humane withdrawal.

Clients will be accepted into the program within twenty-four (24) hours of the referral or sooner if an emergency exists. The type, length, and intensity of an individual’s detoxification are determined by the severity of the addiction. Consultation with the Family Case Manager (FCM) and a new referral must be issued if length of stay is longer than two to six days.

All sample collections drug screens will be observed sample collections screens. Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Propoxyphene, and Methamphetamine and other drugs indicated by client’s history. The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation.

A laboratory participating in DCS/Probation drug testing must comply with all applicable Federal Department of Health and Human Service, and, under these federal requirements, are subsumed Substance Abuse and Mental Health Services Administration (SAMHSA), or...
College of American Pathology (CAP), or Clinical Laboratory Improvement Act (CLIA) requirements.

The provider shall inform the referring worker, of the drug screen results within ten (10) calendar days of the initial test.

The provider will develop a recovery plan. The recovery plan should include client’s mental health status at transition and recommendations for the next level of recovery support services, and substance use recovery resources. The recovery plan could include any needed recommendations for psychological testing, psychiatrist consultation and/or medication evaluation. A consultation with the Family Case Manager to obtain a new referral must be completed to refer client to the next level of care.

Best practice will have client transition only when the next step of the recovery plan is available immediately or in a short time frame.

III. When DCS is not paying for services:

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

IV. Target Population

Services must be restricted to the following eligibility categories:

1) Children and families who have substantiated cases of Use and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or CHINS status.

2) Children and their families which have an IA or the children have the status of CHINS or JD/JS.

3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

V. Goals and Outcomes

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

Outcome Measures:
1) 90% of services initiated within 24 hours of the referral.
2) 100% of recovery reports will be submitted to the Family Case Manager or Probation Officer.
3) 100% of cases will include a consultation with the Family Case Manager Probation Officer to discuss the recommended next level of care.

**Goal #2: Effective treatment for individuals**

Outcome Measures:

1) 90% of clients will participate in continuing care upon completion of detoxification.

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

Outcome Measures:

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

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

**VI. Qualifications**

**Licensed Physician:**
A licensed physician by the professional licensing agency shall be identified as the program’s medical director. The vendor shall be licensed and/or certified by the Indiana Division of Mental Health and Addiction according to state law.

**VII. Billable Units**

**Medicaid:**

Providers should bill Medicaid or private insurance when appropriate. For information on coverage of detoxification services and specific Medicaid Programs, please refer to the Indiana Health Coverage Programs (IHCP) Provider Manual located at [www.indianamedicaid.gov](http://www.indianamedicaid.gov).

**DCS funding:**

- **Detoxification Services (inpatient):** For those not eligible for Medicaid a Per Diem rate
will be paid for services as defined in this service standard. Detoxification Services will not be paid for services not deemed medically necessary.

- **Detoxification Services (outpatient):** For those not eligible or Medicaid, a Per Diem rate will be paid or services as defined in this service standard. Detoxification Services will not be paid for service not deemed medically necessary.

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

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

**VIII. Case Record Documentation**
Case record documentation for service eligibility must include:
1. A completed, signed, and dated DCS/Probation referral form authorizing services
2. Written reports no less than 7 days from transition to next level of care. Case documentation shall show when report is sent.
3. Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

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

**X. Adherence to the DCS Practice Model**
Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.
SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
RESIDENTIAL SUBSTANCE USE TREATMENT
(Revised 2/1/2012-Effective 3/1/2012)

I. Service Description
This service standard applies to families and children involved with the Department of Child Services (DCS) and/or Probation. Services may be provided for clients of all ages with a substance-related disorder and with minimal manageable medical conditions; minimal withdrawal risk; or emotional, behavioral cognitive conditions that will not prevent the client from benefiting from this level of care. Residential treatment programs are characterized by offering 24 hour supervised living with a highly structured treatment program that includes individual, group, and family counseling. Residential treatment is most appropriate for clients who are unsuccessful in outpatient. Residential treatment is comprehensive and intensive. The focus of residential treatment is to give the client the tools to begin a substance-free lifestyle. The program must be licensed and/or certified by The Division of Mental Health and Addictions. The program shall be staffed by appropriately credentialed personnel who are trained and competent to implement residential programming.

II. Service Delivery
The minimum length of stay in the program shall be 10 days and the maximum stay 21 days.

The service provider must identify a plan to engage the client in the process, a plan to work with non-cooperative clients including those who believe they have no problems to address as well as working with special needs clients such as those who are mentally ill or developmentally delayed.

Services are planned and organized with addiction professionals and clinicians providing multiple treatment service components for the rehabilitation of alcohol and drug abuse or dependence in a group setting.

An individualized recovery plan must be developed that considers the client’s age, ethnic background, cognitive development and functioning, and clinical issues. Recovery plans should connect substance use and how it affects child safety. Attention to adverse experiences in the client in an attempt to break the cycle of child maltreatment. Recovery plans shall provide a framework for measuring success and progress. Recovery plans should also include goals and objectives. Goals shall be designed to address the issue(s) identified in the substance use assessment and include an achievable time frame. Objectives shall have an expected result. A recovery plan partially based on a functional assessment of each resident's daily living, socialization, and coping skills that is based on structured evaluation and observation of behavior.
Residential treatment services must be based on a written, cohesive, and clearly stated philosophy and treatment orientation and must include the following standards:

1. There must be evidence that the philosophy is based on literature, research, and proven practice models.
2. The services must be client centered.
3. The services must consider client preferences and choices.
4. There must be a stated commitment to quality services.
5. The residents must be provided a safe, alcohol free, and drug free environment.
6. The individual environment must be as homelike as possible.
7. The services must provide transportation or ensure access to public transportation in accordance with the recovery plan.
8. The services must provide flexible alternatives with a variety of levels of supervision, support, and treatment as follows:
9. Service flexibility must allow movement toward the least restrictive environment but allow increases in intensity during relapses or cycles of relapse.
10. The Residential services must provide continuous or reasonably incremental steps between levels.
11. An agency cannot terminate a consumer from all services because of a need for more supervision, care, or direction without the agency making a good faith effort to continue to provide adequate, safe, and continuing treatment unless the resident is transferred to another entity with continuing treatment provided to the resident by that entity.
12. The treatment services must be carried out in residences that meet all life safety requirements and are licensed or certified as appropriate.
13. Residential services shall include specific functions that shall be made available to consumers based upon the individual recovery plan. These functions include the following:
   - Crisis services, including access to more intensive services, within twenty-four (24) hours of problem identification.
   - Case management services, including access to medical services, for the duration of treatment, provided by a case manager or primary therapist.
   - A consumer of Residential treatment services must have access to psychiatric or addictions treatment as needed.

All sample collections drug screens will be observed sample collections screens. Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Propoxyphene, and Methamphetamine and other drugs indicated by client’s history. The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation.

A laboratory participating in DCS/Probation drug testing must comply with all applicable Federal Department of Health and Human Service, and, under these federal requirements, are
subsumed Substance Abuse and Mental Health Services Administration (SAMHSA), or College of American Pathology (CAP), or Clinical Laboratory Improvement Act (CLIA) requirements.

III. Target Population
In addition, services must be restricted to the following eligibility categories:

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

IV. Goals and Outcome Measures
Goals #1 Recovery plan goals developed from the substance use assessment

Outcome Measure
1) 100% of referred clients will have a recovery plan developed following the assessment with the recovery plan provided to the referring worker within 10 days of completion. Treatment goals will be individualized based on assessment with easy to evaluate outcomes. All goals will be developed with the expectation that the client will remain drug free.

Goal #2 Regularly modify and update the recovery plan to reflect client changes and progress

Outcome Measure:
1) 100% of Recovery plan should identify short term goals attainable at 10 to 21 days and measurable by an expected performance or behavior.
2) 100% of cases where the client successfully completes treatment will have a discharge plan submitted to the referring worker within 7 days of discharge. The discharge plan will include client’s response to treatment and the aftercare plan.
3) 100% of cases where the client does not successfully complete treatment will have a recommendation report submitted to the referring worker within 7 days of termination of services.

Goal #3 Drug screens will be provided to the referring worker in a timely fashion.

Outcome Measures:
1) 100% of positive reports will be reported verbally by phone, voice mail or email within 24 hours of receiving the results of the drug screen. Written reports of the drug screen will be mailed/faxed to the referring worker within 24 hours of receipt of laboratory results.
Goal #4 Clients will remain drug free.

Outcome Measures:
1) 95% of clients who participate in Residential treatment will remain drug free during the service provision period as indicated by routine drug screens.
2) 75% of clients who participate in Residential treatment will transition to a lower level of substance use treatment.
3) 60% of clients who participate in Residential treatment will remain drug free until DCS case closure as indicated by routine drug screens.

Goal #5 Provide No-show alert to FCM

Outcome Measures:
1) 100% of no-show alerts will be provided to referring worker immediately following each no-show.

Goal #6 DCS and client satisfaction with services

Outcome Measures:
1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
2) 80% of the clients who have completed substance use treatment services will rate the services “satisfactory” or above.

V. Qualifications
The program shall be staffed by appropriately credentialed personnel who are trained and competent to implement substance use treatment as outlined by state law. IC 25-23.6-10.5-9

VI. Billable Units

Medicaid Funding: Medicaid shall be billed when appropriate.

Providers should bill Medicaid or private insurance when appropriate. For information on coverage of residential services and specific Medicaid Programs, please refer to the Indiana Health Coverage Programs (IHCP) Provider Manual located at www.indianamedicaid.gov.

DCS funding:

Residential Treatment
Those services not deemed appropriate to bill Medicaid eligible client, will be billed to DCS per a day to day per diem rate for services as defined in this service standard.

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

**VII. Case Record Documentation**
Case record documentation for service eligibility must include:
1) A completed, dated, signed DCS/Probation referral form authorizing service;
2) Documentation of regular contact with the referred families/children and referring agency;
3) Documentation of progress notes that provide details of clients increase in performance and/or behavior that demonstrate growth and/or regression regarding the recovery process and lifestyle changes needed for the individual to remain drug free.
4) Recovery plan documenting short term goals attainable at 14 to 21 days and measurable by an expected performance or behavior.
5) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
6) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

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

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

This service standard applies to families and children involved with the Department of Child Services and/or Probation. Services may be provided for clients of all ages in need of an assessment for substance use. The goal of the initial substance use assessment is to evaluate the client’s substance use, the client’s level of functioning and the appropriate entrance into substance use treatment services.

II. Service Delivery

A face-to-face clinical interview must take place with each referred individual. The provider must be able to complete the initial assessment within 72 hours of the referral if an emergency exists or sooner if the Family Case Manager suspects the client is in need of detoxification services. For emergency assessments, it is expected that a verbal report will be provided to the referring Family Case Manager within 72 hours and a written report provided within 7 days after the completion of the assessment with the client. Recommendations regarding the client’s needs must be provided on each assessment.

The following standardized assessment tools for drug/alcohol use may be administered to accurately determine if further substance use assessment is indicated: Substance Use Subtle Screening Inventory (SASSI), Addiction Severity Index (ASI) Teen Addiction Severity Index (T-ASI), ASI Lite, Addiction Society of Medicine Placement Patient Criteria Revised Version II (ASAM PPII), Drug Use Screening Test (DAST), Substance Use Relapse Assessment (SARA). Other standardized tools may be used to best assess the specific needs of the client.

A multi-axial system must be used to develop a comprehensive bio-psychosocial assessment to include a mental status examination at the time of the initial appointment.

Bio-Psychosocial Assessment must include:
A description of the presenting problem. Clinical Syndromes and/or other conditions that may be a focus of clinical attention. An in-depth drug and alcohol use history with information regarding onset, duration, frequency, and amount of use; substance(s) of use and primary drug of choice. Any associated medical, psychological and social history of the client, associated health, work, family, person, and interpersonal problems; driving record related to drinking or drug use; past participation in treatment programs. The assessment will also include client’s attitude toward treatment.
Mental health examination must include: client’s mood, affect, memory processes, hallucinations, judgment, insight, and impulse control.

Therapist Recommendations:
Following the assessment of each client, the service provider must make a recommendation which includes any necessary treatment as well as the treatment modality and length.

Services must be available to clients who have limited daytime availability. The service provider must identify a plan to work with non-cooperative clients including those who believe they have no problems to address as well as working with special needs clients such as those who are mentally ill or developmentally delayed.

No-show alert forms will be provided by the contracted agency to inform the referring worker of the client’s failure to attend the initial assessment. After three no-shows, a new referral from the referring worker must be sent to initiate new services.

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

III. Medicaid
It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The Services not eligible for MEDICAID REHABILITATION OPTION (MRO) or MEDICAID CLINIC OPTION (MCO) may be billed to DCS.

IV. When DCS is not paying for services:

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

V. Target Population
Services must be restricted to the following eligibility categories:
• Children and families who have substantiated cases of child abuse and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or CHINS status.
• Children and their families which have an IA or the children have the with a status of CHINS, and/or JD/JS;
• Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

VI. Goals and Outcome Measures

Goal #1 Maintain timely assessment with the family.
Outcome Measures:

1) 100% of emergency referred clients will be assessed within 72 hours or sooner if a medical crisis exists.
2) 90% of non-emergency referred clients will assessed within 10 days of the initial referral.

Goal #2 Timely receipt of report to prepare for services/court and regular and timely communication with the referring worker.
Outcome Measures:

1) For emergency assessment: 100% of the verbal reports will be received by the referring worker with 72 hours of the assessment; the written report received by the referring worker 7 calendar days after the assessment with the individual.
2) For non-emergency assessments: 100% of the written reports will be received by referring worker 10 days after the completion of the assessment with the individual.

Goal #3 Recommendations relevant and based on documentation in the body of the report.
Outcome Measures:

1) 100% of recommendations prepared as a result of the assessment are appropriate based on interviews, observations, review of other records, and completion of test instruments.
2) 100% of no-show alerts will be provided to referring worker immediately following the clients (3) third no-show.

VII. Minimum Qualifications

Medicaid

Medicaid will reimburse physician or HSPP directed outpatient mental health assessments: (1) of the following practitioners:
(A) A licensed psychologist
(B) A licensed independent practice school psychologist
(C) A licensed clinical social worker
(D) A license marital and family therapist
(E) A license mental health counselor
(F) A license clinical addiction counselor
(G) An advanced practice nurse who is a licensed, registered nurse with a master’s degree in nursing with a major in psychiatric or mental health nursing form an accredited school of nursing
(H) Anyone authorized by the agency

DCS

Minimum Qualifications:
1) The program shall be staffed by appropriately credentialed personnel who are trained and competent to complete Substance Use Assessments as required by state law.

VIII. Billable Units

Medicaid:

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

<table>
<thead>
<tr>
<th>Billing Code</th>
<th>Title</th>
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<tbody>
<tr>
<td>H0015 HW U1</td>
<td>Alcohol and/or other drug services; intensive outpatient (treatment program that operates at least three(3) hours/day and at least three(3) days/week and is based on an individualized treatment plan, including assessment, counseling; crisis intervention, and activity therapies or education</td>
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DCS funding: Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below. These billable units will also be utilized for services to referred clients who are not Medicaid eligible and for those providers who are unable to bill Medicaid.
• **Substance Use Assessment**
  per hour. Includes time face to face with the client administering, scoring, and interpreting testing and writing of reports. Maximum of 1 hour report writing may be billed per assessment.

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

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

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

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

• **Drug Screens**
  Actual cost of the screens.

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

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

**IX. Case Record Documentation**
Department of Child Services
Regional Document for Child Welfare Services
Term 7/1/11-6/30/13
February 5, 2013
Necessary case record documentation for service eligibility must include:

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

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

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

This service standard applies to families and children involved with the Department of Child Services and/or Probation. Services may be provided for clients of all ages with a substance-related disorder and with minimal manageable medical conditions; minimal withdrawal risk; or emotional, behavioral cognitive conditions that will not prevent the client from benefiting from this level of care. A variety of scientifically based approaches to Substance Use Recovery exists. Recovery prescribed for all clients must be evidenced based. Substance Use Recovery can include behavioral therapy (such as counseling, cognitive therapy, or psychotherapy), medications, or their combination.

Effective Recovery attends to multiple needs of the individual, not just his or her substance use. To be effective, Recovery must address the individual's substance use and any associated medical, social, psychological, vocational, and legal problems.

A face-to-face multi-axial clinical assessment must take place prior to admission to an outpatient program.

II. Service Delivery

Services must be available to clients who have limited daytime availability. The service provider must identify a plan to engage the client in the process, a plan to work with non-cooperative clients including those who believe they have no problems to address as well as working with special needs clients such as those who are mentally ill or developmentally delayed.

Services are planned and organized with addiction professionals and clinicians providing multiple Recovery service components for the rehabilitation of alcohol and drug use or dependence in a group setting.

An individualized Recovery plan must be developed that considers the client’s age, ethnic background, cognitive development and functioning, and clinical issues. Recovery plans should connect substance use and how it affects child safety. Recovery plans shall provide a framework for measuring success and progress. Recovery plans should also include goals and objectives. Goals shall be designed to address the issue(s) identified in the substance use assessment and include an achievable time frame. Objectives shall have an expected result.

All sample collections drug screens will be observed sample collections screens. Minimum of
substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Propoxyphene, and Methamphetamine and other drugs indicated by clients history. The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation.

A laboratory participating in DCS/Probation drug testing must comply with all applicable Federal Department of Health and Human Service, and, under these federal requirements, are subsumed Substance Abuse and Mental Health Services Administration (SAMHSA), or College of American Pathology (CAP), or Clinical Laboratory Improvement Act (CLIA) requirements.

**Addictions Counseling (Individual Setting) – is designed to be a less intensive alternative to IOT.**

1. The client is the focus of the service.
2. Documentation must support how Addiction Counseling benefits the client, including when the client is not present.
3. Addiction Counseling requires face-to-face contact with the client and/or family members or non professional caregivers.
4. Addiction Counseling consists of regularly scheduled sessions as needed.
5. Addiction Counseling may include the following:
   - Education on addiction disorders.
   - Skills training in communication, anger management, stress management, relapse prevention.
6. Addiction Counseling goals are rehabilitative in nature.
7. Addiction Counseling must be provided in an age appropriate setting for a client less than eighteen (18) years of age receiving services.
8. Addiction Counseling must be individualized.
9. Drug Screens as recommended per level of care or requested by Family Case Manager.
10. Case managements/referrals to available community services.

**Exclusions:**

1. Clients with withdrawal risk or symptoms whose needs cannot be managed at this level of care, or who need detoxification services.
2. Clients at imminent risk of harm to self or others.
3. Addiction Counseling may not be provided for professional caregivers.
4. Addiction Counseling sessions that consists of education services only will not be reimbursed.
Addiction Counseling (Group Setting) - is designed to be less intensive alternative to IOT.

1. The consumer is the focus of Addiction Counseling.
2. Documentation must support how Addiction Counseling benefits the consumer, including when services are provided in a group setting and/or the consumer is not present.
3. Addiction Counseling requires face-to-face contact with the consumer and/or family members or non professional caregivers.
4. Addiction Counseling consists of regularly scheduled sessions.
5. Addiction Counseling is intended to be a less intensive alternative to IOT.
6. Addiction Counseling may include the following:
   - Education on addiction disorders.
   - Skills training in communication, anger management, stress management, relapse prevention.
7. Addiction Counseling must demonstrate progress toward and/or achievement of consumer Recovery goals identified in the IICP.
8. Addiction Counseling goals are rehabilitative in nature.
9. A licensed professional must supervise the program and approve the content and curriculum of the program.
10. Addiction Counseling must be provided in an age appropriate setting for a consumer less than eighteen (18) years of age receiving services.
11. Addiction Counseling must be individualized.
12. Drug Screens as recommended per level of care or requested by Family Case Manager.
13. Case managements/referrals to available community services.

Exclusions:
1. Clients with withdrawal risk or symptoms whose needs cannot be managed at this level of care, or who need detoxification services.
2. Clients at imminent risk of harm to self or others.
3. Addiction Counseling may not be provided for professional caregivers.
4. Addiction Counseling sessions that consists of education services only will not be reimbursed.

Intensive Outpatient Recovery (IOT)
1. Regularly scheduled sessions, within a structured program, that are at least three (3) consecutive hours per day and at least three (3) days per week.
   1. IOT includes the following components:
      a. Referral to 12 step programs, peers and other community supports.
      b. Education on Addictions disorders.
c. Skills training in communication, anger management, stress management and relapse prevention.
d. Individual, group and family therapy (provided by a licensed professional or QBHP Only)

2. IOT must be offered as a distinct service.
3. IOT must be provided in an age appropriate setting for a client age eighteen (18) and under.
4. IOT must be individualized.
5. Access to additional support services (e.g. peer supports, case management, 12-step programs, aftercare/relapse prevention services, integrated Recovery, referral to other community supports) as needed.
6. The client is the focus of the service.
7. Documentation must support how the service benefits the client, including when the service is in a group setting.
8. Services must demonstrate progress toward or achievement of client Recovery goals identified in the IICP.
9. Service goals must be rehabilitative in nature.
10. Up to twenty (20) minutes of break time is allowed during each three consecutive hour session.
11. Drug Screens as recommended per level of care or requested by the Family Case Manager.
12. Referral to available community services is available.

Exclusions:

1. Clients with withdrawal risk/symptoms whose needs cannot be managed at this level of care or who need detoxification services
2. Clients at imminent risk of harm to self or others.
3. IOT will not be reimbursed for clients receiving Group Addictions Counseling on the same day.
4. IOT sessions that consist of education services only are not reimbursable.
5. Any service that is less than three hours may not be billed as IOT, but may be billed as Group Addictions Counseling (if provider qualifications and program standards are met)

Specialized Recovery:

Substance use Recovery can also be provided through the use of individual sessions as needed and 1 to 1.5 hours of group weekly or more than once weekly group counseling session based on assessment of individual’s needs. Services will be conducted as outlined in the counseling and group counseling section of this service standard, and can include gender specific group counseling to deal specifically with gender issues that may cause barriers to the individual’s ability to remain drug free i.e. domestic violence, traumatic events and/or childhood trauma.

Specialized Recovery can also include modalities of brief counseling therapy.
III. Medicaid

It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid.

IV. When DCS is not paying for services:

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

V. Target Population

In addition, services must be restricted to the following eligibility categories:
1) Children and families who have substantiated cases of use and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or CHINS status
2) Children and their families which have an IA or the children have the status of CHINS, and/or JD/JS
3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed

VI. Goals and Outcome Measures

**Goals #1**
Recovery plan goals developed from the substance use assessment

Outcome Measure
1) 100% of referred clients will have a Recovery plan developed following the assessment with the Recovery plan provided to the referring worker within 10 days of completion.
Recovery goals will be individualized based on assessment with easy to evaluate outcomes.

**Goal #2**
Regularly modify and update the Recovery plan to reflect client changes and progress.
Outcome Measure:
1) Recovery Plan should identify long and short term goals attainable at 2-, 4-, and 6-month’s intervals and measurable by an expected performance or behavior.
2) Vendor shall maintain progress notes that provide details of clients increase in performance and/or behavior that demonstrate growth and/or regression regarding the recovery process and lifestyle changes needed for the individual to remain drug free.
3) Upon successful completion of Recovery the provider shall submit a discharge plan to the referring worker to include client’s response to Recovery and aftercare plan.
4) Written reports with no less than monthly or more frequently as prescribed by DCS

Goal #3
Drug screens will be provided to the referring worker in a timely fashion.
Outcome Measures:
   1) 100% of positive reports will be reported verbally by phone, voice mail or email within 24 hours of receiving the results of the drug screen. Written reports of the drug screen will be mailed/faxed to the referring worker within 24 hours of receipt of laboratory results.

Goal #4
Provide No-show alert to FCM.
Outcome Measures:
   1) 100% of no-show alerts will be provided to referring worker immediately following each no-show.

Goal #5
DCS and client satisfaction with services
Outcome Measures:
   1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
   2) 80% of the clients who have completed substance use Recovery services will rate the services “satisfactory” or above.

VII. Minimum Qualifications

Medicaid Reimbursed
It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid provider qualifications.

DCS Reimbursed
The program shall be staffed by appropriately credentialed personnel who are trained and competent to complete Substance Use Outpatient Treatment as required by state law.
VIII. Billable Units

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

MRO

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<tr>
<th>Billing Code</th>
<th>Title</th>
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<tbody>
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<td>H2035 HW</td>
<td>Alcohol and/or other drug Recovery program, per hours</td>
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<tr>
<td>H2035 HW HR</td>
<td>Alcohol and/or drug Recovery program, per hour</td>
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<td>(family/couple, consumer present)</td>
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<td>H2035 HW HS</td>
<td>Alcohol and/or drug Recovery program, per hour</td>
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<td></td>
<td>(family/couple, without consumer present)</td>
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<tr>
<td>H0005 HW</td>
<td>Alcohol and/or other drug services; group counseling by a clinician.</td>
</tr>
<tr>
<td>H0005 HW HR</td>
<td>Alcohol and/or drug services; group counseling by a clinician.</td>
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<td>(family/couple, consumer present)</td>
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<tr>
<td>H0005 HW HS</td>
<td>Alcohol and/or drug services; group counseling by a clinician.</td>
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<tr>
<td></td>
<td>(family/couple, without consumer present)</td>
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<tr>
<td>H0015 HW U1</td>
<td>Alcohol and/or other drug services; intensive outpatient (Recovery program that operates at least three (3) hours/day and at least three (3) days/week and is based on an individualized Recovery plan, including assessment, counseling; crisis intervention, and activity therapies or education</td>
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</table>
DCS funding: Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below. These billable units will also be utilized for services to referred clients who are not Medicaid eligible and for those providers who are unable to bill Medicaid.

Addictions Counseling (Individual & Family): To be billed per hour

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

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

Addictions Counseling Group
Services include group goal directed work with clients. To be billed per person per hour.

Intensive Outpatient Treatment
Services include goal directed services as defined in this Service Standard. Per three hour session per person

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

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

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

Court Appearance

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

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

**Drug Screens**
Actual cost of the screens.

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

**IX. Case Record Documentation**
Case record documentation for service eligibility must include:

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

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

**XI. Adherence to the DCS Practice Model**
Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, assessing, planning and intervening to partner with families and the community to better outcomes for children.
SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
DAY REPORTING/TREATMENT PROGRAMS

I. Service Description
Day Treatment/Day Reporting programs provide intensive supervision to children exhibiting a pattern of delinquent behavior. The primary functions of Day Treatment/Day Reporting can include intensive supervision, utilization of a cognitive behavior change approach, and be utilized to prevent the removal of the child from the home, to increase community safety, and to improve family functioning.

Day Treatment/Day Reporting programs can vary in the intensity and length of supervision and service hours the child and family receive.

The Day Treatment service is designed to provide an environment in which each child can develop the skills necessary for successful living, and to alter the previous environment of the child so that newly acquired skills are encouraged and old inappropriate behaviors are discouraged. Family involvement is highly encouraged. The service also addresses the educational needs of the individual child, based on an assessment of their academic progress.

The day reporting service provides daily supervision and structured activities for youth who require more intensive oversight, as an alternative to secure detention. This program serves pre- or post-adjudicated youth.

Day Treatment
Providing agency receives referrals from the Department of Child Services FCM or the Probation Officer.

Upon receipt of a referral, the provider will respond to the referral source within two business days. Provider will conduct an interview with the child and family within 5 business days of the referral and notify the referral source regarding acceptance into the program within 24 hours after the interview.

Service delivery can range from 1-180 days, at 4-10 hours per day. Service delivery may be extended beyond 180 days if approved by referral source. Programs must be open and available for at least 20 hours each week, if a youth is in the program for at least 4 hours on a day, the Per Diem can be billed.

Services shall include, but are not limited to: Individualized educational planning, life skills training (including work readiness if appropriate), and community service projects.

Services shall also include a minimum of 6 hours per week of cognitive based instruction in a curriculum that demonstrates best practices of model programs. The use of role playing and interaction to teach new skills may be utilized. Services can address thinking errors, anger
management, substance abuse, and other mental health needs identified by the provider and referral source.

Pre- and post-tests for evaluation and progress must be utilized.

Provider must also include a component that requires family involvement for a minimum of one hour per week. This may be in the form of a parenting support group or parenting instruction.

Provider will communicate progress to the referral source at least once per month in the form of a written progress report and monthly attendance in program, including number of contact hours. Provider will attend all Court review hearings and provide written progress reports to the Court at each review hearing.

**Day Reporting**
Providing agency receives referrals from the Department of Child Services FCM or Probation Officer.

Upon receipt of a referral, the provider will respond to the referral source within two business days. Provider will conduct an interview with the child and family within 5 business days of referral and will notify the referral source regarding admission status within 24 hours of the interview.

Service delivery can range from 1-180 days, at 4-10 hours per day. Service delivery may be extended beyond 180 days if approved by referral source. Programs must be open and available for at least 20 hours each week, if a youth is in the program for at least 4 hours on a day, the Per Diem can be billed.

Services shall include, but are not limited to: Intensive supervision, educational planning assistance, and community/recreational activities.

Provider will communicate progress to the referral source and monthly attendance in program, including number of contact hours performed. Provider will submit written progress reports to the referral source prior to each court hearing.

**II. Target Population**
Services must be restricted to the following eligibility categories:

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

Day Treatment

Goal #1: Reduce the risk of repetitive delinquent behavior.

Outcome Measures
1) 100% of children in the Day Treatment program will receive a minimum of 6 hours per week of cognitive based instruction required to successfully complete the program.
2) 50% of children will successfully complete the program with a reduction of the risk to re-offend based on a validated risk assessment tool.

Goal #2: Prevent removal from home or community.

Outcome Measures
1) 70% of parents will participate in required family activities as identified by the individual program.
2) 70% of children who successfully complete the program will have exhibited improved family relationships.
3) 70% of families that were intact at the initiation of service will remain intact with no out-of-home, county paid placement for more than five days throughout the service provision period, and will have avoided out of home placement 6 months following service closure.

Goal #3: Enrollment in education programming

Outcome Measures
1) 100% of children will be enrolled in some type of educational programming during their involvement in the program.
2) 70% of children will be enrolled in an education program three months after program completion.

Goal #4: Provide opportunities for the child to make meaningful contributions to their community.

Outcome Measures
1) 100% of children will be given opportunities to participate in employment, community, and recreational activities during their involvement in the program.
2) 70% of children will be employed or involved in community activities three months after program completion.

Day Reporting

Goal #1: Provide supervision as an alternative to incarceration.

Outcome Measures
1) 75% of youth will not return to secure detention while in the program.
2) 100% of youth will receive intensive supervision and participate in other activities while in the program.

Goal #2: Provide opportunities for the child to make meaningful contributions to their community.
community.

Outcome Measures
1) 100% of children will be given opportunities to participate in employment, community, and recreational activities during their involvement in the program.

2) 70% of children will be employed or involved in community activities three months after program completion.

Goal #3: Enrollment in educational programming.

Outcome Measures
1) 100% of children will be enrolled in some type of educational programming during their involvement in the program.
2) 70% of children will be enrolled in an educational program three months after program completion.

IV. Minimum Qualifications

Direct Worker:
Program Coordinator must hold a Bachelor’s degree in criminal justice, sociology, psychology, social work or related field.

Supervision:
Program Supervisor must hold a Master's degree in criminal justice, social work, psychology, Social Work or related field.

Overall supervision of the Day Treatment program must be provided by a person with a Master's degree in Supervision/consultation. Supervision is to include not less than one (1) hour of face to face supervision/consultation per 20 hours of direct client services provided, and must occur every two (2) weeks or more frequently.

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

V. Billable Units

Per Diem cost for each client placed in the program. This per diem rate includes all costs of the program. Programs must be open and available for at least 20 hours each week, if a youth is in the program for at least 4 hours on a day, the Per Diem can be billed. (There are two per diem units Day Reporting and Day Treatment.)

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

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

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

VIII. Adherence to the DCS Practice Model
Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.
SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
TRUANCY TERMINATION
(Revised 2/1/2012-Effective 3/1/2012)

I. Services Description
The purpose of Truancy Termination services is to provide school drop-out prevention education, job readiness skills services, parent education, and family support services to youth and their families in order to reduce recidivism of delinquent youth and truants.

Family Support Services
Family support workers are to work with family members to identify reasons for youth’s truancy and barriers to regular and positive school attendance as well as work with school personnel and Probation Officers to identify solutions and interventions necessary to ensure school attendance, increase the youth’s involvement in the school, and improve academic performance.

Accomplishing these objectives may require the support worker to attend parent/teacher conferences and attend classes with the student. The support worker shall provide services in the areas of parent education and crisis intervention, including direct services. The support worker will be present as the court directs, including, but not limited to the initial hearing, where the worker will meet with the youth and family and complete the preliminary intake. The purpose of the preliminary intake is to gather basic information and provide a brief overview of the program.

The support worker is responsible for providing weekly written reports attending court hearing to provide testimony on progress, submitting monthly written progress reports regarding each family’s circumstances, and monitoring school attendance, performance, and behavior. These reports shall reflect ongoing collaboration and cooperation among the family support workers, school social workers, and Probation Officers.

The family support workers shall conduct and complete comprehensive intake and assessment for each referral to create a Family Development Plan (FDP). The FDP will be shared with school social workers and Probation Officers. The family support worker will assist families with transportation to the program.

Training Modules
Training modules consist of six (6) weekly skills-based classes which the youth and parents are required to complete. The family support worker will assess progress of all program graduates, and identify youth and families who may benefit from additional training. Subsequent to the training an assessment of progress, including areas where additional improvement is needed should be made and any additional services recommended shared with school social workers, probation officers, and the court.
Youth Modules
The following youth modules of Skills Based programming will be taught:
- Personal Hygiene
- Truancy
- College Awareness
- Conflict Resolution
- Relationships (peer to peer and peer to parent)
- Substance Abuse
- Decision Making, Time Management, and Goal Setting

Parent Modules
The following parent modules of Skills Based programming will be taught:
- Role as a parent and self-esteem
- Understanding child growth and development/Sibling Rivalries
- Communication and listening skills/Relationships
- How to use effective discipline/Problem solving
- Anger management/Conflict resolution/Stress maintenance
- Teaching morals, values, and respect
- Financial Management

Subsequent to the completion of the training modules the family support worker shall continue to work with the school social workers, probation officers, and the court to monitor families’ well-being to monitor school attendance. The support worker will conduct monthly activities designed to connect youth and families with positive sources of ongoing encouragement (i.e. carrier fairs, family dinners, age appropriate sports and/or entertainment events, etc.).

II. Target Population
Services must be restricted to the following eligibility categories:
- Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
- All adopted children and adoptive families.

III. Goals and Outcomes
Goal #1 Ensure youth and parents participating in the program build skills in the module areas.
Outcome Measures
1) 85% of youth and parents referred by the Juvenile Court shall complete six (6) skills-based modules.
2) 85% of those families completing the modules shall demonstrate increased knowledge resulting from participation in the skills-based modules.

Goal #2 Increase regular school attendance of youth completing the program.

Outcome Measures
1) 75% of youth completing the six week modules will have 95% attendance during the service provision period.
2) 75% of youth will have 95% attendance during the period of time that begins at program completion and ends at 6 month follow up.

Goal #3 Juvenile Court and client satisfaction with services

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

IV. Minimum Qualifications

Training Facilitator (Paraprofessional):
A high school diploma or GED and 21 years of age. Must possess a valid driver’s license, the ability to transport self and others, and must have state minimum car insurance coverage in force at all times.

Family Support Worker:
Bachelor’s Degree in social work, psychology, sociology, or a directly related human service field.

Supervisor (Professional):
Bachelor’s Degree in social work, psychology, sociology, or directly related human service field plus three (3) years related experience.

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

V. Billable Unit

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

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

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

Group (Effective 3/1/2012)

Group will be defined as at least 3 clients (who are DCS or Probation referrals and are from no less than two different referred families. If there are less than 3 clients from at least two DCS/Probation referrals, the payment would be the face to face rate for each referral.

Issue:
Question: The provider has 3 DCS/Probation clients referred from 2 different families. When cost allocating it, do they charge 1/3 or ½ (by client or referral)?
Answer: By number of referrals. Therefore, ½ charged to each referral, or ½ of the cost would be allocated to each family.

Question: What if there are less than 3 clients referred?
Answer: The payment would be by the Face to Face rate for each referral. Example, if the Face to Face rate is $50, then the claim would be for $50 for each referral.

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

- 0 to 7 minutes  do not bill 0.00 hour
- 8 to 22 minutes 1 fifteen minute unit 0.25 hour
- 23 to 37 minutes 2 fifteen minute units 0.50 hour
- 38 to 52 minutes 3 fifteen minute units 0.75 hour
- 53 to 60 minutes 4 fifteen minute units 1.00 hour
Translation or sign language
Services include translation for families who are non-English language speakers or hearing-impaired and must be provided by a non-family member of the client. Dollar-for-dollar amount.

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

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

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

VI. Adherence to the DCS Practice Model
Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.
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| ST073099  | DOCKSIDE SERVICES, INC. |
| ST017624  | FAMILY CENTERED SERVICES, INC. |
| ST030282  | FAMILY SERVICE SOCIETY INC |
| ST351598  | GATEWAY WOODS FAMILY SERVICES INC |
| ST054005  | LIFELINE YOUTH & FAMILY SERVICES, INC. |
| ST063751  | LUTHERAN SOCIAL SERVICES INC |
| ST092571  | MIDWEST PSYCHOLOGICAL CENTER, INC. |
| ST064986  | NATIONAL MENTOR HEALTHCARE, LLC |
| ST020243  | NORTHEASTERN CENTER INC |
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| ST007949  | PARK CENTER INC |
| ST007949  | PARK CENTER INC |
| ST00000383468 | QUALITY COUNSELING & PSYCHOLOGICAL SRV |
| ST055379  | RES-CARE INC |
| ST125698  | RIGHT MIND PROFESSIONAL CORP. |
| ST000282  | SCAN, INC. |
| ST063846  | TAS-TRANSITIONAL ASSISTANCE SERVICES. |
| ST028842  | THE ARC OF NORTHEAST INDIANA, INC. |
| ST082103  | THE OTIS R. BOWEN CENTER FOR HUMAN SERVICES INC. |
| ST082103  | THE OTIS R. BOWEN CENTER FOR HUMAN SERVICES INC. |
| ST089978  | THE VILLAGES OF INDIANA, INC. |
| ST009813  | WHITINGTON HOMES AND SERVICES FOR CHILDREN AND FAMILIES, INC |
| ST342128  | WRFS SERVICES |
| ST025627  | YOUTH SERVICE BUREAU OF JAY COUNTY INC |
| ST009796  | YOUTH SERVICES BUREAU OF HUNTINGTON COUNTY, INC. |

### HOME-BASED FAMILY CENTERED THERAPY SERVICES

<p>| ST067430  | CARING ABOUT PEOPLE, INC |
| ST285300  | CRIME VICTIM CARE OF ALLEN |
| ST011950  | CROSSROAD CHILD &amp; FAMILY SERVICES, INC. |
| ST012344  | DEKALB COUNTY PARENT GROUP FOR HANDICAPPED CHILDREN D/B/A CHILDREN FIRST CENTER, INC. |
| ST073099  | DOCKSIDE SERVICES, INC. |</p>
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## Community Partners for Child Safety

**Lead Agency Name:** SCAN, Inc.  
**Contact Person:** Rachel Tobin-Smith  
**Address:** 500 West Main Street, Fort Wayne, IN 46802  
**Phone:** (260) 421-5000  
**Email:** RTobin-smith@scaninc.org

### Subcontractors

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Healthy Families Indiana Program

Agency: North Adams Community Schools
Contact: Sarah Haggard
Address: 805 E. Monroe Street, Decatur, IN 46733
Phone: (260)724-0491   Email: shaggard@mchsi.com

Agency: SCAN, Inc.
Contact: Lorri Rowe Rachel Tobin-Smith Marty Temple
Address: 500 West Main Street, Fort Wayne, IN 46802
Phone: (260)421-5000   Email: lrowe@scaninc.org rtober-smith@scaninc.org mtemple@scaninc.org

Agency: The Villages of Indiana, Inc.
Contact: Deborah Brewer
Address: 2405 N. Smith Pike, Bloomington, IN 47404
Phone: (812) 332-1245   Email: dbrewer@villages.org

Agency: Children First Center
Contact: Jill Wagner
Address: P.O. Box 562, Auburn, IN 46706
Phone: (260)925-2865   Email: jill@childrenfirstcenter.org

Agency: Vistula Park Preschool
Contact: Jennifer Motz
Address: 603 Townline Road, LaGrange, IN 46761
Phone: (260) 463-2363   Email: jenmotz03@yahoo.com

Agency: Family Centered Services, Inc.
Contact: Amy George
Address: 123 South Marion Street, P.O. Box 207, Bluffton, IN 46714
Phone: (260) 824-8574   Email: asstdir@familycenteredservices.org

Indiana Youth Service Bureau

Agency: Allen County Youth Service Bureau
Contact: Greg Barnes
Address: 1117 ½ South Clinton Street, Fort Wayne, IN 46802
Phone: (260)449-7511   Email: greg_barnes@fwymca.org

Agency: Youth Service Bureau of Huntington County
Contact: Jan Williams
Address: 1344 Maple Drive, Huntington, IN 46750
Phone: (260)356-9681   Email: ysbadm@choiceonemail.com

FIRST STEPS

North Central Indiana
7221 Engle Road, Ste. 100
Fort Wayne, Indiana 46804
Phone: 260-207-5799
Toll Free: 1-877-494-5115
Fax: 260-478-4850 or 1-877-494-5116
Counties: Adams, Allen, Huntington & Wells

Northeast Indiana
700 E. Beardsley Ave.
Elkhart, IN 46514
Phone: 574-293-2813
FAX: 574-293-2300
Toll Free: 1-866-725-2398
Counties: Dekalb, Elkhart, LaGrange, Noble, Saint Joseph, Steuben, Whitley
Indiana Department of Child Services
Quality Service Review
Region 4

Conducted
October 2013

Report Issued
November 2013
## Review Team Members

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Review Team Facilitators
Lisa Rich, DCS Deputy Director and Lisa Whitaker, Performance and Quality Improvement State Director, Steve Scott, Region 4 Regional Manager and ShaFonda Lewis, QA Lead.

Quality Service Review Leads for Region 4
Abbi Becker and Regina Drummond
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**Introduction and Background**

The Quality Service Review (QSR) is an action-oriented learning process that provides a way of knowing what is working or not working, at the point of practice, for selected children and families receiving services. The QSR guides next step actions in practice development and local capacity building, leading to better outcomes for children and families. Human Systems and Outcomes, Inc. (HSO) designed the protocol for use in case-based QSR process. The tool guides professional appraisal of the status of a focus child receiving services, status of the parent/caregiver, and adequacy of performance of key service system practices and capacities used for the focus child and family. The protocol examines recent results for a focus child and his/her parents/caregivers and the contribution made by local service providers in the system of care in producing those results. Case review and other findings are used by local agency leaders and practice managers in stimulating and supporting efforts to improve services for children and youth who are beneficiaries of the local community’s system of care that provides child welfare, health, mental health, education, juvenile justice, and other services.

The Quality Service Review was initiated in Indiana in 2007 as part of an overall Child Welfare Reform Plan formulated with the collaboration of the Annie E. Casey Foundation, Child Welfare Practice and Policy Group and Human Systems Outcomes, Inc. The process involves the selection of a small sample of cases in a region that are reviewed through detailed interviews by trained reviewers with key case contributors. The interviewees include individuals such as the case manager, foster parent, focus child and his/her family members, legal partners, providers and others who are materially involved in the case. Reviewers use a structured protocol to guide their inquiry and determine the status or outcome for the child and the quality of practice contributing to that outcome. This appraisal yields an acceptability score that can be aggregated with other case stories to provide a quantitative score for the region being reviewed.

The Child Welfare Policy and Practice Group was retained to assist in the training of review team members and mentor trainers in order to establish a well-trained reviewer pool. All shadow reviewers must have a working knowledge of Indiana’s practice model and the QSR protocol. Shadows can include, but are not limited to, Department of Child Services (DCS) staff, community stakeholders, legislators, foster parents and Court representatives. All mentor
reviewers must have an extensive knowledge of the QSR Protocol, Indiana’s practice model and must have completed the reviewer training. All lead mentor reviewers have been approved by a trained lead prior to becoming a lead mentor reviewer.

In cases where there are immediate safety concerns for children, the case will be scored as concerted action needed, and the Regional Manager will be immediately notified. The State Performance and Quality Improvement (PQI) Director will discuss all management issues and significant policy deviations with the Regional Manager at the time of the review. The Regional Manager will address all policy and safety concerns with the County Directors and will report results of action taken in the monthly regional report.

A Focus on Practice and Results

Rating Scales
The QSR uses a 6-point rating scale as a “yard stick” for measuring the situation observed for each indicator. A full description of the rating scales can be found in Appendix A.

<table>
<thead>
<tr>
<th>Child, Family and System Performance Indicator Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 6 – Optimal and Enduring Status</td>
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<tr>
<td>Level 5 – Good and Stable Status</td>
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<tr>
<td>Level 4 – Minimally Adequate to Fair Status</td>
</tr>
<tr>
<td>Level 3 – Marginally Inadequate Status</td>
</tr>
<tr>
<td>Level 2 – Substantially Poor Status</td>
</tr>
<tr>
<td>Level 1 – Adverse or Poor and Worsening Status</td>
</tr>
</tbody>
</table>

The QSR protocol uses an in-depth case review method and practice appraisal process to find out how children and their families are benefiting from services received and how well locally coordinated services are working for children and families. Each child/family served is a unique “test” of the service system. Samples of cases are reviewed to determine child and parent/caregiver status, recent progress, and related system practice and performance results.
The core content of a QSR protocol is anchored in and designed to test practice performance, capacity, and results at the point and moment when a child and family in need meet and work together with people who help the family address needs. The philosophical basis for understanding this point includes the following:

- Practice should be child-focused and family-centered. Families are full, active participants in every aspect of family change and service processes. The family provides the context for interventions with their children.

- Child and Family Team Meetings (CFTMs) should be used to organize and support the change process for the child and family.

- The family change/service process should be individualized, culturally competent and strengths-based to build capacities for family independence.

- Family change efforts should work toward reaching defined outcomes related to family safety, well-being, child permanency, and family independence from the service system.

- Practice should be outcome-focused and results-driven.

- Children should be served in their own community without having to leave their school and regular relationships for reasons of family safety or treatment.

- Family change efforts should embrace and use evidence-based practice strategies, where available and appropriate to the child and family.

- Services for children and families should be integrated and coordinated across providers, agencies, funding sources and settings, including aligning various change strategies being used across interveners in the life of the child and family into a seamless process for the child and family.

- Well-integrated, coordinated service process for some families may require a service process that is inter-agency, community-based and collaborative in operation.

- Outcomes should be routinely measured for the child, family, program, local system of care, and state-level systems. QSR is a measure of practice and results that will be used in this effort.
Review Findings

In October 2013, a review was conducted in Region 4 of the Indiana Department of Child Services. The review process is organized around analysis of two areas of system functioning. The first is child and parent/caregiver status, regarding current outcomes among indicators such as safety, stability, permanency, well-being, and parenting capacities. The second is system performance, or the practice in which the system is engaging to achieve outcomes, such as family engagement, teaming, assessing, planning, and intervening.

A Quality Service Review (QSR) was conducted in Region 4 in July 2008 to establish a baseline. Subsequent reviews were conducted in May 2010 and December 2011. From the data generated during the previous review, the region identified two indicators to work toward on their Continuous Quality Improvement (CQI) plan. Those indicators selected were Team Formation and Functioning. Strategies to address this indicator had been developed and implemented through the CQI process (Appendix B). The implemented strategies did not yield the intended positive improvements in system performance as evidenced by the results of these indicators. The CQI team will continue to work with the region to adjust strategies toward continued improvement.

In comparison to the previous review, Region 4 increased scores on several QSR indicators. The system faces challenges in some areas that will be addressed in the remainder of this report.

In order to establish the appropriate percentages representing a “snapshot” of each criterion for the sample pull, a sample population of all cases in the region was pulled, using the following four criteria:

- Age of the child
- Length of time in care
- Placement type
- Case type

From the sample population percentages, a random sample of 30 ongoing cases and 6 assessments were pulled for the Region 4 QSR. Prior to the review, there were three case changes. Two of the case changes were due to parents refusing to sign the consent and the other was due to not being able to locate the parents. During this QSR, there was one case not scored due to the review team being unable to locate the family. As a result, there were a total of 35 cases reviewed during Region 4 QSR. The total number of interviews conducted was 274, with an average of 8 interviews per case.
The following charts represent the cases reviewed in Region 4 for the Baseline, Second Round, Third Round, and Fourth Round QSR across the region:

AGE

In Region 4:
- Majority of children reviewed were nine years and younger
- Increase of nine percentage points in children 14+ years between Round 3 and Round 4
In Region 4:
- Decrease in the percentage of cases reviewed in care 37+ months
- Increase of six percentage points in children in care 7 - 12 months
In Region 4:

- Increase in the number of CHINS cases between Round 3 and Round 4
- Decrease in the number of IA’s reviewed between Round 3 and Round 4
In Region 4:
- 65% of the children reviewed resided in either a custodial/non-custodial home or with relatives
- Increase of nine percentage points in foster placements between Round 3 and Round 4
# Indicator Results At A Glance

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>Baseline</th>
<th>Round 2</th>
<th>Round 3</th>
<th>Round 4</th>
<th>Score Change *</th>
<th>Percentage (%)**</th>
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<tbody>
<tr>
<td><strong>CHILD STATUS</strong></td>
<td></td>
<td></td>
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<td>Safety</td>
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<td>97</td>
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<tr>
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<tr>
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<td>97</td>
<td>100</td>
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<td>Learning and Development</td>
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<tr>
<td>Pathway to Independence</td>
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<td>67</td>
<td>0</td>
<td>67</td>
<td>67</td>
<td>NA</td>
</tr>
</tbody>
</table>

| **PARENT / CAREGIVER STATUS**       |          |         |         |         |               |                  |
| Parenting Capacities                | Bio-parent | 39   | 26      | 54      | 50            | -4               | -7.41%           |
| Informal Support                    | Bio-parent | 36   | 40      | 71      | 44            | -27              | -38.03%          |
| Caregiver Capacities                | Congregate | 50   | 100     | 100     | 100           | 0                | 0%               |
|                                       | Current Caregiver | 88   | 94      | 100     | 100           | 0                | 0%               |
| Informal Support                    | Current Caregiver | 94   | 76      | 94      | 90            | -4               | -4.26%           |

| **SYSTEM PERFORMANCE**              |          |         |         |         |               |                  |
| Role/Voice                          | Mother   | 50     | 53      | 68      | 65            | -3               | -4.41%           |
|                                       | Father   | 20     | 34      | 29      | 17            | -12              | -41.38%          |
|                                       | Child/Youth | 53   | 76      | 73      | 57            | -16              | -21.92%          |
| Team Formation                      | 21       | 33     | 54      | 46      | 8             | -14.81%          |
| Team Function                       | 29       | 20     | 52      | 30      | -22           | -42.31%          |
| Cultural Recognition                | 76       | 81     | 100     | 83      | -17           | -17.00%          |
| Assessing and Understanding         | Child    | 55     | 67      | 71      | 60            | -11              | -15.49%          |
|                                       | Family   | 26     | 34      | 75      | 44            | -31              | -41.33%          |
| Long-Term View                      | 33       | 44     | 69      | 29      | -40           | -57.97%          |
| Child and Family Planning Process   | 33       | 31     | 77      | 37      | -40           | -51.95%          |
| Planning Transitions and Life       | 44       | 35     | 79      | 38      | -41           | -51.90%          |
| Adjustments                         | 39       | 61     | 83      | 43      | -40           | -48.19%          |
| Intervention Adequacy               | 73       | 94     | 97      | 100     | 3             | 3.09%            |
| Resource Availability               | 73       | 94     | 97      | 100     | 3             | 3.09%            |
| Tracking and Adjusting              | 45       | 64     | 80      | 49      | -31           | -38.75%          |
| Maintaining Relationships           | Mother   | 56     | 64      | 67      | 76            | 9                | 13.43%           |
|                                       | Father   | 29     | 44      | 33      | 50            | 17               | 51.52%           |
|                                       | Siblings | 78     | 67      | 100     | 50            | -50              | -50.00%          |
|                                       | Extended Family | 53   | 77      | 91      | 56            | -35              | -38.46%          |

*Score change* is the absolute difference (increase or decrease) in percentage points from the Round 3 refine/maintain score to the Round 4 refine/maintain score.

**Percentage (%)** is the relative difference in terms of percentage change (improvement or decline) from Round 3 to Round 4. The formula used is ((Round 4 score – Round 3 score) / Round 3 score)*100 = percentage change.
Child Status Indicators

The following statistics represent the Refine/Maintain scores in the areas of Safety and Behavioral Risk for the Baseline, Second Round, Third Round, and Fourth Round QSR across the region.
Child Status: Safety/ Behavioral Risk

SAFETY
Is the child safe from harm or abuse in their home, school, and community?

Safety Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Children were appropriately supervised at all times
- Children were safe in all environments including home, school, and the community
- Visits with parents were supervised when deemed necessary
- Safety plans and protective orders in place were being followed

Listed below are some characteristics of the case that scored concerted action needed:

- In one case, a child resided with his paternal grandmother and his mother claimed he had sustained cigarette burns while with his father. Father and grandmother claimed child received the burns while with the mother. There was no evidence a report had been made to the DCS Hotline or that an assessment was completed concerning this incident although it was reported to DCS. A safety plan had yet to be developed to keep the child from harm although a recent court order stated that the child would be returning to his mother’s care.
**BEHAVIORAL RISK**

Are children exhibiting behaviors that could be harmful to self and others?

---

**Behavioral Risk Case Specific Findings**

Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Children were free of any behavioral problems that put themselves and/or others at risk
- Children with identified behavioral issues had therapy, medication, or other interventions, such as behavioral IEPs, in place that were successful in managing their behaviors

Listed below are characteristics for the two cases that scored concerted action needed:

- In one case, a three-year-old child had inappropriate boundaries as he was described as knowing no strangers. He was also hyperactive, attention seeking, and displayed impulsive behaviors. In addition, he was aggressive toward other children in which he demonstrated bullying behavior.
- In another case, a 14-year-old child was sexually active in his foster home and at school with other children. Child had STDs and knowingly engaged in sexual behavior with others. Child had a history of violence and continued to bully other children.
The following statistics represent the Refine/Maintain scores in the areas of Stability and Permanency for the Baseline, Second Round, Third Round, and Fourth Round QSR across the region.
Child Status: Stability and Permanency

STABILITY
Over the past 12 months and the next six-months, is the child’s daily living, learning, and work arrangements stable and free from risk of disruption?

Stability Case Specific Findings
Listed below are some of the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Children were maintained in their same placement over the past twelve months
- Team members, both formal and informal, remained consistent throughout the life of the case

Listed below are some of the common patterns for the cases that scored concerted action needed:

- Children had multiple disruptions in placements over the last year, with several occurring in the last three months
- Infrequent visits, incarceration of parents, and pending criminal charges lead to instability of relationships with family members
- Parents lost resources including food stamps, daycare vouchers, etc., which lead to instability in the home
PERMANENCY
Is the child living in a home that everyone believes will endure until adulthood?

Permanency Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Children resided at home with their parents or were placed with relatives
- Children who were removed from their home resided in a placement that was believed to be permanent

Listed below are the common patterns for the cases that scored concerted action needed:

- Team members were unaware of action steps needed to achieve permanency
- No concurrent or alternative plans were in place
- Team members were not able to consistently identify the same permanency plan
- Parent’s pending criminal charges and/or incarceration stalled permanency for children
The following statistics represent the Refine/Maintain scores in the areas of Appropriate Living Arrangements, Physical Health and Emotional Status for the Baseline, Second Round, Third Round, and Fourth Round QSR across the region.
Child Status: Appropriate Living Arrangements, Physical Health and Emotional Status

APPROPRIATE LIVING ARRANGEMENTS
Is the child in the most appropriate/least restrictive living environment?

Appropriate Living Arrangements Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Children were placed with siblings
- Children resided in their own community and were able to maintain family culture and essential connections
- Children's basic needs were met by caregivers

Listed below are characteristics for the case that scored concerted action needed:

- In one case, a 15-year-old youth resided in a congregate placement in which he was unhappy. The youth was unmotivated, did not have a sense of belonging, and did not feel connected to his peers in the placement. There was no evidence of his identity, including but not limited to things he liked or enjoyed, in his room.
**PHYSICAL HEALTH**
Is the child achieving and maintaining his/her optimum health status?

Physical Health Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Children received routine and necessary medical care
- Children were on target with their height and weight
- Children with identified health problems received needed medical care
EMOTIONAL STATUS
Is the child presenting age-appropriate emotional development?

![Child Status: Emotional Status](image)

Emotional Status Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Children displayed age-appropriate emotional development
- Children had developed and were utilizing coping mechanisms to improve their emotional stability
- Therapy and medications were effective in helping children progress emotionally

Listed below are some characteristics of the two cases that scored concerted action needed:

- In one case, a 14-year-old youth had inappropriate reactions to change. Child did not understand the consequences of his actions. Child had past unaddressed traumas. There were additional concerns that the child had sexually inappropriate behaviors that included acting out with others.
- In another case, a five-year-old child was placed with her grandmother. The child was very emotional when thinking about her mother, which often resulted in crying episodes. The child also cried during and after contact with her mother and expressed that she missed her very much. The team had yet to address this issue.
The following statistics represent the Refine/Maintain scores in the areas of Learning and Development and Pathways to Independence for the Baseline, Second Round, Third Round, and Fourth Round QSR across the region.

![Bar chart showing child status on well-being with data points for Learning & Development and Pathways to Independence across different rounds.]

- Learning & Development:
  - Baseline: 85%
  - Round 2: 89%
  - Round 3: 97%
  - Round 4: 78%

- Pathways to Independence:
  - Baseline: 43%
  - Round 2: 67%
  - Round 3: 67%
  - Round 4: 0%
Child Status: Learning and Development and Pathways to Independence

LEARNING AND DEVELOPMENT
Is the child on target developmentally and educationally?

Learning and Development Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- IEPs effectively addressed children’s needs
- Children attended school regularly and were on target for grade promotion
- Children were meeting developmental milestones
- Services, such as Head Start and First Steps, assisted in addressing the children’s developmental needs

Listed below are some characteristics for the case that scored concerted action needed:

- A 12-year-old child was below grade level in reading and math. Not all team members were included in the case conference to address his educational needs. Child was not on target for grade promotion.
PATHWAYS TO INDEPENDENCE
Is the youth learning skills needed to live independently?

Pathways to Independence Case Specific Findings
Listed below are some of the characteristics found for the two cases that scored in the refine/maintain area during the recent QSR:

- In one case, a 16-year-old youth was able to prepare her own meals, budget money, had worked to earn an income, and was actively seeking a new job.
- In another case, a 17-year-old youth earned money babysitting and saved for things she needed. The youth was able to cook, clean, and stay home alone.

Listed below are the characteristics for the case that scored concerted action needed:

- A 17-year-old youth lacked independent living skills, such as banking, scheduling appointments, and following through. Youth had not developed relationships that could support independence in the future.
Parent/Caregiver Status Indicators

The following statistics represent the Refine/Maintain scores in the areas of Parenting Capacities and Informal Supports for the Baseline, Second Round, Third Round, and Fourth Round QSR across the region.
Parent Status: Capacities and Informal Supports

PARENTING CAPACITIES
Do parents have the skills needed to care for their child(ren)?

Parenting Capacities Case Specific Findings
- Of the cases reviewed, 91% were involved with the system due to issues of neglect:
  - Environmental life/health endangering: 74%
  - Lack of food, shelter, clothing: 20%
  - Lack of supervision: 17%

- Stress factors experienced by parents:

<table>
<thead>
<tr>
<th></th>
<th>Baseline 2008</th>
<th>Round 2 2010</th>
<th>Round 3 2011</th>
<th>Round 4 2013</th>
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<tbody>
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<td>Lack of Parental Skills</td>
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<tr>
<td>Insufficient Income</td>
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<tr>
<td>Mental Health Problems</td>
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<td>56%</td>
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<tr>
<td>Abused/Neglected as a Child</td>
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<td>50%</td>
<td>37%</td>
<td>43%</td>
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<tr>
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<td>47%</td>
<td>34%</td>
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• Prior wardship of parents:

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<th>Wardship</th>
<th>Baseline</th>
<th>Round 2</th>
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<td>58%</td>
<td>30%</td>
<td>31%</td>
<td>26%</td>
</tr>
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</table>

Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Parents were bonded and nurturing toward their children
- Parents were active participants in their children’s lives and attended visits, medical appointments, and school meetings regularly
- Parents were invested in co-parenting techniques to work towards the best interests of their children

Listed below are the common patterns for the cases that scored concerted action needed:

- Parents lacked the skills necessary to appropriately care for their children
- Stress factors such as drugs, domestic violence, incarceration, untreated mental health needs, and home conditions, impacted the parent’s ability to meet their children’s needs
- Parents were unable to maintain safe, appropriate housing for the children

**INFORMAL SUPPORTS**
Does the family have a network to assist them on a daily basis?

Informal Supports Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Extended family provided parents assistance with childcare
- Parents regularly utilized identified informal supports for assistance

Listed below are the common patterns for the cases that scored concerted action needed:

- Concerns existed regarding the appropriateness of identified informal supports
- Although supports were identified, there was no evidence they were regularly being accessed for assistance

The following statistics represent the Refine/Maintain scores in the areas of Congregate Capacities, Current Caregiver Capacities, and Informal
Supports for the Baseline, Second Round, Third Round, and Fourth Round QSR across the region.

Parent Status: Congregate/Current Caregiver Capacities and Informal Supports
CONGREGATE CAPACITIES
Do congregate caregivers provide the supports necessary in the areas of supervision, education, development, and independence of the child/youth adequately on a consistent daily basis, as appropriate to age and need?

Congregate Capacities Case Specific Findings
Listed below are some of the characteristics found for the two cases that scored in the refine/maintain area during the recent QSR:

- A 14-year-old youth was thriving in the congregate setting where the facility encouraged and supported his desire for advanced education. Facility addressed the youth’s behavioral and therapeutic needs. The placement rewarded his good behavior and made accommodations for his food allergies.
- In another case, a 15-year-old youth resided in a placement that provided intensive therapeutic and trauma-informed services that led to recent progress in his behaviors. The facility provided adequate supervision, met the youth’s daily needs, and was working with the youth to develop independent living skills. The youth was able to maintain connections with his family and to attend public school.

CURRENT CAREGIVER CAPACITIES
Do caregivers have the skills needed to care for their child(ren)?
Current Caregiver Capacities Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Caregivers had a strong bond with the children
- Caregivers provided safe, appropriate homes with structure and routines
- Caregivers were active in the children’s lives, participated in their extracurricular activities, and maintained all medical appointments

INFORMAL SUPPORTS
Does the caregiver have a network to assist them on a daily basis?
Informal Supports Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Current caregivers utilized community resources for assistance
- Neighbors, adult children, and extended family provided support and assistance to current caregivers

Listed below are some of the characteristics found for the two cases that scored concerted action needed:

- In one case, only a limited number of informal supports were identified for the current caregiver. In addition, there was no evidence of utilization of these supports by the caregiver.
- In another case, the caregiver’s identified informal supports were also being utilized as a relative placement. This limited their ability to provide assistance to the current caregivers due to their own caregiving responsibilities. The caregivers were unable to identify any additional supports that could offer assistance.

Practice/System Performance Indicators
Practice Performance: Engagement

The following statistics represent the Refine/Maintain scores in the area of Engagement: Role and Voice for the Baseline, Second Round, Third Round, and Fourth Round QSR across the region.

Engaging: Role and Voice
Are family members active participants in case decisions?

Role and Voice – Mother Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Mothers were active participants in CFTMs and were able to decide who was on their team
- Mothers were able to have a strong voice in court which influenced the direction of the case
- Mothers felt their voices were heard and their concerns were addressed
- Mothers participated in decision-making processes, such as determining which services were needed and the children’s placements

Listed below are the common patterns for the cases that scored concerted action needed:

- Mothers felt they did not have a voice in their children’s cases and were told what to do
- Mothers were not active participants in planning, which resulted in their lack of understanding of the case plans and goals
Role and Voice – Father Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Fathers were active in decision-making processes and were consulted for input regarding their children’s cases
- Fathers felt they had a strong voice in their cases

Listed below are the common patterns for the cases that scored concerted action needed:

- Fathers were not engaged in any aspect of the case, often due to incarceration
- Fathers had a passive role in decision-making processes and chose not to participate in CFTMs
Role and Voice – Child/Youth Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Youth were active participants in CFTMs
- Children/youth had good rapport with team members and had input regarding their cases

Listed below are the common patterns for the cases that scored concerted action needed:

- Children were passive participants in their cases and were not participating in CFTMs
- Children were not given the opportunity to speak on their own behalf or made requests that were unaddressed by their teams
Practice Performance: Teaming

The following statistics represent the Refine/Maintain scores in the area of Teaming: Formation and Functioning for the Baseline, Second Round, Third Round, and Fourth Round QSR across the region.
Practice Performance: Team Formation

TEAM FORMATION
Have the people who provide support and services for this child and family been identified and formed into a working team?

Team Formation Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Teams were formed and their attendees remained reasonably consistent
- Team members possessed the knowledge and skills necessary to address the needs of families
- Key team members, both formal and informal, were present at team meetings

Listed below are the common patterns for the cases that scored concerted action needed:

- Key team members were absent from meetings
- Teams were not formed
- Opportunities existed to identify and engage informal supports to participate in team meetings
- Limited or no preparation was done prior to CFTMs
Practice Performance: Team Functioning

TEAM FUNCTIONING
Is the team working collaboratively for best outcomes for the child and family?

Team Functioning Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Team members were unified and worked collaboratively toward the same goals
- Team members were in agreement regarding the goals and action steps of the case
- Good communication among team members helped to keep everyone informed

Listed below are the common patterns for the cases that scored concerted action needed:

- Team members were not unified regarding case goals or action steps
- Identified team members were working in isolation
- Teams had not been formed
- Teams were not meeting regularly or at critical case junctures
Practice Performance: Assessing

The following statistics represent the Refine/Maintain scores in the area of Assessing: Cultural Recognition and Assessing and Understanding for the Baseline, Second Round, Third Round, and Fourth Round QSR across the region.
Practice Performance: Cultural Recognition

CULTURAL RECOGNITION
Are cultural issues of the family being addressed in practice?

![Graph showing practice performance: assessing cultural recognition]

Cultural Recognition Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Children resided with relatives or close to their home community allowing them to maintain cultural connections
- Services were provided in a way that supported and respected families’ cultures
- Cultural issues surrounding domestic violence, substance abuse, prior wardship, and neglect were taken into consideration when planning for services

Listed below are the common patterns for the cases that scored concerted action needed:

- Family norms and traditions were not considered by teams when case planning
- Cultural factors related to drugs, domestic violence, and prior wardship were unrecognized and/or unaddressed by teams
Practice Performance: Assessing and Understanding

ASSESSING AND UNDERSTANDING
Is there a shared, big picture understanding of the family?

Assessing and Understanding – Child Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Formal assessments were completed to identify needs of the children
- Team members shared a big picture understanding of the children including their strengths and needs
- Team members understood the children’s bond with their parents and the need for frequent visitation

Listed below are the common patterns for the cases that scored concerted action needed:

- Strengths and underlying needs of children were unidentified by teams
- Team members had a lack of understanding of past traumas and how these affected children
Assessing and Understanding – Family Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- System partners shared an understanding of the families’ strengths and underlying needs
- Family stressors and what was needed to keep the children safe was understood by team members

Listed below are the common patterns for the cases that scored concerted action needed:

- Team members did not share a common view of underlying needs of families
- Lack of knowledge of family history led to an inability to fully assess families for their underlying needs
Practice Performance: Planning

The following statistics represent the Refine/Maintain scores in the area of Planning: Long-Term View, Child and Family Planning Process, and Transitions and Life Adjustments for the Baseline, Second Round, Third Round, and Fourth Round QSR across the region.

![System Performance: Planning Diagram]

- **Long-Term View**: Baseline - 33%, Round 2 - 44%, Round 3 - 31%, Round 4 - 29%
- **Child & Family Planning Process**: Baseline - 69%, Round 2 - 57%, Round 3 - 77%, Round 4 - 79%
- **Transitions & Life Adjustments**: Baseline - 33%, Round 2 - 37%, Round 3 - 44%, Round 4 - 35%
Practice Performance: Long-Term View

LONG-TERM VIEW (LTV)
Is there a clear guiding view for the family that reflects the permanency plan?

LTV Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Team members had a consistent view of plans and action steps needed to achieve permanency
- Supports were in place and team members were confident in the sustainability of the permanency plan beyond case closure

Listed below are the common patterns for the cases that scored concerted action needed:

- Alternative or concurrent plans were absent or unclear to team members
- Not all team members had an understanding of the action steps needed or time frames associated with next steps in families’ plans
- Concerns existed regarding the sustainability of the permanency plan due to unaddressed or unmet needs of the children and/or families
Practice Performance: Child and Family Planning Process

CHILD AND FAMILY PLANNING PROCESS
Is the planning process individualized and relevant to needs and goals of the family?

Child and Family Planning Process Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Plans were individualized and relevant to the children and families’ underlying needs
- Services and plans were updated and addressed as cases progressed and different needs became evident

Listed below are the common patterns for the cases that scored concerted action needed:

- Team members worked independently, which resulted in different plans and unclear action steps needed to achieve permanency
- CFTMs were underutilized in developing individualized plans for families
- Fathers were often unassessed or uninvolved in the planning process
**Practice Performance: Planning Transitions and Life Adjustments**

**PLANNING TRANSITIONS AND LIFE ADJUSTMENTS**  
Is the current or next life change transition for the child being planned?

![Graph showing round 4 ratings for planning transitions and life adjustments](image)

Planning Transitions and Life Adjustments Case Specific Findings  
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Team members were able to identify future transitions and the associated steps  
- Effective plans were created for upcoming transitions

Listed below are the common patterns for the cases that scored concerted action needed:

- Although the next transition had been identified, the timeline and necessary action steps were unclear  
- Upcoming transitions were unknown or unclear to team members
Practice Performance: Intervening

The following statistics represent the Refine/Maintain scores in the area of Intervening: Intervention Adequacy, Resource Availability, and Tracking and Adjusting for the Baseline, Second Round, Third Round, and Fourth Round QSR across the region.
Practice Performance: Intervention Adequacy

INTERVENTION ADEQUACY
Are services sufficient to meet the needs of the family?

![Bar chart showing intervention adequacy rounds and cases](chart.png)

**Intervention Adequacy Case Specific Findings**
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Services were well-matched to the needs of families
- Services were effective as evidenced by the progress being made by families
- Community-based services were available to continue past case closure

Listed below are the common patterns for the cases that scored concerted action needed:

- Services in place did not address underlying needs
- Opportunities existed to offer services
- Parents were not engaged in services that had been referred
- Liaison in place restricted communication between system partners, which resulted in a lack of knowledge among team members
- Goals of the services or interventions in place were unclear
Practice Performance: Resource Availability

RESOURCE AVAILABILITY
Are services available to meet the needs of the family?

Resource Availability Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- An excellent array of resources such as transportation, libraries, alternative schools, public assistance, healthcare, and housing were local and accessible to children and families
- Timely resources were available with no waiting lists
- Services, such as the local community mental health center, were available to continue with families past case closure
Practice Performance: Tracking and Adjusting

TRACKING AND ADJUSTING
Is the progress of the family being monitored and adjusted, when necessary, by the team?

Tracking and Adjusting Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Team members monitored progress toward goals and adjusted services as needed
- Good communication among team members ensured modifications to plans were made timely

Listed below are the common patterns for the cases that scored concerted action needed:

- Despite the need for adjustments, case plans were not modified
- Fragmented communication among team members limited the ability to appropriately monitor and adjust case plans
Practice Performance: Maintaining Relationships

The following statistics represent the Refine/Maintain scores in the area of Maintaining Quality Family Relationships for the Baseline, Second Round, Third Round, and Fourth Round QSR across the region.

![Bar chart showing system performance of maintaining family relationships across rounds for different family members.](chart.png)
Maintaining Quality Relationships

MAINTAINING RELATIONSHIPS
How are family connections being maintained?

Maintaining Quality Relationships – Mother Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Visitation between mothers and their children occurred regularly
- Mothers were allowed communication outside of visitation, such as phone calls with children
- Mothers were engaged with their children during visitation due to visits being designed around their specific needs and encouraging relationship building

Listed below are the common patterns for the cases that scored concerted action needed:

- Visitations between mothers and their children were sporadic with no additional communication
Maintaining Quality Relationships – Father Case Specific Findings

Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Visitation plans were in place and implemented regularly
- Despite incarcerations, plans were in place that allowed children to maintain communication with their fathers

Listed below are the common patterns for the cases that scored concerted action needed:

- Visitations between fathers and their children were inconsistent or not occurring
Maintaining Quality Relationships – Siblings Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Sibling visitation occurred regularly, often during visits with parents

Listed below are the common patterns for the cases that scored concerted action needed:

- Visitation plans were not in place to maintain contact between siblings
- Face-to-face visits between siblings were not occurring
Maintaining Quality Relationships – Extended Family Case Specific Findings
Listed below are the common patterns found for cases that scored in the refine/maintain area during the recent QSR:

- Children were able to visit with extended family
- Placement with relatives allowed for ongoing contact with additional extended family members

Listed below is the common characteristic for the cases that scored concerted action needed:

- Children had no contact with extended family members
Performance Analysis

Areas of Strength

Child Status:

Physical Health – 100% (p. 22)

Appropriate Living Arrangement – 97% (p. 21)

Learning and Development – 97% (p. 25)

System Performance Indicators:

Resource Availability – 100% (p. 52)

Maintaining Family Relationships – Mothers – 76% (p. 55)

Maintaining Family Relationships – Fathers – 50% (p. 56)

Areas for Improvement

Child Status:

Stability – 46% (p. 18)

System Status:

Team Formation – 46% (p. 40)

Intervention Adequacy – 43% (p. 51)

Team Function – 30% (p. 41)

Long-Term View – 29% (p. 47)
Appendix A

Child and Family Indicator Ratings
Presented below are general definitions of the rating levels and suggested timeframes, as a guideline for reviewers, to be applied for child and family status indicators. The general interpretations for these ratings are defined as follows:

- **Level 6 – Optimal and Enduring Status**
  The Child, parent, or caregiver status situation has been generally optimal (Best attainable taking age and ability into account) with a consistent and enduring high quality pattern evident, without being less than good (level 5) at any point or any essential aspects. The situation may have had brief moments of minor fluctuation, but functioning in this area has remained generally optimal and enduring, never dipping below level 5 at any moment. Confidence is high that long-term needs or outcomes will be or are being met in this area – perhaps reaching the level indicated for safe case closure in this status area.

- **Level 5 – Good and Stable Status**
  The child, parent, or caregiver status situation has been substantially and consistently good with indications of stability evident, without being less than fair (level 4) at any moment or in any essential aspect over that time period. The situation may have had brief moments of minor fluctuation, but functioning in this area has remained generally good and stable, never dipping below level 4 at any moment. This status level is consistent with eventual satisfaction of major needs or attainment of long-term outcomes in the area.

- **Level 4 – Minimally Adequate to Fair Status**
  The child, parent, or caregiver status situation has been at least minimally adequate at all times over the past 30 days, without being inadequate at any point or any essential aspect over that time. The situation may be dynamic with a possibility of fluctuation or need for adjustment within the near term. The observed pattern may not endure or may have been less than minimally acceptable in the recent past, but not within the past 30 days.

- **Level 3 – Marginally Inadequate Status**
  The child, parent, or caregiver status situation has been somewhat limited or inconsistent over the past 30 days, being inadequate at some moments in time or in some essential aspect(s) over this time period. The situation may be dynamic with a probability of fluctuation or need for adjustment at the present time. The observed pattern may have endured or may have been less than minimally acceptable in the recent past and somewhat inadequate.
Level 2 – Substantially Poor Status
The child, parent, or caregiver status situation has been substantially limited or inconsistent, being inadequate at some or many moments in time or in some essential aspect(s). The situation may be dynamic with a probability of fluctuation or need for improvement at the present time. The observed pattern may have endured or may have been inadequate, unacceptable in the recent past, and substantially inadequate.

Level 1 – Adverse or Poor and Worsening Status
The child, parent, or caregiver status situation has been substantially inadequate and potentially harmful, with indications that the situation may be worsening at the time of the review. The situation may be dynamic with a high probability of fluctuation or a great need for immediate improvement at the present time. The observed pattern may have endured or may have recently become unacceptable substantially inadequate, and worsening.

System Performance Indicator Ratings
The same general logic is applied to performance indicator rating levels as is used with the status indicators. The general interpretations for performance indicator ratings are defined as follows:

Level 6 – Optimal and Enduring Performance
The practice/system performance situation observed for the child or parent has been generally optimal (Best attainable given adequate resources) with a consistent and enduring pattern evident, without being less than good (level 5) at any point or any essential aspect. The practice situation may have had brief moments of minor fluctuation, but performance in this area has remained generally optimal and stable. This excellent level of performance may be considered “best practice” for the system function, practice, or attribute being measured in the indicator and worthy of sharing with others.

Level 5 – Good and Stable Performance
The practice/system performance situation observed for the child or parent has been substantially and consistently good with indications of stability evident, without being less than fair (level 4) at any moment or in any essential aspect. The situation may have had some moments of minor fluctuation, but performance in this area has remained generally good and stable. This level of performance may be considered “good practice or performance” that is noteworthy for affirmation and positive reinforcement.

Level 4 – Minimally Adequate to Fair Performance
The practice/system performance situation observed for the child or parent has been at least minimally adequate at all times over the past 30 days, without being inadequate (level 3 or lower) at any moment or
any essential aspect over that time period. The performance situation may be dynamic with a possibility of fluctuation or need for adjustment within the near term. The observed performance pattern may not endure or may have been less than minimally acceptable in the recent past, but not within the past 30 days. This level of performance may be regarded as the lowest range of acceptable performance spectrum that would have a reasonable prospect of helping achieve desired outcomes given that this performance level continues or improves. Some refinement efforts are indicated at this level of performance at this time.

- **Level 3 – Marginally Inadequate Performance**
  The practice/system performance situation observed for the child or parent has been somewhat limited or inconsistent, being inadequate at some moments in time or in some essential aspect(s) over this time period. The situation may be dynamic with a probability of fluctuation or need for adjustment at the present time. The observed pattern may have been less than minimally acceptable (level 3 or lower) in the recent past and somewhat inadequate. This level of performance may be regarded as falling below the range of acceptable performance and would not have a reasonable prospect of helping achieve desired outcomes. Substantial refinement efforts are indicated at this time.

- **Level 2 – Substantially Poor Status**
  The practice/system performance situation observed for the child or parent has been substantially limited or inconsistent, being inadequate at some or many moments in time or in some essential aspect(s) recently. The situation may be dynamic with a probability of fluctuation or need for improvement at the present time. The observed pattern may have endured for a while or may have become inadequate, unacceptable in the recent past, and substantially inadequate. This level of inadequate performance warrants prompt attention and improvement.

- **Level 1 – Adverse or Poor and Worsening Status**
  The practice/system performance situation observed for the child or parent has been missing, inappropriately performed, and/or substantially inadequate and potentially harmful, with indications that the situation may be worsening at the time of the review. The situation may be dynamic with a high probability of fluctuation or a great need for immediate improvement at the present time. This level of absent or adverse performance warrants immediate action or intervention to address the gravity of the situation.
Appendix B
Continuous Quality Improvement (CQI)

1. **Team Formation**
   Goal: Improve Team Formation

   **Action Steps:**
   FCMs will be strongly encouraged to attend all Quarterly CFTM In-services
   Attendance will be required and monitored specifically for the second in-service on formation of a team

   **Measurement:**
   Attendance will be taken

   **Person Responsible:**
   FCM Supervisor will monitor attendance

   **Time Frame:**
   Second Quarter (April-June)

   **Action Steps:**
   Supervisors will debrief staff on what they learned and develop a plan to implement and monitor

   **Measurement:**
   Supervisor will document the discussion with the FCM

   **Person Responsible:**
   Supervisor

   **Time Frame:**
   Completion of task within two months of completing training

   **Action Steps:**
   FCM will show ability to help a parent form a team

   **Measurement:**
   Supervisor will document the FCM ability to direct the forming of a team

   **Person Responsible:**
   Supervisor with assistance of the peer coach

   **Time Frame:**
   Ongoing

   **Action Steps:**
   Quarterly peer coaches meetings. Meetings will list the agenda item of brain storming, “how to help families with limited information oprion build capacity?”

   **Measurement:**
   Minutes of meetings

   **Person Responsible:**
   Peer Coach Consultant

   **Time Frame:**
   Ongoing
2. **Team Functioning**  
Goal: Improve Team Functioning

**Action Steps:**  
FCMs will strongly encouraged to attend all Quarterly CFTM In-services. Attendance will be required and monitored specifically for the third session on team functioning.

**Measurement:**  
Attendance will be taken.

**Person Responsible:**  
FCM Supervisor will monitor attendance.

**Time Frame:**  
Third Quarter (July-Sept)

**Action Steps:**  
Supervisors will debrief staff on what they learned and develop a plan to implement and monitor.

**Measurement:**  
Supervisor will document the discussion with the FCM.

**Person Responsible:**  
Supervisor

**Time Frame:**  
Completion of task within two months of completing training.

**Action Steps:**  
Action Step-In discussion with their supervisor, the FCM will be able to discuss and analyze the function of family’s teams. They should be able to identify problem areas and design solutions to strengthen the team’s abilities.

**Measurement:**  
Supervisor will document the discussion with the FCM.

**Person Responsible:**  
Supervisor and Peer Coach.

**Time Frame:**  
Ongoing
Appendix B

Public Testimony
PUBLIC NOTICE

Public Testimony

Child Protection Service Plan/Biennial Regional Services Strategic Plan

Notice of Public Hearing to Take Public Testimony

The Child Protection Service Plan/Biennial Regional Service Strategic Plan is prepared bi-annually pursuant to IC 31-33-4-1 and IC 31-26-6-5. REGION 4, consisting of La Grange, Steuben, Noble, Dekalb, Whitley, Allen, Huntington, Wells and Adams Counties is seeking Public Testimony on the provision of child protection services, local service need and system change. The services will be targeted to the individual needs of children identified by the Department of Child Services or children alleged or adjudicated as children in need of services or delinquent.

To accommodate a large number of potential speakers, testimony will be limited to 3 minutes per speaker and will be given in the order of signature on Sign-In Sheet available the day of the Hearing. Submission of written comments/testimony is encouraged at the time of the Hearing.

Public Testimony on: Region 4 Child Protection Service Plan/Biennial Regional Services Strategic Plan

Date: October 21, 2013
Time: 12:00 PM
Location: 201 E. Rudisill Blvd, Suite 200, Fort Wayne, IN 46806
PUBLIC NOTICE

Public Testimony

Child Protection Service Plan/Biennial Regional Services Strategic Plan

Notice of Public Hearing to take Public Testimony Biennial Public Meetings

The Child Protection Service Plan/Biennial Regional Service Strategic Plan is prepared bi-annually pursuant to IC 21-33-4-1 and IC 31-26-6-5. The Department of Child Services is seeking Public Testimony on the provision of child protection services, local service need and system change. The services will be targeted to the individual needs of children identified by the Department of Child Services or children alleged or adjudicated as children in need of services or delinquent.

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Below are the dates, times and locations for each of the Department of Child Services Regions covering the entire State of Indiana.

Region 1
Date: October 28, 2013
Time: 3:30 PM
Location: Lake County Juvenile Justice Center, 3000 West 93rd Avenue, Crown Point, IN 46307

Region 2
Date: November 6, 2013
Time: 5:30 PM CST
Location: Wheatfield Town Hall 170 S. Grace St., Wheatfield, IN 46392

Region 3
Date: November 18, 2013
Time: 10:00 AM
Location: Joy Rose Center, 1000 W. Hively Avenue, Elkhart, IN 46517

Region 4
Date: October 21, 2013
Time: 12:00 PM
Location: 201 E. Rudisill Blvd. Suite 200, Fort Wayne, IN 46806

Region 5
Date: November 1, 2013
Time: 9:00 AM
Location: 20 N 3rd Street, Lafayette, IN 47901
Region 6
Date: November 13, 2013
Time: 1:30 PM to 3:30 PM
Location: Peru DCS Office at 12 South Wabash Street, Peru, IN 46970

Region 7
Date: October 11, 2013
Time: 2:30 PM
Location: Delaware DCS-Region 7 Training Room C located at 3600 W Kilgore Ave, Ste 600, Muncie IN 47304

Region 8
Date: October 16, 2013
Time: 4:30 PM
Location: 30 N. 8th Street, Terre Haute, IN 47807

Region 9
Date: October 25, 2013
Time: 9:00 AM
Location: 6570 E. US Hwy 36, Avon, IN 46123

Region 10
Date: November 15, 2013
Time: 10:00 AM
Location: 4150 N. Keystone, Indianapolis, IN 46205

Region 11
Date: October 30, 2013
Time: 10:00 AM
Location: 938 N. Tenth Street, Noblesville, IN 46060

Region 12
Date: November 18, 2013
Time: 3:30 PM
Location: 1503 Eastern Ave, Connersville, IN 47331

Region 13
Date: November 12, 2013
Time: 10:00 AM
Location: Monroe County DCS Training Room 1717 W. 3rd. Street, Bloomington, IN 47404

Region 14
Date: October 22, 2013
Region 15
Date: October 31, 2013
Time: 2:00 PM
Location: 531 W US 50, Versailles, IN 47042

Region 16
Date: November 6, 2013
Time: 11:00 AM
Location: 100 E. Sycamore St, Evansville, IN 47713

Region 17
Date: November 5, 2013
Time: 10:00 AM
Location: Southern Hills Counseling Center 480 Eversman Dr., Jasper, IN 47546

Region 18
Date: October 28, 2013
Time: 10:00 AM
Location: Clark County DCS Office, 1421 E 10th St, Jeffersonville, IN 47130
Indiana Department of Child Services

Biennial Plan Public Notices

PUBLIC NOTICE

Public Testimony

Child Protection Service Plan/Biennial Regional Services Strategic Plan

Notice of Public Hearing to take Public Testimony Biennial Public Meetings

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</table>
Public Testimony Notes

Public Testimony for the Child Protection Service Plan/ Biennial Regional Services Strategic Plan was scheduled for October 21, 2013 at 12:30 PM. It immediately followed the normally scheduled Regional Service Council for Region IV. Notice of the Public Testimony was advertised in each of the nine (9) local DCS counties within Region IV and on the DCS’ website. Written testimony was not submitted. Following is a summary of the Public Testimony provided by the Community.

Rachel Tobin-Smith, Executive Director of SCAN

- Need more money for Prevention Services. There is a need in this Region to have additional Prevention Services available. Healthy Families has been continually cut so there’s even more dependency on Community Partners for the short term. Rachel would like to see a plan for Community Partners and Healthy families in this region to include an enhancement to the Prevention Services.

- There are not enough Masters trained individuals in the Region to provide new services DCS is advocating for. Since DCS has been able to work things out with IU School of Social Work to offer the MSW program here in Fort Wayne she thinks it would be great if they could find some way to build capacity and have more availability of slots for providers of DCS at the local MSW program.

Paige Hamilton, SCAN

- The services that are being provided are now well known through-out Region IV. We’re getting referrals from a variety of sources so we’re getting a broader cross section of people who normally wouldn’t access services. It’s keeping us very busy and unfortunately there are more people than we can serve

Pat Zakula, Children First Center

- I think Prevention dollars are very important. We’re doing some things with Shaken Baby; if we could stop one baby from being shaken it’s definitely worth it but we need more money to do that. Prevention dollars is a way to be creative to meet some of the needs that we identity so it would be nice to have some more money to be creative.

Laura Hoffman, Lutheran Social Services of Indiana

- I also advocate additional Prevention dollars. We serve Community Partners and Healthy Families and we’re seeing a greater need of our families. One is the impact of the economy and the stress meth places on our families. I think there is a need to move more dollars to fund that. We’re doing great work with them.
### Region 4
### PUBLIC HEARING
### SIGN IN SHEET
### October 21, 2013

<table>
<thead>
<tr>
<th>SIGNATURE</th>
<th>PRINT NAME</th>
<th>Do you have Testimony</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rusty Fisher Sr.</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Laura Hoffman</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Pat Zakula</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Pat W. Hearn</td>
<td></td>
<td>✓</td>
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</table>

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Appendix C

Needs Assessment Survey
2013 Needs Assessment Methodology

Initially, invitations to take the Needs Assessment Survey were sent to all employed DCS Family Case Managers (FCMs) in March 2013 as part of the Title IV-E Waiver Evaluation being conducted by Indiana University (IU). The survey was administered by IU via Qualtrics. Respondents answered the survey based on their experience and knowledge of the services offered in their assigned region. There were 753 respondents.

Next, invitations to take the Needs Assessment Survey were sent by email to over 5000 community stakeholder email addresses in October 2013. The survey was again administered via Qualtrics. As part of the invitation, recipients were encouraged to forward the link to anyone they thought might want to answer. A link to the survey was also posted on the DCS website. Respondents answered the survey based on their experience and knowledge of the services offered in one particular county. They were encouraged to take the survey for each county for which they could provide answers. There were 977 responses from community stakeholders.

Community stakeholders were asked to identify themselves by type of agency they represent. The agency types used are in the table below.

<table>
<thead>
<tr>
<th>Agency Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Court Staff</td>
<td>Judge, Attorney, CASA</td>
</tr>
<tr>
<td>Department of Child Services Staff</td>
<td>All DCS employees</td>
</tr>
<tr>
<td>Educational Staff</td>
<td>Administrator, Teacher, School Counselor, School Nurse</td>
</tr>
<tr>
<td>Foster Parent</td>
<td>Current and former foster parents</td>
</tr>
<tr>
<td>Healthcare Provider</td>
<td>Physician, Dentist, Department of Health</td>
</tr>
<tr>
<td>Law Enforcement</td>
<td>Prosecutor, Corrections</td>
</tr>
<tr>
<td>Licensed Child Placing Agency</td>
<td>Employed by an agency that licenses foster homes</td>
</tr>
<tr>
<td>Probation</td>
<td>Juvenile or adult probation</td>
</tr>
<tr>
<td>Residential Staff</td>
<td>Employed by a Residential Service Provider</td>
</tr>
<tr>
<td>Service Provider</td>
<td>Employed by an organization that services the community</td>
</tr>
<tr>
<td>Other</td>
<td>Do not fit in one of the other categories</td>
</tr>
</tbody>
</table>

Respondents had the opportunity to provide input on some or all of the following service categories:

- Home Based Case Management
- Substance Use/Abuse
- Domestic/Intimate Partner Violence
- Father Engagement
- Mental Health
- Employment/Training
- Developmental/Disability
- Legal Assistance
- Legal Assistance
- Public Assistance
• Child Care
• Housing
• Education
• Health Care
• Dental Care Basic Needs
• Placement-Related Assistance
• Global Funds
• Living Skills
• Psycho-Education
• Other

Respondents were first asked to rate the community’s need for a particular service category. They were then asked to rate the availability of that service when needed. Next, they were asked to rate the utilization of the service when available, as well as the effectiveness of the service when utilized.

For the purpose of this survey, the following ratings were used:

<table>
<thead>
<tr>
<th>Needs Report (Please rate the following types of services based on their need.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Not needed- 2 Rarely needed- 3 Sometimes needed- 4 Usually needed- 5 Always needed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Availability Report (Please rate the following types of services based on their availability when needed.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Not available- 2 Rarely available- 3 Sometimes available- 4 Usually available 5 Always available</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Utilization Report (Please rate the following types of services based on their utilization when available.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Not utilized- 2 Rarely utilized- 3 Sometimes utilized- 4 Usually utilized- 5 Always utilized</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Effectiveness Report (Please rate the following type of services based on their effectiveness when utilized.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Not effective- 2 Slightly effective 3 Moderately effective- 4 Very effective- 5 Extremely effective</td>
</tr>
</tbody>
</table>
Surveys were administered to FCMs in March and community members in October 2013 to measure their perceptions about 20 services in their communities in terms of need, availability, utilization and effectiveness. The surveys were administered by Indiana University as part of the Title IV-E Waiver evaluation study and the results are reported using mean (average) ratings.

These data provide an opportunity to identify possible service gaps and areas for program improvement. For example, statewide, FCMs and community stakeholders reported substance use/abuse and mental health services are usually needed in their communities and are less than moderately effective when utilized, but differed in their perceptions of availability and utilization. For employment/training services, both FCMs and community stakeholders felt these services are usually needed, but are only sometimes available and less than moderately effective when utilized. Both groups reported that while there is a need for child care and housing services, those services are only sometimes available and are only moderately effective when utilized. Regions can use these data in a similar way, specific to their regional results, to initiate discussions about service gaps and program improvement opportunities.

| Needs Report (Please rate the following types of services based on their need.) |
| Availability Report (Please rate the following types of services based on their availability when needed.) |
| Utilization Report (Please rate the following types of services based on their utilization when available.) |
| Effectiveness Report (Please rate the following types of services based on their effectiveness when utilized.) |

<table>
<thead>
<tr>
<th>FCMs</th>
<th>Community</th>
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<tr>
<td></td>
<td>Needed</td>
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<td>HB Case Management</td>
<td>State</td>
</tr>
<tr>
<td></td>
<td>Region 4</td>
</tr>
<tr>
<td>Substance Use/Abuse</td>
<td>State</td>
</tr>
<tr>
<td></td>
<td>Region 4</td>
</tr>
<tr>
<td>DV/Intimate Partner Violence</td>
<td>State</td>
</tr>
<tr>
<td></td>
<td>Region 4</td>
</tr>
<tr>
<td>Father Engagement</td>
<td>State</td>
</tr>
<tr>
<td></td>
<td>Region 4</td>
</tr>
<tr>
<td>Mental Health</td>
<td>State</td>
</tr>
<tr>
<td></td>
<td>Region 4</td>
</tr>
<tr>
<td>Employment/Training</td>
<td>State</td>
</tr>
<tr>
<td></td>
<td>Region 4</td>
</tr>
<tr>
<td></td>
<td>Region 4</td>
</tr>
<tr>
<td>Legal Assistance</td>
<td>State</td>
</tr>
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<td></td>
<td>Region 4</td>
</tr>
<tr>
<td>Public Assistance</td>
<td>State</td>
</tr>
<tr>
<td></td>
<td>Region 4</td>
</tr>
<tr>
<td>Child Care</td>
<td>State</td>
</tr>
<tr>
<td></td>
<td>Region 4</td>
</tr>
<tr>
<td>Housing</td>
<td>State</td>
</tr>
<tr>
<td></td>
<td>Region 4</td>
</tr>
<tr>
<td>Education</td>
<td>State</td>
</tr>
<tr>
<td></td>
<td>Region 4</td>
</tr>
<tr>
<td>Health Care</td>
<td>State</td>
</tr>
<tr>
<td></td>
<td>Region 4</td>
</tr>
<tr>
<td>Dental Care</td>
<td>State</td>
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<td>Region 4</td>
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<td>Basic Needs</td>
<td>State</td>
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<td>Region 4</td>
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<tr>
<td>Placement-Related Assistance</td>
<td>State</td>
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<td>Global Funds</td>
<td>State</td>
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</tr>
<tr>
<td>Living Skills</td>
<td>State</td>
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<td>Region 4</td>
</tr>
<tr>
<td>Psycho-Education</td>
<td>State</td>
</tr>
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<td>Region 4</td>
</tr>
<tr>
<td>Other</td>
<td>State</td>
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<td>Region 4</td>
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<td>Home Based Case Management</td>
<td>Substance Use/Abuse</td>
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<tr>
<td>----------------------------</td>
<td>---------------------</td>
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<tr>
<td>Linking clients to resources</td>
<td>Drug/Alcohol treatment</td>
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<tr>
<td>Monitoring case progress</td>
<td>Drug testing</td>
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<td>Referrals</td>
<td>Substance/Alcohol abuse assessment</td>
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<td>Service provision coordination</td>
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<th>Domestic Violence/Intimate Partner Violence</th>
<th>Father Engagement</th>
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<tr>
<td>Batterer intervention program</td>
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<td>Victim/Child referral</td>
<td>Individual case management</td>
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<table>
<thead>
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<th>Employment/Training</th>
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<tbody>
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<td>Couples counseling</td>
<td>Employment assistance</td>
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<tr>
<td>Family therapy</td>
<td>Job training</td>
</tr>
<tr>
<td>Group therapy</td>
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</tr>
<tr>
<td>Home based therapy</td>
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</tr>
<tr>
<td>Individual counseling</td>
<td></td>
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<tr>
<td>Medication management</td>
<td></td>
</tr>
<tr>
<td>Mental health assessment</td>
<td></td>
</tr>
<tr>
<td>Psychological evaluation</td>
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<td>Support groups</td>
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<th>Developmental/Disability</th>
<th>Legal Assistance</th>
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<tbody>
<tr>
<td>Developmental evaluation</td>
<td>Court hearings/cases</td>
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<tr>
<td>First Steps referral</td>
<td>Child support-related assistance</td>
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<tr>
<td>Vocational rehabilitation</td>
<td>Legal fee assistance</td>
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<td>Probation cases</td>
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<table>
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<th>Public Assistance</th>
<th>Child Care</th>
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<td>Food stamps</td>
<td>Child care assistance</td>
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<td>TANF</td>
<td>Referral to Child Care Development Fund (CCDF)</td>
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<table>
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<th>Housing</th>
<th>Education</th>
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<tbody>
<tr>
<td>Appliance/Home repair</td>
<td>Early childhood through adult education</td>
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<tr>
<td>Community based transitional living services (excludes placement with foster family)</td>
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</tr>
<tr>
<td>Help with obtaining housing</td>
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</tr>
<tr>
<td>Utility bill assistance</td>
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</tr>
<tr>
<td>Home furnishing assistance</td>
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</tr>
<tr>
<td>Referral for subsidized housing</td>
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</tr>
<tr>
<td>Rent assistance</td>
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</table>

<table>
<thead>
<tr>
<th>Health Care</th>
<th>Dental Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family planning services</td>
<td>Any dental-related services</td>
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<tr>
<td>Linking families to Medicaid, Medicare, HIP and Wishard Advantage</td>
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</tr>
<tr>
<td>Medicaid cab services</td>
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</tr>
<tr>
<td>Medical services</td>
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<table>
<thead>
<tr>
<th>Basic Needs</th>
<th>Placement-Related Assistance</th>
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<tbody>
<tr>
<td>Clothing assistance</td>
<td>Foster care</td>
</tr>
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<td>Food pantries</td>
<td>Kinship support services</td>
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<tr>
<td>Referrals to homeless shelters</td>
<td>Pre- and post-adoption services</td>
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<table>
<thead>
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<th>Global Funds</th>
<th>Living Skills</th>
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<tbody>
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<td>Budgeting assistance</td>
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<td>Car repair services</td>
<td>Education regarding subsidized housing/Section 8-related services</td>
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<td>Clothing Vouchers</td>
<td>Homemaker services</td>
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<td>Utility bill assistance</td>
<td>Life skills training</td>
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<td>Rent assistance/Housing deposits</td>
<td>Nutrition education</td>
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<td>Transportation assistance/Bus passes</td>
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<table>
<thead>
<tr>
<th>Psycho-education</th>
<th>Other</th>
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<tbody>
<tr>
<td>Diagnosis education</td>
<td>Social activities (e.g.: fees for camps, YMCA, after-school programming, etc.)</td>
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<tr>
<td>Medication education</td>
<td></td>
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<tr>
<td>Symptomology education</td>
<td></td>
</tr>
<tr>
<td>Process education (e.g.: adoption, legal proceedings, etc.) for clients</td>
<td></td>
</tr>
<tr>
<td>Other services</td>
<td></td>
</tr>
</tbody>
</table>

| Other services | |
|---------------| |
Region 4 Data Presentation
Contracted Service Providers by County for SFY2013

"Region Payment in SFY2013" denotes whether or not there were any DCS paid services during SFY2013 in the region for that specific provider and service. An "X" below a county denotes that the provider is currently selected to provide services in that county.

Query date: 10/1/2013

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Service Description</th>
<th>Adams</th>
<th>Allen</th>
<th>DeKalb</th>
<th>Huntington</th>
<th>LaGrange</th>
<th>Noble</th>
<th>Steuben</th>
<th>Wells</th>
<th>Whitley</th>
<th>Region Payment in SFY2013?</th>
</tr>
</thead>
<tbody>
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<td>NORTHEASTERN CENTER INC</td>
<td>CARE NETWORK</td>
<td>X</td>
<td></td>
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<td>X</td>
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<td>X</td>
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<td>CARE NETWORK</td>
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<td>CHILD PREPARATION</td>
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<td>X</td>
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<td>RIGHT MIND PROFESSIONAL CORP.</td>
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<tr>
<td>SPECIALIZED ALTERNATIVES FOR FAMILIES AND YOUTH OF INDIANA INC.</td>
<td>CHILD PREPARATION</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>CRIME VICTIM CARE OF ALLEN</td>
<td>CHINS PARENT SUPPORT SERVICES</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<td>RES-CARE INC</td>
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<td>CARING ABOUT PEOPLE INC.</td>
<td>COUNSELING</td>
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<td></td>
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<tr>
<td>CENTER FOR APPLIED BEHAVIORAL STUDIES LLC</td>
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<td>CRIME VICTIM CARE OF ALLEN</td>
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<td>CROSSROAD CHILD &amp; FAMILY SERVICES INC.</td>
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<td>X</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>DOCKSIDE SERVICES INC.</td>
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<td>X</td>
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<td></td>
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<td>X</td>
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<tr>
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<td>X</td>
<td></td>
<td></td>
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<td></td>
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<td>LaGrange</td>
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<td>Whitley</td>
<td>Region Payment in SFY2013?</td>
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<tr>
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<tr>
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<td></td>
<td></td>
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<tr>
<td>CARING ABOUT PEOPLE INC</td>
<td>VISITATION FACILITATION- PARENT/CHILD/SIBLING</td>
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<tr>
<td>CENTER FOR APPLIED BEHAVIORAL STUDIES LLC</td>
<td>VISITATION FACILITATION- PARENT/CHILD/SIBLING</td>
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<tr>
<td>DEKALB COUNTY PARENT GROUP FOR HANDICAPPED</td>
<td>VISITATION FACILITATION- PARENT/CHILD/SIBLING</td>
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</tr>
<tr>
<td>CHILDREN D/B/A CHILDREN FIRST CENTER INC.</td>
<td>VISITATION FACILITATION- PARENT/CHILD/SIBLING</td>
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<tr>
<td>DOCKSIDE SERVICES INC.</td>
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<td>LIFELINE YOUTH &amp; FAMILY SERVICES INC.</td>
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<td>VISITATION FACILITATION- PARENT/CHILD/SIBLING</td>
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<tr>
<td>SCAN INC.</td>
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<td>SPECIALIZED ALTERNATIVES FOR FAMILIES AND YOUTH</td>
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<td>OF INDIANA INC.</td>
<td>VISITATION FACILITATION- PARENT/CHILD/SIBLING</td>
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<tr>
<td>THE ARC OF NORTHEAST INDIANA INC.</td>
<td>VISITATION FACILITATION- PARENT/CHILD/SIBLING</td>
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<tr>
<td>THE OTIS R. BOWEN CENTER FOR HUMAN SERVICES INC.</td>
<td>VISITATION FACILITATION- PARENT/CHILD/SIBLING</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
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</tr>
<tr>
<td>WHITINGTON HOMES AND SERVICES FOR CHILDREN AND</td>
<td>VISITATION FACILITATION- PARENT/CHILD/SIBLING</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<td>No</td>
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<td>FAMILIES INC.</td>
<td>VISITATION FACILITATION- PARENT/CHILD/SIBLING</td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td>YOUTH SERVICES BUREAU OF HUNTINGTON COUNTY INC.</td>
<td>VISITATION FACILITATION- PARENT/CHILD/SIBLING</td>
<td></td>
<td></td>
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<td></td>
<td>X</td>
<td></td>
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<td></td>
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<td>Yes</td>
</tr>
</tbody>
</table>
Informed Consent

Note: Distribution of this survey has been approved by David Judkins, Deputy Director of Field Operations.

IRB STUDY #1302010762

INDIANA UNIVERSITY STUDY INFORMATION SHEET FOR

Title IV-E Waiver Evaluation
Family Case Manager Survey

You are invited to participate in a study about how the new 2012 waiver may have affected the delivery of child welfare services in Indiana. You were selected as a possible participant because you are a Family Case Manager in the Department of Child Services in Indiana. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

The study is being conducted by Indiana University School of Social Work and School of Medicine, Department of Pediatrics. This evaluation is funded by the Indiana Department of Child Services under the Title IV-Waiver Demonstration Evaluation.

STUDY PURPOSE:

The purpose of this study is to evaluate the impact of the new 2012 IV-E Waiver in Indiana. As part of this study, we are asking Family Case Managers to describe how the 2012 IV-E Waiver may have affected their caseloads and perceptions of service delivery.

PROCEDURES FOR THE STUDY:

If you agree to be in the study, you will fill out an online questionnaire about your DCS case management experiences. The questionnaire will take approximately 30 minutes to complete.

CONFIDENTIALITY:

Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. Your identity will be held in confidence in reports in which the study may be published. Neither your name nor any other identifying information will be linked to your questionnaire. All reports will be based on aggregate data and no individuals will be identified.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the investigator and his/her research associates, the Indiana University Institutional Review Board or its designees, the study sponsor, and (as allowed by law) state or federal agencies, such as the Office for Human Research Protections (OHRP).

PAYMENT:

You will not receive payment for taking part in this study. This survey has been approved to be taken on company time, during regular work hours.

CONTACTS FOR QUESTIONS OR PROBLEMS:

For questions about the study, contact researchers William H. Barton or James A. Hall at (317) 274-8812. For questions about your rights as a research participant or to discuss problems, complaints or concerns about a research study, or to obtain information, or offer input, contact the IU Human Subjects Office at (317) 278-3458 or (800) 696-2949.

VOLUNTARY NATURE OF STUDY:

Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. Leaving the study will not result in any penalty or loss of benefits to which you are entitled. You may choose not to answer
any question(s) that make you uncomfortable. Your decision whether or not to participate in this study will not affect your current or future relations with the Indiana Department of Child Services or Indiana University School of Social Work, Indiana University School of Medicine, Department of Pediatrics.

If you would like a copy of this study information sheet, please click here to print or save this document.

Background

1. Are you a Family Case Manager with an active caseload?
   - Yes
   - No

2. How many of each case type do you currently serve?
   - Assessment
   - Informal Adjustment (IA)
   - Child in Need of Services (CHINS)
   - CHINS/Collaborative Care (combined)
   - Collaborative Care (exclusively)

Most Recently OPENED Case

For the following questions, please answer in regards to your most recently OPENED case/assessment.

Please answer in regards to your most recently OPENED case/assessment.

3. Is the child younger than 2 years old?
   - Yes
   - No

For the following questions, please answer in regards to your most recently OPENED case/assessment.
4. How old is the child?

Age (Months) _______

For the following questions, please answer in regards to your most recently OPENED case/assessment.

4. How old is the child?

Age (Years) _______

5. What is the child's gender?

☐ Female
☐ Male
☐ Other

6. What is the child's ethnicity?

☐ Hispanic
☐ Non-Hispanic

7. What is the child's race?

☐ American Indian/Alaska Native
☐ Asian
☐ Black or African American
☐ Native American or Other Pacific Islander
☐ White
☐ More than One Race
☐ Other (please describe):

8. What was the case type, at the time in which you received the case?

Assessment
Informal Adjustment (IA)
Child in Need of Services (CHINS)
9. Please rate the child based on the following domains, at the time in which you received the case.

<table>
<thead>
<tr>
<th></th>
<th>Poor</th>
<th>Below average</th>
<th>Fair</th>
<th>Above average</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanency</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Well-being</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. Please rate the child based on the following domains, at the time in which you received the case.

<table>
<thead>
<tr>
<th></th>
<th>Adverse/Worsening</th>
<th>Poor</th>
<th>Marginal</th>
<th>Fair</th>
<th>Good</th>
<th>Optimal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Living Arrangement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developmental Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Please rate the child based on his/her Independence Development, at the time in which you received the case.

<table>
<thead>
<tr>
<th>Development</th>
<th>Poor</th>
<th>Marginal</th>
<th>Fair</th>
<th>Good</th>
<th>Optimal</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Development</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Most Recently CLOSED Case**

For the following questions, please answer in regards to your most recently CLOSED case/assessment.

Please answer in regards to your most recently CLOSED case/assessment.

11. Is the child younger than 2 years old?
For the following questions, please answer in regards to your most recently CLOSED case/assessment.

12. How old is the child?

Age (Months)  

For the following questions, please answer in regards to your most recently CLOSED case/assessment.

12. How old is the child?

Age (Years)  

13. What is the child's gender?

- Female
- Male
- Other

14. What is the child's ethnicity?

- Hispanic
- Non-Hispanic

15. What is the child's race?

- American Indian/Alaska Native
- Asian
- Black or African American
- Native American or Other Pacific Islander
- White
  
  More than One Race
  
  Other (please describe):  

16. What was the case type, at the time in which the case was closed?

- Assessment
- Informal Adjustment (IA)
- Child in Need of Services (CHINS)
- CHINS/Collaborative Care (combined)
- Collaborative Care (exclusively)

17. What was the closing status of this most recently closed case?

- Preservation
- Reunification
- Adoption
- Guardianship
- APPLA
- Fit and Willing Relative
- Collaborative Care Case
- Runaway
- Aging Out without Permanency
- Closure by Court
- Other (please describe):
  
18. Please rate the child based on the following domains, at the time in which the case was closed.

<table>
<thead>
<tr>
<th></th>
<th>Poor 1</th>
<th>Below average 2</th>
<th>Fair 3</th>
<th>Above average 4</th>
<th>Excellent 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Permanency</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Child Well-being</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

19. Please rate the child based on the following domains, at the time in which the case was closed.

<table>
<thead>
<tr>
<th></th>
<th>Adverse/Worsening 1</th>
<th>Poor 2</th>
<th>Marginal 3</th>
<th>Fair 4</th>
<th>Good 5</th>
<th>Optimal 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Living Arrangement</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional Status</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Developmental Status
Learning Status

a. Please rate the child based on his/her Independence Development, at the time in which the case was closed.

<table>
<thead>
<tr>
<th>No Development</th>
<th>Poor</th>
<th>Marginal</th>
<th>Fair</th>
<th>Good</th>
<th>Optimal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

20. How many other FCMs also served on this case while it was still active (excluding yourself)?

Number of FCMs (excluding self) [ ]

**Title IV-E Waiver**

21. How well do you understand the current 2012 Waiver?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Slightly well</th>
<th>Moderately well</th>
<th>Very well</th>
<th>Extremely well</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

22. How did you receive information about the 2012 Waiver? (Check all that apply)

- [ ] Email correspondence
- [ ] Special training session
- [ ] Verbal communication with supervisor/director
- [ ] Written memo
- [ ] Did not receive any information
- [ ] Other (please describe): [ ]

23. How much has your job changed due to the 2012 Waiver?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little</th>
<th>Some</th>
<th>Quite a bit</th>
<th>A great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

24. Since July 1, 2012, how has each of the following permanency outcomes shifted in your caseload?
| Services |

We are interested in your perceptions about how often certain kinds of services are needed, as well as the availability, utilization, and effectiveness of these services. On the next few pages you will see lists of service types with examples in the middle of each page.

At the top of the page you will be asked you how often you think these services are needed, and then, when needed, how often they are available. At the bottom of the page you will be asked how often the services are utilized when they are available, and, finally, how effective they are when utilized.

25. Please rate the following types of services based on their need and availability when needed. (See below for examples of each service type)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Need</th>
<th>Availability when Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental-Related Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Care Services</td>
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<td></td>
</tr>
<tr>
<td>Mental Health Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psycho-education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Use/Abuse</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EXAMPLES:**

**Dental-Related Services**

**Health Care Services**

*Family planning services*

*Linking to Medicaid, Medicare, HIP, and Wishard Advantage*

*Medicaid Cab*

*Medical services*

**Mental Health Services**

*Couples counseling*
Family therapy
Group therapy
Home based therapy
Individual counseling
Medication management
Mental health assessment
Psychological evaluation
Psychiatric evaluation
Support groups

**Substance/Alcohol-Related Services**
Drug/Alcohol treatment
Drug testing
Substance/Alcohol abuse assessment

26. Please rate the following types of services based on their *utilization when available* and *effectiveness when utilized*. (See above for examples of each service type)

<table>
<thead>
<tr>
<th>Services/Activities</th>
<th>Utilization when Available</th>
<th>Effectiveness when Utilized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental-Related Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Care Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psycho-education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Use/Abuse</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Services 2**

27. Please rate the following types of services based on their *need* and *availability when needed*. (See below for examples of each service type)

<table>
<thead>
<tr>
<th>Services/Activities</th>
<th>Need</th>
<th>Availability when Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment/Training Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal Assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placement-related Assistance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EXAMPLES:**

Employment/Training Services
Employment assistance
Job training

Housing
Appliance/Home repair
Community based transitional living services (excludes placement w/ foster family)
Help with obtaining housing
Help paying utilities
Home furnishing assistance
Referral to subsidized housing
Rent assistance

**Legal Assistance**
- Court hearings/cases
- Child support-related assistance
- Legal fee assistance
- Probation cases

**Public Assistance**
- Food stamps
- TANF

**Placement-related Assistance**
- Foster care
- Kinship-support services
- Pre- and post-adoption services
- Respite care
- Supervised visitations

28. Please rate the following types of services based on their *utilization when available* and *effectiveness when utilized*. (See above for examples of each service type)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Utilization when Available</th>
<th>Effectiveness when Utilized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment/Training Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal Assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placement-related Assistance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Services**

29. Please rate the following types of services based on their *need* and *availability when needed*. (See below for examples of each service type)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Need</th>
<th>Availability when Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental/Disability Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic/Intimate Partner Violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father Engagement Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home-based Case Management</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EXAMPLES:**

*Developmental/Disability Services*
### Developmental evaluation
- Developmental disability services
- First Steps referral
- Vocational rehabilitation

### Domestic/Intimate Partner Violence
- Batterer intervention program
- Victim/child referral

### Father Engagement Services
- Group educational and information sessions
- Individual case management
- Supportive fathers in Family Team Meetings
- Connecting dads to mentors and/or program graduates
- Advocating, educating, and empowering dads

### Home-based Case Management
- Linking clients to resources
- Monitoring case progress
- Referrals
- Service provision coordination

30. Please rate the following types of services based on their utilization when available and effectiveness when utilized. (See above for examples of each service type)

<table>
<thead>
<tr>
<th></th>
<th>Utilization when Available</th>
<th>Effectiveness when Utilized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental/Disability Services</td>
<td>▼</td>
<td>▼</td>
</tr>
<tr>
<td>Domestic/Intimate Partner Violence</td>
<td>▼</td>
<td>▼</td>
</tr>
<tr>
<td>Father Engagement Services</td>
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<td>▼</td>
</tr>
<tr>
<td>Home-based Case Management</td>
<td>▼</td>
<td>▼</td>
</tr>
</tbody>
</table>

### Services

31. Please rate the following types of services based on their need and availability when needed. (See below for examples of each service type)

<table>
<thead>
<tr>
<th></th>
<th>Need</th>
<th>Availability when Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic needs</td>
<td>▼</td>
<td>▼</td>
</tr>
<tr>
<td>Child Care</td>
<td>▼</td>
<td>▼</td>
</tr>
<tr>
<td>Education</td>
<td>▼</td>
<td>▼</td>
</tr>
<tr>
<td>Global Funds</td>
<td>▼</td>
<td>▼</td>
</tr>
<tr>
<td>Living Skills</td>
<td>▼</td>
<td>▼</td>
</tr>
<tr>
<td>Other</td>
<td>▼</td>
<td>▼</td>
</tr>
</tbody>
</table>

**Examples:**

**Basic Needs**
Clothing  
Food pantries  
Referral to homeless shelters  

**Child Care**  
Child care assistance  
Referral to CCDF (Child Care Development Fund)  

**Education**  
Early through adult education  

**Global Funds**  
Appliance home repair  
Car repair services  
Clothing vouchers  
Help in paying utilities  
Rent assistance/Deposits  
Transportation assistance/Bus passes  

**Living Skills**  
Budgeting  
Education regarding subsidized housing/Section 8-related services  
Homemaker services  
Life skills training  
Nutrition education  

**Other**  
Social activities (e.g., fees, camps, YMCA, after-school programming, etc.)  
All other unlisted services  

32. Please rate the following types of services based on their utilization when available and effectiveness when utilized. (See above for examples of each service type)  

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Utilization when Available</th>
<th>Effectiveness when Utilized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic needs</td>
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<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Global Funds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living Skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Demographics**  

33. Please indicate the following:  

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of months or years of experience you have had in full-time human services work, including your current position:</td>
<td></td>
</tr>
<tr>
<td>Time you have been working with DCS:</td>
<td></td>
</tr>
<tr>
<td>Time you have been working with DCS as a FCM:</td>
<td></td>
</tr>
</tbody>
</table>
34. In what Region do you primarily serve?

35. What is the highest level of education you have completed?

☐ High school diploma
☐ Some college
☐ Bachelor's degree
☐ Some graduate work
☐ Graduate degree

a. In what field was your undergraduate degree? (Check all that apply)

☐ Child Development
☐ Counseling
☐ Psychology
☐ Social Work
☐ Sociology
☐ Other social science field
☐ Any other discipline

b. In what field was your graduate degree? (Check all that apply)

☐ Child Development
☐ Counseling
☐ Psychology
☐ Social Work
☐ Sociology
☐ Other social science field
☐ Any other discipline

36. What is your age at last birthday?

Age

37. What is your gender?
Female

- Male
- Other

38. What is your ethnicity?

- Hispanic
- Non-Hispanic

39. What is your race?

- American Indian/Alaska Native
- Asian
- Black or African American
- Native American or Other Pacific Islander
- White
- More than One Race
- Other (please describe):
Informed Consent

Note: Distribution of this survey has been approved by the Department of Child Services.

IRB STUDY #1302010762

INDIANA UNIVERSITY STUDY INFORMATION SHEET FOR

Child Welfare Service Survey

You are invited to participate in a study about the delivery of services to children and families in Indiana. You were selected as a possible participant because you are an individual whose agency collaborates with the Department of Child Services (DCS) in Indiana. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

The study is being conducted by Indiana University School of Social Work and School of Medicine, Department of Pediatrics. This evaluation is funded by the Indiana Department of Child Services under the Title IV-Waiver Demonstration Evaluation.

STUDY PURPOSE:
The purpose of this study is to describe the perceptions of service delivery to children and families in Indiana. The results of this survey may help DCS in its continuing efforts to improve its delivery of services.

PROCEDURES FOR THE STUDY:
If you agree to be in the study, you will fill out an online questionnaire about your perceptions of services available to children and families in your area. The questionnaire will take about 5 minutes to complete.

CONFIDENTIALITY:
Your survey will be completely anonymous. Neither your name nor any other identifying information will be linked to your questionnaire. All reports will be based on aggregate data and no individuals will be identified.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the investigator and his/her research associates, the Indiana University Institutional Review Board or its designees, the study sponsor, and (as allowed by law) state or federal agencies, such as the Office for Human Research Protections (OHRP).

PAYMENT:
You will not receive payment for taking part in this study.

CONTACTS FOR QUESTIONS OR PROBLEMS:
For questions about the study, contact researchers William H. Barton or James A. Hall at (317) 274-8812. For questions about your rights as a research participant or to discuss problems, complaints or concerns about a research study, or to obtain information, or offer input, contact the IU Human Subjects Office at (317) 278-3458 or (800) 696-2949.
**VOLUNTARY NATURE OF STUDY:**
Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. Leaving the study will not result in any penalty or loss of benefits to which you are entitled. You may choose not to answer any question(s) that make you uncomfortable. Your decision whether or not to participate in this study will not affect your current or future relations with the Indiana Department of Child Services or Indiana University School of Social Work, Indiana University School of Medicine, Department of Pediatrics.

If you would like a copy of this study information sheet, please click [here](https://s.qualtrics.com/ControlPanel/Ajax.php?action=GetSurveyPrintPreview&T=4A5JcO) to print or save this document.

**Services 1 (4 questions)**

We are interested in your perceptions about how often certain kinds of services are *needed*, as well as the *availability*, *utilization*, and *effectiveness* of these services in your primary region. On the next few pages you will see lists of service types with examples in the middle of each page.

At the top of the page you will be asked how often you think these services are needed, and then, when needed, how often they are available. At the bottom of the page you will be asked how often the services are utilized when they are available, and, finally, how effective they are when utilized.

1. Please let us know the region in which you primarily work. (region/counties displayed)

- Region 1 / (Lake County)
- Region 2 / (Jasper, LaPorte, Newton, Porter, Pulaski, Starke Counties)
- Region 3 / (Elkhart, Kosciusko, Marshall, St. Joseph Counties)
- Region 4 / (Adams, Allen, DeKalb, Huntington, LaGrange, Noble, Steuben, Wells, Whitley Counties)
- Region 5 / (Benton, Carroll, Clinton, Fountain, Tippecanoe, Warren, White Counties)
- Region 6 / (Cass, Fulton, Howard, Miami, Wabash Counties)
- Region 7 / (Blackford, Delaware, Grant, Jay, Randolph Counties)
- Region 8 / (Clay, Parke, Sullivan, Vermillion, Vigo Counties)
- Region 9 / (Boone, Hendricks, Montgomery, Morgan, Putnam Counties)
- Region 10 / (Marion County)
- Region 11 / (Hamilton, Hancock, Madison, Tipton Counties)
- Region 12 / (Fayette, Franklin, Henry, Rush, Union, Wayne Counties)
- Region 13 / (Brown, Greene, Lawrence, Monroe, Owen Counties)
- Region 14 / (Bartholomew, Jackson, Jennings, Johnson, Shelby Counties)
- Region 15 / (Dearborn, Decatur, Jefferson, Ohio, Ripley, Switzerland Counties)
- Region 16 / (Gibson, Knox, Pike, Posey, Vanderburgh, Warrick Counties)
- Region 17 / (Crawford, Daviess, Dubois, Martin, Orange, Perry, Spencer Counties)
- Region 18 / (Clark, Floyd, Harrison, Scott, Washington Counties)
2. Please tell us about the type of agency that you represent.

- Community Service Provider
- Court/Legal
- Probation Staff
- Department of Child Services Staff
- Foster Parent
- Educational Staff
- Law Enforcement
- Licensed Child Placing Agency
- Residential Provider Staff
- Healthcare Provider
- Other (please specify)

3. Please rate the following types of services based on their need and availability when needed. (See below for examples of each service type)

Please place the corresponding numbers listed below in each box (USE THE KEY LISTED BELOW)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Need</th>
<th>Availability when Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental-Related Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Care Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psycho-education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Use/Abuse</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NEED** 1-Not Needed  2-Rarely Needed  3-Sometimes Needed  4-Usually Needed  5-Always Needed  6-NA/Don't know

**AVAILABILITY** 1-Not Available 2-Rarely Available 3-Sometimes Available 4-Usually Available 5-Always Available 6-NA/Don't know

**EXAMPLES:**

**Dental-Related Services**

**Health Care Services**
- Family planning services
- Linking to Medicaid, Medicare, HIP, and Wishard Advantage
- Medicaid Cab
- Medical services

**Mental Health Services**
- Couples counseling
- Family therapy
- Group therapy
- Home based therapy
- Individual counseling
- Medication management
- Mental health assessment
- Psychological evaluation
- Psychiatric evaluation
- Support groups

**Psycho-education**
- Diagnosis Education
- Medication Education
- Symptomology Education
- Process Education (process such as adoption, legal proceedings) - for clients and/or families.
**Substance/Alcohol-Related Services**
- Drug/Alcohol treatment
- Drug testing
- Substance/Alcohol abuse assessment

4. Please rate the following types of services based on their *utilization when available* and *effectiveness when utilized*. (See above for examples of each service type)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Utilization when Available</th>
<th>Effectiveness when Utilized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental-Related Services</td>
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<td></td>
</tr>
<tr>
<td>Substance Use/Abuse</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Utilization**  
1-Not Utilized  2-Rarely Utilized  3-Sometimes Utilized  4-Usually Utilized  5-Always Utilized  6-NA/Don't know

**Effectiveness**  
1-Not Effective  2-Slightly Effective  3-Moderately Effective  4-Very Effective  5-Extremely Effective  6-NA/Don't know

**Services 2 (2 questions)**

5. Please rate the following types of services based on their *need* and *availability when needed*. (See below for examples of each service type)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Need</th>
<th>Availability when Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment/Training Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal Assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placement-related Assistance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Need**  
1-Not Needed  2-Rarely Needed  3-Sometimes Needed  4-Usually Needed  5-Always Needed  6-NA/Don't know

**Availability**  
1-Not Available  2-Rarely Available  3-Sometimes Available  4-Usually Available  5-Always Available  6-NA/Don't know

**EXAMPLES:**

**Employment/Training Services**
- Employment assistance
- Job training

**Housing**
- Appliance/Home repair
- Community based transitional living services (excludes placement w/ foster family)
- Help with obtaining housing
- Help paying utilities
- Home furnishing assistance
- Referral to subsidized housing
- Rent assistance

**Legal Assistance**
- Court hearings/cases
- Child support-related assistance
Legal fee assistance
Probation cases

**Public Assistance**
Food stamps
TANF

**Placement-related Assistance**
Foster care
Kinship-support services
Pre- and post-adoption services
Respite care
Supervised visitations

6. Please rate the following types of services based on their utilization when available and effectiveness when utilized. (See above for examples of each service type)

**Please rate each service (USE THE KEY LISTED BELOW)**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Utilization when Available</th>
<th>Effectiveness when Utilized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment/ Training Services</td>
<td>▼</td>
<td>▼</td>
</tr>
<tr>
<td>Housing</td>
<td>▼</td>
<td>▼</td>
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<td>▼</td>
</tr>
<tr>
<td>Placement-related Assistance</td>
<td>▼</td>
<td>▼</td>
</tr>
</tbody>
</table>

**UTILIZATION**
1-Not Utilized 2-Rarely Utilized 3-Sometimes Utilized 4-Usually Utilized 5-Always Utilized 6-NA/Don’t know

**EFFECTIVENESS**
1-Not Effective 2-Slightly Effective 3-Moderately Effective 4-Very Effective 5-Extremely Effective 6-NA/Don’t know

**Services 3 (2 questions)**

7. Please rate the following types of services based on their need and availability when needed. (See below for examples of each service type)

**Please rate each service (USE THE KEY LISTED BELOW)**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Need</th>
<th>Availability when Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental/ Disability Services</td>
<td>▼</td>
<td>▼</td>
</tr>
<tr>
<td>Domestic/ Intimate Partner Violence</td>
<td>▼</td>
<td>▼</td>
</tr>
<tr>
<td>Father Engagement Services</td>
<td>▼</td>
<td>▼</td>
</tr>
<tr>
<td>Home-based Case Management</td>
<td>▼</td>
<td>▼</td>
</tr>
</tbody>
</table>

**NEED**
1-Not Needed 2-Rarely Needed 3-Sometimes Needed 4-Usually Needed 5-Always Needed 6-NA/Don’t know

**AVAILABILITY**
1-Not Available 2-Rarely Available 3-Sometimes Available 4-Usually Available 5-Always Available 6-NA/Don’t know

**EXAMPLES:**

**Developmental/Disability Services**
Developmental evaluation
Developmental disability services
First Steps referral
Vocational rehabilitation

**Domestic/Intimate Partner Violence**
Batterer intervention program
Victim/child referral
Father Engagement Services
Group educational and information sessions
Individual case management
Supporting fathers in Family Team Meetings
Connecting dads to mentors and/or program graduates
Advocating, educating, and empowering dads

Home-based Case Management
Linking clients to resources
Monitoring case progress
Referrals
Service provision coordination

8. Please rate the following types of services based on their utilization when available and effectiveness when utilized. (See above for examples of each service type)

Please rate each service (USE THE KEY LISTED BELOW)

<table>
<thead>
<tr>
<th>Service Type</th>
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</tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Home-based Case Management</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Utilization 1-Not Utilized 2-Rarely Utilized 3-Sometimes Utilized 4-Usually Utilized 5-Always Utilized 6-NA/Don’t know

8. Effectiveness 1-Not Effective 2-Slightly Effective 3-Moderately Effective 4-Very Effective 5-Extremely Effective 6-NA/Don’t know

9. Please rate the following types of services based on their need and availability when needed. (See below for examples of each service type)

Please rate each service (USE THE KEY LISTED BELOW)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Need</th>
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</tr>
</thead>
<tbody>
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<td>Basic needs</td>
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<tr>
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</tr>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Global Funds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living Skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. Need 1-Not Needed 2-Rarely Needed 3-Sometimes Needed 4-Usually Needed 5-Always Needed 6-NA/Don’t know

9. Availability 1-Not Available 2-Rarely Available 3-Sometimes Available 4-Usually Available 5-Always Available 6-NA/Don’t know

EXAMPLES:

Basic Needs
Clothing
Food pantries
Referral to homeless shelters

Child Care
Child care assistance
Referral to CCDF (Child Care Development Fund)
**Education**  
*Early through adult education*

**Global Funds**  
*Appliance home repair  
Car repair services  
Clothing vouchers  
Help in paying utilities  
Rent assistance/Deposits  
Transportation assistance/Bus passes*

**Living Skills**  
*Budgeting  
Education regarding subsidized housing/Section 8-related services  
Homemaker services  
Life skills training  
Nutrition education*

**Other**  
*Social activities (e.g., fees, camps, YMCA, after-school programming, etc.)  
All other unlisted services*

10. Please rate the following types of services based on their *utilization when available* and *effectiveness when utilized*. (See above for examples of each service type)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Utilization when Available</th>
<th>Effectiveness when Utilized</th>
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<td></td>
</tr>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Living Skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Utilization** 1-Not Utilized  2-Rarely Utilized  3-Sometimes Utilized  4-Usually Utilized  5-Always Utilized  6-NA/Don’t know  
**Effectiveness** 1-Not Effective 2-Slightly Effective 3-Moderately Effective 4-Very Effective 5-Extremely Effective 6-NA/Don’t know

11. Are there any other regions that you serve?

☐ Yes  
☐ No

12. Please select all that apply.

☐ Region 1 / (Lake County)  
☐ Region 2 / (Jasper, LaPorte, Newton, Porter, Pulaski, Starke Counties)  
☐ Region 3 / (Elkhart, Kosciusko, Marshall, St. Joseph Counties)  
☐ Region 4 / (Adams, Allen, DeKalb, Huntington, LaGrange, Noble, Steuben, Wells, Whitley Counties)  
☐ Region 5 / (Benton, Carroll, Clinton, Fountain, Tippecanoe, Warren, White Counties)  
☐ Region 6 / (Cass, Fulton, Howard, Miami, Wabash Counties)  
☐ Region 7 / (Blackford, Delaware, Grant, Jay, Randolph Counties)
Region 8 / (Clay, Parke, Sullivan, Vermillion, Vigo Counties)
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Region 13 / (Brown, Greene, Lawrence, Monroe, Owen Counties)
Region 14 / (Bartholomew, Jackson, Jennings, Johnson, Shelby Counties)
Region 15 / (Dearborn, Decatur, Jefferson, Ohio, Ripley, Switzerland Counties)
Region 16 / (Gibson, Knox, Pike, Posey, Vanderburgh, Warrick Counties)
Region 17 / (Crawford, Daviess, Dubois, Martin, Orange, Perry, Spencer Counties)
Region 18 / (Clark, Floyd, Harrison, Scott, Washington Counties)
Appendix D

Fiscal
Below is a listing of available funding sources utilized for service delivery.

<table>
<thead>
<tr>
<th>Federal Funding Source</th>
<th>Objective of Funding Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title IV-B Part II: Promoting Safe and Stable Families Number: 93.556</td>
<td>To fund family preservation that serve families at risk or in crisis, including the following services: reunification and adoption services, pre-placement/preventive services, follow-up services after return of a child from foster care, respite care, services designed to improve parenting skills; and infant safe haven programs; to fund community-based family support services that promote the safety and well-being of children and families, to afford children a safe, stable and supportive family environment, to strengthen parental relationships and promote healthy marriages, and otherwise to enhance child development; to fund time-limited family reunification services to facilitate the reunification of the child safely and appropriately within a timely fashion; and to fund adoption promotion and support services designed to encourage more adoptions out of the foster care system, when adoption, promotes the best interests of the child. In addition, a portion of funds also is reserved in FY 2008 - FY 2011 for a separate formula grant for States and territories to support monthly caseworker visits with children who are in foster care. A small proportion of appropriated funds is reserved for research, evaluation and technical assistance, which may be awarded competitively through contracts or discretionary grants.</td>
</tr>
<tr>
<td><strong>Federal Funding Source</strong></td>
<td><strong>Objective of Funding Source</strong></td>
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</tr>
</tbody>
</table>
| **Community-Based Child Abuse Prevention Grants**  
Number: 93.590 | To assist States to support community-based efforts to develop, operate, expand, and enhance, and where appropriate to network, initiatives aimed at the prevention of child abuse and neglect. |
| **Child Welfare Services State Grants (Title IV-B Part I)**  
Number: 93.645 | The purpose of the Stephanie Tubbs Jones Child Welfare Services program is to promote State flexibility in the development and expansion of a coordinated child and family services program that utilizes community-based agencies and ensures all children are raised in safe, loving families. |
| **Chafee Education and Training Vouchers Program (ETV)**  
Chafee Education and Training Vouchers ETV  
Number: 93.599 | To provide resources to States to make available vouchers for post-secondary training and education, to youths who have aged out of foster care or who have been adopted or left for Kinship guardianship from the public foster care system after age 16. |
| **Chafee Foster Care Independence Program**  
CFCIP  
Number: 93.674 | To assist States and localities in establishing and carrying out programs designed to assist foster youth likely to remain in foster care until 18 years of age and youth who have left foster care because they attained 18 years of age, have not yet attained 21 years of age, to make the transition from foster care to self-sufficiency. |
### Social Services Block Grant

**SSBG Program**

**Number:** 93.667

To enable each State to furnish social services best suited to the needs of the individuals residing in the State. Federal block grant funds may be used to provide services directed toward one of the following five goals specified in the law: (1) To prevent, reduce, or eliminate dependency; (2) to achieve or maintain self-sufficiency; (3) to prevent neglect, abuse, or exploitation of children and adults; (4) to prevent or reduce inappropriate institutional care; and (5) to secure admission or referral for institutional care when other forms of care are not appropriate. In addition, special funding was provided to some states in fiscal year 1995 and 1996 for supplemental SSBG grants in support comprehensive of community revitalization projects in 104 federally designated Empowerment Zones (EZs) and Enterprise Communities (ECs). The supplemental funding is called "EZ/EC SSBG." The States, through the designated localities, may use the EZ/EC SSBG funds for activities included in each locality’s strategic plan for comprehensive revitalization and directed toward goals 1, 2 or 3 listed above. These funds will remain available until December 21, 2004. Information about this component of the SSBG is included below as appropriate.

<table>
<thead>
<tr>
<th>State Funding</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Foster Care Title IV-E</td>
<td>The Title IV-E Foster Care program helps States provide safe and stable out-of-home care for children under the jurisdiction of the State child welfare agency until the children are returned home safely; placed with adoptive families, or placed in other planned arrangements for permanency. The program provides funds to States to assist with the costs of foster care maintenance for eligible children; administrative costs to manage the program; and training for the State agency staff, foster parents and certain private agency staff. In addition, $3 million is reserved for technical assistance and plan development/implementation grants to eligible Tribes beginning in FY 09.</td>
</tr>
<tr>
<td>Number: 93.658</td>
<td></td>
</tr>
</tbody>
</table>

State Funding

Objective of Funding Source
<table>
<thead>
<tr>
<th>Youth Services Bureau (YSB)</th>
<th>Youth Service Bureaus are funded with state funds for the purpose of providing administrative support to those bureaus that deliver services aimed at the prevention of juvenile delinquency. The primary statutory purpose is to provide information and referral to youth and their families, delinquency prevention, community education, and advocacy for youth. There is at least one YSB in every DCS region of the state. For more information, go to the website:</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Funding</td>
<td>Objective of Funding Source</td>
</tr>
<tr>
<td>Project Safe Place</td>
<td>Project Safe Place is funded with state funds for the purpose of providing a community outreach network that delivers emergency services, temporary shelter, and counseling for troubled youth in crisis situations. The triangular signs found in business establishments throughout the state that say &quot;Safe Place&quot; is provided through the efforts of this funding. These signs let youth in crisis know that this is a safe place to ask for help. Staff working in these businesses are trained to assist in offering appropriate referral to these youth.</td>
</tr>
<tr>
<td>Child Welfare Funding</td>
<td>Child Welfare Funding is state funds for the purpose of providing primary or secondary prevention services to reduce abuse and/or neglect.</td>
</tr>
<tr>
<td>Kids First Trust Fund</td>
<td>The Kids First Trust Fund is a fund whose capital is generated by public contribution through the purchase of a Kids First License plate, a portion of the divorce filing fees, and private contributions. The purpose of this fund is to support statewide child abuse prevention efforts. To make a contribution or to learn more about the fund, go to the website:</td>
</tr>
<tr>
<td>Family and Children Fund</td>
<td>Funding provided by the state for out-of-home care expenses as well as the cost of services to the child in need of services and/or delinquent child and their families.</td>
</tr>
</tbody>
</table>