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SECTION 1 - CORE STANDARDS

I. ORGANIZATIONAL AND ADMINISTRATIVE REQUIREMENTS

A. Accreditation/Licensing

Agencies that contract with the TN Department of Children's Services shall be accredited by any recognized accrediting body. By meeting the accreditation standards of one of these organizations, agencies will meet requirements related to agency structure, philosophy, and monitoring of quality. Proof of accreditation will be made available during a Program Accountability Review (PAR) audit. Please refer to [Attachment 6 Licensing Matrix](#) for licensing requirements.

B. Subcontracting

1. All forms and directions for subcontracting are on the DCS Web site under the Provider tab, Policies and Manuals.
 - ♦ <http://www.state.tn.us/youth/providers/policies/PrimaryContractorChecklist.doc>
 - ♦ <http://www.state.tn.us/youth/providers/policies/HighlightsofChangesinSubcontractingforFiscalYear2010.doc>
 - ♦ <http://www.state.tn.us/youth/providers/policies/MasterSubcontractTemplate7.1.09.doc>
2. Subcontracts (SC) are between a contractor, who has entered into a fully executed contract with the Department of Children's Services (DCS) to provide a specific service(s) and referred to in that executed agreement as the "contractor," and a freestanding agency, hereinafter known as the "subcontractor." The purpose of a subcontract is to secure a service that is not provided by the contractor. Subcontracts can also be between a contractor and an individual to provide a specific service (i.e., psychiatrist to provide therapy/counseling).
3. Providers using subcontractors for providing any type of direct services to children and/or families will develop a written master subcontract describing how the services are to be used and monitored with documentation of monitoring. Contractors using subcontractors for providing any type of direct services to children and/or families will utilize the Master Subcontract Template provided by the Department of Children's Services Contracts and Grants Management Unit. The contractor with whom DCS has contracted directly shall remain the prime contractor and shall ultimately be responsible for all work performed.
4. The contractor is responsible for the monitoring of the subcontractor. All subcontractors must meet state licensing requirements and hold a valid license for the period of the contract. Subcontracting templates are located at the following site.
http://www.state.tn.us/youth/providers/prov_policies.htm
5. No placements and/or use of the subcontractor are permitted prior to an explicit written approval from DCS Contracts and Grants Management Unit.

C. Special Health Precautions

DCS Policy [20.19 Communicable Diseases](#)

Tuberculosis Risk Assessment/Screening

All prospective employees who work in congregate care environments and whose responsibilities include direct contact with youth shall have a risk assessment/screening for tuberculosis within ninety (90) days of employment and annually thereafter.

Prospective employees may go to their local health department for a TB risk assessment/screening. Prospective employees requesting a TB risk assessment/screening from the health department should inform staff there that they will be working in a congregate care setting with four or more unrelated individuals to establish both cause and eligibility to obtain the TB screening. The health department staff will determine if a follow-up TB skin test or chest x-ray is necessary, as well as any need for further treatment.

If the prospective employee chooses, they may go to their private physician for a TB risk assessment/screening or a TB skin test. They must bring a written statement from the physician stating they have been screened, tested, or examined and found to be free of infectious tuberculosis.

Cost of the risk assessment/screening or TB skin test by the health department or a private physician shall be borne by the prospective employee.

If the prospective employee chooses not to have a TB risk assessment/screening or TB skin test or any other follow-up diagnostic test or treatment as determined by the health department or private physician, they will be prohibited from direct contact with any custody youth.

If the prospective employee requires treatment for tuberculosis or latent tuberculosis, they will be prohibited from direct contact with any custody youth until such time as their condition is determined to be non-infectious by a licensed healthcare provider.

DCS Policy [20.22 HIV and AIDS](#)

1. The agency undertakes additional health and safety precautions as indicated by client need.
2. The agency that provides any form of child care (day program for young children) or treatment, home care, residential group care, or foster care develops procedures for the maintenance of a safe, hygienic, and sanitary environment and monitors adherence to those procedures.
3. The procedures address
 - a. the potential for the spread of infection in bathrooms, bedding, food preparation areas, and in handling of sick children or adults;
 - b. storage of cleaning supplies and hazardous materials, including medication, in a safe location; and

- c. maintenance of a hazard-free environment in facilities through regularly checking water temperature, covering electric outlets, securing floor covering or equipment, and reviewing the adequacy of lighting and ventilation.
4. Dietary services, when provided as part of a service offered by the agency
 - a. meet national nutritional standards;
 - b. are planned;
 - c. meet general and prescribed dietary needs;
 - d. take into account racial, cultural, ethnic, and religious variations in eating habits; and
 - e. provide appealing, well-balanced meals and snacks according to the posted menus.

D. Physical Environment and Equipment

1. The agency is housed, equipped, and maintained in a manner that is suited to its program of services and that reflects the agency's positive regard for its clients.
2. The physical environment is consistent with contemporary, accepted concepts of service and care and is one that enhances individual dignity and feelings of self-worth for the clients served.
3. The agency allocates sufficient space and safe and varied equipment for outdoor play to meet the children's recreational needs.
4. Offices or rooms are available to personnel to engage in interviewing or counseling families and children in a private and confidential manner.
5. The agency provides access to up-to-date professional and program information by
 - a. maintaining a library or collection of professional periodicals, standard references, and community information; and
 - b. arranging for personnel to have ready access to a nearby information resource.

E. Transportation and Vehicle Maintenance

1. All vehicles must be maintained and operated in a safe manner. (This includes the vehicles owned by the facility and/or by an employee if the employee provides transportation in his/her privately owned vehicle.)
2. The agency provides adequate passenger supervision, as mandated by level of care.
3. All facility-owned and staff-owned vehicles used for transportation of children/youth **must be adequately covered by medical and vehicular liability insurance** for personal injury to occupants of the vehicles. Documentation of such insurance coverage must be maintained in the facility's records.
4. Staff and resource parents providing transportation must possess a valid driver's license. Documentation of the license is to be maintained in the facility's records and validated annually.
5. All facility-owned and staff-owned vehicles used for transportation of children/youth have a current registration and inspection, as required by the county of residence.
6. Appropriate safety restraints must be used as required by state and federal law.

7. The provider agency maintains the primary responsibility for providing transportation to children in the program including transportation to all medical/dental appointments, court appearances, emergency transportation, and transportation to family visits. Transportation that exceeds 150 miles round trip from the agency site will require collaboration and assistance from the FSW.
8. TennCare provides transportation for persons who do not have access to transportation. Children in custodial care are determined to have transportation by virtue of being in custody, and transportation is provided by resource parents, providers, or case managers. In certain circumstances, a TennCare service is geographically challenging, and the TennCare Managed Care Company may provide transportation for enrollees to assist in facilitating access to the service. Therefore, while transportation is determined to be a service that should be provided or coordinated by the DCS provider, there are some instances where TennCare transportation may be offered and utilized to facilitate access to a needed health service.
9. No children in custody shall access public transportation unless supervised by a DCS or a provider agency staff person or designee. Children in custody who wish to travel alone may receive prior approval to use public transportation via a CFTM. This approval as well as any designated persons shall be documented in the child's current child welfare information system case recordings. A copy of the written approval is kept in the child's case file.

F. Non-discrimination

DCS Policy 24.10 Title VI Program and Complaint Process

1. The agency assures that no person shall be excluded from participation, denied benefits, or otherwise subjected to discrimination in the performance of the services or in employment practices on the grounds of disability, age, race, color, language, religion, gender, national origin, or any other classification protected by federal, Tennessee state constitutional, or statutory law.
2. Written agency policy assures that need for the agency's services are the primary criterion of eligibility and its services are offered without discrimination.
3. The agency has a written equal opportunity policy that clearly states its practices in recruitment, employment, transfer, and promotion of employees.
4. The agency actively recruits, employs, and promotes qualified personnel broadly representative of the community it serves and administers its personnel practices without discrimination based upon age, sex, race, ethnicity, nationality, handicap, or religion of the individual under consideration.
5. The agency provides for internal and external dissemination of its equal opportunity policy and recruitment materials that specify the nondiscriminatory nature of the agency's employment practices.
6. If the agency recruits and selects with regard to specific characteristics, it does so with the needs of the agency's defined clientele in mind and in accord with exemptions in the law(s) governing equal opportunity employment.
7. The agency shall show proof of nondiscrimination and post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

8. The agency has among its facilities some that are free of those architectural barriers that restrict the employment of or use by physically handicapped personnel. Likewise, the agency has among its service facilities some that are free of architectural barriers that restrict use by the aged, families with young children, and handicapped persons and/or makes provision for use of accessible facilities in order to provide services to handicapped persons.

G. Confidentiality

- ♦ **DCS Policy [9.4 Confidential Child-Specific Information](#)**
- ♦ **DCS Policy [9.5 Access and Release of Confidential Child-Specific Information](#)**

1. Strict standards of confidentiality of records and information shall be maintained in accordance with applicable state and federal law.
2. The agency establishes policy on release of information about its clients and assures itself that such policies meet any applicable legal requirements. Written policy specifies the responsibility of all personnel for maintaining confidentiality of information contained in client and personnel records.
3. Access to records is limited to the client, the parent or legal guardian when the client is a minor, authorized agency personnel, and others outside the agency whose request for information access is permitted by law and is covered by assurances of confidentiality and whose access is necessary for administration of the agency and/or services to the client.
4. A release of information must be obtained prior to sharing information in any situation other than that described above.
5. A client may review his/her record in the presence of professional agency personnel on agency premises. Such a review must be carried out in a manner that protects the confidentiality of other family members and individuals whose contacts may be contained in the record.
6. All client information is kept in a locked, secure place.

H. HIPAA Compliance

1. Pursuant to the provider's contract with DCS, the contractor must be familiar with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations and must comply with all applicable HIPAA requirements in the course of the contractual relationship.
2. The contractor agrees to cooperate with DCS in the course of performance of the contract so that both parties will be in compliance with HIPAA including cooperation and coordination as necessary with state and DCS privacy officials and other compliance officers required by HIPAA regulations. The contractor agrees to sign any documents that are reasonably necessary to keep the state, DCS, and the contract provider in compliance with HIPAA, including but not limited to business associate agreements, if deemed appropriate.
3. Ongoing monitoring of compliance with HIPAA privacy policies is the responsibility of DCS.
4. Information on HIPAA compliance can be found in **DCS Chapter 32, HIPAA Policies.**

- ◆ DCS Policy [32.1 General HIPAA Privacy Requirements](#)

I. Expansion of Services Protocol

Applies to Residential Congregate Care Treatment Facility and/or Group Home

DCS, Office of Child Permanency, Child Placement and Private Providers (CPPP) Unit is the division responsible for coordinating, analyzing and facilitating the expansion/reduction of services within the provider network. In accordance with Finance and Administration (F&A) rules, DCS procures all residential services through Delegated Authority (DA). The DA clearly defines the process through which services can be procured. In order to maintain compliance with these rules, DCS has established the following guidelines for providers to follow when seeking to expand their congregate care treatment facility or Group Home service capacity.

1. Providers **do not** have the authority to expand their capacity (residential Group Home or congregate care treatment facility service) to serve **DCS CUSTODIAL CHILDREN OR YOUTH** without first consulting the appropriate DCS division (CPPP) and receiving prior written approval from the Department.
2. The issuance of a license for a congregate care treatment facility or Group Home by any licensing agent (DCS, MHDD, and/or DOH) **does not** constitute approval from DCS to accept or place custodial children with any newly-licensed Group Home or other congregate care treatment facility.
3. All providers interested in expansion of **residential** congregate care treatment facility or Group Home services **MUST** contact the Director or Assistant Directors of CPPP in writing on official agency letterhead. This correspondence must be signed by a duly authorized agent and representative of the agency. This agency or representative **MUST** be authorized to negotiate on behalf of the agency.
4. Service expansion includes the development of new or expansion of current Group Homes or other congregate care treatment facilities that are not presently recorded in the current child welfare information system. Non-payable placements which are present in the current child welfare information system are not linked to a provider's current contract and **may not** be considered a part of a provider's contracted capacity.
5. Regional staff may request a provider's congregate treatment facility and /or group home's service expansion through CPPP by completing the Request For Services (RFS) form. No expansion should be speculative in nature since these requests must first be routed through CPPP and approved by the Commissioner/designee of DCS. This protocol is in adherence with guidelines set forth through the Tennessee Department of Finance and Administration.

J. DCS Initiatives

Agencies contracting with DCS should be aware of the following initiatives and plan accordingly.

1. Performance-based Contracting (PBC)
The Department's Performance-Based Contracting (PBC) initiative is the first phase of a greater overarching plan to achieve better and timelier outcomes for the children served by DCS. In the past, DCS purchased out-of-home care services for children in its custody via a per diem reimbursement system.

Performance-Based Contracting uses an innovative approach that stresses permanency outcomes for children and utilizes a payment structure which reinforces provider agencies' efforts to offer services that improve those outcomes. Those permanency outcomes that will be measured include: improved timeliness and likelihood of permanency (reunification, adoption, or guardianship), reduced care days, and reduced re-entries into care.

2. Unified Placement Process (UPP)

The Unified Placement Process is an integrated approach to child placement that timely identifies and provides resources from a continuum of caregiver and service options which are flexible and adaptable to respond to the individualized needs and strengths of children and families.

The Department's goals for a successful Unified Placement Process at full implementation across the State are to:

- a. minimize trauma experienced by children and families;
- b. provide for the child and family needs, no more and no less;
- c. reduce the length of stay in placement;
- d. keep children safe in their own homes;
- e. strive for the first placement to be the best placement;
- f. engage child and family teams in placement decisions to promote safety, permanency and well-being;
- g. place children with siblings, in their home community, and with relatives/kin whenever possible; and
- h. utilize Resource Homes unless there is documented justification for a congregate treatment placement.

3. Evidence-based Practice with Youth Adjudicated Delinquent

Public Chapter 585 was enacted by the Tennessee General Assembly in 2007 in order to insure that the Department of Children's Services is funding programs for the treatment, training, and rehabilitation of juveniles that have been proved to be evidence-based. DCS in conjunction with the TN Commission on Children and Youth, TN Administrative Offices of the Court, the TN Alliance for Children and Families and Dr. Mark Lipsey of the Vanderbilt Institute for Public Policy Studies will be working together to evaluate current programs across the state. A report was compiled and submitted to the Governor and Tennessee General Assembly in January 2009.

4. Child and Adolescent Needs and Strengths (CANS)

The CANS tool has been chosen by DCS as the assessment tool which best exemplifies strengths based, culturally competent and family focused casework. In accordance with their contract with DCS, the private provider will incorporate and accept the CANS assessment analysis for establishing a level of care recommendation. The CANS produces the least stigma or label for children and families served and CANS provides a communication basis for understanding the permanency and treatment needs of youth and for making decisions about care. DCS Regional offices provide training for providers on the CANS.

The CANS consists of approximately sixty-five (65) items to evaluate how the Department and its partners should act in the best interests of children and families. A number of studies have shown

that CANS has demonstrated reliability and validity in relationship to level-of-care decisions and other similar measures of symptoms, risk behaviors and functioning. DCS staff, after becoming certified as reliable, will complete the CANS tool. Centers of Excellence (COE) will review the completed CANS assessment as the “official” third party reviewer. A hard copy of the CANS will be provided to the private provider when it is first completed and at key intervals in the life of the case.

The provider will use the CANS information to identify areas of treatment and will incorporate that information in the treatment plan. The provider will also collaborate with the DCS Family Service Worker by providing monthly summaries and other information that is needed to keep the CANS updated.

5. The Practice Model

DCS has presented a Practice Model used in working with children and families to promote permanency and provide appropriate services. Refer to [Attachment 10, DCS Practice Model](#), for a full explanation including a visual representation of the Practice Model called The Practice Wheel.

6. Placement Quality Team System (PQTS)

While all agencies are reviewed by their licensing entities and monitored through the Program Accountability Review (PAR) process, additional targeted monitoring ensures that ongoing safety and well-being concerns are identified and resolved through the PQTS. The PQTS is a decision-making body which makes informed decisions based on data aggregated from various reports, provides recommendations to the Department’s senior management and assists contract agencies with ensuring the safety and well-being of custodial children and youth. The PQTS consists of a hierarchy of three levels. Each level includes a cross-functional team which includes representatives from the Central Office, Regions and other Departmental Divisions.

K. Invoicing Reconciliation

The prompt remittance of payment for services rendered and the resolution of invoicing and billing issues is a priority for DCS. Timeliness of billings and payments is important for all financial, management and reporting reasons. It is also an important performance measure. Provider agencies **MUST** invoice in a timely fashion in accordance with their contract and as detailed below.

It is crucial for providers to work closely with the Department to bring prompt resolution to all issues of outstanding payment. The calculation of PBC re-investment dollars is dependent on definitive placement information. This information is taken from the current child welfare information system in the form of an Admissions and Discharges (A&D) Report, a monthly data extract. In order to help ensure accuracy in the calculation of re-investment dollars, this information is directly correlated to billing. These data extracts are then remitted to the Chapin Hall Center for Children for analysis. When reinvestment dollars are calculated at the end of a given fiscal year, these calculations are predicated on the resulting synthesis.

Consequently, it is critical that any invoicing and billing issues or irregularities be resolved immediately. Once re-investments have been finalized and delivered to a provider, the billing period connected to those re-investments is to be considered definitively closed. As a result, a mechanism

must be implemented that ensures any issues of this nature are brought to a timely resolution in order to protect not only the Department but providers as well.

Pursuant to the terms of a provider's contract, all invoices are to be submitted for payment no later than 30 days after the end of the month in which the service was rendered. This invoicing should be for the month in which the service was rendered and the service must be available in the system for invoicing.

The following process must be followed in an effort to resolve any billing/invoicing problems:

1. In instances where a provider is unable to invoice for a service in accordance with the aforementioned 30-day rule, that provider must engage the regional Fiscal Director within 90 days of the date the invoice was originally submitted.

Example: A provider submits an invoice on 02/20/08 for services rendered in January of that year. It is then discovered in March that the invoice of 02/20/08 was not paid.

At this point, the provider has 90 days from the date of the invoice in question (02/20/08) to contact the regional Fiscal Director for resolution of the matter.

2. If the billing/invoicing issue is not resolved within the period detailed above, the provider should contact, in writing, the Executive Director of the Department's Office of Finance & Support about the delay in resolving the billing/invoicing issue. The Executive Director will then have an additional 30 days to resolve the issue with the provider;

If after engaging both the regional Fiscal Director as well as the Executive Director of the Department's Office of Finance & Support, the issue remains unresolved, the provider should contact the CPPP Unit for assistance.

Important Notes:

- Resolution of invoicing issues outside the prescribed time frames listed above will be problematic, if not impossible. Any delay in seeking resolution to invoicing/billing issues within the period identified may result in the loss of payment for the services rendered.
- Providers should maintain all communications detailing their attempts to resolve the matter within the timeframes identified.

L. Facility Change of Location/Address/Contact Web Address

DCS must have accurate and current contact information on all facilities where custody children are served. Providers are responsible for notifying DCS of **contact web addresses**, changes of address for administrative offices, residential facilities, group homes, in-house schools, conversion of facilities, and significant expansion or addition to the physical plant. This responsibility also includes changes in provider sub-contract.

Providers will notify DCS Central Office, CPPP of the above-referenced changes using the "Provider Change in Address and Location" form which must be requested from the Director of CPPP.

This form must be signed by the Executive Director of the primary contracting agency (or person holding a similar position). This form must be submitted to the Director of CPPP at least five (5) business days prior to the change.

M. Utilization Review

The agency shall participate in utilization reviews at least every ninety (90) days as initiated by the Department. Utilization reviews are to include regional UR representatives (these are usually the Resource Placement Specialists in the region) to evaluate the necessity, appropriateness, quality, and intensity of individual client services to facilitate permanency and most appropriate setting for service delivery as soon as possible. The utilization review focuses on appropriateness and effectiveness of client services, and reduction of length of stay in out-of-home care. Measurable criteria are utilized in the review process, extended treatment or service, changes in status or level of need presented by the client, and/or other criteria developed by the agency.

N. Compliance with the False Claims Act

All DCS Contract Agencies receiving in whole or part funding from the TennCare (Medicaid) program must comply with the Deficit Reduction Act of 2005, Section 6032. DCS Contract Agencies providing Level 2 therapeutic foster care, medically fragile foster care, Continuum Services, Level 3 and Level 4 services do receive funding and are required to comply with this provision, which is also specified in the Provider Agreement.

The Deficit Reduction Act of 2005, section 6032 requires that as a TennCare (Medicaid) provider, you are required to have a specific policy regarding the False Claims Act, and you must educate all employees regarding this policy. This includes new employees, as well as all employees on an annual basis.

Your policy must include at a minimum the following information:

DCS contract agency employees are encouraged to report suspected or known fraud and fiscal abuse. They may report TennCare enrollee fraud and fiscal abuse to the State of Tennessee Office of Inspector General, TennCare Fraud Division at 1-800-433-3982.

Employees may report TennCare (Medicaid) provider fraud and fiscal abuse to the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit at 1-800-433-5454.

Under the Deficit Reduction Act of 2005, section 6032, Whistle blowers are protected by federal law. No retaliation of any nature is tolerated for the reporting of fraud and abuse to this agency or the Tennessee Office of Inspector General or TBI Medicaid Fraud Control Unit.. Call the Provider Fraud and Fiscal Abuse Hotline if you have information on fraud and fiscal abuse by this agency. 1-800-433-3982 FRAUD AND FISCAL ABUSE HOTLINE.

Provider fiscal abuse includes provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid (TennCare) program, or in reimbursement of services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid/ TennCare/Cover TN Program. For DCS contract agencies, failure to provide services that are required in the scope of the per diem constitutes provider fiscal abuse. Accessing services from a community TennCare provider when such services are to be covered in the scope of the services for which a provider has contracted also constitute provider fiscal abuse.

Examples of cases that the Office of Inspector General investigates include unreported income or insurance, TennCare/Cover TN recipients living out of state, drug seeking behavior, incarceration, individuals receiving bills (or EOB statements) for services never provided, provider billing irregularities, over or under utilization of health care services, and misrepresentation of credentials. Provider fraud involves not only doctors, but nursing homes, home health, durable medical equipment,

pharmacies, mental health facilities, laboratories, transportation and dentists, to name a few. Refer to DCS policies and documents:

- ♦ DCS Policy [20.3 Reporting Suspected TennCare Fraud or Fiscal Abuse](#)
- ♦ [Stop TNCare Fraud Poster](#)
- ♦ [Dr. Shopping is a Crime Poster](#)

II. PERSONNEL REQUIREMENTS

A. Personnel Policies and Practices

1. The agency has written personnel policies that are formally adopted by the governing body, reviewed at intervals no greater than every two (2) years, and readily available to personnel.
2. Personnel policies specify the responsibilities of all employees, volunteers, and the agency.
3. Agency policies address personnel practices; confidentiality; working conditions; wages and benefits; insurance protections provided for personnel including unemployment, disability, medical care, liability for malpractice and use of agency premises, motor vehicles, and/or other equipment, as appropriate; and training and development opportunities for personnel.
4. The agency has a written job description for each agency position or group of like positions that clearly states qualifications and responsibilities.
5. The agency maintains a work schedule of personnel assigned to a service or department including names, dates, hours, and tasks, or implements another functionally equivalent mechanism accounting for assignments.
6. The agency complies with applicable laws and regulations governing fair employment practices and contractual relationships.
7. Provider personnel must meet all applicable state licensing and /or certification requirements for their agency and use of professional titles. A provider agency **must** obtain and maintain proof of licensure.

B. Background Checks

1. Refer to DCS Policies:
 - ♦ [4.1 Employee Background Checks](#)
 - ♦ [16.4 Resource Home Approval](#)
 - ♦ [16.8 Responsibilities of Approved Resource Homes](#)

2. Fingerprint Checks

Tennessee Code Annotated (TCA) **37-1-414**, **37-5-511§**, **49-5-413§** and **71-03-507§** requires fingerprint checks for all persons who have direct contact with children regardless of the length of employment with the agency and past policy requirements.

3. The Department has implemented an oversight process for ensuring direct-care staff compliance with background checks requirements; **DCS Policy 4.1 Protocol for Facility staff: ??**
DCS Policy [4.1 Employee Background Checks](#)

C. Personnel Files

1. Provider agencies shall maintain a system of personnel records for all employees and those volunteers who have direct contact with children.
2. Each record will contain identifying information, a current job description, names of persons to contact in case of emergency, performance evaluations, and all documents pertaining to performance including disciplinary actions. Providers shall develop and retain clear policies/tools surrounding annual performance evaluations and disciplinary action guidelines. Such evaluation policies/tools shall include, **at a minimum**, an annual evaluation of performance for each level of staff within the agency. Policy shall clearly indicate actions that will be taken by the agency for failure to receive a satisfactory job performance evaluation during any evaluation period.
3. Prior to the employment of contract agency staff, the approval of volunteers, and the approval of resource parents, agencies must obtain, verify, and maintain in each employee **and** resource parent file the items listed below. All background and registry checks must be run for all known aliases which are not obvious variations of the person's name.
 - a. An application
 - b. Three (3) letters of reference from unrelated persons
 - c. Verification of education including diploma(s) and/or transcript(s), as required for the particular position
 - d. Documentation of prior experience
 - e. Health certificate or screening conducted by a licensed health care provider certifying that the employee is free of communicable diseases
 - f. Agreed upon terms of employment, including signed documents or agreement to agency policies on confidentiality and child abuse reporting
 - g. A valid motor vehicle driver's license from the state of residence (New Tennessee residents are required to obtain a Tennessee driver's license within 30 days.) This is validated annually for those staff transporting children.
 - h. Driving record background check
 - i. Proof of vehicular and medical liability insurance for anyone who will be transporting children in DCS custody
 - j. Court record checks (see B above.)
 - k. Sex offender registry verification (see B above.)
 - l. Elderly or vulnerable abuse registry verification (see B above.)
 - m. Results from DCS Child Protective Services' search (see B above.)
 - n. Fingerprint-based background check (Results are not required prior to hire but will be filed immediately upon receipt.) See Section **One, Chapter II, B, 3, d.**
 - o. Annual evaluation and recommendations

4. All volunteers who have direct contact with youth and all persons over the age of 18 (who are not resource parents) residing in a resource home must have the same screening, background checks, and fingerprint-based checks completed and on file as employees. (See B above.)
5. Additional information added to the employee files throughout the period of employment includes:
 - a. Documentation of training
 - b. Updated health cards or reports of annual physicals, when required by law
 - c. Renewed motor vehicle driver's license (this also applies to resource parents)
 - d. Renewed vehicle insurance showing vehicular and medical liability coverage (this also applies to resource parents)
 - e. Awards and recognition
 - f. Termination summaries and
 - g. Additional written documentation regarding personnel when agency policies and procedures require its inclusion.

D. Staff Responsibilities and Qualifications

The agency retains personnel qualified to carry out its program of services. Specific criteria for hiring, training, and promoting shall apply to all family services workers and supervisors with direct responsibility for the cases of foster children.

1. Program Director or other position title having responsibilities listed below is qualified by education, training, experience, and management skills to ensure effective utilization of the agency's personnel and financial resources and coordination of the agency's program of services with other community services. The program director's responsibilities include but are not limited to agency planning; budget preparation; recruitment, selection, and hiring of employees; training; interpretation of the agency's program to the community; and implementation of the agency's policies and procedures. In small programs, the program director may also be responsible for providing treatment or supervising treatment staff. In this situation (or any other in which a staff member fulfills the roles/responsibilities of more than one position), the program director must also meet the qualifying requirements for the Clinical Services Director.

Qualifications for Program Director

The **program director** has at least a bachelor's degree from an accredited program of social work education or an advanced degree from an accredited academic program in another field of human service with at least two years of progressively responsible supervisory and management experience in direct services for individuals, families, and children or in another field directly related to the service being provided.

2. Clinical Services Director provides supervision of clinical and/or medical programs.

Qualifications for Clinical Services Director

The **clinical services director** is licensed to supervise clinical or medical programs and meets all requirements to provide supervision and services under license requirements for this particular profession.

3. Clinical Service Provider (therapist) (or other position title having responsibilities listed below) is an appropriately licensed or certified professional who may work directly with children and families or

may serve as treatment and program consultant to the agency's casework supervisory staff. This individual may be on staff with the agency or may be a contracted service provider.

Qualifications for Clinical Service Provider

The **clinical service provider** must be appropriately licensed or certified and be a medical doctor or have a master's degree, Ed.D. Ed.S., or Ph.D. in the behavioral sciences. Five years of pertinent experience is desired. The clinical service provider's area of concentration or experience should be appropriate to the issues of consultation. Staff members providing counseling/ therapy services must be eligible to do so under state licensing and supervision requirements. An individual with a master's degree who is on a licensure track and under the supervision of a licensed practitioner is acceptable as a clinical service provider. All required documentation for licensure track and supervision should be included in the personnel file of the clinical service provider.

4. Case Manager Supervisor (or other position title having responsibilities listed below) may be a full-time employee of the agency or a part-time contracted employee. The case manager supervisor's responsibilities may include oversight/supervision of case management staff, coordination of training for staff, review of case managers work activities and products, and approval of foster home/adoptive home studies.

Qualifications for Case Manager Supervisor

The **case manager supervisor** with supervisory responsibility for case managers (may be called case workers, social workers, family workers, etc.) shall have a minimum of a master's degree from an accredited college in social work or related behavioral field (excluding criminal justice) with a focus and at least three years experience as a case worker in child welfare.

5. Case Manager (also referred to as case worker, social worker, family worker, etc., or other position title having responsibilities listed below) is generally a fulltime employee of the agency working on site; however, some agencies may contract for part-time casework services. Responsibilities may include participation in development of treatment plans; implementation of treatment plans (if applicable) for children and/or families; maintenance of casework documentation and progress notes; serving as liaison between DCS and schools; therapeutic support to children regarding educational goals, anger control, grief issues, separation issues, and other personal/family issues; crisis intervention; transportation of children; developing foster/adoptive homes studies; and facilitation of group process and structured treatment activities.

Qualifications for Case Manager

The **case manager** must have a minimum of a bachelor's degree from an accredited college with a major in social work or a related field and one (1) year of pertinent experience in the human services field with children or in a residential treatment setting. Volunteer experience and practicum and intern experiences in programs/facilities that work with children and families may be counted as pertinent work experience. A master's degree in the social sciences may be substituted for the one year of work experience.

6. Direct Care Worker Supervisor (or other position title having responsibilities listed below) is the direct supervisor of the direct care workers. Responsibilities of the direct care worker supervisor may include such duties as providing supervision of direct care staff as they participate in recreational activities with the youth, prepare meals with the youth, instruct the youth on the

practice of independent living skills and proper hygiene and plan for transportation for appointments and activities.

The supervisor will report or supervise the reporting of significant events and will assist in crisis intervention and insure that the Direct Care Workers are working within the guidelines of the agency's therapeutic milieu. The supervisor will provide mentoring and training to insure the provision of therapeutic support to the youth in care.

Qualifications for Direct Care Worker Supervisor

The **direct care worker supervisor** must have an Associate's Degree with emphasis in working with children. One (1) year of experience working in a children's services program is required with experience in a residential setting. Two additional years working in a residential setting with children may substitute for the Associate's Degree.

7. Direct Care Worker (or other position title having responsibilities such as those listed below) provides the direct supervision of children. Titles for this job may be Child Care Worker, Youth Worker, Residential Worker, or Front line worker but whatever the title, the role is that of direct responsibility for the care and supervision of the children/youth. Responsibilities of the direct care worker may include providing a role model for children, supervision of children in completing household chores, participation in and supervision of recreational activities, assisting in the preparation of meals and the supervision of children/youth during meals, encouraging/assisting children in the practice of proper hygiene, health practices and independent living skills, transportation of children, reporting significant events that occur during a shift, assistance in crisis intervention and documentation of services. The Direct Care Worker will perform within the guidelines of the agency's therapeutic milieu and will provide therapeutic support to youth.

Qualifications for Direct Care Worker

The **direct care worker** must have a minimum of a high school diploma or a GED. One (1) year of experience working in a children's services program is preferred. Volunteer experience and practicum and intern experience in programs/facilities that work with dysfunctional children and families may be counted as pertinent experience.

E. Staff Development

Pre/in-service Training for Direct Care Staff, Case Manager, and Case Manager Supervisor (For Resource Parents, see Section II, Foster Care/Resource Homes.)

Staff development is an ongoing, integral, and identifiable part of the agency's program of services, and the agency has specific guidelines as to the time commitment expected of personnel in various positions. In accordance with contractual stipulation, as well as established policy, providers are fully responsible for recruiting and maintaining an appropriately trained workforce. These personnel must meet or exceed both the pre-service as well as in-service requirements of DCS with regard to agency objectives, policies, services, community resources, DCS policies and best practice standards.

Within this plan, agencies will develop their own unique topics to meet the needs of the agency in training for specific jobs and responsibilities.

Any costs incurred in the development and execution of said training is deemed to be included as administrative cost associated with a provider's contracted per diem billing rate.

1. Pre-service Training Hours
 - a. Direct Care Staff. Thirty (30) hours of pre-service training.
 - b. Case Manager. Case managers will complete or will have completed (see Substitution of Required Pre-service and In-service Training below) the following pre-service training before assuming full responsibility for a case, except as part of a training caseload: **eighty (80) hours of pre-service instructional training and eighty (80) hours of pre-service on-the-job or supervised field training**. On-the-job (OJT) or supervised field training may include but is not limited to shadowing a trained employee to visits, court, foster care review meetings, CFTMs, and residential activities. Every activity shall be documented by outlining what was completed and who was seen; dates and hours of OJT credit are to be recorded in a notebook, or similar format, to become part of the case manager's personnel file. The agency employee supervising the OJT shall verify the training documented by the case manager.
 - c. Case Manager Supervisor. **Every new case manager supervisor shall complete a minimum of forty (40) hours of in-service training directed at the supervision of child welfare case workers. This training shall begin within two weeks of assuming supervisory responsibility and completed within six months.**
2. Pre-service Training Topics Training for direct care staff, case managers, and case manager supervisors should include skills and information which enhance staff ability to carry out the agency's programs; work cooperatively and effectively with other personnel who fulfill different tasks or responsibilities; and demonstrate an awareness, sensitivity, and appreciation of the cultures and perspectives of the children and families served by the agency. Pre-service and in-service training requirements for resource homes are located in this manual in **Section Two** - Resource Homes. Specific training topics for indicated personnel include but are not limited to the following. Agencies will develop objectives and goals for each topic.
 - a. Non-Direct Care Staff. The agency has discretion regarding training requirements and topics.
 - b. Direct Care Staff.
 1. Agency mission statement, history, and policies
 2. Health and safety
 - a. First aid
 - b. CPR (agency must ensure that someone must be immediately available who has been trained in CPR when supervising youth)
 - c. De-escalation
 - d. Restraint (where appropriate). All staff involved in and monitoring restraints must be CPR-certified and fully trained and certified in nationally recognized physical restraint methods. Refer to DCS Policy **27.3** on restraint.
 - e. Medication administration (training should be provided to anyone who will be administering or supervising the administering of medication)
 - f. Serious Incident reporting
 - g. Recognition of substance abuse
 - h. Child abuse prevention/reporting

- i. Suicide prevention
 - j. HIPAA/confidentiality
3. Policies and procedures
- a. Sexual harassment prevention
 - b. Cultural awareness
 - c. DCS Policy where applicable
 - d. Fostering Positive Behavior (available on CD from DCS)
- c. Case Manager and Supervisor. The agency is to ensure new case managers are competent in the professional knowledge, skills, and attitudes surrounding services to children and families. **Every case manager supervisor shall complete a basic supervisor training and pass a skills – based competency assessment geared specifically to child welfare supervision.** Topics may vary based on agency-specific population (s); however, all agency case managers are expected to complete training on the concepts and practices listed below which correspond with the DCS Pre-service Curriculum provided for DCS Family Service Workers. (Refer to Provider Staff Development Guide for further information. This guide is available on the DCS Provider Web Site.)
1. Building a Trusting Relationship involves understanding the value of and how to build a trusting relationship, benefits of working together, principles of conduct, interpersonal helping skills and problem-solving, and understanding the roles of team members.
 2. Family-centered Assessment includes understanding that the family, as a whole, is to be assessed and engaged in the assessment process focusing on safety, well-being, permanency, family strengths and the resources needed for desired outcomes.
 3. Family-centered Planning includes the family in the planning process with a focus on outcomes that reflect the family's culture, reduces risks and leads to permanency.
 4. On-the-job Training

OJT plays a crucial role in the transfer of learning and the identification of areas of deficiency. Agencies will provide practical and meaningful experiences for new workers including proper supervision and documentation of OJT hours.
 5. Competency Assessment is important to determine the level of staff competency regarding the subject matter and the experiences of OJT and classroom training. Providers will use an assessment tool such as a written test in combination with observation to determine competency and will maintain written documentation of the assessment results.
 6. Fostering Positive Behaviors

Explores the assessment of underlying conditions from a strengths based, family centered, culturally responsive perspective to help case managers determine the most appropriate services and plan necessary in reducing those behaviors. DCS has **CD-ROM training** that can be utilized by providers for this training.
 7. Psychotropic Medication Policy

Emphasize the rights and responsibilities of case managers, resource parents/providers and families regarding the proper consent and administration of psychotropic medications

to children and youth. DCS has CD- ROM training that can be utilized by providers for this training.

8. Serious Incident Training defines the different categories and levels of incidents as well as provides an overview of the process by which incidents involving custodial children are reported to DCS and the specified period of time for reporting such incidents.

- d. Case Manager Supervisor.

The Case Manager Supervisor is assumed to have completed the agency pre-service curriculum for case managers. If the person has not, he/she should attain that competency within the first 90 days after assuming the supervisory position.

3. In-service Training Hours Agencies should provide in-service training and continuing education opportunities to ensure that its staff members have the specialized skills and knowledge necessary to provide quality services. The in-service training curriculum should include competency-based modules to ensure that staff continues to improve their knowledge of family, children, and the community and should be based on staff needs. In-service training requirements begin after the first year of employment following pre-service and are tracked and documented by hire date.

- a. Direct Care Staff. Twenty-four (24) hours annually.
- b. Case Managers. Forty (40) hours annually.
- c. Case Manager Supervisors. Twenty-four (24) hours annually.

4. In-Service Training Topics//Methods can include but are not limited to

- a. mandatory topics repeated for continued certification
- b. quality improvement activities
- c. implementation of new policies and procedures
- d. specialized training topics
- e. guest speakers
- f. conference trainings
- g. new initiatives from the Department of Children's Services
- h. development of new skill areas
- i. specialized reading materials
- j. specialized training as the needs of the clients change

5. Substitution of Required Pre and In-service Training

- a. Four (4) training hours per each semester hour of college credit completed within the current year in an applicable social science area may be substituted for annual training.
- b. A new employee who is hired within one (1) year after having left employment with another private provider children's services agency or DCS may be credited with the training hours received from the prior employment. Evidence of such training must be documented in the employee's personnel file.
- c. An employee who has resigned in good standing from the agency's program and is rehired within one (1) year of the resignation is not required to repeat the pre-service training and in-service training if they were previously completed. The annual ongoing in-service training

requirement must be fulfilled beginning with the date of rehire.

6. Staff Development Plan and Documentation of Training Hours

Pursuant to the Brian A. Settlement Agreement, "Prior to contracting with any agency, DCS will review, approve, and monitor the curriculum for caseworker pre-service and in-service training to assure that general content areas are appropriate to the work being performed by the agency. Where casework activities mirror the duties of the DCS case manager, the curriculum will correspond with DCS pre-service and in-service training."

In accordance with the Brian A. Settlement Agreement, providers will implement an appropriate performance evaluation process to ensure the competency of those staff with responsibilities comparable to DCS case managers.

Agencies will receive written notification of review and approval or denial. Any changes to the plan or calendar will be submitted to the Department of Children's Services as an addendum within 30 days of the changes being instituted by the agency.

Submit plans for review to the following address:

**Tennessee Department of Children's Services
Professional Development and Training Division
1276 Foster Avenue, Menzler #3
436 Sixth Avenue North
7th Floor Cordell Hull Building
Nashville, Tennessee 37243**

a. Potential Contract Private Provider Agency

Any private provider desiring to contract with DCS for child welfare services is required to submit the following.

- i. the agency's pre-service training curriculum outline for case managers and case manager supervisors,
- ii. the agency's in-service training calendar for case managers and case manager supervisors to meet required annual staff development training hours,
- iii. Competency tools used to evaluate staff competency in pre-service curricula

b. Current Contract Private Provider Agency

Projected Staff Development plans and calendars for agencies who were contractors in the previous contract year are due on or before January 01 for the upcoming contract year. **In accordance with the Brian A. Settlement Agreement, providers will implement an appropriate performance evaluation process to ensure the competency of those staff with responsibilities comparable to DCS case managers. The Competency Tools will be submitted at the above address on or prior to September 01 each contract year.** Contractors are strongly encouraged to submit their plans and calendars in a timely fashion in order for the review and approval process to be completed prior to the contract renewal time. The agency will receive written notification of review and approval or disapproval.

Required documents:

- i. Pre-service training curriculum outline (If it has not changed significantly from previous

year, it is not necessary to resubmit for annual approval.)

- ii. In-service training calendar for upcoming year
- iii. Competency tools used to evaluate staff competency in pre-service curricula, if changed from previous year

c. Documentation of Training Hours

The agency will document the participation of personnel in appropriate training.

Any exemptions granted are based upon procedures which assess the demonstrated competency in tasks to be assigned. Agencies will provide proof, by individual, that training requirements are being fulfilled. Review of those records will occur during monitoring. Date of training, number of training hours, and signatures of participants obtained at the time of training will serve as proof of training.

d. Subcontracting by Primary Private Provider Agency

Private provider agencies sub-contracting with non-DCS contract agencies will be responsible for reviewing and approving the sub-contractor's training plans and schedules and will have those plans and schedules available to DCS for monitoring purposes.

F. Caseload Size

1. Provider agencies will comply with their accrediting body's standards for caseload sizes or will follow the Brian A Settlement Agreement numbers and DCS Policy or whichever is most stringent.
 - One (1) Caseworker per 20 cases for Standard Foster Care
 - One (1) Caseworker per 10 cases for Continuum or Medically Fragile Foster Care
2. When the provider case manager's caseload consists of a mix of children and youth in regular foster care and those in medically fragile or continuum foster care, the caseload size should be weighted accordingly and the ratio adjusted.
3. To determine the weighted caseload, one medically fragile or continuum foster child equals two children in regular foster care. For example, a case manager could have eight continuum/medically fragile and four regular foster care children.
4. At no time can a case worker with medically fragile or continuum foster care children have a weighted caseload that would exceed the maximum caseload size for those services.
5. Provider agency case manager supervisor shall supervise no more than five case managers. Case manager supervisors may carry a client caseload under certain conditions and only in accordance with the Brian A Settlement Agreement requirements.
6. Provider agencies shall establish a process for reassigning cases to ensure coverage at all times and to maintain the continuity of agency case management without interruption by:
 - a. Reassigning cases within one (1) business day of the departing agency worker leaving employment.
 - b. Arranging a face to face meeting between the departing agency worker and the receiving worker, unless there is a documented emergency or the agency worker leaves without notice.
 - c. Making a determined effort to have the departing agency worker introduce the receiving

agency worker to the child and family.

G. Requirements for Case Reassignment

The Settlement Agreement establishes requirements related to the process for reassigning cases from one worker to another. These requirements include the following:

All cases MUST have an identified case worker and cannot be unassigned for any period of time;

- a. cases of any worker leaving the agency are to be reassigned within one business day of the worker's departure;
- b. there is to be a face-to-face meeting between the departing worker and the receiving worker for each case, unless there is a "documented emergency" or the case manager leaves without notice; and
- c. every effort is to be made to have the departing worker introduce the receiving case manager to the child and family.

H. Employee Performance Review and Accountability

1. The agency provides for a system of supervision and evaluation or other procedures for holding personnel accountable for the performance of assigned duties and responsibilities.
2. Frequency of individual or group supervision is arranged according to the level of skills of the provider and supervisor, the complexity and size of the workload, and the newness of the assignment.
3. At least once a year, personnel performance reviews are conducted jointly between each employee and the management or direct-service volunteer with ongoing responsibility and the person to whom he/she is accountable for his/her performance.
4. Performance reviews include an assessment of job performance in relation to the quality and quantity of work defined in the job description and to the objectives established in the most recent evaluation; clearly stated objectives for future performance; and recommendations for further training and skill-building, if applicable.
5. When the agency employs, contracts for, or otherwise utilizes the services of a professional on a per interview, hourly, or other part-time basis, it holds those workers accountable in the same way it does its other personnel by requiring appropriate recording, participation in conferences or review processes as needed, and regular reporting to a supervisor or other senior personnel.
6. Staff will not be permitted to take a child home on an overnight basis under any conditions or for any other reason(s) including working in staff's home(s). On very special occasions such as holidays, staff members may take a group of no less than two (2) children home for holiday-related activities. On such occasions a male and female adult must be present and prior written approval at least one week in advance must be granted by the DCS FSW.
7. Compliance with any/all other prohibitions as specified in the provider's contract must be maintained.
8. **The private provider agency must not encourage nor in any way suggest to parents/guardians of a non-custodial child that the child should be put in DCS custody in order to receive services.** The private provider agency should refer the parent/guardian to the Behavioral Health Organization (BHO) or to the DCS Regional Well-Being Unit.

The private provider agency must not suggest custody by indicating that the agency only serves custody children. The private provider agency must provide information regarding the DCS Regional Well-Being Unit to the parent/guardian. DCS is better positioned through the Well-Being Units to discuss with parents/guardians options for services short of the state assuming custody.

III. GENERAL PROGRAM REQUIREMENTS

All requests for waivers to policy except for Background Check requirements must be submitted to CPPP for review and approval/disapproval prior to action being taken. Refer to DCS Policies 4.1, 16.4, and 16.8.

Provider agencies shall adhere to the applicable mandates as set forth in the [Brian A. Settlement Agreement](#).

A. Referral, Acceptance and Admissions Procedures

1. Children Served

Only children referred by the regional placement services division (PSD) who meet the criteria as specified in the definition of services of the DCS Provider Agreement will be served. The provider **MUST** accept referrals that meet the criteria outlined in the scope of services. Determinations regarding the order of admission are subject to the discretion of DCS staff. Providers will be held accountable for refusing to accept appropriate referrals.

2. Referral Packet Information

- a. Referrals will contain certain information and will be forwarded to the residential provider agency with an attached cover letter. The referral packet will contain the following:
 1. Cover letter
 2. child and adolescent needs and strengths (cans) assessment (if completed)
 3. The family functional assessment and/or social history with any addenda and revisions to include behavior and placement summary for the last six months
 4. Critical medical information, the needs of the child for any ongoing medical treatment, current prescription (and other) medication the child is taking
 5. Any “zero tolerance” issues that may exist
 6. Psychological assessment, if appropriate
 7. Permanency Plan packet including any revisions. (The permanency plan packet includes the Permanency Plan, attachment of Notice of Equal Access to Programs rights, attachment of Appeal Rights [for appeals within the region], and attachment of Notice of Termination Procedures. The new Notice of Action (NOA) and the TennCare Medical Care Appeal form should be attached.)
- b. Agencies should admit emergency referrals without referral packets or with incomplete referral packets with information forwarded immediately as available by regional staff. All agencies are required to provide to their respective program coordinators in the DCS CPPP emergency contact information for their gatekeeper. The gatekeeper must be available 24/7 and must be empowered to make placement decisions on behalf of the agency.

3. Referral Acceptance or Appeal
 - a. The provider will respond to the request for service(s) within four (4) hours of receiving a referral packet.
 - b. Provider agency will follow RA to RA protocol when making a placement out of region in a resource home. Refer to Attachment 12 Regional Administrator (RA) to RA Approval.
 - c. If the provider determines that the referral is not appropriate or not within their scope of services, the provider may appeal the referral immediately but no later than one working day after packet receipt. Refer to Section One, Core Standards, III Program Requirements, W Appeals
 - d. If the appeal is not filed within this time frame, the provider must accept the referral.
4. Waiting List, Authorization for Services and Admission Packet
 - a. The PSD staff has the responsibility for maintaining the regional waiting list for the provider's program. Special classes of children/youths may be identified as priorities for waiting lists. The regional staff determines the next admission for openings from the waiting list.
 - b. Authorization for services
Admission can occur only when the appropriate regional resource placement specialist authorizes the client in the current child welfare information system. The provider may print an authorization from the application if needed.
 - c. Admission Packet. The following information will be included in the packet:
 1. school records, including special education records
 2. immunization records
 3. court order(s)
 4. birth certificate
 5. Social Security cardMCO/BHO identification numbers (if not available, a copy of the TennCare application is required)

B. Client Information and Records

1. Client Information
 - a. Basic Client Information
 1. The agency follows its written policies and procedures that meet applicable legal requirements, if any, governing the collection and maintenance of client information essential to the provision of its services.
 2. The agency maintains a record for each individual client, family unit, or group receiving service of such essential information as is deemed necessary to provide appropriate services, protect the agency, or comply with legal regulation. Each record is organized into sections and includes a table of contents so that all documents within the record are readily accessible. All client records are accessible for monitoring.
 3. If a group home is located in a remote location from the central location, minimum records must be kept in the remote location to include face sheet with critical, emergency

information, basic medical information, copy of current treatment plan and progress notes, and documentation of participation in groups conducted at the facility. If these records are accessible electronically at the remote location, they do not have to be maintained as hard copies at the remote facility.

4. The record for an individual client contains, at a minimum, the following information:
 - a. biographical or other identifying client information;
 - b. the nature of the client's problem or reason for requesting or being referred for services;
 - c. the service plan; and
 - d. services provided to the client by the agency or through referral.
 - b. Basic client information is supplemented by the following:
 1. psychological, medical, or psychosocial evaluations;
 2. court reports;
 3. documents of guardianship or legal custody, birth or marriage certificates, and any court orders related to the service being provided;
 4. financial information used to establish fees; and
 5. documentation by the agency of ongoing services to the client.
 - c. Written order for medications or special treatment procedures when directly prescribed by the agency or when administered directly by agency personnel to clients in a residential, day treatment, or day care facility
2. Minimum Treatment Record Standards
- a. Private Provider Contract agencies must include the following information in their treatment record.
 1. cover sheet
 2. initial assessment
 3. treatment planning and implementation
 4. progress notes
 5. medical services
 6. treatment documentation/case notes/coordination of care documentation
 7. release of information
 - b. Treatment records must be maintained for seven (7) years after the child's twenty-second (22nd) birthday.
 - c. All aspects of individual, group, and family treatment must be documented and meet the following minimum standards:
 1. written in clear and complete sentences
 2. name and relationship to the child of each person documenting, with credentials, as appropriate for clinical service providers
 3. all entries in records signed by the author and dated
 4. entries legible to someone other than the writer

5. location of contact(s)
6. beginning and ending times of the contacts
7. purpose of contact, observations/assessments/clinical information, and next planned contact
8. identifying information for the client on each page
9. consecutive entries, no blank spaces
10. no white-out
11. no post-its
12. no stapled or loose pages in the record
13. errors crossed out and initialed
14. use of black or blue ink
15. approved/generally recognized abbreviations

C. Initial Assessment

1. The initial assessment contains information concerning the child's initial treatment needs, obtained upon placement. Information will come from referral packets, intake information, family members, previous placements, and information forwarded by the child's DCS FSW. If any information is unavailable for any reason, the DCS private provider's requirements will be deemed fulfilled if the record contains documentation of reasonable efforts to obtain the information.
2. Within thirty (30) days of placement, information related to the initial provision of appropriate clinical services will be included in the client's treatment file. This information shall include:
 - a. a description of the child or youth's general physical and mental health status at the time of intake,
 - b. a psychiatric history that includes a description of the child's presenting clinical/psychiatric issues, risk factors, psychiatric symptoms, a five-axis diagnosis of mental illness using the most current edition of DSM (if completed and available), and any history of alcohol and drug abuse,
 - c. a summary of medical history that includes medical problems, alerts, present medications, and medication history,
 - d. Family Functional Assessment,
 - e. a general evaluation regarding the youth's functioning in the domains of community or family support, educational activities/status, family status and involvement, current physical health, emotional/behavioral health, substance abuse evaluation or risk, and risk factors for suicide, runaway, violence, or sexual behaviors,
 - f. an assessment or review of strengths, potential permanency goals, personal goals, and projected needs,
3. The initial assessment will be augmented and revised as more complete information and

assessments are available.

D. Treatment Plan and Documentation

1. Treatment Planning:
 - a. Each agency shall develop structures that allow for comprehensive treatment planning, implementation, and evaluation.
 - b. The development of the treatment plan shall be completed using a CFT model/process (family inclusion) within the first 30 days of admission to the program.
 - c. The treatment plan is a dynamic document and is in a constant state of change. The plan changes to reflect the course of treatment whether there is progress or regression.
2. Treatment Plan:
 - a. Using information from the youth's Permanency Plan (developed by DCS FSW) and from the following, the agency shall develop the Treatment Plan:
 1. Assessments—those recently completed as well as others from past treatment or services
 2. Clinical discussions and observations
 3. Any medical information—The inclusion of medical information into the treatment plan will depend on the nature of the child's condition. For medically fragile children with minimal or no mental health concerns, the treatment plan would be dominated by medical concerns. For situations where the youth's medical condition may affect treatment for mental health issues, the treatment plan should reflect the necessary interdisciplinary approach.
 4. Education information
 5. Past treatment involvement
 6. Unique needs of youth and family
 - b. Treatment plans must also be based on the following information:
 1. Medical necessity and need for counseling/ therapy and treatment.
 2. Consideration of service(s) needed for either mental health case management, Continuous Treatment Team services, or Comprehensive Child and Family Treatment as appropriate. This may include need for said services as youth is transitioned out of facility.
 - c. The agency treatment plan helps in the revision of the DCS Permanency Plan by providing information as to the progress or lack of progress of the youth/family.
3. Treatment Areas:
 - a. All treatment plans should include, at a minimum, the following treatment areas:
 1. Emotional/Behavioral
 2. Education/Vocational
 3. Health/Medical
 4. Social/Independent Living (youth 14 and over)
 5. Family
 6. Recreation

7. Discharge Planning
 - b. Areas such as alcohol/drug treatment and sexual perpetrators treatment may fall under the emotional/behavior category.
4. Treatment Plan Components:
 - a. Goals – Goals state what is to be accomplished. There should be at least one (1) goal for each treatment area.
 - b. Objectives—State in descriptive terms what the youth or family is to actually do in the process.
 1. Objectives are measurable, objective and determinate
 2. There is usually action associated with the objective. For example
The youth will demonstrate...
The youth will communicate...
 - c. Frequency/Time Frames, Interventions, and Responsible Individuals
 1. The treatment plan must contain the frequency (how often, how many times) with which the youth/family is to engage in the objective.
 2. List the types of interventions that may be used to be able to achieve the objective are listed.
 3. List the person who is going to be responsible for the objective. This individual keeps track of or records how the youth responds or works toward accomplishing the objective. An objective can have multiple people involved or listed on the treatment plan.
 4. The treatment plan shall include a time frame for the projected completion of specific goals and objectives.
 - d. Signature Page
 1. Each treatment plan shall include a signature page which contains the signatures of those individuals who have been involved in the treatment planning process.
 2. The listed signatures are the agreement by all parties that they agree to the plan and its components. The youth (when appropriate based on age and youth's level of comprehension) and family's signatures need to be on the signature page.
 - e. Treatment Plan Review
 1. The agency develops and reviews the treatment plan for each youth on a regular basis. Revisions will be documented and communicated to all parties on the team.
 2. While a CFTM does not have to be called to review the treatment plan, the agency can request one or invite the family and other treatment team members from outside the agency. (Legal personnel, DCS FSW) The youth should be part of the treatment plan review process.
 3. There should be a signature page with each treatment team meeting. The signatures account for attendance as well as agreement of the discussion and changes in the plan.

4. Regardless of the agency's treatment plan review, a formal review and revision of services occurs through the Child and Family Team Meeting every three (3) months, or more often if the treatment needs change.
5. Documentation of the three-month treatment plan review must be contained in the treatment record. A signature page must be attached.

f. Medication Information

Provider agency must gather medication information on each child and maintain and update this information in the youth's treatment record. The medication information includes but is not limited to:

1. A medication sheet or progress note that includes documentation of current psychotropic medication with dosages and dates of dosage change(s)
2. Documentation of the child's education regarding possible side effects
3. Documentation that the reason for medication was explained to the parent(s) and/or child (if age appropriate)
4. Documentation that a female youth of child-bearing age is educated about taking psychotropic medication while pregnant
5. Documentation of child's verbalization of understanding medication education (if age appropriate)
6. Evidence that all DEA scheduled drugs (i.e., any drug listed on DEA Schedule I-IV) are avoided in the treatment of children with a history of substance abuse/dependency.

g. Coordination of Care Documentation

1. Records should indicate other clinicians providing care and documentation of any communication. Records must demonstrate an ongoing coordination with any clinicians providing services and ongoing efforts to ensure continuity of care post discharge. Medical care must be coordinated with the primary care provider in the MCO.
2. The provider is also responsible for maintaining appropriate releases and documenting any information that has been released.
3. The provider should also document efforts to coordinate care with the DCS FSW and parent(s) and/or child (if appropriate). Provider must demonstrate that the FSW has approved the treatment plan and efforts have been made to ensure participation of all involved adults in the treatment planning.

h. Continuity of Care notes should contain:

1. Progress notes that reflect the date(s) of appointments or any follow-up appointment(s)
2. Documentation that the child is referred for and receiving medical evaluation for psychotropic medication (if applicable)
3. Correspondence concerning the child's treatment to DCS FSW, parents, and other treating providers
4. Signed and dated notations of telephone calls concerning the child's treatment to DCS FSW, parents, and other treating providers
5. Documentation stating when and what information about the child is released to an

individual or organization

6. Copies of Notice of Action (NOA) for any reduction, suspension, or termination of services
- i. Other Provider information
 1. The “Other Provider” section of the treatment record shall contain copies of other providers’ records that have been obtained to assist in the current treatment of the youth.
 2. Release(s) of Information: Copies of Release(s) of Information sent to other providers to obtain information or provided to the provider by the Department of Children’s Services to obtain information.
- j. Documentation/Progress notes in child’s file:
 1. Any incident or major episode in treatment
 2. Dates of family and sibling visitation and dates of contact
 3. FSW (DCS) visitation
 4. Telephone contacts
 5. CFTMs
 6. At least weekly documentation of progress in foster homes
 7. Daily documentation of progress for all continuum foster care, medically fragile foster care, and all types of Level 2 services
 8. At each change of shift for residential treatment Level 3 RTF and Level 4
 9. Providers must submit monthly summaries for all levels of care through the current child welfare information system. In the event that the system of record is not implemented, providers will default to submitting monthly summaries to the SAT Coordinators and TennCare Advocates.
 10. All medical services
 11. All clinical services
 12. All collaborative meetings
- k. Discharge summary of the services provided is entered into the client’s case record within fifteen days of discharge and includes recommendations for any needed future services and the assignment of aftercare responsibility, when indicated in the treatment plan.

E. Monthly Summaries

Monthly Summaries – are recordings that are submitted to DCS by private providers via TFACTS. Monthly Summary reports are categorized by four major domains: safety, well-being and permanency. Monthly Summaries also includes visitations and contact information.

Monthly Summaries are to be entered into TFACTS by the 15th of the next month in which services were rendered. A Monthly Summary Guide/Template with an example of a completed summary is located at: <http://www.tn.gov/youth/providers/tfactsdocs/ProviderMonthlySummaryOutline.DOC>

The Monthly Summaries are to be completed on a monthly basis for each family case served by your agency and must be submitted in TFACTS as a Private Provider Monthly summary case.

They include, at a minimum:

1. Description of child/family strengths, progress and limitation in achieving treatment plan goals with intervention plans for overcoming barriers,
2. Observations, assessments, intervention, and planned interventions,
3. Discharge notes must document achievement of goals or necessary referral to assist in the final attainment of goals.
4. A discharge summary must be written within fifteen (15) days of discharge and should include discharge reason and discharge placement (recommendation).

For health or behavioral health services not provided directly by the agency, but received by the child through community clinicians, the agency is asked to ensure communication about those health services by providing DCS form **CS-0689 Health Services Confirmation and Follow up Notification** to the community provider. The Health Services Confirmation provides information about the service that was received and notes an follow up services needed. This is provided to DCS either by the DCS provider agency or sent directly to DCS by the community clinician. The Health Services Confirmation and follow up notification form should be sent to the regional SAT coordinator, who will enter the received service in the child welfare tracking system.

F. Rights of Youth and Family

1. The agency protects client rights in all phases of the agency-client relationship from initiation of service through aftercare including release of information.
2. A child or youth shall not be denied admission to a program and/or services due to an encountered language barrier.
3. The agency develops and implements policies and/or procedures that afford special protections to its clients.
4. The agency informs clients of the rights and responsibilities of client and agency.
5. Summary information about client rights is made available to all clients through a brochure or other written material that is available or posted in the agency's reception area or that is handed to clients during their initial contact with the agency.
6. Information about client rights is made available in a language that the client can understand, in sign language or in verbal or written form as may be required by a visually or hearing impaired client, or to the client's parents or legal guardian as well as to the client if the client is a minor or is mentally disabled.
7. The outgoing and incoming mail of clients in any form of out-of-home care is not censored except that mail suspected of containing unauthorized, injurious, or illegal material or substances is opened by the addressee in the presence of designated personnel.
8. A child or youth placed in out of home care has the right to visit the family in the family home, receive visits, and have telephone conversations with family members, when not contraindicated by the CFTM or permanency plan, have personal property and a place for safe storage, be free from exploitation in employment-related training or gainful employment, and express opinions on issues concerning his or her care or treatment.
9. A child or youth placed out of his or her own home has the right to receive care in a manner that

recognizes variations in cultural values and traditions including, wherever possible, being placed with a family of the same or similar background and be free from coercion with regard to religious decisions.

10. The agency has a process to assure that, whenever practical, the wishes of the parents with regard to a child's religious participation are ascertained and followed.
11. The agency fulfills its responsibility for protection of the client and the community, when the client may be endangered and/or may be harmful to others by written policies regarding disclosure of such client information to administration, parents, legal guardians, or community authorities and administrative review of case records to determine that appropriate disclosure takes place.
12. Agency policies prohibit the requirement or encouragement of public statements that express gratitude to the agency or using identifiable photographs or videotapes for public relations purposes without the consent of the client and, in the case of a client who is a minor, both the client and the parent or guardian of the minor client.
13. Uniforms and jumpsuits DCS strongly urges agencies, whenever possible, to afford children the freedom to dress in ways that preserve their dignity, their freedom of expression, and their cultural identity. Agencies will not use uniforms, outfits, or identifying visual markers according to children's disabilities, diagnoses, or referral behaviors. Generally, wearing one's own clothing should not be held out as a reward but as a basic right. Any facility policy which requires a uniform or identifying clothing when a child is in a community setting; *i.e.*, community schools **must be eliminated immediately**, etc.

DCS recognizes the need for agencies to utilize dress codes in order to maintain standards of hygiene and decency or to maintain accountability to the youth at certain times. Private provider agencies should involve youth as much as possible in decisions about reasonable limits of clothing or dress codes. Correctional-type jumpsuits are only appropriate for correctional settings such as detention centers.

G. Search Procedures [See Attachment 9 Guide to Search Policy.](#)

There are situations when searches may be required to ensure the safety of the youth and others. The agency must establish a search policy that maintains the dignity and privacy of the youth and includes the following.

1. establish procedures to ensure searches of children/youth and their personal property are conducted by identified, properly trained and same-gender staff,
2. have at least two (2) staff members present and able to take part in every search,
3. establish a process for the Prior Notification of the youth and parent or guardian of those instances when searches might be conducted during the youth's stay in the program,
4. perform an administrative review of the process for documentation, notification, monitoring of the policy as part of an on-going quality review,
5. document in a narrative format the reasonable cause and assessed risk of harm to self or others which triggers any search.

Types of Searches

- a. **Non-Invasive Searches:** Non-invasive searches range from a visual inspection of appearance, which is expected at all service levels, to a child-driven search, such as the turning out of pockets and a self-pat-down with staff watching, or in some cases the use of standard scanning equipment or wands designed to capture metal or dense objects. Most programs, Level 2 and below, need only conduct non-invasive searches. Level 2 programs with special populations, such as Alcohol and Drug programs or Sex Offender programs, may require a more invasive search to identify and prevent certain types of contraband.
- b. **Invasive Searches:** Invasive searches are always conducted by the same gender staff as the youth being searched and may follow admissions or returns from unsupervised outings or home passes or after a suspicious activity which would suggest hidden objects or weapons.
 1. staff/child physical contact, such as a pat-down search-- Pat-down searching does not involve the touching of private areas (those which would be covered by a swimsuit).
 2. a clothing search, which would involve the removal of a youth's clothing for the clothing to be searched--This type of search is allowed only in those programs in which safety is a regular concern. This includes Level IV programs which need to take certain precautions for safety, particularly for those children who are at risk of harming themselves or others. Generally, youth are not monitored while disrobing.

Criteria for Searches

- a. **Search Criteria A:** All programs are allowed this level of search at any point: Intake/Admission, return from pass, suspicious activity, staff discretion, etc.
- b. **Search Criteria B:** Criteria for searches at B level involve circumstances in which a child is returning from an unsupervised home visit, from a community-based school, or other times in which the child has been out of the range of normal staff or DCS supervision. Trips to court with a DCS family services worker and uncomplicated outings or recreation center visits are examples of activities that do **not** meet these search criteria.
- c. **Search Criteria C:** Some programs must search children even when they have left the facility in the care of a responsible adult (family services worker or agency staff) such as a court or doctor's visit, because the child has had contact with other family members or other children that are not DCS charges or participants in the program in which as child is placed. This triggers the possibility of pat-down searches for those levels of care where such a search is allowed.
- d. **Search Criteria D:** Searches may be allowed if a child engages in suspicious activity regarding objects or persons which would indicate possible concealed contraband. These searches are specific to the levels of care marked, and performed only upon an objectively formed suspicion of a safety issue.
- e. **Search Criteria E:** Clothing searches may be performed by Alcohol and Drug programs with strict adherence to the procedures for clothing searches when warranted by unsupervised contact with persons outside the treatment setting.

H. Grievance Procedures

Agencies may use the following DCS policies as a guide, for information:

DCS Policy [24.10 Title VI Program and Complaint Process](#).

These policies have been deleted due to the DCS Group Homes closing.

~~DCS Policy 24.11 Grievance Procedures for Youth in DCS Group Homes.~~

Policy Statement:

All youth in DCS Group Homes shall have the opportunity, free from fear of reprisal, to file grievances about matters that affect their daily routine.

<http://www.tn.gov/youth/dcsguide/policies/chap24/24.11.pdf>

~~DCS Policy 24.13 Access to Legal Counsel for Youth in DCS Group Homes (for information).~~

Policy Statement:

Attorneys or authorized legal representatives shall be granted liberal access to youth in all DCS group homes for the purpose of interviewing, consulting and providing legal services to youth. If necessary, staff must assist all youth in making confidential contacts with attorneys and/or their authorized representatives to include but not limited to telephone communications, uncensored correspondence and visits.

<http://www.tn.gov/youth/dcsguide/policies/chap24/24.13.pdf>

1. The agency has written client grievance policy and procedures that provide clients with a means of expressing and resolving a complaint or appeal.
2. The agency provides basic information to its families and children about the means to lodge complaints or appeals when decisions concerning them or services provided them are considered unsatisfactory.
3. At the time a complaint occurs, the client or parent or legal guardian, as appropriate, is provided with a copy of the agency's written grievance policy and procedure.
4. The agency acts on any complaints in accord with its stated procedures and time lines and documents that it does so.
5. The client is informed of the resolution of any complaint and a copy of the notification is maintained.
6. The agency has a review and reassessment process that includes governing body review of the resolution of client grievances, which is carried out in a manner that protects client confidentiality.
7. Residential programs will have a locked grievance box on site for any youth, staff, or family complaints. The agency will have an administrative staff to review and respond to complaints.

I. Services and Support to Children/Youth and Families

Services are provided to children in order to meet their safety and permanency needs. The agency arranges and maintains stable placements for children by ensuring early intervention for behavioral problems, ensuring ongoing support for the placement and the child to address any problem areas, providing respite to placements, providing 24-hour crisis or support services to families, providing notification of abuse or allegations of abuse immediately to Child Protective Services (CPS) and DCS FSW, and completing an serious incident report in accordance with TCA 37-1-403.

1. Services/Support to children include

- a. provision for meeting the child's normal dependency and developmental needs (child care, education, health, religion, and community activities),
- b. specialized services as required to meet the child's individual needs that are integrated with the child's daily living experience and focus on achieving permanency,
- c. nutritious meals and snacks, companionship, and an atmosphere that is pleasant and conveys dignity and respect for the child,
- d. support and assistance as needed for positive participation in group living and community activities, provided individually or through daily process groups,
- e. maintenance of an orderly daily life in which the child can develop and enhance positive personal and interpersonal skills and behaviors,
- f. provision of personal needs such as clothing and an individual allowance (when required),
- g. the opportunity to participate in recreational activities and receive an educational program in the community,
- h. opportunities for spiritual development respecting the child's background, beliefs, and culture,
- i. opportunities to participate in family and neighborhood activities that are consistent with a child's ethnic and racial heritage,
- j. providing a respite placement when necessary. (Refer to respite section).
- k. recruitment or development of family and support resources,
- l. retention and expansion of the maximum feasible family involvement in decision-making and maintenance of contact between family and child (unless clearly contraindicated by Child and Family Team), and
- m. prepared for discharge and reintegration into the family or other most appropriate setting or if this is not possible, prepared for independent living and helped to identify significant adults with whom relationships can be maintained.
- n. Eligible teens and young adults in foster care ages 14–21 **must** be offered assessment, skills training, counseling, education, and other appropriate support and services to assist their transition to self-sufficiency. Agencies have the responsibility for teaching skills necessary for youth to become self-sufficient and for providing opportunities to use those skills within a supportive environment.

Independent living skills' training is incorporated into all levels and types of care. The skills are age and developmentally appropriate to the child/youth. This shall be reflected in the youth's individual treatment plan. For assistance in beginning the assessment of needs for independent living skills, providers may contact the DCS Regional Independent Living Coordinator. For more in-depth information on services and policies, please refer to **Section Two, V Independent Living Services**.

2. Services/Support to children and families by the private provider agency

- a. helps the youth and family understand and participate, where appropriate, in planning for services and setting goals for both the child and his or her parents and involvement in any changes in the plan as they occur,

- b. helps youth and family resolve conflicts and achieve understanding relating to separation and prospects for returning home or living with another family,
- c. continues the family relationship with siblings and extended family through visits and shared activities,
- d. helps the family to understand the role of the child care professionals and other personnel and consultants who may be working with him or her, and to understand and accept the placement environment and the relationships available there,
- e. helps the family to become familiar with community resources that may assist in reunification and permanency
- f. designs and implements service in a manner that supports and strengthens family relationships and empowers and enables parents and family members to assume their roles,
- g. develops a written plan of family involvement, as part of the treatment plan, to be developed at intake and updated no less than quarterly and will address but not be limited to the following issues:
 - 1. visitation guidelines and/or restrictions
 - 2. agency responsibilities for working with the family
 - 3. state agency responsibilities for working with the family
- h. provides coordination of social services to children, adults, and families that may be necessary to achieve family reunification, stabilize family ties, or obtain a permanent family for a child receiving out-of-home care,
- i. provides services to the child's parents to enable them to plan for the child's return home or for a permanent nurturing family for their child,
- j. provides services to help the child's parents maintain and enhance parental functioning, parental care, the maintenance of parental ties, or, when in the best interest of the child, termination of parental rights, and
- k. provides services to improve parenting skills as determined by the permanency plan and will include a written plan of action developed during a CFTM to outline the unique needs of the family. Skills improvement may be addressed during family counseling sessions or in classes depending on assessment of the family needs. Families will not be required to pay for training.
- l. Visitation between the child and family, siblings, and others identified in the child's permanency plan must be flexible and coordinated as outlined by the CFTM.
- m. The private provider agency cannot deny visits, telephone calls, or mail contacts with family members approved by DCS.
- n. Sibling groups in the legal custody of DCS shall be provided with opportunities to visit with one another if they are not placed in the same setting unless there is a court order prohibiting such visitation. Such restrictions must be documented in the case record by the signed court order.
 - 1. Visits shall be for no less than one hour in duration unless the visit is shortened to protect the safety or well-being of the child. Visits should be as long as possible to support the ongoing relationship of the children and may include overnight or weekend visits.
 - 2. Visits must be scheduled as often as possible but no less than 4 hours a month.

3. Visits shall take place in the parents' home, the resource home in which one of the siblings is living, the home of relatives, or the most homelike setting otherwise available.
 - o. Family involvement guidelines include any individual(s) identified in the permanency plan or as a result of a CFTM who are identified as a permanent or discharge option for the child.
3. Health Services - Also refer to **Attachment 4, TENNCARE Services for Children in Custody**
- Health services to children and youth in care includes the coordination and/or provision of health care in accordance with the policies and documentation requirements below.
- a. Agencies will use the Early Periodic Screening Diagnostic Treatment (EPSDT) behavioral/medical guidelines to provide or plan and coordinate health services.
 - ◆ **DCS Policy [20.7 TENNderCare Early Periodic Screening Diagnostic Treatment Standards](#)**
 - ◆ **DCS Policy [20.12 Dental Services](#)**
 - b. Agencies will have a written summary of the youth and the family's known medical history including immunizations, operations, and childhood illnesses.
 - ◆ **DCS Policy [20.25 Health Information and Access](#)**
 - c. Agencies will document that the youth has received age-appropriate instruction regarding pregnancy prevention, AIDS prevention, and general information about the prevention and treatment of disease.
 - d. Agencies will provide communication of all required and received health services to the DCS Regional Services and Appeals Tracking (SAT) Coordinator by submission of the Health Services Confirmation and Follow Up Notification, CS-0689.
 - e. Appropriate feminine hygiene items are provided to female youth and made readily available.
 - f. Private provider agencies will provide coordination of care when an acute hospitalization occurs including follow-through on medications, clothing, and discharge planning.
- Attachment 11 Psychiatric Acute Care Coordination (PACC)**
- g. Medication will be administered in accordance with the DCS Policy 20.15 and 20.8.
 - ◆ **DCS Policy [20.15 Medication Administration-Storage and Disposal](#)**
 - ◆ **DCS Policy [20.8 Reproductive Health Education and Services](#)**
 - h. Agencies will provide information to pregnant youth under the age of 18 in accordance with DCS Policy 20.9 that provides a court-appointed advocate to represent the youth in court.
 - ◆ **DCS Policy [20.9 Court Advocate Program](#)**

J. Movement and Movement Reporting

1. Movement

Provider compiles information on each youth who moves from one location to another location of any type during the month. A move is any change in placement location (such as a foster home, cottage, or residential or other placement) including temporary breaks in service.

A change in location includes moves from foster home to foster home or from cottage to cottage as well as a change in program. There are two types of moves: *planned* and *unplanned*.

a. Planned Move

A planned move is a move that occurs as a result of a Child and Family Team Meeting (CFTM) that is held prior to the move and which includes all involved adults and age-appropriate children. Consensus regarding the move is achieved and a permanency CFTM form or other staffing form is signed by all documenting the meeting.

b. Unplanned Move

Unplanned moves are non-compliant with best practices and, therefore, are subject to incur penalties unless there is clear and compelling evidence that the move is due to an imminent child safety issue. The provider must report any unplanned move within 24 hours of the move to the Regional Placement Services Division and the child's DCS FSW. Unplanned moves require a CFTM within 72 hours of the next business day after the movement.

NOTE: Psychiatric and medical hospitalizations ARE NOT considered a move.

2. Temporary Breaks

Temporary breaks are interruptions or temporary breaks in placements and include the following.

- a. Runaway and the bed is being held,
- b. Medical or psychiatric hospital and the bed is being held, [Attachment 11 Psychiatric Acute Care Coordination \(PACC\)](#)
- c. Child is in a residential program and is authorized to transition to a foster home prior to the move to the permanency home,
- d. Detention

3. Process for Reporting a Move

Any move must be preceded by a CFTM unless there is an imminent child safety issue. In these instances, the DCS FSW and Regional Placement Services staff must be notified within twenty-four (24) hours of the move and a request made to convene a CFTM.

a. [TnKids TFACTS](#) Reporting:

Providers must notify the FSW and PSD whenever a child moves from one location to another or has any type of temporary break in placement. Notification to the regional FSW and PSD must be in accordance with [TnKids TFACTS](#) Placement Change Notifications and Provider Procedures [section](#) below.

b. System of Record Reporting:

Providers are to notify the FSW and PSD via email of all placement changes within 24 hours of a placement move. Notification of a placement change will be entered into the system of record by DCS once that system becomes available for this functionality.

K. Placement Exception Requests (PER)

- ◆ **DCS Policy [16.46 Child/Youth Referral and Placements](#)**

Placement decisions are made within the context of the Child and Family Team Meeting. If a placement exception is sought, the PER procedure must be used. “Waivers” are not to be used for this purpose. No move requiring a PER shall be made prior to the Regional Administrator’s approval. DCS is responsible for all PERs, but the agency should have a copy of any relevant PER and verification of RA approval of the PER – either the hard copy of the PER signed by the RA, the RA’s e-mail confirming review and approval of the PER, or documentation of approval by the RA using the RA PER approval button in TFACTS once it is functional. In emergency situations, RA verbal approval is acceptable, but DCS should provide written confirmation that the RA has granted verbal approval, and the provider should seek confirmation if not sent; the provider should maintain that confirmation in the child’s file.

L. Detention, Runaways, Hospitalizations

1. Detention DCS shall reimburse providers for no more than 24 hours per child, per provider, per year for children placed in detention. Detention is not to be used as a method to disrupt a child out of a program. Any changes in placement must be as a result of a CFTM.
2. Runaways
 - ◆ **DCS Policy [31.2 Responsibilities Regarding Runaways, Absconders and Escapees.](#)**
 - a. DCS shall only reimburse for up to three (3) days per year, per child, per provider for children on runaway. Providers are not obligated to hold the bed open past three days; however, the child could be referred back to the provider upon return from runaway. This should be processed as a new referral.
 - b. Upon the child’s return to care, a debriefing meeting must occur within 24 hours and will include but is not limited to, the DCS FSW, the provider, the child, and all appropriate family members.

The DCS FSW may participate by phone. At the debriefing meeting, a safety plan must be developed to reduce the likelihood of the child eloping prior to the CFTM.
 - c. The CFTM meeting will be scheduled within seven (7) days of the child’s return to care and a formal Safety Plan created to help prevent future runaways. The Safety Plan would include, but would not be limited to, mental health treatment, reunification/family counseling, medication management, specific extracurricular activities, etc. In addition, specific time and energy will be focused on working with the child to better understand the precursory issues that led to the child’s elopement.
 - d. The CFTM is an essential part of this plan and this is the forum in which all involved parties have an opportunity to assess both the long- and short-term needs of a specific child through close observation and discussion of the child’s behaviors and elopement patterns.

This type of hands-on information may not be available through traditional testing or assessment instruments. As children are, in most cases, either running away from something or running to something, the department and private providers must look to systemic issues rather than solely focusing on the runaway behavior.

3. Hospitalization

The provider may be reimbursed for up to seven (7) days at the discretion of the region and with approval from the regional administrator or his/her designee. After seven days and up to twenty-one (21) days, the provider may be reimbursed with written approval from the DCS Regional Administrator or his/her designee. An agency should not be reimbursed past 21 days; however, in the event that an agency and region agree that the agency should be reimbursed past this time, the Division of Child Placement and Private Providers must be notified and approval sought from the DCS Deputy Commissioner of Protection and Prevention. Hospitalization is not a reason for an agency to disrupt a child from his/her placement. It is assumed by DCS that a child that is hospitalized will return to his/her placement after hospitalization. A change of placement decision can only occur within the context of a CFTM.

M. Respite

Respite care is the provision of short-term, temporary relief provided to resource parents and residential facilities caring for children in the custody of the State. The expectation for respite is that the child/children will return to the original placement. Respite is not considered a placement move unless it exceeds seventy-two (72) hours. If there are extenuating circumstances that require a longer period of respite, a CFTM must be convened for pre-approval. Respite shall not be used as a pretext to disrupt a placement.

N. Reporting, Compliance, Corrective Action Plans

1. The agency must have a current and valid required license for the level of services provided. Failure to have the appropriate licenses is a breach of contract and can ultimately result in closure of the agency.
2. The agency must comply with submission of required reports, site visits, and data requests in a timely and accurate manner.
3. Appropriate action to eliminate or ameliorate identified problems in the agency's program of service is taken including
 - a. revision of policies and/or procedures,
 - b. changes in personnel assignments,
 - c. changes in in-service training, and
 - d. addition or deletion of a program or service.
4. The agency defines, systematically obtains, and maintains in retrievable form , the information it needs to plan for and evaluate its program of services.
5. Information is obtained that, in the aggregate, describes
 - a. referral sources, clients served, services provided, services needed but not provided,
 - b. applicants not accepted for services, the services requested, the reasons for non-acceptance,
 - c. clients who drop out of treatment or terminate services and their reasons for doing so.
6. The agency's board establishes policies governing access to client records by auditing, contracting, and licensing or accrediting personnel.

7. The agency ensures the retention and maintenance of records for a minimum of seven (7) years past the child's twenty-second birthday.
8. Corrective Action Process
 - a. The office of Program Accountability Review (PAR) will issue a PAR report after a review of the provider agency and send a letter to inform the agency of its findings. If a Corrective Action Plan (CAP) is needed, the provider agency is instructed in this letter to submit the CAP to the attention of PAR within **thirty (30) calendar days** of the date of the letter. All findings identified in the PAR report must be addressed in the CAP.
 - b. PAR will review the CAP within 15 working days of receipt, and PAR will contact the agency indicating if the CAP has been accepted or not accepted. If the CAP is not accepted, the agency will be given **seven (7) calendar days** to submit a corrected CAP unless otherwise noted. PAR will review the CAP again and notify the provider agency if the plan is now acceptable or not acceptable.
 - c. When PAR has accepted the CAP, or if the CAP needs further consideration, the CAP will be forwarded to the PQT Green Team for final review and approval. When the PQT Green Team gives final approval of the CAP, an approval notice will be sent to the Agency.
 - d. If the CAP is not approved by the PQT, the PQT Green Team will be convened to discuss possible next steps which may include, but are not limited to, an agency freeze, termination, or exercising contractor rights under the breach of contract language.
 - e. The PQT attempts to review CAPs within a week. Response time depends on the circumstances of the situation and the safety of the youth. The decision of the team is communicated to the agency CEO and the person who submitted the CAP via telephone and followed up in writing.

O. Child and Family Team Meetings

DCS Policy [31.7 Building, Preparing and Maintaining Child and Family Teams](#)

1. The Child and Family Team Meeting (CFTM) is the model utilized by DCS staff to engage families in the decision-making process throughout their relationship with the Department. This model will be utilized for the development of case plans and making permanency decisions as well as for addressing critical decisions about the placement of children. When the permanency plan is completed at a CFTM, the plan serves as the documentation of the team's work. For all other meetings, the team's work and decision(s) are documented in the staffing summary and justification form.
2. CFTMs are expected to be held at the following intervals:
 - a. within seven (7) days for children not entering care via Child Protective Services;
 - b. within thirty (30) days of commitment;
 - c. at the 15-day, 6-month, and 9-month points;
 - d. prior to placement moves (planned or unplanned);
 - e. to determine changes in permanency goals; and
 - f. just prior to discharge.

3. A CFTM will be held at least six (6) months prior to the 18th birthday to examine transitional or independent living services.
4. A CFTM is required (with notice to all involved adults and the child, if age twelve {12} or older) prior to reduction or change in level of services or termination/discharge. When discharge/termination is being planned, the CFTM must be convened.
5. CFTMs do not replace the agency's responsibility for ongoing treatment planning meetings; however, treatment planning may occur within the framework of the CFTM.
6. Provider agencies may **request** that DCS convene a CFTM; however, only DCS staff can convene a CFTM. The DCS Policy 31.7 referenced above has a CFTM Protocol attached which gives an expanded description of each type of CFTM and the time lines attached to each type. Provider agencies must keep copies of all correspondence requesting a CFTM. (Refer to # 10 below.)
7. When a provider agency requests a CFTM related to placement stability, DCS must schedule the meeting within 3 working days of the request and the meeting must be held within 5 days of the request.
8. The CFTM to prevent disruption or following a disruption must take place within 15 days of the move.
9. Special Called CFTM
In the event of an emergency, DCS should schedule the CFTM as soon as possible but within 3 working days. If it is not an emergency, the CFTM should take place within 7 working days. If a child is expelled or suspended from school, the CFTM must take place within 5 working days.
10. Failure to comply with the policy regarding the use of CFTMs for the disruption or movement of a child shall result in penalties as determined by the State for each day the child resides in a placement not approved through a CFTM. *The private provider shall not be penalized if documentation can verify the provider's efforts to coordinate a CFTM with DCS before the disruption or movement of the child.*

P. Face-to-face Contact/Visitation Requirements

- ♦ [DCS Policy 16.38 Face-to-face Visitation with Dependent and Neglected and Unruly Children in DCS Custody](#)
- ♦ [DCS Policy 16.43 Super/Unsupervised Visitation between Child-Youth, Family and Siblings](#)

For children in a resource home or facility operated by a provider agency, DCS shall require and ensure that the private agency case worker visits the child as frequently as necessary to ensure the child's adjustment and progress in placement, to ensure the child is receiving appropriate treatment and services, and to determine that the child's needs are being met and service goals are being implemented. The above-referenced DCS Policies give in-depth instructions as to the minimum requirements of case worker visits and visits between the child and his family. Refer to the [Visitation Protocol Attachment to 16.38](#) "Face to Face Visitation with Dependent and Neglected and Unruly Children in DCS Custody" for a chart detailing the requirements.

If a child moves to a new placement at any time following his/her initial placement, the child shall be visited as if he/she were just entering care. The initial face-to-face visit at the time of placement may be counted toward the required visits.

The DCS FSW must have at least one (1) contact each month with the provider agency's case worker to obtain information regarding the child's progress. Providers must report all face-to-face (F2F) visits through the current child welfare information system.

Visits may take place in the child's placement, at school if the child is of school age, in the case manager's office, or in another appropriate setting. Worker- child visitation shall mean a face-to-face visit between the child's private agency case worker and the child. All visits shall include a private meeting between the private provider case worker and the child out of the presence of the foster parents or other caregiver, except when the child is an infant.

There shall be at least 6 face-to-face visits during the first two months after a child's entrance into custody in a foster home or facility operated by or under a private contract agency, and at least 3 of these visits shall take place in the child's placement. Following the first two months after a child's entrance into custody, there shall be at least two face-to-face visits each month. One of these face-to-face visits must take place in the caregiver's home.

1. Dependent, Neglect, and Unruly Adjudication

Providers will document two (2) "Private Provider – Family/Sibling Visitation F2F" visits per month and provider has to associate at least one family member for the recording as contact information. Providers will document one (1) "Private Provider – Family/Sibling Visitation F2F" visit per month and provider has to associate at least one sibling for the recording as contact information.

2. Juvenile Justice Class Children/Youth

Providers will document one (1) "Private Provider – Face to Face with Client" case worker visit per

month until the child exits care or leaves the agency. This would exclude all detention center placements.

3. Additional Provider Requirements for All Custodial Children

- a. Providers will document all face-to-face contacts before the last day of the following month. Example: If meeting took place on 1/3/07 provider must document and complete the recording by 2/28/07.
- b. Provider will not be required to enter unsuccessful visitation attempts.
- c. Providers will have the ability to print agency's face-to-face documentation.
- d. Providers will have the ability to enter multiple face-to-face contacts per child documentation session within the application.
- e. Provider will only enter quantifiable data into the application. No narrative case detail information is necessary in this application.
- f. The creator of the face-to-face documentation will have the ability to "Mark in Error" if the documentation was entered incorrectly as long as the recording marked as "Complete" is accompanied by an explanation. Provider can delete face-to-face documentation that has not been marked "Complete." Providers will then need to reenter the correct visit within the last day of the following month.
- g. If a DCS family service worker and a provider case worker attend a visit together, each agency (DCS and the contracted provider) will document the visit separately allowing each agency to gain credit for the visit. OIS will have the ability to filter the visit and allow DCS to bill for TCM as well as allowing for the provider to count the visit toward Brian A. visitation requirements.

Q. Child Abuse Reporting/Investigation

1. Tennessee law (T.C.A. 37-1-403) requires that any person having knowledge of child abuse is to report this immediately.
2. Any report of suspected abuse or neglect of a minor child must be reported to DCS.
 - a. **The telephone number to report is 1-877-237-0004.**
 - b. Reports are to be made immediately.
 - c. Reports can be made twenty-four hours a day, seven days a week.

DCS Policy [14.15 Reporting False Allegations of Child Sexual Abuse](#)

3. Further, the legislature has given DCS the power to investigate, without hindrance, all reports of abuse or neglect and directs "any child care program or child care agency" to grant access to premises, children, and records, regardless of whether or not the child is in the custody of the Department of Children's Services (T.C.A. 37-5-512). The department is also empowered to take "certificate or licensing action" to prevent agencies or persons from continuing in any capacity in which harm may occur.

4. While the need for agencies to gather necessary information in order to make the report is recognized, agencies are prohibited from conducting an independent investigation into the validity of the report.
5. If the agency is making the report, the screening/assignment decision will be reported to the agency within twenty-four (24) hours.
6. All reports of endangerment to children are investigated by the Special Investigation Unit (SIU) within DCS. SIU reports all 'initial' investigations to the Child Placement and Private Provider (CPPP) unit.
 - a. CPPP immediately initiates a freeze of admissions on the home and notifies the provider of the freeze via e-mail. The freeze is initiated to prevent any new placements into the home during the investigative period.
 - b. Providers are not required to take any action regarding the home unless notified to do so by the region, SIU or CPPP.
 - c. As soon as the investigation is concluded, SIU will issue a finding of "unfounded" (no evidence to support the allegation) or "indicated" (there is sufficient evidence to support the allegation).
 - d. The freeze will be immediately suspended upon notice of an "unfounded" finding. The provider will be notified of that action via e-mail.
 - e. All resource homes investigated by SIU and classified as "indicated" at the conclusion of the investigation will be closed immediately by DCS.
 - f. The provider and the region (s) will be notified of the action on the same day the notice was received by CPPP.
 - g. If children are currently in the home, an emergency CFTM will be convened by the region to discuss the removal of the children from the resource home immediately.
7. The agency is responsible for the safety of children they serve. The agency must make a safety plan for the child while awaiting the screening/assignment decision.
8. If the report is assigned for investigation, the safety plan will remain in effect until agreement between agency and Special Investigative Unit (SIU) is reached.

◆ **DCS Policy [14.25 Special Investigations](#)**

9. During the investigation, the agency will cooperate fully with SIU. Investigations will be completed within sixty (60) days.

◆ **DCS Policy [14.5 Child Protective Services Planning, Locating Child/Family and Notification to External Agencies](#)**

10. If an investigation cannot be completed within the required time frame due to extenuating circumstances, the agency will be informed.
11. Serious Incident reporting requirements also pertain to child abuse/neglect complaints.

R. Serious Incident Reporting

- ◆ DCS Policy [1.4 Incident Reporting](#)
- ◆ DCS Policy [31.2 Responsibilities Regarding Runaways, Absconders and Escapees](#)

Serious Incidents are child-specific indicators that alert DCS and provider agencies to potential risk to children in their care. Providers must report all incidents through the current child welfare information system within 24 hours of the incident occurring. If the application is not available, the provider must fax or e-mail the information to: CPPP at: (615) 532-5723. When the system becomes available, the provider agency must enter the information through the online application.

1. All Serious Incident reports (listed below) are reported via the current child welfare information system.
 - a. Abduction- A child or youth is taken from the facility by unauthorized individuals (i.e. alleged perpetrators of abuse, non-custodial parents or relatives).
 - b. Abuse or neglect- A DCS or contract agency staff member or any person in contact with the youth is alleged to have physically, sexually or verbally abused a child or youth.
 - c. Contraband-Any item possessed by an individual or found within the facility that is illegal by law or that is expressly prohibited by those legally charged with the responsibility for the administration and operation of the facility or program and is rationally related to legitimate security, safety or treatment concerns.
 - d. Major Event at Agency-An event causing a significant disruption to the overall functioning of the program and necessitating notifying an emergency official. This event affects all, or nearly all, of the children and staff at the location. Examples include riot, fire, death of a child or staff member (while at the location), a flood, etc.
 - e. Arrest of child or youth-A child or youth is arrested while in the custody or control of DCS, and the arrest has been confirmed by a law enforcement agency
 - f. Assault-A willful and malicious attack by a child/youth on another person (This is not meant to include horse-play.)
 - g. Arrest of parent, surrogate or staff person-The arrest of a DCS or a contract agency staff member, including foster parent or others affiliated with the youth and /or family and has been confirmed by a law enforcement agency
 - h. Runaway-Child or youth leaves a program without permission and their whereabouts is unknown or not sanctioned
 - i. Emergency Medical Treatment-A child/youth has been injured or has suffered an illness that requires emergency medical attention. (In an instance of treatment of a child or youth, the child or youth's custodial adult must be notified.)
 - j. Medication Error- DCS Policy [20.59, Medication Error Guideline](#) A medication error occurs when a medication is not administered according to the prescribing provider and /or according to DCS policy and procedure. Therefore, when a child **refuses** medication and the medication is not administered according to the orders from the prescribing provider, this is considered a medication error. According to DCS Policy [20.15 Medication Administration](#),

[Storage and Disposal](#), the prescribing provider can be notified any time a child refuses prescribed medication, but the prescribing provider MUST be notified if a child continues to refuse medication for 48 hours. The 48 hour time frame is also used for the submission of the IR related to medication refusals. Agencies should first make contact with the prescribing provider to determine the appropriate course of action. The prescribing provider may indicate that the medication can be discontinued. In this case, no IR is necessary because the child is being taken off the medication. However, if the provider indicates the child should continue on the medication, the IR should be submitted. Details of the discussion with the prescribing provider and his/her direction about the medication refusal should be included in the IR.

- k. Emergency Use of Psychotropic Medications(s)-An emergency one-time dose of a psychotropic medication in the event of a psychiatric emergency when all other measures have been determined unlikely to prevent the child/youth from imminent harm to self and /or others, DCS Policy 20.21, Emergency and PRN Use of Psychotropic Medication.
 - l. Mechanical Restraint- The use of a mechanical device that is designed to restrict the movement of an individual. Mechanical restraints shall be defined as handcuffs, chains, anklets, or ankle cuffs or any other DCS approved or authorized device.
 - m. Seclusion-The placement or confinement of an individual alone in a locked room or egress is prevented
 - n. Physical Restraint-The involuntary immobilization of an individual without the use of mechanical devices. This includes escorts where the youth is not allowed to move freely.
 - o. Mental Health Crisis-A child or youth has engaged in or experienced: self injurious behavior; suicidal ideation or behavior; homicidal ideation or behavior or acute psychotic episode.
2. The Web Based Training for serious incidents can be located at:
<http://www.state.tn.us/youth/providers.htm>

S. Allowance, Clothing and Incidentals

1. Allowance
 - a. The provider shall set aside a minimum of \$1.00 per day for each child in the program as the child's personal allowance.
 - b. This requirement does not apply to detention centers or emergency shelters. Also, continuum providers have the option of continuing to give the child an allowance once the child is placed in his/her own home.
 - c. The child's personal allowance is included in the per diem rate reimbursed by the state to the provider.
 - d. If at all possible, a child should be allowed to manage his/her money, choose how the money is spent as long as it does not violate law or program policy, and have access to pocket money.
 - e. The provider must track the allowance in such a way that the child's allowance account reflects the date of the child's admission to the provider's program and debits and credits to the account and maintains a running balance showing the amount of allowance money the child has at any one time.

- f. The provider must maintain a separate log for allowances, identifying the child's full name. Allowance credits should be initiated upon a child's entrance into the provider's program. Allowance debits by amount are to be recorded on the date of the transaction with accompanying signature of the child or two signatures of a witness in the event that the child is unable to sign for himself/herself.
 - g. The allowance follows the child and is the property of the child. When a child leaves the agency's program, the agency should submit allowance funds in the total amount to the child. In the case of the death of a child, the money will be returned to the state.
 - h. When the child leaves the facility, a check will be made out to the child to cover the allowance balance and the child's allowance account will be closed and a description for "zero out allowance" will be printed on the child's account.
 - i. The child's allowance cannot be used to purchase items that become the property of the agency, for normal age appropriate hygiene items and/or clothing needs, for items that are an inherent part of the agency's program including special clothing required by the agency, or for program planned outings. However, children can use their own allowances for extras while on these outings and may purchase their own clothing if they do not wish to use clothing provided by the agency.
 - j. The child's allowance cannot be withheld as a form of punishment. Restricting use of allowance must be pre-approved by a CFTM.
 - k. A portion of the child's allowance may be applied toward the cost of restitution for damaged property as long as it is approved by the CFTM.
2. Clothing and Incidentals
- a. All children who enter state custody are eligible for an initial clothing allowance if clothing is unavailable or inadequate. Additional clothing purchases may be approved if clothing is lost during moves from one placement to another or in case of fire or other natural disaster. The DCS FSW is responsible for authorizing the purchase of clothing in these situations.
 - b. The provider agency is responsible for routine and ongoing clothing purchases after the child enters the program. Clothing purchases are included in the provider's per diem rate.
 - c. Clothing is the property of the child and moves with the child when the child leaves the program. Clothing left behind when the child is moved must be moved by a DCS representative within 30 days.
 - d. The provider agency must supply any special clothing required for the child to participate in a certain program.
 - e. The provider is responsible for program and normal age-related personal incidental costs for children in the program such as bedding, camping equipment, diapers for infants, toiletries, personal hygiene items for females, etc.

T. Educational Standards

The provider will ensure that the educational needs of students are thoroughly assessed and that appropriate educational opportunities are provided according to DCS Policy. Whenever possible,

children/youth in custody should attend public schools. The provider will maintain a contact and liaison with the local education agency.

Attachment 7 Educational Standards for DCS Providers provides in-depth information on serving the educational needs of youth in care including hyperlinks to appropriate DCS Policies.

U. Mandated “Protection from Harm” Standards and Policies

Agencies will use the DCS policies listed below to insure that legal and appropriate standards are followed in serving children/youth and their families. Adherence to these policies is mandatory. Follow the links to referenced policies and print in their entirety including any attachments.

1. Informed Consent for Treatment

- ◆ **DCS Policy [20.24 Informed Consent](#)**

Refer to **Attachment 8** [Informed Consent Provider Information](#) for a summary sheet that can be copied and given to medical providers to explain what is needed to assure informed consent. Providers should help families and children/youth understand treatment and medication practices.

2. Medication Standards and Practices

- ◆ **DCS Policy [20.15 Medication Administration-Storage and Disposal](#)**
- ◆ **DCS Policy [20.18 Psychotropic Medication](#)**
- ◆ **DCS Policy [20.59 Medication Error Guidelines](#)**

3. Behavioral Management Interventions

- ◆ **DCS Policy [25.10 Behavior Management](#).**
- ◆ **DCS Policy [19.9 Psychiatric Emergency Use of Mechanical Restraints](#) (also refer to 31.15)**
- ◆ **DCS Policy [31.15 Guidelines for Transportation of Child/Youth by Regional Employees](#)**
- ◆ **DCS Policy 27.2 [Use of Seclusion](#)**
- ◆ **DCS Policy [27.3 Physical Restraint](#)**

4. Clinical Information

- ◆ **DCS Policy [19.1 Suicide Self-Harm Intervention](#)**

V. Successful/Unsuccessful Program Completion

Agencies will maintain information on youth leaving program with discharge placement and type:

1. Successful non-continuum program completion/discharge: Youth left the contract, successfully completing the program treatment plan.
2. Successful continuum completion/discharge: Youth left the program to the permanency goal placement as outlined in the permanency plan.
3. Unsuccessful non-continuum program completion: Youth left the program without successfully completing the program treatment plan. Youth ran away and did not return; youth went to a hospital or detention center and did not return to the contract agency. This also includes youth who went to other programs/contracts without successfully completing this program/contract due to disruption.
4. Unsuccessful continuum program completion: Youth left the program without achieving permanency as outlined in the permanency plan. Youth ran away and did not return; youth went to a hospital or detention center and did not return to the contract agency. This also includes youth who went to other programs/contracts without successfully completing this program/contract due to disruption. Planned Permanent Living Arrangement is considered to be an unsuccessful continuum program completion.
5. Contract agencies will provide the following information on youth in care:
 - a. Length of stay for all youth discharged by discharge placement
 - b. Length of stay for all youth remaining in the program
 - c. Reentry to custody of youth completing the program

W. Discharge and De-authorization of Services

1. Successful Program Completion (Discharge)
 - a. Prior to successful completion of a program, the provider will prepare a discharge packet and forward it to DCS in anticipation of the child's planned departure from the agency.
There must be a CFTM held prior to release.
 - b. A TennCare Notice of Action will be issued to all involved adults and child prior to discharge for all Level II and above services.
2. Premature Discharge
 - a. The provider may request a CFTM to remove a child from the program if the child has exhibited behaviors that would place him/her in the category of children who are not eligible for admission to the program. The provider shall be expected to exhaust and document all available means of service intervention prior to requesting such discharge. When the provider desires to discharge a child prior to successful completion of the program, the provider must request, in writing, that the department convene a CFTM. The agency cannot discharge a client from the program without a CFTM except in the unusual circumstances described below.
 - b. The meeting will occur as soon as possible but no later than five (5) calendar days from the date of the request. The purpose of the meeting is for the provider, family, DCS FSW, child (if appropriate), and other involved adults to reach consensus on a plan of action that would either

allow the child to remain in the program or move to a more appropriate placement.

- c. The regional placement specialist must be notified of the CFTM. With the exception of very unique and unusual cases, DCS will not support removal of a child from the provider's program with the recommendation to place the child in a program of comparable level and treatment components.
 - d. If there is agreement or if the decision of the appeals committee is that the child needs to move to another placement, DCS will arrange for and move the child within fifteen (15) days following the date of the consensus decision.
 - e. In unusual circumstances when a child's behavior is so out of control as to make him/her a danger to self or others, the provider may immediately remove the child from the program only with the approval from the DCS FSW.
 - f. The provider should assist with this process in accordance with the plan of action that has been developed.
3. Repeat Runaway Situations
- a. In the case of runaway incidents, where the child appears to be a "repeat runaway risk," the provider, DCS FSW, and resource placement specialist should develop a safety plan for the youth and reach a mutual decision on whether or not the child should remain in the program. Strong consideration should be given to the child's history of running away, safety concerns (for both the child and the community), need for additional supervision, and/or need for a more secure facility placement.
 - b. Upon the return of a child from runaway, the provider will notify DCS FSW, who shall convene a CFTM to explore the dynamics leading to the runaway and shall notify law enforcement to cancel any alerts or reports.
4. Criminal Acts by Children While in Placement
- a. Charges may not be filed against a youth by a provider for behaviors that may be symptomatic of the youth's mental health diagnosis and/or treatment needs.
 - b. In situations where there is disagreement as to whether or not the youth's behaviors are symptomatic of the mental health diagnosis or pose a substantial risk to the community, a clinical opinion should be sought to determine if charges should be filed.
 - c. The provider should discuss the situation with the DCS FSW and resource placement specialist and a CFTM should determine whether continued placement is appropriate given the child's history, the incident itself, the risk to others in the program, the possible need for additional supervision, and/or a more secure placement, etc.
 - d. If agreement cannot be reached and the provider maintains that the child should not remain in the program, the provider may file a TennCare appeal, or request an appeal through DCS channels.
 - e. The child will remain in the current placement until a decision is made. If the decision is to remove the child from the program, DCS will remove the child as soon as possible but within fifteen (15) days from the date of the decision.
 - f. All procedures must be carried out in compliance with DCS appeals process.

5. De-authorization of Services

- a. De-authorization may occur when it is determined that appropriate services to the child are not being provided and/or services are no longer needed from the provider.
- b. De-authorization should be a consensual decision within the context of the CFTM.
- c. If there is a clinical disagreement, a referral should be sent to one of the following, as agreed upon in the CFTM, for resolution:
 1. DCS Regional Well-being Unit psychologist and/or nurse as specific situation indicates is most appropriate
 2. DCS director of Medical and Behavioral Services
 3. Center for Excellence
- d. Any involved party has the right to file a TennCare Appeal.

X. Referrals to Post-custody Adult Services for Mentally Ill or Mentally Retarded Youth

Provider agencies are expected to assist youth diagnosed with mental retardation who are aging out of custody in making referrals to the Division of Mental Retardation Services (DMRS) Adult Services.

♦ DCS Policy [19.8 Transitioning Youth into the DIDD Adult Services](#)

1. Transition of Youth with Serious Emotional Disturbance to Adult Mental Health Services
 - a. The provider agency must work to identify youth with severe mental health needs and assist with the move to post-custody services. The transition planning must start by age 16-1/2 years. Part of the process is helping the youth apply for SSI and/or exploring adult services offered by the Department of Mental Health through the community mental health centers.
 - b. Ninety (90) days prior to the youth's custody release dates, a request for adult mental health case management shall be made through the local mental health agency. Sixty (60) days prior to the child becoming age 18, the adult mental health case manager is notified and included in the CFTM to assist in developing a plan for the youth's transition to adult mental health services, well as other community services or outreach programs which might benefit and/or contribute to a level of stability and independence into adulthood.

♦ DCS Policy [19.7 Transitioning DCS Youth with Serious Psychiatric Disorders into Adult Behavioral/Mental Health Services](#)

2. Post-Custody Services for Youth with Mental Retardation
 - a. Youth diagnosed with mental retardation must have a determination made as to whether or not the youth shall require post-custody services through the Department of Children's Services until transition to the Department of Mental Retardation Services occurs. These youth must be identified and a transition plan initiated by age 16-1/2. Part of the process is helping the youth apply for SSI. A concrete workable and realistic plan must be finalized and implemented by the time the youth is 17-1/2 years of age.
 - b. For all youth aging out of custody and in the care of the provider agency, it is expected that the provider agency and the DCS FSW will partner to identify permanency and/or a connection to a caring adult prior to the youth aging out of care to assist with the transition to self-sufficiency. It is further expected that the youth will be stable and not require intensive residential services at the time he/she transitions out of care.

Y. Appeals Procedures

There are certain situations in which private contract providers may feel that it is in their best interest or the best interest of the child and/or family to appeal a decision made by the Department of Children's Services. The following are guidelines that private providers may use to appeal.

1. Program Accountability Review (PAR)

Agencies have the right to appeal a PAR finding or required corrective action included in a PAR report.

- a. The appeal should be sent in writing (or email) to the PAR Director for initial review and resolution within 30 days of receipt of the PAR report.
- b. A copy of the appeal should also be sent to the PAR Lead Monitor and to the Director of DCS Program Quality Team Systems (PQTS).
- c. The PAR Director will contact the Provider regarding the appeal within 5 working days of receipt of the appeal, and issue an initial response to the appeal within 10 working days of that contact.
- d. If the Provider is not satisfied with the response, the appeal may be forwarded with the PAR response to the Director of DCS PQTS for further consideration and final resolution.
- e. The PQTS will utilize all needed DCS sources and program stakeholders to carefully review the appeal. As part of this review, PQTS will contact the provider making the appeal. A judgment will be issued in writing to the provider and this decision is final.
- f. PAR will pursue or amend findings and corrective action based on the decision of the PQTS.

2. CFTM

Private provider agencies may disagree with a decision made by the Child and Family Team. Even though agency staff may be present when the decision is made, the agency may not be able to support the decision of the team. This appeal process is outlined in detail in a two-page document in [Attachment 5 Appeal of Child and Family Team Meeting \(CFTM\) Decision](#).

3. TENNCARE

Details of TennCare appeals can be found in [Attachment 4 TennCare Information](#).

4. Appeal of Placement

Private Provider agencies have the right to appeal a placement decision made by DCS Regional Resource staff.

- a. The provider may appeal a referral by contacting the Division of Child Placement and Private Providers (CPPP).
- b. The appeal must be in written form and forwarded to the CPPP no later than one (1) working day after the agency receives the referral packet.
- c. The written appeal should include the name of the child, the region seeking placement, and the specific characteristics of the child determined by the provider to be beyond the scope of services as outlined in their contract and a copy of the referral packet from DCS.
- d. The referring region will have the responsibility for providing information to CPPP to include the name of the child; the reason the region has deemed the child to be appropriate for that

particular scope of services and any supporting documentation.

- e. A committee of DCS core leadership will be convened within five working days of the receipt of the appeal and is responsible for conducting the review and making the decision.
- f. All parties will be notified by telephone immediately following the decision and a written response will be issued within 24 hours.
- g. If a vacancy exists in the provider's program at the time an appeal is made or being reviewed, the DCS Region has the discretion to hold placement of any other referrals until the appeal is resolved.