



Department of  
**Children's Services**



# Contract Provider Manual

Section One (1)-Core Standards

Tennessee Department of Children's Services | Policy | March 2026



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# ORGANIZATIONAL AND ADMINISTRATIVE REQUIREMENTS

## 1. Accreditation/Licensing

- a) Agencies that contract with the TN Department of Children’s Services will be appropriately licensed according to the population served. The agency must have accreditation by a national entity such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), Council on the Accreditation of Rehabilitative Facilities (CARF), Council on Quality Leadership (CQL), or the Council on Accreditation (COA).
- b) On an ongoing basis the DCS Office of Continuous Quality Improvement, including Provider Monitoring and Evaluation (PME), DCS Licensing, the DCS Provider and Foster Home Quality Teams, and Network Development, will review outcomes and evidence representing each agency’s performance to confirm the quality of service expected from DCS providers and their adherence to contract expectations.

## 2. Subcontracting

- a) 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, 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).
- b) The contractor with whom DCS has contracted directly will remain the primary contractor and will ultimately be responsible for all work performed.
- c) Beginning July 1, 2026, subcontracting for placement services with another agency will no longer be permitted. Agencies may continue to subcontract for services necessary to deliver their required service array.
- d) Contract 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 assuring that the subcontract program meets contract and DCS Policy requirements in all phases of service. The subcontractor will have all program and service documentation available to DCS for monitoring purposes.
- e) All forms, directions and templates for subcontracting are found on the [DCS Provider, Forms and Documents](#) website.

### 3. Transportation

- a) All facility-owned and staff-owned vehicles used for transportation of children/youth will be registered and adequately covered by medical and vehicular liability insurance for personal injury to occupants of the vehicles. Documentation of such registration and insurance coverage will be maintained in the facility's records.
- b) Staff and foster parents providing transportation will possess a valid driver's license. Documentation of the license is to be maintained in the facility's records and validated annually. See DCS Policies [16.4 Foster Home Selection and Approval](#) and [16.8 Responsibilities of Approved Foster Homes](#).
- c) The provider agency maintains the primary responsibility for providing transportation to children in their programs. This shall include transportation to all medical and dental appointments, court appearances, emergency transportation and transportation to family visits. Transportation of children in excess of 150 miles round-trip from the child or youth's placement will require collaboration and assistance from the FSW. If transportation for a parent to a family visit is needed, DCS and the provider agency will share the responsibility.
- d) Use of public transportation will be determined in the context of a reasonable and prudent parenting decision.
- e) Providers will adhere to Policy [31.15 Guidelines for Transportation of Child/Youth by Regional Employees](#).

### 4. Expansion of Services Protocol

Providers wishing to expand their services refer to [Guidelines for Private Provider Expansion of Services for Out-of-Home Residential and Group Care](#).

### 5. Reasonable and Prudent Parenting

- a) Reasonable and prudent parenting is the standard characterized by careful and sensible parenting decisions that maintain the child's health, safety, and best interests. Leadership should ensure foster parents and staff (including group home staff) are educated and supported during the planning process in creating 'normalcy' for the child/youth. DCS/Contract Agencies and other state's child-welfare agencies will adhere to the standard of care used by a caregiver in determining whether to allow a child in his or her care to and participate in extracurricular, enrichment, and social activities. The standard is characterized by careful and thoughtful parental decision-making that is intended to maintain a child's health, safety and best interest while encouraging the child's emotional and developmental growth. This standard applies to group homes, residential settings, and foster homes. Refer to the [Protocol for Reasonable and Prudent Parenting](#) for more information.
- b) Group home/residential administrator, a facility manager, or his or her responsible

designee, and a caregiver use a Reasonable and Prudent Parent Standard in determining whether to give permission for a child residing in foster care to participate in extracurricular, enrichment and social activities. A group home administrator, a facility manager, or his or her responsible designee, and a caregiver will take reasonable steps to determine the appropriateness of the activity in consideration of the child's age, maturity, and developmental level.

- c) A group home administrator or a facility manager, or his or her responsible designee, is encouraged to consult with social work or treatment staff members who are most familiar with the child at the group home/residential in applying and using the reasonable and prudent parent standard.
- d) Leadership should ensure foster parents and staff (including group home staff) are educated and supported during the planning process in creating 'normalcy' for the child/youth.

#### **6. Decision Making and Facility Policy:**

- a) Documentation that shows two (2) or more staff per facility have been designated and trained in Reasonable and Prudent Parenting standard to exercise the reasonable and prudent parent standard to timely meet the needs of the number of youth placed in the setting.
- b) Documentation that the facility has a policy that describes how youth will make requests to participate in activities and the timeline for responses to requests.
- c) Documentation that existing grievance policies have been amended, or new grievance policies have been developed, to provide youth an opportunity to appeal a denial of permission to engage in an activity.

#### **7. Youth Notification and Case Planning:**

- a) Documentation that the facility has developed a policy for how youth will be notified at least every six (6) months of the right to engage in age and developmentally appropriate activities.
- b) Documentation that a plan has been developed that contains concrete actions steps for how youth placed at the facility will have access to age-appropriate activities in the facility and in the community. This must include:
  - A list of the activities the facility provides on-site.
  - A list of the activities that are available in the community.
  - A description of the facility's knowledge and capacity to provide accommodations and supports so that youth with special needs and disabilities can participate in age-appropriate activities to the same extent as their peers.
- c) Documentation that the facility's case plan and case planning procedures have been amended to incorporate notification of the right to participate in age-appropriate activities and the inclusion of goals and action steps in the case plan related to

participation in age-appropriate activities and normalcy.

# PERSONNEL REQUIREMENTS

## 1. DCS Policies

The following DCS policies will be adhered to by the provider agency:

DCS Policy [4.1 Employee Background Checks](#) and [Protocol: Facility and Group Care IV-E Compliance](#)

## 2. Personnel Files

- a) Provider agencies will maintain a system of personnel policies and records for all employees and those volunteers who may or may not have direct contact with children.
- b) Providers will develop and retain clear policies/tools surrounding annual performance evaluations and disciplinary action guidelines. Such evaluation policies/tools will include, at a minimum, an annual evaluation of performance for each level of staff within the agency. Policy will clearly indicate actions that will be taken by the agency for failure to receive a satisfactory job performance evaluation during any evaluation period.
- c) Annual performance evaluation and recommendations are maintained in the file.
- d) Prior to the first day of employment of contract agency staff, the approval of volunteers, agencies will obtain, verify, and maintain in each employee file the items listed below:
  - Verification of education including diploma(s) and/or transcript(s), as required for the position.
  - Health certificate screening conducted by a licensed health care provider certifying that the employee is free of communicable diseases.
  - 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.
  - Proof of vehicular and medical liability insurance for anyone who will be transporting children in DCS custody.
  - Background checks to comply with DCS Policy [4.1 Employee Background Checks](#).
    - Initial Driving Record Check is conducted by the Provider.
    - Annual Driving Record Check: Annual check is conducted by the Provider and can be done in multiple ways. Using the Provider's insurance company is one way to conduct these checks. If the provider chooses this method, the check is completed using the following steps:
      - The provider must send a list of names of employees who may or may not have direct contact with children to the provider's insurance company requesting an annual driving check for employees listed. Annual driving checks include validation of current driver's license and a check of moving violations records.

- The driving record check response from the insurance company must include a list of employees who are approved for insurance coverage for the year, and a list of employees who are NOT approved for insurance coverage for the year. The response must confirm that all employees included on either list have had a completed moving violation record check and check for validation of current driver's license. The response must also include the insurance company's criteria for approval or disapproval of coverage for the year.
- The agency must run a full driver's check on each employee NOT approved for insurance coverage to assess the record violations.
- Any staff that have contact with children and are not included in the insurance check, because their job does not require driving duties, must have a full annual driving record check conducted by the provider.
- The insurance company response should be included in each individual personnel file of staff needing the annual driving check.

### 3. **Volunteer Programs**

Provider agencies with a volunteer program are responsible for the approval of volunteers in accordance to the standards outlined in Personnel Requirements Section 2 above and in alignment with ~~their~~ agency's own established procedures. All volunteers who may or may not have direct contact with youth will have the same screening, background checks, and fingerprint-based checks completed and on file as agency's employees, with the exception of the DCS Records check.

- The agency is responsible for the approval and onboarding process within their agency's standards.
- The agency is also responsible for obtaining, verifying, and maintaining all required documentation in each volunteer's file.
- These records must be retained at the agency level.

### 4. **Staff Responsibilities and Qualifications**

If there is a question about whether a waiver is available for any of the qualifications for these positions, please see the [\*\*Waiver Tip Sheet for Employment, Volunteering and Custodial Placements\*\*](#).

#### a) **Program Director**

Qualifications: The qualifications for a Program Director will largely depend on the duties that the Director will be performing. For instance, the program director may 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 will also meet the qualifying requirements for the Clinical Services Director, Case Manager, Supervisor or Direct Care Supervisor. If the agency serves child/youth with intellectual and developmental disabilities and/or autism spectrum disorders, the program director must have experience working with the specific population(s) served by the program.

b) **Clinical Services Director** provides supervision of clinical and/or medical programs.

Qualifications: 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 profession. Advanced degrees in nursing or applied behavioral analysis (ABA) meet the Clinical Services Provider qualifications for programs that serve the medically fragile and/or children/youth with intellectual and developmental disabilities and/or autism spectrum disorders.

- c) **Clinical Service Provider** (therapist or other position title having responsibilities listed below) is an appropriately licensed or qualified master's level 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.
- Qualifications: The Clinical Service Provider will 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. The clinical service provider's area of concentration or experience will be appropriate to the issues of consultation. Experience in a congregate care or group care facility is preferred but not required. The qualified master's level professional or Ed.S. providing counseling/therapy services will be required to do so under the clinical supervision and consultation of a state licensed professional. Clinical supervision will ideally occur on a weekly basis but no less than three (3) times per month.
- d) **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: The Case Manager Supervisor with supervisory responsibility for case managers (may be called case workers, social workers, family workers, etc.) will have a minimum of a master's degree from an accredited college in social work or related behavioral field (if the degree is in criminal justice there must be a juvenile justice component) and at least three years' experience as a case worker in child welfare.
- e) **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: The Case Manager will have a minimum of a bachelor's degree from an accredited college.

f) **Direct Care Worker Supervisor** (or other position title having responsibilities listed below) is the direct supervisor of the direct care workers.

Qualifications: The Direct Care Worker Supervisor will have an associate 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 (2) additional years working in a residential setting with children may substitute for the associate degree.

g) **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, Direct Support Professional (DSP), or Front-line worker but whatever the title, the role is that of direct responsibility for the care and supervision of the children/youth in a congregate care setting. The Direct Care Worker will perform within the guidelines of the agency's therapeutic milieu and will provide therapeutic support to youth.

- Qualifications: The Direct Care Worker will have a minimum of a high school diploma or a GED.

## 5. Staff Development

Personnel will meet or exceed the following pre-service and in-service training requirements. Any costs incurred in the development and execution of this training are to be included as administrative cost associated with a provider's contracted per diem billing rate.

## 6. Pre-service Training Hours

- a) **Direct Care Staff:** Thirty (30) hours of pre-service training. This pre-service training must be completed before working independently with clients.
- b) **Case Manager:** Case managers will complete or will have completed 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. All training activity will be recorded by topic or activity, date, length of time, trainee and approving trainer and all training records will become part of the case manager's personnel file. The agency employee supervising the OJT will verify the training documented by the case manager by signature.
- c) **Case Manager Supervisor:** Every new case manager supervisor will complete a minimum of forty (40) hours of in-service training directed at the supervision of child welfare case workers. This training will begin within two weeks of assuming supervisory responsibility

and completed within six months.

## 7. **Required Training Topics**

Training for direct care staff, case managers, and case manager supervisors will include skills and information which enhance staff ability to carry out the agency's programs. Specific training topics for indicated personnel include but are not limited to the following:

### 8. **All Staff Training** (pre-service and ongoing as noted)

- a) Medication Administration Training (*pre-service* and every two years only for staff administering medication, N/A for Nurses)
- b) Psychotropic Medication Training (Initial and Every Two Years, N/A for Nurses)
- c) Physical Restraint Training (Initial if physical restraint is utilized)
- d) CPR Certification (certification required only with Physical Restraint Training)
- e) Deficit Reduction Act – Fraud and Abuse Training, including whistle-blower information (Initial and Annual). Adhere to DCS policy [1.8, Guidelines for Reporting False Claims, 1.28 Reporting Suspected TennCare Fraud and Fiscal Abuse.](#)

**Note:** 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.

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 constitutes provider fiscal abuse.

- f) Prison Rape Elimination Act (PREA) Training for Providers with more than fifty (50) percent delinquent youth population. This is outlined in DCS Policy [18.8, Zero-Tolerance Standards and Guidelines for Sexual Abuse and Sexual Harassment Incidents and Prison Rape Elimination Act \(PREA\).](#)
  - g) Reasonable and Prudent Parenting Training (Ref. CPM, Section I – [Organizational and Administrative Requirements](#), Topic 5. – [Reasonable and Prudent Parenting](#) - page-5).
- ### 9. **Direct Care Worker** (pre-service training)
- a) First aid
  - b) CPR: Agency will ensure that someone will be immediately available who has been trained in CPR when supervising youth. All staff involved in performing or monitoring restraints will be CPR certified.
  - c) De-escalation
  - d) Incident reporting

- e) Recognition of substance abuse
- f) Child abuse prevention and reporting
- g) Suicide prevention
- h) HIPPA/confidentiality
- i) Sexual harassment prevention
- j) Cultural awareness
- k) Trauma Informed Behavior Management Techniques to include the following:
  - Understanding of policy [19.12 Behavior Management](#) and use of effective behavior management skills;
  - Skills to support placement stability through effective team, planning and service delivery;
  - Skills to support placement transitions through effective teaming, planning and service delivery;
  - Approaching the work in a strength's based, family-centered, culturally responsive way.

#### 10. Case Manager (pre-service and annual training)

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 and case manager supervisor will complete the pre-service training requirement and pass a skills-based competency assessment geared specifically to child welfare case management and supervision. Case manager training 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:

- a) **Welfare Mission and Values** – Know the mission of child welfare services as protecting children from maltreatment and assuring their safety in stable, permanent families. Understand how a family-centered approach, strength-based approach to child protection can support and sustain the rights of maltreated children and their families. Understand the potential serious negative impact of separation, out-of-home placement, and impermanence on attachment, child development, and family emotional stability and understand the need for timely permanence.
- b) **Role of Child Welfare Agencies** – Understand the child welfare system's responsibility to ensure children permanence by providing reasonable efforts to prevent placement, reunify children and families or pursue permanent alternative placement through adoption, legal custody, or guardianship. Understand the inherent potential tension between parents' rights and children's rights in child protective services. Know provisions of federal laws governing child welfare practice i.e., ASFA, ICWA, P.L. 96-272, MEPA, CAPTA and the state laws that implement their provisions.
- c) **Culture and Diversity** – Know definitions and fundamental concepts of culture and

diversity. Understands how cultural differences in verbal and nonverbal communication can impact the casework relationship and create misunderstandings. Understand how culturally based differences in parenting and childcare practices can influence the determination of child maltreatment.

- d) **Engagement** – Understand how a trusting casework relationship can enhance the effectiveness of the interview and increase the accuracy of the communication. Know the intended purposes, benefits, and limitations of the following interview strategies: Listening and observing, Active listening, Supportive responses, Open-ended questions, Closed-ended questions, Forced choice and yes/no questions, Probing questions, Clarifying responses, Summarizing and redirecting, Giving options, suggestions and advice, Confronting. Know interviewing strategies to deal with conflict, respond to hostile or accusatory statements, or confront family members who are reluctant to deal with critical issues.
- e) **Teaming** – Understand the importance of identifying naturally occurring support systems within the immediate and extended family, neighborhood, and community while utilizing informal and formal supports. Understand ways that family resilience and resourcefulness, constructive coping skills, intra-familial support, and community-based networks can mitigate maltreatment and help families protect their children. Know how to use genograms and eco-maps to gather information about family structure, membership, relationships, and sources of family or community support.
- f) **Assessment** – Know behavioral and emotional indicators of parental mental illness or mental health problems; domestic violence; use or abuse of drugs and alcohol and mental retardation and how they contribute to child maltreatment. Know age-appropriate expectations for children’s behavior at different stages of development. Know the physical, emotional and behavioral indicators of maltreatment: Physical abuse, Sexual abuse, Neglect, Psychological harm, Child fatality /near fatality. Know unique interpersonal and family dynamics typically associated with physical and sexual abuse, neglect, emotional maltreatment, and insecure attachment.
- g) **Planning** – Aware of the potentially destructive impact on children and families of poorly constructed, incomplete, or non-individualized family Permanency Plans. Know strategies to introduce the discussion of permanency issues during the family assessment, and to engage and empower immediate and extended family members to focus on permanence for the children throughout the life of the case. Know the difference between case goals, desired outcomes, and action steps. Aware of the caseworker’s responsibility to help family members remain invested in and involved with their children in placement from the first contact and throughout the life of the case.
- h) **Implementation** – Aware of worker’s role as case manager to help families access needed services to promote children’s healthy development. Recognize the worker’s pivotal role in helping families successfully complete case plan objectives toward reunification.
- i) **Tracking** – Understand the caseworker’s responsibility to monitor and evaluate the effectiveness of services provided by other agencies or providers. Understand the necessity of periodic case reassessment with the family to document changes and to assure the continued relevance of services and activities.

j) **Self-Awareness** – Understands factors that may bias the worker’s interpretation of individuals’ and families’ behavior and communication such as the worker’s own cultural perspective, pre-conceived expectations, and the context of the situation. Know strategies to ensure the caseworker’s safety during on-going family services work with families. Develop strategies to organize workload and manage time and priorities so assigned tasks are completed within required timeframes and can manage personal stress related to child welfare work.

k) **Trauma Informed Behavior Management Techniques**

Curriculum including the following:

- Understanding of policy [19.12 Behavior Management](#) and use of effective behavior management skills
- Skills to support placement stability through effective teaming, planning and service delivery
- Skills to support placement transitions through effective teaming, planning and service delivery
- Approaching the work in a strengths-based, family-centered, culturally responsive way.

l) **Incident Reporting**- The DCS Incident Reporting system is contained within TFACTS. How to use this system is available through the TFACTS Training link on the DCS Internet site. The link to ‘Incident Reporting for Contract Providers’ is:

<https://files.dcs.tn.gov/intranet/cccw/KB/IncidentReporting/IncidentReporting.pdf>

m) Case managers will complete or will have completed (see Substitution of Required Pre-service and In-service Training below) pre-service training before assuming full responsibility for a case, except as part of a training caseload. Pre-service training is defined as 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 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.

n) **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. Successful completion of a competency assessment is required prior to taking responsibility of an independent caseload.

o) **Annual Training**

- Education training – Foster Care case managers are required to have two (2) hours of in-service training per year regarding education services.

## 11. 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 will attain that competency within the first 90 days after assuming the supervisory position. A Competency Assessment will be completed to determine competency, and written documentation of the assessment results will be maintained.

**12. Clinical Service Provider (Ongoing Professional Development)**

Ongoing Professional Development will be required for the Clinical Service Provider such as, but not limited to, Trauma Informed Practice or Care, Motivational Interviewing or Therapeutic Interventions, and appropriate service documentation. Training and development will also be geared toward specific individuals based on their needs or milieu of campus/facility.

**13. Annual In-service Training Hours**

In-service training requirements begin after the first year of employment following pre-service and are tracked and documented by hire date, or by declared agency annual cycle.

- 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
- d) **Direct Care Worker Supervisor:** Twenty-four (24) hours annually
- e) **Clinical Service Provider:** Twenty-four (24) hours annually

**14. 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 contract provider children's services agency or DCS may be credited with the training hours received from the prior employment. Evidence of such training will be documented in the employee's personnel file. The annual ongoing in-service training requirement will be fulfilled beginning with the date of rehire.
- 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 will be fulfilled beginning with the date of rehire.

**15. Staff Development Training Plan and Documentation of Training Hours**

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.

Prior to contracting, a prospective contract provider will be contacted by a representative of the DCS Office of Learning and Development, who will schedule a review of the agency's case manager pre-service training curriculum. The DCS training representative will discuss and review with the agency staff the training modules identified to ensure that the case manager core competencies are adequately covered in the agency's pre-service training. The review will utilize a tool, [CS-1053, Provider Case Manager Pre-Service Curriculum Review](#), developed by the DCS Office of Learning and Development, and will be used to document the results of that review and discussion. When the curriculum review has been completed, the DCS Office of Learning and Development will send documentation to DCS Network Development and the agency confirming the status of each training indicator on the form, with approval of the curriculum if appropriate.

#### 16. **Employee Performance Review and Accountability**

- a) At least once a year, personnel performance reviews will be 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.
- b) 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.
- c) Providers will implement an appropriate performance evaluation process to ensure the competency of those staff with responsibilities comparable to DCS case managers.

#### 17. **Caseload Sizes**

- a) Provider agencies will comply with the following caseload sizes:
  - One (1) Caseworker per 20 children for Standard Foster Care
  - One (1) Caseworker per 10 children for Continuum or Medically Fragile Foster Care
  - One (1) Caseworker per 16 children for Congregate Care
- b) 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 will be weighted accordingly, and the ratio adjusted.
- c) To determine the weighted caseload, one medically fragile or continuum foster child

equals two (2) children in regular foster care. For example, a case manager could have eight (8) continuum/medically fragile and four regular foster care children.

- d) 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.
- e) Provider agency case manager supervisor will supervise no more than five (5) case managers. Case manager supervisors may carry a client caseload under certain conditions.

## 18. Requirements for Case Reassignment

- a) The requirements for reassigning cases from one worker to another include the following: All cases will have an identified case worker and cannot be unassigned for any period of time.
  - Cases of any worker leaving the agency are to be reassigned within one business day of the worker's departure.
  - 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
  - Every effort is to be made to have the departing worker introduce the receiving case manager to the child and family.
- b) Special Staff Requirements
  - 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 will be present and prior written approval at least one week in advance will be granted by the DCS FSW.
  - The contract provider agency will not encourage nor in any way suggest to parents/guardians of a non-custodial child that the child will be put in DCS custody to receive services. The contract provider agency will refer the parent/guardian to the Behavioral Health Organization (BHO) or to the DCS Regional Well-Being Unit.
  - The contract provider agency will not suggest custody by indicating that the agency only serves custody children. The contract provider agency will 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.

## 19. **Conflict of Interest**

To ensure procedures are established to inform providers of conflicts of interest guidelines to determine if a conflict of interest exists and for obtaining permission and approval when entering a contract, refer to DCS Policy [4.10, Conflicts of Interest](#).

For guidelines and placement criteria for contract providers interested in becoming foster parents, refer to the [Protocol for Contract Providers as Foster Parents](#).

# TREATMENT PLANNING, RECORDS, DOCUMENTATION

## 1. **Treatment/Service Plan Documentation**

### a) Treatment/Service Plan-

- Within 30 days of placement, an initial treatment plan will be completed in the client's treatment file. The development of the treatment plan will be completed using a CFT modeled process (family and FSW inclusion). While a CFTM does not have to be called to complete or review the treatment plan, the agency can request one or can invite the family/caregiver and other treatment team members from outside the agency and conduct their own planning process. The youth will be part of the treatment plan review process
- The treatment/service plan will address referral concerns and any other identified underlying/ancillary concerns and be completed using information from the youth's Permanency Plan (developed by the DCS FSW), from available assessments including the CANS and all available social, behavioral and medical information for the child and family.
- The CANS is utilized to target/identify child/youth's specific strengths and needs as well as charting child/youth's progress toward timely permanency or less restrictive setting placement. The juvenile justice model also measures community risks.

### b) Treatment Areas-

All plans will include, at a minimum, the following treatment areas:

- Emotional/Behavioral

- Educational/Vocational
  - Health/Medical
  - Social
  - Independent Living (youth 14 and over)
  - Family (see below)
  - Recreation
  - Discharge Planning
- c) Treatment/Service Plan Components -
- Goals/Objectives - Goals state what is to be accomplished.
  - Frequency/Timeframes, Interventions, and Responsible Individuals
    - The treatment plan will contain the frequency (how often, how many times) with which the youth/family is to engage in the objective.
    - List the types of treatment interventions that will be used to be able to achieve the goals/objectives.
    - List the person(s) who is going to be responsible for the intervention.
    - The treatment plan will include a time frame for the projected completion of specific goals and objectives.
- d) Signature Page:
- Each treatment plan will include a signature page which contains the signatures of those individuals who have been involved in the treatment planning process.
  - The listed signatures are the documentation by all participants 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 included on the signature page.
  - Families will be invited to the agency treatment planning meeting, and if not able to attend, mailed a copy of the document for an opportunity for review, input and signature.
  - The DCS FSW will be notified and offered the opportunity to attend the client treatment team meeting, and if not able to attend, mailed a copy of the document for an opportunity for review, input and signature.
  - A written plan of family involvement, as part of the treatment service plan, will to be developed at intake and updated no less than quarterly and will address but not be limited to the following issues:
    - Visitation guidelines and/or restrictions
    - Agency responsibilities for working with the family

- State agency responsibilities for working with the family
  - Proposed schedule for visits
- e) Every youth in out-of-home care fourteen (14) years of age to sixteen (16) years of age shall have a life skills assessment completed and an Independent Living Plan included as part of the Permanency Plan to help prepare youth for a successful transition to adulthood. These goals shall be developed concurrently with the Permanency Plan within the context of a Child and Family Team Meeting. Youth age fourteen (14) or older must complete the Life Skills Assessment in advance of the plan development. The Assessment includes:
- Has a life skills assessment been completed, and how is the provider supporting this?
  - Does the permanency plan include IL goals and interventions in the area of life skills and social skills, and what is the provider doing to address life and social skills indicators?
  - Does the child's treatment record document the implementation of services to address the child's IL indicators and action steps?
  - Does the child's treatment include IL updates as needed?
- f) Every youth in out-of-home care who is age seventeen (17) years or older shall have a life skills assessment completed and goals included in the transition plan that address transition to adulthood from state custody. Young adults receiving Extension of Foster Care Services shall have a Transition Plan developed by DCS and updated annually. Providers will participate in creating the Transition Plan, which includes:
- Has a life skills assessment been completed, and how is the provider supporting this?
  - Does the transition plan include IL goals and interventions in the areas of: Housing, Employment, Education (financial aid, scholarship), Health (referral to TDMH or DIDD), Communication Skills (essential documents), Finances (access to benefits), Social Skills (identified mentor / support person), Life Skills, Transportation?
  - Does the youth treatment record document the implementation of services to address the Youths Transition Plan indicators, goals, and action steps?
  - Does the youth's treatment plan include IL updates as needed?

g) Treatment/Service Plan Review and Update

The treatment/service plan will be reviewed and updated as needed at least every three (3) months or more often if the treatment needs change. The updated treatment/service plan will include all treatment areas and component elements of the original plan. Treatment team members, including the child, caregiver and FSW, will be offered the opportunity to attend the treatment/service plan meeting. Plan revisions will be documented and communicated to all parties on the team if they are unable to attend. Signatures will document their participation, or review and agreement. Documentation of

the three-month treatment/service plan review will be contained in the treatment record. A signature page will be attached.

h) Coordination of Care Documentation

- Records, including the child's treatment/service plan, will indicate other community clinicians providing care to the child, and document treatment goals and interventions, communications and progress from community treatment/service providers. Records will demonstrate an ongoing coordination with any clinicians providing services and ongoing efforts to ensure continuity of care post discharge. Medical care will be coordinated with the primary care provider in the MCO.
- The provider is also responsible for maintaining appropriate releases and documenting any information that has been released.

**2. Treatment Records**

a) Per TN Rules and Regulations, the following will be adhered to:

- Treatment records will be retained for a period of not less than one year after the youth turns eighteen (18) or seven years from the date of the last clinical contact with the patient, whichever is longer.
- Treatment records for incompetent youth will be retained indefinitely.

b) All other records for youth will be maintained in accordance with applicable federal, state, and local law and regulations.

**3. Monthly Summaries**

a) Monthly summaries are recordings that are submitted to DCS by contract providers via TFACTS. Monthly Summary reports are categorized by three major domains: safety, well-being and permanency. Monthly Summaries also includes visitations and contact information.

b) Monthly Summaries are to be entered into TFACTS by the 15<sup>th</sup> of the next month in which services were rendered. See: [Example of Provider Monthly Summary Report](#) for more information.

c) The Monthly Summaries are to be completed on a monthly basis for each child served by the agency and will be submitted in TFACTS as a Contract Provider Monthly summary case. They include, at a minimum:

- Description of child/family strengths, progress and limitation in achieving treatment/service plan goals with intervention plans for overcoming barriers,
- Observations, assessments, intervention, and planned interventions,
- Discharge notes will document achievement of goals or necessary referral to assist in

the final attainment of goals.

- A discharge summary, including discharge reason and discharge placement recommendation will be provided to the Department no later than the date of discharge to facilitate service delivery to the child.

d) For guidance on how to enter Monthly Summaries, see the [Contract Provider Monthly Summary Guide](#).

#### **4. Documentation and Placement Review**

- a) Providers must ensure that face-to-face contacts sufficient to ensure the safety and treatment of each child are completed and documented in the DCS electronic record within 30 calendar days. Unless otherwise specified, providers must make no less than two face-to-face contacts with each child they serve each month. Minimally, at least one in-person face-to-face contact will occur in the child's living environment.
- b) Case records contain information regarding the agency's efforts to promote Permanency/Treatment Plan goals. Documentation will record, in detail, the agency's attempts to assist the family in:
  - Making a permanency plan for their child;
  - Visiting and maintaining contact with their child;
  - Overcoming barriers to their involvement in the child's care, contact or visitation; and
  - Utilizing the resources the agency offers to prepare the family for reunification.
- c) Document meeting with the child/youth's parent(s) without the child/youth at least one time per month. Goals for these meetings include:
  - Evaluate safety, well-being, and permanency;
  - Monitor and document service delivery; and
  - Assess and support the achievement of permanency and other treatment plan goals.
- d) Document reasonable efforts toward reunification.
- e) Placement appropriateness is reviewed by DCS every six months.

## **MOVEMENT**

### **1. Referral, Acceptance and Admissions Procedures**

a) Children/youth served:

Only children referred by DCS Network Development who meet the criteria as specified in the definition of services of the DCS Provider Agreement will be served. The provider will 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. Providers will be

held accountable for refusing to accept appropriate referrals.

b) Referral Packet Information: Referrals will contain certain information and will be forwarded to the residential provider agency for review and disposition. The referral packet will contain the following:

- **[Initial Intake Placement and Well-Being Information and History form \(CS-0727\)](#)** sufficiently detailed and inclusive of critical medical information outlining current prescriptions (and other medication) the child is taking and ongoing medical treatment requirements, any school zero tolerance issues, court restrictions/requirements and any safety planning requirements necessary to ensure the safety of the referred youth and other youth in placement;
- History of Prior DCS Placement;
- For referrals to Level 3 and 4 residential treatment programs, current or recent (past 60 days) medical and mental health treatment records necessary to establish significant mental health diagnosis;
- Education Records sufficient to identify special education needs/disabilities;
- DCS clinical review for SORT.

c) At the time of Admission, DCS will ensure the residential provider agency receives the following:

- Court Order placing the child in custody;
- Forms **[CS-0206, Authorization for Routine Health Services for Minors](#)**, **[CS-0627, Informed Consent for Psychotropic Medication](#)**, and **[CS-4246, Consent for Vaccination](#)**;
- Any agency specific admission packet documents;
- Any available information from section d) below.

d) Following Admission, the Network Development team who made the referral will be responsible for ensuring the residential provider agency receives the following:

- Child and Adolescent Needs and Strengths (CANS) assessment (when completed and required by DCS policy);
- Most Current Permanency Plan, and attachments (**[CS-0158, Notice of Equal Access to Programs](#)**, Appeal Rights [for appeals within the region], Notice of Termination Procedures, **[CS-800, Notice of Action \(NOA\)](#)**, and **[TennCare Medical Care Appeal](#)** form).
- Historical medical and mental health treatment records. \*Medical and mental health records will typically include treatment provided in the past year unless there is an indication of significant diagnosis that is not addressed in the most recent records, and it is relevant to service delivery decisions.
- School Records
- Immunization Record
- Birth Certificate
- Social Security Card

- MCO/BHO Identification Numbers

e) Referral Review

- The provider will respond to the request for service(s) within four (24) hours of receiving a referral packet in writing.
- Providers may stop seeking placement for a particular youth once DCS has notified them that placement has been found.
- Provider agency will provide, in writing, the specific reasons a youth falls outside the scope of services for which the child or youth is referred when denying a referral.

f) Waiting List, Authorization for Services and Admission Packet

- Network Development staff has the responsibility for maintaining the waiting list for the provider's program. Special classes of children/youth may be identified as priorities for waiting lists. Network Development staff determines the next admission for openings from the waiting list.
- Authorization for Services: Admission can occur only when the appropriate Network Development staff authorizes the client in the current child welfare information system. The provider may print an authorization from the application, if needed.
- Admission Packet: The following information will be included in the packet:
  - School records, including special education records;
  - Immunization records;
  - Court Order(s);
  - Birth Certificate;
  - Social Security Card; and,
  - MCO/BHO identification numbers (if not available, a copy of the TennCare Application is required).

## 2. Movement and Movement Reporting

- **Movement:**

The provider will compile 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, 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. Whether a move is planned or unplanned, providers are to notify the FSW via email and Network Development via the web portal of all placement changes on the day the move occurs. There are two (2) types of moves: **Planned and Unplanned**.

- **Planned Move:** A Planned Move 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.

- **Unplanned Move:** Unplanned moves are non-compliant with best practice and, therefore, are subject to immediate review by the Office of Network Development unless there is clear and compelling evidence that the move is due to an imminent child safety issue. The provider will report any unplanned move within 24 hours of the move to Network Development 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 break in contract.

- Temporary Breaks: Temporary breaks are interruptions or temporary breaks in placements and include the following:
  - Runaway and the bed is being held;
  - Medical or psychiatric hospitalization and the bed is being held;
  - Detention

### 3. Placement Exception Requests (PER)

The following DCS policy will be adhered to by the provider agency:

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 will be used. "Waivers" are not to be used for this purpose. No move requiring a PER will be made prior to the Regional Director's (RD) approval. DCS is responsible for all PERs, but the agency will 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 RD or the RD's e-mail confirming review and approval of the PER. In emergency situations, RD verbal approval is acceptable, but DCS will provide written confirmation that the RD has granted verbal approval, and the provider will seek confirmation if not sent; the provider will maintain that confirmation in the child's file.

### 4. Changes in Level of Care

Changes in level of care (foster care or residential) that do not involve a physical move for a child will be handled as an administrative matter. The provider will submit a request for level change to Network Development, outlining the services provided and justification that the child's needs exceed their current level of service.

- If the request is approved, the Department will update the child's placement in the electronic record effective the day the request is approved.

- If the request is not approved, the provider may request a meeting of the Child and Family Team to discuss further.

## 5. Detention, Runaways, Hospitalization

### a) Detention:

- DCS will reimburse providers for no more than twenty- four (24) hours per child, per provider, per fiscal 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 will be as a result of a CFTM. The child is not discharged from the program regardless of the number of days spent in detention until the CFTM concurs the child is no longer appropriate for the placement, unless otherwise approved by Network Development.

### b) Runaways:

- As soon as it is discovered a youth has run away from a placement, contract agency staff complete the following steps immediately in the order listed below:
  - Contacts local LE to report the youth is missing and requests the youth be entered into the National Crime Information Center (NCIC) database as nationwide pickup and not eligible for bond.
  - Completes DCS form [CS-0705, Notification Checklist for Absconders/Runaways/Escapees \(Part A\)](#), and submits this to [EI\\_DCS.AbsconderUnit@tn.gov](mailto:EI_DCS.AbsconderUnit@tn.gov) with a current photograph of the youth and the NCIC number.
  - Calls the FSW/JSW to report that the youth has absconded and provides the NCIC number.
  - Files an incident report in the Electronic Records System per DCS Policy [1.4, Incident Reporting](#).
- DCS will only reimburse for up to three (3) days per fiscal 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 will be processed as a new referral.
- Upon the child's return to care, a debriefing meeting will occur within twenty-four (24) hours and will include but is not limited to, the DCS FSW, the provider, the child, and all appropriate family members. At the debriefing meeting, a safety plan will be developed to reduce the likelihood of the child eloping prior to the CFTM.
- The CFT 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.

- 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 contract providers will look to systemic issues rather than solely focusing on the runaway behavior.

b) **Hospitalization:**

- **Bed hold:** Temporary Breaks for hospitalization, whether for psychiatric or medical reasons, are not limited as far as how many unique break episodes there can be for any given length of time: calendar year, fiscal year, etc. The only stipulations lie in the length of the break. There are three (3) separate periods of time that require different levels of approval if a break is to be recognized for continued payment to a contract provider. The duration of the break is the cumulative number of days per fiscal year.
- **Temporary Break of 1 - 7 days:** this length of break is the most common and may be reviewed and approved by a Network Development Director or their designee.
- **Temporary Break of 8 - 21 days:** breaks of this length will be approved by the Network Development Director. This is the "outer end" of what would be considered reasonable for the vast majority of breaks.
- **Temporary Break of more than twenty-one (21) days:** extenuating circumstances will exist for a break longer than twenty-one (21) days. The Executive Director for Network Development or their designee will review and approve a Temporary Break of this extended length.
- **Note:** 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 will only occur within the context of a CFTM. The child is not discharged from the program regardless of the number of days spent in hospital until the CFTM concurs the child is no longer appropriate for the placement, unless otherwise approved by Network Development.
- **Sitter services:** In instances where a youth is hospitalized, it is often necessary for a caregiver to be present around-the-clock, for twenty-four (24) hours at a time. If this scenario arises and the child or youth is receiving Level 2 services or higher, the provider will supply the caregiver for twelve (12) hours per day and DCS will supply the caregiver for the remaining twelve (12) hours. If the child or youth is receiving Level 1 services, the provider will supply the caregiver for four (4) hours per day

while the child is in the hospital and DCS will be responsible for the remaining balance of the day.

**Note:** If a provider intends to supply only the required hours of caregiver time (12 hours a day for Level 2 youth and above – 4 hours a day for Level 1 youth), it is that provider's responsibility to notify the DCS FSW of this decision immediately upon hospital admission so that DCS may have ample time to procure and coordinate caregiver responsibility for the remaining balance of the day.

## 6. Discharge and De-authorization of Services

DCS Policy [16.12 Severe Abuse Review](#)

- a) Successful Program Completion (Discharge)
- b) 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 will be a CFTM held prior to release.
- c) DCS will generate a TennCare Notice of Action (NOA) and disseminate it to all involved adults and child prior to discharge for all Level II and above services.
- d) A discharge summary, including discharge reason and discharge placement recommendation will be provided to the Department no later than the date of discharge to facilitate service delivery to the child. It is important for DCS to have a discharge summary for future caregivers and providers to read. Additionally, giving consistent information to the courts across the states is beneficial to the Judges who want basic information regarding the youth when they are considering whether or not to approve the youth for release. The providers will include the information below in a discharge summary for each youth:

- What needs and strengths did the youth have at the time of entry into the facility?
- Discuss the results of assessments and how assessments results were followed with treatment provisions for the youth and family.
- What is the youth current educational status?
- What are the youth's future plans, school or career plans?
- Include information regarding the child's behavior history to include major incidents within the past three months.
- Were any specific treatment recommendations identified in the court order if the youth is delinquent? If so, were they completed?
- Include services youth received while at your facility to include alcohol/drug, sex offender treatment, risk reduction, etc.
- Document the youth's strengths and success in addressing issues that brought them into custody.

- Include information regarding unmet service needs, why they were not met and the plan to address them after leaving your facility.
- Has the family participated in the youth's treatment, was family counseling done, how will the family support the youth's successful reintegration into the community?

e) **Premature Discharge**

- 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 will 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 will make a written request through Network Development that the department convene a CFTM. The agency will not discharge a client from the program without a CFTM except in the unusual circumstances described below.
- The meeting will occur as soon as possible but no later than five (5) business 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.
- With the exception of 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. Such a removal requires the approval of the Executive Director of Network Development.
- If there is agreement or if the decision of the appeals committee is that the child needs to move to another placement, the provider will assist with this process by providing a written discharge summary at the CFTM when the decision to make the move occurs. DCS will arrange for and move the child within fifteen (15) calendar days of receiving the written discharge summary.
- Under no circumstances will a provider agency representative advocate, intimate, or otherwise engage in activities to illicit support from any party to remove a child from their program in any manner that is not consistent with the procedures outlined in the Movement section of this document.

f) **Repeat Runaway Situations**

- If a child/youth has chronic runaway problems, the provider will develop a safety plan for the youth. The provider, DCS FSW, and DCS foster placement specialist will reach a mutual decision on whether or not the child will remain in the program. Strong consideration will be given to the child's history of running away, safety concerns (for

both the child and the community), need for additional supervision, and the need for a more restrictive placement setting.

- Upon the return of a child from runaway, the provider will notify DCS FSW, who will convene a CFTM to explore the dynamics leading to the runaway and will notify law enforcement to cancel any alerts or reports.
- Criminal Acts by Children While in Placement.
- 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.
- 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 will be sought to help determine whether charges will be filed.
- The provider will discuss the situation with the DCS FSW and foster placement specialist and a CFTM will 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 restrictive placement, etc.
- If agreement cannot be reached and the provider maintains that the child will not remain in the program, the provider may file a TennCare Appeal, or request a CFTM Appeal (see Appeal Procedures section below).
- 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 no later than fifteen (15) calendar days from the date of the decision to remove.

**g) De-authorization of Services**

- 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.
- De-authorization will be a consensual decision within the context of the CFTM. Clinical disagreements should be resolved by requesting a consult with the DCS Regional Mental Health Clinician, Regional Nurse, or Director of Psychology as the specific situation indicates is most appropriate.
- Any involved party has the right to file a TennCare Appeal.
- Agency will participate in DCS Utilization Reviews (UR). UR generally occurs at 30-day intervals.

# SAFETY

## 1. Rights of Youth and Family

At initial agency contact, all clients are provided a written summary or handbook of their rights and responsibilities. Clients Right's information is provided in a form that the client can understand (e.g., appropriate language or verbal for visually impaired clients). Client's Rights should include, but not be limited to:

- a) Timely treatment/service planning to include input from child/youth and family-DCS Policy [20.24, Informed Consent](#)
- b) Confidentiality of records and client privacy- DCS Policies [9.4 Confidential Client-Specific Information](#), and [32.2, Client Privacy Rights](#).
- c) Provision of Interpreter Services-DCS Policies [1.1, Providing Equal Access to Programs, Services, and Activities for Individuals with Disabilities under the Americans with Disabilities Act \(ADA\)](#) or [1.10, Title VI Program and Complaint Process](#)
- d) Complaint/grievance/appeals process - DCS Policy [1.10, Title VI Program and Complaint Process](#).
- e) Refusal of treatment/protected health information- DCS Policy [20.25, Health Information Records and Access](#)
- f) Appropriate contact with family and support persons- DCS Policy [16.38, Face-to-Face Visitation with Dependent/Neglected/Unruly Children in DCS Custody](#) and [Visitation Guide](#).
- g) Youth will be permitted contact with their DCS Family Service Worker (FSW), attorney or Guardian Ad Litem upon request, based on circumstances.
- h) Special needs considerations for ongoing care and placement-to include: deaf, bilingual, MR, LGBTI.
- i) Pursuit of education-DCS Policies- [21.14, Serving the Educational Needs of the Child/Youth](#) and [24.14, Title IX Program and Complaint Process](#).
- j) Protection from physical, sexual, emotional or other abuse and harassment-DCS Policy [18.8, Zero-Tolerance Standards and Guidelines for Sexual Abuse and Sexual Harass Incidents and Prion Rape Elimination Act \(PREA\)](#).
- k) Safe and respectful environment-DCS Policy [16.46, Child/Youth Referral and Placement](#)
- l) Appropriate medical/mental health treatment-DCS Policy [20.7, Health Services for Children/Youth in DCS Custody](#) and [Healthcare Consent Guidelines for Youth in DCS State Custody](#).
- m) Preservation of religious or cultural values- DCS Policy [16.8, Responsibilities of Approved Foster Homes](#).
- n) Appropriate extra-curricular activities- DCS Policy [16.8, Responsibilities of Approved Foster Homes](#).
- o) 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.

If the content of mail may be therapeutically harmful to the child, absent knowledge of a court order to the contrary, the therapist has the discretion to review mail and determine whether the content is appropriate, in conjunction with the treatment team or supervisor. The letter will be retained, and the event clearly documented by the provider.

- p) 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 and gender identity. Agencies will not use uniforms, outfits, or identifying visual markers according to children's disabilities, diagnoses, or behaviors that may be symptomatic of the youth's mental health diagnosis and/or treatment needs. It is acceptable for youth to be required to wear a school or agency uniform as long as the uniforms do not differ according to disability, diagnosis, or referral behavior. Any facility policy which requires a uniform or identifying clothing when a child is in a community setting; i.e., community schools will be eliminated immediately. 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. Contract provider agencies will 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.

**Note:** (Language from current rules: **0250-4-1-.04 (9)**)

Providers shall not engage in practices which exploit the rights of children and youth in their care. Children and youth shall not be identified in connection with fundraising activities or publicity for any provider. These activities or publicity shall include, but not be limited to, the following: videos, written information, brochures, pamphlets, social media, photographs, quotes or any other form of a child or youth's physical likeness.

- q) For additional information see:
- [Clients Rights Handbook](#)
  - [Independent Living Handbook-Tool Kit to Success](#)
  - [Guide for Teens in Foster Care](#)
  - **Policy [31.12, Access and Engagement](#)**

## 2. **Grievance Procedures**

- a) Agencies may use the following DCS policies as a guide, for information:  
DCS Policy [1.10, Title VI Program and Complaint Process](#)
- b) The agency will have a written client grievance policy and procedures that provide clients with a means of expressing and resolving a complaint or appeal.
- c) 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.

- d) 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.
  - e) The agency acts on any complaints in accord with its stated procedures and timelines and documents that it does so.
  - f) The client is informed of the resolution of any complaint and a copy of the notification is maintained.
  - g) 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.
  - h) 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.
3. **Search Procedures** – Searches will be conducted in a thoughtful and respectful manner and in keeping with DCS Policy [31.4, Search Procedures](#).
4. **Child Abuse Reporting/Investigation**
- a) Tennessee law (**TCA 37-1-403** and **TCA 37-1-605**) require that any person having knowledge of child abuse is to report this immediately.
  - b) Any report of suspected abuse or neglect of a minor child will be immediately reported to DCS by the following methods:
    - Hotline: **1-877-237-0004** or **1-877-542-2873** (staffed day and night)
    - Online reporting: <https://apps.tn.gov/carat/> (may take up to 24 hours to process)
    - Additional reporting resources <https://www.tn.gov/dcs/program-areas/child-safety/report-child-abuse.html>
    - During an investigation, any child care program or child care agency will grant access to premises, children, and records, (**T.C.A. 37-5-512**).
  - c) 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.
  - d) If the referent requests a letter from the hotline, they will receive a letter stating whether or not the referral was accepted for investigation. If the referent requests email notification, they will receive a tracking number. If the referral is accepted for investigation, the referent will be contacted as long as contact information was provided.
  - e) All reports of endangerment to children that are investigated are handled by the Special Investigation Unit (SIU), Prison Rape Elimination Act (PREA) staff in conjunction with SIU, local CPS staff within DCS, or Internal Affairs (IA). SIU handles allegations of abuse or neglect when there is a concern that the contract provider may be responsible in their

- professional or volunteer capacity. Refer to [Protocol for Foster Home Quality Team](#).
- f) The agency is responsible for the safety of children they serve. The agency will make a safety plan for the child while awaiting the screening/assignment decision.
- g) **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. See DCS Policy [14.10, Special Investigations Unit](#) and [18.8 Zero Tolerance Standards and Guidelines for Sexual Abuse and Sexual Harassment Incidents and Prison Rape Elimination ACT \(PREA\)](#).
- If an investigation cannot be completed within the required timeframe due to circumstances, the agency will be informed. See DCS Policy [20.27 Child Death Near Death Rapid Response](#).

## 5. Incident Reporting

Providers adhere to DCS Policy [1.4, Incident Reporting](#) in documenting incidents within the appropriate timeframe to ensure that DCS is aware of incidents involving youth in custody.

## 6. Emergency Services

- a) The program will have a written emergency protocol, including a protocol for responding to behavioral health emergencies ranging from de-escalation strategies that are to be utilized to contacting mobile crisis for assessments and interventions. Such plans will individualize to the youth and be documented in the youth's record.
- b) In case of medical or other type of emergencies, the program will provide respondents with immediate access to relevant information in the child/youth's record (refer to DCS policy [9.5, Access and Release of Confidential Child-Specific Information](#));
- c) The program will provide immediate notification to the parent/guardian/legal custodian in case of emergency; and,
- d) The program will complete the Incident Report (IR) as required by DCS Policy [1.4, Incident Reporting](#).

## 7. Cooperation with Monitoring and Investigations

- a) The agency will fully cooperate with any member of the Department conducting monitoring or investigations, including, but not limited to, providing a copy, or copies, of documents, records, and/or video recordings. All records, to include video recordings, must be preserved for a minimum of 30 (thirty) days.

# WELL-BEING SERVICES

## 1. Health Services: The following health related DCS policies will be followed:

- a) DCS Policy [20.7, Health Services for Children/Youth in DCS Custody](#) Agencies and DCS will collaboratively use the comprehensive medical examination behavioral/medical guidelines to provide or plan and coordinate health services.

- b) DCS Policy [20.8, Reproductive Health Education and Services](#)
  - c) DCS Policy [20.12, Dental Services](#)
  - d) DCS Policy [20.15, Medication Administration Storage, and Disposal](#)
  - e) According to DCS Policy [20.24, Informed Consent](#), contract providers facilitate that consent is obtained from parents who have their rights intact and older youth, according to DCS Policy [20.24, Informed Consent](#), during the admission process and for the duration of that child's care with the provider. When parental rights are intact and the provider is transporting the youth to the appointment, the provider makes every effort to reach the parent to encourage them to participate in the appointment, in person or by telephone, with the healthcare provider. DCS consent is requested only when parental consent cannot be obtained, parental rights have been terminated, or an older youth lacks capacity as certified by the treating physician or psychologist.
  - f) DCS Policy [20.25, Health Information Records and Access](#) Agencies will maintain in the youth's file a written summary of the youth and the family's known medical history, including immunizations, operations, and childhood illnesses. This summary will be initially provided by DCS and maintained by the provider.
  - g) DCS Policy [20.27, Child Death/Near-Death Rapid Response](#)
  - h) DCS Policy [20.19, Communicable Diseases](#)
  - i) DCS Policy [20.22, Human Immuno-Deficiency Virus/Acquired Immune Deficiency Syndrome](#)
2. **Psychiatric Acute Care Coordination:** Contract provider agencies will provide coordination of care when an acute hospitalization occurs, as follows:
- a) As much as possible ensure that some adult known to the child is present upon admission to the hospital to assure the child's well-being;
  - b) Provide clothing/hygiene needs of child upon admission to hospital;
  - c) Provide any pertinent records to hospital regarding child's current/past medical care;
  - d) Provide ongoing visitation/contact with child during hospital stay;
  - e) Notify DCS case manager of admission; coordinate visitation for child with family or others as appropriate;
  - f) Participate in treatment and discharge planning;
  - g) Make sure that medications dosages and other follow up treatment is understood;
  - h) Coordinate discharge transportation with DCS Case Manager;
  - i) Coordinate hospital follow-up appointments with DCS Case Manager;
  - j) Inform caregiver of treatment needs and work with caregiver as needed to integrate child back to daily routine;
  - k) Contact school as needed and coordinate for missed schoolwork; and
  - l) An Incident Report for Mental Health Crisis will be completed in TFACTS within 24 hours.
3. The agency will coordinate the following services for the youth:
- a) Dietetic and Nutrition Services. Services that are necessary to address issues related to

diabetes control, obesity, malnutrition, and/or eating disorders.

- b) Coordination of Medical and Nursing Services. Coordination and documentation of all Comprehensive Medical Exam services provided by a licensed health care provider of the type and duration indicated by documented medical need.
- c) Both private insurance and TennCare require the use of their network providers, which also includes medical labs. Check with the insurance company for a list of participating providers before scheduling an appointment.
- d) 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 [CS-4286, Medical Report](#) Check Report to the community provider. The Health Services Confirmation provides information about the service that was received and notes any 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 will be sent to the regional SAT coordinator, who will enter the received service in the child welfare tracking system.
- e) Occupational Therapy (OT), Physical Therapy (PT), and Speech Therapy. These services can be funded by TennCare as ordered by a medical professional. Provider agencies are asked to coordinate with OT, PT, and Speech Therapy providers, families and schools as with any other service, to ensure that recommendations of treating professionals are followed.
- f) The agency will ensure the child/youth has an understanding of the importance of individual health, hygiene and grooming by:
  - Assisting the child/youth in the independent exercise of health, hygiene and grooming practices;
  - Assisting and encouraging the child/youth in the use of dental, physical or prosthetic appliances or devices and visual or hearing aids

#### 4. **Protection from Harm Policies**

Agencies adhere to the DCS policies listed below to ensure that legal and appropriate standards are followed in serving children/youth and their families.

- a) DCS Policy [20.24, Informed Consent](#)
- b) **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](#)
- c) **Behavior Support and Management Interventions**
  - DCS Policy [19.12, Behavior Management](#)

DCS Policy [19.9, Psychiatric Emergency Use of Mechanical Restraints](#)

DCS Policy [31.15, Guidelines for Transportation of Child/Youth by Regional Employees](#)

DCS Policy [19.11, Use of Physical Restraint and Seclusion](#)

## 5. Education

- a) Please refer to [Section Thirteen \(13\)-Educational Standards](#) for specific information related to the education of students in state custody.
- b) 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 will attend public schools. The provider will maintain a contact and liaison with the local education agency.

## 6. Independent Living

- a) The goals of the independent living program are to increase youth engagement in case planning, and to build a support system. The provider is responsible for the following:
  - Assist regional FSWs with planning and identification of needed services.
  - Assist in identification of appropriate supportive adults to involve in the planning process for young adults.
  - Assist with contacting IL Program staff regarding young adults that are in need of planning or service support.
  - Attend trainings of the IL Program staff to become familiar with and utilize IL Program tools.
  - Attend and participate in all CFTMs related to young adults involved in the IL Planning process.
  - Ensure that Strengths, Concerns, Outcomes and Action Steps on IL and Transition Plans are reflected in the agency's treatment planning and addressed, as applicable, per the agency contract.
  - Adhere to the following policies and resources:
    - DCS Policy [16.51, Independent Living and Transition Planning](#)
    - DCS Policy [16.52, Bright Futures Program for Young Adults](#)
    - DCS Policy [16.53, Eligibility for Independent Living Services](#)
    - [Services Available Under TN DCS Independent Living: Tip Sheet](#)
    - [Identifying and Assessing Independent Living Services Manual](#)
    - [Independent Living Wraparound Services Provided by TDCS](#)

### b) Educational Expenses:

Provider agencies will provide or arrange tutoring, mentoring, college preparation or other educational needs as necessary. Provider agencies will be responsible for these costs up to a total of \$100.00 for each individual youth in a fiscal year. Educational or college preparatory costs will include, but will not necessarily be limited to, such items as:

- General Educational Development (GED) preparation and/or actual testing;
- American College Testing (ACT) preparation and/or actual testing;
- Scholastic Aptitude Test (SAT) preparation and/or actual testing;
- Other miscellaneous testing fees;
- Good grade incentives (\$30 a semester);
- Collegiate application fees;
- Ancillary educational costs (i.e. calculators, specific vocational items, etc.)
- Education-related school trips; and,
- Other education-related items and costs on a case-by-case basis.

c) **Other Expenses:**

DCS Independent Living wraparound funds may be accessed to meet the need for more cost-intensive items such as: senior trips, yearbooks over \$100.00, dorm room deposits, extracurricular activities, prom attire, college orientation costs and graduation packages. The expectation is that the provider will be responsible for anything that costs less than \$100 as that would be an everyday normal expense for a child. If the cost exceeds \$100, the provider should discuss with the DCS Family Services Worker who will seek approval for DCS to pay the entire cost, within reason.

7. **Nutrition:**

a) Food and beverages served should follow the guidance outlined in the [Dietary Guidelines 2020-2025](#). These include the following:

- Increase intake of whole grains, vegetables, and fruits
- Reduce intake of sugar-sweetened beverages
- Monitor intake of 100% fruit juice for children and adolescents
- Three meals and snacks must be provided daily with no more than a 14-hour span between a substantial evening meal/snack and breakfast of the following day (See [https://www.health.ny.gov/prevention/nutrition/resources/docs/adolescent\\_food\\_guidelines.pdf](https://www.health.ny.gov/prevention/nutrition/resources/docs/adolescent_food_guidelines.pdf)).
- Foods and beverages served during meals should meet USDA Dietary Guidelines for Americans 2010.
- Foods and beverages served during snacks should meet the nutrition standards for [Smart Snacks in Schools](#).

All special diet orders must be prepared as prescribed by the physician or recommended by a Registered Dietitian and kept on file for annual review.

b) **Menus**

- Facilities must create cycle menus, one which is planned for a specific period of time and rotated, to offer a wide variety of foods (See sample menus, Appendix A #4).
- Facilities must have a Registered Dietitian approve the cycle menu or use the sample DCS approved menu to ensure that quality foods are served, and the meal components are meeting recommended nutrition needs.
- Menus must be kept on file for a period of one (1) year.
- Additional education and resources should be provided and available to staff and

students to enhance nutrition education and food preparation knowledge.

c) **No Food as Reward/Punishment**

The use of food as a reward and withholding food as a punishment is strictly prohibited.

**Contacts for Nutrition Assistance**

- **Tennessee Department of Health** – A local, health department is available in each county with staff members that are encouraged to be engaged in their community. Sites could contact the health department to establish a partnership. A list of local health departments can be found here: <https://www.tn.gov/health/health-program-areas/localdepartments.html>
- **University of Tennessee Extension** – Each county has a local extension office with agents that can educate the community on a variety of health topics. UT Extension also has a variety of publications and handouts available to use. A list of local extensions offices can be found here: <https://utextension.tennessee.edu/office-locations-departments-centers/>
- **Dietetic Students/Dietetic Interns in Tennessee** – Dietetic students have to complete field experience for their bachelor’s or graduate degree. Dietetic students then can apply to complete a dietetic internship program of at least 1,200 hours of supervised practice. Sites could contact the schools to see if their students need hours for their program. A list of approved education programs in Tennessee can be found here:  
<http://www.nutritioned.org/registered-dietitian-tennessee.html>
- **Coordinated School Health** - Tennessee Coordinated School Health connects physical, emotional, and social health with education through eight inter-related components. The website has a lot of data, reports, and a list of partners. Information including a directory can be found here:  
<https://www.healthprofs.com/us/nutritionists-dietitians/registered-dietitian/tennessee>

8. **Physical Activity**

- a) Adolescents should have the opportunity to do 60 minutes or more of physical activity each day in addition to recreational time. Physical activity should be scheduled as part of daily activities. These activities are separate from daily recreation or free time. Daily schedules are kept on file for review. Facilities should provide space and equipment that supports physical activities.
- b) This amount can be obtained in longer sessions of moderately intense activities, such as brisk walking for 30 minutes, or in shorter sessions of more intense activities, such as

jogging or playing basketball for 15-20 minutes. The hour can be split up into sessions that are at least 10 minutes. Physical activities for adolescents should be developmentally appropriate, fun, and offer variety.

- c) Most pregnant teens should exercise 30 minutes or more on most if not all days of the week. Consult with the obstetrician about what exercises are appropriate and the duration of the exercise program.
- d) Physical activity is not used or withheld as a punishment.

## 9. Allowance, Clothing and Incidentals

- a) Allowance - DCS Policy [3.26 State-Funded Youth Allowances/Incentive Allowances for Juvenile Justice Youth](#)
- b) DCS Policy [16.8 Responsibilities of Approved Foster Homes](#) and [16.29, Foster Home Board Rates](#).
- c) [Protocol for Clothing and Allowance](#)

# CFTM'S, CONTACTS, AND VISITATION

## 1. Child and Family Team Meetings

- a) Providers will adhere to the DCS [Child and Family Team Meeting Guide](#). The Guide provides an expanded description of each type of CFTM, and the timelines attached to each type.
- b) Contract Provider agencies may request that DCS convene a CFTM; however, only DCS staff can convene a CFTM.
  - Under certain circumstances, contract providers may appeal the decisions or recommendations made by the Child and Family Team. The appeal of the CFTM decision may be requested to resolve disagreements only related to the child/youth's type of placement, a child/youth's level of care or the continuation of a child/youth's current services. Contract staff must follow the [Protocol for Provider Agency Appeal of Child and Family Team Meeting \(CFTM\) Decision](#).

## 2. Face-to-Face Contact between the Child/Youth and Contract Agency Worker

Providers will adhere to DCS Policy [16.38 Face to Face Visitation with Dependent and Neglected and Unruly Children in DCS Custody](#).

## 3. Face-to-Face Visitation between Child/Youth, Family and Siblings

- a) Providers will adhere to DCS Policy [16.43 Supervised and Unsupervised Visitation Between Child/Youth, Family and Siblings](#).
- b) The following DCS policy and procedure is utilized by the provider agency when conducting Face-to-Face visitation:

- **Visitation Guide**
  - The contract provider agency will not deny visits, telephone calls, or mail contacts with family members approved by DCS.
  - Contract providers ensure timely documentation of parent/child visits in TFACTS within 30 days of visits occurring. The provider ensures that the entry includes all required non-narrative information including each participant listed at the visit. When visits cannot occur, are cancelled, or caregiver does not show, those types of visits are also documented. A narrative summary of all visits is included in the monthly summary.
  - Contract providers will be responsible for providing transportation for visitation conducted by the provider and provide supports to aid transportation in accordance with the “Transportation” section of Core Standards in unsupervised visits.

#### 4. Shared Responsibility for Ensuring Visitation

##### a) Supervised Visitation

- Supervised visitation is characterized by the presence of an appropriate/responsible adult who provides monitoring, oversight and possible intervention when inappropriate parental interaction occurs with the child(ren) during such a visit. The visit may be terminated when the safety or well-being of the child(ren) becomes a concern.
- All levels of contract providers share the monthly supervised visits 50/50 with DCS unless an alternative arrangement is prudent. Alternate supervision arrangements must be discussed, and agreed upon by the involved parties, within the context of a CFTM.
- Foster parents may supervise this type of visit.

##### b) Therapeutic Visitation

All therapeutic visitation services are initiated through an order of the court.

Criteria	Therapeutic Visitation Level 2	Therapeutic Visitation Level 3
Hours	Up to 5 hours/month *If the court orders visitation that exceeds 5 hours, DCS will provide funding to secure the additional hours.	Up to 8 hours/month *If the court orders visitation that exceeds 8 hours, DCS will provide funding to secure the additional hours.
Staff Qualifications	Bachelor’s in a social science, trained staff member. Therapeutic foster parents can supplement or assist with therapeutic visitation throughout each month. If determined appropriate by the team, therapeutic foster parents can exclusively provide therapeutic visitation after an initial period of co-supervising with the therapeutic worker.	
Supervision of supervising staff	Staff or foster parents supervising therapeutic visits will receive supervisory support/oversight by a supervisor with a master’s degree in a social sciences field.	
Training	All Contract Agency staff and foster parents conducting therapeutic visitation will receive at least one hour of therapeutic visitation specific training in addition to other training hours required.	

Planning	The parent's needs' will be identified through discussion of parents Strength's and Needs during the Child and Family Team Meeting and treatment planning. Specific work with the parents and children to occur during therapeutic visits will be outlined in the CFTM Summary.
Coaching During the Visit	The therapeutic worker or foster parent will work with the parents on the identified goals and provide educational interventions to teach, coach, model, and guide parents in improved parenting skills.

## EVIDENCE-BASED PROGRAMMING FOR YOUTH ADJUDICATED DELINQUENT

1. In accordance with TCA 37-5-121, contract provider agencies and their subcontractors will provide the following evidence-based treatment for youth adjudicated delinquent: Interventions and services provided by a credentialed professional or paraprofessional to serve as a therapy to promote recovery from psychosocial and/or psychological problems. These interventions and services:
  - a) Have policies, procedures, programs and practices demonstrated by scientific research to reliably produce reductions in recidivism; **OR**
  - b) Has been rated as effective by a standardized program evaluation tool.
2. Evaluation of practices with an established evidence-base will be based on fidelity to the model's components, dose, and frequency. Practices without an established evidence-base (as defined above) will be evaluated by Peabody Research Institute researchers to implement the [Standardized Program Evaluation Protocol \(SPEP\)](#).
3. To determine how well programs lacking an established evidence-base match research about the effectiveness of that particular type of intervention for reducing recidivism, DCS partners with Vanderbilt, Peabody Research Institute researchers to implement the [Standardized Program Evaluation Protocol \(SPEP\)](#). The SPEP evaluates interventions/services in the following categories: Type of service, amount of service (service duration in weeks and total number of contact hrs.), juvenile characteristics (re-offending risk level of juveniles served) and quality of the service. Once an existing service is matched, further analysis is conducted at the service and child risk levels to determine if the quantity and quality of services provided match the levels found effective by the research.
4. Providers will reference the [Evidence Based Services](#) in Electronic Record System found on the Provider Training Electronic Record System internet page.
5. **Monitoring, Refinement, and Long-Term Tracking**  
The following are provided and updated by contract providers:
  - a) **Type of Service:**
    - For each delinquent youth in congregate care, the contract provider records the following elements for each evidence-based or generic therapeutic intervention

provided to the youth. These elements are recorded in the TFACTS Evidence-based Service Sessions tab:

- Service Type
- Service Sub-type (where applicable)
- At least twice a year, providers of residential treatment provide a description of Evidence-Based Programming offered to delinquent youth, including any changes (additions or removal) in interventions offered at the facility. This information will be used to classify each provider's program(s) or service(s) according to the intervention types represented in the Vanderbilt, Peabody Research Institute database.

**b) Amount of Service:**

- For each delinquent youth in congregate care, the contract provider records the following elements for each evidence-based or generic therapeutic intervention provided to the youth. These elements are recorded in the TFACTS Evidence-based Service Sessions tab:
  - Date of Session
  - Duration of Session-defined as contact hours received (not hours offered, but hours actually received) during that service. Captured in hours/fractions of hours.
  - Narrative - description of information specific to the youth's progress or lack thereof. May also include whether or not youth completed the total number of weeks expected/required for a particular intervention.

**c) Quality of Service:**

In order to ensure quality of services provided, DCS has the following expectations:

- Staff persons providing the service have received training in that specific service type prior to utilizing the service in treatment.
- The agency has explicit written protocol for delivery of that specific service, e.g., a treatment manual, with which the staff providing the service are familiar.
- The agency has procedures in place to:
  - Monitor adherence to the protocol and other aspects of quality of those providing the service, and
  - Take corrective action when significant departures from the protocol or lapses in quality are identified.

## QUALIFIED RESIDENTIAL TREATMENT PROGRAM (QRTP) REQUIREMENTS

A Qualified Residential Treatment Program (QRTP) is a specific category of a non-foster family home setting that must be licensed by the appropriate state licensing agency; complete criminal records and child abuse registry checks in compliance with DCS Policy [4.1, Employee](#)

**Background Checks**; and be accredited by COA, CARF, or JCAHO. The following levels of service, if provided at a group home or facility, will be considered as potential QRTPs: all Primary Treatment Center (PTC)/Primary Assessment Center (PAC) placements, Enhanced Primary Assessment Center (ENPAC) placements, and all in-state Level 2 and 3 group care placements with the exclusion of Cedar Grove, Hermitage Hall, The King's Daughters' School, Memphis Recovery Center, Mountain Youth Academy, New Beginnings Academy, Norris Academy, Oak Plains, and Steppenstone.

A QRTP must operate a trauma informed treatment model and provide on-site clinical staff as required by the selected treatment model. Since COA, CARF, JCAHO require the accredited agency to operate a trauma informed treatment model, the provider must also provide documentation (either through policy or narrative form) that their treatment model meets the principles found at <https://www.nctsn.org/trauma-informed-care/creating-trauma-informed-systems>.

The QRTP must also have access to nursing and licensed clinical staff 24 hours a day, seven (7) days a week. Providers who are level 3 continuums will continue to follow the nursing and clinical requirements found in their specific scope of service and will provide evidence to the Department that their nursing or clinical staff may return to campus after hours if needed. For those PTC or level 2 providers, the provider will provide the Department their policy that describes their access to nursing and licensed mental health staff during normal business hours (to include community health or community mental health centers). The provider will also provide the Department their mental health crisis policy that is used after hours when a youth demonstrates the need for mental health attention. The Department shall make nursing staff available after hours.

A QRTP must facilitate participation of the family in a child's treatment program and facilitate outreach to family members of the child, including siblings. The QRTP must document outreach efforts, including how efforts were made and contact information for the family member(s). The QRTP must document family contact information for any biological and fictive kin; the number of family members integrated into the child's treatment process including post discharge; and how sibling connections are maintained.

A QRTP must provide discharge planning and family-based aftercare for at least six (6) months post discharge. These aftercare services shall only be required when a child leaves the group home or facility and returns to their home. Those providers who are a QRTP but do not operate on a continuum model shall make phone contact with the family every week for the first 60 days, twice a month for the next 60 days, and then once a month for the final 60 days. The purpose of the phone contact is to ensure that the family is stable and does not need

assistance accessing services in the community. If the family does require assistance, the provider will work in conjunction with the family to identify appropriate providers or other assistance within their community. If the family refuses to speak with the provider, the provider shall maintain documentation of such refusal. Aftercare services provided through telephone contact will be reimbursed through a case service request. Continuum providers are referred to [\*\*Section Ten \(10\)-In-Home Services\*\*](#) for discharge planning and family-based requirements.