Contract Provider Manual

Section Three (3) - Group Care Facilities

Tennessee Department of Children's Services| Policy |March 2025

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GENERAL GROUP CARE FACILITIES

1. **General Characteristics**

   a) Group Care Facilities are designed to meet the needs of children who are unable to live at home, or with a Foster Family, and therefore require temporary care in a group care setting integrated within the community.

   b) The Group Care Facility provides structure, therapeutic support, behavioral intervention and other services identified in a child's permanency plan for children with low to moderate clinical and behavioral needs.

   c) Goals/discharge criteria for Children in Group Care typically include permanency through reunification, kinship care, adoption or guardianship.

   d) The facility will be appropriately licensed according to the population served.

2. **Admission/Clinical Criteria**

The following criteria will be met for admission to a Group Home:

   a) The service is available to child/youth—regardless of adjudication type—whose relationship with their families or whose family situation, level of development and social or emotional problems are such that services in a family setting would not meet the child/youth's treatment needs due to supervision, intervention and/or structure needs.

   b) Programs are designed for child/youth in need of twenty-four (24) hour care and integrated planning to address behavioral, emotional, or family problems and the need for progressive reintegration into family and community living. Children/youth in Group Home placement remain involved in community-based schools (when appropriate) and participate in community-based recreational activities with appropriate supervision.

   c) Children/youth may have a history of truancy but are typically able to attend public school with liaison and support services provided by the agency.

   d) Child/youth may have a history of impulsive behaviors, aggression and alcohol or drug misuse. The child/youth may also be appropriate for these Group Care programs if displaying, low to moderate sexually reactive behaviors. Child/youth may have patterns of runaway episodes, have difficulty maintaining self-control, display poor social skills and/or have difficulty accepting authority.

   e) Child/youth in this level of care have behaviors that can be treated in a non-secure setting, with adult supervision and intervention.

   f) Child/youth may have completed higher levels or intensity of care and determined appropriate for group placement as work toward permanency continues. In addition, the child/youth may have been treated at a higher level of care for sexually reactive behavior or sex offender issues and has been assessed with a low to moderate risk for reoffending.

   g) Child/youth in this level of care may require community counseling or therapy, medication, and medication management services. These services will be coordinated by the agency and

integrated into Treatment Planning.

h) Child/youth who are ineligible for this level of care are those who have need of acute psychiatric hospitalization and/or require incarceration for major acts of violence or aggression within the past six (6) months. Those who are found to pose a significant risk to the community are not appropriate for this level of care. Child/Youth with a primary diagnosis of intellectual disability are evaluated on a case-by-case basis. Child/Youth with an IQ lower than 55 or who have adaptive functioning indicating a moderate to severe intellectual disability are not appropriate unless the agency is licensed for this service type.

3. Personnel & Staffing Requirements

a) Inappropriate/questionable boundaries between youth and facility staff, as demonstrated by inappropriate physical interactions and/or preferential treatment, are prohibited by the Department. Agency trainings, policies, and supervision plans for staff are to be explicit regarding agency expectations of acceptable and unacceptable behavior between staff and youth and are made available to the Department upon request.

b) Adequate care and supervision is provided to assure that child/youth is safe, and that his/her needs are met, in accordance with child/youth's developmental level, age and emotional or behavioral problems, and include:

- At least one (1) on-duty childcare worker providing continuous supervision for each group of eight (8) children or youth (staff to student ratio of 1:8). This ratio is also maintained at night;
- Higher adult/child ratios during periods of greater activity are recommended; and,
- Availability of additional or back-up direct care staff for emergency situations or to meet special needs presented by the children in care as needed.
- Staff persons counted in the staff-to- youth ratio are persons who have been hired and properly trained to provide direct program services. When necessary, other personnel who have completed appropriate training may also be assigned to perform direct care duties and, at that given time, may be counted in the staff-to-youth ratio. The required staff-to-client ratio must be maintained on-site in each building, or physically separated unit of a building in which youth are housed. While these are the minimum standards, it is strongly recommended that two staff be present at any time when youth are being supervised. Appropriate staff to youth ratio requires close proximity to youth, ensuring easy access at all times and in all settings.
- Documentation of facility staff to youth ratio compliance, accounting for every hour of every day, is available for Department staff to review upon request. This documentation includes staff names and units supervised. Information documenting which youth were on each unit during the same times must also be available.

c) No more than five (5) providers of case coordination or casework services report to one (1) Case Manager Supervisor. The caseloads for personnel providing case coordination or casework services do not exceed sixteen (16) residents.

d) No more than seven (7) direct care staff members report to one (1) Direct Care Worker Supervisor and the ratio is reduced to 1:5 when the workers are newly hired or in probationary status.

e) All prospective employees whose responsibilities include direct contact with youth will have a risk assessment/screening for tuberculosis within ninety (90) days of employment and annually thereafter.

4. Individualized Care Plan

a) An Individualized Care Plan will be developed and implemented for each child/youth. An initial assessment of the child/youth's needs and strengths will be completed within 72 hours of admission. The information gleaned from the assessment will be incorporated into the Care Plan. Detailed guidelines for the Care Plan are listed in ***Section One (1)-Core Standards*** of the Provider Policy Manual.

b) The program will ensure that the following assessments are completed prior to development of the child/youth's Care Plan:

- Assessment of current functioning, and a history in the following areas: Community living skills; living skills appropriate to age; emotional and psychological health; and Educational level (including educational history);
- Basic medical history and information;
- A six (6) month history of prescribed medication(s), frequently used over-the-counter medication and alcohol or other drug use;
- History of prior mental health and alcohol and drug treatment episodes
- DCS' expectation is that the provider will review all available records and will work with the FSW to obtain missing information. This information will be reviewed and integrated into the treatment planning process, including following discharge recommendations of prior treatment facilities as applicable.
- The Care Plan will include specific steps to work toward permanency, including visitation plan. This plan may integrate information from tools such as the CANS, historical FAST, and Permanency Plan. For example, actionable items on the CANS (items rated 2 or 3) will be addressed.

5. Service Overview and Components

The agency will provide a program of group living experiences and a program of specialized services for each child/youth accepted into care. Services provided by the agency include but are not limited to:

a) Structured group activities, team building exercises, life skills groups, skills building activities, and/or educational groups at least two (2) times per week.

b) Alcohol and drug awareness education at least two (2) times per month;

c) Weekly case management and coordination of outpatient mental health services, including support of the DCS Permanency Plan and participation in the Child and Family Team;

d) Coordination of health services, including arranging and accessing community based medically necessary health services through TennCare and private insurance.

e) Educational liaison to interact with the child/youth's educational needs and individualized educational plan. Contact with the youth's school will occur at least two (2) times month and be documented in the youth's record.

f) Provision of recreational activities, social skills training, daily living skills and interdependent living skills. These activities will be appropriate to, and adapted to, the needs, interests and ages of the service recipients. More information about independent living may be found in the IL information located in ***Section One (1)-Core Standards*** portion of this manual.

g) Additional Mental Health Services:

Payment responsibility is dependent on contract type. In consultation with the child/youth's parent/guardian, the program will arrange access for each child/youth to have ongoing mental health services not provided by the program and assist the child/youth in keeping appointments and participating in such treatment programs. Referrals for such services will be made within 7 days of admission to the group home and documentation of such referrals will be kept in the child or youth's record. If no mental health treatment is needed or is needed less often than what is outlined below, then documentation from a clinical service provider indicating such will be kept in the child or youth's record. Children/youth in a group home will receive the following:

- Individual therapy at least two (2) times per month from a clinical service provider.
- Family therapy at least two (2) times per month by a clinical service provider.
- Group therapy as needed and recommended by a clinical service provider.
- Intensive outpatient therapy, either mental health or alcohol and drug, as needed and recommended by a clinical service provider.
- Medication management and medications may be arranged and accessed through TennCare and private insurance if applicable.
- Medication management (psychopharmacological treatment) will be accessed quarterly or more often as medically necessary.

6. Education of the Child/Youth

a) Youth in Group Care Facilities may attend public school or may attend an in-house, non-public school that is approved by the Tennessee State Department of Education and recognized to educate students in custody by the DCS Education Division. Regions and providers will work collaboratively through the CFTM process to determine educational services for a child/youth in congregate care.

b) Please refer to ***Section Thirteen (13)-Education Standards*** for specific information related to the education of students in state custody.

7. Records Management

The individual record for each child/youth will contain the following information:

a) Documentation of the Treatment Plan and of its implementation;

b) A list of each article of the child/youth's personal property valued at one hundred dollars ($100.00) or more and its disposition if no longer in use;

c) Documentation of abuse, medical problems, accidents, seizures and illnesses. This documentation will include the treatment for such abuse, accidents, seizures and illnesses and any reports generated as a result of such incidents;

d) Results of assessments required by this rule;

e) Discharge summary detailing the child/youth's condition at the time of discharge and the signature of person preparing the summary; and,

f) Appropriate consents and authorizations for the release and obtaining of information about the child/youth.

8. Discharge Criteria

a) A preliminary discharge plan with discharge goals, projected length of stay, tentative discharge date, and tentative aftercare plan will be formulated and shared with the DCS Regional Licensed Mental Health Clinician, educational specialist, family services worker, and placement specialist.

b) A youth is ready for discharge when he/she no longer meets the admission criteria (outlined above) and sufficient aftercare services (e.g., mental health, education, family, medical/physical) have been arranged to allow for a smooth transition.

9. Qualified Residential Treatment Programs

Agencies will be expected to comply with Qualified Residential Treatment Program Requirements. Please refer to ***Section One (1)-Core Standards*** for specific information related to Qualified Residential Treatment Program Requirements.

10. Special Populations Group Care

Education:

a) Youth in this program may attend public school; however, if students are unable to attend public school, programs, they will attend an in-house, non-public school that is approved by the Tennessee State Department of Education and recognized to educate students in custody by the DCS Education Division.

b) Please refer to ***Section Thirteen (13)-Education Standards*** for specific information related to the education of students in state custody.

ENHANCED LEVEL 2 A/D SERVICES

1. General Characteristics

This time limited program addresses the treatment needs of adolescents, ages 13 to 18. These youth display moderate impairment in family, social, educational or occupational functioning due to alcohol and/or other drug use. The program is designed for adolescents who need continued structure beyond a typical family setting to provide protection from negative peer influences while promoting a sustained focus on their recovery and rehabilitation. The goal of the program is to attain permanency through reunification if at all possible, upon completion of the program or soon thereafter. The group care facility uses a limited 24-hour supervision environment to achieve rehabilitation. The program will adhere to the General Group Care portion of this manual unless otherwise noted below. The group care program is designed to be brief in nature and is not to exceed 60 days.

2. Admission/Clinical Criteria

a) The adolescent has a substance-related disorder as a primary or secondary diagnosis. Adolescents eligible for enhanced Alcohol and Drug treatment services may exhibit co-morbid substance-related and mental health disorders.

b) The adolescent is ineligible if he or she requires medical detoxification, is actively suicidal or homicidal, or has psychosis that is not controlled by medication. Adolescents with a diagnosis of Intellectual Disability are evaluated on a case-by-case basis. Adolescents with an I.Q. lower than 55, or who have adaptive functioning indicating moderate to severe Intellectual Disability are not appropriate, unless the agency is licensed for this service type.

c) The adolescent will be assessed as being low to moderate community risk.

d) The adolescent is likely to be cooperative and ready to participate in the treatment process at this level of treatment intensity. Some level of denial and resistance is common in most adolescents who abuse drugs and alcohol, and the treatment program will be expected to work with some clients who start the process without motivation for recovery.

3. Personnel

The agency will adhere to the Personnel requirements of a General Group Care facility. Additionally:

a) The agency will have a clinical services director who in addition to meeting the criteria in ***Section One (1)-Core Standards*** section of this manual, is trained in and knowledgeable of current approaches in the field of adolescent addiction treatment.

b) A Clinical Service Provider including a qualified master's level professional, LADC 1, or LACD 11 will be available to complete the assessments, and provide consultation and supervision as needed to other staff. LADC 1 or master's level professional will both practice under the supervision of a licensed clinical professional.

c) Treatment will be conducted by a clinical service provider including a qualified master's level professional, LADC1 or LADC 11 with training in the area of adolescent addiction. Clinical supervision will be provided by a licensed clinical professional.
d) To better implement an enhanced program, non-clinical support staff who also have contact with or supervise children also need initial and ongoing training in the core functions of alcohol and drug counseling and support.

4. Individualized Treatment Plan

a) In addition to the treatment plan components identified in the General Group Care portion of this manual, a nationally recognized A&D evaluation instrument must be administered by designated addictions treatment personnel or addictions-credentialed clinician.
b) Because Specialized A/D programs are brief in nature, the initial treatment plan will be completed within 24 hours of admission. The comprehensive assessment and clinical interview should be completed within three (3) days of program admission, and a comprehensive treatment plan developed within seven days of admission.
c) There must be pre & post-test measure employed to indicate progress in meeting treatment goals.

5. Service Components & Overview

a) The program will adhere to all of the same Service Components and Overview items noted above in the General Group Care section of this manual, with the exception of frequency of therapy, which is outlined below.
b) Therapy includes a minimum of five therapy contacts per week of at least 60-90 minutes duration per session. These five contacts will be comprised of at least three group therapy sessions per week and at least one individual therapy sessions per week.
c) Group therapy sessions will have a minimum of four (4) and no more than twelve (12) participants for a valid group session. Groups over six (6) must be facilitated by at least two staff. The facilitator will have the appropriate credentials and will have training in group facilitation.
d) In addition to the five therapy sessions per week, a minimum of five psycho-educational groups will be provided each week.
e) Family therapy will be provided at twice per month, with the expectation of these being face-to-face sessions. Alternate forms of contact such as phone or video conferences are acceptable for the additional sessions. The provider will also engage families through education and support groups and will assist the family in getting referrals to a variety of community services to improve their general functioning.
f) The Program will provide an evidenced based model(s) as defined by SAMHSA or California clearing house. The program will be designed for the population served. The program will

develop and maintain a manual that details the agency's plan for staff training in the model, maintaining model fidelity, and will define how staff will adhere to components of the manual.

g) The program may also provide additional services such as 12-step or self-help programs such as AA/NA or specialized relapse prevention therapy.
h) The A&D treatment component can be purchased from an outside entity with the credentials identified above and the appropriate A&D licenses.
i) The program will have a very intense in-home service component that provides support to the child and family in order to maintain and achieve permanency.

6. Qualified Residential Treatment Programs

Agencies will be expected to comply with Qualified Residential Treatment Program Requirements. Please refer to ***Section One (1)-Core Standards*** for specific information related to Qualified Residential Treatment Program Requirements.

7. Education of the Child/Youth

a) Youth will attend an in-house, non-public school that is approved by the Tennessee State Department of Education and recognized to educate students in custody by the DCS Education Division. Please refer to the General Group Care section of this manual for additional details.
b) Please refer to ***Section Thirteen(13)-Educational Standards*** for specific information related to the education of students in state custody.

8. Records Management

Please refer to the General Group Care section of this manual.

9. Discharge Criteria

Please refer to the General Group Care section of this manual.

SUPPORTED LIVING SERVICES

1. General Characteristics:

Supported Living community homes are designed for youth who present with periodic behavioral difficulties that cannot consistently be managed in their primary home or in a less intensive treatment setting. These programs are designed for child/youth in need of twenty-four (24) hour care and integrated planning to address behavioral, emotional, and family challenges. The supported living community home provide structure, therapeutic support, behavioral intervention for children and youth with moderate clinical and behavioral needs that can be met in the supported living home and through community and/or outpatient services.

Children/youth in this moderate level of group home care may require community counseling or therapy, medication, and medication management services, and/or educational advocacy and planning. Providers delivering this model provided comprehensive, integrated care coordination and treatment planning, and

ensure that all needed clinical, behavioral, and other services and supports are provided to youth and their families as identified in a child's permanency plan.
While the youth's behaviors may currently be beyond the capacities or capabilities of their own family, the program team works with the youth and their family network. An important element of the program is to help the family and/or permanency resource build skills and increase their capacity to care for the child/youth in their own home and community whenever possible.
Children/youth may have a history of school related issues but can attend public school with liaison and support services provided by the agency. They remain involved in community-based schools and participate in community-based recreational and vocational activities with appropriate supervision.

2. Admission/Clinical Criteria:

a) Youth eligible for this level of care must have an established diagnosis of Intellectual or Developmental Disability, Brain Injury, Autism Spectrum Disorder and/or significant medical fragility or be suspected of having such diagnosis and are undergoing assessment to make that determination.

b) Youth exhibit periodic episodes of challenging behavior(s) in the home, school or community that are consistent with their intellectual and/or developmental disability diagnosis as well as childhood trauma and loss. For example, children/youth may have a history of periodic, impulsive behaviors, aggression, and/or may experience reactive responses related to past trauma, including sexually reactive behaviors. They may have experienced occasional runaway episodes, have difficulty maintaining self-control, engage in property destruction, or display poor social skills and/or have difficulty accepting authority. They may require an increased number of medical visits and/or need increased assistance in activities of daily living (ADLs).

c) Youth may have a planned or an immediate need for short-term, intermittent stays or long term stays in the program as determined by DCS. They may have completed higher levels or intensity of care and been determined appropriate for community-based, group placement as work toward permanency continues.

3. Service Components & Expectations:

Supported Living Homes are trauma-informed programs. In addition to providing a child's basic living needs (food, clothing, shelter, and ensuring that educational and vocational and recreational needs are met), there is a therapeutic program that provides for the unique needs of the population served and promotes development, independence, improved life skills, and supports healing from trauma.

a) The model includes 24-hour comprehensive integrated programming and therapeutic services in a structured and supervised environment.

b) Immediately upon placement admission, the provider agency will begin to ensure complex care coordination of all services to the youth. Some of these services may be provided directly by the provider and some may have to be secured through formal arrangements with community service providers. Providers must ensure the provision of all required services received on-site and/or via community-based care, individual, family and group therapies, and other rehabilitation services that promote development, independence, and improved life skills as determined by their comprehensive, individualized service plan. Services focus on maintaining previously acquired behavioral self-help, socialization and adaptive skills that increase independence, productivity, enhance family functioning, and inclusion in community. Any barriers to obtaining these services will

continually be communicated and addressed collectively and through the TNCare Appeals process.

c) The provider agency shall ensure that each youth has the opportunity to be educated in the least restrictive educational environment consistent with the youth's treatment needs as determined by the multi-disciplinary team and comprehensive treatment/service plan. The provider agency is required to coordinate (in partnership with the DCS Education Specialist) school enrollment, including advocating for and ensuring educational testing and or plans are completed as necessary, and that accommodations and/or supports are in place to aid in the youth's educational progress. Each youth's treatment/service plan should include formal academic goals for remediation and continuing education. Please refer to the Education Standards section of this manual for specific information related to the education of students in state custody.

d) The agency must have structured group activities, life skills groups, skills building activities and /or educational groups on a daily basis. These activities will be appropriate to and adapted to, the needs, interests and ages of the youth served.

e) The agency must ensure that youth have at minimum, daily opportunities to participate in recreational activities, hobbies, arts, sports, music, etc. Such opportunities are provided both on-site and through community activities, organizations and events and will provide critical opportunities for normalcy.

f) To the extent that it is safe and appropriate, and in partnership with the Department, the provider agency and the foster family will provide mentorship/coaching to the birth family, relatives, and/or other key members of the child/youth's family network, documenting all efforts to involve the family. Through their engagement with and collaboration with the youth's birth family and other kin/family connections or permanency resources, the goal is to support the strengthening of the child's relationships and build and support the family's capacity to care for the child in their own home and community.

g) All necessary mental health treatment services will be coordinated by the agency. This includes, but is not limited to, individual, group, and family therapy, alcohol and drug treatment, ABA services, mental health/behavioral treatment, and medication management.

4. Individualized Treatment/Service Plan

All children and families will have an individualized Treatment/Service plan developed specifically for their needs and circumstances and recognizes their personal strengths, talents and interests. The service plan should be developed in partnership with and full involvement of the parents and family.

a) Within thirty (30) days of placement, a written Treatment/Service plan is developed by the provider agency with the Child and Family Team, using the Child and Family Team Meeting process incorporating a person-centered approach. This plan supports the permanency goal(s) of the DCS Permanency Plan and provides details specific to the agency's role in supporting the child and family in achieving permanency. The Treatment/Service plan, reviewed quarterly, includes child and family visitation as detailed in the child's Permanency Plan. (See Section One, Core Standards, Chapter III for complete information on Treatment/Service planning requirements.)

b) The agency engages in strength-based planning and incorporates strengths identified in the CANS into the service plan. Contract agency case managers address needs identified by the CANS in the Treatment/Service planning. Any CANS domain scored a "2 or "3" is considered in the Treatment/Service plan.

c) The Treatment/Service plan should outline how the planned site-based and community activities are expected to support the child/youth's socialization and adaptive skills development, support the improved management and reduction of their challenging behaviors and conditions, and the maximum independence possible for each young person.

5. Staffing Requirements:

a) The provider has trained personnel who can meet the developmental, therapeutic, and supervision needs of all children/youth accepted for services. All staff, whether agency or contracted staff, must be trained in the practice model of the agency and receive specialized training that addresses the unique service needs of the population served.

b) Supportive Living staff provides adequate care and supervision to assure that the child/youth is safe and that his/her needs are met in accordance with the youth's intellectual and developmental level, age, and emotional status. These expectations include, but are not limited to:

- The staff to child/youth ratio should be at a minimum of two (2) staff to every three (3) children/youth (2:3) during waking hours to provide services, assistance with daily living activities and supervision for the youth/child to maintain safety and health unless there are two (2) or less children placed in the home. When this occurs, one (1) awake staff must be present at all times, though additional on-call staff resources must be available should an urgent/emergent situation arise; higher staff/child ratios during periods of greater activity are recommended.
- There must be available additional or back up direct care staff for emergency situations or to meet special needs presented by the child in care.
- Appropriate staff to youth ratio requires close staff proximity to youth, ensuring easy access to the youth at all times and in all settings.
- During normal sleeping hours, the program provides no less than one (1) accessible awake direct-care staff persons on site in each supportive living arrangement home with additional on-call staff resources available to respond to any urgent/emergent situations.

c) The provider agency must have staff coverage available 24 hours a day, 7 days a week to respond to crises that may arise. For programs that serve children or youth with complex medical needs, the agency must have access to qualified nursing or medical staff if urgent medical crises arise.

d) The agency must have a clearly documented emergency response plan for youth in crisis that seeks to avoid the involvement of law enforcement or the use of emergency medical services when behavioral challenges arise.

6. Records Management

a) 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.
- Utilizing the resources the agency offers to prepare the family for reunification.

b) Document meeting with the child/youth's parent(s) at least one time per month. Goals for these meetings include:

- Evaluate safety and well-being, and permanency.
- Monitor and document service delivery.
- Assess and support the achievement of permanency and other treatment plan goals.
- Evaluate efforts to engage the youth's parents, when not present.

7. Discharge Criteria

Please refer to the Group Care section of this manual.

a) population served. The program will develop and maintain a manual that details the agency's plan for staff training in the model, maintaining model fidelity, and will define how staff will adhere to components of the manual.

b) The program may also provide additional services such as 12-step or self-help programs such as AA/NA or specialized relapse prevention therapy.

c) The A&D treatment component can be purchased from an outside entity with the credentials identified above and the appropriate A&D licenses.

d) The program will have a very intense in-home service component that provides support to the child and family in order to maintain and achieve permanency.

8. Qualified Residential Treatment Programs

Agencies will be expected to comply with Qualified Residential Treatment Program Requirements. Please refer to Section One (1)-Core Standards for specific information related to Qualified Residential Treatment Program Requirements.

9. Education of the Child/Youth

a) Youth will attend an in-house, non-public school that is approved by the Tennessee State Department of Education and recognized to educate students in custody by the DCS Education Division. Please refer to the General Group Care section of this manual for additional details.

b) Please refer to Section Thirteen(13)-Educational Standards for specific information related to

the education of students in state custody.

ENHANCED SUPPORTED LIVING SERVICES

Enhanced Supported Living Services differ from the base Supportive Living Services in that they support children with more extensive or persistent treatment needs. The Service Components & Expectations, Individualized Treatment/Service Plan requirements, Records Management requirements and Discharge Criteria are the same.

1. General Characteristics:

Enhanced supported Living community homes are designed for youth who present with persistent challenging behaviors that cannot safely and consistently be managed in their primary home or in a less intensive treatment setting. These programs are designed for child/youth in need of twenty-four (24) hour care and integrated planning to address behavioral, emotional, and family challenges. The supported living community home provides structure, therapeutic support, behavioral intervention for children and youth with moderate to high clinical and behavioral needs that can be met in the supported living home and through community and/or outpatient services but may need a higher staffing ratio or additional services than regular supported living.

Children/youth in this highest level of group home care require community counseling or therapy, medication, and medication management services, and/or educational advocacy and planning. Providers delivering this model provided comprehensive, integrated care coordination and treatment planning, and ensure that all needed clinical and behavioral services are provided to youth and their families as identified in a child's permanency plan.

While the youth's behaviors may currently be beyond the capacities or capabilities of their own family, the program team works with the youth and their family network. An important element of the program is to help the family and/or permanency resource build skills and increase their capacity to care for the child/youth in their own home and community whenever possible.

While the youth's behaviors may currently be beyond the capacities or capabilities of their family, the program team works with the youth and their family network. An important element of the program is to help the family and/or permanency resource build skills and increase their capacity to care for the child/youth in their own home and community whenever possible.

Children/youth may have a significant history of school related issues but can attend public school with liaison and support services provided by the agency. They remain involved in community-based schools and participate in community-based recreational and vocational activities with appropriate supervision.

2. Admission/Clinical Criteria:

a) Youth eligible for this level of care must have an established diagnosis of Intellectual or Developmental Disability, Brain Injury, Autism Spectrum Disorder and/or significant medical fragility or be suspected of having such diagnosis and are undergoing assessment to make that determination.

b) Youth eligible for Enhanced Supported Living present with significant difficult and challenging needs/behaviors in the home, school or community that are consistent with their intellectual and/or developmental disability diagnosis as well as childhood trauma and loss. Those eligible for this level exhibit frequent, intensive, challenging behavior(s) that impair functioning at home,

school or community. For example, they may frequently: exhibit impulsive behaviors, aggression and/or may experience significant reactive responses related to past trauma, including sexually reactive behaviors. They may have patterns of runaway episodes, have difficulty maintaining self-control, engage in property destruction, or display poor social skills and/or have difficulty accepting authority. They may require an increased number of medical visits and/or need increases assistance in activities of daily living.

c) Youth exhibit periodic episodes of challenging behavior(s) in the home, school or community that are consistent with their intellectual and/or developmental disability diagnosis as well as childhood trauma and loss. For example, children/youth may have a history of periodic, impulsive behaviors, aggression, and/or may experience reactive responses related to past trauma, including sexually reactive behaviors. They may have experienced occasional runaway episodes, have difficulty maintaining self-control, engage in property destruction, or display poor social skills and/or have difficulty accepting authority. They may require an increased number of medical visits and/or need increased assistance in activities of daily living (ADLs).

d) Youth may have a planned or an immediate need for short-term, intermittent stays or long term stays in the program as determined by DCS. They may have completed higher levels or intensity of care and been determined appropriate for community-based, group placement as work toward permanency continues.