



Department of  
**Children's Services**



# Contract Provider Manual

## Section Two (2) - Foster Care Services

Tennessee Department of Children's Services | Policy | September 2024



# Table of Contents

<b>Standard Foster Care Services.....</b>	<b>3</b>
General Characteristics .....	3
Admission/Clinical Criteria .....	3
Foster Parents.....	3
Individualized Treatment/Service Plan .....	4
Service Components and Overview.....	4
Education of the Child/Youth.....	7
Records Management.....	7
Discharge Criteria .....	8
<b>Therapeutic Foster Care Services.....</b>	<b>9</b>
General Characteristics.....	9
Admission/Clinical Criteria.....	9
Personnel and Foster Parents.....	9
Individual Treatment/Service Plan.....	11
Service Components and Overview.....	11
Education of the Child/Youth.....	11
Records Management.....	11
Discharge Criteria.....	12
<b>Exceptional Treatment Foster Care .....</b>	<b>12</b>
General Characteristics.....	12
Admission/Clinical Criteria.....	12
Service Components and Overview.....	13
Individual Treatment/Service Plan.....	14
Records Management.....	15
Discharge Criteria.....	15
<b>Exceptional Treatment Foster Care Plus.....</b>	<b>16</b>
General Characteristics.....	16
Admission/Clinical Criteria.....	16
<b>Specialized Treatment Foster Care Services.....</b>	<b>17</b>
General Characteristics.....	17
Admission/Clinical Criteria.....	17
Additional Requirements.....	18
Individual Treatment/Service Plan.....	20
Service Components and Overview.....	20
Education of the Child/Youth.....	20
Records Management.....	20
Discharge Criteria.....	21

# STANDARD FOSTER CARE SERVICES

## 1. General Characteristics

Standard Foster Care Services provide safe, nurturing care and guidance in private homes when children/youth are unable to receive the parental care they need in their own home. The child/youth is integrated fully into the community and provided opportunities for participation in community and extracurricular activities as well as development of talents, interests and hobbies. The placement will be in a home-like, least restrictive setting that meets the unique need of the child/youth with respect to their community/school district and placed with siblings, if possible. The foster parents receive standard foster parent training and are supervised and supported by agency staff, working together to meet the goal of permanency based on the best interest of the child. The families of children in foster care are offered support services to facilitate reunification whenever appropriate.

The child/youth's emotional and behavioral clinical needs are mild or short-lived and can be met through outpatient services.

## 2. Admission/Clinical Criteria

Children/youth appropriate for Standard Foster Care:

- a) Are unable to receive the parental care they need in their own home.
- b) Appear to be capable of participating in a family unit and able to participate in family and community activities without posing a serious danger to themselves or others.
- c) May be of any adjudication type and are not excluded from admission when their risk is low or they have successfully completed a treatment program.
- d) May have a history of mild mental health or behavioral concerns that require monitoring or observation to prevent an increase in severity. Youth may have current emotional or behavioral symptoms which are mild or transient in nature. These may manifest themselves in difficulty coping socially, occupationally, or in school functioning.
- e) Have a Child and Adolescent Needs and Strengths (CANS) recommending Level 1 intensity of services or have only one rating of 2 or 3 within the domain of child behavioral or emotional needs, such as psychosis, anxiety, or adjustment to trauma. Any ratings within the domain of risk behaviors are low (0 or 1).
- f) Youth in this level of care may experience episodes of behavior needs from time to time. The transient (approximately 2-3 months) need for more intensive or frequent therapeutic interventions may be appropriate and is not considered exclusionary or justification for an increase in level of care.

## 3. Foster Parents

- a) All new foster parents are required to complete Tennessee Knowledge Empowers You (TN KEY) training and core topics as described in DCS Policy. Training hours are documented in the current child welfare information system.

- b) Each foster parent will adhere to DCS Policy [16.9 Required Foster Parent In-Service Training](#) to remain in good standing. Completion of these trainings is documented in the Foster Home Maintenance Database and maintained in the agency foster home file.
- c) The agency provides foster parents with training to meet the needs of each child placed in the home. This includes individual or group training, ongoing in-services, and any required or requested specialized trainings needed to meet the needs of the youth.
- d) Provider agency staff is responsible for educating their foster parents about infant “safe sleep” practices and ensuring foster parents practice safe sleep with all children under the age of 1. Provider agency staff assess for safe sleep during home visits and ensure a safe sleep environment (defined as a crib, bassinette, or pack-n-play) is available, at the time of placement, for foster children under the age of 1. All safe sleep furniture must meet [federal safety standards](#). For more information, review [Protocol for Safe Sleep Education and Delivery of Safe Sleep Furniture](#).

#### **4. Individualized Treatment/Service Plan**

- a) Within thirty (30) days of placement, a written Treatment/Service plan is developed by the provider agency along with the Child and Family Team, using a Child and Family Team Meeting 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) 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 agency engages in strength-based planning and incorporates strengths identified in the CANS into the service plan.

#### **5. Service Components and Overview**

- a) Agency Responsibilities and Services
  - ◆ When placing a child/youth in a foster home, the agency will share all available pertinent information regarding the child/youth’s record with the foster family.
  - ◆ Prepare the child/youth for placement with a specific foster family to help with adjustment.
  - ◆ Provide case management and coordination of services, including support of the DCS Permanency Plan and participation in the Child and Family Team.
  - ◆ Assist in preparing the child/youth for return home or for placement in a stable, nurturing, permanent environment
  - ◆ Assist and support the child in receiving outpatient therapy, if indicated, up to twice

monthly.

- ◆ Assist and support the child in receiving medication management, if indicated. Medication management (psychopharmacological treatment) is accessed at least quarterly or more often as medically necessary.
- ◆ Coordinate health services, including arranging and accessing community based medically necessary health services through TennCare and private insurance.
- ◆ Provide educational liaison to interact with the child/youth's educational needs and individualized educational plan. The educational liaison may be the foster parent. Contact with the youth's school will occur as needed and be documented in the youth's record.
- ◆ Provide recreational activities, daily living skills and interdependent living skills. These activities are appropriate to, and adapted to, the needs, interests and ages of the service recipients and are community based (e.g. community center, clubs, churches, sports). More information about independent living may be found in the IL Core Services portion of this manual.
- ◆ Provide information to DCS about family activities and progress toward the goal of permanency.
- ◆ Provide services to help the child's permanency family maintain and enhance parental functioning, parental care, and parental ties unless the child/youth's safety would be compromised.
- ◆ Providers meet 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 service delivery
  - Assess and support the achievement of permanency and other treatment plan goals.
- ◆ Assess and support the achievement of permanency and other treatment plan goals
- ◆ DCS and active Contract Providers may agree to share foster homes for DCS youth. Specific agreements must be documented in writing and signed by the DCS and the Contract Provider. For specific details, please refer to DCS Policy [16.11 Shared Foster Homes](#)
- ◆ Provide board rates that meet or exceed the basic board rates outlined in DCS Policy [16.29, Foster Home Board Rates](#) and DCS Policy [16.8, Responsibilities of Approved Foster Homes](#), and [Protocol for Respite Care and Other Events](#).
- ◆ Providers adhere to DCS Policy [16.43 Supervised and Unsupervised Visitation between Child/Youth, Family and Siblings](#).
- ◆ Providers adhere to DCS Policy [16.38 Face-to-Face Visitation with Dependent and Neglected and Unruly Children in DCS Custody](#)
- ◆ Providers adhere to DCS Policy [16.4, Foster Home Selection and Approval](#)

## 2 – FOSTER CARE

- ◆ Providers adhere to Section G of DCS Policy [16.46: Child/Youth Referral and Placement](#) when determining how many youth to place in a foster home.
- b) Foster Family responsibilities and services
- ◆ Foster parents adhere to DCS Policy [16.8. Responsibilities of Approved Foster Homes](#),
  - ◆ Assume an integral role in providing care and services for children placed in their homes.
  - ◆ Provide safe, stable care in a nurturing environment to facilitate permanency as well as to promote development and growth.
  - ◆ Provide guidance, structure, protection, and offer participation/inclusion in as many positive experiences as possible.
  - ◆ Work constructively within the policy framework in developing plans and meeting the needs of the child and his/her family.
  - ◆ Provide information to the agency regarding the needs of a child in care.
  - ◆ Accept and use professional consultation including mental health and educational assistance.
  - ◆ Participate fully in therapeutic and medical services provided for the child/youth.
  - ◆ Participate fully in social and educational services (e.g., PTA meetings, parent-teacher conferences, etc.).
  - ◆ Provide opportunities for the child to participate in appropriate extra-curricular activities (sports, dance, band, Scouts, etc.) in order to enhance his/her strengths and address needs.
  - ◆ Provide developmentally appropriate activities and support designed to prepare the child/youth to lead self-sufficient adult lives, in accordance with their service plan.
  - ◆ Encourage maintenance of contact with the child/youth's family or "circle of support" and provide support in making such arrangements, unless specifically contraindicated because of the child's safety;
  - ◆ Assist in maintaining the relationship with siblings through visits (no less than monthly), and shared activities unless contraindicated because of the child's safety or contradictory to treatment plan or court order, if they are not placed in the same foster home (includes Juvenile Justice Youth in a YDC).
  - ◆ Provide routine transportation for the child/youth placed in their home (150 miles or less round-trip).
  - ◆ Maintain confidentiality regarding the child/youth and his or her birth parents;
  - ◆ Work in partnership with the agency and the Department of Children's Services to make key decisions related to the placement of children and termination of parental rights.
  - ◆ Assist in preparing the child/youth for return home or for placement in a stable, nurturing, permanent environment.

## 2 – FOSTER CARE

- ◆ Foster parents will be home at all times if a private duty nurse is serving the youth. The use of a TennCare nurse does not replace the need for a foster parent or other adult caregiver to be present in the home with the child. The Bureau of TennCare rules state “To the extent that private duty nursing services are provided to a person under 18 years of age, a responsible adult (other than the private duty nurse) must be present at all times in the home during provision of the private duty nursing services in order to assure the child’s non-health care needs are addressed. General childcare services and other non-hands-on assistance such as cleaning and meal preparation will not be provided by a private duty nurse.” (Paragraph 80-Private Duty Nursing Services of rule 1200-13-13-.01 of TennCare rules).

## **6. Education of the Child/Youth**

- a) Children/youth in standard foster care with emotional/behavioral health care needs typically attend public school.
- b) Please refer to the Educational Standards section of this manual for specific information related to the education of students in state custody.

## **7. Records Management**

- a) The agency foster home file will indicate the functional capacity of the home, which can be described as the maximum number of children the foster home is approved for within the home study and agreed upon by the foster parents and home study writer. Functional capacity is the actual number of children that the foster parent(s) can serve and is not necessarily the maximum number of children allowed in the home per DCS Policy [16.46. Child Youth Referral and Placement](#). Please note that the functional capacity cannot exceed the maximum number allowed.
- 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) at least one time per month. Goals for these meetings include:
  - ◆ Evaluate safety and well-being, and permanency;
  - ◆ Monitor and document service delivery; and
  - ◆ Assess and support the achievement of permanency and other treatment plan goals.
- d) 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 canceled, or caregivers do not show, those types of visits are also documented.

A narrative summary of all visits are included in the monthly summary.

- e) Providers are also required to enter other types of contact into TFACTS on a monthly basis. Those types of face-to-face contacts required to be entered include:

- ◆ **Face-to-Face Contact with Child or Youth** - This is used when a contract provider case manager makes actual, physical face-to-face contact with the child or youth.
- ◆ **Family/Sibling Visitation Face-to-Face Contact** - This is used when the child or youth visits with a sibling or other family member (such as a parent or other relative) and a contract provider case manager or other case management staff who meet the requirements for face-to-face are also present for the visit.
- ◆ **Family/Sibling Visitation NOT Face-to-Face Contact** - This is used when a child or youth visits with a sibling or other family member (such as a parent or other relative) and a contract provider case manager or other case management staff are NOT present for the visit. This may be used when DCS support staff or contract provider staff provides supervision.

Note (1): Each family/sibling visitation that occurs must be entered separately. For example, if a child has four (4) separate visits with a parent, there should be four (4) separate entries. This allows the provider to receive full credit for all of the parent/sibling visits. However, if a parent/child visit occurs and consists of multiple days in duration (such as over a weekend or collective days for a holiday); it only should be entered one (1) time and would only be considered one (1) visitation.

Note (2): Providers are not required to include a narrative along with the entry of face-to-face contacts. A narrative summary of all visits must be included in the Monthly Summary.

## **8. Discharge Criteria**

- a) The Child and Family Team reviews the permanency plan at scheduled intervals or when needed. The CFT determines when goals for permanency have been met and recommends discharge with input from all members of the child/youth's team.
- b) Discharge includes planning for the child's:
- ◆ Educational needs;
  - ◆ Additional support for stability for the child and family;
  - ◆ A plan for accessing community support;
  - ◆ An inventory of the child's personal items to ensure availability at time of discharge;
  - ◆ Emotional and behavioral needs (continuation or referral for services);
  - ◆ Accessing health insurance; and
  - ◆ Needs identified by CANS that still need to be addressed on trial home placement or exit from care.

# THERAPEUTIC FOSTER CARE SERVICES

## 1. General Characteristics

Therapeutic Foster Care Services provide safe, nurturing care and guidance in private homes when children/youth are unable to receive the parental care they need in their own home. The child/youth is integrated fully into the community and provided opportunities for participation in community and extracurricular activities as well as development of talents, interests and hobbies. The placement will be in a home-like, least restrictive setting that meets the unique need of the child/youth with respect to their community/school district and placed with siblings, if possible. The foster parents receive standard foster parent training and are supervised and supported by agency staff, working together to meet the goal of permanency based on the best interest of the child. The families of children in foster care are offered support services to facilitate reunification whenever appropriate.

The child/youth requires a higher level of clinical support, intervention and case coordination than those eligible for standard foster care. Their emotional/behavioral needs within the family are met through care by parents who have received standard foster parent training as well as specialized training to meet the higher therapeutic needs of the children/youth they serve. Moreover, the child/youth's emotional/behavioral clinical needs are moderate and can be met through community and/or outpatient services.

## 2. Admission/Clinical

Children/youth appropriate for Therapeutic Foster Care:

- a) Are unable to receive the parental care they need in their own home.
- b) Appear to be capable of participating in a family unit and able to participate in family and community activities without posing a serious danger to themselves or others.
- c) May be of any adjudication type and are not excluded from admission when their risk is low or they have successfully completed a treatment program. For information about youth adjudicated delinquent in foster care, refer to DCS Policy [16.46 Child/Youth Referral and Placement](#).
- d) May have a history of moderate mental health, and behavioral concerns that require monitoring or observation to prevent an increase in severity. Youth may have current emotional or behavioral symptoms which are moderate or transiently severe in nature. These may manifest themselves in difficulty coping socially, occupationally, or in school functioning.
- e) Have a Child and Adolescent Needs and Strengths (CANS) recommending Level 2 or Level 3 services. The child or youth scores a 2 or 3 within the domain of child behavioral or emotional needs, such as psychosis, anxiety, adjustment to trauma and an elevated rating on either life domain functioning or child risk behaviors.

## 3. Personnel and Foster Parents

- a) Foster Parent training

In addition to the Standard Foster Care pre-service training, all newly approved therapeutic foster parents are required to complete additional hours of specialized training targeted toward the population to be served (i.e. mental health, juvenile justice) prior to caring for the children/youth.

- ◆ Juvenile Justice

- 9 hours of Juvenile Justice Training

- TIPS (Trauma Informed Parenting Strategies)-Classroom Training

- Parenting the Justice Involved Youth –Online Training

- ◆ Mental Health

- Fifteen (15) hours of behavioral/mental health oriented training which addresses at a minimum the following topics:

- Policy and Procedures
    - Protocol / Professional Expectations for Foster Parent
    - What is behavioral/mental health foster parent care?
    - YOUR RIGHTS as a Foster parent
    - Confidentiality
    - Emergencies
    - Additional Services and assistance in home care
    - Education services for child that is behavioral/mental health
    - Engaging families and birth parents
    - Common Conditions of Children
    - Understanding Growth and Development
    - Trauma and its effects on the child/youth
    - Mental Health Support
    - Preparing for the child/youth to leave home
    - Self-Care for Caregivers

- ◆ Additionally, therapeutic foster parents will receive specialized training on the specific mental health or behavioral needs of each child/youth to be placed in their home

b) Agency staff training

Contract provider case managers will complete specialized pre-service training targeted toward the population they will serve.

- c) Foster parents providing continuum foster care services have the maturity to be able to care for children/youth needing this higher level of service. It is recommended that these foster parents be at least twenty-five (25) years of age. If the foster parent is not at least twenty-five (25) years of age, the agency can still approve the parent by documenting that the parent has shown the maturity to be able to perform these services. Documentation can take the form of letters of reference and interviews discussing this issue specifically. Currently approved parents not meeting this age limit will remain approved (grandfathered in).

## **2 – FOSTER CARE**

#### **4. Individualized Treatment/Service Plan**

- a) Within thirty (30) days of placement, a written Treatment/Service plan is developed by the provider agency along with the Child and Family Team, using a Child and Family Team Meeting 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) 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 agency engages in strength-based planning and incorporates strengths identified in the CANS into the service plan.
- d) When an agency directly provides therapeutic or counseling services to children in Therapeutic Foster Care, refer to standards for Clinical Service in this section.

#### **5. Service Components and Overview**

- a) Providers adhere to Agency Responsibilities and Services outlined in the Standard Foster Care portion of this chapter.
- b) Foster parents adhere to Agency Responsibilities and Services outlined in the Standard Foster Care portion of this chapter.

#### **6. Education of the Child/Youth**

- a) Children/youth in therapeutic foster care with emotional/behavioral health care needs typically attend public school.
- b) Please refer to the Educational Standards section of this manual for specific information related to the education of students in state custody.

#### **7. Records Management**

- a) The agency foster home file will indicate the functional capacity of the home, which can be described as the maximum number of children the foster home is approved for within the home study and agreed upon by the foster parents and home study writer. Functional capacity is the actual number of children that the foster parent(s) can serve and is not necessarily the maximum number of children allowed in the home per DCS Policy [16.46, Child Youth Referral and Placement](#). Please note that the functional capacity cannot exceed the maximum number allowed
- 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) at least one time per month.  
Goals for these meetings include:
- ◆ Evaluate safety and well-being, and permanency;
  - ◆ Monitor and document service delivery; and
  - ◆ Assess and support the achievement of permanency and other treatment plan goals.

## **8. Discharge Criteria**

Please refer to the Standard Foster Care portion of this chapter.

# **Exceptional Treatment Foster Care**

## **1. General Characteristics:**

Services provide safe, nurturing, trauma-informed care and guidance in private homes where the child/youth is integrated fully into the community and provided opportunities for participation in community and extracurricular activities as well as development of talents, interests, and hobbies. The placement will be in a home-like, least restrictive setting that meets the unique need of the child/youth with respect to their community/school district and supports placement with siblings, if possible. The child/youth's emotional/behavioral clinical needs are moderate and require clinical support, intervention, and case coordination, but their needs can be met through community and/or outpatient services.

The foster parents receive specialized training and are supported by agency staff, working together to meet the goal of permanency based on the best interest of the child. Their emotional/behavioral needs within the family are met through care by parents who have received specialized training to meet the higher therapeutic needs of the children/youth they serve. While the child's behaviors may currently be beyond the capacities or capabilities of their own family, an important focus of the program is to make all efforts necessary to maintain and strengthen family connections and to prepare family and/or kin for reunification whenever possible.

## **2. Admission/Clinical Criteria:**

- a) Children/youth 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) The child/youth's current living environment, family setting and extended community cannot currently provide the support and access to the services needed to regain or maintain stability or maximize daily functioning.

- c) Eligible youth may be experiencing occasional, low to moderate intensity episodes of difficult behavior in the home, school, and/or community that are consistent with their Intellectual/Developmental Disability or medical diagnosis. For example, the youth may be occasionally: exhibiting aggression towards family or providers and requires additional behavioral supports, engaging in property destruction, exhibiting reactive behaviors consistent with developmental trauma, or requiring an increased number of medical visits and/or need increased assistance in activities of daily living.

### **3. Service Components & Expectations:**

In addition to providing a child's basic living needs (food, clothing, shelter, and ensuring that educational and vocational and recreational needs are met), the special nature of this level of service and the population served requires additional qualifications from both the foster family and provider. The provider agency and foster family must have skills in advocating for and coordinating services and supports through medical, mental/behavioral health and educational systems.

- a) 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. The provider must ensure the coordination of all required community-based care, therapy and other rehabilitation as defined by the youth's individualized child and service plan. Services focus on generalizing and maintaining previously acquired behavioral self-help, socialization and adaptive skills that increase independence, productivity, enhance family functioning, and inclusion in community. These may include Intensive In-home clinical stabilization services as needed to include Functional Behavior Assessment, ABA, and other related interventions. When assessed as needed, qualified provider agency staff is deployed to the home to assist with adaptive skill training, assistance with ADLs and community integration. The provider agency will ensure efforts to secure community services are documented in the child's record. Any barriers to obtaining these services will continually be communicated and addressed collectively and through the TNCare Appeals process.
- b) 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 child and family team (to include the child's school and DCS Education Specialist) and comprehensive treatment/service plan. 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.
- c) The provider agency is required to coordinate (in partnership with the foster parents and DCS Education Specialist) school enrollment, including advocating for and ensuring all educational testing and or plans are completed as necessary, and that accommodations and/or supports are in place to aid in the child's educational progress.
- d) Foster parents in this model have specialized training and skills in providing and helping to

coordinate services to support and care for the children in their care. In addition to TN Key and therapeutic foster training, the family must commit to additional specialized training(s) specific for meeting the unique and individual needs of the child being placed.

- e) Foster families actively participate in the agency treatment team and child and family team meetings with the Department. They are an essential part of the service delivery model, actively implementing services outlined by the program treatment/planning team.
- f) Foster families are actively engaged in the child/youth's medical, mental/behavioral health and educational appointments, whether provided at home or outside of the home. They provide logistical support, transportation and coordination of activities, and keep a record of activities in accordance with the treatment/service plan and as agreed upon with the provider agency.
- g) 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.
- h) Providers adhere to Agency Responsibilities and Services outlined in the Standard Foster Care portion of this chapter in addition to any expectations outlined in this section.
- i) Foster parents adhere to Agency Responsibilities and Services outlined in the Standard Foster Care portion of this chapter in addition to any expectations outlined in this section.
- j) 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 service children or youth with complex medical needs, the agency must ensure that foster parents have access to qualified nursing or medical staff if urgent medical crises arise
- k) The agency must have a clearly documented emergency response plan for children and/or foster families in crisis that seeks to avoid the involvement of law enforcement or the use of emergency medical services when behavioral challenges arise.
- l) 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 that recognizes their personal strengths, talents, and interests.

## **2 – FOSTER CARE**

The treatment/ 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 Treatment/Service Plan should outline the weekly recreational activities, hobbies, arts, sports, music, community-based activities, and other normalcy activities to support the child/youth's socialization and adaptive skills development to support the improved management of their challenging behaviors and conditions and the maximum independence possible for each young person.
- c) 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.
- d) The agency engages in strength-based planning and incorporates strengths identified in the CANS into the service plan.

## **5. 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.

## **6. Discharge Criteria**

# Exceptional Treatment Foster Care Plus

Exceptional Treatment Foster Care Plus differ from the base Exceptional Treatment Foster Care 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:**

Services provide safe, nurturing, trauma-informed care and guidance in private homes where the child/youth is integrated fully into the community and provided opportunities for participation in community and extracurricular activities as well as development of talents, interests, and hobbies. The placement will be in a home-like, least restrictive setting that meets the unique need of the child/youth with respect to their community/school district and supports placement with siblings, if possible. The child/youth's emotional/behavioral clinical needs are moderate and are higher than those in base model and require more intensive clinical support, intervention, and case coordination, but their needs can be met through community and/or outpatient services.

The foster parents receive specialized training and are supported by agency staff, working together to meet the goal of permanency based on the best interest of the child. Their emotional/behavioral needs within the family are met through care by parents who have received specialized training to meet the higher therapeutic needs of the children/youth they serve. While the child's behaviors may currently be beyond the capacities or capabilities of their own family, an important focus of the program is to make all efforts necessary to maintain and strengthen family connections and to prepare family and/or kin for reunification whenever possible.

## **2. Admission/Clinical Criteria:**

- a) Children/youth 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) The child/youth's current living environment, family setting and extended community cannot currently provide the support and access to the services needed to regain or maintain stability or maximize daily functioning.
- c) Eligible youth may be experiencing persistent challenges and/or severe intensity episodes of difficult behavior in the home, school, and/or community that are consistent with their Intellectual/Developmental Disability or medical diagnosis. For example, the youth may be regularly exhibiting aggression towards family or providers and requires additional behavioral supports, engaging in property destruction, exhibiting reactive behaviors consistent with developmental trauma, or requiring a significant number of medical visits and/or need significant assistance in activities of daily living.
- d) Youth in the exceptional treatment foster care plus may require some type of consistent monitoring during awake hours and may occasionally require some type of monitoring

during sleep hours.

# **SPECIALIZED TREATMENT FOSTER CARE SERVICES**

## **1. General Characteristics**

Specialized Treatment Foster Care is an intensive, clinical, and evidence-based program model delivered in a private home setting for children/youth with highly specialized or complex treatment needs that would otherwise require placement in a congregate care setting. This level of care requires the commitment of at least one full-time caregiver in the home, working closely and under the direction of an active clinical team to deliver a highly structured, therapeutic environment that provides for the child/youth's needs for nurturance, stability, independence, safety and supports the safety of others. The foster parent(s) is an active member of the clinical team and responsible for implementing services outlined by the clinical team. To the extent their safety and the safety of others can be assured, children in this setting are integrated into the community and provided opportunities to participate in community, educational programming appropriate to meet their needs, and extracurricular activities as well as the development of their interests and hobbies.

Children/youth eligible for this level of care have specialized treatment needs such as autism, severe sexualized behaviors, and/or intensive mental health issues that requires periodic stabilization. Children/youth with a history of human trafficking may be appropriate for this level of care after assessment. This level of care may also be appropriate for children/youth who have not successfully stepped down from Level 4 Residential settings and psychiatric residential treatment facilities (PRTF), experienced multiple disrupted foster care placements and to avoid the placement of children under the age of 12 in restrictive residential treatment facilities.

## **1. Admission/Clinical Criteria:**

- a) Child/youth present with difficult and challenging needs/behaviors and require short-term or intermittent stays in a hospital setting.
- b) The child/youth has a significant mental health disorder (DSM-IV-TR or DSM-5) and is impaired in social, educational, familial and occupational functioning. This level of functioning is not due exclusively to intellectual or developmental disability or organic dysfunction. The youth needs psychiatric consultation as well as daily supportive guidance to achieve/maintain optimal stabilization.
- c) The child/youth's current living environment, family setting and extended community cannot provide the support and access to therapeutic services necessary to maintain stability or maximize effective daily functioning and/or the youth has not been successful in lower levels of treatment efforts (i.e., has failed to maintain or sustain adequately).

The child/youth cannot achieve successful adaptation for the purpose of stabilization, at this time, without significant structure and supportive guidance that can only be provided

## **2 – FOSTER CARE**

through consistent caregiving in a highly structured environment.

- d) The child/youth does not require medical substance abuse treatment (e.g. detoxification) as the primary treatment need.
- e) Child/youth may be of any adjudication type.
- f) Child/youth may pose a risk for elopement, present instability in behavior and mental health status or occasionally experience acute episodes. These youth also experience persistent maladjustment of peer and other social relationships or other influencing systems which interfere with learning and social environments.
- g) Children/youths with a primary diagnosis of intellectual disability are evaluated on a case-by-case basis for admission. Children with an IQ lower than 55 or who have adaptive functioning indicating moderate to severe intellectual disability may not be appropriate unless the agency is able to make appropriate adjustments to the regular programming as needed.

Children to be referred for this level of service require the consultation of internal DCS leadership and the express written approval of the Executive Director of Network Development/designee prior to the referral being made. Prior to the placement of a child in this setting, a detailed safety plan must be developed that both the provider agency and foster family commit to implementing.

## **2. Additional Requirements**

The specialized nature of this level of service and the population being served requires additional requirements/restrictions on the on the foster family and the agency supporting them.

- a) Treatment foster families actively participate in the agency treatment team and child and family team meetings with the Department.
- b) Treatment foster families are part of the service delivery model, actively implementing services outlined by the clinical team under their supervision.
- c) Treatment foster families will typically serve only one child at a time. A second placement may be considered on a case-by-case basis, with the approval of the DCS Executive Director of Network Development/designee.
- d) Treatment foster families with an active placement may not provide respite to another child(ren).
- e) The Treatment foster family must have an adequate support system, assessed during the home study process to support full time caregiving. Each home must have no less than one full-time adult caregiver in the home specifically designated for the care of the child/youth. Single parent homes are not appropriate for this treatment model except when the home study assessment confirms the commitment of a second adult committed to the full-time support of the caregiver. Foster families considered for this model must have no less than three years of experience providing services to children with therapeutic needs (level 2 or 3). In addition to TNKey training and therapeutic foster parent training, the family must commit to additional specialized training(s) specific for meeting the unique

### **2 – FOSTER CARE**

and individual needs of the child being placed.

- f) Treatment foster families provide transportation and are actively engaged in the child/youth's therapy session as directed by the treating provider.
- g) Treatment foster families must engage positively with the child's birth/other family including permanency resource(s).
- h) Treatment foster families commit to no less than 9 months of continuous care for each child/youth placed and are encouraged to utilize respite and take breaks in between placements.

In addition to the requirements/restrictions specific to the treatment foster family, the provider agency must ensure the following conditions are met:

- a) The agency must utilize a fully approved evidence-based treatment model. Preference is given to agencies that utilize multiple evidence-based interventions proven effective with the population served.
- b) The agency should have an established track record of service delivery to the population of children/youth accepted for placement under this level of service. In lieu of this requirement, the agency may provide the necessary specialization through formal arrangements with external consultants.
- c) All necessary mental health treatment services will be provided by the agency. This includes individual, group, and family therapy, alcohol and drug treatment, and mental health/behavioral treatment. Exceptions to this rule are granted for ABA services and medication management. The cost of these services is included in the per diem rate paid to the provider by DCS. Appropriate agreements with external providers will ensure that those providers will not also bill TennCare or any other insurance provider for the service as it is covered under the per diem.
- d) The treatment family is to be reimbursed at rate equal to or exceeding 39% of the per diem rate paid to the agency.
- e) The agency should initiate the delivery of clinical services on the day of placement, but no later than the day following placement.

Through the intensive delivery of services and interventions and structure, the provider is responsible for meeting the following outcome goals:

- a) Children/youth admitted achieve no less than 9 months of stability no less than 60% of the time.

- b) No less than 60% of youth admitted discharge to permanency or a less restrictive environment and successfully maintain in the less restrictive environment for at least six months following discharge.

### **3. Individualized Treatment/Service Plan**

- a) Within thirty (30) days of placement, a written Treatment/Service plan is developed by the provider agency along with the Child and Family Team, using a Child and Family Team Meeting 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) 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 agency engages in strength-based planning and incorporates strengths identified in 2 – FOSTER CARE 12 the CANS into the service plan.
- d) When an agency directly provides therapeutic or counseling services to children in Therapeutic Foster Care, refer to standards for Clinical Service in this section.

### **4. Service Components and Overview**

- a) Providers adhere to Agency Responsibilities and Services outlined in the Standard Foster Care portion of this chapter.
- b) Foster parents adhere to Agency Responsibilities and Services outlined in the Standard Foster Care portion of this chapter.

### **5. Education of the Child/Youth**

- a) Children/youth in therapeutic foster care with emotional/behavioral health care needs typically attend public school.
- b) Please refer to the Educational Standards section of this manual for specific information related to the education of students in state custody.

### **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; and
  - ◆ Assess and support the achievement of permanency and other treatment plan goals.

## **7. Discharge Criteria**

Please refer to the Standard Foster Care portion of this chapter.