

**DEPARTMENT OF SOCIAL & HEALTH SERVICES
CHILDREN'S ADMINISTRATION**

**BEHAVIORAL REHABILITATIVE SERVICES
HANDBOOK**

JULY 1, 2015

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1. BRS GENERAL GUIDELINES

1.1. What are Behavior Rehabilitation Services?

The Behavior Rehabilitation Services (BRS) is a temporary intensive wraparound support and treatment program for youth with extreme, high level service needs used to safely stabilize youth and assist in achieving a permanent plan or a less intensive service. These services can be provided in an array of settings and are intended to:

- Safely keep youth in their own homes with wraparound supports to the family
- Safely reunify or achieve alternative permanency more quickly
- Safely increase family based care by using a wraparound approach
- Safely reduce length of service by transitioning to a permanent resource or less intensive service

The desired outcomes for this service, is to increase the child's behavioral stability, increase school stability, increase placement stability and increase potential to reach permanency. A major focus is to develop necessary supports which would allow the child to maintain or develop a permanent family connection and to reside in his/her own community in an identified permanent resource.

A wide array of services can be provided under a BRS contract, ranging from Short-Term/Emergent Care to longer term On-going Services. On-going services are expected to last only as long as needed with a goal for the child to transition on or before 12 months. Services can be delivered in the child's legal guardian or permanent resource home, a treatment foster home, or facility.

The services outlined in this contract are designed to be all inclusive and the monthly service rates the only payment reimbursement. Any exceptions are outlined in the contract.

Any services provided by the Contractor which fall outside of this contract are not reimbursable unless those services are deemed necessary to the youth's treatment plan and agreed upon in advance and in writing by the assigned CA social worker and the Regional BRS manager

The provisions listed in sections 1-4 are required by all BRS contractors. Sections 5-11 are required depending on the type of service being provided, location of the service and licensed held by the contractor.

1.2. How are Behavior Rehabilitation Services (BRS) referrals made?

“Home region” refers to the DSHS region in which the Contractor's headquarters is located. The CA BRS Regional Manager in the Contractor's home region is the gatekeeper for placement of DSHS-paid children. The Contractor must receive approval from the Contractor's home region BRS Regional Manager before accepting referrals served under the BRS contract.

1.3 What actions shall be taken if there are additional concerns or presenting problems that were not stated in the CA referral?

If the Contractor determines that there are additional health and safety concerns, suspected substance abuse and/or other presenting problems, which were not stated in the CA referral to the Contractor, the Contractor shall immediately report this information to the CA Social Worker. The verbal notification shall be followed by written notification within 72 hours.

1.4 Are there any additional policies that must be followed when serving youth through the Developmental Disabilities Administration (DDA) Voluntary Placement Program?

The Contractor shall also follow DDA policies when serving DDA enrolled youth through the DDA Voluntary Placement Program. Policies can be accessed at: <https://www.dshs.wa.gov/dda/policies-and-rules/policy-and-rules>

1.5 What notifications are required?

Notifications: The Contractor shall notify CA described below when the following situations occur. Verbal notification and/or written notification sent by fax or secure e-mail shall be made within the time lines stated:

- a. **Immediate notification to CA.** Immediate notification to CA requires the Contractor to:
 - (1) During Business hours speak with a live person, the child's assigned social worker, a supervisor, or a local CA intake person. If outside of normal business hours (after 5pm, weekends, holidays) contact Central Intake (1-800-562-5624); AND
 - (2) Leave a voice message for the assigned social worker; AND
 - (3) Provide written documentation of inform of an incident report of concerns to the child's assigned CA social worker and Regional BRS manager within 24 hours from the of the incident.
- b. **Immediate notification is required in the following situations:**
 - (1) **Safety Concerns.** The Contractor must provide immediate notification to CA when they become aware of:
 - An allegation of child abuse or neglect toward the CA child;
 - Any safety concern regarding the parents during visitations which may place the child at risk for abuse and neglect;
 - A safety plan violation which may place the child at risk for abuse and neglect;
 - A new safety concern surfaces that may place the child at risk for abuse and neglect

(2) **Unusual Incidents.** The Contractor must provide immediate notification to CA when they become aware of an unusual incident which may impact the child's health, safety or wellbeing, the child's living situation or permanent plan. Examples of unusual incidents include, but are not limited to:

- Sexual assaults or sexual behaviors that are age inappropriate;
- Self-harm or suicidal ideation;
- Physical assaults of others;
- Severe behavioral incident(s) unlike the child's ordinary behavior;
- Running away;
- Any incident that necessitates serious medical attention or hospitalization;
- An unexpected serious adverse reaction to medication, food, etc.;
- A child's caregiver, or person incorporated into the child's safety plan, is injured or dies.
- Child Commits a probation or parole violation resulting in detention stay;
- Any high profile incidents or criminal behavior occurring in the community

c. **Notification within 24 hours is required in the following situations:** The Contractor shall notify the child's assigned CA social worker in writing by fax within 24 hours in the following situations, but not limited to:

- Child changes placement;
- Parent address changes;
- Child is suspended or kicked out of school;
- Child changes schools;
- Parent misses visits
- Non-emergent health concerns for the child;
- Child violates probation or parole not resulting in detention stay

1.6 What is considered to be an "incident"?

Incident shall be defined as per Licensing WAC 388-148-0120. All reporting Requirements regarding an incident shall follow WAC 388-148-0120. Licensing WAC can be viewed at <http://apps.leg.wa.gov/wac/>

1.7 What actions must be taken when an incident occurs?

The Contractor shall take actions as required by their License and outlined in WAC 388-145-1535 or WAC 388-147-1540 and notification requirements in section 1.5 of this handbook.

1.8 What actions should be taken if the youth or his or her family misses a scheduled appointment?

The Contractor shall:

- Document missed appointment in the client file.

- When specific appointments are specified in the ISTP and the youth or family misses the appointment, the contractor shall:
 - Immediately notify the CA/DDD Social Worker by phone of the missed appointment; and
 - Fax written notification to the CA/DDD Social Worker within one working day of missed appointment

1.9 What happens if the contractor wants to stop serving a child and family?

The contractor must make every effort to serve children within that the contractor's system. If a contractor wants to stop serving a child and family under their BRS contract, the contractor **must provide 30 days written notice to DSHS**, unless there is a written agreement between DSHS and the contractor that an immediate change must occur.

1.10 What steps must be taken when transitioning a youth from care?

The contractor shall convene a Child and Family Team Meeting to include the youth's social worker before transitioning a youth from the Contractor's program to their family or other placement or to independent living. County Mental Health or Region Support Network shall be invited to the meeting if a youth has screened in as eligible for WISE.

Youth shall be referred for a WISE screen before transitioning from BRS services, when implemented in the Contractors County. For more information go to;

<http://www.dshs.wa.gov/dbhr/cbh-wise.shtml>

A copy of the WISE screen or the results shall be a part of the discharge summary.

The Contractor shall review the youth's safety plan with individuals who have a role in monitoring the child's safety before the transition takes place. The Contractor shall complete a CFARS and Youth Transition Report, along with a discharge summary. The Youth Transition Report shall be mailed to the assigned social worker and the Regional BRS Manager no later than 30 days of the youth's discharge or transition from the program.

1.11 Are Contractors required to attend Child Protective Team (CPT) meetings, prognostic staffing's or other formal staffing's?

The Contractor shall participate in Child Protective Team (CPT) meetings, prognostic staffing's, fatality reviews, or any other formalized staffing's when requested by DSHS to attend specific meetings or staffing's. In the event that the Contractor is unable to attend a meeting or staffing, the Contractor shall provide a written report of information needed for the meetings or staffing.

1.12 Can client records be released to the Office of the Family and Children's Ombudsman?

Office of the Family and Children's Ombudsman.

The Office of the Family and Children's Ombudsman (OFCO) shall have the same right of access to clients as DSHS.

The Contractor shall release records relating to services provided to youth that are dependent under Chapter 13.34 RCW to the OFCO. The Contractor can release records for dependent youth under Chapter 13.34 without the consent of a dependent youth's parent or guardian or the youth if the youth is under the age of 13 years, unless law otherwise specifically prohibits such release.

The Contractor shall notify the CA headquarters BRS Program Manager when the OFCO makes a request

1.13 What services must be provided for Limited English Proficient clients?

- In accordance with DSHS policy, the Contractor shall provide Limited English Proficient (LEP) clients with certified or qualified interpreters and translated documents and shall provide deaf, deaf-blind, or hard of hearing clients with the services of a certified sign language interpreter. Interpreter and translation services shall be provided at no cost to the client. All interpreter and translation costs shall be the financial responsibility of the Contractor. These costs are included in the rate.
- Extraordinary costs, which create an undue hardship for the Contractor in providing interpretation and/or translation services to an individual client, may be reviewed and addressed for supplemental reimbursement by the Regional Administrator on a case by case basis.
- BRS is a service package that potentially includes room and board, informal services that happen in the course of daily living, and formal services as identified in the youth's service plan. All of these elements should support the youth's personal growth and development and contribute toward the remediation of the client's presenting problems. As such, youth with LEP must have a mechanism for communication in their native language during all waking hours, including meals and free time. This requirement may be met in a variety of ways: through the use of contracted interpreters; through the use of bi-lingual staff or volunteers who have been certified or qualified through a DSHS language fluency examination; or by the use of the ATT Language Line. Contractors must choose a mechanism appropriate to the situation.

1.14 How shall culturally, ethnically and religiously relevant services be provided under BRS?

- The Contractor shall provide accessible services to clients that are culturally relevant and respond to each client's cultural beliefs and values, ethnic norms, language needs, religion, and individual differences. Service providers are encouraged to employ a diverse workforce that reflects the diversity of their clientele and the community.
- In order to ensure that services are culturally relevant, the Contractor may need to obtain consultation from a consultant who is recognized by the community at, or prior to, the initial planning meeting.

1.15 What factors must be considered in delivering services to children?

- Services shall be provided in accordance with BRS Provider Qualifications (*see appendix*).
- The services must be individualized and respond to the identified needs of the client. Recommendations from DSHS generated evaluations or screenings shall be considered in the service plan.
- Family focused services shall be provided and the contractor shall encourage active involvement of the family team. Upon intake the Contractor shall focus on a discharge plan. This plan shall include the CA plan for permanency.
- The contractor shall ensure supervision of staff providing direct services.
- Services shall be accessible and culturally appropriate.

1.16 Will payment be paid when a youth is on the run, in detention or hospitalized?

- A. CA shall pay for temporary absences of children from BRS only in compliance with CA policy. In addition, the following conditions shall apply:
 1. CA shall not pay for absences of a child from BRS, unless there is an agreement in writing with the Contractor for the child to return to their placement within 15 days.
 2. When a child leaves a BRS placement, unless there is agreement in writing by CA and the Contractor to place the child back into their placement, the social worker shall only pay the actual days of care provided, not including the last day of placement. Acceptable absences, where the plan is to return the child to the foster home within 15 days, include:
 - a. Planned visitation;
 - b. Hospitalizations;
 - c. Attendance at summer camps and similar activities;
 - d. Respite placements;
 - e. Temporary placement while Treatment foster parent(s) is vacationing or receiving medical treatment;
 - f. Juvenile detention placement of youth; or
 - g. Runaways when the bed is being held for the return of the child.
 3. An exception to policy (ETP) may be submitted to the Regional Administrator to continue payment beyond 15 days of absence or when a planned absence is for a reason other than listed above, if continued payment is necessary to continue a plan of care which is in the child's best interests. Payment for absences with Regional Administrator or designee approval shall not exceed 30 days.

1.17 Can I limit or censor the mail or phone calls of children and youth I am serving?

- A. Children and youth served by your program shall have reasonable access to uncensored communication with parents, relatives, and other people important to the child. Communication restrictions must be based on a pending investigation or an identified

child safety issue and be addressed in a court order or service plan. Child safety issues must be addressed prior to allowing the child to participate in any communications with parents, relatives or people important to the child. Contractors shall discuss and collaborate with the social worker to determine whether there are individuals with whom contact is not allowed or there are any other circumstances that require monitoring of communications. The communication plan shall be provided by or developed with the social worker. Unless such circumstances dictate, children and youth shall be allowed uncensored mail, calls and electronic communications. Access to electronic communication is based on reasonable caregiver or social worker discretion and on electronic device availability.

1.18 What assessments are required?

➤ *Children's Functional Assessment Rating Scale (CFARS)*

The Contractor shall complete a CFARS on each youth at a minimum, but not limited to within 14 days of entry and within 30 days prior to exiting BRS. If youth is being served under interim care the Contractor shall complete a CFARS upon entry, but only complete a CFARS upon exit if youth is served for a period longer than 60 days. The Contractor shall, at a minimum, but not limited to, complete a CFARS on youth currently in BRS longer than 30 days, at the time of the youth's quarterly report, then within 30 days prior to exiting BRS. If the youth is discharging on or before the next quarterly report a CFARS is not required.

The Contractor is not required to complete a CFARS on youth being served under the Medically Fragile or Developmentally Disabled (3A, 3B, 3C) service levels.

- Wraparound Intensive Services (WISe) Screen and or Assessment. CA will refer youth to RSN for a WISe screen prior to entering BRS.
- When implemented within the Contractors County the Contractor shall:
 - Refer a youth for a WISe screen at least every six months. To help reduce workload and avoid a flood of referrals for screens all at the same time, you can use a staggered approach methodology by referring youth for a WISe screen at or around the time of their next quarterly report, and every six months thereafter, or every other quarterly report.
 - WISe screens at the time of a youth's discharge from BRS. A WISe screen is not required if a youth is transitioning from one BRS contractor to another or from one BRS program to another. If the youth is discharging from BRS services within 60 days of their last WISe screen another screen is not required.
 - Contact information for a WISe screen can be accessed at:

<https://www.dshs.wa.gov/bhsia/division-behavioral-health-and-recovery/wraparound-intensive-services-wise-implementation>

2. BRS PROGRAM SERVICES FOR YOUTH

2.1 Who convenes the Child/Family Team Meeting?

- The Contractor shall have the responsibility of convening and developing the framework for an individualized child/family team. The Contractor is responsible for facilitating the child/family team meetings unless otherwise instructed by the CA Social Worker. This team will form the basis for a network of community support for the client incorporating a wraparound approach. The youth and family shall have a role in identifying people who should be on the child and family team. The CA Social Worker shall be a member of the team. Other child/family team members should include:
 - Immediate family members
 - Extended family members
 - Foster parents
 - Concerned professionals
 - Concerned community members
 - Other natural supports
 - Other significant individuals identified by youth
 - Tribal members when appropriate.

- In the event a child/family team has already been developed, the contractor shall work cooperatively with the existing team. The contractor, CA Social Worker, and child/family team shall evaluate team membership and appropriate adjustments shall be made.

- Child and Family Team meetings shall be convened in collaboration with the CA Social Worker, no later than 30 days after entering services and 30 days prior to the child exiting services. These meetings shall coincide with the quarterly reports or every 90 days. These meetings should be designed to engage the child and family in order to maximize their respective involvement in the case plan and follow a wraparound approach. The child and family should have input in the development of the permanency plan. If the child is in Assessment or Interim care services there may only be time to convene one Child and Family Team meeting.

2.2 What is the role of the Child and Family Team?

An individualized care planning and management process to collaboratively develop an individualized plan, implement this plan, monitor the efficacy and work towards the problem-solving skills, coping skills, and self-efficacy of the child and family members. The child and family team composed of natural and system supports is a key component in developing the support network necessary for a youth to make a successful transition from resource intensive care to less intensive services. The Contractor shall ensure that the team is involved in the development of the ISTP and IBMP and involved with all major decisions pertaining to the client.

If youth is involved in Wraparound Intensive Service (WISe) through the RSN or county MH, the child and family team shall collaborate with the mental health wraparound support team essentially forming one child and family team.

2.3 What steps shall be completed upon a youth's admission?

- **HEALTH ASSESSMENT:** Ensure the youth is assessed to identify any emergent or chronic health needs that require immediate attention. The Health Assessment shall be completed within 24 hours of intake. The Health Assessment shall include, but not be limited to the following:
 - Identification chronic medical issues
 - Identification immediate health concerns
 - Identification follow-up action needed
 - Identification if an emergency or medical appointment visit is necessary immediately
 - Identification if the EPSDT needs to occur
 - Signature of the BRS staff completing the form, along with the time and date completed

- **PROGRAM ORIENTATION:** Provide an orientation within 8 hours of the youths admission to the program for the youth, which shall include but not be limited to:
 - Behavioral expectations
 - Method for contacting the CA/DDD Social Worker
 - Crisis Response Protocol for the youth and caregiver
 - CA and Contractor responsibilities to youth. The Contractor shall post, review and provide each youth *Your Rights Your Life* document, which explains CA and Contractor responsibilities to the youth. This form will be provided by CA to the Contractor and posted at;

<http://independence.wa.gov/?s=your+rights+your+life>

- **INDIVIDUAL BEHAVIOR MANAGEMENT PLAN (IBMP):** The Contractor shall develop a proactive IBMP with input from DSHS and from the youth within 24 hours of their start date in your BRS program. The IBMP must identify strategies and consequences to be used in managing behavior specific to youth's presenting problems. This plan shall take into account factors of all children residing in the same placement to ensure their safety and protection. Family members and/or Foster Parents shall be involved in the development of the plans and shall have copies of the plans. The IBMP plan shall be reviewed and updated 30 days after initial intake, then at least every 90 days as the needs, issues and/or behaviors of the child change. The IBMP may be part of the ISTP or separate document. The IBMP must be available for all BRS staff. In addition to specific behavioral goals, the IBMP shall include the following components:
 - ***Individualized Supervision Plan*** which addresses:
 - ✓ Supervision needs
 - ✓ Other youth with whom the youth will interact
 - ✓ Interactions with the community

- **Individualized Safety Plan** which addresses:
 - ✓ Safety issues for the youth
 - ✓ Factors that may contribute to escalated behavior for the youth
 - ✓ Preferred response strategies for preventing or defusing escalated behavior
 - ✓ Back-up plan for de-escalating behavior
 - ✓ Behavior management goals aimed at reduction of unsafe behaviors through skill building
 - ✓ Crisis response plan
- The Contractor shall obtain signatures from the youth's CA/DDD Social Worker, parent, and the youth if 13 years old or older. If the youth is placed in a foster home, the foster parent must also sign the IBMP.

If the CA/DDD social worker, parent or foster parent signature is unattainable, the Contractor shall document why the parent did not sign the IBMP.

- **INDIVIDUAL SERVICES AND TREATMENT PLAN (ISTP):** The Contractor shall develop an ISTP within 30 days of the youth's start date in the BRS program. The CA/DDD Social Worker, the Contractor's social service staff, the youth and the youth's family and/or the foster parents shall participate in the development of the ISTP. The ISTP must address all of the major needs and risk factors identified by DSHS and identify members of the child/family team. The contractor shall be responsible to ensure the needs stated in the ISTP are met. The ISTP must be readily available for all BRS staff. The ISTP shall be reviewed and updated every 90 days. The ISTP shall include the following components:
 - **Assessment:** An assessment of the youth and family's current level of functioning, strengths, treatment needs and support needs. The WISE screen should be included (if available).
 - **Permanency Plan:** A permanency plan for the child and an indication of how the current intervention strategies support the goals of the permanent plan. In addition to the primary plan, an alternate plan for permanency shall be included.
 - **Discharge Plan:** The discharge plan and estimated time frame for discharge. In collaboration and mutually agreed upon with CA the targeted discharge date and transition placement.
 - **Goals:** Goals that describe short-term benchmarks of success for the child and family. These benchmarks shall be used in determining when a child and family are ready for less intensive supports.
 - **Intervention Strategies:** A description of how identified strengths will be utilized to meet identified treatment and support needs.
 - **Strength Utilization:** A description of how identified strengths will help the child and family achieve the individualized goals.

- **Assignment of Responsibility:** A method for assigning lead responsibility and time frames for the completion of treatment and support system development tasks.
- **Child/Family Team:** A method for identifying child/family team members and their role in providing support to the child/family team.
- **Independent Living Service Plan (ILS)** for all youth who are age 16 or over. Please see Section 1.9 regarding ILS plans and services.
- **ISTP Signatures:** The Contractor shall obtain signatures on the ISTP from the following parties: the youth's DSHS social worker, parent, contractor's social service staff, the youth, if 13 years old or older, and the foster parents if the youth is in a foster home placement. If the parent's signature is unattainable, the Contractor shall document why the parent did not sign the ISTP.

2.4 What are the guidelines for Independent Living Skills (ILS)?

1. The Contractor shall assist youth age 15 years and older in out-of-home care with enrichment opportunities regarding independent living skills that they will need upon turning age 18. Such essential skills will help ensure the youth's ability to live independently. ILS for youth 15-17 should be provided by a contracted ILS provider.
2. The Contractor shall provide enrichment opportunities for youth ages 13 through 14 that primarily focuses on successful school achievement and the skills critical for negotiating early adolescence.
3. In coordination with the assigned CA Social Worker and where services are available, all ILS eligible youth shall be referred for services to a contracted ILS provider. The Contractor is not responsible for payment of ILS services by a contracted ILS provider. If no contracted ILS provider is available, the Contractor shall assist the youth in completing the following ILS assessment and plan:
 - a. Complete an assessment of the youth's current ILS skills using the Ansel Casey Life Skills Assessment. The ACLSA can be accessed at <http://www.caseylifeskills.org/>.
 - b. Ensure that the youth has a written ILS plan that defines services to be provided which will assist the youth to become self-sufficient in the following areas:
 - Education (*GED, or high school completion, post-secondary education etc.*)
 - Income maintenance (*budgeting, opening and maintaining a checking/savings accounts, comparative shopping, etc.*)
 - Housing (*"know-how" to securing adequate housing, i.e., rentals, shared housing, transitional living housing resources, etc.*)
 - Vocational goals (*obtaining marketable skills, job search skills, work place expectations, volunteer or employment experiences, etc.*)
 - Daily living skills (*cooking, chores, transportation, community resource access, etc.*)
 - Interpersonal skills (*communication, anger management, dating, parenting, etc.*)

- c. Assist with the completion or update of the ILS plan as follows:
 - (1) Determine if a plan has been developed for the youth. If the youth has a current plan, the Contractor shall review, assist with the update and revise the plan in collaboration with the youth and ensure the plan addresses the elements described above under item b of this section.
 - (2) If the youth does not have a plan, assist in developing a written plan in collaboration with the youth using the Ansel Casey Life Skills Assessment. The plan shall address the elements described above under item b of this section. The ACLSA can be accessed at <http://www.caseylifeskills.org/>.
- d. Submit the following reports to the youth's assigned CA/DDD Social Worker within 15 days of completion:
 - (1) Assessment of the youth's current ILS skills
 - (2) ILS Plan
- 4. The Contractor shall assist with the update of the ILS plan every 90 days and shall incorporate the plan into the ISTP.
- 5. The Contractor shall assist the youth in identifying, establishing and maintaining connections with significant adults. This can be accomplished by working with appropriate adults the youth already has a connection with or by assisting the youth to obtain a mentor.
- 6. If the youth is expected to exit the BRS program to independence, the Contractor shall work with the youth's child/family team to ensure the youth has:
 - ✓ Adequate housing
 - ✓ A means of financial support
 - ✓ Connections to adult supports
 - ✓ Connections to needed services

2.5 What services shall be provided for each youth?

- **BEHAVIORAL SERVICES:** Behavioral assessment and intervention as indicated in the IBMP, either as part of the contractor's service network or in conjunction with community resources. Options for intervention should include individual, family and group services.
- **COUNSELING AND THERAPY:** The contractor shall advise or give guidance to the family and child(ren) and provide services or activities intended to remedy or alleviates a disorder or undesirable condition. BRS youth are also eligible to be screened through the Regional Support Network (RSN) for Mental Health Services. The BRS contractor shall be responsible for activities specific to the child's behavior in the youths setting. These services shall focus on behavior rehabilitation directly related to the child's level of functioning. The provider shall be responsible to ensure the needs are met that are stated in the ISTP. Activities focused on long term family

reconciliation goals or resolution of issues underlying the behavioral problems, may be provided by the RSN or other private practitioners.

- **SUBSTANCE ABUSE SERVICES:** Substance abuse assessment, education, treatment and relapse prevention shall be provided where indicated either as part of the contractor's service network or in conjunction with community resources.
- **CASE MANAGEMENT SERVICES:** Oversight of the IBMP/ISTP; communication and coordination with community partners, family, foster family, DSHS staff, and other child/family team members. To assist the social worker in implementing the permanent plan for each youth.
- **EDUCATIONAL SERVICES:** Educational services shall be provided either by means of an on-ground self-contained education program or through the use of public schools. DSHS is not responsible for education costs, including a 1:1 school aid for a youth. When, or if the contractor needs support with the public school, the Contractor shall utilize educational advocate resources to ensure the youth is receiving all appropriate services. CA has the authority to provide BRS for youth from eighteen through twenty years of age to enable them to complete their high school, vocational school program or post-secondary education (RCW 74.13.031). The continuation of services for 18-20 year olds shall only occur if the following criteria are met;
 - Youth continues to attend high school or equivalent program or is enrolled in a post-secondary education program are eligible for extended foster care (policy 43105), agrees to stay in care and complies with all CA and Contractor placement requirements.
 - Youth continues to meet eligibility for BRS and need that level of care.
 - CA agrees to continue to pay for BRS.
 - The Contractor agrees to continue to provide BRS.
 - CA Regional RA or designee provides approval per CA policy 4533.
- **HEALTH CARE SERVICES:** To include emergency care, routine health care, health maintenance and disease prevention services such as: nutrition, hygiene, pregnancy prevention, preventing sexually transmitted infections, etc. The Contractor must comply with the provisions of RCW 13.34.060 *Authorization of Routine Medical and Dental Care* and Chapter 71.34 RCW *Mental Health Services for Minors*, for children prescribed psychotropic medication. Per Chapter 71.34 RCW and CA policy 4541, consent for the administration of psychotropic medication can only be given by;
 - The parent of the child or
 - CA social worker if child is legally free or with a court order authorizing administration or
 - The child is age 13 or older and competent to give consent on their own behalf.

If the child gives consent on their own behalf the Contractor must clearly document the consent and place the documentation in the child's records. The contractor shall also submit a copy of this documentation to the CA social worker.

- **REMEDICATION AND STABILIZATION:** Education and other services focused on skill acquisition, stabilization of behaviors and resolution of conflicts shall be offered. Options for intervention should include individual, family or group services and shall be provided either as part of the contractor’s service network or the contractor shall arrange for these services in the community. The cost of these services shall be the financial responsibility of the Contractor. These costs are included in the rate.
- **AGGRESSION /ANGER MANAGEMENT SKILLS:** FOR ALL YOUTH WHO EXHIBIT OR HAVE A HISTORY OF ASSAULTIVE OR AGGRESSIVE BEHAVIOR. THIS INTERVENTION SHOULD TEACH ADOLESCENT TO UNDERSTAND AND REPLACE AGGRESSION WITH POSITIVE ALTERNATIVES. **COMMUNITY SUPPORT DEVELOPMENT:** Efforts shall be made to identify and develop linkages to support the family and child to facilitate the child’s continued success in the community where the child will reside.
- **TRANSPORTATION:** Routine transportation for youth in care shall be the primary responsibility of the Contractor. Routine transportation shall include, but not be limited to transportation to: educational, recreational, medical and counseling and/or other therapeutic services, visitation and community support development appointments. The Contractor shall also assist with transportation upon transition into and out of their program, based upon the agreement with the CA Social Worker. The Contractor shall ensure the supervision and safety of the youth while providing transportation as outlined in RCW 46.61.687 Child passenger restraint requirements and WAC 388-148-0210 What requirements do I need to follow when I transport children.

At the discretion of DSHS, DSHS may pay for non-routine travel. The Contractor must obtain prior written approval for all non-routine travel from the CA Regional Administrator, or designee.

2.6 Are youth served under BRS required to have an EPSDT?

Youth served under BRS are eligible for health care screenings through Early Periodic Screening Diagnosis and Treatment (EPSDT) administered in Washington State as the “Healthy Kids” program. The Contractor shall arrange for an EPSDT screening for each youth within thirty (30) days of placement. If a youth has a current EPSDT exam upon placement, the Contractor shall facilitate the process for the youth to obtain an inter-periodic screening. The Contractor shall facilitate annual EPSDT health screenings thereafter. A licensed professional healthcare provider shall perform the screening. The Contractor shall follow through with obtaining or providing any recommended treatment or services. If the youth is being served outside the State of Washington, the provider will identify a similar service for the youth.

The Contractor shall submit the EPSDT results to the CA Social Worker within 15 days of receiving the EPSDT results from the healthcare provider.

2.7 What is a wraparound approach?

Wraparound is an intensive, holistic, individualized, team-based, method of engaging with individuals and families with complex needs so they can safely live in their homes

and communities. The wraparound process aims to achieve positive outcomes by providing a structured creative and individualized collaborative team planning approach.

The principles of wraparound are:

1. Family voice and choice

Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.

2. Team based

The wraparound team consists of individuals agreed upon by the family and committed to the family through informal, formal, and community support and service relationships.

3. Natural supports

The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.

4. Collaboration

Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.

5. Community based

The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life

6. Culturally competent

The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/ youth and family, and their community.

7. Individualized

To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services.

8. Strengths based

The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.

9. Unconditional

A wraparound team does not give up on, blame, or reject children, youth, and their families. When faced with challenges or setbacks, the team continues working towards meeting the needs of the youth and family and towards achieving the goals in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer necessary.

10. Outcome based

The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

A Resource Guide to Wraparound can be accessed at the National Wraparound Initiative at: <http://www.nwi.pdx.edu/NWI-book/index.shtml>

Or at; <http://www.wrapinfo.org/>

2.8 When a youth is missing from care and returns what services should be provided?

- Conduct a run debriefing interview. When the debriefing interview is completed send a copy to the CA social worker. A copy of the run debriefing form can be accessed at: <https://www.dshs.wa.gov/ca/contracted-providers/children-missing-care>
- Run prevention plan should be developed with the youth, caregivers and CA social worker. Based on information obtained in the debriefing interview, this plan should contain targeting interventions designed to reduce the likelihood the youth will run again. A copy of the run prevention plan can be accessed at: <https://www.dshs.wa.gov/ca/contracted-providers/children-missing-care>

3. BRS PROGRAM ADMINISTRATION

3.1 Who is responsible for assuring youth health and safety?

- In the delivery of services under this Contract, youths' health and safety shall always be the first concern of the Contractor.
- The Contractor shall be responsible to assure the health and safety of all clients served.
- The Contractor shall provide services which help alleviate immediate danger to the child and if working with the family provide services which aid parents alleviate potential future endangerment of their child.

3.2 Is mandated reporter training required?

The Contractor shall ensure employees view the Mandated Reporter Toolkit. within two (2) weeks of initial employment. After viewing the material in the toolkit, each employee shall sign and date a statement acknowledging his or her duty to report child maltreatment and the Contractor shall retain the signed statement in the employee's personnel file. This training toolkit is located at:

<https://www.dshs.wa.gov/ca/child-safety-and-protection/how-report-child-abuse-or-neglect>

3.3 What actions must be taken if child abuse is suspected?

- Contractors are mandated reporters under Chapter 26.44.030 RCW. The Contractor must immediately report all instances of suspected child abuse to (1) CA Intake and (2) the assigned CA Social Worker. All verbal notifications shall be followed by written notification within 72 hours.
- CA Intake shall make the determination of whether the referral constitutes an allegation of Child Abuse or Neglect that shall be accepted for investigation, a possible Health and Safety Deficiency, a licensing issue or a matter of "information only".

3.4 What are the job qualifications for Contractor staff?

- Contractors licensed as a Child Placing Agency providing treatment foster care under the BRS contract. Staff qualifications per Chapter WAC 388-147 Licensing Requirements shall be met.
 - Case Consultants shall meet all requirements listed in Chapter WAC 388-147 and shall be licensed or certified in WA State with DOH.
- Contractors with licensed facility based programs under the BRS contract shall meet all requirements listed in Chapter WAC 388-145.
 - Case Consultants shall meet all requirements listed in Chapter WAC 388-145 and shall be licensed or certified in WA State with DOH

- Contractors licensed in another State shall meet the staff qualifications listed in Chapter WAC 388-145 (facility based) and 388-147 (treatment foster care)
- Chapter WAC 388-145 and 388-147 can be accessed at:
 - <http://app.leg.wa.gov/WAC/default.aspx?cite=388-145>
 - <http://app.leg.wa.gov/WAC/default.aspx?cite=388-147>

3.5 What is the maximum caseload size per Case Consultant staff?

- The contractor must limit caseloads to 25 cases per Case Consultant staff.

3.6 What are the job responsibilities of a Case Manager

Case Managers staff shall have the primary responsibility of planning, developing and implementing services for youth. Case manager staff shall collaborate with DSHS in delivering services to each youth:

- Arranging for counseling as described in the ISTP.
- Coordinating mental health, drug/alcohol, medical or other treatment as described in the ISTP.
- Reviewing and participating in the development of the youth's Individual Education Plan (IEP) in coordination with the child/family team. Advocating with the local school district to ensure that the youth receives appropriate educational services.
- Coordinating and ensuring inclusion of the child/family team in planning and decision making processes.
- Providing on-going assessment of service and support needs of the client. Advocating for youth to be moved to a less intensive support structure as functioning improves.
- Ensuring that services provided are documented in the individual client file.

3.7 What is the maximum caseload size per case manager?

- The contractor must limit caseloads to an average of 10 BRS cases per 1 FTE case manager, with a maximum of 12 cases. Factors to be considered in determining whether caseload size should be smaller include but are not limited to:
 - size/density of geographic location
 - scope of case manager's job responsibilities
 - differences in the population being served
 - number of sibling groups.

- Should a contracting agency wish to have specific caseloads larger than 12, it must submit a plan of how the case manager will successfully manage the increased caseload.

3.8 Is BRS staff required to attend training?

All BRS staff that have unsupervised contact with clients providing supervision, recreation, or any other activity or **individuals who supervise these staff shall attend 30 hours of training annually** and it shall be documented in the staff's social service summary. **The contractor must also provide 30 hours of training annually to all BRS professional staff.** Topics offered must be based on the staff members needs for skill development, their interests, and the issues of the children they are serving. The training shall also be relevant to the staff's specific job duties. Prior to the Contractor accepting referrals for youth identified as sexually aggressive or physically assaultive/aggressive the Contractor shall ensure or provide any staff responsible for the supervision or care of these youth have completed specialized or specific training for sexually aggressive or physically assaultive/aggressive youth. CA does offer such trainings. These trainings can be taken in a classroom, online or the contractor can provide the training using a DVD offered upon request by CA. Information may be accessed at:

<http://allianceforchildwelfare.org/content/training-videos>

Working with Children Exhibiting Physically Aggressive Behaviors

Working with Children Exhibiting Sexual Behavioral Problems

3.9 Who must receive a criminal history background check before delivering BRS?

- This Section applies to employees, volunteers and subcontractors only. This section does not apply to licensed foster parents who are affiliated with the Contractor. Licensed foster parents are subject to the criminal history background provisions associated with obtaining and maintaining a current foster license.
- The Contractor shall initiate a criminal history background check through the Children's Administration pursuant to RCW 43.43.832 and 43.43.834, for all prospective employees, volunteers and subcontractors who may have unsupervised access to DSHS clients. Such persons shall not have unsupervised access to youth in care until a satisfactory background check is completed and documentation qualifying the individual for unsupervised access is returned to the Contractor.
- Background checks completed through Division of Licensed Resources (DLR) shall be acceptable under this requirement.
- In addition to a satisfactory background clearance through the Children's Administration, the Contractor shall obtain a fingerprint background check through the FBI for all prospective employees, volunteers, subcontractors and other persons who may have unsupervised access to DSHS clients if such persons have resided for less than three (3) years in the State of Washington. If the Contractor elects, pursuant to RCW 43.43.832 (7), to provisionally hire a person who has resided in

this state for less than three years pending the results of the required FBI background check, the Contractor shall not permit that person to have unsupervised access to children who are served under this contract or under any other contract with the Children's Administration until a satisfactory FBI background check is completed. If the FBI check disqualifies the applicant, RCW 43.43.832 requires DSHS to notify the Contractor that the provisional approval to hire is withdrawn and that the applicant may be terminated.

3.10 What measures must be taken to assure client confidentiality?

- The Contractor shall not disclose information on individuals directly or indirectly except in compliance with state RCW, WAC and federal law.
- The Contractor shall not use or disclose any information concerning any DSHS client for any purpose not directly connected with the administration of the Contractor's responsibilities under the Contract unless the Contractor obtains prior written consent from the client and provides prior notification to CA.
- If the client is a dependent child and is not of legal age to provide consent, the Contractor must obtain such prior written consent from the parent or legal guardian of the child or from the assigned CA/DDD social worker, if the child is in the custody of DSHS.
- The Contractor shall maintain information concerning individuals in strictest confidence and safeguard all information, electronic and hard copy.
- The Contractor shall assist foster parents to develop strategies, methods and mechanisms to safeguard confidential information in their homes. Confidential information includes, but is not limited to, ISSPs, health passports, school and mental health records. The Contractor shall follow guidelines in section F of the ISSP regarding the sharing of parent information with the child/youth caregiver.

3.11 What records shall be retained under BRS contracted services?

In addition to the records required under Minimum Licensing Requirements, the Contractor shall retain and make available the following records:

- **CLIENT RECORDS**
 - Current Legal Authorization (court order, VPA, etc.)
 - Approval for Placement, which includes documented agreement of the start date and BRS service level
 - Information regarding intake, assessment and referral
 - Case planning documents to include ISSP and ISTP
 - Quarterly Reports
 - Cultural relevancy, LEP and ILS plans, when appropriate
 - EPSDT assessment, or equivalent in other states
 - Medical care provided to youth
 - Professional consultation notes, to include who provided consultation

- Assessment of potential conflict of interest, if the youth is placed in a foster home setting
- Placement extensions from DSHS
- Incident Reports involving the youth
- Health Assessment
- Program Orientation
- IBMP
- ISTP
- ILS assessment and Plan
- Copies of Aftercare Service Plans

➤ **ADMINISTRATIVE RECORDS**

- ***Child Protective Services Log*** to include all alleged incidences of Child Abuse/Neglect.
- ***Monthly Census Report***
- ***Documentation*** of all audits, license review, or contract monitoring, and corrective actions required and action taken.
- ***Protected Groups Data Collection***

When collecting this data, the Contractor shall inform staff and clients that: (1) the furnishing of the information is entirely voluntary; (2) the refusal to furnish the data shall not have adverse effects.

- A list of all current staff by position that addresses date of birth, sex, and identified protected group status, including race, Vietnam Era Veteran, Disabled Veteran, and person of disability.
- A list of all clients served that addresses date of birth, sex, and race.

➤ **STAFF RECORDS**

- DSHS criminal history background check approval
- FBI criminal history background check if a Washington State resident for less than 3 years
- Statement acknowledging duty to report child maltreatment
- Academic history and credentials
- Employment and experience history
- Staff training log
- Consultation log

- **SUBCONTRACTOR RECORDS** (*if the Contractor receives written approval to subcontract*)
 - ***Subcontractor File*** containing the contracts or agreements between the Contractor and the subcontractors for services required by the contract. The file shall also document the qualifications, credentials and criminal history background check for each subcontractor and each person employed by same who have unsupervised access to youth served under the contract.

3.12 Can the Executive Director or CEO of the agency also be the primary therapist?

To prevent potential therapeutic abandonment the assigned therapist should not be the Executive director or CEO of the contracting agency.

4. BRS REQUIRED REPORTS

4.1 Census Reports

4.1.1 How often shall census reports be submitted?

The Contractor shall submit a monthly census report to the Contractor's home region BRS Regional Manager on or before the 5th of each month, which lists the census for the previous month. The monthly census report shall include the following information for all youth residing in each facility:

- Name (optional for private pay)
- Date of birth
- Admission date
- Service level
- Name of social worker contact, DSHS division, region
- Exit date and name of children that have discharged from your program within the last 3 months, and their destination.
- Whether the child is receiving ILS
- Current Location of youth's residence

4.2 Progress Reviews

4.2.1 How often shall cases be reviewed?

- The case shall be reviewed and a report generated at intervals within the specified number of days according to the service category.
 - Initial Reports within 30 days of intake
 - Assessment Services: 30 days
 - Interim Care Services: 60 days
 - On-Going Services: 90 days (Child and Family Team meetings)
- The contractor shall convene the child/family team to review the progress made toward short-term and the permanency goals identified in the ISTP. At a minimum, the following shall be reviewed:
 - Client's strengths and successes
 - Any barriers to movement and eventual discharge
 - Strategies to resolve any barriers
 - Type, frequency and quality of contact with family of origin and/or family resource
 - Primary and alternate permanency goals and progress in identifying and finding a permanent home
 - Service level to which the child is assigned in relation to ISTP accomplishments
 - Educational progress
 - Progress in achieving skills for independence for youth 16 years of age or older

- A determination on whether or not the youth can be served at a lower intensity and less costly level of service
- Any changes to the ISTP or the IBMP
- Wraparound Intensive services (WISe) screen and or evaluations. Along with other mental health information and progress.
- Review all updated reports from outside agencies

4.2.2 What elements must be included in a Progress Report?

The contractor shall prepare a written Progress Report for each youth with input from the child/family team. The Progress Report shall document progress made toward goals identified in the ISTP. The report shall include, at a minimum:

- Identified client's and family strengths and successes
- Any barriers or challenges that may prevent achievement of goals outlined in the ISTP
- Strategies to address barriers and challenges
- Type, frequency and quality of contact with family of origin and/or family resource
- Primary and alternate permanency goals and progress in identifying and finding a permanent home, including the targeted transition placement and exit date
- Educational progress
- Progress in achieving skills for independence for youth 16 years of age or older
- Any modifications to the ISTP
- Evaluation of service category assignment including why the service level has or has not changed
- Documentation of decision to continue services past 18th birthday and the youth is eligible for extended foster care.
- Any WISe screens/evaluations completed or the results and any WISe services provided through RSN along with other mental health issues.

4.2.3 Who should receive copies of the Progress Report?

The contractor shall distribute copies of the Progress Report to:

- CA/DDD Social Worker
- Parents and/or foster parents
- Others designated by DSHS

4.3 Transition Report

4.3.1 When is the Transition report to be done?

The Contractor shall complete a Youth Transition Report on all youth exiting BRS and send a copy of this report to the CA assigned Social Worker and Regional BRS manager. This report shall be mailed, faxed or E-mailed no later than 30 days after the youth's transition or discharge. (This report can be E-mailed as long as the youth's CA identification number is only used and not their name).

If the Contractor serves youth under the Medically Fragile service level the Transition Report is not required.

4.4 Annual Report

4.4.1 When is the Annual Report due?

The Contractor shall complete an Annual report and mail, Fax or E-mail this report to the CA Regional BRS manager and CA headquarters BRS manager no later than 30 days after the end of the state fiscal year which ends on June 30th. This report shall cover the time period starting July 1st and ending June 30th of the following year.

If the Contractor is only serving youth under the Medically Fragile service level the Contractor is only required to complete the average length of stay and transition placement sections of the annual report.

If the Contractor is only serving youth under the Developmentally Disabled (3A, 3B, 3C service levels, the Contractor is required to complete all sections of the annual report except the CFARS scores.

5. DEFINITIONS FOR SERVICE CATEGORIES

5.1 What are the behavior definitions of youth to be served by On-Going Services that are not considered to be medically Fragile?

BEHAVIOR DEFINITIONS

Frequency, intensity and duration of client behaviors are defined below. Behaviors that are considered a danger to the child, to others or to the community/tribe (*e.g., fire setting, sexual predation, and suicidal gestures*) must be weighted appropriately and separately in determining the overall risk of the child. These definitions serve as guidelines:

Extreme

- a) *Frequency:* behaviors occur several times per day.
- b) *Duration:* behaviors have historically occurred for more than 2 years.
- c) *Intensity:* individual incidents last over 30 minutes and/or present an extreme danger to self, others and /or property.

Severe

- a) *Frequency:* Behaviors occur daily.
- b) *Duration:* Behaviors have historically occurred for 1 - 2 years.
- c) *Intensity:* Individual incidents last from 15 - 30 minutes and/or present a danger to self, others and/or property.

Serious

- a) *Frequency:* Behaviors occur several times per week.
- b) *Duration:* Behaviors have historically occurred for 6 - 12 months.
- c) *Intensity:* Individual incidents last from 5 - 15 minutes and/or present a considerable risk to self, others and/or property.

Moderate

- a) *Frequency:* Behaviors occur one time a week or less.
- b) *Duration:* Behaviors have historically occurred 6 months or less.
- c) *Intensity:* Individual incidents last less than 5 minutes and/or present a risk to self, others and/or property.

5.2 What are the client definitions for the On-Going Service levels?

5.2.1 BEHAVIORALLY/EMOTIONALLY DISORDERED

It should be recognized that children/youth who are behaviorally/emotionally disordered may also have multiple behavioral problems or core disability characteristics in addition to severe family conflict or dysfunction. In this service level, services should address the elements of the child's behavior which necessitate this level of care. Services must be available to ameliorate, to the extent possible, barriers to the child's reunification with the family. These children often are professionally diagnosed with serious mental health disturbances, Fetal Alcohol Syndrome, Alcohol Related Neurological Disorder and/or developmental disabilities.

The range of behaviors includes, but is not limited to:

- Impulsive behavior
- Property destruction
- Hearing impaired/deaf
- Self-Abusive
- Inability to protect self
- Runaway
- Aggressive assaultive
- Unpredictability
- Sexual acting out
- Encopresis
- Vision Impaired/blind
- Attachment disorder
- Manic
- Obsessive/compulsive
- Social skill deficit
- Physically aggressive
- Enuresis
- Substance abuse
- Fire setting
- Depression
- Risk to community/tribe
- Verbal threats/abuse
- Stealing/theft
- Animal abuse/cruelty
- Eating disorders
- Suicidal
- Delusion
- Non-compliant
- Uncontrollable rage

CATEGORY 1-A EXTREME BEHAVIORS: These children have often been through several failed placement settings, are considered a danger to themselves or other children. These children may also have exited psychiatric treatment facilities and are in continued need of highly structured settings. These children/youth display a range of *extreme behaviors* and emotional difficulties and may include SAY youth who are resistant to treatment.

CATEGORY 1-B SEVERE BEHAVIORS: These children have often been through several failed placement settings, are at considerable risk to themselves or other children. These children/youth display a range of *severe behaviors* and emotional difficulties.

CATEGORY 1-C SERIOUS BEHAVIORS: These children present very challenging behaviors in a number of areas (*community, family, educational etc.*). Past efforts to intervene have not been successful. Family functioning may contribute to behavioral difficulties. Increased structure will be needed to ensure safety. These children/youth display a range of *serious behaviors* and emotional difficulties.

CATEGORY 1-D MODERATE BEHAVIORS: These children present challenging behaviors in a number of areas (*community, family, educational etc.*) Past efforts at intervention have had little success. Family functioning may contribute to behavioral difficulties. These children/youth display a range of *moderate behaviors* and emotional difficulties.

5.2.2 SEXUALLY AGGRESSIVE

It should be recognized that children who are sexually aggressive might also have additional behavioral problems, mental health disturbances or developmental disabilities. In this service level, the treatment should address sexually aggressive behavior as the primary behavioral indicator. Many of these children/youth will have experienced sexual abuse themselves. These children may have been criminally adjudicated for these acts and present a potential risk to the community/tribe where they live.

The range of behaviors includes, but is not limited to:

- Rape
- Incest
- Assaultive
- Inability to connect cause and effect
- Developmentally disabled
- Anti-social behavior
- Prostitution
- Violent sexual acts
- Public masturbation/exposure
- Unpredictability
- Attachment disorder
- Denial
- Adjudicated sexual crimes
- Coercion
- Peeping/voyeurism
- Resistant to treatment
- Mental health problems/diagnosis
- Deviant sexual preoccupation
- Fire setting
- Sexual offenses/non-adjudicated
- Seduction
- Physically aggressive
- Stealing
- Animal abuse/cruelty
- Enuresis/encopresis
- Chemically dependent

CATEGORY 2-A HIGH RISK SAY: These children have a history of and are at high risk to continue displaying a range of sexually aggressive behaviors toward peers and younger children. The level of supervision that is required for the *high-risk sexually aggressive* youth is approximately equal to the severe behaviorally disordered designation.

CATEGORY 2-B MODERATE RISK SAY: These children have a history of and are at moderate risk to continue displaying a range of sexually aggressive behaviors toward peers and younger children. The level of supervision that is required for the moderate risk sexually aggressive youth is approximately equal to the severe or serious behaviorally disordered designation.

5.2.3 DEVELOPMENTALLY DISABLED (DD)

It should be recognized that children who are developmentally disabled (*including Fetal Alcohol Syndrome and Alcohol Related Neurological Disorder*) may also have behavioral disabilities, serious physical health impairments and require partial or total personal care. At this service level, the service should address those behavioral disabilities, which pose barriers to the child's ability to remain in the family home or in a less restrictive setting. In addition to developing effective behavioral management strategies for the child, supports and/or training will be provided (*when possible*) which enable family reunification. The degrees of developmental disability that may affect a person are commonly described as: mild, borderline, moderate, severe and profound. The children described in this category may fit any of these. Children may rely on adaptive devices for mobility, communication and self-care.

These children often display a range of behaviors that may include:

- Kicking/hitting
- Stealing
- Non-compliance
- Expressive/receptive language problems
- Property destruction
- Echolalia
- Tourette's syndrome
- Uncontrollable rage
- Low self-protection skills
- Frequent tantrums
- Aggression
- Impulsiveness
- Obsessive/compulsive
- Sensory integration problems
- Speech/motor delays
- Physical disabilities
- Limitations in self-help skills (toileting, bathing, dressing hygiene, etc.)
- Victims of physical abuse/neglect
- Inability to connect cause and effect
- Lack of impulse control
- Lack of safety skills
- Communication disorders
- Obsessive speech patterns
- Verbally abusive
- Hearing impaired/deaf
- Unpredictability
- Sexual acting out
- Victim of sexual abuse
- Physically assaultive
- Non verbal
- Seizure disorder
- Non-compliant
- Vision impaired/blind
- Self-abusive (head banging, biting, hair pulling, mutilation, etc.)

CATEGORY 3-A EXTREMELY BEHAVIORALLY DISTURBED DD CHILDREN: dually diagnosed with mental health issues and impaired reasoning and intellectual functioning. These children may also have pervasive emotional and *extreme behavioral* disturbances resulting in a range of behaviors potentially injurious to self or others.

CATEGORY 3-B SERIOUSLY BEHAVIORALLY DISTURBED DD CHILDREN: dually diagnosed with developmental disability, mental health issues, and impaired reasoning and intellectual functioning who also have *serious* emotional and behavioral disturbances.

CATEGORY 3-C BEHAVIORALLY DISTURBED CHILDREN WITH AUTISM: who are professionally diagnosed with autism or pervasive developmental disorder and also display a range of serious behaviors and emotional difficulties.

6. SHORT-TERM/EMERGENT CARE

6.1 What are Short-Term/Emergent Care Services?

The Contractor shall have the ability to provide Short-Term/Emergent Care Services 24 hours a day, seven days a week. Youth entering these programs exhibit a range of behaviors which may include: assaultive/aggressive, self-injurious (*e.g., suicidal gesturing, physically reckless, self-mutilation, etc.*), substance abuse, sexually aggressive, property destruction, running away, defiance, fire setting, stealing, eating disorders, difficulty in understanding cause and effect relationships, and serious family conflict. Stabilization/ resolution of behaviors should be seen as the primary focus of service. Clients placed in short-term/emergent service programs shall be provided direct services, information on available community/tribal support, and training focused on maintaining family, cultural and community/tribal connections. Resources will be provided to the client to achieve family reunification whenever possible at this level of service. Close contact with parents, which involves the family in decision-making, should be maintained to the greatest extent possible.

Short-Term/Emergent Care Services may include:

- Assessment Services (Residential Assessment)
- Interim Care Services (Interim 1A, 1B, 1C, 1D)

6.2 What is the goal of Short-Term/Emergent Care Services?

The goal of these services is to provide a more thorough understanding of the individual, family and community factors which contribute to the identified difficulties of a youth and to stabilize or resolve behaviors which require intensive adult attention. Family inclusion in planning and decision making is critical to the success of treatment, referral and reunification efforts.

6.3 How are referrals made for Short-Term/Emergent Care Services?

The contractor is expected to accept all referrals made by CA authorized staff as outlined in regional protocol. CA staff positions with referral authority will vary by region; thus the contractor must consult regional protocol when determining CA authorization status.

6.4 What is the time requirement for beginning Short-Term/Emergent Care Services?

Contractors providing Short-Term/Emergent, Assessment and Interim Care must be able to begin services within four (4) hours of referral. Services shall be available 24 hours per day, 7 days per week.

6.5 How long may Short-Term/Emergent Care Services be provided?

The maximum length of Short-Term/Emergent Care Services is as follows:

- Assessment Services— maximum of 90 days
- Interim Care Services—maximum of 180 days

6.6 What are the first steps in providing Short-Term/Emergent Care Services?

- The Contractor shall convene the child/family team to develop a case plan:
 - within 5 days for youth receiving Assessment Services
 - within 15 days for Interim Care Services

6.7 What services shall be provided for each youth under Short-Term/Emergent Care Services?

The contractor shall provide specific services for each youth and their family to address treatment and support needs identified in the youth's ISTP.

6.8 What are the job responsibilities of the contractor's staff for Short-Term/Emergent Care Services?

The Contractors staff shall meet the requirements in Chapter WAC 388-145 and or 388-147 depending on the programs license. See section 3.5 for the hyperlinks to the WACs

7. LONGER TERM SERVICES

7.1 What is the goal of Longer Term Services?

The goal of these services is to stabilize the child's level of functioning and to assist the client in the acquisition of skills and the development of supports which will allow the child to maintain or develop a permanent family connection and to reside in his or her own community with less intensive service needs. Increase stability and transition into a permanent resource. Transition out of BRS should occur at or before 12 months.

7.2 What is the program description of Longer Term Services?

The following is a compilation of characteristic definitions of children to be served within Behavior Rehabilitation Services. A list of possible behaviors/conditions has been included for children requiring therapeutic services through BRS. The list of behaviors/conditions for each category is not intended to be inclusive or exclusive of those that may be encountered during service delivery. Providers will often serve children with combinations of developmental, behavioral and emotional problems and medical conditions at varying levels of intensity. The Contractor can provide services to children as long as it is safe and appropriate to do so within the program or home to which the child is placed. Serving these children shall be in compliance with all licensing WAC's and contract requirements.

Omission of specific medical, psychiatric or developmental/behavior disability diagnosis should not be taken to mean that the children to be served do not demonstrate these conditions. These categories are intended to help clarify for providers the population to be served and the range of behaviors that a provider should have the capacity to safely manage while providing effective care and treatment to individual or groups of children and their families. The assignment of children to categories will be made by DSHS based on the frequency, duration and intensity of behaviors as well as the strengths and resources of the family to support the child's success.

Services to establish and maintain the family's involvement with the child and his/her service plan must be provided. These services should increase the capacity of the family resource to ultimately care for the child within the community/tribe. These services will include educational and supportive interventions, as well as developing and teaching effective behavior management strategies for the child. Services should focus on resolving issues which directly impact client functioning and present barriers to the child's ability to remain in the family home. Involvement of the family as full partners in decision making should be maintained whenever possible.

In the absence of an identified permanent family resource for a child, the provider is expected to actively work with the CA/DDD Social Worker and the child to meet DSHS' goal of identifying, recruiting and finalizing a permanent placement for each child in accordance with the child's ISSP.

7.3 How long can a youth be served by Longer Term Services?

On-Going Services are limited to 12 months per youth unless approval is obtained by CA social worker from the CA Regional Administrator or designee to extend services per CA policy 4533.

7.4 What reviews, plans and reports are required for Longer Term Services that are in addition to the reports required in section 3.13?

- **AFTERCARE SUPPORT PLAN:** The contractor shall develop an aftercare plan in coordination with the child/family team prior to discharge. The plan shall identify community support linkages for the child and family. An aftercare support plan shall be implemented for all youth discharged to a less restrictive setting.
- **DISCHARGE SUMMARY:** The contractor shall submit a written discharge summary within 14 days following discharge to the CA/DDD Social Worker and the child/family team. The summary shall be in accordance with the requirements stated in this handbook.

7.5 Are Aftercare Services required for youth upon discharged from the program?

The Contractor shall provide up to 6 months of aftercare services upon documented request by the DSHS Social Worker, unless the child is moving into another BRS program.

The Contractor shall submit a detailed service plan and budget for each client who will receive aftercare services. All aftercare services must be approved in writing by DSHS prior to delivery of services.

The Contractor shall review the safety plan with the youth's CA/DDD Social Worker, parents, individuals who have regular contact with the child, treatment providers, and others who have a role in monitoring the youth's safety.

Wraparound approach as described in section 2.7 shall be used when providing Aftercare services.

8. IN-HOME SERVICES

Contractors who provide in-home services under a Behavior Rehabilitation Services contract shall adhere to the following expectations as well as all other BRS requirements, policies and procedures set forth in the contract and this handbook. Staff qualifications for in-home services depend on the license held by the program providing the in-home service. See section 3.5.

8.1 What are In-Home service expectations?

- Prior to providing in home services Contractor staff shall view the Introduction to Child Safety Framework, which can be found at the following address:

<https://www.dshs.wa.gov/ca/contracted-providers/information-contracted-providers>

- The Contractor staff shall access the Mandated Reporter Toolkit video online at the following address:

<https://www.dshs.wa.gov/ca/child-safety-and-protection/how-report-child-abuse-or-neglect>

- Wraparound approach as described in section 2.7 shall be used when providing in home services
- Safely keep youth in their own home using wrap around principles to support the family.
- In-home services may be the sole mode of providing services, or may be provided in conjunction with out-of-home placement. In-home services can be provided in the child's family home or in the home of the permanent resource family.
- The contractor shall support families using solution based techniques. Making them primary decision-makers for their children, including them as members of the service planning team and empowering them to identify the goals to be achieved through services.
- The contractor shall complete an in-home assessment of family strengths and needs within the first two (2) weeks of service to the family.
- If the CA assigned social worker has developed and provided a CA Safety Plan to the Contractor, the Contractor shall review the plan with the family to ensure the plan addresses any new safety issues identified by the contractor.
- The contractor's staff shall model the skills identified in the service plan and mentor family members as they master these skills.

- Services to families shall be individualized to meet the family's identified needs and shall be responsive to the family's culture and ethnicity.
- The contractor shall provide staff needed to support the service and or safety plan, to include but not be limited to: social service staff, case manager, clinical consultant, case aides, and 24 hour on-call staff who are familiar with the family and the issues.
- Consistent with service and or safety plan goals, the contractor must assist families in meeting their basic needs (like rent or utilities), both through use of existing community resources and by providing concrete support (short term or time limited rent, utilities) as needed. The contractor is responsible for any cost that may be charged by community resources or costs incurred in providing concrete supports. These costs are included in the rate.

8.2 How often shall respite care be provided for family or the child's family resource?

- Respite care shall be among the range of service options and intervention strategies available at this level of care. Respite may be offered either in the child's home (*allowing the child to stay and the caretaker to leave*) or in the community (*allowing the caretaker to stay and child to leave*). The decision to offer respite services shall be made in conjunction with the child/family team and shall be based on the assessed needs of the client.
- The contractor shall offer and be able to provide a minimum of 2 days per month of respite care, which may be accumulated to a maximum of 6 days per quarter, if consistent with the child's service plan. (*A day is defined as an 8-hour block of time, but may include additional hours of care, up to 24 hours, when respite includes an overnight stay.*)

8.3 What shall be the focus of in-home services?

In addition to the overall BRS goals for behavior stabilization and treatment of present issues, in-home services shall focus on the following:

- Safely keep youth in their own home using wraparound principles to support the family.
- Minimize the disruption caused by a residential move, or avoid a residential move, while providing a high level of services to the child and family.
- Ensure the safety of the child and family throughout planning and service delivery.
- Identify and build upon the individual strengths of each family member.
- Strengthen family members' connections to supports – both within the family and in the community – which will endure once DSHS services have ended.

- Teach family members the skills needed to manage the presenting issues.
- Assist family members in identifying and using community resources.
- Provide opportunities for all family members to experience success in dealing with the issues.
- Increase caregiver's protective capacity.
- Report any new safety concerns that are not described in the existing safety plan to the CA social worker immediately.
- Identify opportunities to improve the Safety Plan to the social worker during Case staffing.
- Take immediate action when present danger is thought to exist and to ensure child safety. Action may include contacting 911 or CPS Intake referral.

8.4 What support services shall be provided for caregivers that are in addition to the support services that are required in sections 1.15 and 2.5?

- The contractor shall offer family members the opportunity to participate in training that is relevant to the needs of their child.
- The contractor must visit the family's home at least weekly as part of the overall service plan. If the service plan calls for decreasing support in preparation for ending services, steps and timelines must be specifically identified in the ISTP.
- Wraparound approach as described in section 2.7 of this Handbook

9. TREATMENT FOSTER CARE (TFC)

Child Placing Agency contractors who provide treatment foster care homes under a Behavior Rehabilitation Services (BRS) contract shall adhere to the following expectations as well as all other BRS requirements, policies and procedures set forth in the contract and this handbook. Staff qualification requirements are described in section 3.5.

9.1 How many children can reside in a treatment foster home?

The contractor shall ensure:

- Treatment foster homes are limited to no more than 6 children, per the Minimum Licensing Requirements.
- Each treatment foster home must operate within the capacity stated in its license.
- Treatment foster homes have no more than 4 of their own minor children or non-TFC children, in the home; and
- No more than 3 TFC foster children are placed in a foster home at one time, unless a sibling group is to be placed together or there is a therapeutic basis for the placement of more than 3 children in the home. All placements in excess of three TFC children must have the approval of the CA Regional Administrator, or designee.
- Within the above parameters, foster families must have no more total children in the home than they can demonstrate the ability to manage successfully -- based on history, training, number of adults in the home, agency support, and physical space.

9.2 How often shall respite care be provided for treatment foster parents?

- Respite care shall be among the range of service options and intervention strategies available at this level of care. Respite may be offered either in the child's home (*allowing the child to stay and the caretaker to leave*) or in the community (*allowing the caretaker to stay and child to leave*). The determination to offer respite services shall be made in conjunction with the child/family team and shall be based on the assessed needs of the client.
- The contractor shall offer and be able to provide a minimum of 2 days per month respite care to foster parents serving children under the BRS contract. (*A day is defined as an 8-hour block of time, but may include additional hours of care, up to 24 hours, when respite includes an overnight stay.*). Respite may be accumulated up to 6 days per quarter, if consistent with the child's service plan.

Rewrite this section.

9.3 Are foster parents required to attend training?

Foster parents shall complete all DLR required foster parent trainings before placement of children in the home.

- The contractor shall develop, monitor, and annually assess training plans for treatment foster parents. **Foster parents must obtain 30 hours of training annually.** Topics offered maybe based on foster parents' needs for skill development, and the issues of the children they are serving. Prior to placing a sexually aggressive (SAY) or physically aggressive assaultive youth (PAA Y) with a foster parent (s) that foster parent (s) shall have specific training to address the safety and supervision of SAY or PAA Y youth. This training can be obtained through DLR in a classroom setting, online or by the Contractor using a DVD provided upon request by CA. Online trainings can be accessed at:

<http://allianceforchildwelfare.org/content/training-videos>

Working with Children Exhibiting Physically Aggressive Behaviors

Working with Children Exhibiting Sexual Behavioral Problems

- The contractor shall provide monthly meetings for informal support and training for foster parents.

9.4 How often shall foster parents skills and abilities be evaluated?

The contractor shall conduct annual evaluations of foster parents to assess their skill and ability to provide and support services for children in their care. If foster parent needs are identified, the contractor shall plan with the foster parents for amelioration; the contractor shall follow up with the foster parents at regular intervals, at least quarterly, and support them in improving their skills and abilities. A copy of the evaluation shall be kept in the foster parent file.

9.5 What support services shall be provided for foster parents?

- The contractor shall initiate and participate in weekly treatment/support meetings with the foster family. At least one meeting per month must happen in the foster home.
- The contractor shall provide the staff needed to support the service plan and the child's success in the foster home, which may include but not be limited to: case manager, clinical consultant, case aides and 24 hour on-call staff who are familiar with the case.
- Wraparound approach as described in section 2.7 of this Handbook

9.6 What are the expectations for Treatment Foster Homes that provide care under the contractor's BRS contract?

1. Foster parents shall serve as the primary service providers for the children placed in their homes, assuming direct responsibility for daily management of the child's emotional and/or behavioral problems.
2. Foster parents shall model appropriate problem-solving, communication, conflict resolution, and other social skills.
3. Foster parents shall act as members of the service team, participating in the development and implementation of the service plan.
4. Foster parents shall maintain adequate records and documentation of each child's activities and behavior to assist the agency and the department in planning for the child.
5. Foster parents shall maintain records of all medical appointments and services provided to the child, including all pertinent information regarding medications.
6. Foster parents shall maintain confidential information about each child in a secure manner so that it is not accessible to children or unauthorized adults.
7. At least one parent in each foster home must be available at all times to respond to the child's needs, unless other arrangements have been specifically made with the agency and DSHS has approved the arrangement.
8. Children in treatment foster care shall not be enrolled in child day care, unless enrollment is consistent with the child's therapeutic needs.
9. With the support of the contracting agency, foster parents shall enroll the child in school and participate in educational planning and school meetings, and shall advocate for the child in the school system.
10. Foster parents should complete all Pre-service and in service Training required and approved Licensing, before serving children under the BRS contract. Foster parents shall participate in at least 30 hours of training annually. This training should be relevant to the types of BRS youth placed in their home.
11. Foster parents shall participate in appropriate support activities offered by the contracting agency.
12. Foster parents shall work with whatever family resources are available for a child, to facilitate reunification, visitation, and/or permanency planning.
13. Foster parents shall provide transportation for the child, as needed, to school, appointments, activities, and other day-to-day appointments and/or activities.

9.7 What steps shall be completed upon a youth's admission that is in addition to section 2.3?

- **PROGRAM ORIENTATION:** Provide an orientation within 8 hours of the youth's placement in the TFC home for the youth, which shall include but not be limited to:
 - ✓ Physical layout of the home including emergency evacuation route
 - ✓ Control of contraband policy
 - ✓ Client visitation policy
 - ✓ Daily program and activities

9.8 What supervision resources are required?

The contractor shall have available the capacity to offer a variety of safety/supervision strategies as appropriate for a youth's assessed needs. These resources may include but are not limited to:

- ✓ Individual sleeping room
- ✓ Additional supervisory staff (including in-home aides)
- ✓ Respite care

9.9 What actions must be taken to avoid any conflict of interest in placing a child?

- The Contractor shall ensure that an assessment of potential conflict of interest occurs before the Contractor places any child in an out-of-home placement. The assessment shall include asking any adult living in the out-of-home placement whether a conflict of interest of the following nature exists. The Contractor must also require that all adults in the home report any conflict of interest that occurs after the child is placed by the following workday.
- A conflict of interest exists when:
 - An adult in the home conducts or has conducted an investigation, as a result of the adult's employment, of an allegation of abuse or neglect of the child; or
 - The child is or has been, or is likely to be a witness against an adult in the home in any pending legal action or claim against the state involving:
 - ✓ An allegation of abuse or neglect of the child or sibling of the child; or
 - ✓ A claim of damages for wrongful interference with the parent-child relationship between the child and his or her biological parent.
- For purposes of this provision, "investigation" means the exercise of professional judgment in the review of allegations of abuse or neglect by (a) law enforcement personnel; (b) persons employed by, or under contract with, the state; (c) persons

licensed to practice law and their employees; and (d) mental health professionals as defined in chapter 71.05 RCW.

- The Contractor shall not place or allow a child to remain in a specific out-of-home placement, when there is a conflict of interest on the part of any adult residing in the home, in which the child is to be or has been placed.

9.10 What actions must be taken to seek reimbursement for damages by a foster child?

- The Contractor shall ensure that the foster parent completes a foster Parent Reimbursement claim form (DSHS 18-400). Foster parents must complete this form to request reimbursement for property damages/losses and initial emergency medical treatment expenses incurred because of an act of their foster/respice care child. Electronic copy of this for can be accessed at;

<https://www.dshs.wa.gov/sites/default/files/SESA/publications/documents/22-090.pdf>

10. FACILITY BASED CARE

Contractors who provide facility based care (licensed as a group home or staff residential home) under a Behavior Rehabilitation Services contract shall adhere to the following expectations as well as all other BRS requirements, policies and procedures set forth in the contract and this handbook. This also includes wraparound approach when possible as described in section 2.7 of this Handbook. Staff qualifications for facility based care are described in section 3.5.

10.1 What steps shall be completed upon a youth's admission in addition to section 2.3?

- **PROGRAM ORIENTATION:** Provide an orientation within 8 hours of the youths admission to the program for the youth, which shall include but not be limited to:
 - Physical layout of the facility including emergency evacuation route
 - Control of contraband policy
 - Client visitation policy
 - Daily program and activities at the facility
 - Behavioral expectations
 - Method for contacting the DSHS social worker

10.2 What supervision resources are required?

The contractor shall have available the capacity to offer a variety of safety/supervision strategies as appropriate for a youth's assessed needs. These resources may include but are not limited to:

- Individual sleeping room
- Additional supervisory staff
- Respite care

10.3 What structured activities should be provided in facility-based programs?

Activities to increase skills, learning and confidence so youth obtain the maximum benefit from this level of care. Activities shall include but are not limited to:

- Aggression Replacement Training (Per section 2.5)
- Drug/alcohol education
- Health education
- Social skill training
- Work/vocational activities
- Physical recreation
- Other recreation

10.4 What are the minimum staff-to-child ratios, which must be maintained for facilities? This includes all licensed staff residential programs

The Contractor shall maintain, *at a minimum*, staff-to-child ratios in accordance with “Ratio of Caretaker Adults to Child” exhibit in the BRS contract.

- Health and safety of children *shall always* be the first concern of the Contractor. It is the Contractor’s duty and responsibility to provide adequate staff to ensure health and safety of children. The Contractor shall provide additional staff if the health and safety of children warrants such action.
- The Contractor shall provide awake staffing at all times per the staffing ratios outlined in the BRS contract exhibit.
- All facility programs shall have rotating staff scheduled to provide adequate supervision and program coverage 24 hours a day, 7 days a week.
- The Contractor staff shall be onsite to receive child(ren) returning from runs, school, (even if earlier than planned), hospital, detention, etc.

11. MEDICALLY FRAGILE SERVICES

11.1 What is the program description for Medically Fragile Services?

Medically Fragile Services are for children with medically intensive needs who require more individual and continuous care than is available from an intermittent visiting nurse. Services are to be supervised by a Registered Nurse (RN) and provided in a licensed foster home, group home, or a licensed facility for severely and multiply handicapped children.

Services to medically fragile children should include the family and extended family in the care and support of each child to the degree that is possible. Coordination with a wide range of disciplines and service providers is expected.

11.2 What is the goal of Medically Fragile Services?

The goal of Medically Fragile Services is to provide transitional services for children who require complex medical care for a condition of such severity and/or complexity that skilled nursing is required. Most children will be moved to a less intensive, more normalized living arrangement at the earliest opportunity permitted by the primary physician. In those instances where death is imminent, the goal shall be to provide comfort and care until death.

11.3 What are the client definitions for Medically Fragile Services?

Children birth through 17 years of age that require complex medical care for a condition of such severity and/or complexity that skilled nursing care is required. This includes children with medically intensive needs that require more individual and continuous care than is available from an intermittent visiting nurse. For the purpose of this contract Medically Fragile means those youth eligible for Medically Intensive Children's Program (MICP) If this definition differs from MICP definition the MICP definition shall be the one used by the provider as a guide for accepting referrals. If the contractor accepts referrals not referred by CA or which do not meet MICP eligibility, CA is not responsible for any gap in service dollar reimbursement.

Conditions include, but are not limited to:

- Mechanical Ventilation Tracheotomy
- Peritoneal Dialysis

Also includes medically fragile children who have care needs that are very labor intensive and such care must be supervised by a RN. Conditions include, but are not limited to:

- Brain tumor causing seizures
- Breathing assistance
- Nephritic syndrome
- Bone cancer
- Severe brain damage
- Tube feeding
- Sickle cell anemia
- Comatose/semi-comatose

- Kidney transplant
- Severe injury
- Life threatening medical/developmental conditions

11.4 What are the first steps in providing Medically Fragile Services for each youth?

- **MULTI-DISCIPLINARY PLAN:** A multi-disciplinary plan of care shall be developed as provided by law to meet the child's needs.

11.5 What services shall be provided for youth in care?

- The Contractor shall provide medical staff as necessary to meet the safety and medical needs of youth in care.
- The Contractor shall provide or arrange for the provision of an Individual Educational Plan (IEP) suited to the unique needs of each youth in care.

11.6 What staff qualifications are required for Medically Fragile Services?

In addition to the qualifications set forth in the BRS Contract, the Contractor shall adhere to the following:

- **ALL STAFF** shall have the necessary license/registration/certification as required by law and DSHS policy.
- **NURSING STAFF** shall be licensed as an Advanced Registered Nurse Practitioner, (ARNP), Registered Nurse (RN) or Licensed Practical Nurse (LPN).
- 50% of *direct childcare staff* shall have a bachelor degree, a nursing degree or have a combination of education and experience commensurate with these qualifications. Remaining direct care staff shall include registered home health aides, (*which includes some certified nursing assistants*).
- **SOCIAL SERVICE STAFF** shall have a master's degree in social work or closely allied field or a bachelor degree in social work or closely allied field with master's level supervision. Master level supervision shall be provided at a rate of 2 hours per week for bachelor level social service staff.
- **PROGRAM COORDINATOR** shall have a bachelor degree in social science or closely allied field with two years' experience and management in a group care program, medically intensive service program, or equivalent.
- **COUNSELORS** shall have a master's degree in social work or closely allied field and one year experience or a bachelor degree and two years' experience.

11.7 Can other sources of funds be utilized for nursing services?

- Nursing services may be funded by:
 - Medical Assistance Administration - Medicaid Private Duty Nursing (PDN) program for medically intensive nursing
 - Department of Developmental Disabilities Medically Intensive Children's Program (MICP), private insurance, military insurance or other family resources.

However, the Contractor must not bill DSHS for services rendered under this Contract when the Contractor is being paid by another funding source which would result in duplicate billing for the same service.

- When space is available, the Contractor shall not deny services or placement to a youth who has been referred by DSHS who meets the medically fragile service definition.

APPENDIX A DEFINITIONS

The words and phrases listed below, as used in this Contract, and the Behavior Rehabilitation Services Contractor's Handbook, shall each have the following definitions:

Abuse of Client: The injury, sexual abuse or exploitation, negligent treatment or maltreatment of a client by any person under circumstances which indicate that the client's health, welfare or safety is harmed thereby.

Authorized: Approved by DSHS Social Worker as evidenced by receipt of a Social Services Payment System (SSPS) notice or other written notice.

BRS: Behavior Rehabilitation Services

CA: The Children's Administration, which is an administration under DSHS.

Central Contract Services: The DSHS Office of Legal Affairs, Central Contract Services, or successor section or office.

Child and Family Team: A group of professionals and others providing services to the child and family, including family members and the DSHS Social Worker, who are convened regularly by the Contractor to evaluate progress, review the effectiveness of the service plan, and build on the strengths of family members.

Child Protective Team (CPT): A group of community professionals with varied expertise convened by DSHS to review DCFS cases at critical decision-making points to strengthen planning and provide expert consultation.

Child, Youth, and Client: Are used interchangeably throughout this contract and shall mean any unemancipated individual who is under the chronological age of 18 years. Youth enrolled in high school or high school completion programs are included in this definition until completion of high school or age 21, whichever occurs first.

COA: Council on Accreditation

Consultant: A person who is qualified by credential, background, or experience to assist in assessing, evaluating, counseling, or treating the client, and who provides technical, clinical, practical or other relevant assistance to the Contractor in the assessment evaluation, counseling, or treatment of a client.

Contract: The entire written agreement between DSHS and the Contractor, including any Exhibits, documents, and materials attached or incorporated by reference.

Contracting Officer: The Contracts Administrator, or successor, of Central Contract Services or successor section or office.

APPENDIX A DEFINITIONS

Contractor: The individual or entity performing services pursuant to the Contract and includes the Contractor's owners, members, officers, directors, partners, employees and/or agents unless otherwise stated in the Contract. For purposes of any permitted Subcontract, "Contractor" includes any Subcontractor and its owners, members, officers, directors, partners, employees and/or agents.

CPS: Child Protective Services

CWS: Child Welfare Services

DCFS: The Division of Children and Family Services, which is a division under CA.

DDD: The Division of Developmental Disabilities, which is a division within DSHS.

DLR: the Division of Licensed Resources, which is a division under CA.

DSHS or the department or the Department: the Department of Social and Health Services of the State of Washington and its employees and authorized agents.

DSHS or DCFS Social Worker: In providing services to Native American children, whenever the term DSHS or DCFS Social Worker is used, the term shall also mean the child's tribe and Tribal Social Worker.

EPSDT: Early Periodic Screening Diagnosis and Treatment, which is administered in Washington State as the Healthy Kids Program.

Family or Family Resource: The biological or adoptive parents, relatives, Tribe, or other on-going significant support people, or past, present and future foster parents who remain consistently involved in the treatment and support of a child.

FRS: Family Reconciliation Services

Handbook: The Behavior Rehabilitation Services Contractor Handbook

Home Region: The DSHS region in which the Contractor's headquarters is located.

IBMP: The Individual Behavior Management Plan

IEP: Individual Education Plan

Incident: a disruption in normal routine of the home as a result of a conflict between youth, youth and staff, or as a result of an external disturbance.

ISSP: The Individual Service and Safety Plan

ISTP: The BRS Individual Service and Treatment Plan

APPENDIX A DEFINITIONS

ILS: Independent Living Skills

LEP: Limited English Proficiency

LICWAC: Local Indian Child Welfare Advisory Committee

Personal Information: Information identifiable to any person, including but not limited to, information that relates to a person's name, health, finances, education, business, use or receipt of governmental services or other activities, addresses, telephone numbers, social security numbers, driver license numbers, other identifying numbers, and any financial identifiers.

RCW: Revised Code of Washington. All references in the Contract to RCW chapters or sections shall include any successor, amended, or replacement statute.

Regional Administrator: The Regional Administrator of the administration, DCFS or DDD that has primary responsibility for that client.

Regulation: Any federal, state, or local regulation, rule or ordinance.

Staffing's: Formal or informal meetings of two or more DCFS or professional staff, consultants, parents, or others to review, discuss, or make decisions concerning a client or case.

Subcontract: A separate contract between the Contractor and an individual or entity ("*Subcontractor*") to perform all or a portion of the duties and obligations that the Contractor is obligated to perform pursuant to the Contract.

TFC: Treatment Foster Care, also known as Therapeutic Foster Care.

WAC: The Washington Administrative Code. All references in the Contract to WAC chapters or sections shall include any successor, amended, or replacement regulation.

APPENDIX B
RATIO OF CARETAKER ADULTS TO CHILD

(To be provided during Regional Contract Negotiations)

APPENDIX C BEHAVIOR MANAGEMENT GUIDELINES

The contractor should follow CA Behavioral Management Guidelines which can be accessed, copied and or printed on the sites listed below.

<https://www.dshs.wa.gov/ca/contracted-providers/contracted-services>

SOLUTION BASED CASE WORK

<https://www.dshs.wa.gov/ca/advancing-child-welfare/solution-based-casework>

DEVELOPMENTAL DISABILITIES POLICIES

When serving a DDA youth not in the care and custody of CA and under the BRS contract the Contractor shall adhere to the following DDA policies.

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These policies can be reviewed or printed at DDA website:

<https://www.dshs.wa.gov/dda/policies-and-rules/policy-manual>

THE RESOURCE GUIDE TO WRAPAROUND

The Resource guide to Wraparound can be accessed at:

<http://nwi.pdx.edu/NWI-book/>

The National Wraparound Initiative website is at: <http://www.nwi.pdx.edu/> or <http://www.wrapinfo.org/>